AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Medication Reconciliation Post Discharge

Quick Reference Guide

2026

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MEASURE SNAPSHOT

CMS Part C Star Measure: C17 – Medication Reconciliation Post-Discharge

CMS Definition: The percentage of discharges from **January 1 to December 1** of the measurement year, for patients 18 and older, for which **medications were reconciled within 30 days after discharge** (31 total days).

Medication reconciliation is a formal clinical process performed within 30 days of inpatient discharge where a qualified professional (prescribing practitioner, clinical pharmacist, PA, or RN) explicitly compares a patient's newly prescribed hospital discharge medications against their pre-admission home regimen, documents any additions, changes, or continuations, and updates the outpatient medical record (reported via **CPT-II 1111F**).[1]

FIELD	ENTRY
CMS measure name	Medication Reconciliation Post-Discharge, MRP
Domain	Managing Chronic (Long Term) Conditions
CMS weighting category	Process Measure
Weight	**1, standard-weighted**
Primary data source	HEDIS, claims and medical-record documentation
Unit of measurement	CMS contract-level measure, individual clinicians and practices do not receive a C17 Star Rating
Trend direction	**Higher is better**
Case-mix adjusted	No
Measurement period	01/01/2024 – 12/31/2024. Used to calculate Star Ratings Year 2026, published two years after the measurement period ends[1]
Star measure credit	A qualifying reconciliation documented in the outpatient record inside the 31-day window, reached through a claim carrying **CPT II 1111F** or an eligible bundled code, or through chart documentation found at medical-record review. **No face-to-face visit is required**; a telephone or chart-review reconciliation by an eligible healthcare professional counts[1,2]
Measure retirement	**SY2026 is the final Star Ratings year in which this measure appears standalone. It is removed beginning Star Year 2027.** The same reconciliation work continues to earn Star credit as one of the four components of Transitions of Care **(C20)**[3]
Statistical method	Clustering. Cut points are recalculated each year from the distribution of contract scores and are not fixed targets[1]

FIELD	ENTRY
Not reported for	Prescription Drug Plans. Reported for all other health plan types, including I-SNP-only health plans
Reporting codes (support administrative capture)	**CPT II 1111F:** discharge medications reconciled with the current outpatient list; billable alone, no visit required **CPT 99495/99496**: Transitional Care Management, when contact and visit timing are met **CPT 99483** (cognitive assessment and care planning) and **99605/99606** (pharmacist medication therapy management)[2,4]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; I-SNP = Institutional Special Needs Plan; MRP = Medication Reconciliation Post-Discharge (HEDIS label); NCQA = National Committee for Quality Assurance

How The Years Line Up

Care Delivered
Eligible discharges **January 1 to December 1, 2024**, each reconciled within its own 31-day window. The December 1 cutoff exists so every discharge gets the full window inside the measurement year

↓

Data Reported
HEDIS reporting and medical-record review during 2025, through the health plan's certified HEDIS submission

↓

Published Rating
Reported in the 2026 Star Ratings, published October 2025

↓

Payment Year
Contributes to the Star Rating used for 2027 Medicare Advantage quality bonus determinations

The 2026 Star Rating reflects windows that closed in 2024. Since this measure is removed beginning Star Year 2027, a reconciliation completed this month will **not earn standalone credit in any future rating**: from here forward the same work counts through the Transitions of Care measure **(C20)**.[1,3]

In One Sentence

For every eligible hospital discharge, this measure asks one question: were the discharge medications compared and reconciled against the patient's outpatient list, by a qualified clinician, and documented, within 31 days?

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points from the 2024 measurement year can be used as a directional benchmark but should not be interpreted as guaranteed prospective thresholds.

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<40%	≥40% to <60%	≥60% to <74%	≥74% to <87%	≥87%

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug

2026 Industry Performance

National numeric average: 77%, for an average measure rating of **3.8 Stars** in the 2026 Star Ratings. This is one of the stronger-performing Part C process measures.[1,3]

The **5-Star threshold** requires a rate of **≥87%**. The current gap between **77%** and **87%** is attributable almost entirely to operational factors rather than clinical performance. This includes discharges that go unreported to the practice, reconciliations that are completed but not coded, and documentation that lacks the specificity required to meet review criteria.[1,2]

Broader MA market context: roughly **64%** of MA-PD enrollees are in contracts rated four or more stars for 2026, and 18 MA-PD contracts earned an overall 5-Star rating.[4]

