



Academy of
Managed Care
Pharmacy®

Mapping Your Career in Managed Care Pharmacy

A Student Pharmacist's Guide



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Mapping Your Career in Managed Care Pharmacy: A Student Pharmacist's Guide



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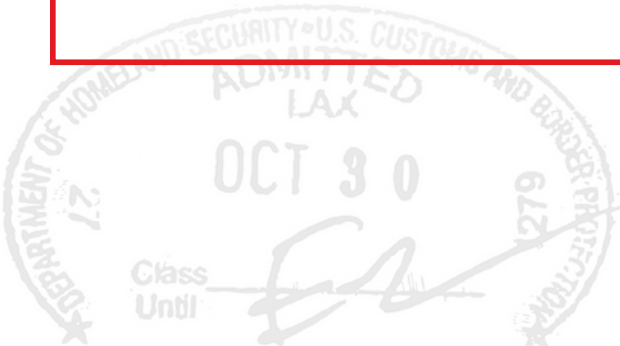
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Introduction

The US health care system is constantly evolving. Health care financing and the delivery of services has changed profoundly over the past few decades and managed care has been a leading force in that change.

Understanding the many intricacies of the health care system may seem daunting. This booklet offers a set of directions—a roadmap—for the student pharmacist to understand managed care pharmacy and the career opportunities it offers.

Health care in America is integrating various health care professionals to provide coordinated, cost-effective, seamless patient care. Managed health care systems are designed to address the overall health of population groups. Managed care strives to optimize all aspects of patient care by providing access to appropriate, affordable, comprehensive, high-quality care. As health care delivery systems have changed, so have the roles of pharmacists. Managed care pharmacy offers pharmacists exciting opportunities, including expanded functions in the clinical, administrative and pharmacoeconomic realms.

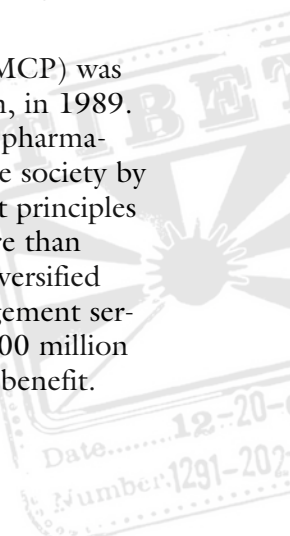
Managed care pharmacy will continue to have a profound impact on patient care. Pharmaceuticals are a vital part of promoting patient health; managed care systems offer numerous opportunities for pharmacists who are trained to improve and committed to improving medication use and treatment outcomes.



Pharmacists practicing in managed care settings apply their skills in areas such as assessing the appropriateness of medication therapy, cost containment and quality enhancement. They improve patient care through their work in formulary development, pharmacy benefit design, disease state management, patient and provider education, outcomes research, drug utilization management, data integration and analysis, medication therapy management and more. With their unique pharmacological and drug information knowledge, managed care pharmacists have a critical role in assuring that the patient receives optimal results from medication therapy in a timely and cost-effective manner. In a managed care system, the pharmacist is an integral part of the health care delivery team.

Over the last few decades, pharmacy drug benefits provided by insurance plans (including Medicaid and Medicare plans) have grown immensely. With the passage of the Medicare Modernization Act (MMA) in 2003, Medicare beneficiaries now receive prescription drug coverage under Medicare Part D. This presents a tremendous opportunity for pharmacists to apply their knowledge and skills to ensure efficient and appropriate medication therapy management. Pharmacists are now being recognized for their cognitive service contributions to patient care through medication therapy management interventions.

The Academy of Managed Care Pharmacy (AMCP) was founded during this time of health care evolution, in 1989. AMCP is the national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. More than 5,700 AMCP members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit.





Schools and colleges of pharmacy increasingly are focusing on preparing student pharmacists for the field of managed care. Significant curricular strides have been made and many pharmacy schools and colleges have AMCP student chapters. As managed care topics are fused into the curricula—and as managed care organizations provide more and more opportunities for student pharmacist development—the educational preparation for managed care pharmacy careers is expected to flourish, both in the classroom and during experiential training.

Mapping Your Career in Managed Care Pharmacy: A Student Pharmacist's Guide is designed to provide student pharmacists with a basic understanding of managed care pharmacy and information about career and networking opportunities. A glossary of key managed care terms is presented in Section Six; you may want to review these key terms before reading Section One, to become familiar with specific terminology used in this booklet.

It is an exciting time to enter a career in managed care pharmacy. Although today's student pharmacist has excellent clinical preparation, you should seek out additional knowledge and experiences to be prepared to excel in managed care pharmacy. *Mapping Your Career* is your first step in the journey of exploring a career in managed care pharmacy.







SECTION ONE



What is Managed Care Pharmacy?

Managed care is an organized approach to health care delivery that seeks to improve the quality and accessibility of health care—including medication therapy—in a cost-effective manner. Managed care pharmacy develops and implements comprehensive programs that deliver effective medication therapy and specific patient-care services to improve the overall health care of the patient.

Pharmaceutical expenditures have grown more rapidly than any other component in the health care system as a result of (1) the increased use of prescription medications, (2) the number of people covered by drug benefits and (3) the introduction of expensive new drugs into the marketplace. Pressures from employers, government agencies and consumers to curb health care expenditures challenge managed care organizations to initiate interventions that will improve outcomes for the populations they serve.

The delivery of health care in the United States has changed dramatically since President Richard Nixon launched the Health Maintenance Organization Strategy in 1968. A number of social and economic factors played a role in the passage of the federal Health Maintenance Organization (HMO) Act of 1973, but it was the market-



place that propelled the subsequent range of innovation we have found under managed care. Health care delivery systems face new challenges today, as federal and state governments subsidize Medicare and Medicaid beneficiaries and employers demand cost constraints. Managed care pharma-

Managed Care Statistics

Here are a few managed care statistical trends. For the latest managed care pharmacy statistics, visit www.amcp.org; click on Professional Practice and then Statistical Resources.

- In 1984, HMO enrollment was 15.1 million. It peaked at 80.1 million in 2000 and decreased to 72.7 million in 2006.
- In 2002, 99% of HMOs and point-of-service plans covered prescription medications.
- HMOs dispensed an average of 26.3 prescriptions per Medicare member in 2006, up 6.0% from the average of 24.8 prescriptions per member the previous year.
- One pharmacy benefit management company reported that plan participants 43 years of age and older account for almost 50% of its enrollment and more than 75% of drug costs.
- Mail service pharmacy options were offered by 96% of HMOs and point-of-service plans in 2002.
- The trend for specialty drugs rose 20.9% in 2006.
- In 2000, health plans spent \$27.80 per month on prescription medications for Medicare beneficiaries vs \$14.60 per month for non-Medicare plan enrollees.

Source: America's Health Insurance Plans (AHIP) 2002 Chartbook of Findings, CVSCaremark 2007 TrendsRx[®] Report, Express Scripts 2006 Drug Trend Report, The Kaiser Family Foundation and the sanofi-aventis Managed Care Digest Series 2007.



cy is well-positioned to curb rising health care costs through effective management of pharmaceutical expenditures.

