Strategies for Managing Orthopedic Implant Costs

Orthopedic implants are some of the most expensive supply purchases hospitals make, and the cost of orthopedic implants continues to rise by an estimated 13 percent annually. As clinical indications for hip and knee implants increase and the U.S. population ages, more patients will require orthopedic replacement surgery, driving costs up even further. For hospitals operating on razor thin margins, there is a growing need to rein in implant costs while sustaining care quality. In this HFMA Executive Roundtable, sponsored by Implant Partners, several healthcare leaders share their organization’s strategies for balancing cost considerations with quality goals.

What key strategies is your organization using to manage orthopedic implant costs?

James McManus: St. Joseph Health System relies on a specialty committee made up of orthopedic surgeons to discuss implant management strategies and make recommendations. The committee reviews current spend and looks at which implants would be clinically appropriate for our organization going forward. They consider product equivalency and whether any one product is clinically superior to others, focusing discussions on current research and other relevant marketplace information and avoiding conversations about personal preference. They also evaluate if it is better to pursue different vendor contracts for different regions or engage in a systemwide contracting exercise. They also determine whether to partner with more than one vendor or pursue a single-source relationship.

Once they agree on a strategy, we send out a request for proposal (RFP) and speak with suppliers. The committee reviews the RFPs and selects the vendors with which to contract. Currently, we use three suppliers for implants.

A crucial aspect of our strategy is that we advise physicians not to use implants that are not covered under our contracts, unless the physician can demonstrate to the orthopedic surgery committee—using clinical research—that the product he or she wants to use is clinically superior to those with which we contract. This allows us to remain consistent in the products we use as well as in our support for our suppliers. Without a policy like this, contracts can become somewhat meaningless because everyone can just come in and use whatever they want.

Matthew Pehrson: For the past 5 years, Presbyterian Healthcare has focused on capitation for orthopedic implants, and that journey has brought us from five vendors to four, then two, and ultimately to a sole-source provider. We have found this approach to be beneficial from a cost as well as an efficiency perspective. The more vendors you have coming into the OR
[operating room)—especially ones that work with central sterile or have lots of different instrumentation—the more difficult it is to have quick turnaround time and throughput. With a sole-source vendor, we gain efficiencies in cleaning and flipping the OR while standardizing instrumentation sets—because we are only managing the work of one vendor.

On the cost side, there are price advantages to using a sole source. To fully realize those benefits, we made sure to lay the groundwork up front in the contract, aligning our goals with those of the vendor and putting in very specific language to prevent upselling in the OR. Basically, we outline the “basket of goods” we agree to use and the price we will pay for those goods. If a particular case requires a product that is outside the contract, then the product must go through a formal approval process before we will agree to use and pay for the product. If the case is done without approval, then the vendor knows we will not pay more than the agreed upon price.

Although using a sole source is a good strategy for us, we did give up certain advantages that come with using more than one vendor. To a degree, we gave up price competition and also potentially exposed ourselves to a price increase at the time of contract renewal. Since our surgeons will have worked with one vendor and become comfortable and proficient using those implants, it may be harder to negotiate price. We took all these factors into consideration before making the decision to go the sole-source route, getting our CEO, medical director, and surgeons involved in the choice. Eventually we opted for this approach because it gave us excellent pricing and the opportunity for greater standardization. Plus, we felt it could best support our quality care goals.

Daren Relph: Wayne County Hospital manages implants a little differently because we are a small critical access hospital, and we only have one orthopedic surgeon. Because of our size and relatively remote location, not every implant vendor is willing to come and meet with us, and it can be difficult to negotiate price. For the most part, we rely on our surgeon to recommend appropriate vendors and work with those suppliers who are amenable to a partnership.

In some cases, we have to educate the vendors on how we get reimbursed for implants and why having a lower cost is so important in terms of our cash flow. We often carry costs for 12 to 18 months without receiving payment, so the lower implant cost is necessary for us to remain financially stable.

One cost-cutting strategy for implants and other high-cost clinical supplies is price transparency. How aware are your surgeons of implant prices?

Pehrson: We certainly inform our surgeons of the price we pay, but I don’t believe it is a top concern for them when choosing which implants to use. They are more focused on the quality of the equipment and its ability to support a good outcome for the patient. With that said, I think the tide is turning as physicians get more involved in the revenue cycle and pay more attention to how hospital financial performance impacts their pocketbooks. We have a lot of employed physicians, and while it doesn’t always make price conversations easier, we are all on the same team, so the physicians are starting to appreciate the economic barriers the hospital faces.

At the end of the day, however, choosing the right implants is still a balance between costs and the equipment surgeons are accustomed to, comfortable with, and feel safe using.

McManus: Our orthopedic committee is also aware of implant costs. The supply chain team shares with the committee all the pricing information they have on different implants and what that information means. We also provide the committee with data about price variation across suppliers and within a supplier, comparing high-technology versus low-technology. Furthermore, we share benchmarking information with the committee in the form of a blinded report that shows what other organizations are paying for implants by geographic region. This data also helps us during conversations with our suppliers if we feel they are way off in the prices they are negotiating.

Despite being fully informed about price, the committee still looks at clinical indicators first when making a recommendation. Price can play a part, but the ultimate driver is whether the implant can deliver quality outcomes for patients.

Jason Baty: An organization’s culture will determine the role price plays in the implant decision. If surgeons feel they can choose any implant they want regardless of price, then that is what they will do. However, if the culture is one where surgeons evaluate options, assess costs, gain consensus, and implement a defined strategy,
then there will be a process in place to marry cost considerations with quality goals, especially if there is some form of shared savings with the surgeons. When organizations give surgeons a portion of potential savings, it highly incents physicians to reduce costs while maintaining quality.

