APhA
American Pharmacists Association

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[Submitted electronically to Neelam.Gazarian@hhs.gov]

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Dear Lieutenant Commander Gazarian:

The American Pharmacists Association (APhA) would like to thank you for meeting to discuss pharmacists' roles in providing HIV preventative care and opportunities to increase access to programs through appropriate coverage and reimbursement of pharmacists' patient care services. Per your request, we are happy to provide an overview of potential administrative pathways to expand coverage under two pathways: 1) Medicare Part B and, 2) state Medicaid programs. This document is intended to summarize potential pathways that are believed to not require statutory changes.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care and enhance public health.

1) Medicare Part B

There are several potential administrative pathways for expanding coverage of pharmacists' services within Medicare Part B. We have provided a list of these administrative pathways below and have prioritized them based on the profession's preference.

1. **Centers for Medicare and Medicaid Services (CMS) updates regulations to allow a pathway for pharmacists to enroll as "other qualified nonphysician practitioners" (QHPs) under Medicare Part B and bill for services authorized under their state scope of practice.** Congress recently emphasized in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill, 2022 (H. Rept. 117-96): "The Committee appreciates CMS' recognition of the expanding roles of pharmacists with broadened scopes of practice. The Committee requests CMS hear from physicians, pharmacists, and other qualified health professionals on their efforts to work with the

American Medical Association (AMA) CPT Editorial Panel to develop mechanisms to attribute, report, and sustain pharmacists' medication management and other patient care contributions to beneficiaries in the Medicare Part B program." APhA also appreciated CMS' statements in the CY 2021 PFS final rule (FR 84583) that "[w]e agree with certain stakeholders that under the general CPT framework, pharmacists could be considered QHPs or clinical staff, depending on their role in a given service." "We understand and appreciate the expanding, beneficial roles certain pharmacists play, particularly by specially trained pharmacists with broadened scopes of practice in certain states, commonly referred to as collaborative practice agreements. We note that new coding might be useful to specifically identify these particular models of care."

2. **CMS uses a waiver using section 1135 of the Social Security Act (SSA) to allow pharmacists to enroll as providers under Medicare Part B and bill for services allowed within their state scope of practice.**
3. **CMS uses enforcement discretion to allow pharmacists to enroll as providers under Medicare Part B and bill for services allowed within their state scope of practice.** For example, CMS exercised "enforcement discretion," which allowed Medicare-enrolled immunizers, including but not limited to pharmacies working with the U.S., to bill directly and get direct payment from the Medicare program to administer COVID-19 vaccines to Medicare Skilled Nursing Facility (SNF) residents. In addition, CMS exercised enforcement discretion under the second Interim Final Rule with Comment (IFC) (85 FR 27558) clarifying that "during the COVID-19 PHE, COVID-19 tests may be covered when ordered by any healthcare professional authorized to do so under state law," including pharmacists.
4. **CMS allows pharmacists to bill Medicare Part B for services allowed within their state scope of practice under demonstration authority or other pathways as another provider type (such as, but not limited to, a mass immunizer, pharmacy, etc).** (See, Over-the-Counter COVID-19 Test Demonstration) under section 402(a)(1)(B) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)(1)(B)).
5. **Either, CMS updates internal definitions to include pharmacists within the definition of QHP so pharmacists can bill incident to a physician or non-physician practitioner (NPP) current procedural terminology (CPT) codes 99202-99205 & 99212-99215,** *or,*
    a. **CMS internally updates the definition of CPT codes 99202-99205 & 99212-99215 to allow pharmacists to bill these codes incident to a physician or NPP.**

Unfortunately, CMS adopted AMA's Guideline Changes, for time-based billing,"[f]or office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of *clinical staff* [which includes pharmacists according to CMS] who perform the face-to-face services of the encounter, [physicians/ other qualified health care professionals must] use 99211." It is important to emphasize that AMA's CPT Editorial Panel is a non-governmental body. It is also important to note that the pharmacy profession is well-represented within the AMA's CPT structure. A pharmacist, is one of two nonphysician members from the CPT Health Professionals Advisory Committee who sit on the 17 member CPT Editorial Panel. The rest of the CPT Editorial Panel is comprised of physicians and representatives from 4 designated organizations. CPT codes are structured to account for service delivery by a variety of health care professionals, including pharmacists. CMS, not AMA, is the final governmental authority on implementation of any new coding and regulatory guidance. As such, CMS can and should use its regulatory authority to permit physicians or nonphysician practitioners (NPPs) to bill for pharmacists' E/M services under incident to arrangements at higher levels of complexity or time than CPT 99211 (e.g., 99212-215), when the care provided supports use of the higher code.

