Report extract: Integrated Delivery Networks in the US
Payment Pressures: IDNs as a Solution

Datamonitor Healthcare insights and strategic recommendations:

- Healthcare delivery systems of all types are under financial pressures and are having to rethink how they can increase efficiency, cut costs, gain better patient outcomes, provide differentiation, and improve the quality and coordination of care, as well as reduce the variability. This is driving the creation of new healthcare entities and the uptake of value-based medicine.

- Consolidation has moved from horizontal and vertical integration of hospitals to the creation of integrated delivery networks (IDNs), which aim to deliver higher quality, lower cost, and better-coordinated care, effectively from the cradle to the grave. IDNs also have the potential to bring together and streamline the fragmented US healthcare system.

- One of the challenges still faced by IDNs is the ability to measure their performance, as the limited data available so far are mixed. Further research and data collection is important, in order to reflect on the progress made to date and provide feedback for future changes.

FOCUS ON VALUE IS DRIVING CREATION OF NEW HEALTHCARE ENTITIES

Payment pressures from rising healthcare costs are making providers rethink how they can cut costs while maintaining or improving patient outcomes. Shifting the focus towards value-based medicine and care that is focused more on outcomes and value than simply on volume will help to achieve this goal.

There has been a move toward consolidation in many industries across the healthcare continuum, and this includes healthcare providers. Here, the drivers are a desire to increase efficiency, cut costs, gain better patient outcomes, provide differentiation, and improve the quality and coordination of care, as well as reduce the variability between healthcare offerings. "There are a number of driving forces to the move toward integrated medicine, which include government and policy elements, CMS, and value-based reimbursement. Integrated care reduces wastage and improves the timeliness of care," says William Fleming, president at Humana Pharmacy Solutions (personal correspondence, 2016).

This consolidation also supports, and incorporates, the move towards value-based medicine, which is defined as "the practice of medicine incorporating the highest level of evidence-based data with the patient-perceived value conferred by healthcare interventions for the resources expended," which includes the quality of evidence, the value to the patient (including improved outcomes and better quality of life), and the cost-effectiveness of the treatment (Bae, 2015; Brown and Brown, 2013). All of these have potential to build a system that is more patient-centered, with lower costs in the long-term.

"Value-based medicine is all part of population health management – the two go hand in glove," says Fleming (personal correspondence, 2016).

NEW HEALTHCARE ENTITIES ARE A RESULT OF THE SHIFT TOWARDS CONSOLIDATION

The current shift towards consolidation has its roots in the 1980s and 1990s, when hospitals were involved in both vertical and horizontal integration (Pan American Health Organization, 2004).
These steps toward integration have formed the basis of what have now become known as IDNs. Physicians have also started to make similar moves, driven to joining with larger management groups and health systems by the savings and efficiency improvements that are possible when working at scale. Examples of these moves towards consolidation and integration were highlighted in a healthcare services acquisition report carried out by Irving Levin Associates (Irving Levin Associates, 2016). In 2011, there were 115 physician group mergers and acquisitions, but this dropped by over a third in 2012 to 70, and continued falling until 2014, reaching just 60. The numbers then started to pick up in 2015, growing to 88. As these data only go back to 2011, it is not clear when this trend began, or whether 2015 was an outlier year. However, it may be that 2011’s large number of deals reflected a higher number of smaller deals, and the fall between 2012 and 2014 was as a result of all the “low-hanging fruit” having already gone. This is perhaps supported by the number of larger deals between the bigger players in 2015, for example the acquisition of IPC Healthcare by TeamHealth to create a larger physician services organization (Irving Levin Associates, 2016).
STREAMLINING THE HEALTHCARE PATHWAY

As a multi-payer system, the US healthcare system is very disjointed, and one of the important roles of the IDN is in integrating and therefore simplifying and streamlining different parts of the system. This has potential to introduce opportunities for cost savings by reducing supplication and improving efficiency, as well as improving the care pathway for patients.

"US healthcare can be fragmented and so there are opportunities in the gaps – integrated care connects the dots between acute and chronic care," says Fleming. "Humana is a payer and a health plan, and we have aspects that perform like an integrated delivery network. For example, we have pharmacies within practices, and many wholly-owned or joint venture physician practices. These contribute to population health and integrated care* (personal correspondence, 2016).

By integrating decision-making in areas such as formulary, treatments, health IT adoption, sales rep access, drug sampling policies, and new product uptake, the processes become simpler, and duplication of effort is reduced, as well as enabling potential savings made through economies of scale and more opportunities for negotiation and dealmaking.

