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# Assurance and Sustainability

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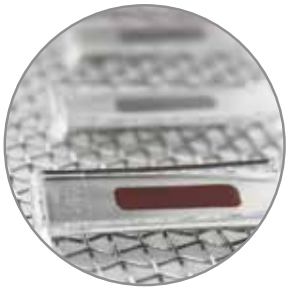

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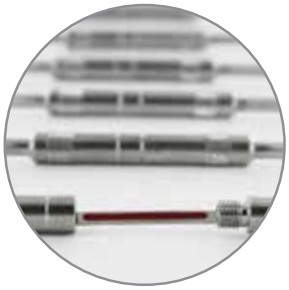

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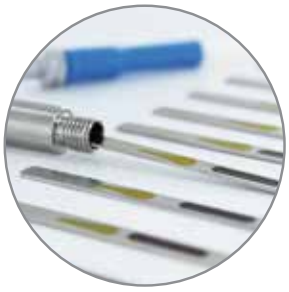

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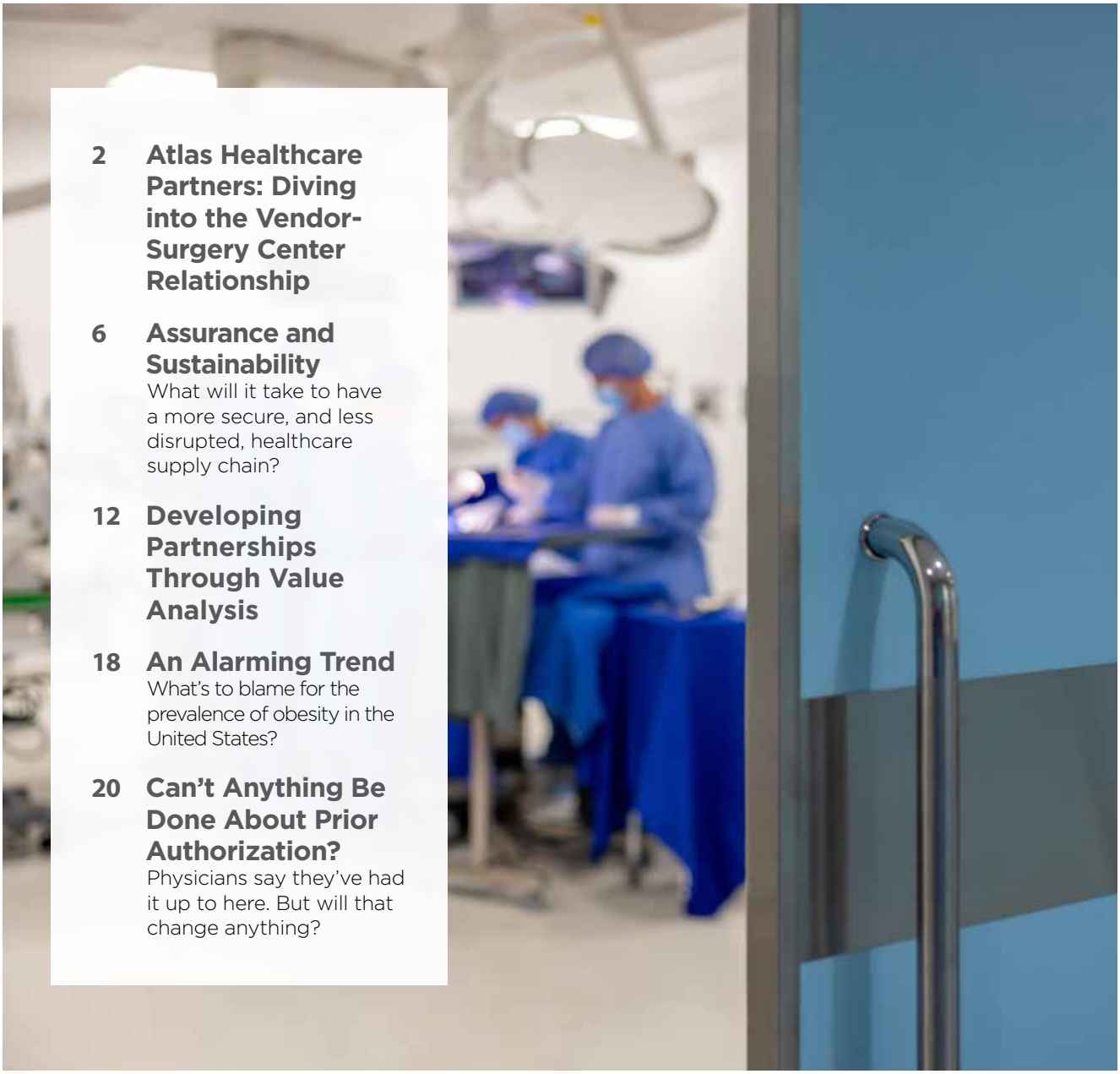


2 **Atlas Healthcare Partners: Diving into the Vendor-Surgery Center Relationship**

6 **Assurance and Sustainability**
What will it take to have a more secure, and less disrupted, healthcare supply chain?

12 **Developing Partnerships Through Value Analysis**

18 **An Alarming Trend**
What's to blame for the prevalence of obesity in the United States?

20 **Can't Anything Be Done About Prior Authorization?**
Physicians say they've had it up to here. But will that change anything?


*The Journal of Healthcare Contracting* is published bi-monthly
**by Share Moving Media**
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*The Journal of Healthcare Contracting* (ISSN 1548-4165) is published bi-monthly by Share Moving Media, 350 Town Center Ave, Ste 201, Suwanee, GA 30024.

