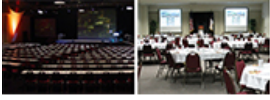

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Premier position

As hospitals face pressure to trim costs while serving more patients, Susan DeVore prepares her purchasing group to make the process hum.

By Lisa Davis

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Six years ago, Carolinas HealthCare System tapped Charlotte-based Premier Inc. to put data collected by the group's 900 hospitals and medical sites to use in improving care. The system has since expanded its ties to Premier, and today, about half of its $1.2 billion in annual supplies are procured through contracts hammered out by the company. Other Premier programs help Carolinas HealthCare integrate claims and clinical data, staff hospitals more efficiently and promote its interests in Washington.

While hundreds of buying groups exist, Premier is among the largest as an alliance of 3,400 hospitals — roughly two-thirds of all U.S. community hospitals — and 110,000 nursing homes, surgery centers, doctors' offices and other health care sites. The company writes contracts for $41 billion in annual supply spending for Charlotte-based Carolinas HealthCare, CaroMont Health in Gastonia and other members.

Now, the company plans to parlay its deep hospital connections and technical savvy to become even more integral to the $3 trillion U.S. health care industry. Premier has access to a trove of data, millions of bits of information about surgical procedures, disease rates and more. It has data on about one out of every three discharges from U.S. health care systems. Premier takes that data and connects, compares and shares it — and sells these services to its member hospitals. (The data is cleansed so that personal information isn't disclosed.) To accelerate its growth, Premier went public two years ago in an $874 million initial offering and has used that capital to beef up its technology and data capabilities, spending about $260 million to acquire six tech companies. Analysts who track the company suspect a bigger deal is in the offing.

“They’ve had a line of sight on where the puck is going on population health,” says David Cyganowski, a managing director with consulting firm Kaufman Hall in New York. Health care is shifting away from paying providers a fee for every procedure to a value-based model that rewards those who keep people well. The change puts pressure on hospitals to reduce costs and improve care. Premier wants to provide the tools to do that. Premier “saw the future coming,” Cyganowski says, “and they were investing time and dollars and enormous resources into that, years before they decided to become a public company.”

Premier is one of only two publicly traded health care group purchasing organizations, known as GPOs, and its stock, along with many in the sector, is climbing, fueled by Affordable Care Act-related spending increases. Leading its growth is CEO Susan DeVore, among only five women to head one of North Carolina’s 75 largest public companies (page 70) and the first to top the annual list of highest-paid CEOs compiled by *The Charlotte Observer*. DeVore envisions Premier as the infrastructure of a new, improved health care. She’s not the only one with such designs, and competition in the health information-technology industry is mounting. What Premier has that other companies don’t, DeVore says, is the ability to tie it all together. “We think we are one of very few companies that have that depth and breadth.”

Female CEOs of top 75 public companies based in N.C.

CEO	Company	Headquarters	Years as CEO	2014 total compensation (million)
Susan DeVore	Premier	Charlotte	6	$24.91
Susan Cameron	Reynolds American	Winston-Salem	1	10.75
Lynn Good	Duke Energy	Charlotte	2	8.31
Michelle Berrey	Chimerix	Durham	1	3.48
Prabhavathi Fernandes	Cempra	Chapel Hill	9	2.32

But Premier is a leader in an industry that has drawn sharp criticism for its business practices, and the role of GPOs remains controversial. Like everything else involving health care charges and payments, it’s complicated. Critics say the groups have done little to check the fast rise of U.S. health care spending. The way the industry is structured, they say, GPOs are more likely to increase costs than reduce them.

The first GPO started in 1910, after New York hospitals decided it would be cheaper to handle their laundry together. GPOs were mostly regional alliances focused on negotiating contracts for commodities like gauze and gowns. In the ’70s, their numbers grew, and they began writing contracts for pharmaceuticals and other supplies. After labor costs, supplies are hospitals’ second-biggest expense. They spend millions stocking shelves with rubber gloves, syringes, antibiotics and bandages. They buy X-ray machines, computers and cardiovascular stents. Almost all of them make at least some purchases through alliances with other hospitals, pooling their purchasing power to get better deals from suppliers. Different structures of GPOs emerged: Some are hospital-owned; others, independent. As the nation’s hospital systems expanded and consolidated, so did the GPOs. Among the largest mergers involved Charlotte-based SunHealth Alliance Inc., Chicago-based Premier Health Alliance Inc. and San Diego-based American Healthcare Systems Inc., which formed Premier in 1996.

In 1986, Congress passed an exemption to anti-kickback laws that allows GPOs to collect fees from suppliers of generally up to 3% of the value of the contracts they negotiate. The purpose of GPOs was to help hospitals reduce costs, and the fees served as a source of revenue for them to do their job. The GPO negotiates supply contracts for its member hospitals, and the suppliers pay the GPO administrative fees based on the contracts’ value. The GPO deducts its expenses and, in some cases, returns fee revenue to its members.

