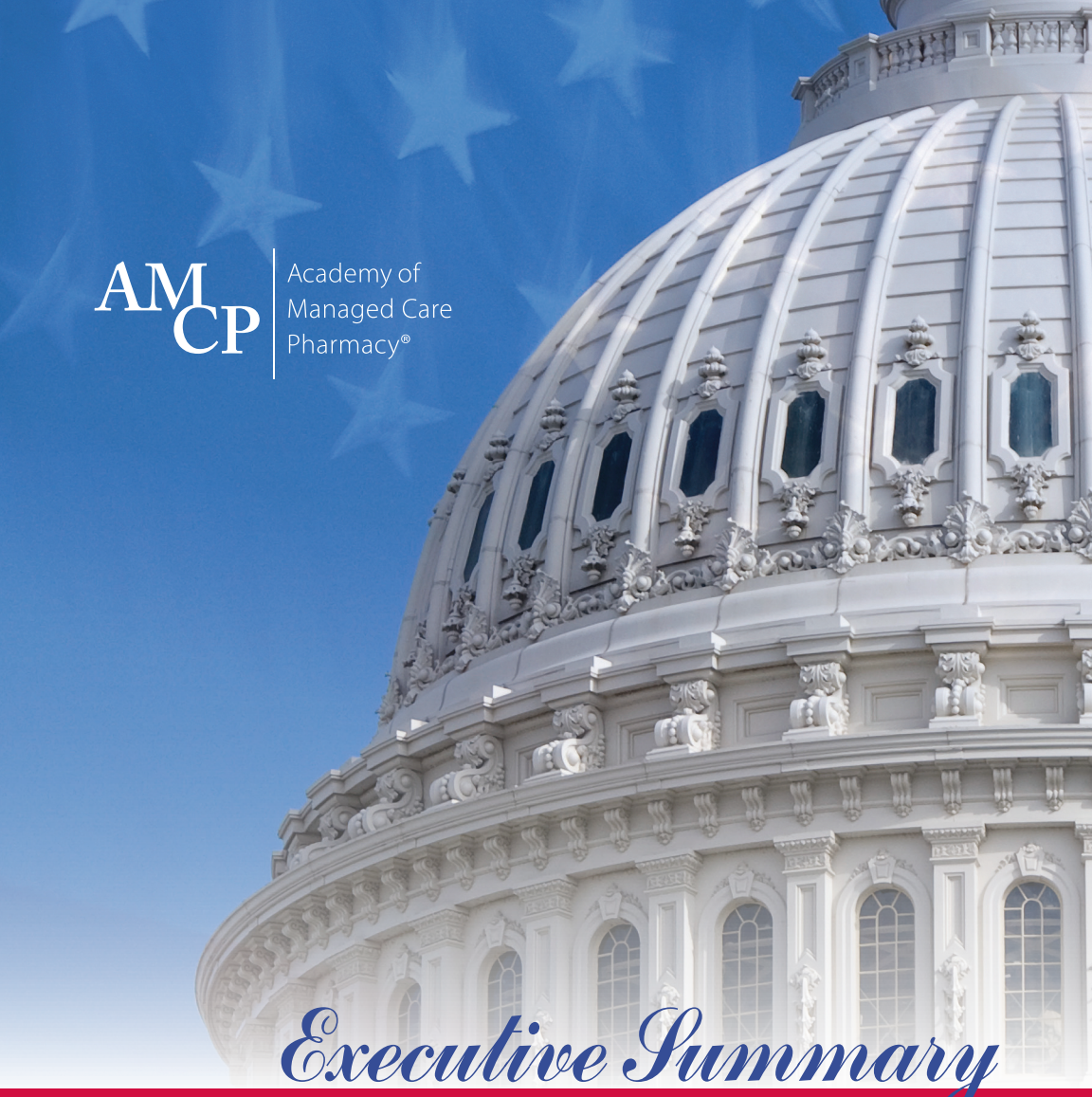


AMCP Academy of Managed Care Pharmacy®

Executive Summary

HEALTH PLAN EXECUTIVE FORUM

DECEMBER 2, 2014 | THE ST. REGIS HOTEL | WASHINGTON, DC

Hosted by the Academy of Managed Care Pharmacy in partnership with

CVSHealth MedImpact novo nordisk®

February 2015

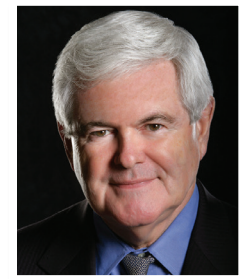
AMCP | 100 N Pitt Street | Suite 400 | Alexandria, VA 22314 | Tel 703/683-8416 | *www.amcp.org*

Host

Edith A. Rosato, RPh, IOM
Chief Executive Officer, Academy of Managed Care Pharmacy

Moderator

David B. Nash, MD, MBA
Dean, Jefferson School of Population Health, Thomas Jefferson University



Keynote Speaker

Newt Gingrich
Former Speaker of the US House of Representatives

Faculty

Panelists

Steven G. Avey, RPh, MS, FAMCP
Vice President, Specialty Programs, MedImpact Healthcare Systems, Inc.

David Dross, MBA
Partner, Mercer

Cathy K. Eddy
President, Health Plan Alliance

Thomas Gibbons, RPh
Senior Vice President of Payer Relations/Managed Care, CVS Health/CVS Pharmacy

Robert K. Kritzler, MD
Deputy Chief Medical Officer, Care Management, Johns Hopkins HealthCare

Alan M. Lotvin, MD
Executive Vice President of Specialty Pharmacy, CVS/Specialty, CVS Health

Jeremy Nobel, MD, MPH
Medical Director, Northeast Business Group on Health

Thomas Parry, PhD
President, Integrated Benefits Institute

Margaret Rehayem, MA
Senior Director of Strategic Initiatives and Communications, Midwest Business Group on Health

Matt Salo
Executive Director, National Association of Medicaid Directors

Michael S. Sherman, MD, MBA, MS, CPE, FACPE
Chief Medical Officer, Senior Vice President, Harvard Pilgrim Health Care

Danilo Verge, MD, MBA
Vice President, Medical Affairs, Diabetes, Novo Nordisk, Inc.

INTRODUCTION