# Atlas Healthcare Partners: Diving into the Vendor-Surgery Center Relationship

BY PETE MERCER

**Businesses are built off relationships in every industry, but they are especially critical in healthcare. With all the** challenges that healthcare organizations face with issues of compliance, it's important to partner with someone you can trust to meet the needs of your business. But what does it take to maintain those relationships in an environment that's constantly changing?

*The Journal of Healthcare Contracting* recently sat down with Marc Toth, Market President, Cardiovascular Services at Atlas Healthcare Partners; Kristen Richards, Regional VP of Cardiovascular Operations at Atlas Healthcare Partners; and Adam King, Senior Director Ambulatory Surgery Centers at Medtronic, to discuss the value that ambulatory surgery centers can provide for patients and providers, a new agreement for Atlas Healthcare Partners and Medtronic, as well as a close look at the relationship between vendors and surgery centers.

## Who is Atlas Healthcare Partners?

Atlas Healthcare Partners is a company that partners with health systems and physicians to develop and own ambulatory surgery centers. Atlas provides comprehensive management and revenue cycle services as well as all non-physician staff to these ambulatory surgery centers through a professional management team with the necessary experience to help operate and grow the center's business.

Toth said, "As a company, we do all the procurement, staffing, and day-to-day operations. When we buy from companies like Medtronic, the contract is negotiated with Atlas and its in-house experts, including legal. All of our ASCs involve physician and health system ownership."

The mission of Atlas is to deliver exceptional care and outstanding service to every single patient, every single time, as Toth put it. Part of what differentiates Atlas from other organizations in this field is that they have a dedicated cardiovascular team – Toth and Richards are both on the cardiovascular leadership team.

While many companies might have taken steps to include cardiovascular services, Atlas is focused on all of the nuances regarding cardiovascular. MedAtlasCV is the direct result of that focus – a partnership formed between Atlas and MedAxiom to provide higher quality clinical care and operational outcomes for cardiovascular ambulatory surgery centers.

In addition to the focus on cardiovascular care, Atlas is also unique in that it forms a master joint venture with a health system for a particular market area (which in some cases is state-wide) and then serves as the strategic partner to the health system to develop a network of ASCs in the market area, all of which have physician investors. According to Toth, 49% of each surgery center is owned by the physicians and 51% is owned by the master joint venture between Atlas and the health system.

Adam King from Medtronic explained that ambulatory surgery center management companies are well positioned

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for vendors to collaborate with because of the expertise they can provide both hospital-owned and physician-owned centers. "As hospital systems look to open more ASCs, they may find that the management of those centers can vary greatly from their general acute care hospital. Services, staffing, and patient throughput can be different, and working with a partner that has expertise in surgery centers can be beneficial. From the physician perspective, working with a partner on the complex business side of managing ASCs can be equally beneficial, creating an opportunity for collaboration."

The arrangement between Medtronic and Atlas is due in large part to Atlas's cardiovascular specialization that allows it to diversify and provide deeper expertise to surgery centers than organizations that try to simply manage them.

## The value of ambulatory surgery centers

With about 6,500 Medicare certified surgery centers in the United States, it's important to understand how they operate, why they are valuable, and how they are supplied. The first surgery center was opened in Phoenix, Arizona in 1970 (which is, coincidentally, owned by Atlas) as a way for physicians to provide timely and convenient same-day procedures for patients in their community who needed them.

In recent years, Medicare has been shifting more procedures into surgery centers, which has the potential to benefit patients. Toth said, "Surgery centers tend generally to be lower-cost sites of care, so we get reimbursed about half of what the hospital gets reimbursed. That means the patient's copay is less. It's a comfortable, convenient setting for the patient to go to. You don't have to park in a parking deck and wind through the hospital. Every procedure is same-day discharge. We have no overnight stay."

Surgery centers can deliver positive results for all parties involved. "The physicians have an investment opportunity as well as a major say in operations," Toth said. "Payers are happy with these sites because they are usually reimbursed at lower rates than hospitals, and patients are happy because of their convenience. I like to say that surgery center sites are better for the greater good."

When it comes to keeping surgery centers stocked with all of the necessary supplies needed to provide adequate patient care, companies like Atlas will usually negotiate agreements with vendors for supplies. Because ambulatory surgery center reimbursement is usually lower than reimbursement for hospitals, Toth said that pricing is an important factor in his team's negotiations with vendors. Options to achieve better pricing may include volume purchasing and a shift toward standardization across broader service lines.

Atlas's Kristen Richards said, "Every one of our centers has a group of different physicians that have different needs and requests. It requires a fine balance of managing those needs. Our ultimate goal is to standardize and get the best pricing on supplies, which our physicians really do care about in this setting. In a hospital setting, they may not care so much because it's the hospital paying for those supplies – that's why the needs are so different from center to center."

From the vendor's perspective, King said, "The ability to standardize in an ambulatory surgery center is more realistic than standardization in a hospital. In a surgery center, you're going to get more uniformity by patient type and procedures, which allows some potential standardization for the vendor as well."

## Atlas's rebate arrangement with Medtronic

Medtronic and Atlas recently agreed to a new arrangement that provides Banner Cardiovascular Center West Valley the option to apply rebates earned on purchases of Medtronic products to the cost of third-party capital equipment used in the center. This arrangement is known as the Medtronic Customer Choice Rebate Program, where the customer chooses the capital that it needs for its surgery center and has the option to offset the cost by applying rebates earned on associated product purchases.

King said, "There are a lot of options. We work with the customer to determine appropriate commitment levels based on their own projections and customize a program."

For Toth, this program is a beneficial offering by Medtronic. He said, "Partnering with Medtronic enables our surgery centers to offset capital expenses and use best-in-class products that they already use and our physicians like."

This program adds to the already existing relationship between Atlas and Medtronic and differentiates Medtronic from the other vendors in this space.

