Specialty Pharmacy: Market Update 2011

Introduction

Specialty drugs have seen a tremendous boost within the pharmaceutical marketplace over the past several years. Consider some of the telltale

[MORE ON PAGE 2]

Activities of NQF’s Measure Application Partnership Gain Momentum

AMCP Focuses on Medication Therapy Issues

The Academy of Managed Care Pharmacy has been working with other national health care stakeholders over the past year to identify

[MORE ON PAGE 6]

Proportion of Days Covered (PDC) as a Preferred Method of Measuring Medication Adherence

By David P. Nau, Ph.D., Senior Director, Research & Performance Measurement, Pharmacy Quality Alliance

Background

The Pharmacy Quality Alliance (PQA) has developed, tested and endorsed numerous measures of medication-use quality. PQA members

[MORE ON PAGE 7]

URAC and AMCP want to better understand how our readers are using the newsletter and what we can do to improve it. Please help us by completing a brief questionnaire. Click here or visit www.amcp.org.
This document highlights the rapid growth of the specialty pharmaceutical industry and the roles that key stakeholders play along the continuum as well as why specialty pharmacy is on an upward trend, with particular attention to emerging areas such as patient-centered care, care coordination and patient management. In addition, amid the current states of health and health care in the U.S., the contributing factors as to why specialty drugs, specialty pharmacies and programs that focus on holistic care are on the rise, and ultimately, here to stay.

Background

Assessing the sheer number of new drugs on the market and the overhead picture of total utilization figures, the latest numbers and statistics clearly demonstrate that specialty pharmaceuticals are rapidly moving forward on a train of upstream momentum. This class of drugs, defined by high costs and, among other characteristics, special handling requirements, comprises more than 16 percent of national pharmaceutical spending in the U.S. today, according to the latest research. Additional data, which conveys the small-but-robust nature of the specialty sector, reveals that more than two-thirds (70%) of the changes in drug cost and utilization over the past year are attributable to specialty drugs. The specific therapeutic usage of specialty drugs, along with what is often unrivaled stature as therapeutic options in today’s market, gives them impressive leverage in the health care marketplace.

Over the past decade-plus, specialty drugs have steadily encroached on the total share of the national pharmaceutical market (Reuters), the world’s largest, which boasts total annual spending of $307 billion. In the two-year period from 2008 to 2010, specialty drug spend increased from 12 percent of total market share in 2008 to 14 percent in 2009, followed by a 13 percent year-to-year jump that pushed the dollar amount to more than 16 percent of overall drug revenue in 2010—a 22 percent increase in three years. Research shows that this steady expansion may be a mere sign of things to come. Health care consulting firm IMS Health predicts that global revenues in the specialty sector will surpass $160 billion in 2013. Meanwhile, a recent Express Scripts report predicts that the total drug spend devoted to specialty meds will reach a full 40 percent of total share by 2014, or what amounts to an estimated $123 billion in today’s dollars.
With specialty drug spending on the rise, the systems that create, harness and deliver these high-touch pharmaceuticals—manufacturers, payers, providers, pharmacies and other stakeholders—are in a state of evolution as well. More than 700 new specialty drugs are currently in development, and the expected stream of specialty approvals is making stakeholders reconsider and redesign their channels of delivery and access. Presently there are multiple access channels available for end users, ranging from physician providers; facility providers (e.g., inpatient and outpatient); ancillary providers like home infusion companies; and the wide swath of pharmacy providers, which includes retail, mail services and specialty pharmacy. During a time when payers are placing a keener focus on patient-centered care and patient management, and when physicians may be reluctant to purchase high-cost drugs for which they potentially won’t be reimbursed, full-service delivery and distribution specialists are offering a sought-after value proposition that combines services geared to promote appropriate use and to supply patient education, therapy management and adherence programs.

