NCI's - HealthCare Management Conference
May 3rd, 2004

PANEL DISCUSSION

1. Are "Physician Preference Items" Unnecessarily Overpriced?

Opinion (45 seconds)

- ❖ Struggled with this Question . . . . as it does not lead to an answer of understanding . . . . . somewhat like "are we paying too much for the quality of our care?

- ❖ Let's first reference what we mean by "Physician Preference Products" . . . . the issue in this category really appears to target Medical Devices . . . . or more specifically ***Implantable Medical Devices*** . . . . such as; reconstructive joints, stents, cardio defibrillators, spinal instrumentation and the like.

- ❖ This type of question drives the **price/volume business model** on products that don't fit a standard business process . . . . or CLINICAL versus BUSINESS ECONOMICS. Consider:

  When you discuss product pricing in this context . . . it always relates to costs . . . which is evaluated with revenue. This infers are we paying too much for the revenue we are receiving!! The real question here . . . are we financially rewarding those treatments which are truly contributing to our quality of care.

- ❖ I would purport this type of approach has contributed to the polarization on the respective positions of buyers and sellers and have lead to nothing but huge barriers, further segmenting the Health System.

Problem-Solving (45 seconds)

- ✓ **Throw away** current volume/price models in favor of a more collaborative approach that seeks value at the **local level**. The key here is at the local level, as I don't believe this can be provided at the national scene . . . . either by the buyer (GPO) or by the supplier (Company)

- ✓ The key to collaboration is developing a reciprocal platform where both parties practice better listening and are operating and committing within their realistic parameters. If necessary . . . seek third party assistance that can arbitrate the process, tearing down barriers and establishing simplified agreements.
  - o **Providers** – need to recognize supplier services and the economic value provided to the facility . . . with an understanding of its cost . . . . such as the instruments used for joint reconstruction procedures (with a cost of $20k-$50k per set) which as become a no charge service. Remember, these companies are not start-ups looking for VC to fund their R&D . . . rather they fund their development through existing product sales . . . example, Boston Scientific laid off 2,000 employees and closed 3 plants to amass the $250 million per year needed for Taxus development.
  - o **Suppliers** – needed to go back to basics . . . . consumed in the Qtrly Measurement of the investor world, suppliers have displaced their intuitive interest for their customer's financial viability, with the mounting pressures of growing margins.

- ✓ A Final Thought . . . . let's all agree on the enormous contribution IMD's have made to health care improvement and we must sustain the process for their development.

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2. Are IDN's truly integrated?

Opinion (45 seconds)

- ❖ An Integrated Health Network has been commonly referred to an organization that owns or contracts with healthcare facilities to deliver integrated health care services. These alignments serve to improve healthcare delivery and reduce costs within a defined geographic area. Further to their underlying strategies is the obvious need to reduce operational cost, increase service offerings and broaden geographic access within a geographically defined healthcare market. **Key to their business strategy is positioning their influence with the intent to market themselves as one unit to payers . . . .** *and I will leave this area to my colleague with United to determine how well they are doing.*

- ❖ Currently there are 593 identified IDN's matching the above definition, with 533 incorporating central purchasing. Additionally there are 522 with at least three different facility types, ie. Hospitals, physician practices and nursing home. These organizations represent 65% of the staffed beds and 75% of the total surgeries in the US . . . . . Verispan Report, *2003 Guide to Healthcare Segments.*

- ❖ From a supplier's perspective, reduced operational costs would be evident in the strength of the purchasing volume, with the integration value stemming from one entity speaking for the whole. This would obviously produce compliance and generate stellar savings, when compared to the individuals. From this vantage point and as with most general statements . . . . there is no one set answer that fits all, however generally speaking **I would say that IDN's are not doing very well on taking advantage of the synergy from their integration**. Example: while you clearly have power house IDN's like Kaiser and IHC (owned) that move market share with most contracts, they are also struggling with the IMD previously discussed and have moved to provide more supplier access.