Not being subject to anti-kickback laws has skewed the industry’s financial incentives, says S. Prakash Sethi, a Baruch College professor in New York and author of a book on GPOs. “You are paid based not on how efficient you are, but how much billing you do. If you are paid 3% of everything you sell, why would you want to sell less or sell at a lower price?”

DeVore rejects that view. She compares Premier to online retailer Amazon.com Inc. or retiree lobbyists AARP. “You think about all these organizations that aggregate consumers of products, and then a supplier pays a transaction fee or an administrative fee. It’s the same thing.” Ultimately, she says, “there is no other vehicle for hospitals to aggregate their volume and buy together to get pricing discounts.”

GPOs give hospitals negotiating leverage with big suppliers, says Kester Freeman Jr., retired CEO of Columbia, S.C.-based Palmetto Health and a former Premier board member. “Even a [Winston-Salem-based] Novant or a Carolinas HealthCare System in Charlotte, as big as they are, are not as big as a Johnson & Johnson or Baxter or Siemens or GE.”

Whether GPOs lower hospitals’ costs and by how much is hard to pin down. Health care pricing is difficult to gauge, in part because suppliers often require hospitals to sign nondisclosure agreements about what they charge. Six years ago, an industry-funded survey of more than 400 hospitals by Eugene Schneller, a business professor at Arizona State University, found that GPO contracts led to $36 billion in annual price savings. A small study by the U.S. Government Accountability Office in 2002 looked at purchases of pacemakers and safety needles by hospitals in one city. It found that GPO prices were not always lower, and were

sometimes higher, than if the hospital had negotiated directly with the supplier.

By 2002, the industry had concentrated such that two GPOs, Premier and Irving, Texas-based Novation LLC, were writing supply contracts for about half of U.S. nonprofit hospitals, according to *The New York Times*, which that year ran a series called "Medicine's Middlemen" that examined the two companies. It featured the inventor of a device that measured blood oxygen levels of infants more effectively than traditional pulse oximeters. He had little luck selling it, however, because many hospitals had long-term, GPO-negotiated contracts with a large supplier. It's almost impossible, he said, for small device makers like him to break in.

The articles reported that Premier's then-CEO Richard Norling and other executives had stock options in some suppliers, and that Premier co-founded a drugmaker, American Pharmaceutical Partners Inc., and wrote contracts for it to supply hospitals without fully disclosing Premier's ownership stake. Government investigations and congressional hearings ensued. Despite expectations that Congress might change the anti-kickback exemption or take other action, the GPOs emerged intact.

DeVore, a longtime industry consultant whose late father was a co-founder of SunHealth, joined Premier in 2003 to lead its supply-chain business, which makes up 73% of annual revenue.

Read more about Susan DeVore: ***(articles/2015-08/family-business-category/)*** **Family business (articles/2015-08/family-business-category/)**

"I was able to come in, listen to all the opportunities for improvement, and then I was able to implement it," she says. "The work we were doing was all the right work. We just needed to put some more structure and infrastructure and discipline around it."

Premier signed the industry's code of conduct developed in the wake of the hearings and hired an ethicist to create their own code. "We set about transforming everything," DeVore says, "from our ethical code of conduct to the way we made decisions about products, to the way in which we implemented that in our health systems, to our efficiency opportunities." She consolidated operations in Charlotte, then moved the headquarters there when she became CEO in 2009. She doesn't own options in suppliers.

In 2006, Premier won a prestigious Malcolm Baldrige National Quality Award, one day after it settled an antitrust lawsuit by paying $8.8 million to catheter maker Rochester Medical Corp. The Stewartville, Minn.-based company alleged that Premier and other GPOs blocked entry by competitors. Premier denied wrongdoing and said it settled to avoid legal costs. Three years earlier, the company and two other defendants had paid $55 million to settle a similar lawsuit by Little Elm, Texas-based Retractable Technologies Inc., a maker of syringes.

Being sued by device makers doesn't mean Premier is stifling competition, says Freeman, now executive director of the South Carolina Institute of Medicine and Public Health. "If we could produce better products at lower costs, that was what we were looking for. Whenever you award a contract to one company and you don't award it to another, [that company] is going to be unhappy." A Premier program now enables small companies to put their devices into hospitals without waiting until a contract cycle ends, DeVore says. "We've gone to great lengths to ensure that the small and diverse suppliers with innovative technologies have an opportunity to get to our health systems."

Griffin Davis

With reimbursements declining, health care systems have to find ways to cut costs and provide better, more efficient care. They are looking to GPOs and elsewhere to find it — the spectre of distribution giant Amazon.com looms over the business. "What these GPOs are trying to do is differentiate themselves from their competitors," Cyganowski says. "In doing so, they've had to go well beyond what they used to do years ago when they simply just provided supplies at a lower cost."

To expand its offerings, Premier spent more than $86 million to rebuild its technology platform about five years ago so it can retrieve data from many software systems. It also developed a social network that connects some 100,000 doctors, chief medical officers, materials managers and others who can compare notes and find information. Called PremierConnect, the technology is the basis of an array of products pitched to health care systems.