The concepts of managed care can be traced back to the 1930s and the formation of *prepaid group practices*. Although these progressive plans offered more comprehensive services than fee-for-service medicine, traditional indemnity plans (in which insurance companies pay for “necessary services” ordered by a physician) remained the predominant form of health care coverage. Some prepaid plans—for example, the Kaiser Permanente system, various union-sponsored plans and numerous physician group practices—were able to thrive nonetheless; these precursors to managed care usually offered well-accepted services with a preventive component, at a less inflationary pace than fee-for-service plans. When health care costs began to increase rapidly in the 1970s, employers took a greater interest in managed care and propelled it forward.

In the 1980s, overall health care costs continued to rise at up to double the rate of the consumer price index. HMOs began to flourish as the pressure to contain costs increased. By the mid-1980s, several HMOs began public for-profit corporations and insurers and employers started to embrace preferred provider organizations. Competition for greater market share arose among managed care organizations locally and nationally.

The biggest change to federal coverage of health care since the 1965 establishment of Medicare came with the passage of the Medicare Modernization Act (MMA) in 2003. This act provided the first comprehensive outpatient prescription drug benefit for seniors through the newly-created Medicare Part D. As a result, many pharmacy providers, health plans and pharmacy benefit management companies throughout the country became involved in Medicare Part D benefit and care coordination. Another section of the act authorized Medicare Advantage plans to offer full pharmacy coverage to Medicare beneficiaries. The MMA presents a tremendous opportunity for pharmacists and managed care organizations to develop effective medication therapy management programs.





SECTION TWO



Who Is Involved in Managed Care Pharmacy?

Managed care has gained a significant prominence in the US health care system. Managed care encompasses various health care professionals striving to achieve better health outcomes for their patient populations. There are traditional managed care organizations that include pharmacy and pharmacists, but there also are a number of settings that influence managed care or work with managed care. Pharmacists can be found in each of these managed care settings. (For information on the roles of pharmacists in managed care pharmacy, see Section Three.)

Health Plans/Health Maintenance Organizations (HMOs)

There are four types of HMO models: staff, group, network and independent practice association (IPA). Only a few “pure” HMO or health plan models exist today; most are either hybrids or combinations.

- **Staff model HMOs** employ salaried physicians who treat patients in HMO-owned and operated facilities. Other services such as laboratory, diagnostic and pharmacy usually are provided onsite. Example: Group Health Cooperative of Puget Sound.



- **Group model HMOs** contract with a multispecialty physician group practice to provide care for members. Example: Kaiser Permanente Health Plans.
- **Network model HMOs** contract with several primary and multispecialty group practices to offer greater geographic coverage. Independent and chain pharmacies also are under contract. Example: Health Insurance Plan of New York.
- **IPA model HMOs** do not have their own facilities; instead, they contract with community-based physicians or select group practices to provide care to their members. The IPA HMOs also contract with pharmacies, laboratories, community hospitals and diagnostic centers separately. Example: United Healthcare.
- **Preferred Provider Organizations (PPOs):** a contracted network of physicians, hospitals, pharmacies and other health care providers. The network usually is larger than what an HMO would offer and thus gives greater choice in accessibility of providers for a higher cost-sharing.
- **Point-of-Service (POS) Plans:** a hybrid of the HMO and the preferred provider organization (PPO). Point-of-service plan members may obtain care through low-cost HMO providers or pay higher copayments to access the preferred provider organization providers. Premiums are higher, so greater choice in access results in higher out-of-pocket costs for consumers.
- **Mixed model** and **hybrid HMOs** are developed to meet specific care needs, goals or objectives. Special populations—for example, older patients or patients with certain chronic diseases—are served under such provider arrangements.

Pharmacy Benefit Management Companies

Pharmacy benefit management companies—referred to as “PBMs”—administer all aspects of a plan sponsor’s prescription drug benefit. A PBM may be owned by or affiliated with an insurance company, a health plan or preferred provider organization, a community pharmacy chain corporation, or another managed care organization; conversely, it may be a



private, independent enterprise. PBMs may provide services directly or may oversee contracts with claims processors, provider networks, drug manufacturers and clinical consultants. PBMs offer services such as:

- Drug formulary management, which includes developing and maintaining the drug formulary for the managed care plan, developing clinical and pharmacoeconomic criteria and evaluating studies by pharmacy and therapeutics (P&T) committees.
- Negotiating with pharmaceutical manufacturers to provide disease management programs, other value-added programs and volume discounts based on utilization of the pharmacy benefit.

In 2001, pharmacy benefit managers joined together to form RxHUB as a conduit for e-prescribing. The hub brought gathering patient medication records together and providing them to the prescriber at the point of care. Drug interactions, other drug-related safety alerts and plan coverage/prior authorization rules could then be recognized before the prescription order was written. In 2008, RxHUB merged with SureScripts, another e-prescribing network, to form SureScripts-RxHub. RxHub's expertise in patient identification and delivering drug benefit information to the physician at the point of care complements SureScripts' focus on electronic prescription routing from the physician's office to the pharmacy. The new company forms a single, secure, nationwide network for e-prescriptions and the exchange of health information

Multi-Specialty Group Practice

Multi-specialty group practices are defined as a group of physicians in a number of specialties providing a continuum of care for a community. These group practices may engage in a number of managed care contracts to provide care—including that of medication therapy. Many multi-specialty groups employ pharmacists to advise on medication such as formulary management and medication therapy. They may also work with individual patients by providing medication therapy management.



Community Pharmacy

Community pharmacies also are involved in managed care pharmacy. Chain and independent pharmacies provide prescription services for members of most managed care delivery systems. Health plans, pharmacy benefit management companies and other managed care organizations contract with community pharmacies to create a network that provides drug dispensing and other services at negotiated rates. The community pharmacist is responsible for providing necessary patient care services as well as for processing prescriptions and sending the claim information to the managed care organization via the pharmacy's operating system computer. Although they are not employed by the managed care entity, these community pharmacists are the front line for many managed care organizations. Their face-to-face contact with the patient affects the administration of the pharmacy benefit, the quality of care the patient receives and the ultimate consumer satisfaction with the managed care organization.

Many community chain pharmacy corporations have followed the lead of pharmaceutical manufacturers and developed managed care divisions. In addition, many also operate their own pharmacy benefit management companies and have mail service operations.

“ Managed care pharmacy allows the practitioner to view patient care through all realms of health care—inpatient, outpatient and ambulatory care.”

—Phillip A. Drum, PharmD



Health Benefit Management Firms and Consultants

Health benefit management firms help their purchaser clients evaluate the performance and proposals of managed care organizations. Pharmacists and other employees of health benefit management firms serve as consultants to health care purchasers (such as large corporate employer groups) to assist in determining which managed care organization offers the most appropriate services, integration of benefits and access for their workforce.

Consultant opportunities in managed care go well beyond health benefit management firms. Various managed care organizations or health care purchasers seek pharmacist consultants with experience and training in managed care. The business relationships and policies within managed care have become complex and have led to numerous consulting opportunities for pharmacists who have specialized in managed care.

Pharmaceutical Industry

Pharmaceutical manufacturers work with managed care organizations to optimize pharmacist-provided patient care services and overall medical care, develop treatment algorithms, support disease management programs and outcomes research and develop patient education information.

Pharmacists in the managed care divisions of pharmaceutical manufacturers work as account managers, medical science liaisons, pharmacoeconomists, market researchers and drug information specialists. Their expertise also is used in areas such as marketing, economic modeling, managed care organization contracting and legislative affairs.