Impending changes in leadership in Washington, DC; the upcoming Supreme Court decision on Affordable Care Act (ACA) subsidies; and health care market forces, including specialty drug trends, are stressing a health care delivery system that has been marked by expansion and turmoil in the past several years. "More than four years into health reform, 18% of people surveyed by the Kaiser Family Foundation think that the ACA has already been repealed," said David B. Nash, MD, MBA, moderator of the first Academy of Managed Care Pharmacy (AMCP) Health Plan Executive Forum. Held in Washington, DC, on December 2, 2014, the Forum was conducted by AMCP with sponsorship support from CVS Health, MedImpact and Novo Nordisk.

"Today is a very special day for AMCP," pronounced Edith A. Rosato, RPh, IOM, Chief Executive Officer of the Academy. "This is the first time we're hosting senior executives from across the health care system and the nation for a day of serious thinking and dialogue about the top health care challenges and opportunities facing us. The assembled panelists represent the entire health care sector and are a powerhouse of knowledge, experience and insight."

Ms. Rosato hoped that this meeting will "advance and clarify our understanding of the future of health care, especially from a business perspective." The event followed on the heels of the AMCP Foundation's recently published "Ahead of the Curve: Top 10 Emerging Health Care Trends." Part of this forum's mission was to discuss how these trends will affect key stakeholders in the next five years.

KEYNOTE ADDRESS

Former Speaker of the US House of Representatives Newt Gingrich indicated that he entered the health care fray when he was first elected as a Republican representative from Georgia. His talk focused on observations about "discontinuities," particularly as they pertain to the health care system.

