GLOSSARY

DECEMBER
2025

AMCP

GLOSSARY OF MANAGED CARE TERMS

A

À la Carte Pharmacy Benefit
A pharmacy benefit structure in which a health plan contracts with a pharmacy benefit manager (PBM) to administer selected services—such as claims processing, formulary management, or network contracting—while maintaining oversight and ultimate accountability for the overall pharmacy benefit.

Access
A patient's ability to obtain and utilize healthcare services and products is determined by their availability and acceptability to the patient, geographic location of healthcare facilities, transportation options, hours of operation, patient preferences, and cost of care.

Accountable Care Organizations (ACOs)
Groups of doctors, hospitals, and other healthcare providers that voluntarily collaborate to deliver coordinated, high-quality care to health plan beneficiaries. ACOs are designed to improve health outcomes and reduce costs by emphasizing accountability and shared financial risk/reward.

Adherence
The extent to which a patient takes medications or follows a treatment regimen as prescribed, including correct dose, route, timing, and duration. Optimal adherence rates may vary by disease state and desired clinical outcome. Common methods for measuring adherence include Medication Possession Ratio (MPR) and Proportion of Days Covered (PDC).

Adjudication
The process—often automated—by which a payer or delegated entity (such as a pharmacy benefit manager) validates a healthcare claim, applies coverage rules and system edits, and determines whether to approve or deny payment. In pharmacy benefits, PBMs commonly perform real-time adjudication for prescription claims as part of their core services.

Agency for Healthcare Research and Quality (AHRQ)
A federal agency within the U.S. Department of Health and Human Services (HHS) dedicated to improving the safety, quality, effectiveness, and efficiency of healthcare for all Americans. AHRQ develops evidence-based tools, data, and research to support clinical practice, healthcare delivery, and policy decision-making.

Alternative Payment Models (APM)
A payment approach that moves away from traditional fee-for-service models by linking reimbursement to the quality, outcomes, and cost-efficiency of care over a defined period. APMs are designed to promote value-based care by encouraging provider accountability, care coordination, and improved patient outcomes. They may involve bundled payments, shared savings, capitation, or performance-based incentives.

AMCP Research Institute (ARI)
The AMCP Research Institute is a research-based resource that conducts and facilitates projects aligned with the mission of managed care pharmacy, contributing to the broader goal of improving public health in the United States.

Annual Notice of Change (ANOC)
A required annual document sent to Medicare Advantage and Part D plan members that outlines changes to plan benefits, costs, and coverage for the upcoming year. The ANOC helps beneficiaries compare plans and make informed enrollment decisions during open enrollment.

Annuity-Based Contracts
A multi-year agreement reimbursement model for a medical intervention, therapy, or device made in scheduled installments over time. These payments are often contingent on the product achieving pre-defined clinical outcomes, utilization benchmarks, or cost-effectiveness measures during the contract period.

Antimicrobial Stewardship
A coordinated program that promotes the appropriate use of antimicrobials to improve patient outcomes, reduce microbial resistance, and decrease the spread of infections caused by multidrug-resistant organisms. Antimicrobial stewardship aims to ensure the right drug, dose, and duration are used for each patient.

Appeal (also known as Redetermination)
A formal process by which a member, provider, or representative requests a review of an adverse coverage or payment decision made by a health plan or pharmacy benefit manager. In Medicare Part D, this is called a redetermination. Appeals ensure members have access to due process for denied claims or coverage determinations.

Attribution
In quality measurement, attribution is the process of assigning a patient's care or outcome to a specific entity - such as a pharmacy benefit manager, health plan, hospital system, or provider group based on predefined rules or criteria. This enables accurate performance measurement and accountability.

Authorized Generic
A drug that is chemically identical to its brand-name counterpart but marketed without the brand name, typically at a lower cost. Authorized generics are produced under the brand manufacturer's original New Drug Application (NDA), ensuring therapeutic equivalence to the brand product.

Average Acquisition Cost (AAC)
The average price that pharmacies pay to acquire a prescription drug. AAC may vary depending on factors such as pharmacy type, purchase volume, contracts with wholesalers, special pricing agreements, or prompt-pay ("cash") discounts.

Average Manufacturer Price (AMP)
The average price that wholesalers pay to a pharmaceutical manufacturer for drugs to be distributed to retail pharmacies, calculated net of prompt-pay ("cash") discounts and other price concessions.

Average Sales Price (ASP)
The average price a manufacturer receives for a drug or biologic from all purchasers, calculated net of discounts, rebates, chargebacks, and credits. For Medicare Part B drugs and biologics, ASP is determined by dividing the manufacturer's total net sales revenue by the total units sold during a specific period.

Average Wholesale Price (AWP)
The average price that wholesalers sell a drug to their customers. It is not regulated by the government, and it serves as a commonly used pricing benchmark for many payers. AWP is thought of as a "sticker price" that rarely reflects the actual price after discounts and rebates are applied.

B

Benchmark
The external standard or predetermined performance threshold used to evaluate and compare the quality, efficiency, or effectiveness of healthcare services, providers, or organizations.

Beneficiary (also called Eligible, Enrollee, Insured, or Member)
An individual who is covered under a health care entity, including commercial insurance, Medicare, Medicaid, or other public or private program.

Benefit Design
The process of defining the scope, level, and structure of coverage for medical and pharmacy benefits, including which services are covered, cost-sharing requirements, and any limitations or exclusions.

