

THE USE OF INTEGRATED DELIVERY NETWORKS AS PIONEERS FOR MANUFACTURER HEOR PROGRAM / STUDY SUCCESS

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INTRODUCTION

Given the unique makeup of the Integrated Delivery Network (IDN) system, the ability to capture both claim and resultant clinical data makes them a suitable partner for manufacturers looking to facilitate a HEOR (Health Economics Outcomes Research) program. However, before an agreement can be reached, IDNs will seek specific terms that support their philosophy of what constitutes a productive program. Understanding the nuances involved in establishing these HEOR programs can conceivably improve their future rate and success.

OBJECTIVE

Our research aimed to identify the impact of utilizing Integrated Delivery Networks and their in-house resources in fulfilling HEOR program requirements.

METHODS

The study was conducted through teleconference discussions with both pharmacy and medical directors with various IDN systems (N=6). The questioning focused on several different topics including:

1. Structure of the IDN and associated ability to reference specific patient level claims information
2. Preferences for types of HEOR data
3. Examples (positive & negative) of partnerships with manufacturers to achieve HEOR program criteria
4. Recommendations on best practices for future HEOR program partnerships

RESULTS


INTEGRATED DELIVERY NETWORK VS. MANAGED CARE ORGANIZATION SYSTEM DYNAMICS

	INTEGRATED DELIVERY NETWORK (IDN)	MANAGED CARE ORGANIZATION (MCO)
System for following the claim	The electronic medical record system associated with the IDN is functioning across both the ambulatory (outpatient) and hospital (inpatient) settings, allowing for a “total cost of care” assessment	Managed care systems are able to track a claim but in most cases have siloed systems for pharmacy and medical benefits and additionally have less view within the inpatient setting
Claim analysis	The IDN has the ability to not only track the claim but the subsequent “clinical data result” of the claim, hence allowing for a more granular look into downstream economic analyses	Has the ability to follow the claim but less structure in triangulating the clinical data outcome
In-network membership	A significant portion of members are cared for within the IDN system by IDN providers – therefore the ability to capture comprehensive HEOR savings is high	In-network care is subject to lower OOP costs for the member, but options to go out-of-network are available
Membership turnover	Patients can remain, on average, with some IDNs for 10+ years; therefore, for longer term HEOR analyses, the IDN patient remains a feasible option	Patients can remain, on average, with the MCO ~2 years; making it difficult to allow for standardized follow-up

HEOR PROGRAM ALIGNMENT


IDNs express a keen interest in associating with manufacturers in a partnership that supports fulfillment of a HEOR program. However, like any agreement, both parties are coming in with a set of expectations that they are looking to achieve. Deliberation on necessary “changes” to proposed parameters is likely, with inability to land on agreed terms being a common result. Nevertheless, while IDNs are different in their perspective of “starter / non-starter” requirements for participation in the HEOR program, there are several key points of reference that manufacturers should be aware of prior to approaching IDNs with a proposal.

1 The results of this HEOR program ultimately help the patient



a. The product(s) that is a part of the HEOR program has to be providing a clinical benefit to the patient in line with standard of care – “does this make sense from the patient perspective?”. Once this is confirmed, the IDN is then comfortable evaluating what the economic outcomes associated with the HEOR program could show.


2 The IDN is compensated – with enhanced knowledge / information to inform future decisions



a. Specific data being available as an output of the HEOR program can be leveraged to support changes within the product formulary that could result in improved savings for the IDN.


b. Moreover, taking steps in patient management that can lead to improved HEOR outcomes could translate to better quality metric results (i.e. Medicare Star rating; Oncology Medical Home measures) for the IDN.

3 The IDN is compensated – with financial payment



a. While the HEOR findings are valuable for the IDN, ultimately financial concessions from the manufacturer are a primary driver ratifying an agreement between both parties. That financial amount is influenced by several factors, but the size of the IDN (and hence the amount of available data) and perceptions of “data quality” are key.