In addition to an increasing preference for patient management, payers are seeing a change in their internal processes as well. According to research, a large portion of spending growth has taken place in the medical benefit. Between 2005 and 2008, several drug categories saw significant increase in medical drug spend, increasing by approximately 327% for multiple sclerosis, 204% for hypertension, and 57% for inflammatory conditions. Overall, roughly 55% of total drug spend occurs on the medical portion of the benefit. Yet the proportion of specialty drugs available through the pharmacy benefit is on the rise. Research suggests that specialty trend under the pharmacy benefit will expand by approximately 27% in each of the next three years. Spending on inflammatory conditions, multiple sclerosis and cancer will continue to make up approximately two-thirds of drug spend within the pharmacy benefit over the next three years.

While the overriding factors behind the division between medical and pharmacy benefit classification are somewhat nebulous, a look at one predominant historical trend sheds a hint of light on the future position of these benefits as the industry moves forward. Traditionally, drugs that require an extra layer of care, such as infusions for hemophilia, are likely to exist within a plan’s medical benefit. Conversely, drugs requiring less intensive interventions, such as oral medication and other self-administered agents, fall under the umbrella of the pharmacy benefit. With an increasing number of disease categories that are host to therapeutic options that cross this historical divide—multiple sclerosis, for instance, which is treated through both oral and IV medications—industry reports reveal an unprecedented cohesion between medical and pharmacy benefits, with more than 70 percent of health plans reportedly mandating that their internal pharmacy departments track such drugs across both benefits.

### Comparing Pharmacy Benefit vs. Medical Benefit

<table>
<thead>
<tr>
<th>Pharmacy Benefit</th>
<th>Medical Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs intended to be self-administered</td>
<td>Drugs administered by health care professionals</td>
</tr>
<tr>
<td>Self-administered subcutaneous drugs; injectables; oral meds</td>
<td>Infusions; most MI injections; some subcutaneous drugs; intra-articular drugs</td>
</tr>
<tr>
<td>50% of specialty drugs</td>
<td>50% of specialty drugs</td>
</tr>
<tr>
<td>45% of specialty spend</td>
<td>55% of specialty spend</td>
</tr>
</tbody>
</table>


Of course, manufacturers are integral to the growth of specialty pharmacy. Today, drug manufacturers are producing more drugs that fit within the confines of the specialty category than ever. With the recent torrent of personalized drugs, biologics and biosimilars, the sheer number of specialty drugs available is in an upward swing, continuing to take over a greater share of new drugs entering the market. In 2010, the Food and Drug Administration approved 27 new drugs (15 new molecular entities, six biologics and six therapeutic biologics) and granted 33 new indications for medication that was already on the market. Specialty drugs boasted high percentages in both categories, seizing 56 percent (15 out of 27) of the approved drugs and nearly half of the new indications (16 out of 33). In terms of cost and utilization, three disease categories comprised the bulk of the attention. Specialty drugs manufactured for the treatment of
rheumatoid arthritis, multiple sclerosis and cancer led the way in 2010, though the cost and use of specialty drugs for hemophilia, metabolic disorders and pulmonary arterial hypertension saw sizable year-to-year advancements as well.

While this class of drugs has long been characterized by injectable medicines, manufacturing advancements continue to create opportunities for easier administration, notably in the realm of oral medication. This is best encapsulated by Gilenya™, the first oral drug for the treatment of multiple sclerosis, which was approved in the fourth quarter of 2010. In early 2011, a rash of oral treatments gained approval for conditions that include thyroid cancer, prostate cancer and RA. While advanced delivery continues to gain ground, traditional models also remain strong. Other specialty drugs of note that have crossed the approval line since 2010 include new infusions for rheumatoid arthritis, prostate cancer and breast cancer (Actemra®, Jevtana® and Halaven®, respectively), as well as the MS injectable Ampyra®, which has already gained a strong foothold within the patient population.

