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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3317-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies [Docket No. CMS-3317-P]**

The American Pharmacists Association (“APhA”) and the National Community Pharmacists Association (“NCPA”) are pleased to submit these comments on the Centers for Medicare & Medicaid Services’ (“CMS”) proposed rule regarding Medicare and Medicaid patient discharge planning requirements for hospitals, Critical Access Hospitals (“CAHs”), and Home Health Agencies (the “Proposed Rule”). In addition to our comments below, we also support the Pharmacy Health Information Technology Collaborative (“HIT Collaborative”) comments on the Proposed Rule, which have been submitted separately.

APhA represents more than 62,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, physicians’ offices, community health centers, managed care organizations, hospice settings, and the uniformed services.

NCPA represents the interests of America’s community pharmacists, including the owners of more than 23,000 independent community pharmacies—representing an \$88.7 billion health care marketplace, dispensing nearly 40% of all retail prescriptions, and employing more than 300,000 individuals, including 62,000 pharmacists. To learn more, go to [www.ncpanet.org](http://www.ncpanet.org) or read NCPA’s blog, The Dose, at <http://ncpanet.wordpress.com/>.

We thank CMS for the opportunity to comment on the Proposed Rule. Because APhA and NCPA consider safe medication use foundational to care quality and outcomes, we were pleased with the Proposed Rule’s emphasis on improving medication safety. We support the intent of

CMS' proposal to include medication reconciliation as an essential element of discharge planning for hospital and CAH patients. However, we recommend that CMS develop standards that utilize pharmacists, the medication experts on the health care team, as fully and effectively as possible to optimize the benefits of discharge planning services.

## **I. Defining Medication Reconciliation Standards**

Given that medication-related problems generate close to \$300 billion in health care costs annually, APhA and NCPA strongly support CMS' proposal to require medication reconciliation as an essential element in hospital and CAH patient discharge plans. We encourage CMS to work with stakeholders to develop robust medication reconciliation programs that will reduce difficulties associated with care transitions and that will enhance patients' understanding of their medication regimens. In the Proposed Rule, CMS states that "medication reconciliation would include reconciliation of the patient's discharge medication(s) as well as with the patient's pre-hospitalization/visit medication(s) (both prescribed and over-the-counter); comparing the medications that were prescribed before the hospital stay/visit and any medications started during the hospital stay/visit that are to be continued after discharge, and any new medications that patients would need to take after discharge."<sup>1</sup> In addition to these identified elements, we believe that CMS should clearly articulate that medication reconciliation is not a singular service provided once but rather an ongoing process. Ongoing monitoring of patient adherence and outcomes is an essential element of the joint American Society of Health-System Pharmacists ("ASHP")-APhA definition, which defines medication reconciliation as:

"[t]he comprehensive evaluation of a patient's medication regimen any time there is a change in therapy in an effort to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions, as well as to observe compliance and adherence patterns. This process should include a comparison of the existing and previous medication regimens and should occur at every transition of care in which new medications are ordered, existing orders are rewritten or adjusted, or if the patient has added nonprescription medications to [his or her] self-care."<sup>2</sup>

Using the medication reconciliation process at discharge may help patients utilize medications more safely and effectively—potentially reducing readmissions and their corresponding negative impacts on patient well-being and system costs.

## **II. Providing Meaningful Medication Reconciliation**

APhA and NCPA share CMS' view that effective discharge planning will require active engagement of the patient and his/her entire health care team. However, the fact that the Proposed Rule makes no mention of pharmacists, the clinicians with more medication-related education and training than any other health care provider, raises serious concerns. In the Proposed Rule, CMS notes that "[i]nadequate patient education has led to poor outcomes, including medication errors and omissions, infection, injuries, worsening of the initial medical condition, exacerbation of a different medical condition, and re-hospitalization" and that "[l]ack

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<sup>1</sup> 80 Fed. Reg. 68134 (Nov. 3, 2015).

