REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Access to Health Plan Information regarding Lower-Cost Prescription Options
(Resolution 213-NOV-20)
(Reference Committee G)

EXECUTIVE SUMMARY

At the November 2020 Meeting, the House of Delegates referred Resolution 213, "Pharmacies to Inform Physicians when Lower Cost Medication Options are on Formulary," which was sponsored by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American Medical Association (AMA) to support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates.

Resolution 213-NOV-20 highlights the untenable position patients and their physicians encounter as they attempt to choose among appropriate prescription drug options with incomplete information. When recommending a pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of joint decision-making, patients and their physicians often lack access to critical prescription drug price information. Instead, patients and their physicians may choose a clinically appropriate prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy Benefit Manager (PBM) formulary and utilization management information, they may not know until the patient attempts to purchase the drug at a pharmacy that the selected pharmaceutical was unaffordable for the patient.

This report studies the communication challenges that arise among patients, physicians, pharmacies, and health plans when patients are unable to afford prescribed medication and health information technology solutions that can help. In addition, this report highlights ongoing AMA advocacy to improve prescription drug price transparency and presents policy recommendations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 02-N-21

Subject: Access to Health Plan Information regarding Lower-Cost Prescription Options
              (Resolution 213-NOV-20)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

1   At the November 2020 Meeting, the House of Delegates referred Resolution 213, "Pharmacies to
2   Inform Physicians when Lower Cost Medication Options are on Formulary," which was sponsored
3   by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American
4   Medical Association (AMA) to support legislation or regulatory action to require that in the event a
5   patient cannot afford the medication prescribed, either because it is not on the formulary or it is
6   priced higher than other medications on the formulary, the pharmacist must communicate to the
7   prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to
8   the patient. Reference committee testimony at the meeting was mixed regarding Resolution 213.
9   While testimony supported the intent of Resolution 213, testimony also expressed concern that
10 Resolution 213 could lead to unintended consequences of creating unnecessary administrative
11 burdens on physicians, confusion for patients, and potential pharmacy scope of practice expansion.
12 The Board of Trustees assigned this item to the Council on Medical Service for a report back to the
13 House of Delegates. This report studies the communication challenges that arise among patients,
14 physicians, pharmacies, and health plans when patients are unable to afford prescribed medication
15 and health information technology (HIT) solutions that can help. In addition, this report highlights
16 ongoing AMA advocacy to improve prescription drug price transparency and presents policy
17 recommendations.
18
19 BACKGROUND
20
21 Patients are directly impacted by high prescription drug prices when they are still in the deductible
22 period of their insurance plans, when the drugs prescribed are not covered by their insurance, when
23 a nonpreferred formulary status for a particular drug leads to a higher patient cost-share, when
24 Medicare Part D beneficiaries are in the "donut hole," or when patients are uninsured. As the
25 number of patients enrolled in high-deductible health plans and Medicare Part D continues to rise,
26 more patients may struggle with prescription affordability challenges. Resolution 213-NOV-20
27 highlights the untenable position patients and their physicians encounter as they attempt to choose
28 among appropriate prescription drug options with incomplete information. When recommending a
29 pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient
30 preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of
31 joint decision-making, patients and their physicians often lack access to critical prescription drug
32 price information. Instead, patients and their physicians may choose a clinically appropriate
33 prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy
34 Benefit Manager (PBM) formulary and utilization management information, they may not know
35 until patients attempt to purchase their drugs at the pharmacy that the selected pharmaceuticals are
36 unaffordable for the patient.