All of this begs the question, why is the prevalence of specialty drugs on the rise? And more importantly: What does this portend for suppliers in this increasingly complex marketplace? As mentioned above, advances in clinical research and delivery capabilities are one major reason. Yet there is more to the trend than newfound manufacturing prowess. Indeed, a health care professional does not need to look far to see another prominent driver. The average patient (read: individual) in the U.S. today has a 50 percent chance of presenting with at least one chronic illness, according to national data. Approximately one in five adults, or 50 million people, has been diagnosed with arthritis; as the nation’s leading cause of disability it limits the daily activity of more than 20 million per year. Cancer prevalence in 2007 (the latest year for which comprehensive data exists) fell just shy of 12 million cases, according to the American Cancer Society. Roughly 400,000 people are affected by MS. And the growing obesity epidemic has taken its toll on the health of the population. The CDC reports that one-third of American adults are obese, and the condition is considered a contributing factor to nearly every chronic illness on the shelf.

The rise of chronic illness, coupled with the increasing sophistication of the pharmaceutical sector to pinpoint more efficacious and personalized drugs, has created a dynamic environment for the growth of the specialty pharmaceuticals on the whole.
Specialty Pharmacy: Market Update 2011

[CONTINUED FROM PAGE 4]

For more on Specialty Pharmacy and its focus on patient-centeredness, medication adherence and the call for accreditation, click on the link below for The Patient-Centered Outgrowth of Specialty Pharmacy white paper. www.urac.org/Whitepaper/PQM-Specialty_Pharmacy.pdf.

References

ABOUT URAC

URAC is an independent, nonprofit organization whose mission is to promote continuous improvement in the quality and efficiency of health care management through the processes of accreditation and education. To support this goal, our Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers’ compensation carriers and regulators.

Incorporated in 1990, URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer 27 accreditation and certification programs across the health care spectrum.

Many states have found URAC accreditation standards helpful in ensuring that managed care plans and other health care organizations are meeting quality benchmarks. Forty-six states and the District of Columbia currently reference one or more URAC accreditation programs in their statutes, regulations, agency publications or contracts, making URAC the most recognized national managed care accreditation body at the state level.

At the federal level, four federal agencies recognize URAC accreditation. The Centers for Medicare and Medicaid Services recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC’s Health Network Accreditation; and the Department of Veterans’ Affairs recognizes URAC’s Health Call Center Accreditation.
and recommend quality measures for use in public reporting systems and performance-based payment arrangements under public health programs.

AMCP is a voting organizational member of the National Quality Forum’s (NQF’s) Measure Applications Partnership (MAP) Coordinating Committee, and was appointed as the sole organization for medication therapy related issues.

The broad mandate of MAP is to: (1) provide input to Department of Health and Human Services (HHS) on the selection of available measures for public reporting and performance-based programs; (2) identify gaps for measure development and endorsement; and (3) encourage alignment of public and private sector programs and across settings.

The Academy’s Director of Pharmacy Affairs Marissa Schlaifer recently has taken on the role of representing AMCP on the MAP Coordinating Committee.

“The work of the MAP is well under way and operating under a very aggressive timeline to provide an array of deliverables by June 2012,” says Schlaifer. “As each of the workgroups report out draft recommendations, the Coordinating Committee has one month in which to assess the draft, solicit and interpret public comment, and then produce a final submission for HHS. Furthermore, each of the draft recommendations has had only a two-week public comment period.”

To accomplish these ambitious goals, the work of MAP is being carried out under a two-tiered structure. The Coordinating Committee sets the overall strategy for MAP and provides direction to the various advisory workgroups. These workgroups, in turn, advise the Coordinating Committee on a diverse range of quality measures, which will serve as the basis for the Coordinating Committee’s recommendations to HHS.

Recent Activities

The NQF MAP Coordinating Committee has issued three draft reports to date, and AMCP has provided public comments. They are:

(1) The Clinician Performance Measurement Coordination Strategy draft report aims to enhance alignment across federal programs focusing on aligning measures and data sources, characterizing an ideal measure set, defining data platform principles, and determining a pathway for improving measure application. The clinician coordination strategy also features a draft version of the MAP measure selection criteria that will be used to assess fitness of a measure set for use in a specific program. AMCP has indicated that it is unclear how this information will be useful to the Department of Health and Human Services (HHS), which is looking to identify specific measures to incorporate across the board in a national measure set. The missing piece seems to be MAP identifying specific measures that meet the MAP recommended criteria agreed upon, or, singling out gaps if no specific measures are available.

