Figuring who calls the shots: IDN or Payer?

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Abstract

Today, the prescribing behavior of physicians is shaped both by the Payer and the IDN. In some cases, it is the IDN that prevails. In other cases, it is the Payer. This talk describes a technique we have developed over the years to quantify the level of control an entity such as a Payer or an IDN exerts on the prescribing behavior of physicians.

What makes this technique stand out is that it can be applied to situations where both IDN and Payer are at play at the same time, in which case it tells us who has the upper hand. As a result, this technique shines a new light on a myriad of questions including the nature of the dynamics that undergird a geographic market, cost-effective ways to increase drug access, and effective promotional mix tactics to maximize sales. Also, it helps us take apart highly visible deals that make healthcare headlines.

Another remarkable feature of this technique is its simplicity. It only requires physician-level data or patient-level data along with a couple of auxiliary resources.
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1. The Target List Mess
2. Unprepared for the Job
3. Our Approach
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1. The Target List Mess
Starting Point

• Background: We just sent the list of target physicians along with the corresponding messages to the field.

• Issue: Reps are complaining that the list does not work, and the message is not right either. They claim their territories are special and need special treatment.

• Action: Really? Well, let’s see what the complaint is about...
1. UPMC Refuses to renew contract with Highmark.
2. Approached Aetna, Cigna, HealthAmerica, and United.

Highmark terminates 689 UPMC Physicians. UPMC says this is illegal!

Highmark refuses to pay UPMC for cancer care.

Auto employer to ditch Highmark because of UPMC-Highmark quarrel.

Highmark will not cover deliveries at Magee for women that have an independent obstetrician.

- Dominant Player
- $12.8 Billion
- 20 hospitals
- 500 locations

- $2\textsuperscript{nd} largest provider in the region
- 2 tertiary hospitals
- 6 community hospitals
- Employs 2,100 Phys
1. Blue Shield says Sutter Health’s rates too high (up to 30%). 280K Blue Shield Patients may have to find another doctor outside Sutter. Finally, an agreement is reached.

2. Employers and Labor Unions complain that Sutter forces them to pay sharply higher rates: 95% of full charges for out-of-network care in hospitals and clinics.
1. Rush fires Aetna as it cannot accept a 30% cut in reimbursement. This impacts 17K workers and family members that Aetna insures for Rush.

2. Rush replaces Aetna with Cigna. Cigna will be processing claims and managing how Patients get reimbursed. Rush is self-insured.
Another Rep From Chicago
Merger - Advocate NorthShore Health Partners

1. One of the largest mergers in recent history in the Chicago area.
2. Illinois saw in 2011 the birth of Presence Health, the merger of Resurrection Health Care (12-hospital System) and Provena.

Advocate
#1 System in Illinois

NorthShore
#1 Network in Chicago
Evanston Hospital
(previously known as Evanston Northwestern)

16 Hospitals
Revenue = $6.5b
Income = $400m
Let’s Hit Pause for a Sec

• The reps may have a point. We did not factor in the impact of IDNs.
• IDNs seem to impact different geographies differently.
• We need to understand IDNs better.
• Let’s first classify them. Should not be too hard.
Horizontal vs. Vertical

Horizontal
- Partners Health Care
- University of Pittsburgh Medical Center
- Sutter Health

Vertical
- Kaiser Permanente
- Geisinger

“Cradle to Grave”

Acquire and combine prestigious hospitals and then achieve higher reimbursement rates from payers willing to pay more for their services.

Include acquisitions and alliances involving Physicians, Health Plans, Academic Medical Centers, Long-Term Facilities and Home care Facilities.
Kaiser Permanente – Fact Sheet

- Operates in nine states, including Washington, DC, and has almost 9 million members, 14,000 doctors and 160,000 employees.
- The system owns and operates more than 420 Freestanding Ambulatory Care Facilities and 30 Medical Centers (hospitals and ambulatory).
- Medical Centers offer one-stop shopping for most services including hospital, outpatient offices, pharmacy, radiology, laboratory, surgery and other procedures, and health education centers.
- This set-up encourages patient compliance and enhances opportunities for physicians at the primary care level to communicate and consult with specialists, hospital personnel, pharmacists, etc.