Managed care organizations may work with pharmaceutical manufacturers on various projects such as outcomes research and demonstration projects involving medication therapy for certain disease states. Most pharmaceutical manufacturers employ pharmacists in managed care divisions as primary contacts for managed care organizations.



Academia

Academic pharmacists play a critical role in educating and preparing student pharmacists for careers in managed care pharmacy and serve as a valuable resource for student pharmacists. As of Fall 2007, there were more than 4,600 full-time faculty members in the more than 100 schools and colleges of pharmacy in the United States. In addition to teaching, pharmacy faculty members may be involved in various research projects and collaborative activities for managed care. Areas that focus on managed care in academia include administrative management, clinical science, experiential training and continuing education.

A number of schools and colleges of pharmacy offer undergraduate courses in managed care and experiential training opportunities with managed care organizations. Some pharmacy schools and colleges now provide graduate courses in specific aspects of managed care, such as health policy, program development and evaluation, pharmacoepidemiology and pharmacoconomics. Pharmacists also may pursue coursework or degrees in public health and business to acquire specialized knowledge for managed care pharmacy positions.





SECTION THREE



Why Should You Consider a Career in Managed Care Pharmacy?

More than 18,000 pharmacists are employed by health plans and pharmacy benefit management companies. They are responsible for a broad and diverse range of clinical, quality-oriented drug management services. As in other settings, pharmacists in managed care are committed to ensuring that medications are used appropriately and cost-effectively to improve patients' health.

“ Managed care pharmacy offers so many different opportunities and you’re always learning something new. It’s a great way to use your clinical knowledge and loop it in with the business skills that you’ll gain in this field.”

—*Maribeth M. Bettarelli, PharmD, RPh*

Pharmacists are discovering exciting positions in health plans, preferred provider organizations, point-of-service plans, pharmacy benefit management companies, corporate employee benefits firms, consulting firms, pharmaceutical manufacturers and government agencies (e.g., Centers for Medicare & Medicaid Services, Veterans Administration, Public Health Service, Department of Defense) where they can apply their clinical, administrative and pharmacoeconomic knowledge to create better health outcomes for the populations they serve.



What are the roles of pharmacists in managed care organizations?

Pharmacists' roles in managed care are varied. Some of the more prominent categories include the drug distribution process; patient safety; clinical program development; communications with patients, prescribers and other pharmacists; plan benefit design; business management; and cost management.

Formulary System Management

Managed care pharmacists develop documents that provide background for clinical decisions made as part of the pharmacy & therapeutics (P&T) committee deliberations. Pharmacists involved in the formulary development process are responsible for:

- Assessing peer-reviewed medical literature, including randomized clinical trials, pharmacoeconomic studies and outcomes research data,
- Employing evidence-based practice guidelines,
- Comparing efficacy as well as the type and frequency of side effects and potential drug interactions among alternative drug products,
- Evaluating drug products in terms of their impact on total health care costs,
- Preparing clinical therapeutic drug class monograph reviews for P&T committees, and
- Developing and maintaining clinical coverage criteria to support the formulary.

Drug Distribution Process

Managed care pharmacists manage the drug distribution process through:

- The managed care organization's pharmacy,
- A community pharmacy network,
- Mail service or online services, and
- Collaboration with physicians and other health care providers.



Patient Safety

Managed care pharmacists help to ensure patient safety by analyzing prescription claims data to identify problematic prescription use patterns, intervening with prescribers and patients to help correct such problems and educating prescribers. They also design and administer the following to ensure patient safety:

- Drug utilization review (DUR) programs,
- Prior authorization (PA) programs,
- Monitoring programs, and
- Quality assurance (QA) programs.

Clinical Program Development

To enhance patient care—particularly for patients with chronic conditions whose quality of life depends on prescription drugs—managed care pharmacists design clinical programs that:

- Evaluate scientific evidence,
- Assess the effectiveness of treatments,
- Use evidence-based clinical research data to create disease management programs,
- Increase understanding of the ways in which clinical therapies affect quality of life, and
- Conduct outcomes-based research.

“ Being in managed care has helped me learn many areas that I may not have been involved in—it’s broadened my horizons. Without this experience I would not be where I am today. I have found that managed care pharmacists are very helpful and a close-knit family.”

—Deb Schering, PharmD



Communications with Patients, Prescribers and Pharmacists

Managed care pharmacists design and use communication protocols to ensure that there is an exchange of necessary information among patients, their physicians and their pharmacists. Activities may include:

- Helping physicians and other prescribers choose medications.
- Providing patients with information about their individual prescription histories.
- Educating patients about medications.
- Helping patients manage their health care.

Plan Benefit Design

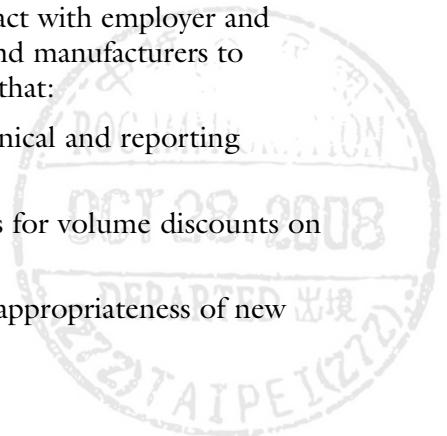
Managed care pharmacists collaborate with other health care professionals to design effective benefit structures that will serve a population's needs by determining:

- Whether a formulary should be used,
- How to structure a “participating” pharmacy network, and
- What criteria and procedures for drug utilization should be established.

Business Management

Managed care pharmacists contract with employer and health plan clients, pharmacies and manufacturers to structure business arrangements that:

- Allow clients to customize clinical and reporting requirements.
- Negotiate with manufacturers for volume discounts on drug prices for clients.
- Assist clients in assessing the appropriateness of new drugs.





Here is a sampling of pharmacists' positions in managed care organizations.

Director of Pharmacy: Oversees pharmacy administrative activities such as benefit design, dispensing practices, quality assurance, the pharmacy and therapeutics (P&T) committee and formulary development, drug utilization review, disease management and contracting with pharmacy networks and pharmaceutical manufacturers.

Director of Clinical Services: Coordinates clinical partnership strategies with pharmacy benefit management companies, managed care organizations and pharmaceutical manufacturers. Also may create and administer the managed care organization's medication therapy management programs.

Drug Information Specialist: Provides drug information to health care professionals, patients and the public; evaluates coverage positions; develops monographs for P&T committees; establishes clinical practice guidelines; and writes pharmacy newsletters for managed care organization staff.

Clinical Pharmacy Manager: Designs and implements clinical pharmacy programs for pharmacy benefit management companies and health plans and evaluates the performance of the clinical programs.

Clinical Specialist/Academic Detailer: Works to educate physicians regarding clinically appropriate and cost-effective prescribing.

Staff Pharmacist: In a group-model or staff-model HMO, primarily dispenses medications, delivers patient-care services, counsels patients and performs drug utilization review with objectives of managed care in mind.

Clinical Pharmacist: Often specializes in specific disease states, such as infectious disease or oncology, in which drug therapy is a primary treatment modality; attends rounds with physicians in hospitals and prepares drug selection analyses for P&T committees.

Call Center Pharmacist: Provides telephone-based patient and prescriber education, patient counseling, drug information and customer service, as well as drug utilization review, health management and formulary management to promote effective drug therapy. Call center pharmacists are employed primarily in HMOs, pharmacy benefit management companies and health plans, but they also may be found in other environments.