Speaker Gingrich explained that discontinuities, as defined by the author Peter Drucker, are disruptions in patterns that make predicting the future extremely difficult. During a period of continuity, the pattern can be identified and reliably forecasted. With discontinuity, the situation three, six or 12 months into the future cannot be

KEYNOTE ADDRESS
continued

predicted. Consider the current production output and price of oil as an example.

In terms of health care policy, Speaker Gingrich emphasized that "we almost never succeed in controlling costs." In fact, he believes the best market actions result "when a market crashes," which creates new opportunities and a new reality for management and control.

According to Speaker Gingrich, Alzheimer's disease represents perhaps the "number 1 project we should be thinking about today in health care." By 2050, Alzheimer's costs will accumulate to approximately $20 trillion, he stated—"much more than the national debt." A breakthrough in the treatment and prevention of Alzheimer's disease would be a tremendous discontinuity in health care, which may head off an expenditure that would dwarf the national debt.

He also pointed to the rise of smartphones as a discontinuity that represents, in the next 30 to 40 years, "a new, decentralized instrument of power and education." For a poor person moving to a new town, an app will tell him or her where the closest federally sponsored health center is located. It will help translate medical information that is written well above the average person's medical literacy into a form that is more easily understood. It may help individual employees track heart rate, blood pressure, and other functions, and compel further movement to a more consumer-esque approach to health care.

Speaker Gingrich mentioned that whereas high-deductible health plans are a positive form of encouragement for consumers to be more involved with their health decision making, consumers do not have access to the information necessary to make value-based decisions. "We've been waiting for a 'Travelocity'-type information exchange for health care consumers for 15 years," he said. This also has implications for high-cost, low-value medical interventions, including some specialty pharmaceuticals. He commented that overarching policy changes are needed to address expensive specialty pharmaceuticals—he suggested a scenario in which the federal government may purchase patent rights to certain drugs "and sell them as a commodity." For other specialty drugs, he suggested that

KEYNOTE ADDRESS
continued

the answer may lie in reinsurance. For patients with disorders like hemophilia, he said, "we need a much more sophisticated model. We know they need expensive drugs, we can predict when they need them."

Speaker Gingrich believes that medical and health travel (or "medical tourism") will be an influential discontinuity and gain ground, because the health outcomes seem to be equally good to those in the US but at only a small fraction of the cost. With price differentials so vast, payers will increasingly look to other providers, even outside this country, to perform surgeries, both routine and complex. "You can't have a huge price differential without people finding out via the Internet," he said, and this also applies to drug importation. People will seek medications at lower prices from other countries, almost without regard for their quality.

He reminded the attendees, "One of your jobs is to look for discontinuities. Look outside your profession to see what is happening around you. Many of these will affect your profession."

PANEL SESSION 1

Population Health and the Insurance Marketplace

Panelists: **Cathy K. Eddy**, President, Health Plan Alliance; **Jeremy Nobel, MD, MPH**, Medical Director, Northeast Business Group on Health; **Matt Salo**, Executive Director, National Association of Medicaid Directors; **Danilo Verge, MD, MBA**, Vice President, Medical Affairs, Diabetes, Novo Nordisk, Inc.

Consumers and Information. Ms. Eddy added to Speaker Gingrich's focus on increased consumerism, saying that "health plans have to move to a retail environment—we're selling more to individuals than we are to groups." Dr. Nobel cautioned that this movement assumes faith in consumers' ability to get information and make good decisions themselves at the point of decision making. "With high-deductible health plans ($2,500 and up), we're betting the farm on this." However, he doubts that consumers can know what they need to know at the point of decision or that their decision-making will necessarily be rational. Dr. Nobel pointed to the following example: A new diabetes prescription is written by a doctor, and the patient goes to the pharmacy to pick it up. The patient is told it will cost $350. Will the patient walk out without the

PANEL SESSION 1
continued

medication, deciding whether to spend that money on gas, food, living expenses, or a different health care need?

