Surgery centers zero in on savings on supply costs

While the nation concentrates on the consumer implications of health care reform, ambulatory surgery centers (ASC) are examining its provisions for clues to the impact it will have on their operations and revenue.

One likely outcome is that the Patient Protection and Affordable Care Act (ACA) will transform their supply chains. Here’s why: While the law makes few actual references to medical-surgical supplies, it does call on the health care system to reduce costs to patients and insurers such as Medicare. Reduced reimbursement, shared savings programs such as accountable care organizations (ACO), and conversion to value-based purchasing are likely to narrow the gap between revenue and expense. This will make it essential for ASCs to continually improve efficiency and trim costs.

ACOs are networks of providers such as physicians and hospitals that will work together to manage care for their populations. The government has started the first round of the program. Medicare’s value-based purchasing program (VBP) for ASCs, still in the planning stages, would begin a shift from paying facilities for the volume of their services to linking payments to quality measures and outcomes. VBP for hospitals has already been introduced.

Skeleton crews
Generally, there are 2 ways to accomplish this: reduce labor costs or cut nonsalary expenses. For the former, there is little for ASCs to trim; nurses and administrative staff are already limited, often sharing responsibilities. As Richard Peters, senior director of surgical services at Provista, explains, “ASCs are very efficient in the way they operate. They have skeleton crews. They can’t reduce staff unless they reduce their case volume.” Provista, a group purchasing organization (GPO) in Irving, Texas, serves ASCs and other nonacute-care facilities. Earlier this year, it polled ASC members on how they were preparing for health care reform. More than 90% said they were trying to reduce supply costs.

It is not just the expected 1% decline in Medicare payments for 2013 that is driving the effort, Peters says.

As with many of the law’s provisions, the concept of ACOs is still being worked out, but Peters expects some realignment of incentives to take hold.

“If ACOs really catch on as a model, as surgery centers look to align themselves with ACOs, they will need to be attractive, streamlined, and profitable.”

Even if ACOs are not widely adopted, the law will continue to promote coordination of care. ASCs need to prepare without knowing exactly what the future will look like—hence the current focus on financial health, Peters says. “That’s what’s driving a lot of nervousness.”

Strategies for implants
Since the greatest expense, and therefore potential savings, are in the physician preference products such as implants, ASC managers are redoubling efforts to work with surgeons to standardize on suppliers. Case cost comparisons demonstrate the ways
volume can push down prices without sacrificing the quality of care.

ASCs are also revisiting private insurance contracts, Peters notes, to demand better terms.

“Some insurers are paying a set fee for each procedure, and if implants or parts become more expensive, the procedure will become unprofitable,” he says.

**Remove the middleman**

Group contracts have succeeded in reducing or minimizing increases in nearly every category of medical-surgical products, along with a wide range of other supplies and services. Surgical implants have been slow to follow that pattern, primarily because of relationships between manufacturers’ representatives and physicians that influence product choice more than cost comparisons.

The current situation, according to consultant John Sommer, is that physicians trust the reps not only to provide good products but also to train clinicians in their use and then be available in the operating room to answer questions that may arise during the procedure. This service comes at a high price, however, he says, because the cost of distributors, sales reps, and consigned instruments is buried in the price of the implant.

**A direct model**

Sommer is director of supply chain logistics and operations at OrthoDirectUSA, Fort Wayne, Indiana (www.orthodirectusa.com). The company trains physicians and OR staff to use the implants, parts, and instruments. He has also lined up manufacturers, mainly smaller companies, that are willing to sell at wholesale prices direct to providers who do agree to receive training from OrthoDirectUSA.

Sommer says many ASCs already follow this model: “ASCs are more self-reliant because reps don’t like spending a lot of time there because they don’t make a lot of money.”

For example, orthopedic ASCs tend to focus on shoulder implants and are familiar with the products and instruments. Therefore, he says, they should be paying 60% to 80% less than the typical $300 each for suture anchors by ordering direct from manufacturers and bypassing the rep.

Even with knees and hips, Sommer notes, patents are rapidly expiring, and newer models are enhancements rather than completely new products.

“Generics are coming,” he says.

**The tax question**

One of the few times the ACA refers to medical devices is when it imposes a 2.3% excise tax on devices beginning January 1, 2013. Manufacturer groups such as AdvaMed (www.advamed.org) continue to push for repeal of the tax, and opponents of the ACA have brought it to public attention.

The tax is unlikely to affect ASCs, however. The manufacturer is responsible for paying the tax at the time of sale. The tax does not apply to retail items such as hearing aids or contact lenses, designed for sale directly to a patient. It includes most implanted devices and equipment used in patient care. It does not apply to manufacturers with annual revenue of less than $5 million nor to sales outside the United States.

