

GLOSSARY

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GLOSSARY OF MANAGED CARE TERMS



A.

À la Carte Pharmacy Benefit

Selection of specific services through a sub-contract agreement with a pharmacy benefit manager (PBM); however, the health plan/PBM administers the overall pharmacy benefit.

Access

A patient's ability to obtain and utilize health care services is determined by their availability and acceptability to the patient, the location of health care facilities, transportation, hours of operation, and cost of care.

Accountable Care Organizations (ACOs)

Groups of doctors, hospitals, and other health care providers, who voluntarily work together to provide coordinated high-quality care to their Medicare patients and accept financial risk/reward tied to clinical outcomes. The Centers for Medicaid & Medicare Services (CMS) govern ACOs' licenses and measure ACOs' performance.

Adherence (formerly called Compliance)

The ability of a patient to take a medication or comply with a treatment protocol according to the prescriber's instructions; a patient taking the prescribed dose of medication at the prescribed frequency for the prescribed length of time. The optimal adherence percentage varies for certain disease states depending on the intended outcome. There are two methods to calculate adherence, Medication Possession Ratio (MPR) and Proportion of Days Covered (PDC).

Adjudication

The transaction process of completing all validity, process, and file edits necessary to prepare a claim for final determination of payment or denial.

Agency for Health care Research and Quality (AHRQ)

A federal agency in charge of improving the safety and quality of health care for the United States population. They develop knowledge, tools, and data to improve the health care system.

Alternative payment models (APM)

A payment approach centered on providing predictable costs that tie payment to provider or therapy performance over a defined period of time.

Antibacterial Stewardship

Program to improve the use of antimicrobials such as antibiotics for better clinical outcomes and to decrease the occurrence of antimicrobial resistance.

Annuity-Based Contracts

A multi-year agreement that ties reimbursement installments for a medical intervention or manufactured product to pre-determined outcomes or cost measures over a defined period of time.

Annuity-Based Models

A multi-year contract model that spreads reimbursement installments for manufactured products over time.

Attribution

In quality measurement, attribution refers to the method for assigning a patient to the entity being measured, such as a drug plan, health insurance plan, hospital system, or provider group.

Average Acquisition Cost (AAC)

The average cost paid by pharmacies for a prescription drug. AAC may vary by pharmacies, volumes of drugs purchased, contracts with wholesalers, special deals, or prompt-pay ("cash") discounts.

Average Manufacturer Price (AMP)

The average price paid to a pharmaceutical manufacturer by wholesalers for drugs distributed to retail pharmacies, net of prompt-pay ("cash") discounts.

Average Sales Price (ASP)

A manufacturer's average sales price to all purchasers, net of discounts, rebates, chargebacks, and credits for drugs and biologicals covered under Medicare Part B. It is calculated by dividing the total revenue earned by the total units sold.

Average Wholesale Price (AWP)

The average price that wholesalers sell the drug to their customers. It is not regulated by the government and is a generally accepted drug payment benchmark for many payers. AWP is thought of as a “sticker price” that rarely reflects the actual price after discounts have been subtracted.

B.

Benchmark

The external standard or predetermined performance threshold that measures are compared against.

Beneficiary (also called Eligible, Enrolled, Insured, or Member)

A person who has health care insurance through a commercial carrier, Medicare, Medicaid, or another health insurance/health benefits plan.

Benefit Design

A process of determining what level of coverage or type of service should be included in a medical or pharmacy benefit.

Biologics and Biosimilars Collective Intelligence Consortium (BBCIC)

A nonprofit research consortium that monitors the safety and effectiveness of biosimilars and novel biologics and provides the assurance needed to determine which medications deliver the best health outcomes.

Biosimilar Drug

A highly similar drug to the reference biologic product with no clinically meaningful differences in terms of safety, efficacy, purity, and potency.

Brand-Name Drug

A drug that has a trade name and is protected by a patent.

Brown Bagging

A process by which a drug is purchased through a specialty pharmacy and shipped directly to the patient. The patient then takes it to a clinic or provider’s office for administration.

C.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

A survey developed and managed by the US Agency for Healthcare Research and Quality (AHRQ) to assess patient experience in a health care setting, including overall satisfaction, access to care, communication with providers, and availability of health plan information.

Carve-Out Pharmacy Benefit

The separation of a service (or a group of services) from the basic set of benefits in some way. In a carve-out pharmacy benefit, the plan sponsor separates (“carves out”) the pharmacy benefit from the medical benefit and hires a pharmacy benefits management (PBM) company to provide and manage these pharmacy benefits.