Biologics and Biosimilars Collective Intelligence Consortium (BBCIC)
A non-profit research consortium that collects and analyzes real-world data to monitor the safety, effectiveness, and utilization of biosimilars and novel biologic therapies. BBCIC provides evidence to support informed decision-making about which medications deliver optimal health outcomes.

Biosimilar Drug
A biologic product that is highly similar to an FDA-approved reference (i.e., originator, innovator) biologic product, with no clinically meaningful differences in safety, efficacy, purity, and potency. Biosimilars are designed to provide the same therapeutic effect as the reference product.

Brand-Name Drug
A medication marketed under a proprietary trade name that is protected by a patent, granting exclusive rights to the manufacturer to produce and sell the drug for a specified period.

Brown Bagging
A process by which a drug is purchased through a specialty pharmacy and dispensed to the patient, who then brings the drug to a clinic or provider's office for administration.

C

Capitation
A payment model in which a health plan or payer pays a fixed, per-member-per-month amount to providers or organizations for delivering a defined set of healthcare services, regardless of the actual number or cost of services provided. Capitation incentivizes cost control and care coordination.

Carve-Out Benefit
A benefit design in which pharmacy benefits are managed separately from medical benefits. The plan sponsor contracts with a pharmacy benefit manager (PBM) to administer services such as formulary management, claims adjudication, and utilization management independently of the medical benefit. Carve-outs allow specialized management and cost control but may create challenges for care coordination and data integration.

Catastrophic Coverage (Prior to 2025)
Under the previous Medicare Part D design, catastrophic coverage was the final phase of the benefit that began after a beneficiary's out-of-pocket spending reached a set threshold. During this phase, beneficiaries paid a small coinsurance (typically 5%) for covered drugs, while Medicare and plan sponsors covered most remaining costs. This structure was eliminated in 2025 under the Inflation Reduction Act, which introduced a $2,000 annual out-of-pocket cap and zero cost-sharing beyond that limit.

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services (HHS), formerly known as the Health Care Financing Administration (HCFA). CMS administers major public health insurance programs, including Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP).

Certificate of Coverage (COC) (also called Evidence of Coverage or Summary of Benefits and Coverage)
A document provided by an insurance carrier that details the benefits, coverage terms, and conditions of a health plan. It is required by state law and outlines the coverage available under the contract issued to the employer or plan sponsor.

Coinsurance/Co-insurance
A cost-sharing arrangement in which a health plan member is responsible for paying a fixed percentage of the allowed charge for a covered healthcare service, such as a prescription drug, after any deductibles are met.

Commercial Plan (Private employers)
Health insurance is provided, managed, and administered by a private company rather than the government. These plans are typically offered by employers and fall into two primary categories:

- **Fully insured:** Health plans assume financial risk for the members' claims in exchange for a premium. These plans are regulated under state insurance laws.
- **Self-insured (or Self-Funded):** The employer assumes the financial risk for enrollees' claims and typically contracts with a third-party administrator (TPA) to manage plan operations. These plans are governed by the federal Employee Retirement Income Security Act (ERISA).

Community Pharmacy (also called Retail Pharmacy)
A pharmacy, either independently owned or part of a chain, that dispenses medications and provides services directly to the public. Medications are compounded or dispensed under the supervision of a licensed pharmacist. Community pharmacies also offer patient counseling, over-the-counter (OTC) medications, immunizations, and other health-related services.

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. CER may compare similar therapies, such as competing drugs, or distinct approaches, such as surgery versus medication. Its goal is to identify which treatments work best for which patients, considering both clinical outcomes and cost-effectiveness.

Comprehensive Medication Review (CMR)
A structured, patient-centered review of all medications a patient is taking, conducted by a pharmacist or qualified provider as part of Medication Therapy Management (MTM). The CMR identifies medication-related problems, optimizes therapy, and includes patient education and a personal medication record.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
A standardized survey program developed and managed by the U.S. Agency for Healthcare Research and Quality (AHRQ) that measures the patient experience and satisfaction with healthcare services. CAHPS surveys assess areas such as access to care, communication with providers, responsiveness, and availability of health plan information.

Coverage Determination
A decision made by a health plan or pharmacy benefit manager regarding whether a requested drug or service is covered under the member's benefit plan. Coverage determinations include approvals, denials, and exceptions, and are subject to appeal and grievance processes.

Covered Outpatient Drug (COD)
A prescription drug that is eligible for reimbursement under Medicaid or other public programs, subject to federal and state requirements. CODs must meet criteria for FDA approval, prescribed use, and manufacturer participation in rebate agreements.

Copayment/Co-payment
A fixed dollar amount that a health plan member pays out-of-pocket for a covered healthcare service at the time of care. Copayments are a type of cost-sharing and typically apply to services such as office visits, emergency care, or prescription drugs. The amount is defined by the member's health plan and does not vary with the total cost of the service.

Copay Coupons/Copay Cards
Discount programs offered by pharmaceutical manufacturers that help reduce a patient's out-of-pocket cost for a specific prescription medication. These cards or electronic codes are typically used by commercially insured patients at the point of sale to offset copayments, coinsurance, or deductibles—usually for branded drugs. Copay assistance is generally available for a limited time, may apply to the first fill or multiple refills, and is not permitted for patients with government-sponsored insurance (e.g., Medicare or Medicaid).