(2) The Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers draft report identifies three focus areas for aligning public and private efforts to reduce healthcare-acquired conditions and readmissions: measures, data, and specific coordination strategies. On this report, the Academy recommended that the MAP specifically draw attention to the issue of adverse drug events and medication errors as a cause for readmissions.

(3) Performance Measurement Coordination Strategy for Post-Acute Care (PAC) and Long-Term Care (LTC) identifies six priority areas for measurement in the PAC and LTC settings. The priority areas are: function, goal attainment, patient and family engagement, care coordination, safety and cost access. Adverse drug events are mentioned as one area of focus for PAC and LTC providers in the area of safety. AMCP recommended that the MAP draw additional attention to the issue of adverse drug events and medication errors during transitions of care.

Interested in helping?
The Academy will electronically disseminate reports as they become available to interested parties. Individuals can then respond directly to MAP with their comments. If you would like to be on the list to receive drafts for review, please send your contact information to AMCP Pharmacy Affairs Director Marissa Schlaifer at mschlaifer@amcp.org. To learn more about MAP and its ongoing work, visit www.qualityforum.org/map. For more on the NQF, visit www.qualityforum.org/Home.aspx. ●
identified medication adherence as an important component of medication-use quality, and therefore PQA sought to endorse a standard method for calculation of medication adherence using data that would be widely available across prescription drug plans and pharmacies. After reviewing the extant literature and conducting tests of draft measure specifications, PQA chose to endorse the method known as Proportion of Days Covered (PDC).

**Review of Methods for Adherence Measurement**

Numerous methods have been utilized to estimate patients’ adherence to a medication regimen. Since PQA sought a method that could be derived from drug claims data, the review of methods focused on the two most common claims-based approaches to estimating adherence, namely the medication possession ratio (MPR) and the proportion of days covered (PDC). PQA first convened a workgroup of experts in 2006 to review the literature and to call upon their experience to select the preferred method of adherence measurement for PQA. This workgroup continues to exist within PQA and has re-affirmed PQA’s adherence methods as of 2012.

**Medication Possession Ratio.** The most commonly used method for claims-based adherence measurement was the medication possession ratio (MPR). As noted by Peterson and colleagues (2007), the MPR has been operationally defined in many different ways. In general, it involves the summation of the “days supply” of medication refills across an interval; however, researchers have defined the numerator and denominator of the ratio in differing ways, and also report the MPR in varying ways. In some cases, the researchers defined the time interval as the time between the first fill and last fill of a medication. This approach focuses only on the time period that the patient was persistent with the medication, and does not account for a patient’s discontinuation of the medication. In other cases, the interval was defined as the time from the first fill until the end of a measurement period (typically, the end of a calendar year). This approach does account for a patient’s discontinuation of medication. The numerator of the MPR has also been defined in varying ways. Although the basic calculation is to sum the days supply for the fills of medication, some researchers will exclude the days supply of the final fill while others will include the days for the final fill but cap the ratio at 1.0.

The MPR has sometimes been criticized by some researchers for its likelihood of overestimating the true rate of medication adherence. The overestimation is most likely to occur when the patient receives early refills of the target medications which may result in an “extra fill” during a defined measurement interval. If this situation is not addressed by capping the ratio at 1.0, then any resulting reports on the average MPR will be skewed upwards. Additionally, since the MPR is often calculated for a class of medications (e.g., all statin drugs), a switch between medications in the same class during the interval, with an overlap of the new drug with the prior drug, will inflate the MPR. The MPR is similarly inflated if the patient takes concurrent medications from within the same class during the measurement period. This occurs frequently with antipsychotic drugs (Martin et al., 2009).
Proportion of Days Covered (PDC) as a Preferred Method of Measuring Medication Adherence

[CONTINUED FROM PAGE 7]

Proportion of Days Covered. The proportion of days covered (PDC) is a newer method than the MPR but has been studied extensively in recent years. One of the first reports of PDC was by Benner and colleagues (2002). Although some variations in PDC calculations exist (Choudhry et al, 2009), the PDC tends to be operationally defined more consistently than is the MPR.