Discontinuities in Health Care. Mr. Salo remarked that one of the most problematic discontinuities in health care is that people want more for themselves, and they want to pay less for it. This is still true, even in the Medicaid population, where individual Medicaid beneficiaries pay little for their care. In Medicaid, value-based insurance design cannot drive decision-making. "How do we empower that consumer? And with what information?" he asked. "We need the patient to be better informed and more involved in their health. Most people didn't know Medicaid was part of Affordable Care Act. There's a discontinuity right there. Medicaid pays for 40% of all births, and majority of long-term care, but the vast majority of people doesn't understand this."

Dr. Verge specified another discontinuity, in terms of diabetes care: Medical schools spend only an average of one week on teaching about this problem that accounted for $245 billion (or 9% of the total US health care expenditures) in 2012 (based on American Diabetes Association figures).

Dr. Nash pointed out that the supply of medical professionals in this country can meet the need ("we've doubled the medical school seats in this country"), but the maldistribution of clinicians represents an important discontinuity.

Population Health. The term has picked up a lot of traction since the "Triple Aim" of health care has gained attention, said Ms. Eddy. "Insurers have been doing this for years for the populations they serve. Now, providers are beginning to define what it means to them."

For employers, said Dr. Nobel, "the concept is very natural. They are driven by bottom-line considerations. Their engagement revolves around labor economics, with important constructs that are key to population health: (1) to attract and maintain a healthy workforce and (2) to be able to buy health insurance at an affordable and competitive price."

PANEL SESSION 1
continued

With regard to Medicaid, Mr. Salo asserted, "we would describe population health as the demise of the fee-for-service payment model (if not the delivery model). The old model of paying for widgets of health care service rarely has any connection with actual improved health." He suggested instead that a holistic approach is needed, considering factors that affect the patient and the population, and how we provide this care on a patient-by-patient basis that is financially and politically sustainable.

Dr. Verge stated that pharmaceutical companies study how a drug will work in an entire group of patients—to yield an average response. "But when you give it to individual patients, the drug may show a variety of effects," he said. "How do we bridge that? The drug is given to an individual, not a population."

Focusing on the Healthy as Well as the Sick. An audience member contended that in today's existing "sickness system" of health care delivery, we are not engaging people who do not engage the system. Ms. Eddy agreed that "we spend a lot of time on the 5% that drive most of the cost, but we've learned from the exchanges that we need the healthy population to help keep costs down. How do you engage this population with wellness, education, and outreach? There is a big challenge for the health care system—it is used to addressing people only after they need care." Dr. Nash confirmed, "If we ignore keeping healthy people healthy, we do this at our peril."

An audience member recommended that the best way to do this is to employ more global types of payment mechanisms. "On the pharmaceutical side, they are getting paid for pills, not solutions. What can we do to align incentives for pharmaceutical companies?" he asked. Dr. Verge replied that the classic model is to gather evidence from phase I, II, and III trials, get approval from the Food and Drug Administration, and try to convince payers that our results with the narrow clinical trial populations will apply to the broader groups of your membership. "And clearly that is not the case," he said. "We now have a collaboration with Humana, where we are looking at their populations with them, and considering the value of drugs for these populations, and what part of their populations

PANEL SESSION 1
continued

may most benefit." It was suggested by members of the audience that risk-based contracting would be a step in the direction towards population health and value-based pharmaceuticals.

PANEL SESSION 2

Narrow Network vs. Value Network

Panelists: **David Dross, MBA**, Partner, Mercer; **Thomas Gibbons, RPh**, Senior Vice President of Payer Relations/Managed Care, CVS Health/CVS Pharmacy; **Robert K. Kritzler, MD**, Deputy Chief Medical Officer, Care Management, Johns Hopkins HealthCare; **Michael S. Sherman, MD, MBA, MS, CPE, FACPE**, Chief Medical Officer, Senior Vice President, Harvard Pilgrim Health Care

Narrow Network vs. Value Network: Is There a Difference? A narrow network is based on a volume-discount philosophy, whereby the payer drives volume to a few providers who give the payer significant discounts. In a value network, which also comprises fewer choices than other conventional networks, the providers have demonstrated the ability to yield high-quality care at low cost. With that said, there is little reason why pharmacies cannot also be subject to narrow networks, reminded Mr. Dross. "There are other things that pharmacies can do to go beyond lower unit cost. The value piece is around lowering cost by improving adherence."