Richards said, "Our relationship with Medtronic helps to further establish Atlas in the cardiovascular space. The Medtronic cardiovascular portfolio is deep and broad, and its technologies are expanding throughout Atlas's organization. That's why King continues to work with our procurement team, because we see how Medtronic can support the surgery centers we manage and, in turn, the patients they serve." ■


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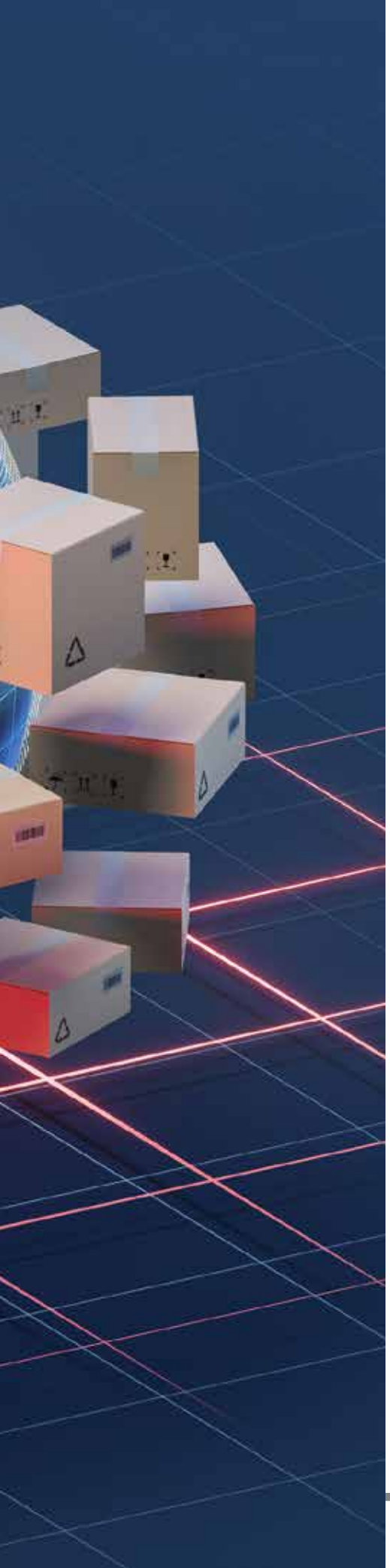

# Assurance and Sustainability

## What will it take to have a more secure, and less disrupted, healthcare supply chain?

**In a recent conversation with *The Journal of Healthcare Contracting*, several** supply chain leaders discussed a variety of topics including sustainability, supply assurance and the importance of nearshore manufacturing. Participating in the discussion were:

**Tim Bugg, CMRP,** President & CEO, Capstone Health Alliance

**Allen Passerallo,** Former supply chain leader at Johns Hopkins Health System, current Vice President Category Management, Vizient

**Mark Welch,** Sr. Vice President, Novant Health

**John Wood,** Chief Executive Officer, Encompass Group, LLC

## Sustainability

**Allen Passerallo:** We evaluate suppliers as best we can, especially within warehousing and the ability to fill their orders. We measure their ability to meet our demands and take that into consideration for our penalty language in our contracts and agreements as well as future strategies when awarding multiple suppliers.

If it's a category that is frequently disrupted and the players come from the same geographical area, it requires us to diversify. Ensuring we have a sustainable operation requires supply assurance.

**Healthcare is at approximately 18.5% of GDP at present. I've been told 20% is the magic number. If we hit 20%, then is it unsustainable? And at some point, does the government step in?**

When we're managing cost structure with clinicians and trying to standardize and reduce variation for a lower price point, but they're bringing up their preference and want to have more suppliers to support future patient treatment, it's challenging. We don't have anybody to pass the cost on to.

Cost has to be taken into consideration. We try to balance the good and bad of having multiple suppliers to support our clinical needs, while achieving a competitive price point. We bid contract opportunities in multiple ways – single vendor, dual vendor and more. We create a structure where we're evaluating risk based on the cost savings difference between those different contract structures.

**Tim Bugg:** In our annual meeting this past October, I had a supplier session. I asked them what they thought the average margin of a hospital was. I had answers of three, four, six and eight, but of course, the answer in this country is below one. I showed them a scale of how provider costs continue to rise, and reimbursements continued to decline.

I find the reps in the hospitals are not in tune to the market in which they sell. Words like sequestration and pay go are foreign to suppliers, but they shouldn't be. Sequestration has been delayed since the pandemic. That is 2% cuts of Medicare year over year as part of the Affordable Care Act in 2010. Pay go is the 4% Medicare cuts to pay for the Covid dollars from 2020 to hospitals which has not been implemented yet. At some point, providers could expect an additional 6% cuts coming.

Our suppliers must understand the market they're selling in and why sustainability is important. Cost pressures are important.

Healthcare is at approximately 18.5% of GDP at present. I've been told 20% is the magic number. If we hit 20%, then is it unsustainable? And at some point, does the government step in?

Increasing cost, declining reimbursement, and unaligned goals with suppliers make sustainability a hard goal to achieve.

**John Wood:** The supplier community probably doesn't fully understand all of the nuances that are causing financial pressures, but I think good suppliers understand that these pressures are real and that sustainability and flexibility in the supply chain is important.

As Encompass increased our nearshore presence in 2018 and 2019, it was about mitigating risk in the environment and the quality of employees we could get nearshore. The communication with our employees in our nearshore manufacturing facilities is much better than it is in Asia. Lower transportation costs, a better environmental footprint and a reduction in supply interruption has created a much better experience for our customers.

We continue to see fluctuation in transportation, raw material, and labor cost globally. And we are very concerned about worldwide unrest. For these reasons, Encompass continues to use a mix of onshore, nearshore, and offshore approaches.

**Mark Welch:** Sustainability is a priority. Our organization set Science Based Targets to reach net zero by 2050. We are working to reduce our greenhouse gas emissions, divert waste from the landfills, and optimize our water utilization.