The PDC calculation is based on the fill dates and days supply for each fill of a prescription; however, it differs from the MPR in that the PDC is not a simple summation of the days supply. The denominator for the PDC (at the patient-level) is the number of days between the first fill of the medication during the measurement period and the end of the measurement period. For example, if the measurement period is a calendar year (364 days), and if the patient’s first fill of the medication is on day 10 of the year, then the denominator period is 354 days (364 – 10 = 354). This means that a patient who discontinues the medication during the measurement period will still be tracked through the end of the year, and thus the non-persistence is accounted for in the PDC.

The patient-level numerator for the PDC is the number of days covered by the prescription fills during the denominator period. Rather than summing the days supply, the analyst should create time arrays (or vectors) to reflect the dates that were encompassed by each fill. So, a 30-day supply of medication obtained on March 1st would create an array that covers March 1-30. Once the arrays are created for each fill during the denominator period, the analyst can then determine how many of the days in the denominator period were covered by at least 1 array. This method is described in detail, along with SAS program codes, by Leslie (2007). PQA also recommends the method described by Leslie for adjusting the start date of each array when the patient has overlapping arrays for an identical (e.g., generically equivalent) medication. This adjustment is based on the premise that when a patient refills a prescription before the preceding medication supply was exhausted (i.e., early refill), that the patient finishes the supply for the preceding fill before starting the new supply. However, when patients are taking multiple concurrent medications within a broad class (e.g., a class defined as all oral diabetes drugs), then the arrays would not be adjusted since the patient was taking the medications concurrently. Therefore, the PDC would reflect whether the patient had at least one of those drugs available on a particular day (i.e., if they are taking metformin and glipizide on the same day, the day is only counted once as a covered day). This approach is similar to the “at least 1” method for PDC suggested by Choudhry and colleagues (2009).

Comparison of MPR and PDC. A few studies have directly compared the adherence rates calculated by both MPR and PDC. Martin and colleagues (2009) showed that the PDC will provide a more conservative estimate of the adherence rate in situations when the patient has switches of medications within a class or concurrently uses more than one drug in a class. During 2010-11, FMQAI (a CMS-contracted quality improvement organization) worked with RAND and the University of Florida to compare the MPR and PDC measures across multiple classes of medications in a Medicare population from Florida and Rhode Island (Campbell et al, 2011). We believe the following inferences can be made from the FMQAI analyses: 1) the PDC and MPR will provide nearly identical results...
when examining adherence to a single drug (e.g., only levothyroxine; 2) the PDC will provide a more conservative estimate of adherence when examining adherence to a class of drugs that are prone to frequent switching and concomitant therapy with multiple drugs within the class (as with antipsychotic drugs); and 3) adjustment for inpatient hospital stays does not significantly alter the population estimate for adherence, even within a population that is prone to frequent inpatient visits (e.g., schizophrenia patients using antipsychotics).

Using the PDC as a Performance Measure

Performance measures are typically expressed as a rate (numerator divided by denominator) wherein the denominator includes all eligible patients and the numerator is the subset of denominator patients who met a specified parameter. When using PDC as a performance measure for a health plan or pharmacy benefit manager, PQA recommends that the denominator include the patients who were continuously-enrolled in the plan and who used at least one drug from the target class (e.g., statins). The numerator would include the subset of the denominator patients who achieved a high-level of adherence. Based on numerous studies of the relationship of medication adherence and healthcare outcomes, PQA selected 0.8 (or 80%) as the threshold above which the patient can be considered to be highly-adherent for most classes of medications (antiretrovirals for HIV/AIDS being a noted exception to this general rule wherein a 90% threshold was chosen). Consequently, when the PDC is used within a performance reporting program, the “adherence rate” that is reported reflects the percent of patients who achieved a high level of adherence to the target class of drugs.