Note: DC has 250 KP Physicians that have privileges in partner hospitals (source: Simon Fitall).
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<th>IDN - 4 Models</th>
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<tr>
<td><strong>Network</strong></td>
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<td>• Has a long history of physician independence and single-specialty groups.</td>
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<td>• Can readily participate in capitation and shared savings but not in bundled payments.</td>
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<td><strong>Medical Group</strong></td>
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<td>• Well positioned to participate in payment models such as P4P and bundled payments.</td>
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<td><strong>Hospital Systems</strong></td>
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<td>• Leverages the hospital structure to focus on new risk-sharing mechanisms and clinical redesign.</td>
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<td><strong>Collaborative</strong></td>
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<td>• Difficult to manage as control is decentralized.</td>
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**Many systems in the East Coast.**
- Dartmouth-Hitchcock

**Geisinger Health Partners**
- Intermountain
- Mayo
- Kaiser Permanente

**In California:**
- Sutter
- Sharp
- Scripps

**Midwest:**
- Iowa Health Sys + United + John Deere
- N. Cal: Catholic HC West + Hill Physicians + CalPERS + Blue Shield of Cal
IDN – 4 Categories

1. Category 1 is a multi-specialty group practice with a health plan, which is both a provider and a Payer. Involves physicians in strategic planning. Its advantages include data integration and utilization review. Little duplication of services.

2. Category 2 is a single-entity delivery system that does not own a health plan.

3. Category 3 involves private networks of independent providers. This category also includes: (1) Physician-Hospital Organizations, (2) Management Service Organizations, (3) Group Practices without walls, (4) Individual Practice Associations.

4. Category 4 includes government-facilitated networks of independent providers on both the state and local levels. Governments take an active role usually to create a delivery system for Medicaid beneficiaries.

- **Kaiser Permanente** follows this model by serving only members in its health plan.
- **Geisinger Health System** also follows this model, but serves patients outside of its health plan.
- **Mayo Clinic** is the world’s oldest and largest integrated multi-specialty group.
- **HealthCare Partners** Medical Group is a non-profit organized delivery system in greater Boston and eastern Massachusetts.
- California "delegated model" health maintenance organizations.
- **Community Care of N. Carolina**, a public-private partnership.
IDNs Come in Different Shapes and Sizes

Above the 2 major dimensions along which IDNs can be differentiated, although an accurate classification is more daunting.
Another Wrench: Provider-Sponsored Health Plans

• With a PSHP, Patients and Employers can deal directly with Providers that are both their insurers and caregivers.
• The PSHP turns the HMO on its head. The HMO fell out of favor because it simply limited utilization of healthcare services.
• A PSHP focuses instead on preventative care. It encourages access to the most effective interventions. Also, a PSHP tends to have a limited network of providers so that it can more closely coordinate care within the network.

120+ PSHPs including:
1. Kaiser Permanente
2. Driscoll Children’s Health Plan in TX.
3. Alliant Health Plans in Dalton, GA
2. Unprepared for the Job
When IDN’s emerged in the 1990’s, they were only IDNs in name. Today’s IDNs are a different beast. This new breed of IDNs can truly drive control thanks to their centralized data collection (EMR and CPOE), a capability they had to develop to respond to the demand of Payment Reform.
IDN – Yesterday vs. Today

1990’s – Under Clinton
1. Network of providers were formed to fight managed care (HMO Capitation).
2. IDNs only happened in name – mere networks.
3. What followed was disaggregation of hospital services with the rise of free standing surgery centers and outpatient facilities.

2016 – Payment Reform
1. New rules of Payment spurred the rise of EMR and CPOE to provide quality measures.
2. Quality Measures promoted Consumerism which in turn legitimized Quality Measures.
3. Information available across entire organization enables true integration and control.
4. Solo practices are rare. Most physicians operate in IPAs, MSGPs, and groups associated with IDNs.
Analyses done in this space were exclusively meant to explain Rx behavior as a function of payer formulary: tier status, prior authorization, step therapy, NDC block, etc. IDNs, being a recent phenomenon, were understandably ignored.
What’s Needed

A methodology that:

1. Measures the influence of the Payer and the IDN on the Rx habits of a physician at the same time.

2. Quantifies the level of control based on performance variables (Rx’s, Rx share, units, etc.) that indicate what actually happened. Independent variables not limited to proxy variables that indicate what should happen: geographic footprint, level of use of EMR, number and type of ACO contracts, stage in the integration process, etc.

3. Requires no assumptions regarding the type of IDN or Payer prior to measurement.
3. Our Approach
Take a look at the results below. Question: What’s your rationale for saying that one shooter is better than the other?