Cost Effectiveness Analysis (CEA)
An economic evaluation that compares the relative costs and health outcomes of two or more interventions. It estimates the cost required to achieve one additional unit of health benefit—such as a life-year gained, a hospitalization avoided, or a death prevented—compared to an alternative treatment or standard of care. CEA helps decision-makers determine which interventions provide the best value for the resources spent.

Cost-Sharing
A payment method in which an insured individual is responsible for paying a portion of the costs for healthcare services or medications. Cost-sharing mechanisms include deductibles, coinsurance, and copayments, but do not include the monthly premium payments. The goal of cost-sharing is to encourage more cost-conscious healthcare decisions and reduce unnecessary utilization.

Coverage Gap (also called "Donut Hole")
Prior to 2025, the coverage gap—commonly known as the "donut hole"—was a phase in Medicare Part D prescription drug coverage where beneficiaries paid a higher share of drug costs after reaching an initial coverage limit, until they qualified for catastrophic coverage. The coverage gap was eliminated by the Inflation Reduction Act of 2022, and as of 2025, Medicare Part D no longer includes this phase. Beneficiary out-of-pocket costs are now capped annually, and the coverage gap no longer applies.

D

Deductible
A fixed dollar amount that an insured person must pay out-of-pocket for covered healthcare services before the insurance plan begins to pay. The amount

paid is typically the contracted cost for those services, as negotiated between the provider and the health plan—not the provider's full billed charge. Deductibles usually apply on an annual basis and may differ between medical and pharmacy benefits. Some preventive services may be exempt from the deductible under certain health plans, particularly those complying with the Affordable Care Act (ACA).

Digital Health
A broader term that encompasses the use of health, technology, and digital tools to improve healthcare delivery, access, and outcomes. Digital health includes a wide range of technologies such as mobile health apps, wearable fitness trackers, telehealth, remote patient monitoring, and digital therapeutics. These tools often rely on computing platforms, connectivity, software, and sensors to collect, share, and analyze health data, supporting both clinical decision-making and patient self-management.

Digital Health Technologies
Software, applications, platforms, and tools used in the healthcare and social care system to support prevention, diagnosis, treatment, monitoring, and management of health and wellness. These technologies may function independently (e.g., mobile health apps, decision-support software) or be integrated with other products, such as medical devices, wearables, or diagnostic tests. They are designed to enhance clinical workflows, improve patient engagement, and support data-driven care.

Digital Therapeutics (DTx)
Evidence-based software-driven interventions designed to prevent, treat, or manage medical conditions either as standalone therapies or in combination with medications and other treatments. Unlike general wellness apps, prescription or regulated DTx products make specific health claims that are validated by third parties, such as regulatory authorities (e.g., FDA), and often require clinical evidence to support their safety and efficacy. DTx aims to improve health outcomes through personalized, scalable, and accessible digital interventions.

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 (YLL) due to premature death and the years lived with a disability (YLD) to measure the impact of a specific disease and health condition on a population's health.

Disease Management (also called "Care Management")
A coordinated approach to reducing healthcare 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 focus on early identification, prevention, and effective treatment of chronic diseases through integrated care, with the goal of minimizing complications, slowing disease progression, and enhancing quality of life.

Dispense As Written (DAW)
DAW codes are standardized numeric values used in pharmacy claims to communicate the reason a brand-name drug was dispensed instead of a generic equivalent. These codes serve to document the rationale behind product selection that can be due to prescriber instructions, patient preferences, payer requirements, and pharmacy-level decisions.

Dispensing Fee
The dispensing fee is a fixed negotiated fee between the health plan or PBM and the pharmacy to cover the cost of processing and dispensing a prescription. This is a separate reimbursement fee from the ingredient costs of the medication.

Drug Compendia
Authoritative databases that provide clinical, pricing, and coding information about prescription drugs. Common drug compendia include Medi-Span, First Databank, and Red Book. These resources support formulary management, drug utilization review, and claims adjudication.

- **Medi-Span:** Provides drug classification, GPI codes, and clinical data.
- **First Databank:** Offers drug pricing, classification, and coding information.
- **Multi-Source Code (MSC):** Indicates whether a drug is single-source or multi-source, impacting reimbursement and substitution policies.

Drug Monograph
A comprehensive, evidence-based document developed to inform Pharmacy & Therapeutics (P&T) Committee decisions on formulary placement, whether addition, renewal, or removal. Drug monographs typically include product characteristics, clinical efficacy and safety data, relevant guidelines, therapeutic need, alternative treatments, and pharmacoeconomic analyses, along with cost considerations.

Drug Utilization Review (DUR)
A structured, ongoing process that evaluates prescribing, dispensing, and patient use of medication to ensure appropriate and effective drug therapy. Reviews are completed by clinical pharmacists at the PBM or health plan.
DUR includes:

- **Prospective DUR (ProDUR):** Conducted before dispensing to identify issues such as drug interactions or duplicate therapy.
- **Concurrent DUR (cDUR):** Performed in real time at the point of dispensing to prevent medication errors and optimize therapy.
- **Retrospective DUR (RetroDUR):** Conducted after dispensing to analyze patterns of inappropriate use, overuse, or non-adherence.

In managed care pharmacy, DUR supports regulatory compliance, patient safety, and cost containment through provider feedback and targeted interventions.

E

Edits
Automated rules within a claims processing system that evaluate submitted claims for compliance with plan criteria. If the criteria are not met, the system will "reject" the claim or flag it for further manual review. Edits are used to ensure accuracy, prevent inappropriate utilization, and enforce clinical or benefit rules.

