REPORT 02 OF THE COUNCIL ON MEDICAL SERVICE (JUN-21)
Continuity of Care for Patients Discharged from Hospital Settings
(Resolution 212-A-19, Second Resolve)
(Reference Committee G)

EXECUTIVE SUMMARY

Medications are frequently prescribed or changed during hospital discharge, and although medication reconciliation is used by hospitals to boost adherence after discharge, barriers to filling or refilling hospital discharge medications remain. Some discharge prescriptions go unfilled due to mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record or other easily accessible tool. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to adverse tiering or prior authorization.

The Council researched numerous strategies employed by hospitals to ensure continuity of care after hospital discharge, as well as health information technology solutions such as real-time pharmacy benefit (RTPB) tools. The Council recognizes that, because inpatient and outpatient formularies differ, ensuring continuous coverage of medications and medical services is not always feasible, in part, because some hospital physicians lack access to patients' outpatient formulary information. Accordingly, the Council recommends that the American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. Additional report recommendations support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications and call for AMA advocacy with the Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services on RTPB technology.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 02-JUN-21

Subject: Continuity of Care for Patients Discharged from Hospital Settings (Resolution 212-A-19, Second Resolve)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 212, which was introduced by the New York Delegation and directed our American Medical Association (AMA) to advocate to ensure that medications prescribed during hospitalization with ongoing indications for the outpatient and other non-hospital-based care settings continue to be covered by pharmacy benefit management (PBM) companies, health insurance companies, and other payers after hospital discharge. The referred second resolve clause was crafted by the reference committee and was assigned by the Board of Trustees to the Council on Medical Service for a report back.

This report discusses strategies to ensure continuity of care and safe transitions after hospital discharge; highlights real-time pharmacy benefit (RTPB) tools intended to generate cost and coverage data at the point of care; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

The intent of the reference committee's second resolve clause of Resolution 212-A-19 is to ensure continuity of care for patients transitioning from a hospital to an outpatient setting by ensuring coverage of hospital prescribed medications that are to be continued after discharge. Adherence to medications has long been recognized to be a key component of effective medical treatment and is associated with decreases in morbidity, mortality, and hospitalizations. As discussed in Council on Medical Service Report 7-I-16, Hospital Discharge Communications, patients often experience medication-related problems during the period following hospital discharge, and more than a third of post-discharge follow-up testing is never completed.

Medications are frequently prescribed or changed during care transitions, including hospital admissions and discharges, which can be confusing for patients and put them at risk of nonadherence. Medication reconciliation—the process of reviewing and resolving discrepancies between medications a patient is using and new medications that have been ordered for the patient—is employed by hospitals during the discharge process to boost adherence to prescribed regimens and prevent adverse health outcomes. Medication reconciliation is built into the National Patient Safety Goals developed by The Joint Commission,[1] which recognizes that organizations face challenges with medication reconciliation and that its effectiveness will increase as more advanced health information technology (IT) systems are adopted.[2]

Importantly, barriers to filling or refilling hospital discharge medications remain even when medications have been effectively reconciled. Some discharge prescriptions go unfilled due to

mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record (EHR) or other easily accessible tool. Accordingly, access to outpatient drug formularies is vital to medication management and continuity of care during patient hospitalizations and the period after discharge.

Formulary systems can be complicated and confusing for both patients and physicians. First, hospital inpatient formulary systems have traditionally been distinct from health plan outpatient formularies, which differ among themselves and are frequently adjusted (even during the benefit year). Hospitals that have merged with or grown into larger health systems, including those that have integrated with payers, may have multiple formularies in place, each of which is continuously evaluated against lists of available medications and prescribing guidelines.[3] Hospital formulary systems are managed by a pharmacy and therapeutics committee (P&T committee), which oversees medication management and use at the hospital. A P&T committee usually reports to the medical staff, which should have final approval over the hospital's medication-use policy.[4] Because hospitals/health systems are unable to procure, stock and administer all available medications, most hospital formularies make one or two medications available for each therapeutic class. A hospital formulary may also restrict the prescribing of some medications to certain specialties, although medications not available on the formulary can generally be requested.[5]

Upon admission to a hospital, hospitals may substitute a patient's home (outpatient) medication through approved therapeutic interchange if that medication is not part of the hospital's formulary. Ideally, at the time of discharge, patients should be reconciled back to their home medications to ensure continued adherence. Hospital physicians may also prescribe new medications intended for use after discharge, and those prescriptions may be based on the hospital formulary. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to restrictions such as adverse tiering or prior authorization (PA). Accordingly, patients may be discharged with prescriptions that will not be adequately covered or paid for by their pharmacy benefits plan.