1   Pharmacists play an important role in identifying instances of prescription drug prices impairing
2   access to care. Critically, a pharmacist may be the first, and potentially only health care
3   professional, who knows that a patient has declined a prescribed medication due to cost. The
4   prescribing physician should be informed when a patient declines to fill a prescription as soon as
5   possible, but as noted in testimony on Resolution 213-NOV-20, requiring pharmacists to
6   communicate to the prescriber a lower-cost medication option can be problematic. Ideally, patient
7   out-of-pocket costs associated with prescription options would be easily available through the
8   electronic systems used by physicians and pharmacists, but that information is not currently
9   universally available. In the absence of a technology tool, the only way to know which medications
10   are on the formulary is for the physician, pharmacist, or patient to research the formulary and/or
11   call the insurance plan or PBM. Clearly, such a process is burdensome for everyone. Since the
12   ultimate decision regarding which medication is most appropriate for a patient is made directly
13   between physicians and patients, requiring pharmacists to research patients' formularies and
14   discuss their research with the physician unnecessarily adds burden to both physicians and
15   pharmacists. Moreover, unnecessarily inserting pharmacists into the prescribing process may
16   increase confusion among patients and scope of practice concerns as patients seek prescription
17   guidance from their pharmacists. Rather than imposing burdensome new legal requirements on
18   pharmacists, the goal of improved prescription drug price transparency at the point of prescribing
19   could be accomplished via improved HIT.
20
21   PRICE TRANSPARENCY AT POINT OF PRESCRIBING AND REAL-TIME PRESCRIPTION
22   BENEFIT TECHNOLOGY
23
24   To empower informed joint decision-making, patients and physicians must have a way to obtain
25   real-time, patient-specific prescription drug coverage information at the point of prescribing in
26   physicians' electronic health records (EHR)s.[1] Having access to accurate, current information
27   about a patient's prescription benefit will enable physicians and patients to evaluate drug costs and
28   consider possible alternative therapies when selecting a medication regimen. Drug price
29   transparency at the point of care has the potential to reduce drug costs for patients (and public and
30   private payers). Additionally, provision of such data within the e-prescribing workflow will ensure
31   physician awareness of utilization management requirements, such as prior authorization
32   requirements, step therapy protocols, and quantity limitations at the point of prescribing.
33   Transparency of patient out-of-pocket costs and coverage restrictions in EHRs can therefore help
34   mitigate medication nonadherence and treatment abandonment. Finally, by leveraging a technology
35   solution embedded into existing EHRs, neither patients, physicians, pharmacists, nor payers would
36   be burdened with the time-consuming process of manually cross-checking current formularies and
37   potential medication alternatives. This technology solution currently exists in proprietary form, and
38   a standardized version is on the horizon.
39
40   Real-Time Prescription Benefit (RTPB) technology, also known as Real-Time Benefit Tool
41   (RTBT) technology in federal regulatory language, is a prescription drug decision-making tool that
42   embeds real-time, patient-specific benefit information in the e-prescribing workflow.[2] RTPB tools
43   allow prescribers to access accurate, patient-specific coverage and benefit information, including
44   the expected out-of-pocket cost, for a chosen medication and pharmacy. RTPB tools also present
45   prescribers with utilization management restrictions and plan-preferred alternative medication
46   options, which may be more cost-effective for the patient.[3] RTPB tools represent a significant
47   improvement over the drug formulary information otherwise incorporated into EHRs and e-
48   prescribing. Existing drug formulary information is often inaccurate, outdated, and generally
49   unreliable due to delayed updates and lack of patient specificity. The significant limitations in drug
50   formulary information embedded into EHRs have caused some physicians to distrust (and
51   consequently ignore) the formulary data currently available in EHRs.