Catastrophic Coverage

Under Medicare Part D prescription drug coverage, after a beneficiary’s total drug costs reach a certain maximum (e.g., coverage gap limit), the beneficiary pays a small coinsurance or copayment for covered drug costs until the end of that calendar year.

Centers for Medicare & Medicaid Services (CMS)

Formerly known as the Health Care Financing Administration, CMS is a federal agency within the United States Department of Health and Human Services. CMS is responsible for Medicare, Medicaid, and State Children’s Health Insurance Program.

Certificate of Coverage (COC) (also called Evidence of Coverage or Summary of Benefits and Coverage)

A description of the benefits included in a carrier’s plan, which is required by state laws and represents the coverage provided under the contract issued to the employer.

Coinsurance/Co-insurance

A cost-sharing arrangement in which a health plan member pays a percentage of the charge for a specific service, such as a percentage of the cost of a prescription drug.

Comparative Effectiveness Research (CER)

A rigorous evaluation of the impact of different options that are available for treating a given medical condition for a particular set of patients. Such a study may compare similar treatments, such as competing drugs, or it may analyze very different approaches, such as surgery and drug therapy. In some cases, a given treatment may prove to be more effective clinically or more cost-effective for a broad range of patients, but frequently a key issue is determining which specific types of patients would benefit most from it.

Commercial Plan (Private employers)

Health insurance is provided, managed, and administered by a private company rather than the government.

Fully insured – Health plans assume financial risk for the members’ claims in exchange for a premium. Operate under state insurance laws.

Self-insured – Employer group assumes risk. Operate under federal the Employment Retirement Income Security Act of 1974 (ERISA).

Community Pharmacy (also called Retail Pharmacy)

An independent pharmacy or a chain pharmacy where medication orders are compounded or dispensed to the general public under the supervision of a pharmacist.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

A survey to assess patient experience in a health care setting, including overall satisfaction, access to care, communication with providers, and availability of health plan information.

Copayment/Copay

A cost-sharing arrangement in which a health plan member pays a specified charge for a specific service, such as a fixed dollar amount for a prescription drug.

Copay Coupons/Copay Cards

Discount cards are provided by pharmaceutical manufacturers to patients to reduce patient cost-share for prescription (or first fill of several refills) drugs, typically for a specified period of time.

Cost Effectiveness Analysis

An economic analysis that compares the relative costs and outcomes of different courses of action. The analysis compares one intervention to another (or the status quo) by estimating how much it costs to gain a unit of a health outcome, such as a life year gained, or a death prevented.

Cost-Sharing

A payment method in which a person is required to pay some portion of costs associated with health care services/products. Cost-sharing includes deductibles, coinsurance, and copayments, but not the premium paid by the insured person.

Coverage Gap (also called “Donut Hole”)

Under Medicare Part D prescription drug coverage, the coverage gap is when Medicare temporarily stops paying for prescriptions after the initial yearly coverage limit is met. Beneficiaries in the coverage gap may be responsible for some or the entire cost of medications until reaching the threshold for catastrophic coverage.

D.

Deductible

A fixed amount that an insured person must pay out-of-pocket before health care benefits become payable. Usually expressed in terms of an annual amount.

Digital Health

A broader term referring to the combination of health and technology is meant to improve health care delivery and outcomes. Includes technologies such as apps, fitness trackers, telehealth, and remote patient monitoring. These technologies use computing platforms, connectivity, software, and sensors for health care and related uses.

Digital Health Technologies

Apps, programs, and software used in the health and social care system. They may be stand-alone or combined with other products such as medical devices or diagnostic tests.

Digital Therapeutics (DTx)

Products designed to stand alone or work in combination with existing medications or

treatments, helping patients prevent, treat, and/or manage their disease while ensuring optimal health outcomes from therapy. A key distinguishing feature of a prescription (or regulated) DTx product is that it makes a health claim that is validated by a third party (e.g., a regulatory authority).

Disability-Adjusted Life Year (DALY)

A quantifiable measurement of a population's overall burden of diseases, injuries, and health conditions. DALY combines the years of life lost due to premature mortality and the years lived with a disability to measure the impact of a specific disease or condition.

Disease Management (also called "Care Management")

An approach to reducing health care costs and improving quality of life for individuals with chronic conditions by preventing or minimizing the effects of the disease through integrated care. Disease management programs are designed to improve the health of persons with chronic conditions and reduce associated costs from avoidable complications by identifying and treating chronic conditions more quickly and effectively, thus slowing the progression of those diseases.

Dispensing Fee

The dispensing fee is a set fee negotiated between the health plan or PBM and the pharmacy filling the prescription. This is a separate reimbursement from the ingredient costs of the medication.