Strategies to ensure continuity of care after hospital discharge

Strategies to ensure continuity of care after hospital discharge are numerous and varied and include pharmacist interventions to address medication and/or insurance issues, as well as discharge checklists that require confirmation of coverage of prescribed discharge medications. Examples of care transition interventions centered on discharge include the SafeMed care transitions model and Project BOOST (Better Outcomes for Older Adults through Safe Transitions). SafeMed uses intensive medication reconciliation and home visits to manage high-risk/high needs patients as they transition from the hospital to outpatient setting. As part of its Steps Forward™ initiative, the AMA developed a module for implementing the SafeMed model within primary care practices. Project BOOST is the Society of Hospital Medicine's signature mentoring program for improving the care of patients as they transition home from the hospital or to other care facilities. Among other interventions, Project BOOST identifies patients at high risk of hospital readmission and follows up with them to monitor adherence after discharge.

Some hospitals have established bedside medication delivery services to help mitigate the number of hospital prescriptions that go unfilled after discharge. Also known as "meds-to-beds" or "meds-in-hand" interventions, these services are provided by hospitals in partnership with their outpatient pharmacies, which are able to access outpatient formulary information[6] and coordinate PA requirements. A study of one hospital's "meds-in-hand" process highlighted use of the hospital

outpatient pharmacy to reliably verify insurance coverage of prescribed outpatient medications, and further posited that patients may incur lower costs from receiving medications from the outpatient pharmacy rather than the inpatient pharmacy.[7] Another study found that a pediatric "meds-in-hand" project increased the proportion of patients discharged in possession of their medications and may have decreased unplanned visits to the emergency department in the 30 days after discharge.[8] In addition to bedside medication delivery services, some hospitals provide a transitional supply of medications to high-risk uninsured patients at the time of discharge and also help patients obtain medications through patient assistance programs.[9] Many hospitals routinely follow up with patients after discharge to check on medication access and adherence.

Real-time pharmacy benefit (RTPB) tools

Transparency of drug coverage and formulary information in EHRs could prove useful in preventing medication nonadherence and treatment abandonment during the post-discharge period. To ensure such transparency, accurate, real-time information needs to be available at the point of prescribing. Although the AMA has been advocating that insurers, PBMs, and EHR vendors move quickly to develop point-of-care software that provides patient coverage and cost-sharing information, problems remain. Specifically, there are concerns with the accuracy of Formulary and Benefit (F&B) files based on how often payers update their formularies and provide the F&B update files to intermediaries and EHR vendors. Notably, F&B files are static and may not represent the most current formulary data. Moreover, these files do not provide drug coverage information at a granular, patient-specific level of detail.

In contrast, real-time pharmacy benefit (RTPB) technology holds promise for improving continuity of care for patients discharged from the hospital setting. Although RTPB tools are relatively new and have not yet been widely implemented, adoption continues to improve, and prescribers should have greater access to real-time benefit and coverage restriction information at the point of care through RTPB tools in the near future. To accelerate the use of electronic RTPB tools in the Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) requires every Part D plan to support one or more real-time benefit tools capable of integrating with at least one e-prescribing system or EHR, effective January 1, 2021. While this requirement falls short of ensuring that all prescribers have access to RTPB information for every patient they encounter, it is a positive step for increasing RTPB tool adoption and improving access to benefit information. In addition, CMS will require Part D plans to offer a consumer-facing RTPB tool starting January 1, 2023, which will allow patients to obtain information about medication costs and possible lower-cost alternatives under their prescription drug benefit plan.[10]

Over the past few years, the National Council for Prescription Drug Programs (NCPDP) has been developing an electronic standard for the communication of real-time prescription drug coverage and pricing information, including therapeutic alternatives, between payers and prescribers. The AMA actively participates in the NCPDP effort to ensure that the standard will provide the prescription drug information that physicians need at the point of prescribing. Based on progress of the NCPDP work, it is expected that an RTPB standard will be recommended to CMS for an eventual federal mandate under the Part D program in late 2021. Because there are several proprietary RTPB systems on the market, the AMA supports a standardized RTPB process that allows providers to access information for all of their patients, regardless of what payer the patient is covered under or what EHR/e-prescribing system is used by the provider. The AMA also strongly advocates for alignment between the prescription drug data offered in physician-facing and consumer-facing RTPB tools, as any discrepancies in the pricing or coverage information presented to these different audiences will result in increased administrative burdens for physicians, patient dissatisfaction, and mutual confusion.

