HIRA Annual Conference 2011

Nashville, Tn.
June 23, 2011
Tod Jeffers
Objective: To better understand the increasingly complex healthcare supply chain.
The MAX by the numbers...

- 155,000 facilities....

Laboratory: 28,020
Clinic/Physicians-Primary Care: 18,308
Supplier: 17,442
SNF/long-term care (LTC) unit: 17,117
Home health (HHA): 13,817
Surgery center/ASC: 9,071
Assisted living center: 5,886
Hospital (Acute + Specialty Acute): 5,679
Imaging Location: 5,230
# The State of Healthcare Contracting - IDN’s

<table>
<thead>
<tr>
<th>System</th>
<th>Total IDNs</th>
<th>Shareholders of a GPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>System IV</td>
<td>140</td>
<td>88</td>
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<tr>
<td>System III</td>
<td>470</td>
<td>101</td>
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<tr>
<td>System II</td>
<td>685</td>
<td>60</td>
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<tr>
<td>System I</td>
<td>30</td>
<td>3</td>
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</table>
HIDA GPO Report

- Average # of GPOs per hospital is 2.4
- Average # of GPOs per IDN is 1.7
- Estimated GPO compliance is 55%-60%
Alternate Site Trends: Growth Drivers

- Aging Population
  - Skilled nursing facilities predicted to grow 5.1% annually
- Government reimbursement structure
  - Decreasing length of hospital stays
- Technology
  - Care Migration
## Overall Comparison of Major GPOs
### 2009 and 2010

<table>
<thead>
<tr>
<th>Rank by Volume</th>
<th>GPO</th>
<th>Contract Volume ($B)</th>
<th>Acute</th>
<th>Non-acute</th>
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<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2010 (est.)</td>
<td>2009</td>
<td>2010</td>
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<tr>
<td>1</td>
<td>Novation</td>
<td>$37.8</td>
<td>$39.0</td>
<td>1,600</td>
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<tr>
<td>2</td>
<td>Premier</td>
<td>$36.0</td>
<td>$39.0</td>
<td>2,400</td>
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<tr>
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<td>MedAssets**</td>
<td>$24.0</td>
<td>$25.0</td>
<td>2,595</td>
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<td>4</td>
<td>Healthtrust</td>
<td>$17.0</td>
<td>$18.0</td>
<td>1,339</td>
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<tr>
<td>5</td>
<td>Broadlane**</td>
<td>10.3^</td>
<td>$11.0</td>
<td>1,132</td>
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<tr>
<td>6</td>
<td>US Govt</td>
<td>$8.7</td>
<td>$9.4</td>
<td>212</td>
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<tr>
<td>7</td>
<td>Amerinet</td>
<td>$7.0</td>
<td>$7.5</td>
<td>2,092</td>
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<table>
<thead>
<tr>
<th>GPO</th>
<th>Acute</th>
<th>LTC</th>
<th>Alt Care</th>
<th>Physicians</th>
<th>Total Alt Care</th>
<th>Total Healthcare</th>
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</thead>
<tbody>
<tr>
<td>US Govt</td>
<td>212</td>
<td>226</td>
<td>1,137</td>
<td>133,500</td>
<td>134,863</td>
<td>135,075</td>
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<td>Premier</td>
<td>2,410</td>
<td>14,826</td>
<td>24,289</td>
<td>40,273</td>
<td>79,388</td>
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<td>Broadlane</td>
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<td>43,377</td>
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<td>MedAssets</td>
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<td>6,442</td>
<td>3,199</td>
<td>27,043</td>
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<td>39,883</td>
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<td>Amerinet</td>
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<td>31,600</td>
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<td>HealthTrust</td>
<td>1,695</td>
<td>274</td>
<td>1,390</td>
<td>4,752</td>
<td>6,416</td>
<td>8,111</td>
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</table>
Catholic Contracting Group

5 IDNs (200 hospitals, 2,600 Alt. Site)
- Bon Secours
- Catholic Healthcare West
- Catholic Healthcare Partners
- PeaceHealth
- SSM Healthcare

$16b in Net Patient Revenue
$3b in supply expense budgets
$40m in savings
80 contracts
What is a Regional Purchasing Coalition?