Drug Monograph

A write-up of essential drug information is given to the Pharmacy & Therapeutics (P&T) Committee to evaluate the addition, renewal, or removal of a medication on the formulary list. A drug monograph format may include the basic medication information, clinical efficacy, safety, clinical guidelines, standards of medical practice, therapeutic or unmet needs, other treatment options pharmacoeconomic models, and cost.

Drug Utilization Review (DUR)

A structured, ongoing review of health care provider prescribing, pharmacist dispensing, and patient use of medication. Reviews are completed

by clinical pharmacists at the PBM or health plan. It occurs prospectively (before dispensing) or retrospectively (after dispensing) and includes educational programs to educate prescribers on common drug therapy problems.

E.

Edits

Criteria that, if unmet, will cause an automated claims processing system to "reject" a claim for further manual review.

Electronic Data Interchange (EDI)

The electronic transfer of claims data or other information between two or more health care organizations.

Electronic Prescribing (e-Prescribing)

Prescribing medication through an automated data-entry process and transmitting the information electronically to participating pharmacies.

Endorsement

A process by which quality measures are determined to be appropriate for use in the health care system. As the nation's leading organization for measure endorsement, the National Quality Forum (NQF) evaluates proposed quality measures according to standardized criteria.

Evidence-Based Medicine (EBM)

The conscientious, explicit, judicious, and reasonable use of modern, best evidence in patient care decision-making. EBM incorporates clinical experience, as well as patient values, with the available research information.

Explanation of Benefit

A report from the health plan for members to track service/medication use, charges, payments, true or total out-of-pocket costs, and formulary changes.

F.

Feasibility

A characteristic of a quality measure, feasibility refers to the availability of resources and data elements required to calculate a measure.

Flexible Spending Account (FSA)

A tax-sheltered savings account that may be used by beneficiaries to pay for routine health care expenses. Funds are allocated and spent on an annual basis.

Format for Formulary Submission (also called Dossier)

A format or dossier that is standardized by the Academy of Managed Care Pharmacy (AMCP) for manufacturers' submission of clinical and economic evidence in support of formulary consideration. Manufacturers and managed care organizations (MCOs) use the format to formalize, standardize, and expand information for P&T Committee review.

Formulary/Preferred Drug List (PDL)

A continually updated list of medications and related products supported by current evidence-based medicine, as well as the judgment of physicians, pharmacists, and other experts in the diagnosis and treatment of disease and preservation of health. The primary purpose of the formulary is to encourage the use of safe, effective, and affordable medications.

There are two basic formulary types:

- **Open Formulary:** Reimbursement generally is provided for most or all medications with few exclusions. Patients may or may not incur additional out-of-pocket expenses for using non-formulary drugs. Some drug classes may be excluded by plan design.
- **Closed Formulary:** Reimbursement is provided for a more finite list of medications that are included for coverage for disease states. Drugs with superior clinical outcomes and/or have similar clinical outcomes with reduced cost may be more favored.

Formulary Management

An integrated patient care process that enables physicians, pharmacists, and other health care professionals to work together to promote clinically sound, cost-effective care and positive therapeutic outcomes.

Formulary System

An ongoing process whereby a health care organization—through its physicians, pharmacists, and other health care professionals—establishes policies on the use of drugs and related products/therapies and identifies drugs and related products/therapies that are the most medically appropriate and cost-effective to best serve the health interests of a given patient population.

G.

Gatekeeper

A designated person in charge of a person's treatment when it is used in relation to health insurance. A gatekeeper is a health care provider who is the primary point of contact for a patient, often a primary care provider. Anyone who receives care from a health maintenance organization (HMO) is assigned a gatekeeper or allowed to choose one.

Generic Drug

A drug that contains the same active ingredient as a brand-name drug and may be manufactured and marketed after the brand-name drug's patent expires. Generic drugs are identical to the brand name drug in terms of efficacy, safety, side effect profile, and dosing.

Generic Product Identifier (GPI)

A 14-character number to identify generic products with each number representing specific information on the drug, including drug group, drug class, drug subclass, drug base name, drug name, dosage form, and dosage strength.

Generic Substitution

The practice of dispensing a generic version of a prescribed brand-name drug without advance approval of the prescriber. Generic substitution is subject to state and federal regulations.

H.

Health Equity

The state in which everyone has a fair and just opportunity to attain their highest level of health.

Health Disparities

Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Health disparities result from multiple factors, including poverty, environmental threats, inadequate access to health care, individual and behavioral factors, and educational inequalities.

Health Maintenance Organization (HMO)

An entity that provides, offers, or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. The members of an HMO are generally required to use participating or approved providers for all health services.