The PDC calculation is based on the fill dates and days supply for each fill of a prescription; however, it differs from the MPR in that the PDC is not a simple summation of the days supply.

PDC Calculations as Specified by PQA

1. Determine the patient’s measurement period, defined as the index prescription date to the end of the calendar year, disenrollment, or death.

2. Within the measurement period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescription fills for the same drug overlap, then adjust the prescription start date to be the day after the previous fill has ended.

3. Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

4. Count the number of patients who had a PDC greater than 80% and then divide by the total number of eligible patients.


References


Specialty Pharmacy Identified as a Priority for AMCP’s Foundation for Managed Care Pharmacy

The Foundation for Managed Care Pharmacy has identified specialty pharmacy as a priority for ongoing research and understanding.

“Our ultimate goal is to meet our members’ needs in achieving recommendations for and widespread adoption of common definitions, as well as patient-centered, service-level specifics in the delivery of specialty pharmacy services and products”, said Norrie Thomas, FMCP’s Interim Executive Director.

During FMCP’s initial work and report on specialty pharmacy, four important priorities for further research and focus were indentified:

- **Priority Item #1**: Gain consensus on definitions, terminology and language in specialty pharmacy.
- **Priority Item #2**: Assess current benefit design and care delivery methods.
- **Priority Item #3**: Examine service-level specifics, incentives and fees associated with specialty pharmacy products and offerings.
- **Priority Item #4**: Assemble information on the pipeline that helps decision-makers understand and interpret the new products.

Further initiatives are now underway to address the need for better understanding of how to optimize the coverage and management of specialty pharmaceuticals.

The second annual FMCP Research Symposium scheduled for October 2, 2012, in conjunction with the AMCP Educational Conference in Cincinnati, Ohio, will focus a half-day session on research in specialty pharmacy. The session will bring together multiple stakeholders to continue discussion and share important information as well as update participants with the activities of innovative organizations.

Diane Giaquinta, President of StrategiCare, will be responsible for program planning and recruiting national experts.

“The meeting will be a forum to discuss our progress in advancing the understanding of specialty pharmacy needs for managed care pharmacists,” she said. “Our expectation is that as our knowledge and experience evolves, the need for meetings such as this to present stakeholder views becomes increasingly important.”

The conference will also include an update from the Academy’s Format Executive Committee. AMCP Director of Pharmacy Affairs Marissa Schlaifer noted, “the AMCP Format is used today to evaluate specialty medications and we want our members to participate in making changes to the format process to focus on specialty pharmacy decision-making.”

Thomas added that “as we identify faculty for the FMCP Research Symposium 2012 we will continue discussions to identify important trends and needs for better understanding of specialty pharmacy needs. We will also work with both the Research and Specialty Pharmacy FMCP committees to continuously gather current trends, as well as URAC and PQA.”

For more information on FMCP’s existing work on specialty pharmacy, visit www.fmcpnet.org and click on the Resources tab. Or contact Ebony Clay, Foundation for Managed Care Pharmacy, at eclay@fmcpnet.org.

“Our ultimate goal is to meet our members’ needs in achieving recommendations for and widespread adoption of common definitions, as well as patient-centered, service-level specifics in the delivery of specialty pharmacy services and products.”
who use the tools and techniques of managed care in the practice of pharmacy. At the heart of every member is commitment to a simple goal: Provision of the best available pharmaceutical care for patients.

As an organization, the Academy strives to achieve its mission of empowering its members to serve society by providing opportunities for continued professional growth, by advancing individual and collective knowledge. Throughout the year, AMCP provides conferences, online learning access, peer-reviewed literature through its Journal of Managed Care Pharmacy, and leadership development seminars. Each is designed with the goal of advancing professional knowledge, improving the design and delivery of pharmacy benefits, and ultimately, patient satisfaction and health outcomes.