1   Several proprietary RTPB tools are already being used by some physicians and health systems, but
2   the proprietary nature of these tools limits their impact. Currently, physicians' ability to access
3   RTPB information for a specific patient depends on whether there is a business relationship
4   between the physician practice's RTPB tool software provider and the patient's drug plan. For
5   example, Surescripts is collaborating with several EHR companies and leveraging information
6   from the PBMs CVS Health and Express Scripts to provide RTPB tools for the patients and
7   physicians in their network.[4] Similarly, OptumRx and UnitedHealthcare are collaborating to
8   provide a similar tool, specifically for their enrollees.[5] Accordingly, some physicians may have
9   access to RTPB tools for some patients, but physicians cannot yet access comprehensive benefit
10   information across all prescription drug plans, and tools do not yet integrate with all EHRs/e-
11   prescribing systems. To achieve that level of universal access and transparency, a non-proprietary
12   RTPB standard is required.
13
14   To test the hypothesized benefits of a standard RTPB tool, a research team at Johns Hopkins
15   Medicine recently studied the impact of an RTPB tool integrated into the EHR at their institution.[6]
16   The study found that the RTPB tool reduced physician prior authorization burden, achieved patient
17   cost savings, and facilitated improved medication adherence. Specifically, the cost and day-supply
18   information provided by the RTPB tool frequently led physicians and patients to choose a 3-month
19   supply of medication instead of a 1-month supply, as many PBMs discount the copay on 3-month
20   supplies, making the 3-month supply more cost effective. This has important health outcomes
21   implications, as medication adherence increases with longer day-supply of prescriptions.[7] The most
22   common changes in drug selection involved switching to alternatives with minimal clinical, but
23   notable financial, significance. In addition, the information provided by the RTPB tool was able to
24   guide prescribers in choosing medication alternatives without prior authorization requirements, and
25   to convert from an agent covered with restrictions to one covered without restrictions, or to convert
26   from an agent not covered to one covered with restrictions. These features reduced administrative
27   burden on prescribers and increased the likelihood of patients being able to obtain their medication
28   without delay. The study found patient cost savings of up to $2,370 when a prescription was
29   switched from a retail to mail order pharmacy. The average patient out-of-pocket cost savings due
30   to changes in prescription was approximately $21. Essential to building physician trust in the tool,
31   the study found that the price estimates provided by the RTPB tool were accurate in 98 percent of
32   the orders. The research team emphasized that webinars and in-person meetings were held to
33   promote increased adoption and appropriate use of the RTPB tool, and since going live with the
34   tool, they observed a significant increase in awareness from prescribers about the tool.
35
36   CMS intensified the need for standardized RTPB technology with its May 2019 final rule requiring
37   that each Medicare Part D plan adopt one or more RTBTs that are capable of integrating with at
38   least one EHR or e-prescribing system by January 1, 2021.[8] While this mandate could potentially
39   help accelerate physician practices' access to RTPB tools, the CMS rule is significantly limited.
40   The CMS rule allows Medicare Part D plans to support a single RTBT that is required to integrate
41   with only one physician EHR/e-prescribing system. As such, physicians and their EHR vendors
42   could presumably need to support a different RTBT for every Medicare Part D plan in order to
43   have access to prescription benefit information for every Medicare patient treated by the practice.
44   This would be an overwhelming, expensive, and burdensome proposition for vendors and
45   physicians and would likely discourage adoption of this technology. Alternatively, since CMS is
46   only requiring *one* RTBT capable of integrating with at least *one* e-prescribing system or EHR,
47   some physicians may find that they have RTPB information for some, but not all, of their patients.
48   Such incomplete access to RTPB information may lead to greater confusion and frustration, both
49   among physicians and patients. An RTPB standard is needed to progress beyond the current
50   proprietary and incomplete RTPB technology landscape and allow all physicians access through
51   any EHR to any patient's specific benefit information.