The primary HMO models are:

- **Staff Model:** All providers are in a centralized site that offers all clinical services and may offer inpatient services and pharmacy services. Providers in this model are more likely to be employees of the HMO.
- **Group Model (also known as Group Purchasing Organization):** The HMO contracts with a single provider group, which is paid a fixed amount per patient to provide specific services. This type of HMO usually is in a hospital or clinic setting and may include a pharmacy.
- **Network Model:** The HMO contracts with more than one provider group and may contract with single or multi-specialty groups as well as hospitals and other health care providers.
- **Independent Practice Association (IPA) Model:** The HMO contracts with independent providers who work in their own private practices and see fee-for-service patients as well as HMO enrollees.

Health Plan

A plan that offers health care benefit products, which may include medical, pharmacy, dental, vision, and/or chiropractic benefits, to private and public purchasers. Includes several types of models such as health maintenance organization (HMO), preferred provider organization (PPO), point-of-service plan (POS), and high-deductible health plan (HDHP).

Health Plan Accreditation

Evaluation process of a health plan's operations and processes against national standards, which are defined by health plan accrediting organizations like the National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). Accreditation is voluntary.

Health Reimbursement Arrangement (HRA)

An employer-funded, tax-advantaged arrangement that reimburses employees for covered health care expenses.

Health Savings Account (HSA)

A tax-sheltered savings account that may be used by beneficiaries covered by high-deductible health plans (HDHPs) to pay for routine health care expenses. It is a fixed dollar amount per year and any unused amounts may be rolled over into following years.

Health Technology Assessment (HTA)

A systematic, multidisciplinary process to evaluate the properties and effects of health technologies and interventions. This evaluation is used to determine the value and use of health technology within health systems.

Healthcare Effectiveness Data and Information Set (HEDIS)

A measure of health plans' performance based on five care domains: effectiveness of care, access/availability of care, experience of care, utilization and relative resource use, and health plan descriptive data.

High Deductible Health Plan (HDHP)

A health plan with specified minimum limits for the annual deductible (e.g., \$1,000 for individual coverage/\$2,000 for family coverage) and maximum limits for annual out-of-pocket expenses (e.g., maximum \$5,000 for individual coverage/\$10,000 for family coverage). The HDHPs offer lower premiums but higher deductibles than traditional health plans.

High Deductible Health Plan with Saving Options (HDHP-SO)

An HDHP is paired with a health savings account

(HSA) or health reimbursement account (HRA). Saving option funds can help pay high deductibles or other eligible health care costs not covered by insurance.

I.

Indemnity Insurance (also called Fee-For-Service Plans)

Traditional fee-for-service plans in which health care providers are paid according to the service performed and beneficiaries are reimbursed for health care expenses incurred.

In-House Pharmacy

An on-site pharmacy at the employer's facility, which usually is the preferred pharmacy of the staff model/group model/mixed model health maintenance organization (HMO).

Insurance Department (also called Insurance Commission)

The acting government agency that holds the primary regulatory authority over insurance companies in each state.

Integrated Delivery System/Network (IDS/IDN)

A network of health care organizations and providers all under the same parent company that may include primary care providers, physicians, hospitals, pharmacies, and insurers to provide a coordinated continuum of services to a defined population.

Integrated Pharmacy Benefit

A pharmacy benefit that is developed and provided by the internal pharmacy department of the health plan.

Interchangeable Biosimilar

May be substituted at the pharmacy for the reference product without the intervention of the prescribing health care provider – much like how generic drugs are routinely substituted for brand-name drugs. However, not all biosimilars are interchangeable. The manufacturer must seek specific approval from the FDA for their product to be considered interchangeable. Refer to the Purple Book for an FDA-approved list of licensed interchangeable biologics.

Independent Review Organizations (IROs)

A third-party medical review resource that provides objective, unbiased medical determinations that support effective decision-making that is based on only medical evidence. (e.g., PA requests)

Indication-specific Pricing (ISP)

A pricing strategy used by payers establishes different prices for drugs based on the clinical benefit provided for each FDA-labeled indication or for each distinct patient subpopulation treated by the drug.

Institute for Clinical and Economic Review (ICER)

An independent nonprofit organization that provides an independent source of evidence review through comprehensive clinical and cost-effectiveness analyses of treatments, tests, and procedures.

J.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

A United States-based, nonprofit organization that accredits health care organizations and programs. Its mission is to ensure patient safety and continuously improve the quality of care in addition to improving the operational efficiency of its teams and programs.

M.