Cost Management

Managed care pharmacists help their clients (employers, HMOs, Medicaid, etc.) evaluate and improve their pharmacy benefit by:

- Encouraging prescribers to make cost-effective drug choices.
- Integrating improvements so that costs are actually saved.
- Introducing system interventions that enhance quality.
- Using data to identify adherence and nonadherence with prescribing guidelines.

To learn more about each of these areas, refer to AMCP's *The Roles of Pharmacists in Managed Health Care Organizations*, which is available on the AMCP web site (www.amcp.org).

When Should You Begin Preparing for a Career in Managed Care Pharmacy?

Opportunities for pharmacists are found in community pharmacy, hospital pharmacy and managed care pharmacy settings as well as in the pharmaceutical industry. No matter which practice area you choose as a career path, managed care will affect it. That is why it is critical to learn about managed care pharmacy as a student pharmacist.

There are a variety of resources available, but the best way to learn about managed care pharmacy is through an experiential training experience, an internship, or a residency program.

“ My role as a managed care pharmacist has been both a challenging and rewarding experience for me. I enjoy the many opportunities available to me as a pharmacist employed with a PBM—I have been able to work in a variety of roles and I truly enjoy using my clinical skills every day.”

—Kim Hedstrom, PharmD



“ A career in managed care pharmacy is a hidden jewel! Patient-focused care—it’s everything most all of us hoped to do when we chose this profession.”

—Karen W. Lee, PharmD, BCPS

You also can learn about managed care pharmacy and meet current managed care professionals by joining AMCP. You will find that AMCP provides a supportive environment for student pharmacists, enhancing your credentials and broadening your access to opportunities in managed care pharmacy organizations.

Managed Care Pharmacy Internships

Exposure to managed care operations can be a most enriching experience. Many managed care organizations offer summer internships. In these settings, AMCP members can mentor your development and advise you on steps you can take to enhance your career choices. A listing of internship sites, with descriptions and application information, can be found on the AMCP web site (www.amcp.org).

AMCP/FMCP Summer Internships

AMCP and the Foundation for Managed Care Pharmacy (FMCP) offer 10-week summer internships that include placement at a managed care organization and pharmaceutical manufacturer with a 1-week rotation at AMCP headquarters. Interns are selected through a national application process; applications typically are due in January each year. Applicants must be enrolled full time in an ACPE-accredited school or college of pharmacy and in the second or third year of a 4-year Doctor of Pharmacy degree program. Visit the FMCP web site (www.fmcenet.org) to access additional information about the AMCP/FMCP Summer Internships.



Residencies in Managed Care

Understanding health care delivery system dynamics and current health policy debates is crucial for a well-rounded pharmacy education today. Residencies expose pharmacists to the latest tools and techniques of managed care pharmacy.

Residencies typically are 1-year postgraduate training programs in general or specific pharmacy practice. Postgraduate year one (PGY1) pharmacy residency training is an organized, directed, accredited program that builds on the knowledge, skills, attitudes and abilities gained from an accredited professional pharmacy degree program. The PGY1 residency program enhances general competencies in managing medication-use systems and supports optimal medication therapy outcomes for patients with a broad range of disease states.

AMCP has partnered with the American Society of Health-System Pharmacists (ASHP) in the accreditation of residency programs in managed care pharmacy. Student pharmacists in their final year of school are eligible to apply for admission into residency programs. Positions in accredited residency programs are offered to applicants through the ASHP Resident Matching Program. The deadline for submission of applicant and program Rank Order Lists typically is in early March, with the actual matching process occurring later in the month. As of July 2008 there were 44 managed care residency programs, 31 of which were accredited or in the process of becoming accredited.

“ Managed care offers pharmacists unlimited opportunities to make a difference. Instead of treating one patient at a time, you have the potential to impact several thousand patients through medication therapy management programs, counseling, formulary and benefit design programs.”

—Jean Brown, PharmD, RPh, FAMCP



One way to get to know the managed care residency programs is by attending the AMCP Residency Showcase held each fall in conjunction with the AMCP Educational Conference. A complete list of managed care residencies with descriptive information for applying also may be found in the September or October issue of the *Journal of Managed Care Pharmacy* each year.

For the most current information on managed care residencies, visit the AMCP web site at www.amcp.org. For the most current information on the Resident Matching Program, visit the ASHP web site (www.ashp.org).







SECTION FOUR



Academy of Managed Care Pharmacy: How Do You Get Involved?

AMCP History & Background

In 1988, eight visionary pharmacists came together at the Northwestern University Kellogg Management Institute in Evanston, Illinois, to discuss the need to establish a professional organization for managed care pharmacists. They worked quickly to make this a reality and the Academy of Managed Care Pharmacy (AMCP) was formed in 1989.

AMCP

Academy of
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AMCP is a professional association of individual pharmacists who use the tools and techniques of managed care in the practice of pharmacy. As an organization, the Academy strives to achieve its mission of empowering members to serve society by providing opportunities for continued professional growth and by advancing individual and collective knowledge. Throughout the year, AMCP provides conferences, online learning opportunities, peer-reviewed articles and leadership development seminars. Each is designed with the goal of advancing professional knowledge, improving the design and delivery of pharmacy benefits and ultimately increasing patient satisfaction and health outcomes.



AMCP Vision, Mission and Strategic Objectives

AMCP Vision: Managed care pharmacy improving health care for all.

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

AMCP Strategic Goals

- **Advocacy Goal:** AMCP will effectively represent the interests of the membership in public policy that affects medication management services, medication therapy access and medication use to improve health care for all.
- **Member Services Goal:** Members will obtain value from the Academy's programs and services to satisfy their needs and expectations.
- **Professional Affairs Goal:** AMCP will be the primary source of knowledge and standards about the practice of pharmacy in the area of population-based care that optimizes medication therapy.
- **Outreach Goal:** AMCP will expand the use of managed care pharmacy principles to improve health care by leveraging external relationships.
- **Organizational Strength Goal:** AMCP will be a dynamic member- and profession-focused organization.
- **Student Pharmacist Strategy Goal:** AMCP will expose student pharmacists to the practice of managed care pharmacy and its rewarding career opportunities.

“ Student pharmacists truly represent the future of pharmacy and more importantly managed care pharmacy. There is no employment setting in pharmacy today that does not utilize one or more managed care pharmacy techniques. AMCP and its membership feel a profound responsibility to make sure that student pharmacists have opportunities to learn how to use these tools effectively. Only through the proper deployment of managed care pharmacy tools will patient care truly be enhanced.”

—Cathy Carroll, AMCP President 2008–09



AMCP & Student Pharmacists

AMCP welcomes student pharmacists in its membership. There were more than 1,100 student pharmacist members in 2008. Here are just a few of the reasons why membership in AMCP is important to your career in managed care pharmacy.