1 The National Council for Prescription Drug Programs (NCPDP) has been developing an electronic
2 standard for RTPB technology since 2014.[9] The NCPDP's Real Time Prescription Benefit
3 Standard Task Group (RTPB Task Group) is responsible for developing the RTPB standard,[10] and
4 the AMA has participated in the RTPB Task Group since its inception. At its August 2021 Virtual
5 Interim Work Group meeting, the RTPB Task Group agreed to recommend that CMS recognize,
6 via the federal rulemaking process, the RTPB standard that has been developed by NCPDP.[11] It is
7 anticipated that the RTPB standard will have an implementation time-period of 2 years following
8 the publication of a final rule.
9
10 As articulated in Resolution 213-NOV-20, currently it can be impossible for insured patients and
11 their physicians to know at the point of prescribing what a prescribed drug will cost the patient. A
12 standardized RTPB tool embedded into physicians' EHRs will close the current information gap
13 among insurance plans, PBMs, pharmacies, patients and their physicians. The universality of a
14 standardized RTPB tool is expected to significantly improve interoperability, expand transparency,
15 increase prescription drug adherence, and promote informed communication and trust between
16 patients and their physicians.[12]
17
18 ENHANCED PHYSICIAN EDUCATION REGARDING APPLICATION OF RTPB
19 TECHNOLOGY
20
21 The Council commends the resolution sponsors for highlighting the critical problem of cost-related
22 non-adherence and prescription abandonment and the urgent need for tools that will enhance
23 communication among physicians and pharmacists on behalf of patients. Resolution 213-NOV-20
24 also illustrates that RTPB technology is not currently a top-of-mind solution for the majority of
25 physicians. The AMA's 2020 Physician Practice Benchmark Survey (2020 Benchmark Survey),
26 which is a nationally representative survey of US physicians who provide patient care, and which
27 included an explanation of RTPB technology, found that only 35.7 percent of physicians had heard
28 of RTPB technology prior to taking the survey.[13] Moreover, among that portion of the physician
29 population who had heard of RTPB technology, only about 55 percent of those physicians had
30 access to RTPB technology. This may be due to the proprietary nature of the currently available
31 RTPB tools. However, the physicians who have access to RTPB technology overwhelmingly
32 choose to take advantage of the tool. In fact, the 2020 Benchmark Survey found that physicians
33 who have access to RTPB tools are over four times as likely to use the RTPB technology available
34 to them than not. Accordingly, not only is there an urgent need for a standard RTPB tool that will
35 provide all physicians access to all patients' specific benefit information at the point of prescribing,
36 but there is also an urgent need to help the approximately 64 percent of physicians who are
37 unfamiliar with RTPB technology understand the tool's significant value so that they will be
38 prepared to optimally utilize RTPB technology, once it is available to them.
39
40 ADDITIONAL TOOLS TO FILL PRESCRIPTION DRUG COST INFORMATION GAPS
41
42 The Council recognizes that RTPB technology is not a panacea that can solve the much broader
43 problem of prescription drug cost transparency in all contexts. As the "Benefit" element of the
44 RTPB name implies, RTPB tools will only increase point of prescribing price transparency for
45 insured patients. Yet, out-of-pocket prescription drug cost transparency is essential for all patients.
46 Some patients are uninsured or underinsured, and formulary status may not be relevant to these
47 patients. Some local pharmacies may charge lower retail prices for certain prescription drugs than
48 others, and there may be prescription discount programs available for some medications (e.g.,
49 directly through manufacturers or through drug discount aggregator websites, such as GoodRx).
50 Clearly, there is an urgent need for ongoing HIT innovation to enhance prescription drug price
51 transparency in all contexts, and the AMA continues to advocate for improvements.

