Group Purchasing Organizations: Gaming the System

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Introduction

Both government and private entities are looking for treatable causes of the high costs of medical care. Over the last 15 years, Group Purchasing Organizations (GPOs) have been on the radar as a contributing factor to rising hospital costs, medication shortages, and stifling introduction of innovative products from smaller companies.

Hospital supply costs are substantial. In 2013, U.S. hospitals on average spent $3.8 million each on supply expenses, with a median of $9.1 million. Supply expenses averaged 15 percent of total hospital expenses, and the average patient admission required $4,470 of supply expenses. Supply costs were as high as 30 or 40 percent in hospitals with, for example, complex cases or a large surgical service.[1] GPOs were intended to reduce these costs.

Background: A Good Idea Gone Bad

What is a GPO? GPOs are purchasing intermediaries that negotiate contracts between their customers—medical facilities such as hospitals, and vendors, distributors, and other suppliers of medical and pharmaceutical products and services. Such goods and services range from simple commodities like bandages to pharmaceuticals to high-tech devices like pacemakers. GPOs are supposed to facilitate better deals for their customers by means of volume purchasing. GPOs may also fund additional services outside of group purchasing for their customers, e.g., product evaluation, and marketing and insurance services.

The Hospital Bureau of New York established the first GPO in 1910, and now approximately 97 percent of hospitals in the United States purchase through GPO contracts. The Healthcare Supply Chain Association, a trade association representing 15 GPOs, estimates there are two to four GPOs per facility, and some 72 percent of hospital purchases are done using GPO contracts.[2,3]

Until the 1970s, GPOs' main source of revenue was through membership dues. To lessen the burden on smaller or struggling hospitals that could not afford the dues, GPOs began collecting "contract administrative fees" (rebates, kickbacks) from the vendors (see Figure 1). Such fees are typically based on a percentage of the costs of the products that GPO customers purchase through GPO-negotiated contracts.[2]

Normally, this fee arrangement would violate the federal healthcare program Anti-Kickback Statute.[4] Federal anti-kickback provisions[5] were passed as part of the Social Security Act Amendments of 1972 to "protect patients and the federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions."[6]

Initially, the statute made the receipt of kickbacks, bribes, or rebates in the Medicare and Medicaid programs a misdemeanor punishable by a fine, imprisonment, or both. In response to testimony that these penalties were not adequate deterrents and were inconsistent with other federal criminal codes sanctions that made similar actions felonies, Congress strengthened the statute. The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 broadened the language to also prohibit the offer or receipt of "any remuneration" to induce a referral, and elevated the misdemeanor classification to a felony.[7] However, this statute had an exception for discounts if the discount was (1) disclosed, and (2) reflected in the costs claimed for reimbursement from the government. The Senate Finance Committee included this provision to "ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal. In fact, the [finance] committee would encourage providers to seek discounts as a good business practice which results in savings to medicare and medicaid program costs."[8]