4 Ensure the HEOR program functions as a scientific data assessment




a. The manufacturer should be cognizant that the IDN, in most instances, wants to confirm the agreement will allow them to “solve for a problem”.

b. The manufacturer proposed endpoints of the HEOR program cannot be overly complex and must matter to the IDN.

c. IDNs were clear in conveying any HEOR program they participate in will follow a defined methodology. Hence, financial compensation purely to obtain data (data dump) from the IDN’s network does not align with their philosophy of being a research partner.

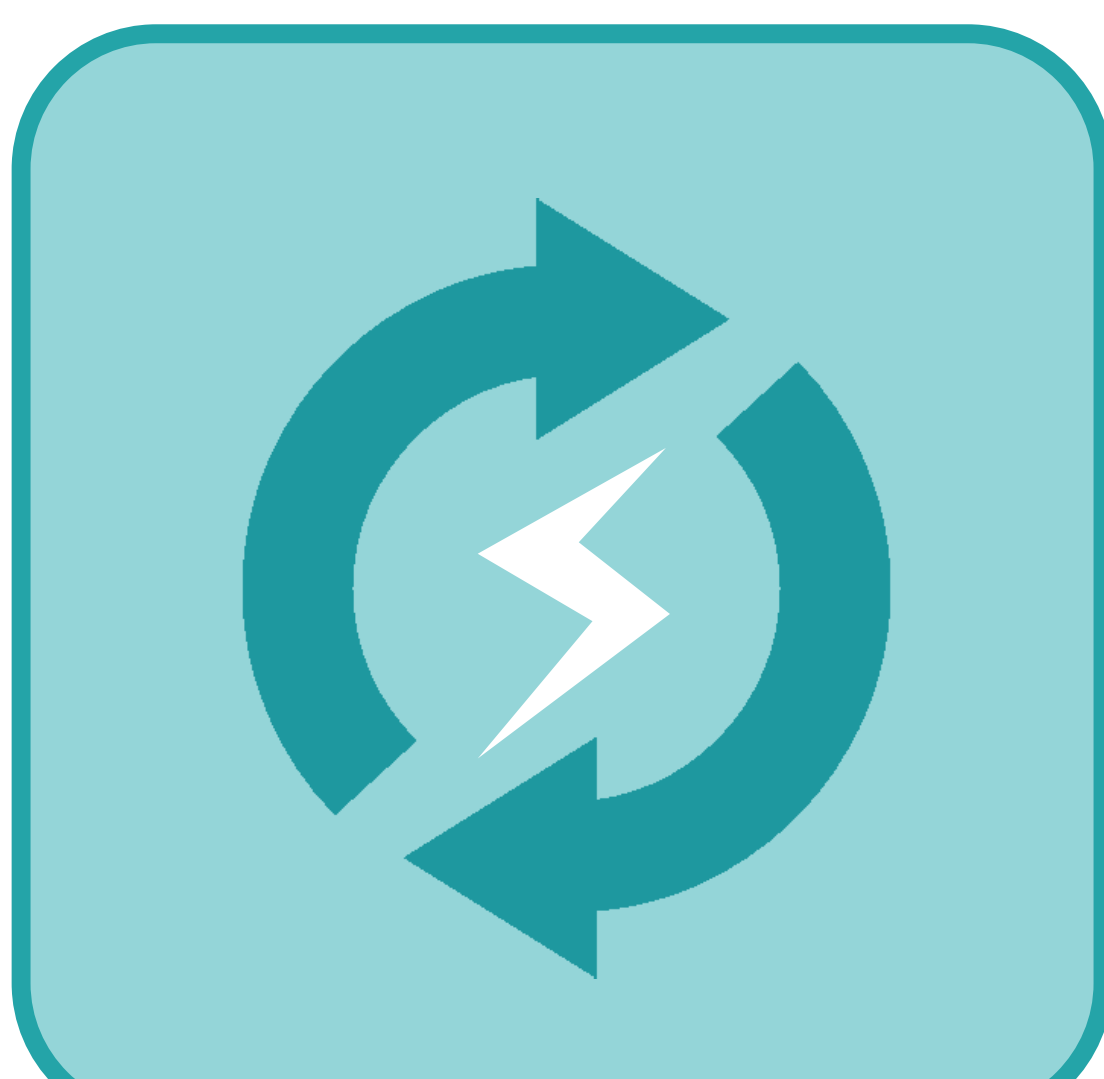
d. The IDN, for their part, not only provides an internal team that helps manage the process (led by a project manager), but in some cases also incorporates physician input to help “sanity check” the data.