- Group of healthcare providers
- Voluntarily combining purchasing volume
- To access higher tier pricing
- Through their GPO or
- Directly with suppliers
- Aka
  - Supply Networks
  - Regional Collaboratives
  - Regional Groups
  - Aggregation Groups
  - Virtual IDNs

GPO Contract

- Lowest Tier
- 2nd Tier
- 3rd Tier
- 4th Tier
- Best Pricing
What is a Regional Purchasing Coalition?

• RPC members *almost always* in same GPO
  – Premier members band together to aggregate volume against an existing Premier contract
• Vary in size and institution type
  – Small independent hospitals
  – Large IDNs
• Membership through parent IDN
  – Physician practices
  – Ambulatory surgery centers
  – Long-Term Care Facilities
Regional Purchasing Coalitions

We have identified 128 RPCs that represent

- 820k Beds
- 29m Admissions
- 127m Outpatient visits

- Co-operative Services of Florida (LeeSar)
- Carolinas Shared Services
- Illinois Purchasing Collaborative
- Coastal Cooperative of New Jersey
Regional Purchasing Coalitions by State

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Types of Purchasing Coalitions

Three different ways of structuring

• Regional Purchasing Coalitions
  – VHA of Georgia (VHA)
• Independent Networks
  – Yankee Alliance
• Coalitions of Similar Interests
  – Catholic Contracting Group (Premier)

• All have common goals but differ in structure
## Alignment of RPCs with Beds and Discharges

<table>
<thead>
<tr>
<th>Rank by Discharges</th>
<th>Primary Alignment</th>
<th>Minimum # of RPCs</th>
<th>Est. Beds</th>
<th>Est. Discharges</th>
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<tbody>
<tr>
<td>1</td>
<td>Novation</td>
<td>26</td>
<td>268,568</td>
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<td>15</td>
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<td>7,379,547</td>
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<td>Premier</td>
<td>34</td>
<td>147,405</td>
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<tr>
<td>4</td>
<td>Nonaligned</td>
<td>8</td>
<td>35,662</td>
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<td>Amerinet</td>
<td>12</td>
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<td>MHA</td>
<td>2</td>
<td>24,236</td>
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<td>7</td>
<td>Govt</td>
<td>19</td>
<td>7,290</td>
<td>861,618</td>
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<td>8</td>
<td>HealthTrust</td>
<td>11</td>
<td>11,759</td>
<td>540,650</td>
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<tr>
<td>9</td>
<td>Broadlane</td>
<td>1</td>
<td>448</td>
<td>18,948</td>
</tr>
</tbody>
</table>
RPCs by the numbers

We surveyed 226 Hospital/IDN Supply chain executives

- 40% were not part of an RPC
- Less than 25% of their purchases are currently through RPC Contracts
- Very high level of satisfaction for their RPC
Medtronic decision

The Journal of Healthcare Contracting

Time will tell if other PPI manufacturers follow Medtronic’s lead, or if they seize the opportunity to show GPOs the love.
Health Care Reform formalizes the Accountable Care Organization (ACO) model

- Beginning **1/1/2012**, hospitals, in cooperation with physicians, may provide leadership in voluntary ACOs, which would be responsible for managing the care of certain beneficiaries, and allows the HHS Secretary to share some of the savings from improved care management with providers.

- Beginning **in 2013**, the HHS Secretary must establish a national, voluntary, five-year pilot program on bundling payments to providers around 10 conditions. If successful, the Secretary may expand the pilots after 2015.