Managed Care

A structured approach to financing and delivering covered health care benefits designed to provide affordable access to improve the quality of care in a cost-effective manner.

Managed Care Organization (MCO)

The general term for a health care company or health plan that manages a population to ensure cost-effective and quality care to the population; also, may be called Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Point-of-Service Plan (POS), although the MCO may not conform exactly to any of these formats.

Managed Care Pharmacy

Managed care pharmacy is the practice of developing and applying evidence-based medication using strategies that enhance patient and population health outcomes while optimizing health care resources in a cost-efficient manner.

Managed Medicare (also called Medicare Part C or Medicare Advantage)

An alternative to Medicare Fee-for-Service that provides Medicare Part A and B coverage and may come with Part D. Beneficiaries join a private Managed Medicare plan and see network providers only.

Maximum Allowable Cost (MAC)

The maximum amount that a state Medicaid agency or commercial plan will pay for generic drugs and brand-name drugs that have generic equivalents. A reimbursement limit per individual multiple-source pharmaceutical entity, strength, and dosage form (e.g., \$0.50 per fluoxetine 20 mg capsule). The maximum amount that a state Medicaid agency or commercial plan will pay for generic drugs and brand-name drugs that have generic equivalents.

Mail-Service (Mail-Order) Pharmacy

A pharmacy that dispenses prescription drugs or devices and delivers them to patients' homes (or other designated locations) by mail, a common carrier, or a delivery service. The average quantity dispensed is a 90-day supply. The mail-order service is either voluntary or mandatory for patients for maintenance medications used to treat chronic conditions (e.g., diabetes, hypertension).

Maximum Out-of-Pocket Costs

The limit on total member copayments, deductibles, and co-insurance under a health care benefit contract.

Medicaid

A joint federal and state program that provides public assistance to eligible persons, regardless of age, whose income resources are insufficient to pay for health care. Most recipients are low-income women and children, as well as nursing homes and other long-term care services for the elderly and disabled people. The federal

government has general rules that all state Medicaid programs must follow, but each state runs its own program.

Medicaid Fee-for-Service (FFS)

A Medicaid program that is managed and funded by the state and federal government to provide health care to low-income citizens.

Medicaid Managed Care Organizations

A non-government organization or health care company that manages the health care of the Medicaid population. It must adhere to the contracted terms of the Medicaid program as well as the state regulations in which the population resides.

Medicare

A federal program operated by the CMS that provides health insurance benefits primarily to persons over 65 years of age and under 65 years of age with permanent disabilities.

Different "parts" of Medicare cover different health care services:

- **Part A:** Pays for inpatient hospital, skilled nursing facility (SNF), and home health care .
- **Part B:** Pays for providers' professional services, some outpatient services, preventive services, infusions, and durable medical equipment. Part B coverage is optional with no out-of-pocket maximum.
- **Part C (also known as Medicare Advantage):** Encompasses Part A and B benefits, certain Part D components, and some non-traditional supplemental benefit coverage like vision and dental through a private plan.
- **Part D:** Pays for outpatient prescription drugs through private plans such as Standalone Prescription Drug Plans or Medicare Advantage with Prescription Drugs. Part D coverage is optional.
 - o **Medicare Advantage with Prescription Drugs (MA-PD):** Beneficiaries get all coverage from one entity.
 - o **Prescription Drug Plan (PDP):** Patients can purchase an optional PDP separately if they qualify for Parts A and B.

Medicare Fee-for-Service (FFS)

A combination of Medicare Part A and B with an optional addition of Part D. Patients receive care from any provider that accepts Medicare patients and the provider bills Medicare directly.

Medication Possession Ratio (MPR)

The sum of the days' supply for all fills of a given drug in a particular time period, divided by the number of days in the time period.

Medication Quantity Limit

A limit on the amount of medication dispensed as a measure of utilization management to ensure appropriate medication use.

Medication-Related Action Plan (MAP)

A patient-centric document containing a list of actions for the patient to use in tracking progress for self-management.

Medication Therapy Management (MTM)

A distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product.

Medication Therapy Review (MTR)

A systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them. The MTR can be comprehensive or targeted.

Moral Hazard

A risk that an individual's behavior may change depending on whether or not they are insured.

N.

National Committee for Quality Assurance (NCQA)

A private, nonprofit organization dedicated to improving health care quality. NCQA develops a rigorous set of quality standards and performance measures for the accreditation of a broad range of health care entities.

National Council for Prescription Drug Programs (NCPDP)

A nonprofit standards development organization that creates and promotes consensus standards for the transfer of data related to medications, supplies, and services within the health care system.