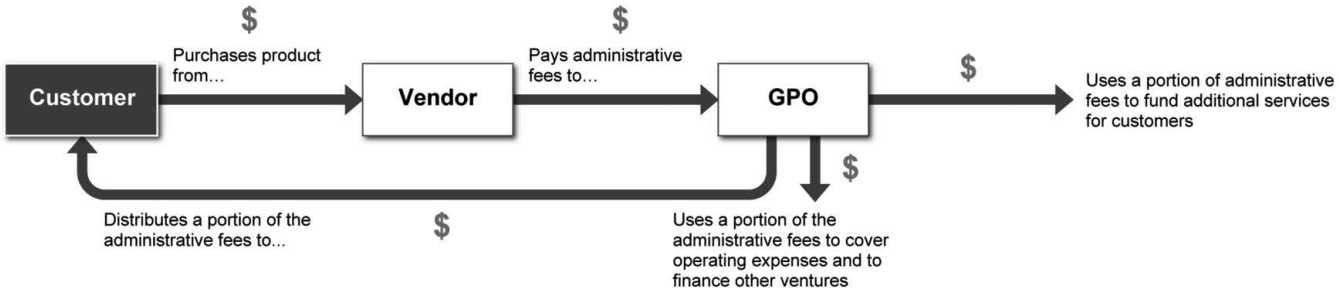

Figure 1. General Flow of Administrative Fees

In the early 1980s, the federal government's response to steeply rising Medicare costs may have triggered the interest in questionable business arrangements. The Medicare payment method was revised from a retrospective fee-for-service system to a prospective payment system (PPS) in an effort to control costs. Under PPS, hospitals receive a fixed amount for treating patients diagnosed with a given illness, regardless of the length of stay or type of care received.[9]

Hospitals complained that PPS cut into their profit margin, so they expanded services and sought ways to enhance revenue, some of which may have violated the anti-kickback law.[10] Hospitals asserted that the 1977 amendments effectively prohibited long-standing industry practices necessary to day-to-day operations. Congress believed that GPOs could "help reduce health care costs for the government and the private sector alike by enabling a group of purchasers to obtain substantial volume discounts on the prices they are charged."[11] Consequently, as part of an Omnibus Budget Reconciliation Act of 1986 miscellaneous technical amendment to Medicare, Congress added an exception to the Anti-Kickback Statute to permit fees paid by vendors to a GPO if: (1) there was a written contract with fees at a fixed amount or a fixed percentage of the value of the purchases, and (2) entities that were service providers disclosed such fees to the customer.[12,13]

The next year, Congress passed the Medicaid Patient and Program Protection Act of 1987, directing the Secretary of Health and Human Services (HHS) to create additional payment and business practice exceptions to the Anti-Kickback Statute ("safe harbors") because such practices would be unlikely to result in fraud or abuse.[14] (It also re-designated the GPO exception to a different section of the Social Security Act.)

On July 29, 1991, the HHS Office of Inspector General (HHS-OIG) issued the first in a series of regulations implementing the safe harbors. The GPO regulations fixed the contract administrative fee at 3 percent or less of the purchase price of the product or service, and required disclosure of fees received from all types of vendors to the respective customer.[15]

The Antitrust Safety Zone

In response to antitrust concerns, in 1996 the Federal Trade Commission (FTC) studied GPOs. The FTC determined that joint purchasing arrangements provided to hospitals or other health care providers do not raise antitrust concerns. The FTC reasoned that through such joint purchasing arrangements, the participants frequently obtain volume discounts, reduce transaction costs, and have access to consulting advice that may not be available to each participant on its own. Thus, GPOs provided significantly more efficiency, benefited consumers, and did not raise antitrust concerns.

The resultant FTC enforcement guideline sets forth an "antitrust safety zone" for GPOs where the FTC and Department of Justice (DOJ) will not challenge, "absent extraordinary circumstances," any joint purchasing arrangement among health care providers where two conditions are met:

1. Purchases through a GPO must account for less than 35 percent of the total sales of the product or service in question (e.g., stents) in the relevant market (which could be regional or national). This condition addresses whether the GPO accounts for such a large share of the purchases of the product or service that it can effectively exercise increased market power as a buyer. If the GPO's buying power drives the price of the product or service below competitive levels, consumers could be harmed if suppliers respond by reducing output, quality, or innovation.

2. The cost of purchases through a GPO by each member hospital that competes with other members must amount to less than 20 percent of each hospital's total revenues. This condition looks at whether the GPO purchases constitute such a large share of the revenues of competing member hospitals that they could result in standardizing the hospitals' costs enough to make it easier to fix or coordinate prices.[16]

GPO Fees: By the Numbers

While there are more than 600 GPOs in various industries, only a few GPOs dominate the medical market. A 2015 Government Accountability Office (GAO) study found that during fiscal year 2012, the five largest GPOs contracted for similar products reported a total purchasing volume of $130.7 billion, and received fees totaling about $2.3 billion in 2012.[17] (While these GPOs were not named in that GAO report, later reports indicated they were MedAssets (purchased by Vizient), Premier, Novation (part of Vizient), HealthTrust, and Amerinet (now called Intalere). This was a 20 percent increase in the total fees collected from vendors in 2008 (adjusted for inflation). The GPOs attribute the growth in volume of fees to increases in purchasing volume by customers and additional products being added to contracts.

