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Rethinking Healthcare Expense Management Post-COVID

The Kaiser Family Foundation estimates the cost of treating a single COVID-19 patient in a US hospital could reach $20,000.[1] If ICU care and ventilation therapy are required, these costs could reach $88,000 per patient. For a large metropolitan level one trauma center with 70+ critical care beds, if all beds are 100% occupied with COVID-19 vented patients, the cost of care could reach $6.7 million. Few, if any, hospitals can sustain this kind of expense.

The pandemic hit hospitals like a perfect storm, exacerbating and conflating all three of their costliest areas of operation: labor, supplies and bad debt. A recent national survey of healthcare executives conducted by FTI Consulting confirmed that COVID-19 shook the operational expense management programs of most hospitals, and their Group Purchasing Organization (GPO) partners provided little to no assistance, leaving even the better-performing hospitals struggling to sustain their pre-COVID supply chain operating margins.[2]

Less efficient hospitals that were already wrestling with razor-thin operating margins prior to the outbreak are taking the hardest blows. One such example is a rural facility in Kentucky where, in a good year, the CEO hopes for 0.6% operating margins. The hospital post the first COVID wave saw operating margins at negative 25%.[3,4]

We don't pretend to know what the future of healthcare will look like in a post-COVID world, but what we do know is, if healthcare systems continue to operate with a "business as usual" attitude once we emerge from this perfect storm, they are all setting themselves up for an endurance course laced with choppy waters.

Almost immediately after the initial Spring 2020 COVID surge abated, hospitals began stockpiling 90-120 days of personal protective equipment (PPE) and other respiratory equipment in their warehouses to buffer against the next anticipated surges. Supply chain executives responding to FTI's national GPO survey,

indicated stockpiling was necessary, largely because many manufacturers and distributors they had counted on (associated with their GPO memberships) failed them in the spring 2020 surge and they did not want to be caught flat-footed if/when the next surge came.[2] Stockpiling product is just one of many course correction tactics supply chain managers are taking as a result of lessons learned from wave one. GPOs, manufactures, and distributers are making some course corrections, as well.

Have We Put Too Many Eggs in the GPO's Basket?

Healthcare GPOs have become Wall Street and Washington power brokers. In fact, according to The Healthcare Supply Chain Association (HSCA), a handful of mega healthcare GPOs now act as supply expense management intermediaries for 96%-98% of all hospitals in the United States and control close to 60% of a hospital's non-labor annual spend.[5] With these types of statistics, it is easy to see how the U.S. hospital supply chain has become so intrinsically intertwined with GPOs. As previously noted, FTI Consulting's national client survey showed that when hit by the catastrophic event of the COVID-19 hit, GPO member hospitals experienced limited to no help from their GPO's contractual agreements when it came to procuring products at contracted pricing rates.[2] Suddenly, a program contractually designed to help most American hospitals control their expenses had little to no effect or influence in doing so. In fact, many hospitals that pledged and were honoring their GPO's high-commitment purchasing thresholds, created through single-supplier contract strategies, found themselves aggressively competing with peers in their purchasing aggregation cohort for the same supply pallet of PPE, sparking bidding war frenzies among local hospitals within the same community.[5,8]

The Society for Healthcare Organization Procurement Professionals (SHOPP) estimates that pre-COVID, PPE cost the average US hospital $0.35 per bed per day. Within the first weeks of the COVID pandemic, PPE requirements for the average COVID epicenter hospital tripled or quadrupled, sending the average cost of PPE to a whopping $25.58 per bed per day.[6,7]

How to Stabilize and Strategize Supply Chain Core Operations

The current situation with COVID-19 has created an unforeseen burden on supply chain operations. We see five critical elements to stabilizing short-term needs and developing a mid-term strategy:

Be Flexible and Transparent

1. Manage extra capacity for critical resources
2. Provide a rapid response
3. Reconfigure process flow to support operations as needed
4. Provide realistic advice related to availability and forecasting of critical supplies
5. Support workforce and communicate