Problem-Solving (45 seconds)

- ✓ I envision the 533 so-called central purchasing entities function similar to national account structures in corporations, with similar problems . . . . . organizational placement, strategic support, integration of assets have not included physician staff. The IDN commitment clearly needs to come from central strategy and organizational structure . . . .

  Example: when Jim Francis worked at BJC in St. Louis, he was the captain steering the materials function of those facilities . . . now he is at Mayo which is much more political and he appears to be engulf in internal selling

  an IDN requires structuring that shows commitment from the top level, not on a similar horizontal reporting line as the facilities.

- ✓ **IDN's have not found the bridge from (1) deliver (acute facility) to (2) delivery (physician)**

- ✓ From a 50,000 foot view, the IDN's need to be more consistent with their strategies
  - First they buy physician primary physician practice, then sell them back
  - They talk about collaboration with physician staff, however do not seem to listen or at least react to their needs, such as; assistance with liability support, which is not on the radar screen.

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3. Are GPO's a key ingredient to the supply chain?

Opinion (45 seconds)

- **Of course they are . . . . . .**
- The only reason this question would be asked is their customers . . . . the hospital . . . . is asking them **"what have you done for me lately"**. Obviously, once a benefit is provided . . . **it becomes a given and no longer recognized as value** . . . . . until it is removed.
- According to a 2003 Verispan Report . . . 97% of hospitals belong to at least one GPO and they saved those hospitals $33.7 billion as stated in an HIGPA Study. Another independent study by Arizona State University . . . . indicates hospitals would increase cost $353,147 w/o GPO's
  Therefore it would seem we have a more of a communications problem between the GPO's and their members.
- Clearly they have proven they have optimized lower costs by aggregating commodity products. This is an expertise that most or at least many of their members have already pared out of their personnel and productivity costs.
- The question then is not are they a key ingredient, but rather where is their value and how best to apply their competencies.

Problem-Solving (45 seconds)

- ✓ GPO's are not evolving fast enough to keep up with the market, need to embrace the fact they cannot serve all master . . . . . understand their core competencies. They can be more innovative in developing activities that bridge their varied members.
  Example – Consorta has develop their C-Contracting Approach for IDN members like Trinity & Ascension
- ✓ Need to niche their strategies
  Example: GPO core competency is developing and negotiating contracts, therefore apply more resources toward assisting those local efforts of their members
- ✓ If you really want to step out of the box . . . . what about coordinating service efforts at the national level which has regional influence, setting the stage for local relationships:
  Example
  - *Need for companies like GM to educate employees on HSA programs*
  - *Developing Captive-insurance programs to support physician liability*
- ✓ More leadership in B2B ecommerce activity

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4. Do all supply chain stakeholders have aligned incentives?

Opinion (45 seconds)

- First let's identify the stakeholders:
  - Care Providers – Hospitals
  - Care Delivers – physicians
  - Government
  - Third Party Insurers
  - Consumers
  - Suppliers

- Clearly there is no alignment . . . even payments from Medicare (Part A & B) come from separate pockets. Most programs initiated incentivize one component or the other, but I am not aware of anyone at this point that has come up with a common financial approach.

  Example: The Medicare Prescription Drug and Modernization Act passed in December 2003 provides movement to tax incentives to the consumer for them to pay for their own decisions . . . . who else is involve.

  Additionally the Hospital Quality Incentive Demonstration Project launched by CMS and Premier are providing financial incentives for hospitals to compete in the higher decile of measurements in Quality . . . . only between two components.

  Meanwhile, various legal restraints do not allow local programs to tie other components together

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Problem-Solving (45 seconds)

- ✓ Benchmark Development is certainly needed that involves all parties involved

  Example: Premier and CMS are supporting the Hospital Quality Incentive Demonstration Project, which is a good start, however only aligns two components

  Further: HSA's are probably a needed component to involve the consumer financially for their decisions on the type of care they want.

- ✓ Additionally we have to collaborate across all functions . . . . which means better recognition by each party of the other's issues

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