These five GPOs reported that the most frequent vendor fee they received in 2012 was 3 percent, and that such fees accounted for 92 percent of a GPO's revenue.[17] GPOs report that nearly 70 percent of these fees ($1.6 billion) was passed on to GPO customers or owners ("share-backs," a.k.a. rebates). The remainder of the revenue came from member fees, outside investments, vendor exhibit fees, and licensing fees—which are also based on a percentage of the purchase price of products—to market their products using the GPO's brand name.

Inherent Conflict of Interest

The current fee structure raises an obvious conflict of interest: when members (customers) paid the dues, the clear goal was to find lower prices for the member. Now, since vendors pay the fees as a percentage of the product cost, the higher the price, the higher the GPOs' fees. Since 2002, GPOs have come under scrutiny for their contribution to increased costs to federal health programs, drug shortages, and effect on the introduction of new products.

Additionally, it has been reported that at least two

GPOs and/or their officials have accepted stock in supplier companies in lieu of or in addition to cash payments, or have significant investments in medical supply companies.[18]

Questions also have been raised about sole-source contracting, in which GPOs may contract with only one vendor for a given product when multiple vendors of comparable products are available. Here, the GPO contract may have minimum purchase requirements. Smaller hospitals may tend to purchase more than they need to reach the minimums. Overspending to get a purported discount is not a good trade-off. Other practices under scrutiny are product bundling, in which price discounts are linked to purchases of a specified group of products; long-term contracts of 5 years or more; and tiered or loyalty discounts where the discount (rebate) increases as the hospital buys a greater percentage of a specific product through that GPO. Additionally, the GAO had questioned whether GPOs were actually saving money.[19]

No Evidence of Consistent Cost Savings

The justification for allowing GPOs' rebates and fee structure to be exempt from the Anti-Kickback Statute was that it would save money. The GAO studied several representative hospitals and found that GPOs' contract prices were not always lower, and were often higher than prices paid by hospitals negotiating with vendors directly. One factor is that the price breaks varied by product model. For example, for some pacemaker models, the hospitals using GPO contracts got up to 26 percent lower prices than the hospitals not using a GPO contract. But for other models, hospitals using a GPO contract got prices that were up to 39 percent higher than hospitals not using a GPO contract. Additionally, the size of the hospital affected the price savings. Large hospitals (greater than 500 beds) got lower prices negotiating on their own. But while small and medium hospitals were more likely to benefit from a GPO contract, this was not a consistent finding. Price savings had little relationship to the size of the GPO. Hospitals contracting with large GPOs—those whose members purchase more than $6 billion per year with their contracts—did not necessarily obtain better prices than hospitals using smaller GPOs.[19]

Further, the GAO was unable to identify any published peer-reviewed studies that included an empirical analysis of pricing data that indicated whether GPO customers obtain lower prices from vendors.[20] Industry-supported studies claim savings, but a private 2012 study found hospitals achieved an average price reduction of 10–14 percent from 2001 through 2010 when the transaction was brokered by an agent not compensated by suppliers.[21]

Limited Government Oversight

The DOJ, the HHS-OIG, and the FTC are responsible for oversight of GPOs. After negative publicity in the early 2000s, GPOs formed a voluntary GPO membership association, the Healthcare Group Purchasing Industry Initiative (HGPII) in 2005 to "self-police" by promoting best practices and public accountability among member GPOs.[2]