Mr. Gibbons specified that in a value network, there is a pricing component and a service component, expressed as a continuum. Depending on the client, "you can simply have a conversation regarding how many pharmacies are in the area, or you can discuss what is the right messaging using the health plan's database, their understanding of risk assessment and gaps in care, and how we use our pharmacies and our various patient interactions to relay that message."

Dr. Kritzler said that a narrow network has been the keystone of Kaiser Permanente, "but that was pretty unpopular east of Colorado." He believes that access and choice are part of the formula. "We have to be responsive to customers who worry that their employees won't have access."

Coming to grips with value in medicine is an inherent part of providing care in the Boston area, noted Dr. Sherman. "Although we have great quality of care, we are also number 1 in per-capita

PANEL SESSION 2
continued

spend on health care. Employers and legislators are fed up." When Harvard Pilgrim evaluated their medical expenses, executives stratified providers into three tiers based on costs alone. Their analysis revealed the absence of "any measurable differences in outcomes quality among tiers." Three years ago, they introduced tiered provider networks. If patients went to highest cost (tier 1) providers, they were subject to higher copays and deductibles than if they went to low-cost tier 3 providers. "You were not getting lower quality—that was the key. It not only gives purchasers and members choice, it also creates an opportunity for providers to gain volume."

Educating Members About Narrow or Value Networks. This is acknowledged to be a common failing of plans and employers. Dr. Sherman admitted that this is a learning process on the part of the plans. Harvard Pilgrim's customer satisfaction ratings indicate that they have not done an adequate job of educating and preparing members. Today, Dr. Sherman's organization is trying to do a better job at the point of enrollment. Also, he noted, when members who are subject to a narrow network plan interact with case managers, it is indicated on the case manager's screen. This allows the case manager to also address the narrow network with the member, to improve his or her understanding.

Dr. Kritzler agreed that it is incredibly hard to explain to the member. "The consumer's definition of a high-value network is that 'my physician is in it.' Why is that physician high value? Because the patient likes the doctor," he said. "We haven't figured out how to explain this yet."

"When talking to members, the key is simplicity," explained Mr. Dross. "At a member level, the approach should be: 'We're giving you a narrow network to help you get a lower price.'" For a value network, the approach should be "we want the pharmacies that we contract with to take better care of you; they know you better and they can help you manage your condition better." Yet, he pointed out that value-based pharmacy network development is at least a decade behind medical network development.

PANEL SESSION 2
continued

Information Technology Requirements for Narrow Networks. Members are not the only groups that need better information about narrow networks—it is also difficult to explain to physicians who are left out of them, said Dr. Kritzler. "I have to show them that their cost or quality outcomes does not meet the criteria for inclusion in our network. I need the information technology (IT) infrastructure to be able to do this."

This requires software that can link the medical and pharmacy databases, and an IT program that can identify which members are patients of those high-cost physicians. Dr. Sherman pointed out that in closed-panel HMOs, this is straightforward. However, in a point-of-service plan, it is much more complex. "And you need to conclusively demonstrate that lower-cost providers do not mean lower quality," he said. "You need the ability to produce reports for physicians to show them why they are not in high value networks."

Pharmacy and Risk. From the perspective of the Northeast Business Group on Health's constituents, "people are trying to sell them stuff all the time. And it is always characterized as 'value.'" Dr. Nobel said, "Unless you are going to measure it and be willing to go at risk for it, our employers will not generally want to sign a contract for new services." He noted that in pharmacy, this is perhaps five years away. "At least consider going at risk for your fees, if not outcomes," he advised.

