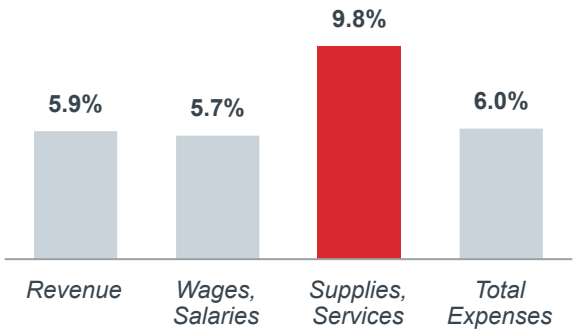
Revisiting Supply Cost Strategies

A Disciplined Approach to Managing Your GPOs in Today's Cost Environment

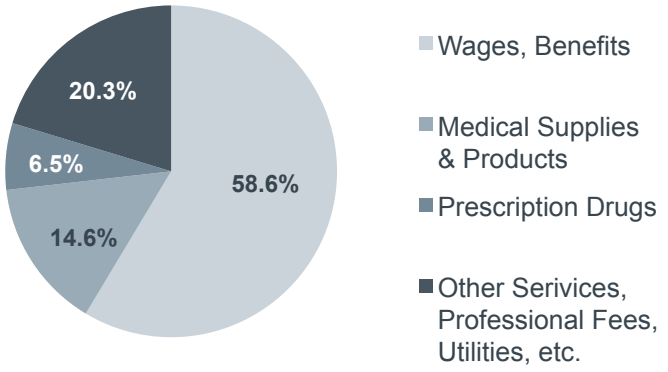
For nearly all hospitals and health systems, group purchasing organizations (GPOs) have been key partners in strategies for sourcing and purchasing drugs, devices, and other supplies and services. Fundamentally, GPOs act as contracting agents for groups of providers, in an attempt to create greater bargaining leverage over manufacturers, vendors, and distributors—and therefore secure lower overall prices for key supplies in return for increased volume.

In theory, GPOs should act as a governor on unit price growth, and as they compete with one another for hospital business, their own margins should moderate over time as well. Nonetheless, providers' supply costs have actually increased at a faster rate than any other spending category over the past several years. This is partly the result of higher prices and utilization for physician-preference items (PPIs), which are often purchased outside of GPO contracts. But costs have been increasing across all spend categories, and the operating cash flow margins of the largest GPOs (which can be north of 40%), indicate that competition has not necessarily driven down contracting costs to providers.

Average Three-Year Compound Annual Growth Rate[1]