5 The HEOR program results are permitted to be published, with the IDN as a main reference




a. Gaining public exposure and establishing / growing a reputation is important for priming the IDN’s future opportunities.

6 Ideally the HEOR program involves a “chronic” therapy



a. IDNs are more interested in “chronic care products” for HEOR outcomes given the recurring nature of savings vs. a one-off savings.


7 IDNs having a disposition toward support of retrospective vs. prospective studies



a. Retrospective studies tend to be more prevalent as these are less costly, require a shorter timeframe, but still provide the lookback analysis to identify any potential health resource savings.

b. Prospective studies, while more rigorous / robust of a design, must be balanced by the manufacturer in terms of expenses and compliance (i.e. IRB) requirements to conduct the research.

8 The manufacturer is content knowing the HEOR program data results are coming from a “closed” system



a. Recognizing data from the IDN system may not be generalizable to other broader healthcare entities (i.e. managed care organizations) is a consequence manufacturers need to take into account.

CASE STUDY: PROJECTS OF HIGHER INTEREST

Treatments targeting HIV/AIDS have continued to improve over the years in that many patients are now able to live with the virus continuously suppressed. The focus in a category like this has always been “clinically driven”; however, with these product advances being achieved on a consistent basis, IDNs are now more inclined to participate in HEOR programs specifically tracking economic benefit over time.

CASE STUDY: PROJECTS OF LOWER INTEREST

Chronic Hepatitis-C products have demonstrated remarkable efficacy improvements, in some select patient cases providing a 95%+ cure rate.

Following the launch of these products, some Hepatitis-C manufacturers approached IDNs with a proposal to further prove health resource savings. While on the surface this appears to have valid rationale – the IDNs were already bought in to the efficacy and expectation for downstream cost offsets. Therefore, an additional program to validate the savings was not necessary as the resultant data would not change their perceptions of the products or how they approached management of these patients.

HEOR DRIVERS

The IDN is responsible for the total cost of care; therefore, any manufacturer proposing a new HEOR program should be cognizant that the IDN will be pushing for this as a primary endpoint of the study. More specifically, tracking how a specific product (in a select population) alters care over a 12 to 24-month period. That total cost of care consideration accounts for most direct costs (i.e. drug cost, reduced hospitalizations, reduced ER visits, avoid surgeries / procedures, fewer office / home care visits, etc.). Entertaining endpoints that include indirect costs are less likely to be acceptable to the IDN.

VALUE-BASED CONTRACTS (VBC)

While distinctive from HEOR programs, the concept of a value-based contract is also top-of-mind for IDNs when considering partnerships with pharma. And while collection of data to validate the contract may be less resource intensive for the IDN, they may not necessarily have an advantage over other standalone MCOs given both organizations are encountering similar challenges, mainly:

- The disease category or set of products within that category do not propose a high priority for the payer
- Proposed VBCs in many instances do not provide straightforward ways to measure the contract
- The standard “rebate based” contract remains the easiest and most preferred option

ABBREVIATIONS: HEOR: Health Economics and Outcomes Research; IDN: Integrated Delivery Network; OOP: Out Of Pocket; IRB: Institutional Review Board; VBC: Value-Based Contract; MCO: Managed Care Organization

CONCLUSION

- US IDN organizations offer a valuable initial opportunity to utilize in-house data in order to understand the impact of HEOR program success
- There are several “parameters” the IDN is seeking when considering partnership with a manufacturer on instituting an HEOR program. These are guided by both collection of data insights and financial compensation provided to the IDN but should also be structured in the form of direct cost offset endpoints that are driving the study
- Replication of results to managed care organizations is a subsequent step, but IDNs offer a good first prospect for assessing HEOR program impact



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