- 1. Get answers to your managed care pharmacy questions.** AMCP's web site—www.amcp.org—gives you access to a wealth of information, including the ASCENT Center exclusively for student pharmacist members. These resources are sure to be useful as you get involved in class assignments, internships and your pharmacist career.
- 2. Find career opportunities.** If you're looking for a position in managed care pharmacy, be sure to visit the Career Center at www.amcp.org. Not only can you search job listings, you can post your curriculum vitae (CV) for potential employers to see. Finding your first position will be much easier with AMCP on your side—and on your CV.
- 3. Explore the possibilities in managed care.** Investigate the online ASCENT Center and enhance your awareness and knowledge of managed care pharmacy. Check out the new video about AMCP and managed care pharmacy, learn about the roles of pharmacists in managed care, find a summer internship on a new and improved page, view a list of managed care pharmacy residencies and more!
- 4. Discover new trends in managed care pharmacy.** Stay on the cutting edge with subscriptions to the *Journal of Managed Care Pharmacy (JMCP)*, *AMCP News* and the electronic *Weekly News*—all part of your AMCP membership!
- 5. Profit from great networking.** Meet fellow student pharmacists and a network of managed care pharmacists who share your interests and may shape your career.
- 6. Build your leadership skills.** Numerous leadership and volunteer opportunities await you now and after graduation. Getting involved in AMCP allows you to develop your leadership skills and build your professional network.



7. Prove your commitment to managed care pharmacy.

When you join AMCP, you're clearly demonstrating your commitment to managed care pharmacy practice. That's one commitment employers all over the country will respect!

8. Advance the future of managed care pharmacy.

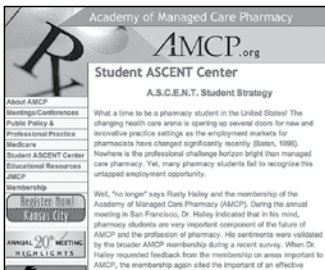
As an AMCP member, you'll join more than 5,700 managed care pharmacists, students and other health care professionals dedicated to sound medication management principles and strategies to improve health care for all.

9. AMCP Student Chapters.

As an AMCP member you can be a part of or start an AMCP Student Chapter at your school!

AMCP Web Site and the Student ASCENT Center

You will find a wealth of information and resources to navigate on the AMCP web site—www.amcp.org. Plus, you will find the AMCP ASCENT Center just for you—today's student pharmacist interested in managed care pharmacy practice.



The ultimate goal of the ASCENT Center Web-based resource is to provide the tools necessary to augment knowledge and skills so that student pharmacists can become highly effective contributors to managed care pharmacy immediately after graduation. ASCENT represents a six-step

strategy to enhance a student pharmacist's awareness and knowledge of managed care pharmacy.

The ASCENT Center...

- Provides **Awareness** and **Access** to information specific to managed care pharmacy principles and practices.
- Challenges employers and the academic community to provide **Shadowing** opportunities for student pharmacists in managed care pharmacy.
- Highlights the importance of a student pharmacist's **Connectivity** with AMCP, Diplomats, employers, learning opportunities and other student pharmacists.



- **Encourages** student pharmacists to **Expand** their knowledge and skills in managed care pharmacy.
- Assists student pharmacists in understanding the managed care pharmacy world and the employment opportunities they must **Navigate** before and after graduation.
- Provides student pharmacists links to opportunities for **Training** and reinforces the responsibility that each AMCP member has to build the next generation of talent to carry an evolving toolbox of managed care principles and practices into the future.

AMCP Student Pharmacist Chapters

The first AMCP Student Chapter was formed at the University of Illinois at Chicago in 1995. As of Fall 2008, AMCP Student Chapters are active in 30 schools and colleges of pharmacy. AMCP Student Chapters conduct a number of projects at their school or in the community including men-



toring programs for students interested in pharmacy school, asthma awareness programs, managed care career panels and events with speakers from managed care practice. Visit the AMCP web site for a current list of AMCP Student Chapters.

AMCP Student Chapters also are eligible to compete in the national AMCP/FMCP

Pharmacy & Therapeutics (P&T) Competition, which is held in conjunction with the AMCP Annual Meeting & Showcase. This competition challenges chapter members by simulating a real-world experience implementing AMCP's *Format for Formulary Submissions*. Eight AMCP Chapters are invited to participate each year.

For additional information on AMCP Student Chapters, including how to start a new chapter, visit the AMCP web site.





SECTION FIVE



Where Can You Learn More About Managed Care Pharmacy?

Academy of Managed Care Pharmacy (AMCP)

AMCP is a principal source of managed care pharmacy news, resources, position statements, continuing education and more.

- The *AMCP web site* (www.amcp.org) provides open access to a wide array of information about managed care pharmacy. (Certain areas, such as the Advocacy Center, can be accessed by AMCP members only.)
- The *Journal of Managed Care Pharmacy (JMCP)* is a peer-reviewed research journal published by AMCP. It is the most authoritative and up-to-date source of articles in managed care pharmacy. Student pharmacists receive a subscription with their AMCP membership.
- *AMCP News* is a monthly newsletter produced by AMCP that features information on the latest managed care trends and issues, including employment opportunities. Student pharmacists receive AMCP News with their AMCP membership.
- *AMCP Weekly e-News* keeps members informed about AMCP news and deadlines, along with managed care and health care news from the week. This quick read e-mail is sent to all members each Friday.



Foundation for Managed Care Pharmacy (FMCP)

The Foundation for Managed Care Pharmacy is a 501(c)3 nonprofit charitable trust that is the educational and philanthropic arm of AMCP. The Foundation supports the goals and mission of AMCP and exists to advance the knowledge and insights of those interested in the major issues associated with the practice of pharmacy in managed health care settings.

Managed Care Textbooks and Journals

There are a number of resources that can provide a solid foundation in the history, operations and issues of managed care pharmacy. Some of these resources are described in detail below.

BOOKS

You can check your campus library for these books or purchase them from any of the online book sellers.

- *The Essentials of Managed Health Care* (2001), by Peter Kongstvedt, is a textbook that provides an introduction to managed health care concepts.
- *The Managed Health Care Handbook* (2000), by Peter Kongstvedt, offers insights into the critical issues of managed care and an overview of the complex managed care environments and methods.
- *Managed Care Pharmacy Practice, 2nd edition* (2008), edited by Robert Navarro, PharmD, is the authoritative textbook on the managed care pharmacy practice.
- *Managed Care: What It Is and How It Works* (2004), by Peter Kongstvedt, provides a solid grounding in and clear understanding of managed health care concepts.
- *PBM Formulary Strategies and Their Impact on Payers* (2003), by Tim Watson, provides an overview of how PBMs use formularies to control costs while balancing clinically appropriate treatment.



PERIODICALS

Many of these periodicals offer online viewing for free; however, a number of them require subscriptions. You may wish to check with your campus library for access.

- *Business and Health* (businessandhealth.com) is a publication providing coverage and analysis of insurance, business and the health care industry.
- *Disease Management* (www.liebertpup.com) is a bimonthly, international, peer-reviewed periodical that covers the clinical and business aspects of disease management. It is the official journal of DMMA: The Care Continuum Alliance.
- *Formulary* (www.formularyjournal.com) is a peer-reviewed drug management journal for decision-makers in managed care organizations and hospitals.
- The *Journal of Managed Care Pharmacy (JMCP)* is a peer-reviewed research journal published by AMCP. It is the most authoritative and up-to-date source of articles in managed care pharmacy. Student pharmacists receive a subscription with their AMCP membership.
- *Managed Care Magazine* (www.managedcaremag.com) is a guide for health plan executives and physicians on capitation and other health insurance and delivery issues.
- *Managed Care Interface* (www.medicomint.com) is a monthly peer-reviewed journal of original research, clinical reviews, pharmacy practice studies and health economic investigations in the managed care industry. It is the official journal of the P&T Society.
- *Managed Healthcare Market Report* (www.corpreasrch-group.com) is a twice-monthly periodical devoted to competitive analysis for providers and purchasers of managed care. It is published by the Corporate Research Group.
- *Managed Healthcare Executive* (<http://managedhealthcareexecutive.modernmedicine.com>) is a monthly controlled-circulation magazine that provides in-depth analysis on the business of health care. It is published by Advanstar Communications.