Hospital Cost Breakdown

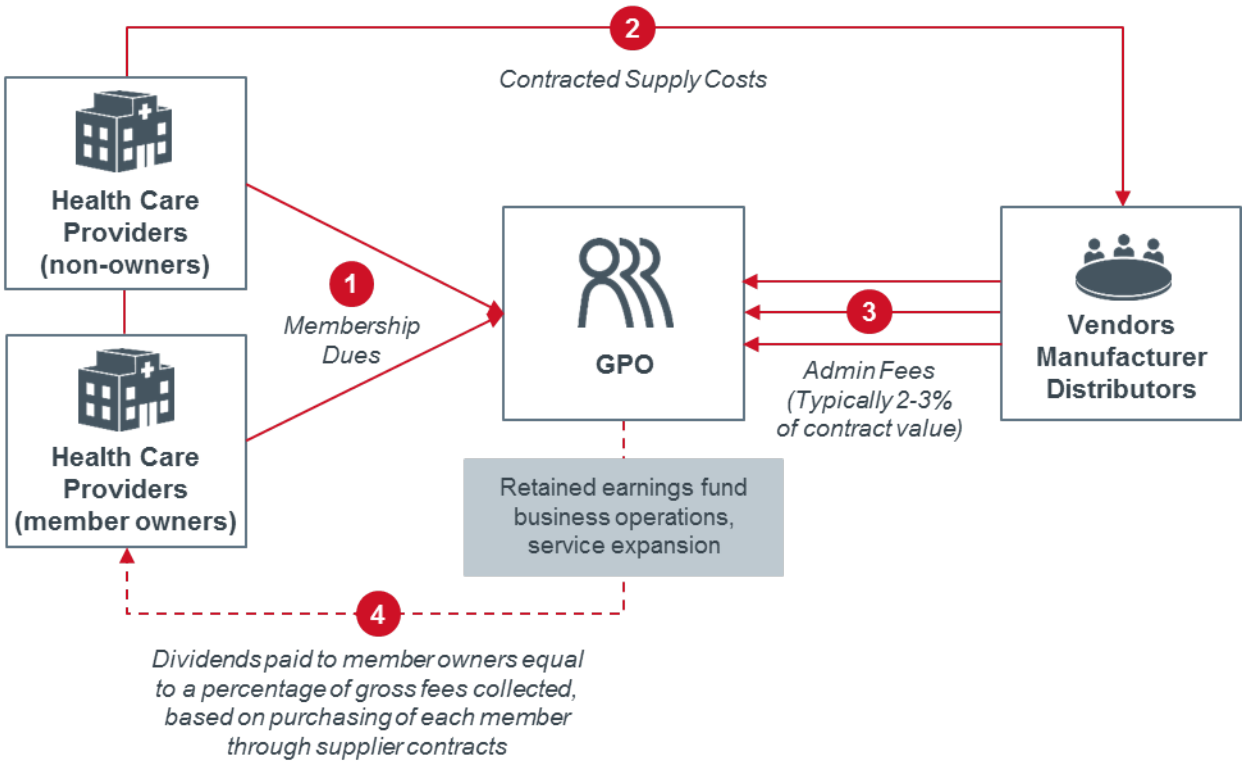


Given the immense margin pressures most hospital and health systems are experiencing as a result of decelerating reimbursement growth, it's worth examining the typical GPO business model to determine (1) how the economics of group purchasing can potentially hinder price moderation over time, (2) in which categories of spend GPOs are most effective, and (3) how providers can generate greater value from their supply contracts.

The GPO Fund Flow Model

Originally conceived in the 1960s, GPOs were developed as not-for-profit organizations funded solely by provider dues. Over time, for-profit GPOs emerged, and by the 1980s, Congress allowed GPOs to receive funding from suppliers, distributors, and vendors, in addition to collecting dues from providers. For GPOs, supplier fees turned out to be a far more efficient (though nonetheless laborious) means of funding the organization than provider-based dues alone had been—reducing the funding burden from providers eager to see a further reduction in contracting costs. Today the GPO funding model—while allowing for many contractual variances—resembles the figure below.

1) Lichtenberger, S, et al., "How Sourcing Excellence Can Lower Hospital Costs," *Health International*, 2010, 10: 18-29.



On the provider side, GPOs are funded by a mix of hospitals and health systems, some of which can have significant ownership stakes (either as closely held or publicly traded shareholders), both of whom often pay membership dues. Manufacturers, distributors, and vendors also pay administrative fees, which are generally calculated as a percentage of contract value (typically about 3%). Depending on the provider-GPO contract, owner hospitals and health systems can also receive dividends usually equal to a percentage of gross fees collected (in 2010, 59% of provider fees were expected to be returned in the form of such dividends and other contractual allowances).[2]

Thus GPOs have potentially conflicting incentives to not only secure lower unit prices for providers, but also increase providers' overall contract value with suppliers. To help increase the value they generate for providers, GPOs increasingly have developed new service offerings sold to providers that extend beyond group purchasing to consulting, benchmarking, and analytical services. Nevertheless, membership and administrative fees—from both providers and suppliers—accounted for about 84% of GPO revenue as recently as 2010. Today, five GPOs control roughly 90% of GPO-related purchases by U.S. hospitals.[3]

The Challenge of Volume Commitments

Paradoxically, one of the biggest challenges that the large national GPOs have in securing lower prices is a result of their size. Because national GPO contracts can represent an enormous portion of a given supplier's business, many are loath to give their best prices to GPOs, especially if they cannot enforce volume commitments. Although GPOs negotiate contracted terms, hospitals and health systems are often not obligated to purchase at the volume levels mandated in the contract.

2) "Healthcare GPO revenue to hit $2B in 2010," *Healthcare Finance News*, 2010, accessed on September 18, 2013 at, http://www.healthcarefinancenews.com/news/healthcare-gpo-revenue-hit-2b-2010.

3) "Group Purchasing Organizations: Services Provided to Customers and Initiatives Regarding Their Business Practices," United States Government Accountability Office Report to the Ranking Member, Committee on Finance, U.S. Senate, August 2010.

To help alleviate these potential disincentives to pricing moderation, many GPOs have established so-called regional GPOs, which aggregate bargaining power only within a particular market or region. This narrower focus enables the regional GPOs to (1) enforce volume commitments because they have a greater ability to predict volume needs at a local level and standardize within a smaller group of members, and (2) increasingly leverage dual-sourcing contracts that encourage greater price competition among suppliers. Other groups of providers are establishing their own regional coalitions, similar to the not-for-profit group purchasing model developed in the 1960s. Today there are about 125 regional coalitions in total, 86 of which are affiliated with a national GPO.