Balance Accountability and Demand

1. Establish collaborative communication with clinical leadership for demand planning
2. Develop surge and contingency plans to provide the proper lead time
3. Establish process for managing cost and financial impact from increased demand

Centralize Procurement

1. Centrally control all buying, inventory management and distribution
2. List and prioritize needed at-risk supplies and Rx daily
3. Leverage GPO – relationships with suppliers and wholesaler resources
4. Catalog the quantities of essential medications, materials

Manage Sourcing

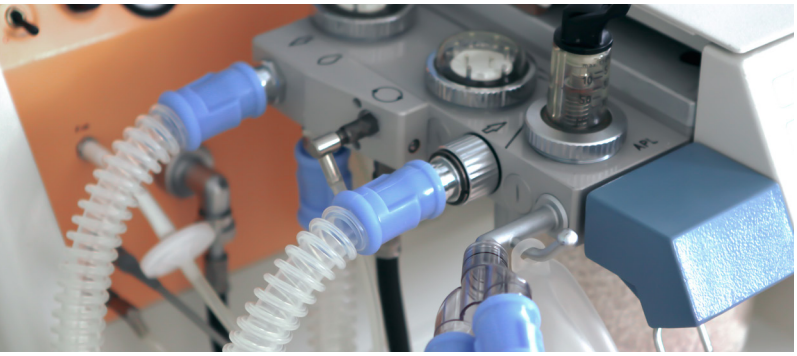
1. Know your suppliers and develop alternate distributors
2. Identify supplier risks and sourcing red flags
3. Demand backorder and forecast reports from distributors
4. Utilize available resources from GPOs and distributors
5. Identify substitute products and alternative vendors

Monitor Inventory

1. Understand critical vulnerabilities and risks
2. Track and trend daily burn rates, inventory on hand, pending orders in pipeline
3. Be informed about gov't and voluntary organization support
4. Inventory critical equipment for advanced therapies including those under service/repair
5. Collaborate with regional providers for mutual support

Over the years, many healthcare stakeholders, including Congress, have questioned, studied and reported on the role healthcare GPOs play in managing overall U.S. supply chain expenses. Study after study validated that GPOs provide savings, particularly in the commodity-based product areas.[8,9] However, COVID's PPE procurement debacle exposed that cost-savings on commodity products means nothing if you can't procure quality product from the GPO's contracted supplier in a timely fashion, at the contracted price and for the quantities required.

Hospitals aren't the only ones that learned from the spring COVID-19 surge; GPOs, distributors and manufactures gleaned valuable insights, too. They learned some of their GPO-within-GPO aggregation expense management strategies, which use high-dollar or market-share compliance threshold requirements for a given product category like PPE, can backfire quickly when everyone is trolling for the same product from the same supplier. Now, much like its hospital members are adapting to the new world order through stockpiling, one GPO is adjusting its business strategy by soliciting member organizations to partner with it to buy controlling interests in PPE manufacturers as a hedge against potential shortages by their current contracted suppliers.[10] A business model where, again, hospitals need to pay more money to GPOs, with little tangible guarantee they will get a return on their investment.



Is It Time to Return to Hospital Self-Contracting Models?

PPE shortages weren't the only expense management gap revealed during the initial COVID outbreak. GPO supplier-negotiated agreements are between the GPO and the supplier, not the hospital and the supplier. During the height of the PPE procurement scramble, many hospitals realized this arrangement left them with limited visibility of what the GPO agreed to with PPE suppliers on their behalf. This lack of transparency became patently more concerning when a pandemic readiness assessment survey conducted in April 2020 found that 27% of global healthcare manufacturers indicated that their organization had no pandemic readiness plan in place, and 42% indicated that their supply chains had not tested their pandemic plan in the last three years.[11]

These statistics got the industry's attention, indicating it may be time for hospitals to rely less on GPO intermediaries for contractual heavy-lifting and more on themselves to vet chosen business partners' capabilities.