In the antitrust arena, the DOJ and FTC receive and investigate about one complaint per year against GPOs. The GAO found one lawsuit filed by DOJ against a GPO in 2007. DOJ challenged actions by the GPO for temporary nursing services and its member hospitals, alleging that the GPO caused the wages paid to temporary nurses in Arizona to fall below competitive levels. The case was resolved with a settlement and consent decree. The DOJ received a complaint in 2010 from certain medical device manufacturers questioning the general structure of the industry and how the industry operates. Although DOJ spoke with the complainants, it did not open an investigation.[2] As of 2014, the FTC had not taken any enforcement action against a GPO since 2004.[22]

Safe harbor protection is afforded only to those arrangements that precisely meet all of the conditions set forth in the regulations.[11] Further, a lawful purpose will not legitimize a payment that also violates the statute. Neither the GPO safe harbor statutory provision nor the regulation require HHS-OIG to routinely review or monitor the required GPO written agreements and disclosures.[15] Indeed, since 2004, HHS-OIG as a matter of course has not exercised its authority to request and review disclosures related to GPOs' contract administrative fees. However, it has collected information on GPOs' contract administrative fees while conducting audits of hospitals' cost reports. HHS-OIG did investigate with DOJ two cases involving allegations that certain GPOs did not comply with safe harbor requirements and violated the Anti-Kickback Statute.[2] Both lawsuits were brought by private citizens on behalf of the United States under the False Claims Act ("qui tam" action). DOJ may intervene and litigate the case along with the private party, but in each of these cases, DOJ declined to intervene.

Medicare provider reimbursement regulations generally require providers to offset purchase discounts, allowances, and refunds of expenses against expenses on their Medicare cost reports that reflect their costs of medical supplies.[23]

In 2005, HHS-OIG found that some GPO customers did not fully account for GPO revenue distributions on their Medicare cost reports. Despite the response by the Centers for Medicare and Medicaid Services (CMS), which issued guidance on proper reporting of GPO rebates, HHS has done no further reviews of cost reports for this information.[2]

The information in cost reports is one element that the Medicare Payment Advisory Commission (MedPAC) reviews in determining the reasonableness of Medicare payment levels for the Prospective Payment System. Additionally, Medicare contractors use parts of the cost reports to compute Medicare reimbursement.[17] If the rebates are not reported on the cost reports, Medicare could be overpaying hospitals.

In its review of GPO payment practices, the GAO's single recommendation was having HHS determine whether hospitals are appropriately reporting administrative fee revenues on their Medicare cost reports, and taking steps to address any under-reporting that may be found.[17]

Consolidation of the GPO Market

As one medical device supplier noted in 2016, "When I started in this space 27 years ago, there were about two dozen GPOs that we recognized as national GPOs. Today there are five."[24] Four GPOs (Vizient, Premier, HealthTrust, and Intalere) have about 90 percent of the market.

Vizient was founded in 2015 as the integration of VHA Inc., a national network of not-for-profit hospitals; University HealthSystem Consortium, an alliance of the nation's leading academic medical centers; and Novation, the health care contracting company they jointly owned. In 2016, Vizient acquired MedAssets' Spend and Clinical Resource Management segment. Vizient has $100 billion annual spend volume, and its membership consists of a little more than 50 percent of the nation's acute care providers.[25] Vizient also serves more than 20 percent of the nation's ambulatory market.

Premier has more than $50 billion annual spend volume. Premier members include 3,750 hospitals, which includes 76 percent of U.S. community hospitals, and more than 130,000 other provider organizations. Premier also provides data analytics and information technology (IT) services, among other services. HealthTrust has $30 billion annual spend volume. Its members include 1,600 hospitals and more than 26,000 non-acute care sites in the U.S. and UK. Intalere has $9 billion annual spend volume and its members include 3,734 hospitals and more than 85,000 non-acute healthcare providers.[25]

The competition and choice promised in the early years of GPOs is clearly lacking.