As an organization we understand that in order for us to fulfill our cause and create a healthier future and bring remarkable experiences to life, we need to address the impacts we are making on our community today. Specifically, as a Supply Chain we are identifying opportunities to reduce the use of products with harmful chemicals. We've engaged our GPO partner to help us identify opportunities to move away from devices which have Phthalates, and other hazardous content. Also, our pharmacy held several successful medication take-back drives and collected 432 pounds of unused medicine from our communities to safely dispose of. We are also choosing to reprocess certain devices thus

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removing single use products from the landfills. While we are investing a lot in order to achieve our goals, unlike previously expected many of these initiatives are a cost savings for our organization.

Finally, our goal for 2050 is to only work with suppliers who set their own Science Based Targets and have reached net zero in their operations. We set a 2022 baseline and are currently at 52% of our goal, so we have some way to go. Our team's goal next year and beyond is to have strategic conversations with our vendors and encourage them to meet this goal in partnership.

## Supply Assurance and Nearshoring

**Passerallo:** Supplier assurance means as much or probably more to us than it does on the nearshore side. I'd rather have the reliability of the supplier being able to fill the orders. When we look at shoring capabilities, the few we've engaged with have trouble meeting our demand.

If they're a smaller startup and want to diversify their customer base, they don't want to say they'll only provide five versus 500, for example, therefore wanting 10% or 15% of your market. That's challenging. We have come across that a couple of times. It depends on the company, but it's been a challenge for us. Nearshoring is a great opportunity to investigate for us and go after. But it continues to come back to cost pressures.

**Bugg:** From a holistic perspective, we're starting to self-correct going back to pre-2020. We're seeing many of our member hospitals moving to hybrid models of self-distribution and traditional distribution. Pre-Covid paradigms such as just-in-time inventory are not the discussions of the day.

**Supplier assurance means as much or probably more to us than it does on the nearshore side. I'd rather have the reliability of the supplier being able to fill the orders.**

From a perspective of nearshore vs. offshore, supply assurance is important to get orders filled, especially after all of the back orders. They can't manage back orders for factor. Providers aren't as concerned as to where product is coming from as long as their orders are filled It's about who can provide product and get it to them, whether it's made in Toledo or Taiwan. Our standard is to ensure we have contracts with suppliers who can ensure supply.

Looking forward, Capstone is seeking ways to invest in organizations or companies who are focused on assurance, consistency, and striving to change the supply chain in an innovative way. We have two investments with suppliers today who are doing just that. One is reimagining how things are being manufactured in Asia, and another that's onshore manufacturing in the U.S. We're proud of those two.

We're trying to be progressive in how we source products and services going forward.

**Wood:** Different regions of the world are good at manufacturing different raw materials. Just because you can manufacture gloves in many locations doesn't mean the raw materials are available from those regions.

We were able to stand up an isolation gown manufacturing line in the U.S. during the pandemic. One reason that we were successful was that raw materials were readily available in the U.S.

The question isn't "is the product manufactured onshore", the question should be is the supply chain sustainable and reliable even during difficult times. We believe that a hybrid approach allows Encompass to do this. ■

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# Developing Partnerships Through Value Analysis

**Value analysis is a critical piece of the healthcare puzzle and crucial to building partnerships between IDNs and** suppliers. At IDN Insights West, sponsored by Allergan Aesthetics, Dee Donatelli, Lead Spend Management at symplr, hosted a panel that included:

**Cheryl Anderson Smith, BSN, RN, MBA, DNP,** System Director, Value Analysis at Steward Health Care

**Dr. Jimmy Chung, MD, CMO** at Advantus Health Partners

**Dee Donatelli**

**Dr. Jimmy Chung**

**Cheryl Anderson Smith**

The two supply chain leaders discussed what value analysis looks like in their organizations and what they are looking for in partnerships.

**Dee Donatelli: Please tell us about your value analysis program and how you feel it's creating a more clinically integrated approach.**

**Cheryl Smith Anderson:** We define it as an integrated analytical approach to evaluating medical products and services for the medical and surgical area. We do it from the perspective of looking at what the patient care outcomes are, patient quality, patient care, and then the last one being cost effectiveness. That's really critical to us.

One thing that happened when I got to Steward is that we had a lot of committees for value analysis on the corporate level, but they didn't have the right people on board. We didn't have the clinicians,


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the nursing educators, the advanced wound care nurses, all the different people that are critical in the decision-making process. We're doing good with working with our nurses and getting their input on a lot of product categories, but I wish we had more physician involvement. We do get our physicians involved when we're looking at specialized categories.

One category we worked on was cellular regenerative tissue. We had our chief medical officer nominate which doctors could be on that committee. We worked with those doctors, spoon-feeding them all the data that we could from a clinical side point and the data point. From there we would meet with these doctors and make sure that the meetings were very comprehensive, concise and would get them out within 30 to 45 minutes – at the times when the doctors were available. All of them had very busy schedules, but we were able to make some significant improvements in the areas that are critical. We worked on hip and knee; we're getting ready to work on trauma. We also started soft tissue biologics. And one thing that I'm proud of that I was able to accomplish there – we developed an advanced wound care formulary and we worked with our AWC chairs at the hospital, and they helped us to go from 248 products with 16 vendors to 26 products and two to three vendors.

**We waste a quarter of our healthcare budget every year. Almost a trillion dollars goes to waste. It's not all supply chain of course, but a lot of it has to do with the lack of interoperability and lack of coordination of care, and duplication and unnecessary care and things like that.**

**Jimmy Chung:** Value analysis is really more than just analysis. We're trying to value optimize, and we're optimizing the value. What does value mean from the perspective of the patient? That means we have to kind of steer away from how valuable this process is to the physician. And I know some of you have heard me say this before, but it's my life's mission to remove the word preference from all things supply chain.