WHAT THE MEASURE IS ASKING

AAVBC PERSPECTIVE — HOW THIS MEASURE WORKS

This measure is initiated by the hospital discharge. The measurement window begins at that event. Credit is assigned based on **claims data (CPT II 1111F).** When no qualifying code is submitted, credit is instead based on documentation in the outpatient record, meaning the reconciliation must occur within the window and be documented in a form the review process can identify. Performance on this measure therefore depends on three prerequisites that precede the office visit itself: **awareness that the event occurred, timely outreach to the patient, and completion of the reconciliation within the required timeframe.**

In Plain Language

Following hospital discharge, a patient's medication regimen reflects new prescriptions, discontinued medications, and dosage changes, in addition to medications already in use prior to admission. This measure evaluates whether a qualified individual **reconciled both medication lists within 31 days of discharge**. An office visit is not required: a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse may complete this by phone or chart review, provided the record documents that the two lists were compared.[1,2]

Why it Exists

The period immediately following discharge carries the highest risk of medication-related harm: approximately **one in five patients** experiences an adverse event within three weeks of discharge, most commonly an adverse drug event,[5] and approximately **one-quarter** of medication changes made at discharge are not followed up on within 30 days.[6] Direct communication between hospital physicians and the primary care practice occurs in a minority of discharges, and the discharge summary is frequently unavailable at the time of the first post-discharge visit.[7] Medication reconciliation is the control point where these two records are compared and consolidated into one accurate list before the patient acts on either.[8]

QUALITY OUTCOME — WHAT THIS MEASURE PROTECTS

Pharmacist-led medication reconciliation programs reduced all-cause readmissions by about **19%** and emergency department visits by about **28%** in a meta-analysis, with adverse-drug-event-related admissions cut by **67%**.[9] In most cases, **comparing the discharge medication list against the patient's outpatient medication list** confirms the two are consistent. The clinical value lies in **identifying the exceptions**, for example a duplicated beta-blocker, an anticoagulant never restarted, or a discontinued medication still being auto-refilled. These are the discrepancies responsible for the readmissions and adverse events this measure is designed to prevent.

What a Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical experiences and workflows that contribute to measure performance. What follows is the part of this measure a care team can influence directly.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Acting on discharge alerts **the same day** • Building the side-by-side list **before outreach** • Completing the reconciliation by phone, chart review, or visit inside the window • The explicit comparison note with date and credential • Billing **1111F** promptly	• Whether the hospital's discharge summary and ADT feed arrive, and whether they arrive **complete and legible** enough to act on • Pharmacy fill data through the **HIE** • Whether prescriptions were picked up • Caregiver availability	• **Who** gets admitted and **where** • What the hospital changed and how **accurate** it documented the change • Cut points, clustering, and the Categorical Adjustment Index • The plan's record-review sample

ABBREVIATIONS: ADT = admission, discharge, transfer; HIE = health information exchange

AAVBC PERSPECTIVE

CMS is retiring this measure after **SY2026**, as performance has become uniformly high across contracts, reducing its value for differentiating plan quality. The underlying clinical requirement is unchanged: the same reconciliation process is one of four components of **Transitions of Care (C20)**, and the same ADT alerts, pharmacist outreach, and documentation practices also support performance on **Plan All-Cause Readmissions (C18)**.[3]

MEASURE SPECIFICATION

HEDIS Episode-Based Measure

ELEMENT	SPECIFICATION
Denominator	Acute and nonacute inpatient discharges between **January 1 and December 1** of the measurement year, for patients 18 or older.[1] The December 1 cutoff exists so every eligible discharge has its **full 31-day window** inside the measurement year[1]
Numerator	Medications reconciled by a **prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse**, with evidence documented in the outpatient record, on the date of discharge through 30 days after (31 total days)[1,2]

ELEMENT	SPECIFICATION
What the documentation must show	The **date performed** and the **current medication list**, plus **evidence the discharge medications were addressed**: a documented comparison of discharge and current medications, a notation referencing the discharge medications (for example, "no changes since discharge"), or documented awareness of the hospitalization with the medication review, per the NCQA specification as restated in plan-published guidance[2]
No visit required	Reconciliation can be completed by **telephone or chart review.** The eligible-clinician and documentation requirements still apply[2]
Administrative pathway	A claim carrying **CPT II 1111F** closes the discharge administratively with no associated visit. Eligible bundled codes **(TCM 99495/99496, 99483, 99605/99606)** count where their own service and timing requirements were met. Where no qualifying code was billed, the discharge falls to medical-record review[2]
Exclusions	Patients in **hospice** or **using hospice services** at any time during the measurement year, and patients who died during the measurement year. Contracts with enrollment under 500, or 500–999 with measure reliability below 0.7, are excluded at contract level[1]
Measurement window	January 1 – December 31, 2024 for the 2026 Star Ratings; eligible discharges end December 1[1]