- *Pharmacy & Therapeutics P&T Journal* (www.ptcommunity.com) is a peer-reviewed journal for managed care and hospital formulary management. It is published by Medimedia USA.
- *PharmacoEconomics* (<http://pharmacoeconomics.adisonline.com>) is a monthly benchmark journal for peer-reviewed articles on the application of pharmacoeconomics and quality-of-life assessment to optimum drug therapy and health outcomes. It is published by Wolthers Kluwer/Adis.
- *Value in Health* (www.blackwellpublishing.com) is a multidisciplinary, peer-reviewed journal reporting on evaluations of medical technologies. It is the official journal of the International Society for Pharmacoeconomics and Outcomes Research.

Reports and Other Resources

Many of the reports and other resources listed below can be found on the publisher's web site or can be requested from the organization.

- *AHIP Survey of Health Insurance Plans: Chart Book of Findings, America's Health Insurance Plans, 2002*, reports data from a periodic survey of US health plans. Available at www.ahip.org.
- *AMCP Format for Formulary Submissions*, Academy of Managed Care Pharmacy, Version 2.1, is a set of guidelines and a template that drug companies can use to prepare submissions of new and existing pharmaceuticals for a pharmacy and therapeutics (P&T) committee. Available at www.amcp.org.
- *AMCP Guide to Pharmaceutical Payment Methods*, Academy of Managed Care Pharmacy, 2007, is a comprehensive, factual description and analysis of alternative drug payment methods and payment systems. It includes a glossary of payment terms, tables showing which payers and settings utilize which methods, payment flowcharts to illustrate how the money flows with each of the payment systems and examples of payment calculations. The executive summary, complete report and online resource library are available at www.amcp.org.



- *Concepts in Managed Care Pharmacy*, Academy of Managed Care Pharmacy, is a series of papers written to explain managed care pharmacy terms and concepts and clearly describe how these concepts are implemented in the managed care setting. Topics include disease management, drug use evaluation, formulary management, maintaining the affordability of the prescription drug benefit, medication errors, medication stockpiling, outcomes research, patient confidentiality, pharmaceutical care, pharmacists' cognitive services, prior authorization and the formulary exception process and specialty pharmaceuticals. Available at www.amcp.org.
- *Drug Trend Report 2008*, Express Scripts, is an annual publication that seeks to provide a better understanding of the dynamics underlying current drug cost increases and future drug cost trends. Available at www.express-scripts.com.
- *DrugTrend Report*, Medco, is an annual publication that provides an in-depth review of the changes contributing to prescription drug spending during the previous year and forecasts for the coming year. Available at www.medco.com/media room.
- *The Framework for Quality Drug Therapy*, published by the Foundation for Managed Care Pharmacy, is a self-assessment tool is intended to be used by individual pharmacists and other health care practitioners and by organizations of virtually any size, from a physician's office to a large corporate health plan, to identify, evaluate and improve upon specific task, skills and functions that contribute to effective medication therapy management. Available at <http://www.fmcenet.org/index.cfm?p=132D8447>.
- *Managed Care Digest Series: HMO-PPO Digest*, sanofi-aventis, 2007, is a comprehensive overview of managed care health plans that monitors trends, establishes benchmarks and identifies opportunities for managed care organizations. Available from sanofi-aventis.



- *The Medco Monitor*, Medco, 2006, is a national market research study that reviews what consumers value most and least in prescription benefit plans. Available at www.medco.com/media room.
- *Navigating the Pharmacy Benefit Marketplace*, California Healthcare Foundation, 2003, provides an in-depth look at the forces that influence pricing in health care. Available at www.chcf.org.
- *Roles of a Pharmacist in Managed Care Pharmacy*, Academy of Managed Care Pharmacy, 2008, is a brochure that describes pharmacists' roles in managed care. Available at www.amcp.org and by request through AMCP.
- *Sound Medication Therapy Management Programs (Version 2.0 with Validation Study)*, a supplement to the *Journal of Managed Care Pharmacy*, is a consensus document that outlines the specific elements that would constitute a sound MTM program. In 2008, the document was validated through a National Committee for Quality Assurance (NCQA) validation process and updated. Available at http://www.amcp.org/data/jmcp/JMCPSuppB_Jan08.pdf.
- *TrendsRx Report*, CVS Caremark, is an annual publication that provides an in-depth look at the factors that drove pharmacy trends during the previous year and previews factors that will affect trends during the upcoming year. Available on www.caremark.com.





SECTION SIX



Glossary of Key Managed Care Terms

This section includes a sampling of managed care terms. For a complete glossary of managed care terms, visit the AMCP web site (www.amcp.org) and navigate to the ASCENT Student Center.

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

Accreditation: Accreditation programs give an official authorization or approval to an organization by comparing the organization with a set of industry-derived standards. The National Committee on Quality Assurance (NCQA) accredits health plans.

Actuaries: Insurance professionals who perform the mathematical analyses necessary for assessing risks and setting insurance premium rates.

Adherence (also referred to as compliance): The ability of a patient to take their medication or follow a treatment protocol according to directions; taking the prescribed dose of medication at the prescribed frequency for the prescribed length of time.



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

Adverse Selection: A phenomenon that occurs within the mix of covered lives for a plan, when patients with high health care utilization habits select a particular plan in greater numbers than are otherwise representative of the population as a whole.

Ambulatory Care: Health services delivered on an outpatient basis. If the patient makes the trip to the doctor's office or surgical center without an overnight stay, it is considered ambulatory care; if the patient is treated at home, it is not.

Benchmarking: A method of identifying the level of performance that can be related to specific outcomes of a particular procedure, intervention, or process. The goal is to identify "best practices." Benchmarking is frequently used as a quality improvement initiative.

Beneficiary (Insured): The primary person receiving the benefit coverage. This information is maintained on the eligibility file of the plan sponsor. If the client can provide the information, dependent names are also maintained.

Benefit Design: A process of determining what level of coverage or type of service should be included within a health plan or specific product, at specified rates of reimbursement, based on a multiple of relatively nonstandardized and often unique factors such as market pressure, cost, clinical effectiveness and medical evidence, legislated mandate, medical necessity and preventive value.

Benefit Package: The services that an insurer, a government agency, a health plan or an employer offers to an enrollee under the terms of a contract.



Capitation: A per-member monthly payment to a provider that covers contracted services and is paid in advance of service delivery. In essence, a provider agrees to provide specified services to HMO members for this fixed, predetermined payment for a specified length of time (usually a year), regardless of how many times the member uses the service. The rate can be fixed for all members or adjusted for the age and sex of the member, based on actuarial projections of medical utilization.

Carve-out: Within a capitation environment, a type of service not included as an agreed service to be provided within the contract; typically high-volume or high-cost services or areas where specialty expertise can reduce costs for that segment.