No matter what anyone tells you, medicine is not an art. There's no room for creativity. There's no room for preference. Individual preference should not be a decision-making tool for healthcare, and we have data to support that. We waste a quarter of our healthcare budget every year. Almost a trillion dollars goes to waste. It's not all supply chain of course, but a lot of it has to do with the lack of interoperability and lack of coordination of care, and duplication and unnecessary care and things like that. So now coming back down to that supply chain value analysis level, what can we do? I would imagine a value analysis process at some point that actually ends up not needing value analysis, so that hospitals don't really have to do value analysis because we already know where the high value is.

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**Donatelli: What does partnership mean to you?**

**Chung:** Some of the vendors and suppliers who we have what we would consider a partnership with, we meet very regularly. Depending on the level, we have executive level quarterly business reviews, and then we have director level monthly review meetings. At the more site manager level, they sometimes will meet weekly. Maybe it's the same agenda every time, but it's still just to keep everybody on the same level in terms of what data are we looking at, what we need to do at that site level to get more compliance, or to make sure that we're hitting our goals. There's more to this financial relationship than just spending money.

Every once in a while, somebody we thought that we had a partnership with raises their prices without even any warning whatsoever and says, "Starting 30 days from now, your product is going to be $200 more." And we're like, "Where did that come from?" I think there must be a lot more flexibility and transparency in terms of what your strategy is versus ours. How can you guys help the health systems meet their margins? Because we're going to be looking for every opportunity to cut costs because revenue is not something we have a lot of control over.

**Anderson:** If we're going in partnership with you on a particular product category, we're going to back you up by making sure that our organizations honor when your representatives come into their hospitals, and that they will meet with you. If they don't meet with you, we will be asking them, "Why are you not meeting with our vendor? This was a savings initiative launched from our value analysis committees that your people were sitting on. This is system-wide, and you need to comply." We will show them their compliance data, we'll say, "Well, you're still buying 70% of your products from this vendor, and you're only buying now 30% from the new vendor we want you to move to. How soon are you going to get there?"

We do an educational process too, so that people know when they become a value analysis committee member at the local level and at the corporate level, what their duties and responsibilities are, and that they're supposed to be our communicators at the hospitals because we have a small team too.

**If we're going in partnership with you on a particular product category, we're going to back you up by making sure that our organizations honor when your representatives come into their hospitals, and that they will meet with you.**

**Donatelli: How do you choose partnerships?**

**Anderson:** It's by their product categories. We know where our spend with our five or six top vendors at our IDN. If a HealthTrust contract comes up, we're going to be looking to you all, especially if we've had a relationship with you in the past and you're on that HealthTrust contract. We're probably going to give you priority to come in to talk to us.

**Chung:** Before AHP became its own company, Bon Secours Mercy Health had relationships with certain suppliers with whom they had more of a partnership type of relationship with. And that may be more of the traditional way of looking at, "Okay, who's giving us the best response in our RFP? And are you ready to be a partner?" From the AHP perspective now that we're creating our own GPO portfolio, it's really more about, "Do you see a vision into the future with us? With our clinically driven model and value creating model, do you understand what we're trying to do? Are you willing to do away with this every three years contract cycle, to look at more of an evergreen, perpetual relationship where we're constantly looking at how do we bring value to each other?" For example, AHP has a partnership with Medline.

We have a partnership with GE for health technology management, and it's all out there, so it's no big secret. And the terms are very clear. We have a vision to grow together into the future. We're going to help each other. We're going to expand this model of business to other health systems and so forth. So, we're in similar discussions, and in a particular category, we might have more than one partner.

We may have about four vendors who are willing to play that partner role with us just in different scenarios. And I'm also not saying that every category has to have a partnership. You don't have to have a partnership for every subcategory of a clinical product, but if you have a generalized way of creating partnerships for things like distribution and med/surg products, or purchase services and things like that, then I think that will help define that relationship with the vendor. ■

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# An Alarming Trend

## What's to blame for the prevalence of obesity in the United States?

**America's busy lifestyles, food and diet habits, and societal influences are leading to poor health outcomes. As a** result, obesity has become an increasing concern throughout the United States. Case in point: the prevalence of adult obesity in 22 states rose above 35% of their respective populations in 2022, according to the Centers for Disease Control (CDC). Yet, ten years ago, there weren't any states that had an adult obesity prevalence above 35%.

The impacts of obesity are costly for the American healthcare system. Health conditions associated with obesity include heart disease, stroke, type 2 diabetes, and certain types of cancer, according to the CDC. These conditions, when associated with obesity, require patients to seek healthcare for preventable chronic disease. The estimated annual medical cost of obesity, according to the CDC in 2019, was nearly $173 billion.

### Causes

The dramatic increase in the prevalence of obesity within the last 10 years is a result of a variety of factors, including national mental health issues, changes in the American lifestyle, diet culture, socioeconomic status, and more. A 2023 study conducted by Batash Endoscopic Wellness, titled "Beyond the Scale: Insights Into Weight Loss Trends and Challenges," explored the causes of the obesity crisis

in the U.S. by surveying 1,000 U.S. adults who identify as overweight.

"This alarming trend of increasing obesity rates is the result of a confluence of factors. Sedentary lifestyles, high-calorie diets, and an abundance of processed foods have become the norm," said Dr. Batash.

Survey respondents were asked about their experiences with weight loss, weight gain, and the challenges associated with being overweight.

The study provided a nuanced look at weight loss to include stress, perception, and societal trends to have a large influence on weight gain and loss struggles. For example, over 60% of respondents said they wanted to lose weight to address both mental and physical concerns, and over half of survey respondents reported stress as the number one reason they struggle to successfully lose weight, according to the Batash Endoscopic Wellness study.