ABBREVIATIONS: CPT = Current Procedural Terminology; NCQA = National Committee for Quality Assurance; TCM = Transitional Care Management

⚠ RED FLAG — WAITING FOR THE OFFICE VISIT IS HOW THE WINDOW CLOSES

This specification **does not require an office visit**, and the most common operational flaw is assuming it does require one. A practice that schedules reconciliation into the next available appointment makes the **31-day deadline** dependent on scheduling availability, patient transportation, and no-show risk. A phone call from a pharmacist or registered nurse **within the first week** completes the measure and identifies discrepancies while they are still resolvable by phone.[2]

Commonly Misunderstood

- Teams assume reconciliation requires the follow-up visit → **it does not.** Phone or chart review by an eligible clinician counts, and informing patients of this **prevents those who cannot travel** from disengaging
- Documenting "medications reviewed" is assumed to satisfy the numerator → **it does not.** The record must show the discharge list was addressed against the current list, with a date and an eligible signature

- A billed TCM code is assumed to always count → **it only counts when its own contact and visit timing were documented. 1111F** carries no such documentation requirements, making it the more reliable mechanism for documenting this measure
- The denominator is assumed to be patients → **it is discharges.** A patient readmitted twice generates three windows, and each is evaluated **independently**

HOW PERFORMANCE IS MEASURED

From Discharge to Credit

Each eligible discharge is assessed once, based on whether a qualifying reconciliation was documented within its **31-day window**. Credit is established administratively when a claim carries **CPT II 1111F** or an eligible bundled code. Discharges without a qualifying code are evaluated through the plan's hybrid medical-record review, where the documentation itself must meet the evidence requirements.[1,2] Timely **1111F** billing therefore serves two functions: it documents completed work in claims data without waiting for record review, and it reduces the volume of record requests the practice receives during HEDIS season.

CMS assigns Star ratings by clustering, includes this measure in the **Part C Improvement Measure** (correlation **0.873**) and the **Categorical Adjustment Index**, and applies **no case-mix adjustment**.[1]

CLINICAL PEARL — THE CODE AND THE NOTE ARE DIFFERENT INSTRUMENTS

The **note** documents the clinical information itself: it must show that the comparison occurred, when, and by whom. The **code, CPT II 1111F,** reports that work to the health plan: it is what removes the discharge from the record-review queue. When a practice documents thoroughly but does not submit the code, the work is **not credited automatically**. The same reconciliation must then be substantiated a second time, later, through medical record review.[2]

Internal Performance is not the Official Star Result

Internal dashboards can support care improvement, but they should be distinguished from the official CMS result because the populations, denominators and data pathways differ.

CALL IT THIS	WHICH MEANS
Official result	The contract-level result calculated and published by CMS using its **own data and methodology**

CALL IT THIS	WHICH MEANS
Internal proxy	An **organization's internal estimate** based on its own patient population and available records. Useful for improvement work, but not equivalent to the official result
Documentation completeness	How **consistently** the care delivered is documented in structured fields
Patient understanding	Whether patients leave encounters with a **clear understanding** of what care they received, supported by an accessible record

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services
**Internal estimates should be labeled clearly and interpreted separately from the official CMS contract-level result because the populations, denominators, and measurement pathways differ

Adjustment and Comparability

This measure is **not case-mix adjusted**.[1] A practice with barriers (such as patients who are discharged from out-of-network hospitals, fill prescriptions across multiple pharmacies, and lack a caregiver available to answer follow-up calls) is compared against the same raw rate as a practice without these barriers.

HIGH-YIELD INTERVENTIONS

The gap between the **77% national average** and the **87% five-star threshold** reflects workflow and documentation gaps, not clinical performance.[1] It may result from discharges the practice is never informed of, reconciliations that were completed but not coded, and/or insufficient documentation. The **first week** of the window addresses patient safety, through direct contact. The remaining weeks address completion, ensuring the work performed is documented in a form the review process can credit.