Premier also forms collaboratives of hundreds of providers working to achieve various goals. Hendersonville-based Park Ridge Health, which owns a 103-bed hospital and about 30 doctors' offices and clinics, is a member of Quest, one of Premier's largest collaboratives with about 350 hospitals. Spurred by an idea from the group, Park Ridge offers earlier palliative-care consultations to patients, which reduces mortality rates. "We know we are driving toward improved quality, reduced costs, a safer patient stay, and Premier is helping us get there more quickly than the average hospital," says Craig Lindsey, vice president of clinical services.

Having your owners as customers has its advantages, DeVore says. They "tell me all the good, the bad and the ugly about everything we do, so I have this insight and this ability to incubate and innovate and then test [a new product] before I scale it to the whole member base, and not a lot of companies have that."

In 2013, Premier decided to go public to raise capital for acquisitions. The first major GPO to go public, Alpharetta, Ga.-based Med-Assets Inc., was not owned by hospitals. The 180 health care systems that owned Premier had to sign on to Premier's restructuring and initial public offering. "It was the longest road show in history," DeVore says. Since the offering, shares have risen from $30.65 on the first day of trading in 2013 to about $37 in mid-July. The 21% gain is less than the Standard & Poor's 500 index, which gained 25% in that period.

In the IPO, the hospitals sold 22% of their stake. New investors received Class A shares. The hospital-owners got Class B shares and the right to exchange up to one-seventh of their stock allocation each year for Class A shares. They also get 30% of fees Premier collects from suppliers, plus funds to cover taxes.

Premier's accounting practices have drawn some unfavorable attention. The Sohn Investment Conference in May is an annual Wall Street fundraiser for pediatric cancer in which fund managers and business-school students pitch their favorite ideas. A finalist this year, Arthur Baer of New York-based Cavendish Fund Management LLC, urged investors to short Premier's stock, citing his research suggesting the company's value was 62% less than its price at the time. He questioned Premier's accounting, including how it reports expenses related to what it returns to its member-owners. The company says it is "comfortable with our accounting practices," which are publicly disclosed, audited by Ernst & Young and reviewed by the Securities and Exchange Commission. Premier's share price is little changed from the day Baer made his case.

Premier's six acquisitions have filled in gaps and strengthened its services. Overland Park, Kansas-based Symmedrx, for example, helps solve the dilemma of the physician preference item. These items — typically ones used in surgery, like a knee implant — are picked by physicians and often fall outside a GPO contract. But Premier says it finally has a way to tap into that business. With its new capability, Premier can compare a device across suppliers, find ones that are identical to a preferred one and help negotiate a lower price.

As the first opportunity for hospital-owners to sell shares approached last fall, shares stalled on fears of widespread trading. Owners exchanged 4.7 million shares, about 29% of eligible shares, and sold 3.8 million of those. The largest seller was the Greater New York Hospital Association, Premier's biggest shareholder. The group said it wanted to diversify its portfolio. Analyst Nicholas Jansen of Raymond James & Associates called the results encouraging. Some investors "were saying, well, if they have an option to sell stock and get money, why wouldn't they? A lot of members didn't, so it does show you that there is more of a partnership between the member-owners and [Premier] than some people thought."

In the future, hospitals will find more ways to buy supplies. The number of coalitions is growing, and Premier has convinced some to use its contracts, ASU's Schneller says. Eventually, GPOs "are going to have to compete with players they haven't competed with before, like Amazon.com." With the rise of e-commerce in mind, Premier is developing new ways for members to use its services, including cloud-based supply-chain management, deeper discounts on group buys and a mobile app on which members can check prices quickly and easily.

The possibility of more government scrutiny hangs over the industry. In filings for the fiscal year that ended June 30, 2014, Premier reported that it had responded to a request from the Department of Health and Human Services for information about its reorganization to go public. Premier says it has had no interaction since then. MedAssets alleged in 2012 that its rival used the prospect of an IPO to recruit new member hospitals, a claim denied by Premier.

A New York-based group called Physicians Against Drug Shortages blames what it calls the anticompetitive contracting practices of GPOs for the chronic shortages of generic drugs in recent years. A Government Accountability Office report last year pointed to multiple causes, though it mentioned GPOs among possible underlying factors contributing to shortages, along with quality issues that caused manufacturing delays. Another GAO report, released in October, questioned whether some hospitals were properly reporting on their Medicare paperwork the GPO fee revenue returned to them. That report was the first time, according to the publication Modern Healthcare, that the GAO has pondered repeal of the provision exempting GPOs from anti-kickback laws.

DeVore says she's not worried. "If we didn't exist, there would be billions of dollars of costs that would be higher for health care systems. The government inherently understands that. They just want to make sure we have the proper guardrails around it."

Premier's future is golden, she says. "We will be sitting inside health systems, with shared technology, shared data, shared

people. Collaboration will continue, innovation will continue, and we will be transforming health care together from the inside."

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