1   While the health care industry awaits implementation of a standard RTPB tool to provide price
2   transparency for insured patients and awaits additional future tools to provide optimal prescription
3   out-of-pocket cost information at the point of prescribing for all patients, physicians may want to
4   further explore how tools within their current EHR systems could be used to mitigate concerns
5   about prescription abandonment. Among the features that are legally required to be included in all
6   EHR software are tools that facilitate communication between pharmacies and prescribers, and
7   these tools could be used to help identify and respond to patients who encounter cost barriers when
8   attempting to fill their prescriptions. For example, the "RxFill transaction" can be used to
9   communicate between a pharmacy and a prescriber, informing a prescriber whether a specific
10   prescription was dispensed (or partially dispensed) to a patient.[14] Accordingly, if a physician is
11   notified that a patient has never picked up an essential medication, the physician can follow-up
12   with the patient to determine why the prescription was abandoned and if an alternative medication
13   is appropriate. Physicians can choose to receive RxFill notifications for certain patients who are
14   prescribed certain medications (e.g., insulin for patients with diabetes), but not for others (e.g.,
15   prescriptions for seasonal allergy medication). EHRs may allow physicians to further customize
16   how and when they are notified. Similarly, physicians can communicate electronically with
17   pharmacies to discuss prescription options. If a patient declines a drug, pharmacies can use the
18   "RxChangeRequest Transaction" to send prescribers options regarding potential alternatives to
19   originally prescribed medications.[15] For example, pharmacists may suggest a generic alternative to
20   a brand-name drug, or they may suggest another drug that is available at a cheaper price. Upon
21   receiving an RxChangeRequest, a prescriber can respond with an "RxChangeResponse transaction"
22   to either approve or decline the RxChangeRequest, and the prescriber is able to provide additional
23   comments in the response.[16] Importantly, both EHR vendor implementation and pharmacy
24   information systems technology implementation of these e-prescribing tools varies. Physicians who
25   believe that the use of RxFill and/or RxChangeRequest and RxChangeResponse could support their
26   practice are encouraged to seek additional information from their EHR vendor and local
27   pharmacies.
28
29   Physicians can also encourage their patients to utilize currently available consumer-facing
30   prescription drug price transparency tools. For example, when shopping for a Medicare plan,
31   Medicare patients can look-up the cost of their prescription medications under various Medicare
32   plan options.[17] There are a variety of drug discount programs, including drug discount aggregator
33   websites, that allow patients to compare prescription drug prices and obtain coupons that can be
34   used at local pharmacies. Drug discount aggregator websites allow patients to view and compare
35   prices of brand name and generic versions of prescription drugs and provide coupons that patients
36   may choose to use when filling their prescriptions. These coupons can be especially helpful and
37   straightforward for patients who do not have insurance coverage for prescription drugs, but because
38   medications purchased using a coupon may not automatically be counted towards insured patients'
39   deductibles, they may not always provide overall cost-savings for insured patients.[18] A federal
40   regulation finalized in 2020 provides insured patients with greater out-of-pocket cost transparency
41   beginning in 2023.[19] The Transparency in Coverage final rule requires most individual and group
42   health plans to make available to participants, beneficiaries and enrollees personalized out-of-
43   pocket cost information for all covered health care items and services, including prescription drugs,
44   through an internet-based self-service tool and in paper form upon request.[20] This will allow
45   patients to obtain real-time, accurate out-of-pocket cost estimates that they can share with their
46   physicians as they engage in joint decision-making and care planning. In addition to providing
47   greater real-time cost transparency for patients and their physicians, starting in 2022, the
48   Transparency in Coverage final rule will require disclosure of in-network negotiated rates and
49   historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location
50   level.[21] Researchers and third-party developers and innovators can use this data to create private
51   sector solutions to achieve greater price transparency.[22]