Electronic Data Interchange (EDI)
The electronic transmission of standardized healthcare data, such as claims, eligibility, billing, or payment information, between healthcare entities (e.g., providers, payers, pharmacies, or clearinghouses). EDI enables faster, more accurate, and more efficient data exchange compared to paper-based processes.

Electronic Prescribing (e-Prescribing)
The process of using electronic systems to generate and transmit prescriptions directly from a prescriber to a pharmacy. e-Prescribing improves accuracy, enhances patient safety, reduces prescription errors, and streamlines medication management by eliminating the need for handwritten or faxed prescriptions.

Encounter
A documented interaction between a patient and a healthcare provider or facility, resulting in the delivery of healthcare services. Encounters are used for claims submission, quality measurement, and network adequacy assessment in managed care.

Endorsement
A formal process by which healthcare quality measures are evaluated and approved for use in performance measurement and accountability programs. As the nation's leading organization for measure endorsement, the National Quality Forum (NQF) evaluates proposed quality measures according to standardized criteria, such as importance, scientific validity, feasibility, and usability.

Evidence-Based Medicine (EBM)
The conscientious, explicit, judicious use of the best current clinical evidence in patient care decision-making. EBM incorporates clinical experience, patient values, and the best available evidence to guide healthcare decision-making and improve patient outcomes.

Explanation of Benefits (EOB)
A statement provided by a health insurance plan to its members after a healthcare service is processed. It outlines what services or medications were billed, the amount the plan paid, what the member may owe (e.g., copay, coinsurance, or deductible), and any adjustments or formulary changes. The EOB is not a bill, but a summary to help members understand their healthcare costs and coverage.

F

Feasibility
A characteristic of a quality measure that refers to the ease and practicality of obtaining the necessary data and resources to calculate and report the measure. Feasibility takes into account factors such as data

accuracy, availability, and accessibility, as well as the burden on data submitters required to calculate a measure.

Flexible Spending Account (FSA)
A tax-advantaged savings account offered by employers that allows employees to set aside pre-tax dollars to pay for eligible out-of-pocket healthcare expenses, such as copayments, deductibles, and certain medical supplies. FSAs are typically "use-it-or-lose-it" accounts, meaning funds must be used within the plan year or a short grace period, or they are forfeited.

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) utilize this format to formalize, standardize, and expand information for the P&T Committee's review.

Formulary/Preferred Drug List (PDL)
A curated list of prescription medications approved for coverage by a health plan or PBM, based on evidence-based medicine, clinical guidelines, and cost-effectiveness. The formulary promotes safe, effective, and affordable therapy.
Types of Formularies:

- **Open Formulary:** Most medications are covered, with minimal restrictions or exclusions. Non-formulary drugs may still be available, but could require higher patient cost-sharing or prior authorization.
- **Closed Formulary:** Coverage is limited to a defined list of medications. Drugs not included on the formulary are generally not reimbursed unless approved through an exception process. This approach often favors medications with superior outcomes and/or better cost-effectiveness.

Formulary Management
The operational process of maintaining and updating the formulary within the formulary system. It involves evaluating drugs for clinical efficacy, safety, and cost; assigning tier placement; applying utilization management strategies (e.g., prior authorization, step therapy); and monitoring formulary performance to ensure optimal therapeutic outcomes.

Formulary System
The overarching governance framework through which a healthcare organization establishes drug-use policies and determines which medications are most appropriate and cost-effective for its population. The formulary system provides the structure for formulary management and P&T Committee decision-making.

G

Gatekeeper
A healthcare provider, typically a primary care physician, who serves as the main point of contact for a patient's medical care within certain health insurance plans, especially Health Maintenance Organizations (HMOs). The gatekeeper coordinates care, manages referrals to specialists, and helps control costs by ensuring appropriate use of healthcare services.

Gene Therapy
A medical intervention that treats or prevents disease by modifying a patient's genetic material. Gene therapies are often high-cost, one-time treatments and may be subject to innovative payment models, such as annuity-based contracts or warranty models, in managed care pharmacy settings.

Generic Drug
A medication that contains the same active ingredient, strength, dosage form, and route of administration as a brand-name drug. Generic drugs are approved by regulatory authorities (such as the FDA) as therapeutically equivalent to the brand-name version, meaning they have the same efficacy, safety, side effects, and intended use. They are typically marketed after the brand-name drug's patent expires and are usually sold at a lower cost.

Generic Product Identifier (GPI)
A hierarchical coding system developed by Medi-Span that classifies drugs based on their therapeutic use and chemical characteristics. The GPI code is typically up to 14 characters long, divided into segments that represent drug group, class, subclass, base name, name, dosage form, and strength. Shorter versions of the GPI (e.g., 8, 10, or 12 characters) may be used to represent higher-level groupings, such as drug class or name, without specifying the dosage form or strength. The GPI system is widely used for drug utilization review, formulary management, clinical decision support, and claims processing. The GPI is a proprietary system developed and maintained by Medi-Span, which is now part of Wolters Kluwer Health.

First Databank (FDB), on the other hand, does not use GPI codes. Instead, FDB uses proprietary identifiers such as GCN (Generic Code Number) for grouping drug products and HICL (Hierarchical Ingredient Code List) for ingredient-level classification. These codes serve similar purposes to GPI in supporting formulary management, drug utilization review, and claims processing. FDB also offers classification systems like the Enhanced Therapeutic Classification (ETC) and Generic Sequence Number (GSN) for broader grouping and therapeutic categorization.