"The result that nearly half of overweight Americans are uncertain about their control over weight gain suggests that there is a significant role of perceived helplessness in the face of obesity. Additionally, mental health challenges, including stress and depression, contribute to weight gain by promoting behaviors like emotional eating," said Dr. Batash.

## Proper management

Obesity is a very complex disease, with a variety of social and environmental factors contributing to a greater risk for some individuals, according to a National Library of Medicine Study, "Social and Environmental Factors Influencing Obesity." Effectively addressing obesity in the U.S. requires an understanding of these complex relationships.

According to Dr. Batash, obesity doesn't just hurt the body; it also makes it harder for people to be productive in their personal lives and at work. "To address this issue, we need to teach people about healthy choices, and help each person adjust to a healthy lifestyle in a way that works for them," he said.

Nearly 50% of individuals surveyed in the study struggled with personal control their over weight loss journeys, indicating that genetics, activity levels, and environmental factors are critical considerations in weight management.

"Individuals embarking on a weight loss journey navigate several personal factors. To determine the individual factors impacting weight loss, one must assess their dietary habits, exercise routines, and psychological barriers such as stress and emotional eating," said Dr. Batash. "Understanding these personal influences is crucial, as 35% of overweight Americans avoid healthcare scenarios due to the negative impact on their mental health, highlighting the need for personalized and compassionate weight management strategies."

Achieving a healthy weight reduces an individual's risk for developing serious disease. According to the CDC, some ways to maintain a healthy weight include physical activity, proper sleep, stress reduction, and healthy eating. Behavior changes such as walking, swimming, making nutritious food choices, and getting enough rest, when combined, can assist patients with the journey of weight management.

According to Dr. Batash, "It is important to approach weight loss with a multi-pronged approach, and to make lasting, long-term changes in how we eat, exercise, and take care of our mental health."

Managing weight is critical to an individual's overall health, as it directly impacts both personal and community-wide well-being. With the prevalence of weight-related illness increasing in the U.S., healthcare professionals must consider the root cause of obesity, and address risk factors and concerns with patients during doctor's visits.

"Weight loss contributes to better mental health and overall energy levels," said Dr. Steven Batash of Batash Endoscopic Wellness. "Proper weight management supports joint health, decreases the likelihood of sleep apnea, and enhances mobility." ■

## Weight's emotional toll

Recently, doctors and health systems have begun considering the emotional and environmental impacts associated with obesity and have integrated lifestyle changes and emotional well-being into care routines for patients with obesity.

"Additionally, achieving and maintaining a healthy weight often leads to improved self-esteem and a positive body image," according to Dr. Batash. "By adopting healthy lifestyle habits, individuals not only prevent health complications but also promote a higher quality of life and longevity."

# Can't Anything Be Done About Prior Authorization?

Physicians say they've had it up to here. But will that change anything?

**Prior authorization is the process by which physicians must obtain advance approval for a device, supply or** medication from the patient's insurance plan to ensure coverage for the recommended service, per the American Academy of Family Physicians. And it's making family physicians – and a lot of other people – angry.

Many physicians believe it makes the insurer the ultimate arbiter on what medical care should or should not be provided to their patients. They resent that practices must complete prior authorizations via multiple platforms, including web portals, electronic portals, electronic medical records systems, fax, paper forms, and phone calls.


Much of the fuss is due to Medicare Advantage plans. KFF (formerly called the Kaiser Family Foundation) reports that in 2021:

- More than 35 million prior authorization requests were submitted to Medicare Advantage insurers.
- The volume of prior authorization determinations varied across Medicare Advantage insurers, ranging from 0.3 requests per Kaiser Permanente enrollee to 2.9 requests per Anthem enrollee.
- Over 2 million prior authorization requests were fully or partially denied by Medicare Advantage insurers.
- Just 11% of prior authorization denials were appealed.
- The vast majority (82%) of appeals resulted in fully or partially overturning the initial prior authorization denial.

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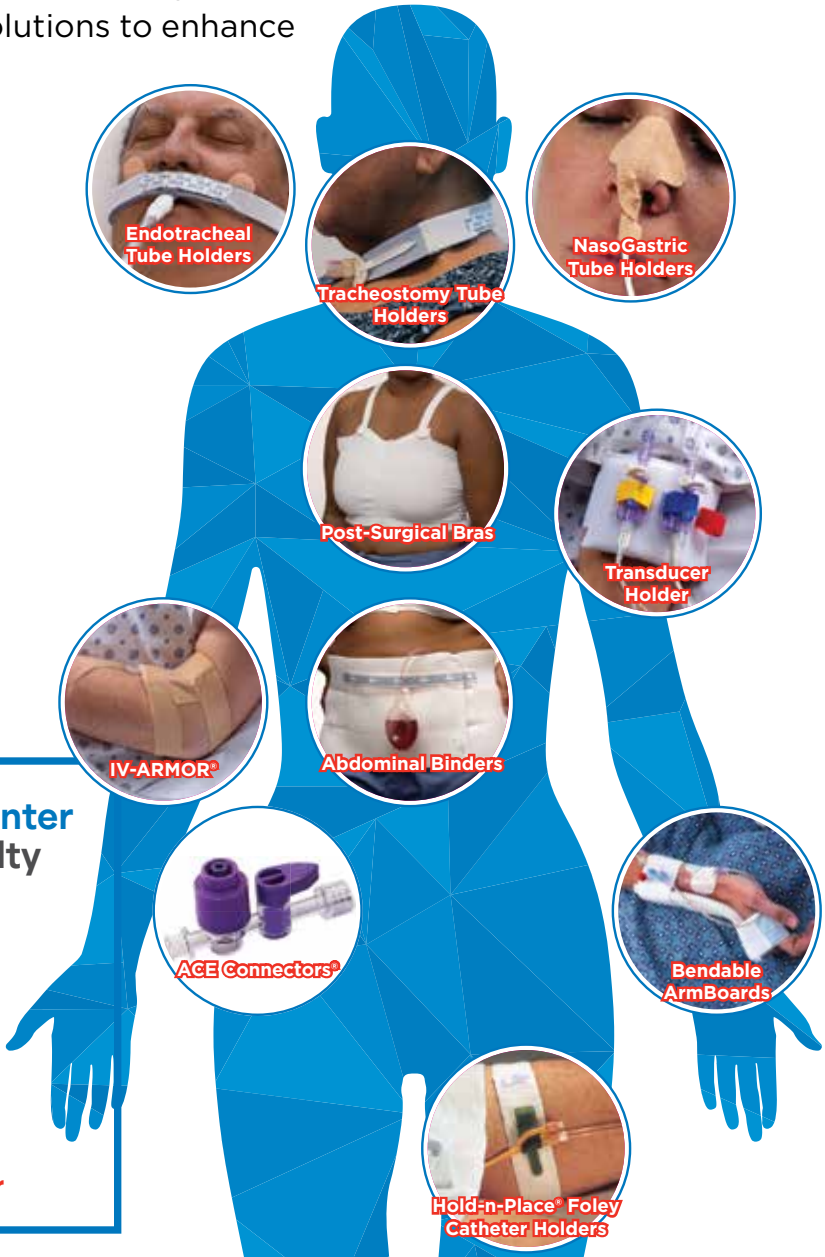