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Work the ADT/HIE feed every morning and route each discharge to a named qualifying professional for this measure within 24–48 hours	**Daily** · Care coordinator	The **ADT feed** provides the discharge notification independent of patient self-report and identifies out-of-network events the practice would not otherwise identify. Hospitals are required to transmit these notifications under **Medicare Conditions of Participation**[10]

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Build the side-by-side before anyone calls: discharge summary and external pharmacy fill history against the outpatient list	**Days 1–2** · Clinical pharmacist or trained MA	Preparing the comparison in advance (discharge summary, pharmacy fill history, and outpatient list) lets the call **verify** medications instead of collecting them for the first time. Pharmacy fill data confirms which medications were actually obtained, and this step identifies the most common inpatient error prior to outreach: a chronic medication **suspended during hospitalization and never restarted**[8]
Tier the day's discharges and call high-risk patients first	**Days 1–3 ·** Care coordinator assigns; pharmacist or RN calls	Prioritization ensures that medication classes and conditions carrying the **highest readmission risk** following a discrepancy are addressed first, per the tier table below
Run the structured 7-minute reconciliation call: brown bag, active verification, the stop-list, teach-back	**Days 2–3** · Pharmacist or RN	Telephone follow-up with medication reconciliation reduced 30-day readmissions by **9.9%**(odds ratio 0.57) in a controlled evaluation.[12] The structured format (direct verification of medication bottles, identification of discontinued medications, and patient teach-back) keeps the call efficient and complete
Complete and document the reconciliation on the call	**Same call** · Eligible clinician (prescriber, pharmacist, PA, or RN)	Telephone reconciliation is credited **only when documented** with the date, a comparison statement, and the clinician's credential.[2] Completing it before the visit allows the visit to proceed from a verified medication list
Bill CPT II 1111F the promptly the reconciliation is documented	**When possible** · Front-desk or coding staff, prompted by the note template	The code closes the discharge administratively and removes it from the record-review queue, converting completed clinical work into **counted measure performance**.[2] Linking the billing prompt to the note template ensures documentation and coding are completed together

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Use TCM (99495/99496) where the full service is delivered — and audit its timing before submission	**Per discharge** · Named owner for the 2-business-day contact	**TCM** bundles patient contact, a follow-up visit, and reconciliation into a single structure whose deadlines satisfy this measure by design. Credit requires that TCM's own timing requirements be documented; reconcile claims against contact and visit dates weekly

ABBREVIATIONS: ADT = admission, discharge, transfer; COPD = chronic obstructive pulmonary disease; MA = medical assistant; PA = physician assistant; RN = registered nurse; TCM = Transitional Care Management

QUALITY OUTCOME: PHARMACIST-LED RECONCILIATION

In one health-system evaluation, pharmacist-led reconciliation after discharge reduced 7-day readmissions from **4% to 0.8%**.[13] The measure allows **31 days** for completion, but the clinical benefit is concentrated in the **first seven days**, when errors such as duplicated therapies and unfilled prescriptions are most likely to result in harm[5,12]

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Learning about the discharge from the patient or from claims	Inpatient and outpatient EHRs rarely sync, and claims post weeks late	Real-time **ADT** and **HIE** feeds, worked daily by a named owner, including out-of-network events[10]
"Medications reviewed" as the entire note	The clinician did the comparison but recorded a phrase that cannot demonstrate it. At record review the discharge falls out	A **standard reconciliation phrase in the note template**: discharge list of [date] compared and reconciled against the current outpatient list, changes stated by name, dated and signed with the credential[2]
Reconciliation done, never coded	The work is complete in the chart, no **1111F** goes out, and the discharge sits in the review queue	Link the **1111F** billing prompt to the reconciliation template so that documentation and coding occur as a single step; review uncoded completions on a weekly basis

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Reconciling from the discharge summary alone	The discharge summary is often treated as authoritative, but discharge medication lists commonly contain automated carry-overs, unreflected specialist changes, and outdated pre-admission data[8]	Verify against the **patient's actual bottles and the pharmacy fill history**. The discharge summary is one input among several, and the discrepancies it introduces are precisely what this verification step is designed to identify
Assuming the hospital or the last clinician completed reconciliation	Without a designated owner, medicine, nursing, and pharmacy each assume another team has completed the reconciliation, and it goes incomplete[13]	**One named owner per discharge**, assigned at the morning ADT review, with the task closed only by a documented, dated reconciliation
Booking the reconciliation into the next available visit	When reconciliation is scheduled around an appointment, the **appointment date becomes the deadline**: a visit set for day 25, followed by a single cancellation, falls outside the 31-day window, leaving the patient on a conflicting medication regimen for up to three weeks	Complete it by phone in week one; let the visit **verify and refine**

ABBREVIATIONS: ADT = admission, discharge, transfer; EHR = electronic health record; HIE = health information exchange

Where the Line Sits

Transition-of-care measures are structured around timing, and meeting the deadline is not the same as delivering clinically meaningful follow-up. The following do not meet that standard:

- A contact documented only as having occurred, with **no clinical content**
- A transitional-care service billed **without the corresponding review** being performed
- Medication reconciliation completed from the discharge summary alone, **without direct patient contact**
- A follow-up recorded as complete when the patient **could not be reached**

CLINICAL PEARL

The follow-up interval specified in these measures is not arbitrary. The **risk of deterioration and medication error is highest in the first few days after discharge**, and the window is timed to identify that period.