National Drug Code (NDC)

A unique 10-digit, three-segment code assigned by the FDA that identifies the labeler, active ingredient, and package size of a drug. The NDC is used to identify the medication in prescription drug claims.

National Quality Forum (NQF)

A nonprofit, nonpartisan, membership-based organization that works to improve health care outcomes, safety, equity, and affordability. They are an affiliate of The Joint Commission.

Network

The group of physicians, other health care professionals, hospitals, or pharmacies that a managed care organization or pharmacy benefit management has contracted with to deliver services to its members.

Non-Formulary Drugs

Drugs not included on an insurance plan's list of covered medications. The majority of plans that use formularies have policies in place to give providers and patients access to non-formulary drugs where medically appropriate.

O.

Open Model Plans

Most health plans contract with independent community hospitals, medical groups, pharmacies, and other contracted providers. All contracted facilities and providers in the plans' network agree to provide services for discounted reimbursement. Provider options in open model plans may be greater than integrated delivery systems, but costs may also be higher.

Out-of-Pocket (OOP) Costs/Expenses

The portion of payments for covered health

services required to be paid by the beneficiary including copayments, coinsurance, and deductibles.

Outcomes-Based Contracts (OBCs) (also called Performance Based Risk-Sharing Contracts)

A contract between a payer, manufacturer, and/or health care provider that links payment for a treatment that meets, exceeds, or fails to meet expected patient health measures or other real-world outcomes over a defined period of time. Failure to achieve the specified terms can result in a financial reimbursement from the manufacturer to the MCO/PBM/HP.

P.

Patient Center Medical Health/Homes (PCMH)

A model of the organization of primary care that delivers the core functions of primary health care to improve health and economic outcomes. The model encompasses five functions and attributes: comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Personal Medication Record (PMR)

A comprehensive record of the patient's medications (prescription and nonprescription medications, herbal products, and other dietary supplements).

Preventative Services

A service that promotes health and wellness such as screenings, vaccinations, check-ups, and patient counseling to prevent illness, disease, and other health problems.

Pharmacy and Therapeutics (P&T) Committee

An advisory committee that is responsible for developing, managing, updating, and administering the drug formulary system. P&T Committees also design and implement formulary system policies on utilization and access to medications. Committees are comprised of primary care and specialty physicians, pharmacists, and other health care professionals (e.g., nurses) and may include legal experts, lay members, and plan administrators.

Pharmacy Benefit Design

Contractually specifies the level of coverage and types of pharmacy services available to health plan members. A sound pharmacy benefit design balances patient care outcomes, costs, quality, risk management, and provision of services expected by beneficiaries. The pharmacy benefit options can be integrated, carved out, or à la carte.

Pharmacy Benefit Managers (PBMs)

Organizations that manage pharmacy benefits for managed care organizations, other medical providers, or employers. PBM activities may include some or all of the following: benefit plan design; creation/administration of retail and mail service networks; claims processing; and managed prescription drug care services such as drug utilization review, formulary management, generic dispensing, prior authorization, and disease management.

Pharmacy Quality Alliance (PQA)

A multi-stakeholder, member-based, nonprofit organization that is a nationally recognized quality measure organization with industry roles as a measure developer, quality educator, researcher, and convener.

Pharmacy Reimbursement

The amount paid by a pharmacy benefit manager to the pharmacy for the total prescription cost, which is comprised of the drug cost and professional dispensing fee. Pharmacies are reimbursed differently based on the plans and the rates they negotiate with the payer.

Plan Sponsor

A purchaser of health care insurance, including private employers, Medicare, Medicaid, other government programs (e.g., TRICARE), and health insurance marketplaces.

Point-of-Service (POS) Plan

A managed care delivery model that combines aspects of a health maintenance organization (HMO) and a preferred provider organization (PPO). Patients can receive care either from a provider contracted with the plan or opt for an out-of-network provider. Financial incentives exist for patients to use contracted providers.

Preferred Drug

A drug designated by a managed care organization as a valuable, cost-effective treatment option. In multiple-tiered pharmacy benefit plans, preferred drugs are assigned to a lower tier than non-preferred drugs. (Drugs that are not designated as preferred are referred to as non-preferred drugs.)

Preferred Provider Organization (PPO)

A managed care delivery model consisting of preferred networks of providers with some out-of-network coverage. PPOs offer patients more choice and flexibility than health maintenance organizations (HMOs) with correspondingly higher premiums.

Premium

The amount paid by the covered member, or on behalf of the covered member, to a health insurance carrier for providing coverage under a contract.

Prepaid Subscription

A subscription health service with defined benefits, fee structure, and provider network. Members share costs through a monthly premium and there is predictable member access (e.g., copay, coinsurance, deductibles, max spending cap).

