September 4, 2012

Centers for Medicare & Medicaid Services
Attention: CMS–1590–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

[Submitted online at: http://www.regulations.gov]

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013 [File Code CMS–1590–P]

Dear Sir/Madam:

The American Pharmacists Association (APhA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule on Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013 published July 30, 2012 (77 FR 44722).

APhA, founded in 1852 as the American Pharmaceutical Association, 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, community health centers, managed care organizations, hospice settings and the uniformed services. Our comments reflect the views of pharmacists practicing across the spectrum of health and patient care settings.

APhA offers comments on the following provisions in the proposed rule.

Section II. H. Primary Care and Care Coordination 1. c. Defining Post-Discharge Transitional Care Management Services (Page 44776)

APhA supports CMS in the development of the proposed new Healthcare Common Procedure Coding System (HCPCS) G-code that would address post-discharge transitional care management. As outlined, the code would cover non-face-to-face services when a patient transitions from a variety of inpatient settings to care furnished by the patient’s primary care physician in the community or other qualified non-physician practitioner.
We appreciate CMS’ effort in improving coordinated and continuity of care for patients transitioning from inpatient settings to outpatient community-based care. Efforts such as this, which take into account the importance of a comprehensive discharge process, have the opportunity to dramatically improve patients’ quality of care while reducing hospital readmissions and costs.

It is important to note the critical role appropriate medication use plays in successful care transitions and we believe that whenever medications are used, the nation’s medication experts – pharmacists – should be engaged. Medication reconciliation is an integral part of the care transitions process in which health care professionals collaborate to improve medication safety as the patient transitions between patient care settings or levels of care. Intensive involvement of pharmacy staff members and a focus on inpatients at highest risk for adverse drug events are two key elements in medication reconciliation that ensures success, according to a systematic review conducted by four physicians and reported in the July 2012 *Archives of Internal Medicine*.¹

Studies have also shown that integrating pharmacists into multi-disciplinary care models has positively impacted patient outcomes and appropriate medication use and reduced costs. The U.S. Public Health Service (PHS) is a successful model in which incentives are aligned to maximize pharmacists’ services. As part of PHS, pharmacists and physicians have for nearly 50 years successfully collaborated to improve patient care. In the recent report to the Surgeon General, the PHS, Office of the Chief Pharmacist, highlighted improved patient safety, enhanced cost-effectiveness, and care delivery through pharmacist-provided services. The report, *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General*, also includes over 27 pages of citations to peer reviewed studies that document the value of pharmacist services.²

**Recommendations**

The successful implementation of transition of care services as described in the proposal will require the coordination of care and communication across multiple providers, including pharmacists. Therefore, APhA encourages CMS to ensure that applicable post-discharge transitions of care services and medication reconciliation activities provided by a pharmacist in collaboration with the patient’s community physician or other qualified provider are covered within the proposed new G-code. Also, we recommend CMS consider if it is necessary to create a different new G-code to accommodate post-discharge transitions of care services provided by a pharmacist, especially when a pharmacist is working in or contracting with evolving integrated patient care models (including patient centered medical homes and accountable care organizations) and community pharmacy settings.

Furthermore, as outlined on page 44777 of the notice, we recommend CMS consider adding the following underlined language or other appropriate language to the existing italicized text in the proposal:

For CY 2014, we are proposing to create a new code to describe post-discharge transitional care management. The service would include:

- **Assuming responsibility for the beneficiary’s care without a gap.**
  - Reviewing medication regimen in discharge summary and providing comprehensive medication reconciliation by or in collaboration with a licensed pharmacist.

- **Communicating** (direct contact, telephone, electronic) with the beneficiary and/or caregiver, including education of patient and/or caregiver within 2 business days of discharge based on a review of the discharge summary and other available information such as diagnostic test results, including each of the following tasks:
  - Communicating with the beneficiary’s community pharmacist and/or pharmacy concerning the beneficiary’s medication regimen as reconciled between the pre- and post-hospitalization.