IDNs can use "units of integration" to create a more streamlined care pathway. These units link different activities and providers by a specific therapeutic need and type of patient, and whether the patient requires a single acute episode of care or chronic continuous support. For acute patients, the economic unit of care would start with admission to hospital, follow through different providers for in-hospital care to rehabilitation, pharmacy support, and then on to home care and discharge. For chronic patients, this would follow the opposite path, beginning with home care and moving through increasingly intensive support to hospital admission. Focusing on this economic unit could help healthcare providers to reduce acute episodes such as hospital admissions through preventive care, disease monitoring, adherence programs, and coordination of care. This kind of integrated approach, which fits into the IDN remit because of its linkages between care activities, has potential to fuse together different parts of care and cut costs, as well as ensuring that patients are treated in the most appropriate centers for their needs (Bain Brief, 2013).

"One of the clear advantages of integrated delivery networks is that they enable physicians to carry out end-to-end healthcare," says Fleming. "For example, when a patient comes into the emergency room, in an IDN, he or she would be placed on observation and his or her doctor would come along to discuss care, which may or may not include admission. In a fee-for-service set up, the emergency room may simply admit the patient without contacting his or her doctor, or the doctor may say ‘admit the patient’ over the phone without attending* (personal correspondence, 2016).

Within IDNs, the physicians still remain accountable for decisions, perhaps more so as they have a stake in the overall “well-being” of the IDN as a whole. "Better physician engagement helps physicians to be more accountable," says Fleming. "And as physicians are made accountable, they become aware of the importance of choosing the right specialists to work with. For example, a physician might choose to refer patients to a specialist who is more cost-effective, who uses the right drugs and right tests. Making physicians care about both costs and outcomes is a positive evolution and provides another tool to manage costs* (personal correspondence, 2016).

Physicians, however, may be one of the key challenges in moving towards IDNs. "The biggest challenge for the move to integrated care is for the physician practice. Doctors may be affiliated with both population health and fee-for-service models, and it is hard for the doctor to work in both models," says Fleming. "The physicians who ‘get’ the concept of integrated care want something different. But those that don’t say ‘why change, the fee-for-service model isn’t broken’* (personal correspondence, 2016).

Digitizing IDNs and applying the data

IDNs have greater levels of digitization, and this increases the amount and quality of data that are collected and analyzed, making information sharing throughout the organization easier and supporting the development of a more joined-up kind of thinking (AccessPoint, 2015; Bain Brief, 2013; FierceHealthPayer, 2016). To use data effectively, a dataset needs to be in a form where it is usable and actionable – for example, some providers and physicians may want a stream of data that can fit into their own systems, whereas others will look for simple spreadsheets of figures. Cigna, while not an IDN, is a health insurer that works closely with networks of physicians, such as the Independent Physicians Network in Florida and networks of providers. Cigna’s aim is to provide data that support providers in their management of patients through finding the gaps in patient care, for example, comparing quality or affordability with similar providers. Better and more useful data will also play a role in the move toward value-based care (FierceHealthPayer, 2016).
In a report published in 2016, researchers at SK&A ranked the top 25 IDNs by total number of facilities. The largest in the US, by number of hospitals, is the Franklin-based Community Health Systems (SK&A: IMS Health, 2016).

The number of physicians at the top 25 IDNs, ranked by total facilities, varies widely, and will depend on the types of facilities, as these will range from acute care to long-term and chronic care. Kaiser Permanente is ranked sixth in terms of facility size and has the most physicians of the top 25 IDNs. Its work is focused around hospitals, and so will have a greater demand for highly qualified healthcare professionals. LifePoint Health, which has the fewest physicians, is ranked 20th by total facilities. Its work focuses on near home care, including outpatient and post-acute care, and so will rely more on other healthcare professionals.
IDNS REQUIRE A DIFFERENT PHARMA SALES MODEL

Decision making has shifted within IDNs

The decision-making power has shifted in IDNs compared with individual prescribers, which impacts pharma’s sales and marketing models. In IDNs, the decisions are likely to be taken at C-suite levels and by administrators with institutional objectives rather than by physicians with a healthcare perspective at the point-of-care, given that as many as one in two scripts are not being based on a physician’s preference within an IDN. Within the traditional healthcare delivery model, physicians’ choice of medicine is also modulated by the individual patients’ formularies, which are formulated by health plans. Contracting practices based on rebate agreements and established market shares tend to be the key drivers of choice of preferred brands, which tend to limit physicians’ brand choices. The C-suite level decisions in IDNs are likely to have a greater focus on institutional objectives such as cost, cost-effectiveness, quality, comparative effectiveness, and healthcare economics, rather than more blunt rebates. They will also have a focus on whole-population patient care and lower systems costs, and tend to take into account a drug’s impact on medical costs more than traditional payers tend to. This pushes the onus onto pharmaceutical companies to understand the organization of the IDN (which may vary from IDN to IDN) and provide evidence for the value of their drugs and services at higher levels in the organization. Given the different structures and foci of IDNs, the value one brand provides may vary considerably from one organization to another, limiting the scalability of any new access initiatives and requiring a significant level of individual tailoring. The old adage of “once you’ve seen one IDN you have only seen one IDN” rings true, and traditionally IDNs have been a particularly hard customer to target for pharma. IDNs may also limit pharmaceutical companies’ sales reps access to physicians, and control their prescribing behavior (BioPharma Dive, 2015; Capgemini Consulting Life Sciences, 2013; eyeforpharma, 2015b; MobiHealthNews, 2015; Pharma Letter, 2017).