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Discontinued medications remaining in the home	A medication is **discontinued at discharge**, but nothing in the home signals that discontinuation, so the patient **continues taking both the new and the discontinued medication**. Reconciliation performed on the record alone does not address medications already in the patient's possession	An **explicit stop-list**, communicated verbally and in writing, identifying discontinued medications by name. Patients should be asked to **physically gather their medication bottles** during the call to confirm which are being discontinued
Cost-driven non-adherence	An **unanticipated copay** results in the new prescription **never being filled**, leaving nothing to reconcile. **Food insecurity and housing instability** independently reduce adherence further[14]	Confirm **fill status through pharmacy data** before and during the call. When cost is the barrier, address it clinically, using **formulary alternatives, prior-authorization follow-through, or plan pharmacy benefits**, rather than documenting the case as nonadherence
Ineffective discharge education	Discharge education is delivered quickly, in complex language, at a point when patient comprehension is limited; limited health literacy **doubles** the rate of unintentional non-adherence to discharge medications[15]	**Teach-back** confirmation during the call and at the visit, **plain-language medication lists** at an accessible reading level, and **one instruction per medication change**[15]

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Undocumented verbal dose changes	A clinician instructs the patient to split a tablet or reduce a dose for cost reasons, but the **medical record is not updated** accordingly. The patient's **actual regimen and the documented regimen no longer match**	**Active verification** during the call, confirming the medication label and the patient's actual dosing pattern, followed by **updating the record to reflect actual practice** or correcting the regimen directly with the patient

CLINICAL PEARL — VERIFY AGAINST THE MEDICATION

Every list in this workflow (the discharge summary, the EHR, and the pharmacy profile) represents a claim regarding the medication the patient is taking**.** A general question such as "are you taking your heart medications?" invites a yes-or-no response; asking the patient to state the name and dose on the bottle identifies discrepancies (for example, a **duplicated beta-blocker**, an **outdated furosemide dose maintained through auto-refill**, or a **sleep aid that was never prescribed)**.

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
EHR interoperability gaps	Inpatient records do not sync with the outpatient system. Discharge summaries arrive as **faxes or scanned images** that cannot be queried, and outdated medication lists persist in patient portals, creating confusion during brief visits	**HIE integration** that delivers discharge documents and pharmacy fill history into **structured fields**, combined with periodic removal of expired entries so the outpatient medication list remains current
Retail pharmacy disconnection	Retail pharmacies operate outside both the inpatient and outpatient networks. Patients fill prescriptions across multiple chains, so **no single pharmacy profile is complete**, and prior authorizations delay time-sensitive medication starts	Incorporating **external fill history** from the HIE or e-prescribing network as a standard step in the pre-visit comparison, with **direct pharmacy calls for Tier 1 patients** to confirm prescriptions were picked up

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Role ambiguity across the team	Reconciliation is assigned to every role in principle, but **overlapping departments** each **assume** the documentation has already been completed[13]	A **single standard template** usable by every eligible clinician type, a **named owner** assigned to each discharge, and a fixed link between the completed template and the **billing prompt**
Specialty and inpatient silos	Inpatient specialists adjust medications within their own domain without cross-checking the patient's chronic regimen, and **suspended medications are frequently never restarted**[8]	The pre-built comparison explicitly flags **suspended chronic medications**, and discrepancies are routed to the ordering or primary clinician before the follow-up visit, so the visit begins from a **verified medication list**

ABBREVIATIONS: EHR = electronic health record; HIE = health information exchange

Disparity Gaps Requiring Targeted Action

The **contract-level rate conceals which patient subgroups are underperforming**, and because this measure applies **no case-mix adjustment**, those differences appear directly in the raw rate.[1] Patients facing **complex medication regimens combined with social barriers** are at the highest risk of not meeting this measure. Completion should be examined by **language, income, age, and medication count**, and the phone-first outreach pathway should be directed toward the populations where these access barriers are concentrated.