As part of current and future transitional care management proposals, we encourage CMS to include pharmacists and consider creating a pilot or demonstration program that recognizes pharmacists as providers under Medicare Part B (pharmacists are currently not listed as providers). Such a program would also provide an avenue for addressing the pharmacist payment recommendations previously discussed.

**Pharmacists Providing Medication Reconciliation as Part of Transitions of Care**

Effective coordination of care among health care team members, including pharmacists in both the inpatient and outpatient settings, is an essential component of medication reconciliation processes. To build on this message, in March 2012, APhA and the American Society of Health System Pharmacists (ASHP) released a white paper entitled *Improving Care Transitions: Optimizing Medication Reconciliation*³ (attached). The resource recognizes the importance of medication reconciliation and the specific role of pharmacists in this process. Numerous studies cited in the white paper highlight pharmacists’ involvement in medication reconciliation during transitions of care improves patient outcomes and reduces overall health care costs. It also provides a better understanding of the medication reconciliation process during transitions in care, its effect on patient care and outcomes, and how pharmacists can contribute to the improvement of this process through medication therapy management (MTM).

The document also aims to stimulate discussion among health care providers and researchers on how to best research and implement improvements in the medication reconciliation process, with the goal of improving patient safety and patient care outcomes. We encourage CMS to utilize this resource as implementation of transitions of care services evolves and builds on current and future proposals.

Medication Reconciliation and Care Coordination in Affordable Care Act

APhA understands that CMS considers this latest proposal to be part of a multiple year strategy exploring best practices to promote care coordination services. Similar to care transitions between hospital physicians and community physicians, we encourage CMS to similarly consider the need for a coordinated transition between hospital pharmacists and the community pharmacists as part of discharge planning. Such action would build upon the important provisions within the Affordable Care Act (ACA; P.L. 111-148) that recognize pharmacists’ role on the medical team as the medication expert.

Reference to pharmacists and the importance of medication reconciliation is reflected in the following provisions in the new health care reform law:

- Section 10328 of the ACA requires Medicare Part D plans to offer a minimum set of medication therapy management (MTM) services to certain targeted Medicare beneficiaries. The minimum set of services must include an annual comprehensive medication review and quarterly targeted medication reviews furnished by a licensed pharmacist or other qualified provider.

- Section 3026 of the ACA establishes a community-based care transitions program (CCTP) to provide high-risk Medicare beneficiaries transitional care interventions. CCTP provides funding both to hospitals with high readmission rates and to community-based organizations (CBOs) that provide services related to transitions of care. Applications must include a detailed proposal for at least one transitions of care intervention, which may include conducting comprehensive medication review and management with, if appropriate, counseling and self-management support.

- Section 3502 of the ACA establishes a program to provide grants to create community-based interdisciplinary teams (which may include pharmacists) that must support access to pharmacist-delivered medication management services, including medication reconciliation. The provision also requires care management and support programs during transitions in care, including medication reconciliation.

- Section 3023 of the ACA establishes a national pilot program for integrated care during a beneficiary’s episode of care around a hospitalization. In order to improve the coordination, quality, and efficiency of health care services, the program would realign incentives to implement a payment model that bundles the patient’s hospital care into one payment. The payment methodology tested under the program must include compensation for providing applicable services such as medication reconciliation.

Section II. H. Primary Care and Care Coordination. 2. Primary Care Services Furnished In Advanced Primary Care Practices (Page 44780)

We appreciate that CMS discusses plans for considering new options and developing future payment proposals for payment of primary care services, chronic conditions, preventive services, and care coordination across the health care team through patient centered medical home models,
generally referenced by CMS as “advanced primary care practice” models. We support such
efforts that, as described by CMS, reflect the need to better accommodate payment options for
evolving integrated care teams and patient centered medical home practice model that may be
limited in the current functionality of the Medicare Physician Fee Schedule. We also support the
important references to medication management, medication reconciliation, and
communication/coordination of care across the patient’s care team and medical neighborhood.