Centers for Medicare & Medicaid Services (CMS):

Previously known as the Health Care Financing Administration (HCFA); the federal agency responsible for administering Medicare and overseeing states' administration of Medicaid and the Office of Prepaid Healthcare Operations and Oversight (OPHCOO), which in turn oversees health maintenance organizations (HMOs).

Certificate of Coverage (COC): The basic document listing all health care benefits within the plan, as required by state law to reflect the contract as negotiated between employer and plan and shared with the employee.

Certificate of Insurance: Document delivered to an individual that summarizes the benefits and principal provisions of a group insurance contract.

Claim: Information submitted by a provider or covered person to establish that medical services were provided to a covered person; the basis for processing payment to the provider or covered person.



Consumer Directed Health Plan (CDHP): A health plan that affords beneficiaries more direct control over medical decisions and costs. Typically, a health spending account funded by the employer and that can be rolled over from year to year. Generally, a “defined contribution,” such as a specific dollar amount, is placed in this account by the employer for the employee. The deductible is funded by the employee and used after the health spending account is exhausted; health insurance is triggered after the deductible is met. Employees also may fund medical reimbursement accounts to pay for their share of expenses.

Coordination of Benefits (COB): A system whereby responsibility for claims is determined for a person who is covered by multiple insurers. Under this system, each person with multiple coverages has primary and secondary insurance based on a set of industry rules. COB rules are designed to prevent duplicate payments for the same service.

Coinsurance: The percentage of the costs of medical services paid by the patient. This is a characteristic of indemnity insurance and preferred provider organization plans. The coinsurance usually is about 20% of the cost of medical services after the deductible is paid.

Copayment: A nominal fee charged to managed care organization members to offset the costs of paperwork and administration for each office visit or pharmacy prescription filled. A cost-sharing arrangement in which a covered person pays a specific 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 and a higher charge such as \$25.00 for a non-formulary product).

Cost-effectiveness: The relationship, usually considered as a ratio, between the cost of a drug or procedure and the health benefits resulting from it. In health care terms, it is often expressed as the cost per year per life saved or as the cost per quality-adjusted life-year saved.

Deductible: A fixed amount of health care dollars a person must pay in full before his or her insurance coverage begins.



Disease Management: A philosophy toward the treatment of the patient with an illness (usually chronic) that seeks to prevent recurrence of symptoms, maintain high quality of life and prevent future need for medical resources by using an integrated approach to health care. Pharmaceutical care, continuous quality improvement, practice guidelines and case management all play key roles in this effort, which also should result in decreased health care costs.

Dispensing Fee: Contracted rate of compensation paid to a pharmacy for the processing and filling of a prescription claim. The dispensing fee is added to the negotiated formula for reimbursing ingredient cost.

Drug Utilization Review (DUR): A system of drug use review that can detect potential adverse drug interactions, drug–pregnancy conflicts, therapeutic duplication, drug–age conflicts, etc. There are three forms of DUR: prospective (before dispensing), concurrent (at the time of prescription dispensing) and retrospective (after the therapy has been completed). Appropriate use of an integrated DUR program can curb drug misuse and abuse and monitor quality of care. DUR can reduce hospitalization and other costs related to inappropriate drug use.

Electronic Medical Record (EMR): An automated, on-line medical record that is available to any number of providers, ancillary service departments, pharmacies and others involved in patient treatment or care, as a result of computer technology that stores, processes and retrieves patient clinical and demographic information upon request of the user.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that regulates employer-sponsored benefit plans and restricts state government from regulating these plans. This law mandates reporting and disclosure requirements for group life and health plans with relevant guidance on the sponsorship, administration, minimum record retention period, servicing of plans, some claims processing, appeals regulations and minimum mandatory clinical benefits.



Exclusions: Drugs not covered under the pharmacy benefit of the health plan. Examples of drug exclusions include cosmetic and fertility drugs, investigational drugs and over-the-counter (OTC) products.

Fee-for-Service (FFS): Traditional provider reimbursement, in which the physician is paid according to the service performed. This is the reimbursement system used by conventional indemnity insurers. The full rate of charge for a patient without any type of insurance arrangement, discounted arrangement or prepaid health plan.

Formulary: A specific list of drugs that is included with a given plan for a client. A continually updated list of medications, related products and information, representing the clinical judgment of physicians, pharmacists and other experts in the diagnosis and/or treatment of disease and promotion of health. Types include closed formulary, negative formulary and open formulary.

Gatekeeper: An individual, usually the primary physician, designated by the health maintenance organization to screen patients seeking medical care and eliminate costly and sometimes needless referrals to specialists for diagnosis and management. The gatekeeper is responsible for the administration of the patient's treatment and must coordinate and authorize all medical services, laboratory studies, specialty referrals and hospitalizations.

Healthcare Effectiveness Data & Information Set (HEDIS): The result of a coordinated development effort by the National Committee for Quality Assurance (NCQA) to provide a group of performance measures that gives employers some objective information with which to evaluate health plans and hold them accountable. HEDIS helps to ensure that plans and purchasers of care are speaking the same language when they are comparing value and accountability. (HEDIS is a registered trademark of NCQA.)



Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law that outlines the requirements employer-sponsored group insurance plans, insurance companies and managed care organizations must satisfy to provide health insurance coverage in the individual and group health care markets. It establishes national standards for electronic health care transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of health data.

Health Maintenance Organization (HMO): A form of health insurance in which members prepay a premium for health services, generally including inpatient and ambulatory care. For the patient, it means reduced out-of-pocket costs (e.g., no deductible), no paperwork (e.g., insurance forms) and only a small copayment for each office visit to cover the paperwork handled by the HMO. There are several different types of HMOs.

Staff-Model HMO: The staff-model HMO is the purest form of managed care. All of the physicians in a staff-model HMO practice at a centralized site where all clinical and perhaps inpatient services and pharmacy services are offered. The HMO holds the tightest management reigns in this setting because the physicians usually do not also see fee-for-service patients. Physicians are more likely to be employees of the HMO in this setting, because they are not in a private or group practice.

Group-Model HMO: In the group-model HMO, the HMO contracts with a physician group, which is paid a fixed amount per patient to provide specific services. The administration of the group practice then decides how the HMO payments are distributed to each participating physician. This type of HMO is usually located in a hospital or clinic setting and may include a pharmacy. These physicians usually do not have any fee-for-service patients.



Independent Practice Association (IPA): The individual practice association contracts with independent physicians who work in their own private practices and see fee-for-service patients as well as HMO enrollees. They are paid by capitation for the HMO patients and by conventional means for their fee-for-service patients. Physicians belonging to the IPA guarantee that the care needed by each patient for whom they are responsible will not exceed a predetermined spending limit. They guarantee this by allowing the HMO to withhold an amount of their payments (usually about 20% per year). If, by the end of the year, the physician's cost for treatment falls under this set amount, the physician receives the entire "withhold fund." If the cost for treatment exceeds the set amount, the HMO can withhold any part of the "withhold fund" at its discretion. Essentially, the physician is put "at risk" for keeping treatment costs down. This is the key to the HMO's financial viability.

Network-Model HMO: A network of group practices under the administration of one HMO.

Health Maintenance Organization Act of 1973: Federal legislation that sought the development of HMOs, preempted restrictive state laws, required employers to offer dual choice for federally qualified HMOs and set standards for federal qualification of HMOs.