Generic Substitution
The practice of dispensing a therapeutically equivalent generic drug in place of a prescribed brand-name drug, typically without requiring prior approval from the prescriber. Generic substitution is permitted when the generic has been approved by the FDA as bioequivalent to the brand-name drug. The process is governed by federal and state laws, which may vary in terms of whether substitution is mandatory or optional, and whether patient or prescriber consent is required.

Gold/Clear Bagging
A distribution model in which a health system-owned specialty pharmacy procures, prepares, and delivers physician-administered drugs directly to the site of care (e.g., hospital outpatient clinic or infusion center) for administration. This model helps maintain control within the health system, supports integrated care, and may streamline patient support and reimbursement processes. Unlike white bagging (from external specialty pharmacies), gold/clear bagging allows the health system to retain control over storage, handling, and clinical oversight of the therapy.

Grievance
A formal complaint submitted by a member regarding dissatisfaction with a health plan's services, processes, or personnel, not related to coverage or payment decisions. Grievances are tracked and resolved according to regulatory requirements to ensure member rights and plan accountability.

H

Health Disparities
Preventable and unjust differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that exist among specific population groups. Health disparities often affect groups that have historically faced multiple challenges, including poverty, environmental disadvantages, inadequate access to healthcare, health-related behavioral factors, and educational inequalities.

Health Equity
The state in which all individuals have a fair and just opportunity to achieve their highest possible level of health. Achieving health equity requires removing obstacles to health such as poverty, discrimination, and their consequences—including lack of access to good jobs, education, housing, safe environments, and healthcare. It involves actively addressing systemic, avoidable, and unjust disparities in health outcomes.

Health Insurance Marketplace/Exchange
A government-established platform where individuals and small businesses can compare, purchase, and enroll in qualified health plans. Marketplaces facilitate access to coverage, premium subsidies, and standardized benefit designs under the Affordable Care Act.

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. Members of an HMO are generally required to use participating or approved providers within the HMO's network.
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 is usually 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 healthcare 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 healthcare 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 qualified covered healthcare expenses, in some cases, health insurance premiums. HRAs are designed to help employees cover out-of-pocket healthcare costs, with funds contributed solely by the employer and often not subject to use-it-or-lose-it rules.

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 healthcare expenses. Contributions are made pre-tax, grow tax-free, and unused balances roll over year to year, allowing the account to build savings over time.

Health Technology Assessment (HTA)
A systematic, multidisciplinary process to evaluate the properties and effects of health technologies and interventions. HTA helps policymakers, healthcare providers, and payers determine the value, effectiveness, and appropriate use of new or existing health technologies within healthcare systems.

Healthcare Effectiveness Data and Information Set (HEDIS)
A widely used set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to evaluate and compare health plans. HEDIS assesses health plan performance across five domains: effectiveness of care, access and availability of care, patient experience of care, utilization and relative resource use, and health plan descriptive information. HEDIS measures are widely used by private and public payers, including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), to monitor and improve quality of care. These measures often form the basis for value-based payment programs, accreditation, public reporting, and financial incentives designed to promote better health outcomes and efficient care delivery. Note: HEDIS is distinct from measures developed by the Pharmacy Quality Alliance (PQA), which focuses specifically on pharmacy-related quality metrics.

High-Deductible Health Plan (HDHP)
A health insurance plan characterized by higher annual deductibles and out-of-pocket maximum limits compared to traditional plans. To qualify as an HDHP, the plan must meet minimum deductible and out-of-pocket thresholds established annually by the IRS. For example, in 2025, the minimum deductible is $1,650 for self-only coverage and $3,300 for family coverage, and the maximum out-of-pocket limit is $8,300 for individuals and $16,600 for families. These limits typically change each year. HDHPs often offer lower monthly premiums in exchange for higher upfront costs when receiving care and are commonly paired with tax-advantaged accounts such as HSAs.

High-Deductible Health Plan with Saving Options (HDHP-SO)
A high-deductible health plan (HDHP) combined with a tax-advantaged savings account—such as a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). Funds in these savings accounts can be used to pay for high deductibles and other eligible healthcare expenses not covered by the insurance plan, helping to manage out-of-pocket costs.

I

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

Indemnity Insurance (also called Fee-For-Service Plans)
A traditional health insurance model in which healthcare providers are paid according to the service performed, and beneficiaries typically pay upfront for care and are later reimbursed by the insurer for healthcare expenses incurred.

Independent Review Organizations (IROs)
A third-party medical review entity that conducts impartial medical determinations to resolve coverage disputes or appeals, such as prior authorization denials. These determinations are based solely on clinical evidence, ensuring objective, unbiased decisions.

Indication-specific Pricing (ISP)
A pricing strategy used by payers that 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.

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 healthcare 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 managed by the internal pharmacy department of the health plan, rather than by an external pharmacy benefit manager (PBM).

Interchangeable Biosimilar
May be substituted at the pharmacy for the reference product without the intervention of the prescribing healthcare 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.

J

Joint Commission (JCAHO)
A United States-based, nonprofit organization that accredits and certifies healthcare organizations and programs. Its mission is "Enabling and affirming the highest standards of healthcare quality and patient safety for all."