In addition, CMS clarified in the second Interim Final Rule with Comment (IFC) (85 FR 27557) that medication management is covered under both **Medicare Part B** and Part D. Under a number of state laws, pharmacists are recognized as providers by state Medicaid programs. Pharmacists have the education and training to meet the

needs of patients with complex conditions and could be better utilized to meet the demands of system and the needs of patients through incident-to-physician services billing with better guidance from CMS. CMS should also clearly convey this guidance to all local MACs to avoid any disruptions in the delivery of team-based E/M services.

2) Medicaid

Under Medicaid, there are numerous examples of pharmacists' patient care services being covered under the state's medical assistance program. APhA has identified over 40 state plan amendments (SPAs) that expand coverage of pharmacists' services and are aware of programs in 28 states where a pharmacists' service is covered by Medicaid fee-for-service. Services are being reimbursed under the medical benefit using Healthcare Common Procedure Coding System Level I and Level II codes similar to those used by other health care professionals (physicians, advanced practice registered nurses, physician assistants, etc.) providing outpatient services, in settings such as pharmacies, offices, homes, walk-in retail health clinics, federally qualified health centers, rural health clinics, skilled nursing facilities, assisted living facilities, or other places of service.

The scope of reimbursable services under Medicaid is variable from state-to-state. Services include, but are not limited to, acute disease state management, chronic disease state management, diabetes self-management training services, hormonal contraceptive services, medication management services, services related to dispensing and education on opioid antagonists, test and treat for minor ailment services (influenza, Group A Streptococcus Pharyngitis, COVID-19, etc), tobacco cessation services, transitions of care services, and travel medication services.

In order to implement these programs, state medical assistance programs are applying to the United States Department of Health and Human Services for amendments to their state Medicaid plan and requesting any necessary Medicaid waiver to implement programs to reimburse pharmacists for their services. For example, state Medicaid programs can submit emergency or regular state plan amendments (SPAs) to add pharmacists as "Other Licensed Practitioners," allowing reimbursement of the necessary "services" required for a patient "service," such as pharmacist-prescribing under the medical benefit. For example, pharmacists in Nevada recently were granted the authority to prescribe HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through a statewide protocol and the state Medicaid program submitted a SPA to allow pharmacists to bill for services associated with the prescribing of HIV PrEP and PEP. In Nevada, pharmacists are able to bill Medicaid using a broad range of codes, including, but not limited to 99202-99205 and 99211-99215.

We have heard through our state affiliates that Medicaid programs greatly appreciated when CMS created a Medicaid State Plan Amendment (SPA) template and instructions to assist states in responding to the COVID-19 national emergency in March 2020. This streamlined SPA template combines multiple, time-limited state plan options into one single template, eliminating the need to submit multiple SPA actions. Given the precedent of this guidance, we believe it would be beneficial to state Medicaid programs to have guidance from CMS to the state Medicaid programs encouraging submission of state plan amendments (SPAs) to add pharmacists as "Other Licensed Practitioners," allowing reimbursement of services with the pharmacists' state scope of practice. We believe guidance and SPA templates and instructions would be very beneficial to support expanded, streamlined, and consistent implementation of these programs in the states.

APhA would welcome the opportunity to work with you and your office on further evaluation and implementation of these potential administrative pathways to expand coverage of pharmacists' patient care services under Medicare Part B and state Medicaid programs. If you have any questions or require additional

information, please contact E. Michael Murphy, PharmD, MBA, APhA Advisor for State Government Affairs at mmurphy@aphanet.org.

Sincerely,

Michael Baxter
Acting Head of Government Affairs
American Pharmacists Association

cc: Harold J. Phillips, MRP, Director White House Office of National AIDS Policy