Manufacturers have warned that the tax will increase health care costs because they plan to pass it along to customers, but other observers say the effect would be negligible—$230 added to the price of a $10,000 device.

Some commenters say it will inhibit investment in new technology, but others
point out that the industry stands to gain potentially 30 million new customers, the number of additional Americans who will become insured under health care reform.

Amy Siegel, a marketing consultant for medical technology companies, concludes the tax should not interfere with the progress of technology. Writing in the online MedCity News, she advises innovative companies to “ignore the tax for now and keep developing products that make a difference.”

Joining the computer age
ASCs are well aware—and often wary—of the necessity of converting to electronic medical records to avoid payment reductions in the future (OR Manager, March 2011).

Many still believe, however, that electronic inventory management is beyond their means. That was once true, before the internet and electronic commerce were fully developed. Only large hospitals and integrated delivery networks could afford to install the equipment and customized software and pay for technical support from employees or vendors.

Now there are systems designed for independent ASCs with direct access through a personal computer. Provista has such a system for its ASC members.

“There’s no capital expense, and it’s affordable to a surgery center. You enter data to the system, and it links to the clinical and accounts payable systems.”

The expense of training and fees are easy to recover, he adds, because the system catches errors and captures charges that might otherwise be overlooked.

ASCs owned or affiliated with large hospitals generally have access to the hospital’s materials management information system (MMIS), while large ASC chains may be able to set up their own.

Leveraging volume
The 14 Denver-area ASCs managed by David Roy share in the financial and inventory systems of their parent company, hospital giant HCA, where Roy is vice president of ASC operations for HCA’s Continental Division. In addition, they pay supply prices based on national contracts managed by HealthTrust Purchasing Group (HPG).

HPG was founded by HCA but later became an independent GPO open to any health care organization. However, it has kept the HCA policy of requiring members to buy nearly all of their supplies from contracted vendors, when available. This commitment provides a negotiating point with vendors.

The Denver ASCs also have something most ASCs would envy: plenty of storage space. They can receive daily deliveries from a central warehouse, using an HPG preferred distributor (Cardinal Health, Dublin, Ohio).

Despite the convenience, not all make full use of the warehouse, according to Roy. He has begun an initiative to increase awareness and utilization among the 14 ASCs.

“Some centers purchase only 15% or 20% of their supplies there,” he says. “I want to raise that to 50% or 60% for all.” Another advantage of this distribution center is that buyers can order smaller quantities, by the box rather than case, but still get the benefit of contract pricing.

Multispecialty Flatirons Surgery Center in Louisville, Colorado, is one of 6 centers owned by United Surgical Partners. As a joint venture with Centura Health System in Denver, Flatirons participates in HPG contracts. But materials manager Cassandra Andersen has found local bargains as well. She asked suture vendors for additional discounts and contracted locally with a smaller company, Suture Express.
She is looking for savings from conversion to reusable supplies where practical, and reprocessing. Rather than use daily delivery, the center increased par levels in the 3 ORs and reduced deliveries to 2 per week. This reduced shipping costs, but Andersen went further and asked vendors to stop charging for shipping.

“About 80% are cooperating,” she notes.

Meanwhile, for orthopedic supplies, group contracts make all the difference.

“With HPG, we pay reduced prices for orthopedic supplies,” she says. “It’s made an incredible difference.”

Using all available means, Andersen is hoping to cut supply expense by 10% to 15% per month.

Choosing procedures

Could the ACA influence the procedure mix at ASCs? It is possible, and that would change the mix of supplies as well. Siegel notes that expanded coverage will raise the demand for procedures not normally associated with Medicare, such as ENT and gynecology.

The US Department of Labor (DOL), on its website, confirms that the law will respect insurance plans that waive copays for colorectal cancer preventive services if the patient uses an ASC: “Plans may use reasonable medical management techniques to steer patients towards a particular high-value setting such as an ambulatory care setting for providing preventive care services,” DOL says.

While the variety of provisions such as those make long-term strategic planning difficult for health care providers, there is no evidence that ACA will adversely affect the industry.

After the Supreme Court upheld the law in June 2012, hospital stock prices rose steeply, according to news reports. Insurance company stocks declined briefly, but they soon recovered.

HCA’s David Roy also expresses optimism for the industry, and advises ASCs to focus on the big picture.

“We’re just focused on delivering the best care we can provide to patients,” he says. “There are things you can control and things you can’t control. As long as surgery centers continue to provide the quality care we have been providing, we’re going to do just fine.”

—Paula DeJohn

References

Department of Labor. FAQs about the Affordable Care Act implementation. www.dol.gov/ebsa/faqs