1 AMA POLICY AND ADVOCACY
2
3 Long-standing AMA policy supports ongoing advocacy for the development of HIT tools, such as
4 an RTPB standard, that enhance prescription drug price transparency. Policy H-450.938 states that
5 physicians should have easy access to and review the best available data associated with costs at
6 the point of decision-making, which necessitates cost data to be delivered in a reasonable and
7 useable manner by third-party payers and purchasers. In addition, the policy calls for physicians to
8 seek opportunities to improve their information technology infrastructures to include new and
9 innovative technologies to facilitate increased access to needed and useable evidence and
10 information at the point of decision-making. Related, Policy H-125.979 encourages PBMs, health
11 insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the
12 point of prescribing, and promotes the value of online access to up-to-date and accurate
13 prescription drug formulary plans from all insurance providers nationwide. Similarly, Policy
14 H-110.990 supports the development and use of tools and technology that enable physicians and
15 patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior
16 to making prescribing decisions, so that physicians and patients can jointly decide on treatment.
17 Recent Policy H-125.974 states that our AMA will advocate to the Office of the National
18 Coordinator for Health Information Technology (ONC) and CMS to work with physician and
19 hospital organizations, and HIT developers, in identifying RTPB implementations and published
20 standards that provide real-time information across all prescription drug plans, patient portals and
21 other viewing applications, and EHR vendors. This policy also states that the AMA will advocate
22 to the ONC and CMS that any policies requiring HIT developers to integrate RTPB within their
23 products do so with minimal disruption to EHR usability and cost to physicians and hospitals.
24 Moreover, the policy establishes that the AMA will support alignment and real-time accuracy
25 between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.
26
27 Additionally, AMA policy and advocacy promote open communication between pharmacists and
28 physicians when issues of prescription unaffordability arise and increased price transparency at the
29 pharmacy. Policy H-285.965 urges pharmacists to contact the prescribing physician if a
30 prescription written by the physician violates the managed care drug formulary under which the
31 patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which
32 may be on the formulary. Moreover, Policy H-110.991 advocates for greater prescription drug
33 price transparency at the pharmacy point of sale by: (1) advocating that both the retail price and the
34 patient's copay be listed on prescription receipts, (2) pursuing legislation that would require
35 pharmacies to inform patients of the cash price as well as the formulary price of any medication
36 prior to purchase, and (3) opposing provisions in contracts between pharmacies and PBMs that
37 would prohibit pharmacies from disclosing when a patient's copay is higher than the drug's cash
38 price (so called "gag clauses"). The AMA developed model legislation consistent with Policy
39 H-110.991, similar bills have been enacted in several states, and federal legislation was enacted to
40 prohibit gag clauses in Medicare, Medicare Advantage,[23] group, and individual health insurance
41 plans.[24] Related, in response to Policy H-110.987, the AMA developed model state legislation
42 entitled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost
43 Increases during the Plan Year" which addresses the issue of timely prescription decision support
44 and would authorize a pilot study to integrate transparency data at the point of care, with
45 information such as medicines' formulary status, cost-sharing tier, patient out-of-pocket cost, and
46 coverage restrictions being integrated into EHRs or e-prescribing systems.
47
48 The AMA continues to advocate extensively in support of an RTPB standard. Since 2014, the
49 AMA has been actively engaged in the development of the NCPDP RTPB standard to ensure that
50 any mandated standard will meet the needs of physician end-users and their patients. The AMA
51 serves as a member of the NCPDP's RTPB Task Group which is comprised of stakeholders from