M

Managed Care
A structured approach to financing and delivering covered healthcare 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, it 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 application of clinical and scientific evidence to support the appropriate use of medications to enhance patient and population health outcomes while optimizing the use of limited health care resources.

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).

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).

Maximum Out-of-Pocket Costs
The limit on total member copayments, deductibles, and co-insurance under a healthcare 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 healthcare. Most recipients are low-income women and children, as well as nursing homes and other long-term care services for the elderly and disabled. The federal government has general rules that all state Medicaid programs must follow, but each state runs its own program.

Medicaid Drug Rebate Program (MDRP)
A federal program requiring drug manufacturers to pay rebates to state Medicaid agencies for covered outpatient drugs dispensed to Medicaid beneficiaries. The MDRP ensures Medicaid pays competitive prices and supports program sustainability.

Medicaid Fee-for-Service (FFS)
A Medicaid program that is managed and funded by the state and federal government to provide healthcare to low-income citizens. Unlike Medicaid managed care organizations, FFS does not involve a health plan; the state pays providers directly for services rendered.

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 applicable to the population residing in that state.

Medical Loss Ratio (MLR)
A financial metric representing the percentage of premium revenue spent on clinical services and quality improvement, as opposed to administrative costs or profit. MLR requirements are set by law to ensure health plans allocate sufficient resources to patient care.

Medically Necessary/Medical Necessity
A determination that a healthcare service, supply, or medication is appropriate and required for the diagnosis, treatment, or prevention of a medical condition, consistent with accepted standards of medical practice. Medical necessity is a key criterion for coverage decisions and prior authorization.

Medicare
A federal health insurance program administered by the CMS that primarily serves persons over 65 years of age and under 65 years of age with permanent disabilities or end-stage renal disease (ESRD).

Different "parts" of Medicare cover different healthcare services:

- **Part A:** Pays for inpatient hospital, skilled nursing facility (SNF), hospice, and home healthcare.
- **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.
    - **Medicare Advantage with Prescription Drugs (MA-PD):** Beneficiaries get all coverage from one entity.
    - **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, often provided by pharmacists, that optimizes therapeutic outcomes for individual patients. MTM typically includes comprehensive and/or targeted medication reviews, development of medication-related action plans, patient education, and coordination with prescribers. MTM services are independent of, but can occur in conjunction with, the provision of a medication product.

Modular Pharmacy Benefit Administration (PBA)
A flexible approach to pharmacy benefit management in which a plan sponsor contracts for selected administrative services, such as claims processing, formulary management, or network contracting, rather than a full-service PBM arrangement. Modular PBA allows customization and control over pharmacy benefit operations.

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

Multi-Ingredient Compound
A prescription medication prepared by a pharmacist that combines two or more active ingredients, typically tailored to meet individual patient needs. Multi-ingredient compounds are subject to specific billing, reimbursement, and clinical review policies in managed care pharmacy.

N

National Average Drug Acquisition Cost (NADAC)
The average price that pharmacies pay to acquire prescription drugs from wholesalers. It's a benchmark used primarily by Medicaid programs to determine reimbursement rates for pharmacies, aiming for a fair national standard. NADAC is calculated by CMS based on voluntary monthly surveys of retail community pharmacies.

National Committee for Quality Assurance (NCQA)
A private, non-profit organization dedicated to improving healthcare quality. NCQA develops a rigorous set of quality standards and performance measures for accrediting a broad range of healthcare entities.

National Council for Prescription Drug Programs (NCPDP)
A nonprofit organization that develops and maintains standards for the electronic exchange of pharmacy-related data, such as e-prescribing, claims processing, and medication history.

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 Provider Identifier (NPI)
A unique, 10-digit identification number assigned to healthcare providers in the United States for use in administrative and billing transactions. The NPI standardizes provider identification across payers and supports electronic claims processing.

National Quality Forum (NQF)
A nonprofit, nonpartisan, membership-based organization that works to improve healthcare outcomes, safety, equity, and affordability. They are an affiliate of The Joint Commission.

NCPDP Claim Codes
Standardized codes used in pharmacy claims processing, such as to communicate information about other insurance coverage (OCC), clarify submission details (SCC), and identify professional pharmacy services (PPS). These codes support accurate adjudication and coordination of benefits.

Network
A group of healthcare providers, hospitals, and pharmacies that contract with a health plan or pharmacy benefit manager (PBM) to deliver services to members at negotiated rates.

Network Adequacy
A measure of whether a health plan's provider network offers sufficient access to covered services for members, based on criteria such as provider types, geographic distribution, and appointment availability. Network adequacy is regulated to ensure timely and appropriate care.

Non-Formulary Drugs
Drugs not included on a health plan's approved drug list (formulary). These drugs are generally not covered unless an exception is granted, often requiring prior authorization to show medical necessity when no suitable formulary alternative exists.

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 plan's 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 co-payments, coinsurance, and deductibles.

Outcomes-Based Contracts (OBCs) (also called Performance-Based Risk-Sharing Contracts)
A contract between a payer, manufacturer, and/or healthcare 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 healthcare to improve health and economic outcomes. The model encompasses five functions and attributes: comprehensive care, patient-centered care, coordinated care, accessible services, and quality and safety.

Per Member Per Month (PMPM)
A standard financial metric representing the average cost or utilization of healthcare services per enrolled member per month. PMPM is used for budgeting, actuarial analysis, and performance benchmarking in managed care.

