Glossary of Managed Care Terms

Access

A patient's ability to obtain health care determined by the availability of services, their 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 voluntary 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 measures ACOs' performance.

Adherence (formerly called Compliance)

The ability of a patient to take a medication or follow 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 for at least 80% of the time. This percentage varies for certain disease states.

Two types of adherence are:

- *Primary adherence:* Starting medication therapy as prescribed.
- *Secondary adherence:* Taking medication as prescribed.

Adjudication

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

A la Carte Pharmacy Benefit

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

Average Acquisition Cost (AAC)

Average cost paid by pharmacies for a prescription drug. AAC may vary month to month by pharmacies, volumes of drug purchased, contracts with wholesalers, special deals, or prompt-pay discounts.

Average Manufacturer Price (AMP)

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 drug pricing method developed for drugs and biologicals covered under Medicare Part B. Manufacturers submit the ASP data for their products to the Centers for Medicare & Medicaid Services (CMS); payment to providers is 106% of the ASP, less applicable beneficiary deductible and coinsurance.

Average Wholesale Price (AWP)

Historically, the generally accepted drug payment benchmark for many payers. Today, AWP is thought of as a “sticker price” that rarely reflects the actual payment after discounts have been subtracted. AWP is usually 20% higher than the wholesale acquisition cost (WAC) but may vary.

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.

Biosimilar Drug

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

Brand-Name Drug

A drug that has a trade name and is protected by a patent. A brand-name drug may be produced and sold only by the company holding the patent.

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 company (PBM) to provide and manage these pharmacy benefits.

Catastrophic Coverage

Under Medicare Part D prescription drug coverage, after a beneficiary's total drug costs reaching a certain maximum (e.g., coverage gap limit), the beneficiary pays a small coinsurance (like 5%) or a small co-payment 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

The percentage of the costs of health care services/products paid by the patient after deductible.

Comparative Effectiveness Research

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.

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/Co-payment

A cost-sharing arrangement in which a covered person pays a specified charge for a specific service, such as a fixed dollar amount for each prescription received (e.g., $5.00 per generic prescription, $10.00 per preferred brand-name prescription). Usually paid when the service/product is provided.

Copay Coupons/Copay Cards

Discount cards provided by pharmaceutical manufacturers to patients to reduce patient cost-share for prescription (or first fill of several refills) of non-preferred 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.

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 coverage limit is met. Beneficiaries in the coverage gap are responsible for payment of the entire cost of medications until reaching the threshold for catastrophic coverage.

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

Technologies that 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).

Discount

Up-front invoice price reductions (e.g., discount percentage off wholesale acquisition cost) reserved

for managed care organizations that take possession of products.

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 more effectively, thus slowing the progression of those diseases.

Dispensing Fee

A contracted rate of compensation paid to a pharmacy for the processing/filling of a prescription claim. The dispensing fee is added to the negotiated formula for reimbursing ingredient cost.

Drug Monograph

A write-up of essential drug information given to the Pharmacy & Therapeutics (P&T) Committee to evaluate the addition of the 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 need, other treatment options pharmacoeconomic models, and cost.

Drug Utilization Review (DUR)

An authorized, structured, ongoing review of health care provider prescribing, pharmacist dispensing, and patient use of medication. Reviews are completed by clinical pharmacists at the PBM of health plan. There are three forms of DUR: prospective (before dispensing), concurrent (at the time of prescription dispensing), and retrospective (after the therapy dispensing).

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.

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.

Format for Formulary Submission (also called Dossier)

A format or dossier that is standardized by the Academy of Managed Care Pharmacy 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

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 formulary and non-formulary drugs. 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:* Non-formulary drugs are not reimbursed (unless authorized by formulary exception policies).

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.

Gatekeeper

In health maintenance organizations (HMOs): the primary care provider's role in coordinating and authorizing all medical services, laboratory studies, specialty referrals, and hospitalizations. In most HMOs, if an enrollee visits a specialist without authorization from his or her designated primary care provider, the enrollee must pay for those services.

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

A 14-character number to identify generic products with each number represents a 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 prescriber. Generic substitution is subject to state and federal regulations.

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 generally are required to use participating or approved providers for all health services.