Medication Shortages

Medication shortages have resulted in tremendous patient harm. Shortages increased by almost 200 percent from 2005 to 2010, and they increased 13 percent between 2009 and 2010 alone.[26] A 2011 U.S. Food and Drug Administration (FDA) study concluded that the cause of shortages was multifactorial, including economic, legal, regulatory, policy, and clinical factors. However, FDA notes that despite high demand for generics and oncology medications, the supply system is "vulnerable to drug shortages because a large supply disruption is difficult to make up with alternative suppliers."[26] A 2014 GAO report found studies that indicated GPOs' administrative fees contributed to generic drug shortages by reducing the profit margins, thereby discouraging increased production, adding to supply-chain fragility.[27,28] A 2011 HHS study focusing on sterile injectables attributed manufacturers' inability to meet the demands to inadequate manufacturing capacity as a consequence of the expansion in scope and volume of products.[29]

The presence of a variety of vendors is key to maintaining a stable supply chain, which can protect against medication shortages. GPOs' exclusive, high-volume, sole-source contracts are awarded to those who can pony up the highest fees. Contracts that bundle products favor vendors offering a broad range of products. Consequently, smaller or single-product companies are shut out of the market. The end users (patients) suffer by being deprived of lower-cost or innovative products—and in some cases can obtain no product at any price.

Conclusion

Since the federal healthcare Anti-Kickback Statute GPO exception was created 30 years ago, the landscape has changed. The current GPO funding structure's incentive is to "negotiate" higher prices for its customers. The vendors with the most money can afford to pay the high fees and buy themselves into the game. The term "payola"—pay to play—comes to mind. The situation is exacerbated because insurers absorb the higher prices and thus hospitals may have less incentive to monitor pricing.

GPOs assert that there is sufficient competition between them to mitigate any potential conflicts of interest with regard to negotiating the lowest prices. But when the FTC issued its "antitrust safety zone" 22 years ago, it noted, "The existence of a large number and variety of purchasing groups in the health care field suggests that entry barriers to forming new groups currently are not great."[16] Only four companies now comprise 90 percent of the GPO market. This industry consolidation should re-ignite antitrust concerns: limited choices, difficulty in changing GPOs, higher prices, and barriers to entry into the market by smaller companies. Worse yet is that patients suffer because of higher prices and insurance premiums.

Vendors could take "dirty" money if doing so helped patients by increasing medical care access and/or choice, or saved the government money. But the arrangements must precisely meet all of the conditions set forth in the regulations. Assuming the inducement was "knowing and willful," based on the three questions the government is supposed to ask current discounting or GPO arrangements look like impermissible kickbacks. Does the arrangement have a potential to interfere with, or skew clinical decision-making? Yes. The vendor who can afford the fees or provide other financial perks gets the contract.

- Does it have a potential to undermine the clinical integrity of a formulary process? Yes. Smaller pharmaceutical companies with a less expensive or better product are frozen out of the contracting process.
- Does the arrangement have the potential to increase costs to federal health care programs, beneficiaries, or enrollees? Yes. There is no evidence that supply costs are lower.[30]

In short, GPOs do not always choose the products that are best for their customers, patients, or the taxpayers. An honest look at the current state of GPOs should label the conduct illegal, yet Congress has not acted to repeal or sharply limit the safe harbor. Just as with GPO contracts, money talks. Premier has 19 lobbyists and spent $1,790,000 on lobbying in 2017. It contributes to Democrat and Republican congressional committees, and to individuals

on both sides of the aisle, including former vice-presidential candidate Tim Kaine, and two prominent physician senators, John Barrasso and Bill Cassidy.[31]

On the positive side, if the government will not enforce the law, the private sector may again take action. According to a large business consulting firm's annual study conducted with hospital administrators, health systems are increasingly receptive to bypassing GPOs for their medical technology contracts.[28] Additionally, there are a growing number of health systems that are "owning and controlling their own supply chain destinies."[32] And, not to be outdone, Amazon's B2B program has entered the healthcare market and promises a marketplace to comparison-shop for the best prices and selection.

The time has come to do what is best for patients and to restore integrity, competition, choice, and cost savings to the purchasing process.

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