1 across the health care industry, including organized medicine, hospitals, payers, HIT vendors, and
2 pharmaceutical/life sciences companies. NCPDP has quarterly workgroup meetings, and the RTPB
3 Task Group meets weekly to discuss and continue developing the RTPB standard. Collectively, the
4 RTPB Task Group is committed to the goal of developing and publishing an RTPB standard that
5 will meet the needs of and benefit every sector of the health care industry and that will be readily
6 adopted by CMS.
7
8 During recent testimony at the Congressional Hearing, "Lowering Prescription Drug Prices:
9 Deconstructing the Drug Supply Chain," the AMA emphasized the challenges patients and
10 physicians encounter due their inability to access patient-specific formulary and cost-sharing
11 information at the point of care.[25] The AMA has also recently submitted written comments to
12 CMS[26] and presented to the ONC Health Information Technology Advisory Committee (HITAC)
13 Intersection of Clinical and Administrative Data Task Force (ICAD) strongly supporting an RTPB
14 standard. Additionally, the AMA recently submitted comments to CMS that highlighted the
15 importance of physicians having access to real-time, patient-specific prescription drug coverage
16 information at the point of prescribing in physicians' EHRs, supported CMS' efforts to expedite
17 industry implementation of RTBT, and recommended that CMS require plans to support a single
18 RTBT standard, when made available.[27]
19
20 Finally, in 2016, the AMA launched a grassroots campaign and website, TruthinRx.org, the goal of
21 which is to address the opaque process that pharmaceutical companies, PBMs, and health insurers
22 engage in when pricing prescription drugs. TruthinRx.org provides a platform through which
23 individuals can sign petitions to members of Congress and template letters that website visitors can
24 customize and directly send to their US Senators and US Representatives, calling on them to
25 support increased transparency in prescription drug prices. Coordinated with AMA model
26 legislation, and state and national engagement, TruthinRx.org is updated to reflect advances in
27 AMA policy and pharmaceutical industry activities.
28
29 DISCUSSION
30
31 Resolution 213-NOV-20 highlighted physicians' need for patient-specific, real-time formulary and
32 cost-sharing information, and an RTPB standard would fill that need. A standardized RTPB tool
33 integrated into EHR systems will allow physicians to have real-time access, at the point of
34 prescribing, to a current report of whether a specific medication is on a specific patient's
35 prescription formulary. A standardized RTPB tool will provide patient-specific out-of-pocket cost
36 for a selected medication at that patient's designated primary pharmacy, and it will alert physicians
37 to applicable utilization management restrictions. A standardized RTPB tool will present
38 physicians with options of alternative medications that are covered by a patient's insurance plan,
39 and this will empower physicians and patients to decide together, before the patient leaves the
40 examination room, whether the medication is not only clinically, but also financially, well-suited
41 for the patient. If the medication is unaffordable, the physician can pull up this same information
42 for other medications equally clinically appropriate for the specific patient, and it will allow
43 physicians to see the drug discount program prices for the queried pharmacy. Accordingly, the
44 Council recommends that the AMA continue to zealously advocate for the development,
45 publication, adoption, and mandated use of standardized RTPB tools with minimal burden on
46 physicians. In addition, the Council recognizes that many practicing physicians have not been made
47 aware of how a standard RTPB tool will enhance their practice, or how HIT tools already available
48 within their EHR and/or e-prescribing systems can enhance communication between physicians
49 and pharmacists. For this reason, the Council recommends that the AMA develop and disseminate
50 educational materials that will empower physicians to leverage these HIT tools to enhance their
51 practices.

1   The Council recognizes that the question of whether a particular prescription drug is on a patient's
2   insurance formulary is just one component of the much larger prescription drug affordability
3   challenge. The AMA will continue to advocate for technology tools to efficiently address the broad
4   range of prescription price transparency and affordability challenges unrelated to insurance
5   benefits. For these reasons, the Council recommends amending Policy H-110.990 to specifically
6   call for the development and use of tools and technology that enable physicians and patients to
7   determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs,
8   taking into account insurance status or payer type, prior to making prescribing decisions, so that
9   physicians and patients can work together to determine the most efficient and effective treatment
10   for the patient's medical condition. Related, the Council recommends amending Policy H-125.974
11   which supports alignment and real-time accuracy between the prescription drug data offered in
12   physician-facing and consumer-facing RTPB tools, and advocates that regulators work with
13   physician and hospital organizations, and HIT developers, in identifying real-time pharmacy
14   benefit implementations and published standards that provide real-time or near-time formulary
15   information across all prescription drug plans, patient portals and other viewing applications, and
16   EHR vendors. The Council recommends adding to this strong policy to also specify that the AMA
17   will advocate that regulators include proven and established real-time pharmacy benefit criterion
18   within EHR certification programs and that integration of RTPB tools within HIT be accomplished
19   without disruption to EHR usability and minimal to no cost to physicians and hospitals. Finally, the
20   Council recommends reaffirming Policy H-450.990 which calls for physician access to the best
21   available cost data at the point of decision-making.
22
23   RECOMMENDATIONS
24
25   The Council on Medical Service recommends that the following be adopted in lieu of Resolution
26   213-NOV-20 and that the remainder of the report be filed:
27
28   1.   That our American Medical Association (AMA) continue to support efforts to publish a Real-
29   Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other
30   prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any
31   insured patient. (New HOD Policy)
32
33   2.   That our AMA advocate that all payers (i.e., public and private prescription drug plans) be
34   required to implement and keep up to date an RTPB standard tool that integrates with all EHR
35   vendors, and that any changes that must be made to accomplish RTPB tool integration be
36   accomplished with minimal disruption to EHR usability and cost to physicians and hospitals.
37   (New HOD Policy)
38
39   3.   That our AMA develop and disseminate educational materials that will empower physicians to
40   be prepared to optimally utilize RTPB tools and other health information technology tools that
41   can be used to enhance communications between physicians and pharmacists to reduce the
42   incidence of prescription abandonment. (Directive to Take Action)
43
44   4.   That our AMA amend Policy H-110.990 by addition and deletion, as follows:
45
46   Our AMA:…
47   2. believes that cost-sharing requirements should be based on considerations such as: unit cost
48   of medication; availability of therapeutic alternatives; medical condition being treated; personal
49   income; and other factors known to affect patient compliance and health outcomes; and
50   3. supports the development and use of tools and technology that enable physicians and
51   patients to determine the actual price and patient-specific out-of-pocket costs of individual