High Deductible Health Plan (HDHP): A medical plan that has specified minimum limits for the annual deductible and maximum limits for out-of-pocket expenses. An HDHP must have a minimum deductible of \$1,000 for individual coverage or \$2,000 for family coverage. Annual out-of-pocket expenses must not exceed \$5,000 for individual coverage or \$10,000 for family coverage. The amounts for deductible and out-of-pocket maximum are indexed annually for inflation in \$50 increments.

Indemnity Insurance: Traditional fee-for-service (FFS) medicine in which providers are paid according to the service performed.



Medicaid: An entitlement program of medical aid funded by the federal and state governments but administered at the state level to provide preventive, acute and long-term benefits with little or no patient cost sharing. Benefits are provided according to established criteria to the poor, aged, blind and disabled, as well as to families with dependent children. The federal government matches each state's contribution on a certain minimal level of available coverage. The states may institute additional services, but at their own expense. Waivers by the federal government are required for managed care organization utilization within states.

Medical Loss Ratio (MLR): The amount of revenues from health insurance premiums that is spent to pay for the medical services covered by the plan. Usually expressed as a ratio; for example, an MLR of 0.96 means that 96% of premiums were spent on purchasing medical services.

Medicare: A national program of health insurance that has been operated by the Centers for Medicare & Medicaid Services (CMS) on behalf of the federal government since 1965, when it was created by Title XVIII—Health Insurance for the Aged as an amendment to the Social Security Act. Medicare provides health insurance benefits primarily to persons older than 65 years of age and others who are eligible for Social Security benefits. It covers the cost of hospitalization, medical care and some related services.

Part A: An insurance program (also called Hospital Insurance program) that provides basic protection against the costs of hospital and related post-hospital services for individuals 65 years of age or older and eligible for retirement benefits under the Social Security or Railroad Retirement System. Part A pays for inpatient hospital, skilled nursing facility (SNF) and home health care. The Hospital Insurance program is financed from a separate trust fund, primarily funded with a payroll tax levied on employers, employees and the self-employed.

Part B: The Medicare component that provides benefits to cover the costs of physicians' professional services, whether the services are provided in a hospital, a physician's office, an extended-care facility, a nursing home or the insured's home.



Part D: The Medicare component that provides benefits to cover the costs of outpatient prescription drugs. Benefits commenced on January 1, 2006, and are administered through private pharmacy benefit management companies or Medicare Advantage health plans.

Medicare Advantage (MA-PD): Previously called Medicare+Choice. A program under which a nongovernment entity arranges for all Medicare-covered services, including physicians, laboratory tests, hospital services and prescription drugs.

Member: A participant in a health plan.

Outcome: Also called health outcome; the result of a process of prevention, detection, or treatment; an indicator of the effectiveness of health care measures on patients.

Outcomes Research: Studies that evaluate the effect of a given product, procedure, or medical technology on health or costs. Outcomes research information is vital to the development of practice guidelines. Outcomes research includes the following:

Outcomes Management: The systematic effort to improve health care results, typically by modifying practices in response to information obtained through outcomes measurement, then re-measuring and re-modifying.

Outcomes Measurement: A method of systematically monitoring a patient's medical or surgical intervention or nonintervention together with the associated responses, including measures of morbidity and functional status; findings from outcomes studies enable managed care entities to outline protocols according to their findings.

Pharmaceutical Care: A health care concept defined by Hepler and Strand in 1990; it is a strategy that attempts to use drug therapy more efficiently to achieve definite outcomes that improve a patient's quality of life. A pharmaceutical care system requires a reorientation of physicians, pharmacists and nurses toward effective drug therapy outcomes. It is a set of relationships and decisions through which pharmacists, physicians, nurses and patients work together to design, implement and monitor a therapeutic plan that will produce specific therapeutic outcomes.

**Pharmacy Benefit Management (PBM) Firm:**

Organizations that manage pharmaceutical benefits for managed care organizations, other medical providers or employers. PBM firms contract with clients interested in optimizing the clinical and economic performance of their pharmacy benefit. PBM activities may include some or all of the following: benefit plan design; creation or 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 and health management.

Plan: An outline of covered items, dispensing limitations and payment guidelines contained on the plan database, as determined by the plan sponsor.

Point-of-Service (POS) Plan: Sometimes referred to as an “open-ended” HMO. The point-of-service model is one in which the patient can receive care either from physicians who contract with the HMO or from other physicians. Physicians who see an HMO patient but do not contract with the HMO are paid according to the services performed. The patient is encouraged to use contracted providers through incentives that pay a greater portion of the fee for contracted care.

Preferred Provider Organization (PPO): A managed care organization in which physicians are paid on a fee-for-service (FFS) schedule that is discounted, usually about 10% to 20% below normal fees. PPOs often are formed as a competitive reaction to health maintenance organizations (HMOs) by physicians who enter into contracts with insurance companies, employers or third-party administrators. A patient can use a physician outside of the PPO providers, but he or she will have to pay a greater portion of the fee.



Quality of Life (QOL) Measures: An assessment of how patients deal with their disease or with their everyday life when suffering from a particular condition. Quality of life measures are subjective in the sense that the kinds of information obtained cannot be measured objectively. They have been a part of the health care literature for at least 20 years but have been used in the area of pharmaceuticals only recently (in the last 5 or 6 years). Through statistical means, the indices that have been developed to measure various aspects of quality of life have been validated over time, and we know that these measures are reliable and reproducible.

Risk Adjustment: A system of adjusting rates paid to managed care providers to account for the differences in beneficiary demographics, such as age, gender, race, ethnicity, medical condition, geographic location, etc.

Self-Funded/Self-Insured: An approach in which employers pay employee health care costs directly and assume all of the financial risk and liability that would normally be covered by an insurance company.

Standard of Care: A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance.

Third Party Administrator (TPA): A company that handles the administration of a program for a group or insurance company.

Utilization Review (UR): Performed by the health maintenance organization (HMO) to discover if a particular physician-provider or other provider (e.g., pharmacy) is spending as much of the HMO's money on treatment or any specific portion thereof (e.g., specialty referral, drug prescribing, hospitalization, radiologic or laboratory services) as his or her peers.

AMCP Student Pharmacist Membership Application

Please Print

NAME (FIRST/MI/LAST)

SCHOOL-YEAR ADDRESS

SCHOOL-YEAR TELEPHONE

PERMANENT ADDRESS

PERMANENT TELEPHONE

CELL PHONE

PRIMARY E-MAIL ADDRESS

ALTERNATE E-MAIL ADDRESS

SCHOOL/COLLEGE OF PHARMACY

YOUR ANTICIPATED DATE OF GRADUATION

AMCP Student Pharmacist Membership Fee \$35.00

- Check enclosed made payable to AMCP for \$35.00 for the national membership.
- Charge \$35.00 to my credit card: Visa MasterCard American Express

CARD NUMBER

EXPIRATION DATE

NAME AS IT APPEARS ON CARD

CARDHOLDER SIGNATURE

There are four easy ways to enroll!

If paying via credit card:

1. Enroll online at www.amcp.org click on "Join"
2. Call the AMCP Membership Department at 800/827-2627
3. Fax this form to AMCP at 703/683-8417

If paying via check or credit card:

4. Mail this form with check or credit card information to:
AMCP Membership Department
100 N. Pitt Street
Suite 400
Alexandria, VA 22314





NOTES







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