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Historically, traditional Medicare rarely required prior authorization, and that is still largely the case, according to KFF. But 99% of Medicare Advantage enrollees were enrolled in a plan that required prior authorization for some services in 2022. Most commonly, higher cost services, such as chemotherapy or skilled nursing facility stays, require prior authorization.

Even the Centers for Medicare & Medicaid Services admits the whole process needs fixing. "Providers expend resources on staff to identify prior authorization requirements that vary across payers and navigate the submission and approval processes, which could otherwise be directed to clinical care," wrote the agency in a proposed ruling in December 2022. "Patients may unnecessarily pay out-of-pocket or abandon treatment altogether when prior authorization is delayed."

Dr. Furr cites American Medical Association data showing that physicians and their staff spend an average of 13 hours each week completing prior authorizations. "The bottom line is our patients' medical care and health is being impacted without any proof that most prior authorizations are necessary or needed," he says.

Anders Gilberg, senior vice president for government affairs for the Medical Group Management Association, says "the increase in utilization of overly burdensome prior authorization requirements by health plans leaves medical groups struggling to ensure patients continue to maintain access to medically necessary care. Medical groups cite delays in prior authorization decisions for routinely approved items and services, and inconsistent payer payment policies as their top challenges."

**Physicians are even having to do prior authorizations for routine tests such as cardiac stress testing and generic medications.'**

## Why so galling?

"In the past, prior authorization was generally used in regard to expensive procedures and medicines," says Steven Furr, M.D., FAAFP, president of the American Academy of Family Physicians. "It has now markedly escalated so physicians are even having to do prior authorizations for routine tests such as cardiac stress testing and generic medications. This leads to a delay in patient care. It can also sometimes lead to a loss of control of difficult medical problems such as diabetes and hypertension."

In its 2023 Annual Regulatory Burden Report, published in November, MGMA reported that 97% of its members report that their patients had experienced delays or denials for medically necessary care due to prior authorization requirements. Ninety-two percent report that their practice had to hire or redistribute staff to work on prior authorizations due to the increase in requests.

"While prior authorization requirements are onerous for all types of practices, certain specialties are subject to more prior authorization requests, namely because of the high expenses tied to their treatments," says Gilberg. Specialties that face the highest rates of prior authorization are radiation oncologists, cardiologists, and radiologists.

"Primary care also bears a significant brunt of the burden of responding to prior authorization requests from insurers," he says. "When making referrals/orders for specialty care, inpatient procedures, ancillary services, and drugs, primary care practices must often justify the request despite not receiving payment for the services ordered or performed. In cases like this, primary care practices bear 100% of the administrative costs."

## In search of solutions

In 2018, five groups signed a "Consensus Statement" on improving prior authorization: the American Hospital Association, America's Health Insurance Plans, American Medical Association, American Pharmacists Association, BlueCross BlueShield Association and the Medical Group Management Association. In their statement, the groups agreed to:

- **Encourage** the use of programs that selectively implement prior authorization requirements based on healthcare providers' performance and adherence to evidence-based medicine. (Some call it a "gold card" system.)
- **Encourage** review of medical services and prescription drugs requiring prior authorization on at least an annual basis, with the input of healthcare providers.
- **Improve** communication channels among health plans, healthcare