Because IDNs do not follow a single organizational model, targeting decision-makers can be more difficult than in the more traditional structures, and the process becomes more complex and less cost-effective for the pharmaceutical company (Cognizant 20-20 Insights, 2014):

• Some IDNs have a single formulary controlled by a corporate team, whereas others may allow physicians freedom of choice in prescribing.

• Some physicians may work at a number of sites within an IDN, or at both IDN- and non-IDN-affiliated clinics, which have different policies.

• Different IDNs will have different policies about whether physicians can meet with sales reps, and if so, under which conditions.

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Hot Topic : Integrated Delivery Networks in the US

Solutions (personal correspondence, 2016).
DEVELOPING VALUE-BASED PRICING STRATEGIES

Drug cost is an important part of the value equation, and here the pharmaceutical companies can play a clear role by being willing to enter into shared-risk and value-based arrangements. Under outcomes-based risk sharing, companies may pay rebates if their drugs do not meet the expected outcomes (Deloitte University Press, 2015). This benefits both the payer, as it does not have to pay out on drugs that do not meet its goals of effectiveness, and the pharma company, because it can penetrate the market more quickly than it might have otherwise, and can get access to real-world evidence of efficacy and cost-effectiveness in comparison with other drugs used in an everyday situation (Garrison et al., 2015; National Pharmaceutical Council, 2015).

Over the past two years there has been an increase in the willingness of US payers and drug manufacturers to engage in risk-sharing schemes, with several outcomes-based deals penned that include reimbursement for failure to deliver pre-agreed outcomes. However, such outcomes-based deals can be administratively burdensome to carry out, which has impeded their widespread uptake, and confined to deals with few large health plan carriers or smaller regional plans with well-integrated data systems, such as Harvard Pilgrim Healthcare.

"In the US, pharma companies have come up with elegant pay-for-performance solutions, which the payers then say are too complex. The systems are unable to cope with, and integrate, the data to evaluate the efficacy and cost savings. For example, hospitals have the clinical data but the providers have the claims data. We have seen some movement towards pay-for-performance but it has been slow, as the healthcare systems struggle to track the payments and savings. They are likely just to ask for a better price. If the healthcare networks manage to solve the data challenges, such as the alignment of various data sources, there will be a lot of pressure for the pharma and medtech companies to meet the needs," says Ritterath (personal correspondence, 2017).

IDNs present potentially more appropriate partners for such agreements due to their high level of data integration as well as focus on the total cost of care rather than just the drug budget found within traditional pharmacy benefit manufacturers. Adopting such outcomes-based deal approaches may enable drug developers to drive product uptake within this otherwise hard-to-reach customer segment.

Upskill the sales force

Selling into IDNs requires a different approach to the more traditional setups, and existing sales reps will need to be trained and upskilled for the newer business model. This includes promoting a more patient-centric approach, and ensuring a better knowledge of the data and the science behind it. Sales reps also need a good understanding of the value of the drugs to the IDN, particularly their cost-effectiveness in the short or long term, for example lower rates of hospitalization or lower costs because of better patient outcomes. Furthermore, sales reps need to be trained on the value-added services associated with the drugs and their impact, for example, increased adherence (BioPharma Dive, 2015; eyeforpharma, 2015c).

IDN accounts are larger than those for standalone hospitals or care plans, expanding the role of account managers, and requiring a much more strategic approach. The pharma sales teams will have to learn to work within an environment that is closer to a business-to-business model rather than a business-to-customer scenario (Pharma Letter, 2017; Pharmaceutical Executive, 2015).

Create partnerships between IDNs and pharma companies

The growth of IDNs offers opportunities for IDNs and companies to work together, providing access to skills, expertise, resources, and data from both partners. One potential for collaboration is in the area of data analysis. Some IDNs lack the technology required to generate some forms of real-world data, and the skills and expertise to analyze the resulting data. Pharmaceutical companies can provide IDNs with access to additional real-world data, such as claims data or social media data, or can help them to pull together their existing sets of data in a way that allows analysis (AccessPoint, 2015).
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