Patients who receive the correct drug in the correct way achieve better outcomes, improving quality of life, the bedrock of our Vision—managed care pharmacy improving health care for all. Equally important to prescribing the right drug, however, is being able to provide adequate access to as many patients as possible. The Academy has been doggedly pursuing strategies to help providers of drug coverage achieve that goal as well, by working in ground-breaking disciplines such as pharmacoeconomics, a branch of pharmacy that seeks to determine the true value of a drug-not product cost, but effectiveness in improving overall health outcomes of patient populations.

The focus of the Academy has been to create scientifically designed methodologies for making medical choices as intelligently as current knowledge will allow, supported by evidence-based clinical studies. Some of the Academy’s most successful products to date are AMCP’s Format for Formulary Submissions and the AMCP Framework for Quality Drug Therapy. The Format is a standardized methodology for assessing drugs scientifically, based on the value they provide. Widely adopted by numerous health plans, governmental agencies such as the Department of Defense and leading pharmacy benefit management companies, the Format has become a de facto industry standard. Managed care organizations employing the Format cover approximately half of all pharmacy care beneficiaries.

The AMCP Framework for Quality Drug Therapy was developed over a period of years with the input and review of over 100 stakeholders, including both providers and users of care. It is essentially a reliable, adaptable and scalable methodology for applying quality improvement initiatives to patient care focused on the patient, not the process. There are about 250 individual components of the Framework that can be applied to any health care setting, from which a practitioner may choose the most applicable. A series of evaluative exercises are supplied, through which the practitioner develops an action plan for quality improvement, measurement and evaluation.

Two other significant contributions to managed care practice include AMCP’s Guide to Pharmaceutical Payment Methods and Sound Medication Therapy Management Programs, V2.0. The Guide is a comprehensive, factual description and analysis of alternative drug payment methods and payment systems, including a review of the history, current application, potential future utility, impact on managed care pharmacy, other stakeholders in the pharmaceutical marketplace and the overall health care delivery system. It includes a glossary of payment terms, tables showing which payers and settings utilize which methods, payment flowcharts to illustrate how the money flows with each of the payment systems and examples of payment calculations. Downloadable in a summary and a comprehensive format from the AMCP website, it is accompanied by a web-based interactive resource library.

In 2005, spurred by the Medicare Modernization Act’s (MMA’s) inclusion of the medication therapy management (MTM) requirement, AMCP and other organizations recognized a lack of clear definition of what specific elements would constitute a sound MTM program. To fill that gap, AMCP assembled a variety of stakeholder organizations that served as a working group to build a consensus document that would define those elements. The Academy issued the consensus document Sound Medication Therapy Management Programs in April 2006. Then, in late 2006, AMCP undertook a project to validate the content of that document in the marketplace. AMCP coordinated the project components and the work of the project’s advisory panel. The National Committee for Quality Assurance (NCQA) performed the project’s field work under contract to the Academy. The Academy believes the final product, Version 2.0, will stimulate the public policy discussion, aid in the evolution of sound MTM programs, enhance patient care and encourage the efficient use of health care resources dedicated to these programs.

These and all other AMCP publications, including the Journal, can be found on the AMCP website, www.amcp.org.
Boehringer Ingelheim ranks among the world’s 20 leading pharmaceutical corporations. Our vision drives us forward. It helps us to foster value through innovation in our company and to look to the future with constantly renewed commitment and ambition.

Our family’s science, your family’s health.

For more than 125 years Boehringer Ingelheim has been committed to the research and development of innovative medicines that help improve the lives of patients and their families.

As the world’s largest privately held pharmaceutical company, we focus on what matters – furthering science to help patients. We are committed to continuing to make advances in respiratory and cardiovascular health, as well as in the areas of diabetes and oncology.

Learn more about us at: us.boehringer-ingelheim.com