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Patients with limited English proficiency	Nearly double the rate of difficulty understanding discharge instructions **(11.3% versus 6.5%)**, with more post-discharge medication concerns and prescription access problems[16]	Language-concordant reconciliation calls or professional interpreters, **not family members**, translated medication lists at an accessible reading level, and teach-back through the interpreter[16]
Low-income and dual-eligible patients	**Copays break the medication chain before reconciliation can happen**; unintentional non-adherence doubles with limited health literacy, and food insecurity and housing instability each independently reduce adherence[14,15]	**Fill-status checks before outreach**, cost barriers routed to formulary and benefit solutions, social-needs screening with navigation, and phone-first completion so transport is never the constraint

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Geriatric patients with polypharmacy	Patients on **five or more cardiometabolic medications** face up to a **50%** risk of a medication error within 90 days of discharge, and cognitive load or absent caregivers makes self-tracking unrealistic[17]	**Pharmacist-led reconciliation**, caregiver involvement with consent, pill organizers and regimen simplification, cognitive assessment where indicated, and MTM review for the most complex regimens
Rural patients	**Distance** and **pharmacy deserts** make an in-person requirement **unreliable** within 30 days	The specification's own answer: **telephone and telehealth reconciliation count**. Add mail-order and home-delivery pharmacy, community health worker visits, and transport assistance for the visits[2]

ABBREVIATIONS: MTM = medication therapy management

DOCUMENTATION REMINDER — TELL THE PATIENT THE PHONE COUNTS

Patients often assume this requirement necessitates an office visit, and those with the **greatest transportation barriers** are the most likely to disengage from scheduling. Informing patients directly that reconciliation **can be completed by phone**, and asking them to have their medication bottles available, addresses the **primary access barrier** associated with this measure.

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Heart failure	**The highest-density discharge medication changes in primary care**, and the strongest evidence base: pharmacist involvement in heart failure transitions has substantially reduced readmissions, with discrepancies found in over half of checked patients[18]	**Higher Risk:** discharge medication complexity**; check** diuretic dose verification against the pharmacy fill, and the stop-list stated for every agent the admission replaced

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
COPD	**Inhaler regimen changes** (device switches, LAMA/LABA dosing) are a **common failure point at discharge**, and medication discontinuation after hospitalization is frequent[9]	**Device-level verification on the call**: which inhalers, which technique, which old devices to retire[19]
Polypharmacy and geriatric complexity	Between one in twenty and **one in four** readmissions in these patients trace back to a medication problem[20]	Pharmacist-led review, caregiver on the call, simplification where possible, and high-risk classes **screened explicitly**
High-alert medications	**Anticoagulants, insulin and sulfonylureas, and opioids convert small discrepancies into emergencies fastest**	**Same-day or next-day contact**, explicit dose-by-dose verification, and prescriber involvement for any discrepancy

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; LABA = long-acting beta-agonist; LAMA = long-acting muscarinic antagonist

Patient Journey

BEAT	CONTENT
Presents as	A patient in his **mid-seventies** with **heart failure** is discharged after a **five-day admission** for volume overload. His furosemide was increased, an SGLT2 inhibitor started new, and the **NSAID** he takes for knee pain was stopped - all on top of a home regimen of lisinopril, metformin and atorvastatin
What happens	The reconciling clinician (on a phone call in week one, bottles out) works the discharge list against what is actually in the pill rotation at home and finds two problems: **the pharmacy auto-refilled the old, lower furosemide dose, and he restarted the NSAID because nobody told him to leave it stopped**
Outcome	Both discrepancies are corrected on the spot (the dose fixed with the pharmacy, the NSAID retired for good) before either becomes a fluid-overload readmission or a kidney injury. The clinician documents the dated comparison explicitly and **1111F** goes out on the claim the same day
Follow-up	The follow-up visit starts from a **clean, verified list** and spends its time on the **titration plan** instead of list archaeology. The same episode also satisfied the reconciliation component of Transitions of Care — the measure this work will be a part of from SY2027[3]

ABBREVIATIONS: NSAID = non-steroidal anti-inflammatory drug; SGLT2 = sodium-glucose cotransporter-2
Note: Case is illustrative and is not a reported individual case

Companion Guides – Making Connections

GUIDE	WHEN TO REACH FOR IT
Transitions of Care QRG (C20)	**The measure C17 moves into from SY2027.** Reconciliation is one of its four components
Plan All-Cause Readmissions QRG (C18)	The outcome the reconciliation call exists to prevent; the same ADT feed and week-one contact serve **both**
Heart Failure QRG	The population where discharge medication complexity is highest and the reconciliation evidence strongest
Follow-up after ED Visit QRG (C21)	The same episode-triggered logic for emergency visits in patients with multiple **high-risk chronic conditions**