Providers are also increasingly renegotiating their contract terms with GPOs to focus on performance-based risk incentives. For example, Advisory Board researchers spoke with a 320-bed academic medical center that restructured its GPO contract to place the GPO on the hook for specific savings targets across a host of categories; if the savings targets were not met, the GPO would return them to the contracting hospital. This strategy netted the organization $8.2 million in savings over 29 months, including $200,000 in administrative-fee sharebacks.

The Future of Self-Contracting?

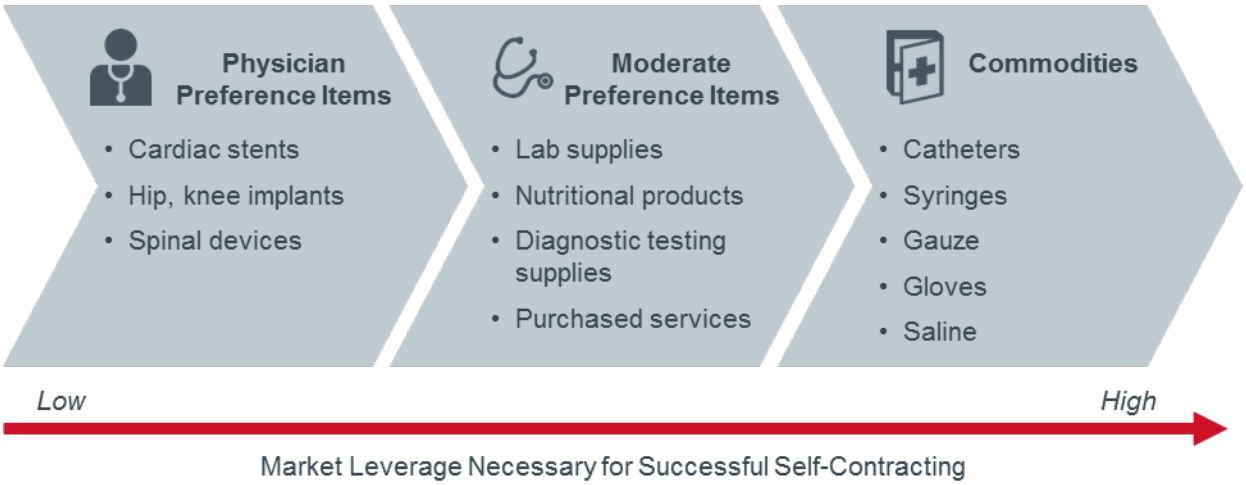
Many hospitals and health systems now have enough local market power to meaningfully impact suppliers' regional revenue growth and therefore serve as a credible contracting alternative to GPO contracts. That said, our research with self-contracting health systems indicates that for true commodities (such as basic hospital items such as catheters, syringes, gauze, etc.), few outside of the largest systems are able to generate enough incremental value beyond their GPO contracts to justify establishing a self-contracting function. But for PPIs and other moderate-preference and customized items (such as diagnostic testing and laboratory supplies, nutritional products, and purchased services), self-contracting can meaningfully expand the value providers generate from their supply contracts. In our research, the key to successful self-contracting lies in:

(1) effective price discovery, enabling key decision makers to evaluate the relative value of different supplier proposals across a variety of spend categories

(2) contracting terms that generate mutual value for supplier and providers beyond pricing concessions, and

(3) credible volume commitments facilitated by close hospital-physician alignment, so that suppliers can have reliable visibility into their customers' true spend.

Self-Contracting Opportunity Assessment



Today, many health care providers already contract directly for relatively low-volume, high-preference PPIs (such as cardiovascular, orthopedic, and spine implants). But to secure competitive proposals from suppliers, providers need the ability to make apples-to-apples comparisons of supplies across a number of quality vectors (determined by clinicians), and then effectively solicit proposals from suppliers that enable both parties to evaluate different bundles of supply contracts that are mutually beneficial. To learn more about how this process works and the infrastructure required, please review a detailed discussion of new technologies that are enabling better price discovery in the Health Care Advisory Board's recent study, ***Next-Generation Supply Cost Savings***. If you would like more information, or would like to request a complimentary customized Self-Contracting Opportunity Assessment, please contact Sean Sullinger at **sullinges@advisory.com**.