<sup>2</sup> APhA and ASHP, *Improving Care Transitions: Optimizing Medication Reconciliation* (March 2012) at p. 1, available at [https://www.pharmacist.com/sites/default/files/files/2012\\_improving\\_care\\_transitions.pdf](https://www.pharmacist.com/sites/default/files/files/2012_improving_care_transitions.pdf).

of patient education concerning medicine storage, disposal, and use may also be a factor in overdoses, substance use disorders and diversion of controlled substances.”<sup>3</sup> Pharmacists, with their advanced training in medications, are uniquely qualified to offer just this type of education. Further, both CMS and the U.S. Department of Health and Human Services (“HHS”) have recognized the value of pharmacists and pharmacists’ services in optimizing patient outcomes in a cost-effective manner (*e.g.*, proposed expansion of pharmacists’ medication therapy management programs).<sup>4</sup> In order to maximize the benefit to patient health and outcomes, we urge the inclusion of pharmacists on each patient’s health care team throughout the discharge planning process—from the development of the discharge plan to the provision of medication reconciliation and beyond—to the greatest extent possible.<sup>5</sup> APhA and NCPA believe that CMS’s proposed discharge planning could significantly improve patient outcomes through optimizing the role of the pharmacist and the value of coordinated care.

### **III. Estimating Discharge Planning Burden**

As noted above, APhA and NCPA support the provision of robust medication reconciliation as part of the discharge plan for each hospital and CAH patient. In the Proposed Rule, CMS states its belief that medication reconciliation is a “near universal practice” for hospital inpatients<sup>6</sup> and does not provide a burden estimate for existing practices. For CAHs, CMS notes that “the time required for . . . reconciliation would vary greatly depending upon the number of medications a patient was taking, both pre-admission and at discharge” and estimates that on average, medication reconciliations would require “3 minutes for each patient or 0.05 hours” when conducted by a nurse.<sup>7</sup> We agree with CMS that the time required for medication reconciliation will vary based on conditions and needs of each patient. However, even given variability in patients, an average of 3 minutes per encounter may not accurately reflect the amount of time robust, meaningful medication reconciliation will take. For example, in other medication-related services, such as Part D medication therapy management (“MTM”) and chronic and transitional care management (“CCM/TCM”) services, our members regularly report that services take, at a minimum, 10-15 minutes per patient, and can take as long as an hour or more for the most complex MTM patients. Thus, time and burden estimates may need to be adjusted to account for the patient education and other medication reconciliation elements that

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<sup>3</sup> 80 Fed. Reg. 68129.

<sup>4</sup> *See, e.g.*, Centers for Medicare & Medicaid Services, *CY 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Programs; Proposed Rule*, 79 Fed. Reg. 1951 (Jan. 10, 2014); *See also* U.S. Department of Health & Human Services, *National Action Plan for Adverse Drug Event Prevention* (2014), available at <http://health.gov/hcq/pdfs/ADE-Action-Plan-508c.pdf>.

<sup>5</sup> APhA and NCPA recognize that pharmacists may not be fully integrated into existing and new care delivery models in hospitals and CAH (*e.g.*, ACOs and patient-centered medical homes), but we continue to advocate for better integration of pharmacists into these care settings to ensure that patients can benefit from improved access to high-quality pharmacists’ patient care services. For instance, the inclusion of pharmacists on the care team, including ACO care teams, can have a profound impact on overall quality of care. Specifically, pharmacists who participate in ACOs have indicated to us that the opportunity to work with other health professionals on the care team on a regular basis improves communication and coordination and provides an often missing in-depth focus on medications by the pharmacist, which leads to improved care for patients.

<sup>6</sup> 80 Fed. Reg. 68146.

<sup>7</sup> *Id.* at 68148.

we believe need to be included in discharge plans to most effectively, efficiently, and positively impact patient outcomes and system costs.

Thank you for the opportunity to provide feedback on the Proposed Rule and for your consideration of our comments.

Sincerely,

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