Mr. Gibbons agreed, adding that risk contracting can only occur if pharmacy has been aligned in the development and in the goals of the program: "I haven't seen that yet. We do have ratings systems (e.g., Medicare Stars program) that now measure pharmacy, but pharmacy does not share in the risk or reward." Mr. Dross added that Medicaid is also investigating some pharmacy risk programs, but he estimated that these are at least three years from implementation.

PANEL SESSION 3

Specialty Pharmacy and Biosimilars — Improving Population Health?

Panelists: **Steven G. Avey, RPh, MS, FAMCP**, Vice President, Specialty Programs, MedImpact Healthcare Systems, Inc.; **Alan M. Lotvin, MD**, Executive Vice President, Specialty Pharmacy, CVS/Specialty, CVS Health; **Thomas Parry, PhD**, President, Integrated Benefits Institute; **Margaret Rehayem, MA**, Senior Director of Strategic Initiatives and Communications, Midwest Business Group on Health

We Know One When We See One. The panelists noted that although little agreement exists on exactly what defines specialty pharmaceuticals, this does not prevent their organizations' efforts to manage them. They agree that specialty drugs are typified by high cost, the need for monitoring, and special distribution or handling requirements. For the panelists, "they know one when they see one" sums up their perception of specialty drugs.

For biosimilars, the question of definition is more complex if one considers more than simply the application of the 351(k) process. For example, growth hormones can be technically called biosimilars, and tbo-filgrastim is a biosimilar to filgrastim, but it was approved through the conventional biologic licensing application process.

Do Specialty Drugs Provide Special Value? Mr. Avey pointed out that the case for value of several specialty drugs is suspect, and the costs for these agents continue to rise. He explained, "About 12 years ago, we treated multiple sclerosis at an annual cost of about $1,000. Today, we're paying $50,000 per year. The evidence that we are getting something for our money is not concrete. I'm not cynical enough to say that specialty drugs are not worth it, but I'm still looking for evidence that they provide acceptable value." He added, "The AMCP Format for Formulary Submissions asks for cost-offset models. We don't see that for specialty drugs; we can't even approximate cost offsets." Instead, pharmaceutical companies talk about the costs of bringing the drug to market and the risk associated with that process, "but we're not satisfied with the results." Mr. Avey suggested that comparative-effectiveness research (CER) is the best answer.

Dr. Lotvin pointed out that Sovaldi® will be used to treat millions of people, and "this has to be looked at in the context of everything

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continued

else we pay for." He believes that "the only way to get competition in this space in the absence of generics is to see more me-too products. We saw this with growth hormones, and I think the same thing will happen in the hepatitis C market."

From the employer perspective, Dr. Parry said that specialty pharmaceuticals focused on serious, low-prevalence diseases have been easily accepted. "As specialty drugs have increasingly been applied to higher prevalence conditions, [employers] have a much greater problem accepting these costs," he said. "Most employers will say that if a specialty drug is linked to less lost work time or productivity, they can blink at that."

Will PCORI Produce Useful CER? The Patient-Centered Outcomes Research Institute (PCORI) is supposed to produce high-quality CER, but doubts exist as to whether or when this will occur. Dr. Nash said that "the issue is how much time it will take to generate. I'm not convinced PCORI will be able to provide it in a timely matter."

Dr. Parry stated that employers know very little about PCORI, and Ms. Rehayem agreed that most employers don't have integrated data needed for meaningful CER. She said that, "Employers are just looking for meaningful data to help them with benefit design, so that employees can engage appropriately and access drugs and care."

Specialty Drugs and Cancer Care. Ms. Rehayem commented, "Cancer care includes some of the most expensive drugs, but employers are viewing cancer through a large lens, trying to help the patient over the long haul. How can you support them through that process? We have many unanswered questions in this realm." Dr. Parry added, "Our employers realize that not all that long ago, cancer was a death sentence. Now people come back to work. It's good for the employee and for the employer."