To be fair, this survey validated that a shift in the market has been occurring since the early 2000s when hospital consolidations peaked, creating multi-state, healthcare mega-systems with the aggregate buying power to actively command the attention of suppliers and business-savvy leaders with global oversight and the ability to nimbly steer their organizations faster than their GPO partners.

FTI Consulting's national healthcare provider survey supports this, indicating that while most healthcare organization's joined GPOs for expense management, many still feel a need to hire third-party benchmarking services to validate that the GPO product pricing is market-competitive.[12] This means hospitals are paying additional fees to outside agencies to validate their GPO membership's value.

FTI National Survey On GPO Satisfaction Survey Results By Service Category

Survey respondents were asked to rate services on a scale from 1 = "Extremely Dissatisfied" to 5 ="Extremely Satisfied"

Levels of survey respondent's overall satisfaction with their GPOvalue-adds were mediocre at best

3.4 **Average Overall GPO Satisfaction Rating**

2.7 Average respondent's **satisfaction score regarding their GPO's pandemic response**

71% Organization's surveyed Indicated [they] **would like improved competitive pricing options for supplies from their GPO**

Commodity Supplies	3.4
Physician Preference Items	2.8
Pharmaceuticals	3.2
Purchased Services	2.6
Software/Tools	2.9
Advisory Services	2.9
Networking	3.2

Putting GPOs to the Test: ROI Walkthrough

This is a high-level hypothetical walkthrough based on experience. Other factors such as required workforce, processes, compliance monitoring and vendor negotiations need to be considered prior to converting from current contracting model.

GPO Contracting	Local Contracting (on GPO paper)	Self-Contracting (GPO vacuum)
$100 Million in Spend	$100 Million in Spend, 5% Savings New spend $95 Million	$100 Million in Spend, 10% Savings New spend $90 Million
2-3% Contract Admin Fee (CAF) from Vendor to GPO[1]	2-3% Contract Admin Fee (CAF) from Vendor to GPO[1]	0% Contract Admin Fee (CAF) to GPO
50-60% CAF Shareback[2]	50-60% CAF Shareback[2]	0% CAF Shareback
$.19/Share Quarterly Dividend @ 1 Million Shares	$.19/Share Quarterly Dividend @ 1 Million Shares	$0/Share Quarterly Dividend @ 0 Shares
$1M-$1.8M CAF Rebate $760K Annual Dividend	$950K-$1.71M CAF Rebate $760K Annual Dividend	HOWEVER, typical direct to vendor contracting negotiations yield 5-15% savings
		Staffing Needs: Contract Managers, Business Intelligence - 10 at $100k each
$1.8M - $2.6M Benefit	**$6.7M – 7.5M Benefit**	**At 10% savings, there is a $9M Benefit! Self-contracting also provides a revenue opportunity.**

[1]Source: Healthcare Supply Chain Association cites 2010 range of 1.22% to 2.25%. Estimate used to show high range benefit possibility
[2]Source: High range estimate based on public statements that sharebacks will be in the "high-40% to low-50% range moving forward"

Preparing for Change in a Post-COVID World

Unlike hospitals, GPOs began planning years ago how to survive in the event Congress eliminated the safe-harbor rules enacted by the Department of Health and Human Services in 1989, allowing them safe harbor of administrative fees from suppliers as revenue streams.[13,14] Over the last several years, the industry has seen GPOs expanding their reach well beyond being purchasing aggregators and intermediaries. They now have strategic business partnerships with governmental agencies such as the National Institutes of Health and the Federal Drug Administration.[15,16]

While healthcare systems have evolved, expanded their footprints and diversified their financial holdings, FTI Consulting's survey indicates that many healthcare organizations haven't evaluated the value their GPO business partners bring to them in over 10 years.[2]

Beyond COVID – Rethink Preparedness

The COVID-19 crisis obliges the health care industry and supply chain to rethink "emergency preparedness" and examine all aspects of operations.