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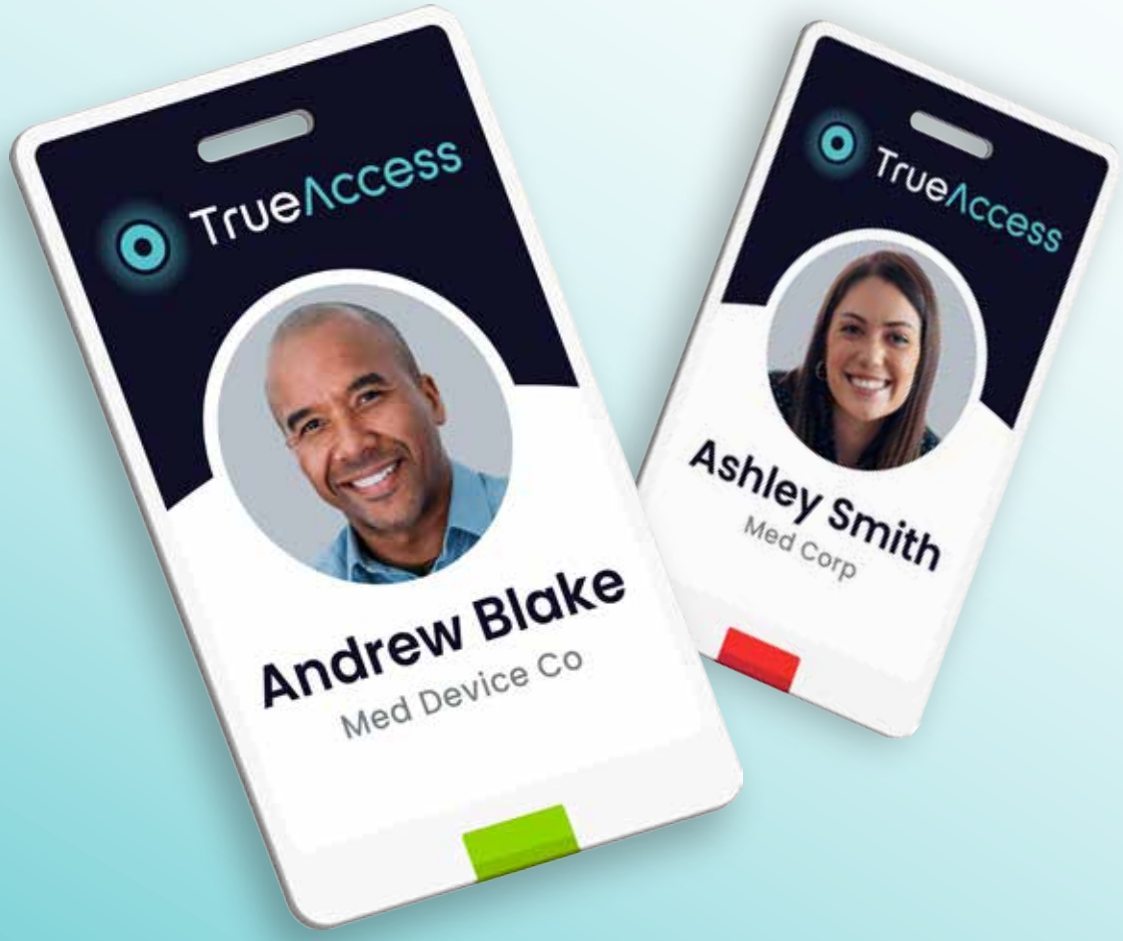


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providers and patients; and encourage transparency and easy accessibility of prior authorization requirements, criteria, rationale, and program changes.

- **Encourage** sufficient protections for continuity of care during a transition period for patients when there is a formulary or treatment coverage change or change of health plan. (In other words, providers of patients on an approved course of treatment would not be required to go through the prior authorization process when that patient changes carriers.)
- **Encourage** healthcare providers, health systems, health plans, and pharmacy benefit managers to accelerate use of existing national standard transactions for electronic prior authorization.

Says Gilberg, "MGMA signed the consensus statement in 2018, alongside several provider groups and health plans, agreeing that selective application of prior authorization, volume adjustment, greater transparency and communication, and automation were areas of opportunity to improve upon. However, since the time this consensus statement was released, medical groups report little progress in any of these areas."

So the search for solutions continues, much of it coming from the federal government, he says.

Earlier this year, CMS finalized its 2024 Medicare Advantage and Part D rule, which included proposals to rein in detrimental prior authorization practices in Medicare Advantage. "MGMA was pleased that the agency heeded our call to finalize the continuity of care provision, as well as the requirement for MA plans to form Utilization Management Committees," he says.

MGMA also supports CMS' proposed Prior Authorization and Interoperability Rule, which would implement a process to facilitate electronic prior authorizations, requiring affected payers to publicly publish aggregated prior authorization data. "Although MGMA's principal goal is to reduce the number of prior authorization requests, an electronic program, if implemented appropriately, has the potential to alleviate administrative burden and allow practices to reinvest resources in patient care," he says.

On the legislative front, in July 2023, the U.S. House Ways and Means Committee passed the "Improving Seniors' Timely Access to Care Act, intended to modernize the prior authorization process in Medicare Advantage. The bill, led by U.S. Reps. Mike Kelly (R-Pennsylvania), Suzan DelBene (D-Washington), Larry Bucshon (R-Indiana) and Ami Bera (D-California) would:

- Establish an electronic prior authorization process.
- Require the U.S. Department of Health & Human Services to establish a process for "real-time decisions" for items and services that are routinely approved.
- Improve transparency by requiring Medicare Advantage plans to report to the Centers for Medicare & Medicaid Services on the extent of their use of prior authorization and the rate of approvals or denials.
- Encourage plans to adopt prior authorization programs that adhere to evidence-based medical guidelines in consultation with physicians. ■

## Prior authorization: A glossary of terms

Step therapy. A specific type of prior authorization requiring patients to try one or more insurer-preferred medications or treatments prior to implementing a physician recommendation. This tool, primarily designed to contain the cost of prescription drugs, is used for many conditions such as cancer, arthritis, diabetes, skin conditions, heart disease, mental illness, and more, says the American Academy of Family Physicians. (The AAFP believes step therapy protocols "delay access to treatments and hinder adherence while risking severe side effects and disease progression for patients.")

Continuity of care. Protecting uninterrupted care (i.e., care without prior authorization) to patients in an active course of treatment when there is a formulary or coverage change or change of health plan.

'Gold card'. Formally referred to as "selective application of prior authorization," the gold card system would fast-track prior authorization requests from physicians who rank high on quality measures and adherence to evidence-based medicine, or who engage in other contractual agreements, such as risk-sharing.

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1 https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm
2 https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00396-6/fulltext

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