the characteristics of community pharmacies in Egypt. The current study and future ones would significantly improve the ability to probe practice-related issues and economic challenges community pharmacies and pharmacists face in Egypt.

**PHP141**

**BRIDGING HTA AGENCIES ACROSS EUROPE: A SYSTEMATIC APPROACH TO CATEGORIZE EVOLVING AGENCIES**

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**OBJECTIVES:** HTA agencies are mushrooming in Europe. Industry faces the challenge to meet their diverse requirements and comply with decision criteria. Our aim was to investigate similarities and distinguishing characteristics of HTA agencies to anchor institutions use different approaches. The project assesses HTA and serve as a reference for others, and to assign other countries to one of the anchor institutes. METHODS: We identified the primary institutions in European countries where HTA plays a role in decision making. We developed a template for the unified assessment of the input needs of the agencies, and a set of criteria an anchor country should meet. Agencies were assessed based on a literature review, and assigned to one of the anchor countries, which was validated by MSD subsidiaries across Europe. Future trends in anchor countries were investigated. RESULTS: We identified three anchor institutes in Europe using different value assessment concepts. IQWIG in Germany primarily assesses HTA submissions on the basis of patient-related outcomes requiring hard endpoints. HAS in France sees the medical benefit of technologies in innovativeness rating them from no innovation to breakthrough innovation. NICE in the UK also rates the cost-effectiveness of HTA, and uses different value magnitudes. CONCLUSIONS: European HTA agencies can be systemized based on their requirements. This review can serve as a repository of individual country needs in HTA, an input to the design of clinical trials, and can support the development of industrial HTA strategies. Such a snapshot however cannot substitute the deep knowledge of local requirements and needs regular update to follow-up future trends.

**PHP142**

**CHANGES IN THE NUMBER OF ENROLLIES IN THE HUNGARIAN MANAGED CARE PROGRAMME**

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**OBJECTIVES:** A pilot care managing programme was introduced in Hungary in 1999. The conceptual foundations of the Hungarian implementation of managed care is closer to what was called the GP fundholding in the UK than HMOs in the USA. To describe the evolution of the number of enrollees in the care managing programme. METHODS: The data derive from the financial database of the Hungarian National Health Insurance Fund Administration (NHIFA) covering the period 1999-2007. We identified the average annual number of persons enrolled to Care Managing Organizations. The Hungarian HTA was financed through a risk adjusted capitation fee and the health services covered by CMOs were defined in legal regulations. RESULTS: The total number of the Hungarian population was around 10 million people (100 %) during the study period. Since the beginning of the programme (1999) the total number of persons covered by the care managing programme increased from 158,984 (1.5 % of the Hungarian population) to 601,915 persons (5.9 %) in 2003 and to 1,961,025 (19.4 %) in 2005. After this peak, the number of enrollees decreased again; in 2006 and 2007 enrollees were at 1,847,552 and 1,786,830, respectively. CONCLUSIONS: With the development of the Hungarian care managing system, the average number of enrollees increased. This increase resulted in larger-pooling structure providing a more stable environment for Care Managing Organizations.

**HEALTH CARE USE & POLICY STUDIES – Risk Sharing/Performance-Based Agreements**

**PHP144**

**THE 2012 US PAYOR LANDSCAPE: RESULTS FROM A SURVEY OF MEDICAL AND PHARMACY DIRECTORS**

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**OBJECTIVES:** To determine the types of approaches preferred by payers to enhance the P&T decision-making process and how medications are covered on the formulary should be covered. METHODS: An onlineinteractive survey of US medical/pharmacy directors (MDs+PDs, respectively). In addition to a 10-point Likert scale (10=agree completely, 1=disagree completely), some questions used qualitative responses and interpretive analysis to explore views and beliefs. RESULTS: Twenty-nine (20 MDs+9 PDs) responded, representing 44 commercial plans, 14 Medicare plans, and 23 Medicaid plans. Respondents indicated that current progress in obtaining usable comparative-effectiveness research (CER) information was slow (average=4.17, MD=4.06, SD=4.0) on the 10-point scale. However, they anticipate regularly utilizing CER in decision making by 2015 (average=6.03, MD=6.0, SD=6.1). Their rating of the use of evidence-based medicine in coverage decision making was somewhat higher (average, 7.08; MD=7.38, PD=6.4). The survey participants pointed out that emerging CER results would greatly affect the following areas: Optimization/improvement of clinical guidelines (22.6%), medical/pharmacy benefit management (19.4%), evaluation of the value (16.1%), appropriateness of care (16.1%), pharmaceutical R&D (6.5%). When asked how they would change their institution's pharmacy benefit design, the most frequent responses were incorporating CER data into copayment tiering management (13.3%), further incentivizing adherence through benefit design (10.0%), and altering benefit design structures to include pharmaceuticals (9.0%), primarily lowering member out-of-pocket costs. To improve their P&T Committee process, 23.3% would incorporate more CER results, 13.3% would enhance the physician/specialist presence on the review committee, and 6.6% would increase the number of rounds allowed for review and rating. CONCLUSIONS: The environment for P&T Committee decision making in managed care is undergoing a series of changes, and payer medical directors and pharmacy directors, who commonly serve as P&T Committee members, have distinct opinions as to how to alter the process to adapt to these influences.