ABBREVIATIONS: ED = emergency department; QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- This measure is scored through **claims data and chart review**. The reviewer must be able to determine that the two medication lists were compared, and identify **when the comparison occurred and who performed it**. A note stating only that medications were reviewed documents that a topic was addressed, not that reconciliation took place
- The compliant note contains **three required elements**:
  - **Explicit acknowledgment of the hospitalization** with a statement that discharge medications were reconciled against the current outpatient list
  - **Specific status statement**, for example "no changes since discharge" or "discontinued [medication] per discharge summary"
  - **Date and the eligible clinician's credential**
- Discrepancies should be **addressed individually**. A statement of "no changes" following a discharge involving four medication changes does not constitute reconciliation, and is **misleading** to the next reader
- Complete documentation and coding in the **same step**: attach the updated current medication list, and prompt **1111F** or the applicable bundled code directly from the note template

What Belongs in the Record

ELEMENT	WHAT TO RECORD
The episode, anchored	Discharge **date** and discharging **facility** named in the **outpatient note**, so the reconciliation ties to the correct denominator discharge
The comparison, stated	**Explicit language** that the discharge medication list of [date] was reviewed and reconciled against the current outpatient list; not "medications reviewed"[2]
Each change, by name	**Continued, discontinued, or modified** — per medication, with the reason where it matters clinically. Suspended chronic medications addressed explicitly
The updated list	**Name, dose, frequency, route**, the working document the patient and the next clinician **actually use**
Date and credential	The **date performed**, inside the 31-day window, and the performing **clinician's eligible credentia**l — prescriber, clinical pharmacist, PA, or RN[2]
The barrier, where one exists	Unreachable after attempts, no discharge summary received, language barrier, cost problem routed to benefits with a named owner and next contact date, so in-progress is distinguishable from abandoned

ABBREVIATIONS: PA = physician assistant; RN = registered nurse

Clinical Documentation Optimization – SOAP

S — Subjective

Telephone medication reconciliation following inpatient discharge on [date] from [facility] for acute heart failure exacerbation. Patient at home with medication bottles in hand; reports mild ankle swelling improving, no dyspnea at rest. States he restarted his knee NSAID this week and that the pharmacy refilled his "water pill" at the usual dose.

O — Objective

Discharge medication summary dated [date] reviewed against the current outpatient medication list and the pharmacy fill history. Discrepancies identified: furosemide filled at pre-admission dose rather than the increased discharge dose; NSAID resumed despite discharge discontinuation.

A — Assessment

Two clinically significant post-discharge medication discrepancies in a patient with heart failure, under-dosed diuretic and a resumed NSAID, together carrying fluid-retention and renal risk.

P — Plan

Discharge medications reconciled with the current outpatient medication list. Corrected furosemide prescription transmitted to the pharmacy at the discharge dose; NSAID discontinued permanently with the reason explained, alternative analgesia reviewed. Stop-list restated and teach-back completed. Updated medication list sent to patient. Reconciliation performed by clinical pharmacist

[name] on [date]; PCP cosign; **CPT II 1111F** submitted. Follow-up visit [date] to reassess volume status and renal function.[2,4]

Documentation Examples

Complete — the reconciliation entry

"*Reviewed the hospital discharge medication summary dated [date]. Reconciled these discharge medications with the patient's current outpatient medication list. Discontinued [medication] as instructed on the discharge summary; patient to continue all other listed medications. Current medication list updated (name, dose, frequency, route). Completed by [name], RN, on [date].*"

Complete — no changes

"*Aware of inpatient discharge from [facility] on [date]. Discharge medication summary reviewed and reconciled against the current outpatient medication list: no changes to medications since discharge; same medications as listed in the discharge summary. Current list confirmed with patient by telephone. Completed by [name], PharmD, on [date].*"

Not enough — Incomplete

"*Patient seen for follow-up post-hospitalization. Continue home medications as before.*" "*Medications reviewed.*" "*No new prescriptions given today.*" *— no reference to the discharge list, no comparison statement, no current list, no date tied to the discharge, no credential. The work may well have happened; the record cannot demonstrate it.*[2]

DOCUMENTATION REMINDER — ONE TEMPLATE, EVERY ELIGIBLE CLINICIAN

Standardize a **single reconciliation template** usable by the physician, the pharmacist, the PA and the RN alike. It should include the comparison phrase, the change-by-name structure, the date, the credential line, and the **1111F** prompt built in. Completion then looks identical regardless of who performed it, which is exactly what the reviewer and the next clinician need

One Status, Clearly Stated

Most records collapse several genuinely different situations into "done" or "not done," and the outreach that follows is wrong for most of them.