Although care has improved dramatically over the past 15 years for several cancers, Dr. Lotvin reminded that "an awful lot of cancer drugs are not cost effective. In lung cancer, for example, we have four regimens. You can't distinguish outcomes among them, but the costs vary by a factor of two. And the least expensive is the least used." He also pointed out that the acquisition of physician

PANEL SESSION 3
continued

practices by hospitals has resulted in much higher costs to administer infused agents: "The physician makes more money, the acquisition cost of the drug goes down (many facilities are 340b eligible), and there is greater arbitrage. It drives up costs for the payer."

Mr. Avey made three key points in specialty drug use for cancer: (1) we need to better understand the value of the specialty products in terms of mortality, morbidity, and quality of life; (2) we need to better understand and manage the appropriateness of the regimen in a particular cancer (and constantly reassessing appropriateness through the patient's treatment); and (3) we need to do the best job possible in managing that patient on that oncology drug. "We really need better answers to our questions regarding value of these drugs. It has to be more than 'trust me, this is a great drug.'"

Whereas Dr. Lotvin is an optimist in our ability to manage these products and their cost, Mr. Avey thinks it will take more to address how much companies in the U.S. pay for drugs: "The current trend is unsustainable. We had a health plan that was seriously considering sending patients with hepatitis C to be treated in Egypt because the cost of medications is so low there." Ms. Rehayem remarked that employers do not know how best to handle specialty pharmacy trends; they are still cost shifting through higher copays and coinsurance and implementing five-tier benefit designs. "The employers are panicking a bit. There are no best practices yet," she said.

Copay Assistance Programs. According to Mr. Avey, patients pay only 1% to 2% of the cost of the specialty products, and in some cases, less than that. In one plan analysis, members should have paid a cumulative $300,000 towards the cost of a specialty therapy but actually paid $62,000. The rest was funded through copay assistance programs or couponing. "The motivation of having a multi-tier specialty benefit design is being countered by these programs. In the future, we will see more coordination with those programs. We're asking specialty pharmacies to not accept assistance for drugs not on the preferred level."

Dr. Lotvin believes that copay coupons will be a steady presence in the marketplace. He said that the best approach to them may

PANEL SESSION 3
continued

be adopting an exclusion formulary (100% copay for noncovered drugs).

The Utility of Pipeline Reports. An audience member, from a national business coalition, said that large employers are tired of playing "catch up" in the specialty area. What is the best way to stay ahead of developments? Each large employer should be receiving, at least quarterly, reports on significant drugs in the pharmaceutical pipeline, with anticipated costs. Mr. Avey suggested that employers can use this information, with their pharmacy benefits manager, to model the impact of these medications. "Looking at the pipeline reports, you'll see several big-dollar drugs that may be approved in the next 12 months, including for cystic fibrosis." Dr. Lotvin agreed that "we've got to get the information in the right hands as far out in the future as possible."

Tumor Mutations, Pharmaceutical Development and Administrative Coding. Dr. Lotvin explained, "The science of understanding the genetic mutations in cancer is preceding by several years the pharma companies' ability to develop treatment for them." Companies now exist that can analyze individual tumors, breaking them down to determine which mutations are expressed. "We don't have the ability to treat based on that, except for breast cancer and perhaps a couple of other cancers," Dr. Lotvin said. However, the diagnosis and management of genetic mutations is on the verge of reaching our coding systems. In the next few years, the number of ICD 9/10 codes will grow related to genetics.

Mr. Avey pointed out that we may be five years away from being able to act on the mutation information, but AMCP is now considering diagnostics information for inclusion in the *AMCP Format for Formulary Submissions*. "We want to better understand which of the diagnostics will be valuable and result in treatment change," he said.

A Message to the President. To close, the panelists were asked what one piece of advice they would give President Obama to address problems in today's health care system. Ms. Rahayem stated that he should look at changing the system in a way to support better health rather than the bureaucratic system of sickness care that now

PANEL SESSION 3
continued

exists. "We continue to remain in our silos and protect our positions, but we need to take down barriers. We need to look past our differences to better support population health."