AMA ACTIVITY

The AMA engages in robust federal and state advocacy on a range of policy issues relevant to improving continuity of care and preventing treatment delays after hospital discharge. The Council has previously discussed concerns related to transparency in drug formularies, which make it exceedingly difficult for physicians to determine which treatments are preferred by a particular health plan at the point-of-care (see Council on Medical Service Report 5-A-19, The Impact of Pharmacy Benefit Managers on Patients and Physicians). For patients, lack of transparency in drug coverage information may lead to treatment delays as well as being unaware of their cost-sharing responsibilities which can affect medication adherence. To expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, TruthInRx.org, in 2016. At the time this report was written, nearly 350,000 individuals had signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency. The AMA has also developed model state legislation which addresses issues related to stabilized formularies and cost transparency.

To educate the public about problems associated with PA and to gather stories from physicians and patients about how they have been affected by it, the AMA launched a second grassroots website, FixPriorAuth.org, in 2018. This site showcases an array of stories about PA requirements delaying care, including one video about a patient who had undergone heart stenting but was unable to fill a discharge prescription for a blood thinner because of a PA hurdle. The physician was unaware that the insurer would not approve the prescription, and the patient ended up back in the hospital after suffering another heart attack.

More broadly, the AMA is very active in advocating for a reduction in both the number of physicians subjected to PA and the overall volume of PA (see Council on Medical Service Report 4-JUN-21, Accountability in Prior Authorization). In January 2017, the AMA and a coalition of state and specialty medical societies, national provider organizations and patient organizations developed and released a set of 21 Prior Authorization and Utilization Management Principles intended to ensure that patients receive timely and medically necessary care and medications and reduce administrative burdens. Four of these principles speak directly to continuity of care, and Principle #8 addresses formulary data transparency in EHRs. In January 2018, the AMA joined the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and the Medical Group Management Association in a Consensus Statement outlining a shared commitment to industry-wide improvements to PA processes and patient-centered care. The Consensus Statement underscores that continuity of care is vitally important for patients undergoing an active course of treatment when there is a formulary or treatment coverage change and/or a change of health plan, and also addresses making PA requirements and other formulary information electronically accessible in EHRs. Additionally, the AMA has model legislation addressing PA and works closely with many state medical associations to enact legislation.

The AMA continues to advocate with the Office of the National Coordinator for Health Information Technology (ONC) and CMS around opportunities to improve health IT and EHRs, including standards, certification and vendor requirements that will help improve interoperability, EHR performance and data usability. As stated previously, the AMA participates in the NCPDP effort to advocate for physicians' interests and supports a standardized RTPB process that ensures alignment between physician-facing and patient-facing RTPB tools.

RELEVANT AMA POLICY

The AMA has extensive policy on hospital discharge and medication reconciliation. Policy D-160.945 advocates for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety. Evidence-based principles of discharge and discharge criteria are outlined in Policy H-160.942. Policy H-160.902, established with Council Report 7-I-16, encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care. This policy also encourages hospital engagement of patients and families in the discharge process, supports implementation of medication reconciliation as part of the discharge process, and encourages patient follow-up in the early time period after discharge. Policy D-120.965 also supports medication reconciliation to improve patient safety.

The AMA also has substantial policy on drug plans and formularies. Policy D-330.910 states that the AMA will explore problems with prescription drug plans, including issues related to continuity of care, PA, and formularies, and work with CMS and other organizations to resolve them. AMA policy objectives addressing managed care cost containment involving prescription drugs are outlined in Policy H-285.965, which speaks to mechanisms to appeal formulary exclusions and urges pharmacists to contact prescribing physicians if prescriptions violate the managed care formulary so that physicians can prescribe an alternative drug that may be on the formulary. Under Policy H-285.952, the AMA will continue providing assistance to state medical associations in support of state legislative and regulatory efforts to ensure continuity of care protections for patients in an active course of treatment.