As discussed earlier, we encourage CMS to recognize the important role that pharmacists play in
such evolving practice models. We recommend CMS address in this rule and/or in future
rulemaking the need for pharmacists’ services to be covered when working with inpatient
physicians, community physicians, other eligible providers, and integrated care teams through
advanced primary care practice models to provide transition of care services, medication
reconciliation, and/or other care coordination services. We anticipate certain situations and
practice settings in which a pharmacist may serve as the care coordinator for the patient’s health
care team. In such circumstances, we recommend that there be a mechanism by which payment
can be made to the pharmacist for the applicable care coordination services provided. Similarly,
as advanced primary care practice models evolve, pharmacists may be providing specific
transition of care and medication reconciliation services on-site in a care team’s practice setting
or through a business relationship as part of an off-site/outpatient pharmacy practice setting. To
align incentives, such practice models must be able to bill for the services provided by
pharmacists or share payment in accordance with the services provided by members of the care
team, including pharmacists.

Overall, as implementation of integrated team-based care and medical home models evolve,
APhA is willing to work with CMS to explore and establish appropriate payment methodologies
to ensure that pharmacists’ services are covered through the appropriate coding structure and
future payment options focused on team-based patient care.

Section III. C. Durable Medical Equipment Face-to-Face Encounter and Written Orders
Prior to Delivery (page 44794)

We appreciate that CMS proposes to reduce the risk of fraud, waste, and abuse of durable
medical equipment (DME) by requiring additional documentation of patient office visits.
However, we are concerned that as a condition of payment for certain DME covered items,
physicians would be required to document and communicate to the DME supplier that the
physician (or a physician assistant (PA), nurse practitioner (NP), or a clinical nurse specialist
(CNS)) has had a face-to-face encounter with the beneficiary no more than 90 days before the
order is written or within 30 days after the order is written.

Specifically, APhA is concerned with the burden on pharmacists and pharmacy practice settings
in obtaining required documentation. For example, CMS is considering an option for the patient
to deliver a copy of the prescriber documentation to the pharmacy but the patient may not have
such documentation and the pharmacy would be forced to refuse dispensing of the DME product.
We request additional clarification on how any required documentation would be electronically
and automatically transmitted to pharmacy DME suppliers without requiring a request from the
suppliers as burdensome logistics would impact pharmacists’ ability to dispense DME supplies in a timely manner.

Furthermore, we appreciate that CMS is proposing a G-code, estimated at $15, to compensate physicians for the burden to document that a PA, NP, or a CNS practitioner has performed a face-to-face encounter. However, we are concerned that the proposal does not include compensation to pharmacy suppliers for the burden to comply with DME requirement. We encourage CMS to consider options in which pharmacists could be similarly compensated for DME activity under Medicare Part B.

**Conclusion**
In conclusion, APhA supports CMS’s efforts to improve care transitions. We recognize that this proposal is one part of various CMS initiatives to improve the quality of patient care and decrease costs to the health care system. We strongly encourage CMS to better reflect pharmacists’ clinical services as a necessary component of transitional care services, medication reconciliation, and care coordination in the final rule and in future payment proposals. Doing so will help ensure that pharmacists working in collaboration with patients, physicians and other providers, and other pharmacists are part of solutions to improve health care and reduce hospital readmissions. We also recommend that CMS provide additional clarification on potentially burdensome documentation requirements for the dispensing of DME products by pharmacy DME suppliers.

Thank you again for the opportunity to provide comments on these important issues. If you have any questions or need additional information, please contact Marcie Bough, PharmD, Senior Director of Government Affairs at mbough@aphanet.org or by phone at (202) 429-7538.

Sincerely,

Thomas E. Menighan, BSPharm, MBA, ScD (Hon), FAPhA
Executive Vice President and CEO

TM/mb

cc: Brian Gallagher, BSPharm, JD, Senior Vice President, Government Affairs
    Marcie Bough, PharmD, Senior Director, Government Affairs

Attachment: APhA and ASHP White Paper: Improving Care Transitions of Care: Optimizing Medication Reconciliation | March 2012