- Certain elements of ACOs may directly conflict with antitrust, physician self-referral, anti-kickback, and civil monetary penalty laws. On October 5th, the FTC conducted a workshop to address and solicit public comments on the legal issues raised by various ACO models being considered by health care providers.
Health reform may require a different strategic posture and thus require a different approach to operational competencies

- The triple aim focuses on cost, quality and patient experience must be a key element in the evaluation of ACOs.
- 5 guiding principles have been framed to guide the development of qualifying and monitoring criteria:
  - ACOs have a strong foundation of primary care
  - ACOs report reliable measures to support quality improvement and eliminate waste and inefficiencies to reduce cost
  - ACOs are committed to improving quality, improving patient experience and reducing per capita costs
  - ACOs work cooperatively towards these goals with stakeholders in a community
  - ACOs create and support a sustainable workforce
- Pursuing these objectives requires a review of operational services to align and develop functional competencies with an ACO model

What are the core elements of ACO’s?

- **Accountable** for health, quality, and costs of care over the full continuum of their patients’ care
- **Collaborate**, share information and manage patient health for a population of patients (physicians, acute care hospitals, wellness, home care, long term care, pharmacies, et al)
- Focus on **improving health and reducing overall costs** for a population of patients
- Able to **measure and report** improvements in patient health and overall costs
- **Integrate financially** to accept and distribute bundled payments and incentive payments or penalty retractions
Requirements to qualify as an ACO

1. Legal structure to receive and distribute shared savings
2. 5,000 beneficiaries
3. Participate in the program for at least three years.

4. Have sufficient information on participating ACO healthcare professionals
5. Have a leadership and management structure that includes clinical and administrative systems
6. Have defined processes to promote evidence-based medicine, report data to evaluate quality and cost measures and coordinate care
7. Demonstrate that it meets patient-centered criteria
ACO Payment Options

- Fee for Service
- FFS + Shared Savings
- Episode Payment
- Partial Comp. Care Pmt. + P4P
- Comprehensive Care (Global) Payment
- Capitation

ALTERNATIVE METHODS OF PAYMENT

- Accurate risk adj.
- Accurate geog. adj.
Types of ACOs

- Physician practice managed.
- Hospital-IDN managed.
- Employer managed.
Launched September 2010
• Received by over 23,000 stakeholders
• 3 issues in 2010
• 9 in 2011
• The only publications dedicated solely to ACO development

WWW.ACOInsights.com
March 31, 2011 Regulations Released

- Beneficiary participation is voluntary
- OIG, IRS, FTC & DOJ guidance
- No more than 25% of the ACO can be owned by business interests
- Massive bureaucracy
- In a 60 day comment period
How Reform and ACOs will affect the Healthcare Supply Chain?

What are hospitals thinking?

“Revenue today is at it’s highest point”

Pat Ryan

“Infrastructure Cost Reduction”

John Bardis
How Reform and ACOs will affect the Supply Chain

- Consolidation (MedAssets/Broadlane)
- Regionalization of Contracting
- Share Services with ACO model
- Physician Preference Items power shift with Docs joining hospitals?
- Will price outweigh preference?
Physician Alignment Study

- Surveyed Supply Executives
  - 56% Hospital
  - 44% IDN
  - 10% from for-profit
  - 90% from non-for-profit
Physician Alignment Study

Key Findings

– 86% are actively acquiring physicians
– 95% indicated in 3 years they will have more
– 53% indicated rate of acquisition will moderately or aggressively increase
– 30% rate of acquisition will modestly increase
Physician Alignment Study

Key Drivers

- 46% Survive reform
- 35% Managing practice and delivering great care is too difficult
- 12% Other
Physician Alignment Study

How do you plan to have your Alternate Site Facilities serviced?

– 44% by my current prime distributor
– 46% by central supply/warehouse
Physician Alignment Study

Should the pricing from distribution be the same to Acute and Alternate site settings?

- 89% Yes

The 11% said it should cost more.

- 60% 0-5% more
Physician Alignment Study

- Changing expectations of distribution
  - System wide service
  - Class of trade pricing collapsing
  - Low UOM
  - Self distribution is an option
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