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Discharge identified	The **ADT alert** has been received and dated, an owner has been assigned, and the tier has been set. The **31-day window** begins on the date of discharge
Reconciled, coded	Documentation is complete, including the date, comparison statement, and clinician credential, and **1111F** or an eligible bundled code has been submitted. The discharge is considered closed

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Reconciled, code pending	The clinical note is complete, but the corresponding claim has not been submitted. This status is resolved through the weekly billing reconciliation process
Unable to reach	Outreach attempts have been logged with dates, including alternative contacts and the pharmacy. The discharge remains open, with a named owner and a scheduled follow-up attempt
Patient declined the call	The specific **reason for decline is recorded**, the patient has been informed that telephone completion is an acceptable alternative, and the opportunity to complete reconciliation remains available. A decline is treated as a barrier requiring follow-up, not as grounds for exclusion from the measure
Window closed, unmet	The reason the window closed without completion is recorded, whether the practice was not notified of the discharge, the patient could not be reached, or the discharge summary was not received. These patterns inform infrastructure improvements for the subsequent quarter

ABBREVIATIONS: ADT = admission, discharge, transfer

FIVE KEY TAKEAWAYS

1 Each discharge is scored on one question

Was the discharge medication list compared against the current outpatient list, by an eligible clinician, and documented with a date and credential, within 31 days of discharge? A yes earns credit for that discharge; a no does not, regardless of the quality of care otherwise provided.[1,2]

2 No in-office visit is required

A phone or chart-review reconciliation by a qualified prescriber, pharmacist, PA, or RN counts when documented (**CPT II 1111F**).[2]

3 Documentation must be explicit

The note must state that the two lists were compared, including a specific status phrase (for example, "no changes since discharge" or "discontinued [medication] per discharge summary"), the date, and the clinician's credential. A generic note stating "medications reviewed" does not satisfy medical record review, even when the reconciliation was actually performed.[2]

4 Bill 1111F the same day or as soon as possible, the work is documented

Doing so converts completed care into counted care and reduces the volume of medical record review requests during audit season. This is the most efficient path to closing the gap between the **77% average** and the **87% five-star threshold**.[1]

5 This is the measure's final standalone cycle

It is removed beginning SY2027, and the identical work then earns credit through Transitions of Care **(C20)**. The ADT feed, the pharmacist call, and the documentation template should be retained, as they also support performance on **C18** and **C20**.[3]

Changes to Monitor

Current as of 2026-08-20.

KIND OF CHANGE	GOOD PRACTICE
Measure status, retirement	**C17 is removed from the Star Ratings beginning Star Year 2027**; SY2026 is its final standalone cycle. The reconciliation work continues to earn Star credit as a component of Transitions of Care (C20), so the workflow, template and coding practice in this guide remain current; only the standalone measure ends.[3] Confirm against the CMS measure list each cycle
Where the work counts next	From SY2027, **track reconciliation performance through C20**, which pairs it with admission notification, discharge-information receipt, and patient engagement — the same episode infrastructure, three more deadlines. The **AAVBC Transitions of Care QRG** carries the component detail
Rating-year methodology	For any cycle in which the measure is scored, **revalidate cut points** (clustering resets them annually), Categorical Adjustment Index treatment, and Improvement Measure inclusion (correlation 0.873 for 2026)

KIND OF CHANGE	GOOD PRACTICE
Specification detail	NCQA HEDIS Volume 2 for the current measurement year remains the citation of record for eligible clinician types, evidence requirements, and window arithmetic — industry analyses report an expanded eligible pharmacist type from MY2027 within the TRC context; confirm against NCQA publication before revising[2]
Coding and payer handling	Confirm current handling of **1111F, TCM 99495/99496, 99483** and **99605/99606**, and each plan's supplemental-data acceptance, before each measurement year
Internal tools and templates	Keep the ADT feed, tier criteria, reconciliation template and **1111F** prompt under annual review as they now serve **C18** and **C20** rather than this measure's scoreboard. Label any previous **C17** cut points or rates as outdated

ABBREVIATIONS: ADT = admission, discharge, transfer; CPT = Current Procedural Terminology; NCQA = National Committee for Quality Assurance; TCM = Transitional Care Management; TRC = Transitions of Care

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