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The Honorable Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1645–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research, CMS–1645–P

Dear Mr. Slavitt:

As one of the nation's largest non-acute care group purchasing organizations, Innovatix appreciates the ongoing efforts by the Centers for Medicare & Medicaid Services (CMS) to improve the services provided through Medicare and Medicaid to beneficiaries residing in post-acute care settings. Innovatix has a national membership of over 33,000 non-acute care providers, including 650 long-term care pharmacies and 6,450 skilled nursing facilities (SNFs), which will be negatively impacted by rule CMS–1645–P as currently proposed. Innovatix believes the proposed measure, "Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care Skilled Nursing Facility Quality Reporting Program," will: (1) increase operational and financial challenges for long-term care providers, (2) establish a measurement system that will not accurately assess performance, and (3) require that clinically-significant medication issues be addressed by the prescriber within too short a timeframe.

<u>Medication Reconciliation Should Remain Separate from Drug Regimen Review</u>

The IMPACT Act of 2014 requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), SNFs, Home Health Agencies (HHAs), and Inpatient Rehabilitation Facilities (IRFs). "Medication reconciliation" is one of the domains the Secretary was called upon to standardize.[i] Innovatix is concerned, however, that the proposed measure for medication reconciliation in SNFs goes beyond statutory intent by incorporating drug regimen review (DRR) into the measure.

Medication reconciliation and DRR are distinctly different services. SNFs rely on consultant pharmacists to provide DRR. The consultant pharmacist will typically visit the SNF at least once a month to perform DRR and other medication-related services.

While it is possible that a consultant pharmacist may visit the SNF more than once per month (or provide services remotely) based on resident or SNF needs, consultant pharmacist visits to the SNF typically adhere to the monthly DRR schedule. Medication reconciliation, on the other hand, could include reconciling a resident's medication list, interviewing the resident or family about the resident's medication history, and checking a resident's prescription containers. Different members of the care team, including the physician, the nurse or the pharmacist, can perform this service.

We are concerned that the CMS proposal to provide medication reconciliation through DRR will require more frequent consultant pharmacist visits to the SNF without providing more funding to cover the additional expenses. This would add significant financial and operational challenges for SNFs and consultant pharmacists, particularly for rural SNFs that are not in close proximity to a consultant pharmacist who can perform these services with the frequency suggested in the CMS proposal. CMS should redefine the measure to require that medication reconciliation be performed, but allow the SNF to continue to determine how the medication reconciliation will be provided (e.g., by the physician, the nurse, or the pharmacist).

While SNFs should be able to choose who provides medication reconciliation, Innovatix believes that pharmacists are ideally equipped to provide this service and should be compensated justly when they do. Many of our member pharmacies that provide medications to SNFs (dispensing pharmacies) routinely reconcile a resident's prescribed medications against the hospital's discharge summary as a best practice. However, the CMS proposal does not address payment to pharmacists for these services, nor does the Social Security Act currently recognize pharmacists as healthcare providers eligible for Medicare reimbursement. This again underscores the need for pharmacists to receive recognition and fair compensation for the full range of services they provide. The Pharmacy and Medically Underserved Areas Enhancement Act (H.R.592/S.314), currently before Congress, would provide for coverage of pharmacist services under the Medicare program. This legislation would allow pharmacists to provide necessary healthcare services for some of our country's most vulnerable patients. We urge CMS to support this important legislation to secure provider status for pharmacists.

Recommendation: CMS should recognize that medication reconciliation and DRR are distinctly different services. CMS should redefine the measure for medication reconciliation to require that it be performed, but allow the SNF to determine by whom the medication reconciliation will be conducted. Innovatix recommends that CMS recognize the essential role that pharmacists play in providing enhanced services to beneficiaries. We urge CMS to support pharmacist provider status legislation currently pending in Congress (H.R.592/S.314) that will address this issue.

Proposed Measurement May Not Accurately Capture SNF Performance

We recognize that the IMPACT Act requires CMS to assess how SNFs reconcile medication; however, we are concerned that the proposed measure goes beyond statutory intent by incorporating DRR as noted above, and will also generate incomplete data on medication reconciliation that CMS will then use to evaluate SNF performance. The proposed formula calls for "documentation of a drug regimen review conducted at admission and also at discharge with a look back through the entire resident stay, with all potential clinically significant medication issues identified… by midnight of the next calendar day." This formula does not incorporate all the work that the SNF and the pharmacy conduct to ensure a resident receives the appropriate medication and that any medication-related issues are addressed in advance, prior to dispensing medication.

For instance, pharmacies that provide medications to SNFs currently work with prescribers to resolve clinically-significant medication issues before the medications are ever dispensed to the SNF. This may be one of many possible explanations for why a SNF may identify only a few clinically-significant medication issues according to the proposed measure. Therefore, we are concerned that CMS may assign the SNF a score that will not be meaningful, and therefore not appropriately recognize a SNF's process for medication reconciliation.

Furthermore, "clinically-significant medication issues" may be interpreted differently by the many providers involved in a resident's treatment, so variation may exist in data reporting. If CMS seeks to understand the impact of the medication reconciliation process at the SNF, it should not rely solely upon a DRR-based measure, but should ensure that quality medication reconciliation is provided upon admission to the facility (e.g., reconciling the hospital's discharge summary and the resident's pre-hospital medications with the resident's medications at the SNF).

Recommendation: CMS should abandon the proposed DRR-based measure and instead look to verify that quality medication reconciliation is provided upon admission (e.g., upon admission and prior to dispensing any new medications, the resident's medications are reconciled with the hospital's discharge summary and the resident's pre-hospital medications).

Short Timeframe (24 Hours) is Not Sufficient to Remedy All Medication Issues

The proposed quality measure includes a requirement to resolve clinically-significant medication issues with the physician or physician designee by midnight of the next calendar day, which is really only 24 hours. We agree that medication issues need to be resolved with urgency, but the timeframe this proposal requires is not feasible due to many factors. These include the prescriber's and the hospitalist's availability to respond to issues and their limited access to information technology that supports the prompt

resolution and documentation of these issues. CMS should work with stakeholders to develop a policy that will meet the needs of residents and be operational by facilities.

Recommendation: CMS should not finalize a rigid 24-hour requirement for resolution of medication-related issues. CMS should work with stakeholders to develop a policy that aligns with the resident's best interest and accounts for the complex post-acute care setting.

Thank you in advance for considering these important issues. We hope that you will review our recommendations and reconsider the proposed requirements for medication reconciliation, refine the measure so that it will appropriately capture SNF performance, and recognize that sufficient time is needed to remedy and document medication issues.

Sincerely,

John P. Sganga, FACHE
Executive Vice President, GNYHA Ventures
President & CEO, Innovatix
President & CEO, Essensa

[i] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html