Primary Care Provider/Physician (PCP)

Usually, the first physician or provider a patient sees for a health complaint. This physician treats the patient directly, provides preventative care, refers the patient to a specialist if needed (secondary care), or admits the patient to a hospital when necessary. Often, the primary care physician is an internist or family physician.

Prior Authorization (PA)

An administrative tool used by health plans or prescription benefit management companies (PBMs) that require prescribers to receive pre-approval for certain drugs, products, or services to qualify for coverage under the terms of the pharmacy benefit. Guidelines and administrative

policies for prior authorization are developed by pharmacists and/or other qualified health professionals who are employed by or under contract with a health plan or PBM.

Proportion of Days Covered (PDC)

A measure of adherence calculated by the number of days with drug on hand across the number of days in a specified time interval. PDC is more conservative than medication possession ratio and avoids double-counting covered days.

Q.

Quality Adjusted Life Year (QALY)

A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One quality-adjusted life year (QALY) is equal to 1 year of life in perfect health.

QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighing each year with a quality-of-life score (on a 0 to 1 scale). It is often measured in terms of the person's ability to carry out the activities of daily life, and freedom from pain and mental disturbance.

Quality Assurance (QA)

A systematic effort or process to ensure requirements and quality standards are met.

Quality Improvement (QI)

To make a difference to patients by improving safety, effectiveness, and experience of care by using an understanding of our complex health care environment, applying a systematic approach, and designing, testing and implementing changes using real-time measurement for improvement.

Quality Rating System

CMS developed the quality rating system to compare the performance of each carrier based on a 5-star scale (5 is the highest) for the Health Insurance Exchanges.

R.

Rebate

A discount that occurs after drugs are purchased from a pharmaceutical manufacturer and involves the manufacturer returning some of the purchase price to the purchaser. When drugs are purchased by a managed care organization, a rebate is based on volume, market share, and other factors.

Reliability

As a property of quality measures, reliability refers to a measure's consistency in deriving results. A poorly reliable measure will yield different results when the actual level of quality has not changed.

Risk Adjustment

Quality measure results can be influenced by population characteristics, such as differences in age, comorbidity burden, or social factors. Risk adjustment provides a methodology to adjust for these differences to better measure the quality of care.

Risk-Based Contract

A contract that links reimbursement to the distribution of risk of a medical intervention or a manufactured product by measuring performance over a defined period of time.

S.

Self-Insured/Self-Funded

Health coverage in which the employer (rather than an insurance company) bears the financial risk for any expenses incurred. Self-insured plans usually contract with a third-party administrator or insurance company to pay claims, determine eligibility, etc.

Specialty Drug

Any high-cost drug (e.g., higher than \$950/month per Medicare Part D) including injectables, infused products, oral agents, or inhaled medications, which require unique storage/shipment and additional education and support from a health care professional. Specialty drugs offer treatment for serious, chronic, and life-threatening diseases and are covered under pharmacy or medical

benefits. "Specialty Drug" does not have a unified regulatory definition.

Specialty Pharmacy

The preferred distribution by payers for prescription benefit specialty drugs because of its lowest net cost, patient education, and adherence support.

Star Ratings

A system run by CMS that rates the quality of Medicare Advantage and Medicare Prescription Drug Plans (Part C and/or D) using a scale of 1 (poor) to 5 (excellent). Plans' payment and rebate amounts are based on quality ratings on clinical performance, patient experience, enrollee complaints, and customer services.

Step Therapy

The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and "stepping up" to alternative agents only when the initial therapy fails (i.e., a first-line drug must be tried before a second-line drug can be used). Step therapy programs apply coverage rules at the point of service when a claim is adjudicated. If a claim is submitted for a second-line drug and the step therapy rule is not met, the claim is rejected, and a message is transmitted to the pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized.

Subscription Models

A payment model that provides a medical intervention or a manufactured product for a set fee to treat a certain proportion of patients, or a set price per patient.

T.

Therapeutic Interchange

Dispensing a chemically different drug, considered therapeutically equivalent (i.e., will achieve the same outcome, clinical efficacy, and safety profile), in place of a drug originally prescribed by a provider. The drugs involved are not generic equivalents. Therapeutic interchange occurs in accordance with procedures and

protocols set up and approved by prescribers in advance; as a result, the pharmacist does not have to seek the prescribing provider's approval for each interchange.