**PHP145**

**A REGRESSION ANALYSIS OF THE IMPACT OF PATIENT ACCESS SCIENCES**

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**OBJECTIVES:** Patient Access Schemes (PASs) are part of the UK Pharmaceutical Price Regulation Scheme (2009). PASs enable patients to receive drugs, and allow pharmaceutical companies to collect cost-effectiveness and efficacy data, even if the drug has not been approved. We evaluated the effect of PASs on patient access (PA) defined by total sales in volume/prevalence of the particular disease group. METHODS: A literature search of Medline and online resources was carried out to capture relevant data for PAS schemes in the UK in which PASs were obtained. Multiple regression was used to test if a relationship exists between the dependent variable, (change in PA) and the independent variable (existence of a PAS) and other factors that may affect change in PA. The other factors were: type of PAS, country, number of competitors, list price, how long the drug has been marketed for, and the orphan drug designation. Five drugs with approved PASs in the UK were analysed. These included: lenalidomide, erlotinib, bortezomib, sunitinib, and cetuximab. These were analysed in France, Germany, Italy, Spain and the UK, between 2010 and 2011 using IMS sales data and the Globocon Project 2008 prevalence data. RESULTS: The results of the regression analysis showed that the existence of a PAS does not seem to have an effect on the change in PA. Therefore, this model cannot support a relationship between the two variables. The R2 is 0.6191, however the only variable which was statistically different from 0 is the number of competitors, with a p-value of 0.014, which means it is the only variable which had a significant effect on the change in PA. CONCLUSIONS: Further research needs to be conducted for a detailed analysis on this relationship.

**PHP146**

**THE CHANGING FACE OF MEDICARE’S NATIONAL COVERAGE FOR NEW TECHNOLOGIES, 1999-2012: MORE PREVENTION, DIAGNOSIS, AND COVERAGE WITH EVIDENCE DEVELOPMENT**

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**OBJECTIVES:** The Centers for Medicare and Medicaid Services (CMS) makes 10-12 National Coverage Determinations (NCDs) for medical interventions each year. Our objective was to identify evolving trends in NCDs. METHODS: We analyzed data from CMS from Tufts Medical Center’s NCD database, which contains detailed information on 165 NCDs since 1999. We evaluated trends in how CMS reported evidence limitations, the use of its “coverage with evidence development” (CED) policy, the type of intervention evaluated, and whether it was for prevention or treatment. We used two-sided Armitage-Church test to identify statistical annual trends. RESULTS: Over time, CMS has increasingly cited evidence limitations in decision memoranda. The proportion of occasions CMS cited a “lack of relevant health outcomes” increased from 14% in 2000 to 67% in 2012 (p<0.0001; CA test, 1999-2012). The proportion of occasions CMS cited, a “lack of studies including Medicare beneficiaries” increased from 7% in 2000 to 67% in 2012 (p=0.0003; 1999-2012). CMS has increasingly relied on coverage with evidence development (CED) policies (p=0.0295; 2003-2012). Since 2009, 10 NCDs (59% of NCDs in this period) resulted in CED policies, more than half of all CEDs (n=19) implemented since 2003. In recent years, NCDs have increasingly pertained to primary and secondary prevention level interventions (p=0.0571; 1999-2012), and now represent 28% (46/165) of all NCDs. The type of intervention evaluated also changed, with more NCDs pertaining to “diagnostic imaging technology” (p=0.9571; 1999-2012), now representing 15% (25/165) of all NCDs, and “health education behavior” (p=0.0149; 1999-2012), now representing 14% (23/165) of all NCDs. CONCLUSIONS: CMS’s NCD process is evolving in important ways. CMS increasingly notes that technologies considered lack relevant outcomes. The agency is increasingly uses CEDs and other evidence development policy, while collecting evidence for future use. It increasingly uses NCDs to evaluate preventive services and diagnostic technologies.

**PHP147**

**WHAT PAYERS WANT? THE ATTRACTION OF THE HEAD-TO-HEAD CONTROLLED TRIAL**

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