Policy H-125.979 directs the AMA to: work with PBMs, health insurers and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing; promote that, in the event that a drug is no longer on the formulary when a prescription is presented, notice of covered formulary alternatives shall be provided to the prescriber so that appropriate medication can be provided; and promote the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. Council on Medical Service Report 5-A-19 established Policy D-110.987, which supports regulation of PBMs and improved transparency of PBM operations, including disclosing formulary information such as whether certain drugs are preferred over others and patient cost-sharing responsibilities, which should be made available to patients and to prescribers at the point-of-care in EHRs. Policies D-125.997 and H-185.942 support protecting patient-physician relationships from interference by PBMs and payers. Policy H-125.979 aims to prohibit drugs from being removed from the formulary or moved to a higher cost tier during the duration of a patient's plan year.

Drug formularies, P&T committees, and therapeutic interchange are addressed in Policy H-125.991, which outlines standards that must be satisfied in order for drug formulary systems to be acceptable. This policy also insists that health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated and discourages the switching to therapeutic alternates in chronic disease patients who are stabilized on drug therapy. Finally, the AMA has numerous policies on usability and interoperability of EHRs, including Policy D-478.995 on health IT which, among other directives, supports AMA advocacy for standardization of key elements of the EHR.

DISCUSSION

Although the referred second resolve clause of amended Resolution 212-A-19 focuses on continued coverage of prescribed discharge medications, the Council believes that continuity of care for medical services is also vital to improving the health outcomes of patients transitioning out of hospitals. The Council recognizes that, because inpatient and outpatient formularies differ, ensuring continuous coverage of medications and medical services is not always feasible, in part because some hospital physicians lack access to patients' outpatient formulary information. Accordingly, the Council recommends that our AMA advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge.

The Council recognizes that there are multiple ways for hospitals to carry out medication reconciliation and does not wish to prescribe how this process should be accomplished. Some hospitals assign staff (usually pharmacy staff) to work through coverage issues and facilitate patient access to discharge medications. Others utilize hospital outpatient pharmacies to review coverage and PA requirements during the reconciliation process. The Council recommends supporting—but not requiring—medication reconciliation that includes confirmation that prescribed discharge medications will be covered by a patient's health plan and completion of PA requirements.

Aside from medication reconciliation, the Council identified other innovative strategies employed by hospitals to improve medication adherence after hospital discharge. "Meds-to-beds"/"meds-in-hand" services take a variety of forms and can be administered hospital-wide or for specific patient populations. However, these programs may not be achievable at all facilities, particularly those without an outpatient pharmacy on site. Safety-net hospitals are more likely to provide an initial 30-day supply of medications to uninsured patients, and the Council supports these efforts—and broadening them—while acknowledging the cost implications for hospitals. Accordingly, the Council recommends a more general policy statement supportive of strategies to address coverage barriers and facilitate patient access to prescribed discharge medications, such as bedside medication delivery services and the provision of transitional supplies of discharge medications.

The Council believes that RTPB systems hold promise for improving continuity of care during the discharge period and looks forward to the release of an RTPB standard, widespread implantation of this technology in physicians' and hospitals' EHR systems, and ongoing evaluations of and improvements to these tools to ensure that RTPB technology meets the needs of prescribers. At this time, the Council believes it is premature to require EHR vendors to incorporate RTPB for certification. Instead, the Council recommends that our AMA advocate that ONC and CMS work with physician and hospital organizations, and health IT developers, to identify RTPB implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. The Council further recommends that any policies requiring health IT developers to integrate RTPB systems within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. Finally, the Council believes that it is critically important for the data offered on emerging consumer-facing RTPB tools to match the drug pricing and coverage information displayed in physicians' and hospitals' EHRs, as discrepancies will lead to confusion and dissuade both physicians and patients from using these technologies. Accordingly, the Council recommends that our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

The Council acknowledges the strength of AMA policy on problems with prescription drug plans and formulary transparency and recommends reaffirmation of Policies H-125.979 and D-330.910. Previous Council reports on hospital discharge communications and physician communication and care coordination during patient hospitalizations underscored that consistent physician-to-physician communication across care settings is integral to achieving a safe and efficient discharge process. The Council recommends reaffirmation of Policy D-160.945, which supports timely and consistent communication between physicians in inpatient and outpatient care settings.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. (New HOD Policy)

2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge. (New HOD Policy)

3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients. (New HOD Policy)

4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors. (New HOD Policy)

5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)

6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. (New HOD Policy)

7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy D-330.910, which directs the AMA to explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work to resolve them. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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