Tiers/Tiered Formulary

A pharmacy benefit design that financially rewards patients for using generic and preferred drugs by requiring progressively higher copayments for progressively higher tiers. For example, in a three-tier benefit structure, copayments may be \$5.00 for a tier 1 generic, \$10.00 for a tier 2 preferred brand product, and \$25.00 for a tier 3 non-preferred brand product. Tiers are commonly based on brand or generic drugs, preferred or non-preferred drugs, and traditional or specialty medications.

U.

Usability

A quality measure must be usable to achieve its goals. The criterion of usability refers to the degree to which a measure can be implemented in practice, and its results used by stakeholders to improve quality.

Utilization Management (UM)

As applied to the pharmacy benefit, any number of measures are used to ensure appropriate medication use. Such measures may include quantity limits, prior authorization, step therapy, or other strategies deemed appropriate by the health plan's P&T Committee.

Utilization Review Accreditation Commission (URAC)

A nonprofit organization promoting health care quality through accreditation, education, and measurement programs. URAC accredits organizations and/or single functional areas within an organization.

V.

Value-Based Care

A health care delivery method that reimburses the provider for therapy performance by expected or measured patient health metrics, real-world outcomes, or costs over a defined period of time.

Value-Based Contract

A performance-based contract among payer, provider, and/or manufacturer stakeholders in which reimbursement is tied to patient health measures or other real-world outcomes and costs for a defined period of time.

Value-Based Purchasing

An adjusted payment for a medical intervention or a manufacturer product that meets pre-determined metrics or payment milestones; the agreement aims to enhance the quality of care by rewarding decisions that improve patient health measures or other real-world outcomes.

Validity

In the context of quality measurement, validity indicates that a measure assesses what it intends to measure and does not measure extraneous attributes.

W.

White Bagging

The distribution of patient-specific medication from a pharmacy, typically a specialty pharmacy, to the site of administration (e.g. physician's office, hospital, or clinic).

Warranty Models

A policy, typically through a third-party administrator, that reimburses treatment-related costs for suboptimal performance.

Wholesale Acquisition Cost (WAC)

Manufacturer's list price for a prescription drug for sale to wholesalers or other direct purchasers. WAC is published by pricing services, such as First Data Bank, MediSpan, and Red Book, but does not include discounts, rebates, or other manufacturer incentives.

COMMON ABBREVIATIONS

AAC	Average acquisition cost	ISP	Indication Specific Pricing
ACO	Accountable care organization	JCAHO	Joint Commission on Accreditation of Healthcare Organizations
AHRQ	Agency for Healthcare Research and Quality	MAC	Maximum allowable cost
AMP	Average manufacturer price	MAP	Medication-related action plan
APM	Alternative payment model	MCO	Managed care organization
ASP	Average sales price	MPR	Medication possession ratio
AWP	Average wholesale price	MTM	Medication therapy management
CAHPS	Consumer Assessment of Healthcare Providers and Systems	MTR	Medication therapy review
BBCIC	Biologics and Biosimilars Collective Intelligence Consortium	NCQA	National Committee for Quality Assurance
CER	Comparative effectiveness research	NCPDP	National Council for Prescription Drug Programs
CMS	Centers for Medicare and Medicaid Services	NDC	National Drug Code
COC	Certificate of Coverage	NQF	National Quality Forum
DALY	Disability-Adjusted Life Year	OOP	Out-of-pocket
DUR	Drug utilization review	OBC	Outcomes-Based Contract
EBM	Evidence-Based Medicine	P&T	Pharmacy and Therapeutics (as in P&T Committee)
EDI	Electronic data interchange	PA	Prior authorization
FFS	Fee-for-service	PBM	Pharmacy benefit manager
GPI	Generic Product Identifier	PCMH	Patient center medical health/homes
GPO	Group purchasing organizations	PCP	Primary care provider/physician
HCDM	Healthcare Decision Maker	PDC	Proportion of days covered
HEDIS	Healthcare Effectiveness Data and Information Set	PDL	Preferred Drug List
HDHP	High-deductible health plan	PDP	Prescription Drug Plan
HDHP- SO	High-deductible health plan savings option	PMR	Personal medication record
HMO	Health maintenance organization	POS	Point-of-service
HRA	Health reimbursement arrangement	PPO	Preferred provider organization
HSA	Health savings account	PQA	Pharmacy Quality Alliance
HTA	Health Technology Assessment	QA	Quality Assurance
ICER	Institute for Clinical and Economic Review	QALY	Quality-Adjusted Life Year
IDS	Integrated Delivery System	QI	Quality Improvement
IDN	Integrated Delivery Network	UM	Utilization management
IPA	Independent practice association	URAC	Utilization Review Accreditation Commission
IRO	Independent review organization	WAC	Wholesale acquisition cost



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