Per Member Per Year (PMPY)
A financial or utilization metric representing the average cost or use of healthcare services per enrolled member per year. PMPY is used for annual budgeting, reporting, and trend analysis in managed care.

Performance Guarantee
A contractual commitment by a pharmacy benefit manager, health plan, or vendor to meet specified performance metrics—such as claims processing accuracy, turnaround time, or clinical outcomes—with financial penalties or incentives for non-compliance or achievement.

Personal medication record (PMR)
A comprehensive record of the patient's medications (prescription and nonprescription medications, herbal products, and other dietary supplements). The PMR includes details such as medication names, dosages, and instructions, and is typically provided as part of Medication Therapy Management (MTM) to improve safety, adherence, and care coordination.

Pharmacy and Therapeutics (P&T) Committee
A multidisciplinary advisory body within a health plan or PBM that oversees formulary management and related clinical policies. The committee evaluates clinical evidence, safety, and cost-effectiveness to guide medication coverage and utilization decisions. Members typically include physicians, pharmacists, and nurses, and may also include legal experts, plan administrators, and patient representatives.

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)
An organization that administers prescription drug benefits on behalf of health plans, employers, and other payers. PBM activities can encompass various services, including benefit plan design, establishing and managing retail and mail service networks, claims processing, and managed prescription drug services like drug utilization review, formulary management, generic dispensing, prior authorization, and disease management.

Pharmacy Network Model
Defines how pharmacies are organized and contracted within a health plan or pharmacy benefit manager (PBM) to deliver prescription drug services. These models influence member access, cost-sharing, and plan performance. Common models include:

- **Open Network:** Members can use any pharmacy, including non-contracted pharmacies, often at higher out-of-pocket costs. Provides maximum flexibility but less cost control for the plan.
- **Closed Network:** Members must use pharmacies within the contracted network for coverage. Offers stronger cost control and formulary compliance but limits choice.
- **Preferred Network:** Includes all network pharmacies but designates certain pharmacies as "preferred," offering lower copays or coinsurance to steer members toward cost-efficient options.
- **Tiered Network:** Pharmacies are grouped into tiers based on cost or negotiated rates. Members pay different out-of-pocket amounts depending on the tier, with lower tiers offering lower copays.
- **Performance-Based Network:** Pharmacies are selected or incentivized based on quality metrics, adherence support, and clinical performance. Members may receive financial incentives

or lower copays for using high-performing pharmacies.

- **Specialty Pharmacy Network:** A subset of pharmacies focused on high-cost, complex therapies requiring special handling, clinical oversight, and patient support services. May include mail service or limited distribution arrangements.

Pharmacy Quality Alliance (PQA)
A multi-stakeholder, member-based, non-profit 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
An entity that funds or offers health insurance coverage for a group of members, such as an employer, government program (e.g., Medicare, Medicaid, TRICARE), or health insurance marketplace. Plan sponsors typically design benefit structures, select insurers or pharmacy benefit managers (PBMs), and manage overall plan administration.

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 regular payment (usually monthly) is made by a member or their sponsor (e.g., employer) to a health insurance plan to maintain coverage. Premiums are separate from out-of-pocket costs such as deductibles, copayments, and coinsurance.

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).

Prescription Drug Event (PDE)
A standardized record of a prescription drug claim submitted by Medicare Part D plans to CMS for payment and program oversight. PDEs capture detailed information about drug dispensing, cost, and coverage for regulatory and quality reporting.

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.

Primary Care Provider/Physician (PCP)
The main healthcare professional is responsible for a patient's routine care and overall health management. PCPs provide preventive services, treat common conditions, manage chronic illnesses, and coordinate referrals to specialists or hospital care when needed. They are often physicians (family medicine, internal medicine, pediatrics), but can also be nurse practitioners or physician assistants.

Prior Authorization (PA)
A utilization management process that requires prescribers to obtain approval from a health plan or pharmacy benefit manager (PBM) before certain medications, products, or services are covered. Prior authorization helps ensure appropriate, safe, and cost-effective use of therapies. Criteria and policies are developed by pharmacists and other qualified health professionals under the plan's guidelines.

Proportion of Days Covered (PDC)
A standard measure of adherence calculated by dividing 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, avoids double-counting covered days, and is the preferred adherence methodology recommended by the Pharmacy Quality Alliance (PQA).

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)
A continuous, systematic process to enhance patient safety, care effectiveness, and overall experience by using an understanding of our complex healthcare 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. Ratings are based on measures of clinical quality, member experience, and plan efficiency.

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 healthcare 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 service.

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

Targeted Medication Review (TMR)
A focused evaluation of a specific medication or therapy for a patient, conducted as part of Medication Therapy Management (MTM). TMRs address identified medication-related problems, adherence issues, or therapy optimization opportunities.

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.

Third Party Administrator (TPA)
An organization that provides administrative services, such as claims processing, eligibility management, and benefit administration, for self-funded health plans, employers, or other payers, without assuming financial risk for claims.

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
In quality measurement, usability refers to how easily a measure can be implemented and whether its results are meaningful and actionable for stakeholders. A usable measure provides clear, interpretable data that supports decision-making and quality improvement.

Usual and Customary (U&C)
The retail price that a pharmacy charges cash-paying customers for a prescription drug, absent any discounts or insurance coverage. U&C pricing is used as a benchmark in claims adjudication and reimbursement calculations.

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 non-profit organization promoting healthcare quality through accreditation, education, and measurement programs. URAC accredits organizations and/or single functional areas within an organization.