The better shooter is the one where the shots are clustered together. In other words, the one where there is less variability in distance from the target. In other words, smaller Standard Deviation.
Question: How does Finance measure risk?

Risk is measured as standard deviation. The higher the standard deviation, the riskier the asset.
Consider the drug market shares of physicians that are affiliated with an organization. If it’s a controlling organization, the market shares will tend to vary little as physicians are driven to adhere to treatment guidelines. Otherwise, the market shares will show greater variation since freedom of choice usually leads to different choices.

Hypothesis: The standard deviation of the market shares of physicians affiliated with an organization is inversely proportional to the level of control of the organization.
Question: Would you change your opinion if you were told the shooter changed handgun midway in the shooting practice?

If you are like most people, the answer is yes. The point is that when it comes to performance, both intrinsic skills and weapon used matter.
When computing the standard deviation of market shares of physicians, consider only prescriptions that pertain to patients of a similar level of severity of illness.

Hypothesis Revisited: The standard deviation of the market shares of physicians affiliated with an organization, after controlling for level of severity of illness, is inversely proportional to the level of control of the organization.
The standard deviation (24.8% in the example above) is a simple and elegant way to capture the variability in Rx behavior of the Providers that make up an Organization.
Gist of the Approach

Below are the standard deviations of the market share of the drug of interest. Question: Which one has the upper hand in that geography, the IDN or the Payer?

Since a change in IDN results in a larger change in standard deviation of market shares than a change in Payer, we can conclude it is the IDN that has the upper hand.
4. Insights and Caveats
Comments on Deployment

• Straightforward – Does not require any assumptions regarding the type of IDN or Payer we are looking at. Works for PSHP’s just the same.

• Works with either Physician-level data or Patient-Level data. Patient-level data is the preferred data source since it allows us to work with a more granular segmentation, one that factors in level of severity.

• Market Share calculations assume a good read on the competition. When that’s not the case (for instance because of data blocking in the SP space), we can alternatively use rates of utilization.

• Not always clear which IDN a physician is affiliated with as data sources are not perfect. Not always clear either who the Payer is. This may be even more challenging since the Payer depends on the Patient.

• The typical geography has more Payers than IDNs. Our approach still works even if there is one or no IDN. When that’s the case, it ranks Payers by level of control.
Insights

1. The level of control an IDN exerts is largely a function of the TA. For cancer, for instance, IDNs display much less control than for primary care disease areas. We believe the IDN may be reluctant to exert control as opposed to being unable to exert control. That’s probably for PR reasons or to avoid litigation.

2. When 2 measurements carried out a few months apart show little difference in control, odds are a third measurement carried out a few months later will also show little difference as well. We take this to mean that integration has peaked. The limitations in efficiency may be coming from the way the system is set up.

3. The control IDNs exert seems to emanate from an adherence to an overarching, clinical algorithm whereas the control Payers exert seems to be more local in nature and not reflective of a bigger picture.
Caveats

1. The level of severity of illness may correspond to a very homogenous group of patients for one disease state and not such a homogeneous group of patients for another. We are looking at the latter when the therapy needs to factor in age, gender, physical state of the patients, prior therapies, and the like. When that’s the case, we may be chalkling up variation in treatment to lack of control.

2. We only have the id of the Payer, not the actual plan (HMO, PPO, HSA, etc.) of the patient. In cases where one plan is more prevalent in one geography than in another, we may be attributing the difference in plan to the IDN. Also, when co-pay or co-insurance is high, or the charges are within the deductible or above the ceiling, patients may be exhibiting a cash behavior which we may mistake for the Payer.
5. Reflections
Reflections

1. More of this type of studies is needed to better understand IDNs. For starters, to be a greater value-added partner.

2. Given the ever-increasing size of the IDN (some are larger than small countries), Pharma companies need to broaden their analytical focus to include not only HEOR types of analyses (to justify the price of the drug) but also to understand how large systems work and locate gaps that impede value creation.

3. Another reason to cozy up to IDNs is they are relative neophytes in regards to uncovering insights from data analysis and would welcome help. It’s only now that they are getting data that cuts across the various parts of the network (thanks in large part to the EMR which is meant to produce quality measures for reimbursement). Payers, by contrast, whose business is much more homogeneous than IDNs, have had claims since the very beginning and are well versed in uncovering insights from data analysis.
6. Q & A
Your Question

Please send your questions to bayser@bayser.com or give me a call at (847) 920-1000. I will respond. Thanks. JP.