The primary HMO models are:

- *Staff Model:* All physicians are in a centralized site that offers all clinical services and also may offer inpatient services and pharmacy services. Physicians in this model are more likely to be employees of the HMO.

- *Group Model:* The HMO contracts with a single physician group, which is paid a fixed amount per patient to provide specific services. This type of HMO usually is located in a hospital or clinic setting and may include a pharmacy.
- *Network Model:* The HMO contracts with more than one physician 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 physicians 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. Types of health plan models are 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's plan operations and processes against national standards, which are defined by health plan accrediting organizations like National Committee for Quality Assurance and Utilization Review Accreditation Commission. 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.

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)

A HDHP that is paired with health savings account (HSA) or health reimbursement account (HRA). Saving option funds can help pay high deductible or other eligible health care costs not covered by insurance.

Indemnity Insurance

Traditional fee-for-service plan 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 employer's facility, which usually is the preferred pharmacy of the staff model/group model/mixed model health maintenance organization (HMO).

Integrated Delivery System/Network

A network of health care organizations and providers all under same parent company that may include primary care physicians, 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.

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)

A generic term applied to a managed care plan; also 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. MCOs manage the cost and utilization of covered services and products to optimize patient care through efficient use of limited resources.

Managed Care Pharmacy

Managed care pharmacy is the practice of developing and applying evidence-based medication use strategies that enhance patient and population health outcomes while optimizing health care resources.

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 joins a private Managed Medicare plan and see network physicians only.

Manufacturer Price Concessions

Pharmaceutical manufacturers offer price concessions in the form of discounts and rebates to MCOs in exchange for an improved drug formulary position.

Maximum Allowable Cost (MAC)

A reimbursement limit per individual multiple-source pharmaceutical entity, strength, and dosage form (e.g., $0.50 per fluoxetine 20 mg capsule). MAC price lists are established by health plans and PBMs for private-sector clients and usually are considered confidential.

Mail-Service (Mail-Order) Pharmacy

A pharmacy that dispenses prescription drugs or devices and delivers them to patients' homes (or other designated location) by mail, a common carrier, or a delivery service. The average quantity

dispensed is 90-day supply. The mail-order service is either voluntary or mandatory to 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

State programs of 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, but 70% of the funds pay for nursing home and other long-term care services for elderly and disabled people.

Medicaid Fee-for-Service (FFS)

A Medicaid program that is managed and paid for by the state.

Medicaid Managed Care Organizations

A Medicaid program in which the State contracts with MCOs for Medicaid coverage, mandates certain coverage, and may include (carve in) or exclude (carve out) pharmacy.

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 physicians' 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):* Pays for Part A and B benefits, certain part D components, and some non-traditional benefit coverage like vision and dental.
- *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.
    - *Medicare Advantage with Prescription Drugs (MA-PD):* Beneficiaries get all coverage from one entity.
    - *Prescription Drug Plan (PDP):* Medicare FFS patients can purchase an optional PDP separately.

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 provider bills Medicare directly.

Medication Possession Ratio (MPR)

A measure of adherence calculated by the summation of days' supply of medication refills in an interval across the number of days in the interval.

Medication Quantity Limit

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

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. (Consensus definition developed by a group of 11 national pharmacy organizations in 2004.)

The core elements of MTM are:

- *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.
- *Personal medication record:* A comprehensive record of the patient's medications (prescription and nonprescription medications, herbal products, and other dietary supplements).
- *Medication-related action plan:* A patient-centric document containing a list of actions for the patient to use in tracking progress for self-management.
- *Intervention and/or referral:* The pharmacist provides consultative services and intervenes to address medication-related problems; when necessary, the pharmacist refers the patient to a physician or other health care professional.
- *Documentation and follow-up:* MTM services are documented in a consistent manner, and a follow-up MTM visit is scheduled based on the patient's medication-related needs or after care transition.

Member

A participant in a health plan; a person covered by health insurance.

National Committee for Quality Assurance (NCQA)

A private, not-for-profit 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 not-for-profit 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.

Network

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

Non-Formulary Drugs

Drugs not included in the formulary. The majority of plans that use formularies have policies in place to give physicians and patients access to non-formulary drugs where medically appropriate.

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 system, but costs may also be higher.

Out-of-Pocket Costs/Expenses

The portion of payments for covered health services required to be paid by the enrollee, including co-payments, coinsurance, and deductibles.