V

Value-Based Care
A healthcare delivery and payment model that ties provider reimbursement to the quality, outcomes, and cost-effectiveness of care rather than the volume of services delivered. Value-based care programs aim to improve patient health, enhance care experience, and reduce overall costs, often using performance metrics and real-world outcomes to determine payment.

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 quality measurement, validity refers to the extent to which a measure accurately reflects what it is intended to assess and is not influenced by unrelated factors. A valid measure ensures that results are meaningful and can be used to drive quality improvement. Validity is one of the key criteria for evaluating performance measures, along with reliability and usability.

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 payment arrangement in which a manufacturer agrees to reimburse some or all treatment-related costs if a drug, device, or procedure fails to meet agreed-upon clinical outcomes. Often administered through a third-party administrator, warranty models are used for high-cost therapies to reduce financial risk for payers and promote accountability for real-world performance.

Wholesale Acquisition Cost (WAC)
Manufacturer’s list price for a prescription drug for sale to wholesalers or other direct purchasers, before any discounts, rebates, or other price concessions. WAC is published by pricing services, such as First Databank, Medi-Span, and Red Book, and is often used in reimbursement calculations, though it does not reflect the actual net cost.

COMMON ABBREVIATIONS

AAC Average acquisition cost
ACA Affordable Care Act
ACO Accountable care organization
AHRQ Agency for Healthcare Research and Quality
AMCP Academy of Managed Care Pharmacy
AMP Average manufacturer price
ANOC Annual notice of change
APM Alternative payment model
ARI AMCP Research Institute
ASP Average sales price
AWP Average wholesale price
BBCIC Biologics and Biosimilars Collective Intelligence Consortium
CAHPS Consumer Assessment of Healthcare Providers and Systems
CDUR Concurrent drug utilization review
CEA Cost effectiveness analysis
CER Comparative effectiveness research
CHIP Children's Health Insurance Program
CMR Comprehensive medication review
CMS Centers for Medicare and Medicaid Services
COC Certificate of coverage
COD Covered outpatient drug
DALY Disability-adjusted life year
DAW Dispense as written
DTx Digital therapeutics
DUR Drug utilization review
EBM Evidence-based medicine
EDI Electronic data interchange
EOB Explanation of benefits
ERISA Employee Retirement Income Security Act
ESRD End-stage renal disease
ETC Enhanced therapeutic classification
FDA Food and Drug Administration
FDB First Databank
FFS Fee-for-service
FSA Flexible spending account
GCN Generic code number
GPI Generic product identifier
GPO Group purchasing organizations
GSN Generic sequence number
HCDM Healthcare decision maker
HCFA Health Care Financing Administration
HDHP High-deductible health plan
HDHP-SO High-deductible health plan savings option
HEDIS Healthcare Effectiveness Data and Information Set
HHS Health and Human Services
HICL Hierarchal Ingredient Code List
HMO Health maintenance organization
HRA Health reimbursement arrangement
HSA Health savings account
HTA Health technology assessment
ICER Institute for Clinical and Economic Review
IDN Integrated delivery network
IDS Integrated delivery system
IPA Independent practice association
IRO Independent review organization
ISP Indication specific pricing
JCAHO Joint Commission on Accreditation of Healthcare Organizations
MAC Maximum allowable cost
MAP Medication-related action plan
MAPD Medicare Advantage with prescription drugs
MCO Managed care organization
MDRP Medicaid Drug Rebate Program
MLR Medical loss ratio
MPR Medication possession ratio
MSC Multi-source code
MTM Medication therapy management
MTR Medication therapy review
NADAC National average drug acquisition cost
NCQA National Committee for Quality Assurance
NCPDP National Council for Prescription Drug Programs
NDA New drug application
NDC National drug code
NPI National provider identifier
NQF National Quality Forum
OBC Outcomes-based contract
OCC Other coverage code
OOP Out-of-pocket
OTC Over-the-counter
P&T Pharmacy and Therapeutics (as in P&T Committee)
PA Prior authorization
PBA Pharmacy benefit administration
PBM Pharmacy benefit management company/ Pharmacy benefit manager
PCMH Patient center medical health/homes
PCP Primary care provider/physician)
PDC Proportion of days covered
PDE Prescription drug event
PDL Preferred drug list
PDP Prescription drug plan
PMPM Per member per month
PMPY Per member per year
PMR Personal medication record
POS Point-of-service
PPO Preferred provider organization
PPS Professional pharmacy services
PQA Pharmacy Quality Alliance
ProDUR Prospective drug utilization review
QA Quality assurance
QALY Quality-adjusted life year
QI Quality improvement
RetroDUR Retrospective drug utilization review
SCC Submission clarification code
SNF Skilled nursing facility
TMR Targeted medication review
TPA Third party administrator
U&C Usual and customary
UM Utilization management
URAC Utilization Review Accreditation Commission
WAC Wholesale acquisition cost
YLD Years lived with a disability

Acknowledgement
AMCP would like to sincerely thank the following volunteers from the Professional Practice Committee, whose expertise and dedication were crucial to this update: Jilian Davis, Alyssa Nissen, Dana McCormick, Binal Patel, Jennifer Polzin, Hiva Pourarsalan, Samuel Sui, and Patty Tadei-Allen. Their dedication guarantees that this resource remains accurate and pertinent for professionals in managed care pharmacy.

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