Dr. Parry believes that the ultimate solution will not be found in financing and coverage. "If the US population continues to get sicker and sicker, I don't care how you finance it, it will break us. Twenty percent of the population accounts for 80% of costs, but it is the 80% of employees that drive your business. We need to maintain their health. It must be part of the same discussion."

Dr. Lotvin concluded that to drive better health in the long term, we need to stop selling cigarettes, stop making medical errors, and stop providing interventions that don't seem to make a difference (e.g., stop doing low back surgeries, angioplasties, or arthroscopies in inappropriate patients). "We need to create a payment system that pays less for low-value interventions and focus our incentives to make better use of things that we know work." Dr. Nash summarized: No outcome, no income!

CONCLUDING REMARKS

"This forum is an extension of AMCP's mission to improve health care for all," said the Academy's CEO Edith Rosato. "We are exploring how these changes [and discontinuities] will affect key stakeholders in the next five years. Health care stakeholders, including AMCP, are wrestling with how political changes like the November 2014 elections and upcoming milestones—such as the introduction of biosimilars and the Supreme Court decision on ACA subsidies—will affect the role managed care pharmacy plays (and can play) in the evolving health delivery system.

"In this 'age of discontinuity,' we learned that we must step back from our profession and see what is going on around us," said Ms. Rosato. "It will be up to us in the health care industry to change the paradigm, to innovate, and to drive the next stage of health care delivery in the United States."

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- Be the first to know about the latest research in managed care pharmacy through the *Journal of Managed Care Pharmacy*. This peer-reviewed publication is dedicated to providing you with the research you need to excel in your practice.
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Babette Edgar
AMCP VALUED MEMBER SINCE 1995

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Strategic Plan

Academy of Managed Care Pharmacy®

AMCP's Strategic Priorities

The Academy of Managed Care Pharmacy continues to invest strategically in the profession of managed care pharmacy through its five strategic priorities.

Strategic Priority 1 –

Be the Leading Provider of Education, Research and Resources for Managed Care and Specialty Pharmacy

Purpose: *Make AMCP the go-to organization for cutting-edge information.*

Strategic Priority 2 –

Expand Value of AMCP Membership

Purpose: *Maximize the membership value to the managed care and specialty pharmacy professional and provide services and resources.*

Strategic Priority 3 –

Improve Patient Outcomes and Health Care Affordability

Purpose: *Ensure managed care and specialty pharmacy practice is at the leading edge in the delivery of quality and affordable health care.*

Strategic Priority 4 –

Be the Credible and Authoritative Voice for Managed Care and Specialty Pharmacy

Purpose: *Develop a better understanding of managed care pharmacy among multiple stakeholders to increase the acceptance and use of managed care pharmacy principles.*

Strategic Priority 5 –

Execute with Organizational Excellence

Purpose: *Operate efficiently, effectively and maintain fiscal health through sound business and association practices.*

For More Information | Please visit the AMCP website at www.amcp.org.

AMCP Vision

Managed care pharmacy improving health care for all.

Mission

To empower its members to serve society by using sound medication management principles and strategies to improve health care for all.

Core Values

In serving and anticipating the needs and interests of our members in the provision of high quality health care, AMCP embraces the following core values:

- **Credibility**
- **Transparency**
- **Collaboration**
- **Innovation**

Envisioned Future

If successful, this strategic plan would move AMCP and its members to a future where…

Managed care pharmacy is widely understood and accepted as integral to the delivery of quality and affordable health care.

Adopted by the AMCP Board of Directors, October 2014

About AMCP

The Academy of Managed Care Pharmacy (AMCP) is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's nearly 7,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit. More news and information about AMCP can be found at **www.amcp.org**.

Moving Forward

The Strategic Plan identifies Strategic Priorities that will guide AMCP for the next three-to-five years. Please visit the AMCP website for details.

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