Government Regulations

1. Assign responsibility for ensuring updates related to regulations and requirements and develop a review cadence
2. Monitor the updates from governmental agencies regularly to adopt potential policy changes and guidelines for supply, equipment and drug utilization
3. Continuously explore FDA information related to mandates on pharma companies and import of generic drugs from other countries when in short supplies as well as mass manufacture needed drugs

Support from Distributors and GPO

1. Develop contingency planning and service-level agreements with your primary distributor (supply and Rx)
2. Establish clear requirements for emergency stock based on lead time
3. Consider developing disaster-related evaluation metrics with distributors and manufacturers
4. Establish an alternate distributors list for critical supplies with clear understanding of logistics and ability to support

Internal Supply Chain Agility

1. Develop business continuity plans and feasibility of surge production
2. Explore enhanced ERP to support the supply forecasting often utilized in other industries
3. Evaluate effectiveness of JIT or LUM for critical supplies
4. Develop and experiment with scenario-based exercises

Cost Management

1. Ensure COVID-related expenses (disposables, capital, purchased services) are monitored, tracked and trended
2. Establish a centrally monitored resource pool
3. Minimize exposure to loss of expensive equipment by assigning accountability
4. Collaborate with finance to monitor changes to reimbursement, as it is changing during this crisis
5. Work with manufacturers, distributors and GPOs to establish contracts and range of pricing, for products and drugs related to crisis management.

In the wake of this pandemic, if healthcare organizations wish to become less dependent on intermediaries, they first need to look within to see what is working for expense management and what is not. GPOs have known for years they are not a "one size fits all" business model. Yet, 96%-98% of healthcare systems have jumped onto the GPO one-size fits all contracting bandwagon for years.[5] Now is the time for healthcare systems to prepare for a post-COVID world that relies less on intermediaries like GPOs, and more on leading practice expense-management tools and well-defined local contracting strategies that fit their organization's individual strategic plans.

In non-labor client work, FTI Consulting has found that very few organizations are functioning at the highest possible maturity expense management thresholds. Our Expense Management Operational Maturity Model below and the following five key elements highlight areas healthcare organizations should check for gaps.

Supply Chain Expense Management Maturity Model

Leading Practice	Base Camp	Starting Out	Maturing	Leading	Innovating	My Score
Organization's supply expense is aligned with clinical service line's product consumption needs.	1	2	3	4	5	
Organization's total number of expired/obsolete/wasted product(s) as a percentage of total purchases is below 10%.	1	2	3	4	5	
Organization measures & monitors top-10 vendors spend quarterly.	1	2	3	4	5	
Organization reviews GPO membership every 2-5 years to ensure pricing and value are commensurate with market.	1	2	3	4	5	
Organization evaluates Supply Expense Per Adjusted Patient Discharge & Case Mix Index (CMI) at least semi-annually and adjusts, as necessary.	1	2	3	4	5	

Key Elements for Effective Expense Management

1. Limit your organization's passive reliance on GPOs as a method to manage contracts, line-item pricing and vendor relations. And, if your organization's expense management strategies are not in alignment with your current GPO business partner, consider a change.
2. Ensure that your healthcare system's emergency preparedness plans to deal with supply chain disruptions are living, breathing documents and not dust collectors on a shelf.
3. Frequently assess your organization's supply-chain operations related to expense management and close gaps when they present themselves.
4. Use technology and predictive data analytics to plan day-to-day supply chain expense management operations to predict product consumption rates, manage inventory and prevent stock-outs.
5. Engage all key clinical and service-line operational stakeholders frequently as business partners in expense management. Listen to their needs and manage expectations.

CONCLUSION

Expense management has become more critical than ever before because of the economic havoc caused by COVID. Tuning up the non-labor expenses and looking beyond traditional reliance on GPOs for cost optimization is critical. Collaborating with clinicians and developing a transparent data exchange under a governance that supports organizational goal of cost optimization is key. If hospitals continue to do the same things over and over, they will always yield the same results. Only when we have the courage to step out of our comfort zones, analyze and rethink why we do what we do, will we become enlightened enough to change and make a difference.

Footnotes:

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