

## Managing implant distribution and costs

By Maureen Leahy

### Two solutions that put surgeons and hospitals in the driver's seat

For several years, there's been a disconnect between payments to orthopaedic surgeons who perform joint replacements and the cost of the procedure itself. While reimbursement for a hip replacement fell nearly 26 percent from 1997 to 2007, for example, the "average selling price" of a total joint implant increased more than 130 percent.

To help control these costs, surgeons and hospitals are implementing newer business models. Two such models are the surgeon-owned distribution company and the joint physician-hospital negotiating team.



*John C. Steinmann, DO Peter D. McCann, MD*

### Surgeon-owned distribution

Traditionally, a hospital purchasing department finds it very difficult to effectively negotiate pricing when it comes to the purchase of advanced surgical implants. These items are purchased at the direction of the surgeon, leaving the purchasing agent with no negotiating leverage, according to **John C. Steinmann, DO**. Highly paid distributors and product representatives also contribute to higher implant costs.

To address these problems, Dr. Steinmann and three other orthopaedic surgeons in California have established their own joint replacement and spinal implants distribution company.

"In our surgeon-owned distribution model, surgeons negotiate directly with implant manufacturers to buy in bulk; we also employ sales representatives and contract directly with hospitals," Dr. Steinmann said. "This model incorporates volume pricing, effective negotiation, and a reasonable salary for sales reps, which results in significantly lower implant costs."

Does this type of distribution model raise legal or ethical concerns or promote the use of lower-quality products? According to Dr. Steinmann, a legal analysis of the distribution model concluded that "manufacturer sales of implants to a physician-owned distribution company, physicians' investment in that company, and sale of implants by the company to hospitals and ambulatory surgical centers (ASCs) should not be found to be prohibited by federal anti-kickback or self-referral laws or similar laws in California." Such entities are also not prohibited by similar laws in many other states.

"This is a highly ethical model that distributes high-quality products, employs qualified reps, provides complete

disclosure to patients and transparency to hospitals and colleagues, and demonstrates cost savings,” said Dr. Steinmann.

He also noted that many implant products approved by the U.S. Food and Drug Administration (FDA) are very similar. The key is finding an implant that can be purchased for a better price—often a half or a third less than similar styles. This is fairly easy to do, he says, because there are many very good and reputable companies that are looking to gain market share.

Successful implementation of a surgeon-owned distribution company involves several steps ([Table 1](#)), and absolute commitment and surgeon leadership are essential, Dr. Steinmann said. In addition to inventory costs, operating expenses include lease or rental payments for an office, supplies, insurance, salaries, and computer and telephone systems. “You can literally get a distribution company up and running in 60 days,” he said.

At the 2009 AAOS Annual Meeting, Dr. Steinmann and his colleagues presented an economic analysis of their distribution model. At the time, the surgeon-owned company had been successful in reducing implant costs by \$1.2 million at its three contracted hospitals.

Dr. Steinmann added that the company has not increased its implant prices since the company’s formation in 2006; in 2010, due to their continued success and desire for the hospitals to remain competitive, the company announced a price reduction.

The surgeon-owned distribution model, said Dr. Steinmann, “introduces market forces, drastically reduces distribution costs, and is sustainable, year in and year out.”

### **Combining hospital and physician interests**

Another way to cut implant costs is for surgeons and hospitals to work together. In 2009, a system of hospitals in New York City began developing a contract negotiation process for joint implants. In preparation for direct negotiations with the manufacturers, the hospitals formed a leadership group—comprising orthopaedic department chairs and supply chain administrators—to align the interests of the institutions and the orthopaedic surgeons, establish specific goals, and obtain practitioner buy-in.

“Aligning the interests of the institution and individual surgeons is key—the two need to partner with each other,” explained **Peter D. McCann, MD**, who spearheaded the process. “We can’t succeed without acknowledging each of our interests and leveraging our combined goals.”

An essential step in this process was the creation of a new administrative position—vice president of perioperative services—that was filled by Donald M. Kastenbaum, MD, who was charged with representing the joint interests of the entire hospital system and its surgeons during implant contract negotiations.

“Taking a reasonable and direct negotiation stance depended on having one voice that spoke not only for the institution but for all the practicing surgeons,” said Dr. McCann.

The leadership group examined the hospitals’ present implant volumes, the types of implants being used, and the cost of the implants. It established criteria for a demand-matching program designed to ensure that patients received the most appropriate implant, based on their level of physical activity. Instead of relying on surgeon preference, the group decided to focus negotiations on three categories of implants (standard, mid-level, and high-demand) that are supported by evidence-based, peer-reviewed literature. They determined what they believed to be fair prices for each category and set a goal of achieving a 10 percent savings over the previous 12 months on new implant contracts. The contracts would be renegotiated every 3 years.

Clinical members of the leadership group then outlined the plan to the practicing surgeons. “Our presentation of the data to the surgeons was complete and fully transparent,” said Dr. McCann. “It was essential that we had their buy-in.”

Once physician support was established, the leadership group initiated direct negotiations with all interested implant manufacturers. Dr. Kastenbaum presented the same offer to each vendor. As with most negotiations, there was give and take on both sides.

“We weren’t rigid—we understood that the companies needed us as much as we needed them,” said Dr. McCann. “That’s why it was important for the process to be transparent, consistent, and cooperative; the relationship had to maintain respect.”

In the end, that reasoning paid off. They surpassed their goal of a 10 percent savings over the prior 12 months for the same volume of implants. In one year, the joint implant negotiation process has evolved into a successful business model that satisfies the needs of all stakeholders, said Dr. McCann. It saves the hospitals money, provides surgeons with the best and most appropriate implants to offer their patients, and permits manufacturers to make a profit.

*Disclosure information: Dr. Steinmann—Alliance Surgical Distributors; Inland Spine and Orthopedic Products; Synergy Surgical Technologies; Specialty Surgical Technologies; Dr. McCann—American Journal of Orthopedics; American Shoulder and Elbow Surgeons.*

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*Maureen Leahy is assistant managing editor of AAOS Now. She can be reached at [leahy@aaos.org](mailto:leahy@aaos.org)*

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6300 North River Road Rosemont, Illinois 60018-4262 Phone 847.823.7186 Fax 847.823.8125

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