**McManus:** We are open to sharing the cost benefits from implant contracts with physicians. This may take the form of gainsharing, a shareback mechanism, or a co-management model. In this case, gainsharing can happen when we meet or exceed specified quality targets and other criteria, with physicians sharing financially in the improvement. Shareback occurs when a percent of savings is delivered back to the hospital for use in upgrading OR equipment, room monitors, and so on.

**How do you ensure your implant management strategy remains appropriate over time?**

**McManus:** After contracts are settled, we engage in monthly and quarterly reporting to verify vendors are meeting our objectives. We also have routine conversations with vendors to make sure both parties are happy with the arrangement. This gives us the opportunity to amend the contract if necessary. For instance, if we feel the vendor is not as price competitive as the vendor was when we first signed the contract, then we may approach the vendor to do a contract amendment and bring the price more in line with other suppliers. This is not a mandate nor do we demand the vendor change price, but we do suggest the idea. Many vendors are open to this because they want to remain competitive throughout the life of the contract and avoid pricing themselves out of the market by the time the renewal process begins.

**Pehrson:** We regularly re-evaluate our approach to implant management, understanding that no single method is a panacea. Our decision to work with a sole-source vendor is appropriate for us right now, but it may not be relevant in the future as payment reforms evolve. Whenever we take on an initiative—such as improving our process for managing implant costs—we always stay open to new ways of doing things. Over the next few months, we may seek different strategies depending on the changes in the marketplace.

**What role can financial executives play in managing implant costs?**

**Pehrson:** Managing implant costs is not just a supply chain or OR initiative, it is a decision that should involve physicians and senior leadership, including financial executives. Senior leadership must appreciate the pain points involved with implant selection and recognize how the organization can address those pain points. They can also spearhead conversations with physicians, shaping the interactions to focus on delivering the best value.

**McManus:** Financial leaders play an important role in supporting the direction our physician committee recommends. They consistently communicate that the review process represents a solid approach to equipment selection, and they uphold and support agreed-upon contracts. If a physician wants to use equipment outside the contract and circumvents our approval process, leadership communicates with the physician that there is a process in place that needs to be followed and there will be consequences if the process is skipped. This ensures that everyone is on the same page regarding how equipment is chosen and used.

**Some organizations have started focusing on managing or reducing the role of the manufacturer’s sales representative in the operating room. How does your organization ensure your relationship with the vendor fully supports your goals?**

**Pehrson:** It is challenging to manage the influence of the manufacturer’s representative because the surgeon-representative relationship is an exceptionally powerful one. Surgeons have long relied on manufacturers’ representatives to keep them abreast of new developments and techniques, and there is a high level of trust there, which is why surgeons are willing to listen to representative recommendations in the operating room. These individuals have the knowledge and expertise to help with surgery.

Unfortunately, representatives can sometimes take advantage of this relationship and upsell products that are not entirely clinically necessary. Plus, their presence can add to the implant costs, and if too many vendors are used throughout an organization, it can negatively impact efficiency in terms of room turnover and throughput.
Many organizations are starting to pursue vendorless operating rooms—the market is moving in that direction. That said, there are potential pitfalls with this approach. Without a manufacturer’s representative, the hospital will need to find a replacement who is well-versed in the equipment, available for procedures, and ready to go at a moment’s notice. That can require additional full-time employees and significant training. Plus, staff cannot become jacks-of-all-trades—assisting with both orthopedic surgeries and spinal surgeries, for example. They will have to specialize to a certain degree.

**Relph:** We are seeing a number of benefits from our relationship with a vendor who limits the role of the manufacturer’s representative. First, we get implants at a reduced cost, because the manufacturer doesn’t have to support the salary of a representative and passes that savings on to us. Second, we can better set expectations for staff performance and monitor that performance because things are now in-house, bringing that aspect of the operating room under our quality control.

Of course taking this approach puts more expectation on our staff because they are now taking on the duties of the manufacturer’s representative. This means more training for staff—but since they are already familiar with the operating room and how to support orthopedic surgery, the training piece is not necessarily a downside. As long as there is sufficient training, we see this as a way of improving our quality while realizing some true cost savings.

**Baty:** Reducing reliance on the manufacturer’s representative does allow an organization to get more control over the operating room. It also encourages an organization to develop its own people to take on more responsibility. Trained staff will learn the technique of the procedure and how to get the instruments into the OR and ready for use as well as complete appropriate paperwork to get supplies replenished. Many OR staff members are eager to assume this responsibility.

In addition, by controlling the presence of the manufacturer’s representatives, you also limit the problem of upselling in the OR, allowing you to better plan for costs, instead of managing them on the fly.

While reducing reliance on the representative is appropriate in many instances—particularly those bread-and-butter cases in which the surgeon does not anticipate complications—there are certain situations where having a manufacturer’s representative present is still a good idea. For instance, if an organization believes that a case will be more complex or is a revision case, then having a representative in the room may be wise as this individual will have a greater depth of experience and can better respond to unexpected events.

One thing to note: Proper economic alignment between hospitals and orthopedic surgeons is essential so that surgeons are regarded as owners in the entire episode of care. Then these choices are made with all information shared among all stakeholders.

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**How does your organization best build a quality case while maintaining implant cost control?**

**Pehrson:** Quality and cost are not mutually exclusive. The reality is that implants do not drive quality—most implants on the market are able to support a quality patient experience. The key quality drivers are pre-operative and post-operative care practices as well as the surgical experience. Our quality department works with surgeons to manage these care aspects, making the choice of implant secondary to the primary concerns of how the organization is managing infection control, resource use, medication use, efficiency, and so forth.

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**Endnotes**


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