1   prescription drugs, <u>taking into account insurance status or payer type</u>, prior to making
2   prescribing decisions, so that physicians and patients can work together to determine the most
3   efficient and effective treatment for the patient's medical condition; <u>and</u>
4   <u>4. supports public and private prescription drug plans in offering patient-friendly tools and</u>
5   <u>technology that allow patients to directly and securely access their individualized prescription</u>
6   <u>benefit and prescription drug cost information</u>.
7
8   5.   That our AMA amend Policy H-125.974 by addition and deletion as follows:
9
10   Our AMA…
11   (4) will advocate to the Office of the National Coordinator for Health Information Technology
12   (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and
13   hospital organizations, and health information technology developers, in identifying real-time
14   pharmacy benefit implementations and published standards that provide real-time or near-time
15   formulary information across all prescription drug plans, patient portals and other viewing
16   applications, and electronic health record (EHR) vendors;
17   <u>(5) will advocate to the ONC to include proven and established real-time pharmacy benefit</u>
18   <u>criteria within its certification program;</u>
19   (5<u>6</u>) will advocate to the ONC and the CMS that any policies requiring health information
20   technology developers to integrate real-time pharmacy benefit systems (RTPB) within their
21   products do so with<u>out</u> ~~minimal~~ disruption to EHR usability and <u>minimal to no</u> cost to
22   physicians and hospitals<u>, providing financial support if necessary</u>; and… (Modify Current
23   HOD Policy)
24
25   6.   That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access
26   to and review the best available data associated with costs at the point of decision-making,
27   which necessitates that cost data be delivered in a reasonable and useable manner by third-
28   party payers and purchasers. The policy also calls for physicians to seek opportunities to
29   improve their information technology infrastructures to include new and innovative
30   technologies to facilitate increased access to needed and useable evidence and information at
31   the point of decision-making. (Reaffirm HOD Policy)

Fiscal Note: Less than $2,500.

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APPENDIX

Policy Recommended for Amendment or Reaffirmation

H-110.990 Cost Sharing Arrangements for Prescription Drugs
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (CMS Rep. 1, I-07 Reaffirmation A-08 Reaffirmed: CMS Rep. 1, I-12 Reaffirmed in lieu of Res. 105, A-13 Reaffirmed in lieu of: Res. 205, A-17 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: CMS Rep. 07, A-18)

H-125.974 Continuity of Care for Patients Discharged from Hospital Settings
Our AMA:
(1) will 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;
(2) supports 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;
(3) supports 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;
(4) will 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;
(5) will 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; and
(6) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. (CMS Rep. 2, A-21)

H-450.938 Value-Based Decision-Making in the Health Care System
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING
1. Physicians should encourage their patients to participate in making value-based health care decisions.

2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmation: I-17 Reaffirmed: CMS Rep. 06, A-19)