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

Pharmaceutical manufacturers provide rebates based upon drug failure to provide specified outcomes to help mitigate financial risk of new drugs with unknown real-word clinical experience. OBCs are common in the United Kingdom and European Union and increasing occurring in the United States headlines.

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.

Pharmacoequity

Ensuring all individuals, regardless of race and ethnicity, socioeconomic status, or availability of resources, have access to the highest-quality medications required to manage their health needs.

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 a 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, non-profit organization which is a nationally recognized quality measure organization with industry roles as a measure developer, quality educator, researcher, and convener.

Pharmacy Reimbursement

Reimbursement of the total prescription cost, which is comprised of the drug cost and professional dispensing fee, to pharmacies. 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, 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 physicians contracted with the plan, or physicians not contracted; 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 to a health insurance carrier for providing coverage under a contract.

Primary Care Provider/Physician (PCP)

Usually, the first physician a patient sees for a health complaint. This physician treats the patient directly, 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 requires prescribers to receive pre-approval for certain drugs to qualify those drugs 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 ration and avoids double-counting covered days.

Quality Rating System

CMS developed the quality rating system to calculate quality ratings for each carrier based on a 5-star scale for the Health Insurance Exchanges.

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.

Two types of rebates are:

- *Access rebate (smaller percentage):* Flat/fixed percentage off WAC in exchange for formulary listing or favorable position (e.g., specific tier, preferred status).
- *Performance rebate (higher percentage):* Variable percentage off WAC based on achieving specific performance parameters. Usually based on market share increases.

Two types of rebate contracts are:

- *Portfolio contract:* Manufacturer with a large number of drugs offer individual drug rebates and extra portfolio incentives to a managed care organization for accepting multiple drugs for formulary addition.
- *Bundle contract:* Manufacturer offers a rebate on a desirable drug (e.g., high market share, first line drug) only if the managed care organization adds one or more other undesirable drugs to the formulary.

Retail Pharmacy

An independent pharmacy or a chain pharmacy dispensing medications to the general public.

Retail pharmacy network may be classified into two categories:

- *Narrow network:* Fewer pharmacies in the network with more financial incentives for patients than an open network.
- *Open network:* More pharmacies in the network with fewer to no financial incentives for patients than a narrow network.

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 $670/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, life-threatening diseases and is covered under pharmacy or medical benefits.

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

CMS 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 was 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.

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 physician. 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 physician'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.

Utilization Management (UM)

As applied to the pharmacy benefit, any number of measures 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 not-for-profit organization promoting health care quality through accreditation, education, and measurement programs. URAC accredits organizations and/or single functional areas within an organization.

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

ACO Accountable care organization

AMP Average manufacturer price

ASP Average sales price

AWP Average wholesale price

CAHPS Consumer Assessment of Healthcare Providers and Systems

CER Comparative effectiveness research

CMR Comprehensive medication review (part of MTM)

CMS Centers for Medicare and Medicaid Services

COC Certificate of Coverage

DUR Drug utilization review

EDI Electronic data interchange

FFS Fee-for-service

HEDIS Healthcare Effectiveness Data and Information Set

HDHP High-deductible health plan

HMO Health maintenance organization

HRA Health reimbursement arrangement

HSA Health savings account

IPA Independent practice association

MAC Maximum allowable cost

MCO Managed care organization

MPR Medication possession ratio (measure of medication adherence)

MTM Medication therapy management

NCQA National Committee for Quality Assurance

NCPDP National Council for Prescription Drug Programs

NDC National Drug Code

OOP Out-of-pocket

OBC Outcomes-Based Contract

P&T Pharmacy and Therapeutics (as in P&T Committee)

PCMH Patient Center Medical Health/Homes

PA Prior authorization

PBM Pharmacy benefit management company/Pharmacy benefit manager

PCMH Patient center medical health/homes

PCP Primary care provider (or primary care physician)

PDC Proportion of days covered (measure of medication adherence)

POS Point-of-service plan

PPO Preferred provider organization

PQA Pharmacy Quality Alliance

TMR Targeted medication review (part of MTM)

UM Utilization management

URAC Utilization Review Accreditation Commission

WAC Wholesale acquisition cost