American Pharmacists Association

September 2, 2022

[Submitted electronically via: susan.dunkin@alaska.gov]

Ms. Susan Miller Dunkin
Department of Health
Division of Health Care Services
4601 Business Park Blvd., Bldg. K
Anchorage, AK 99503

Re: NOTICE OF PROPOSED CHANGES ON MEDICAID PREVENTIVE, THERAPY, & VISION SERVICES COVERAGE & PAYMENT

Dear Ms. Miller Dunkin:

The Alaska Department of Health has recently issued proposed regulations regarding services provided by a pharmacist, based on a law (HB 145) signed in July 2022 by Governor Mike Dunleavy. The American Pharmacists Association (APhA) would like to thank Governor Dunleavy and the Department for their quick work to begin implementing the law.

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. In Alaska, APhA represents pharmacists and students that practice in numerous settings and provide care to many of your constituents. As the voice of pharmacy, APhA leads the profession and equips members for their role as the medication expert in team-based, patient-centered care. APhA inspires, innovates, and creates opportunities for members and pharmacists worldwide to optimize medication use and health for all.

We support the feedback provided by the Alaska Pharmacists Association and appreciate the opportunity to provide comments on this rule package as many of our members will be impacted by these changes. In general, we are supportive of the proposed rule package and believe it will allow pharmacists to provide a new level of care access and quality to Medicaid beneficiaries as reimbursed under the medical benefit. However, we have the following recommendations to ensure the law is implemented as intended and beneficiaries have appropriate access to services provided by pharmacists.

CPT Codes for Pharmacists' Services

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APhA appreciates the list of current procedural terminology (CPT) codes the Department of Health has published for pharmacists to report and bill for their services. However, there are several CPT codes that are missing resulting in the current list of CPT codes not adequately representing the scope of services pharmacists provide. In addition to the CPT codes published by the Department of Health, APhA recommends Alaska pharmacists be able to bill and receive reimbursement for the following CPT codes: 99205, 99401, 99402, 99403, 99404, 99407, 99408, 99409, 99441, 99442, 99443, 96372, G0108, G0109 (see, Table 1), as well as relevant pathology, laboratory, and diagnostic panel codes for pharmacists to bill for point of care tests they are running for patients.

These additional CPT codes reflect the complexity and time for various pharmacists' patient care services and align from a parity perspective with other Medicaid providers. Patient care services provided by pharmacists have been historically undervalued despite the extensive published literature showcasing the high therapeutic and economic value associated with these services.[1,2] To appropriately value the services provided by pharmacists, establish parity with services of other providers, and assure involvement by pharmacists in increasing access to care for Alaskans we recommend that the Department of Health add this set of CPT codes for pharmacists' services in the Medicaid program in addition to the CPT codes already published by the Department of Health.

These CPT codes are recommended because in other states where pharmacists are billing for their patient care services, they are able to bill these additional codes. For example, see Table 1 below that shows where pharmacists in other states are able to bill their Medicaid programs for these additionally recommended CPT codes:

Table 1

CPT code	Examples of states where states can bill Medicaid
99205	Colorado, Nevada, North Carolina
99401	Colorado, Nevada, North Dakota, Ohio, Oregon, Pennsylvania, Utah
99402	Colorado, Nevada, Ohio, Oregon
99403, 99404	Colorado, Nevada, Oregon
99407	Colorado, North Carolina, North Dakota, Vermont
99408, 99409	Colorado
99441, 99442, 99443	Colorado, Indiana, Ohio
96372	Colorado, Missouri, North Dakota, Ohio, Oregon
G0108, G0109	Colorado, Indiana, Louisiana, Missouri, Ohio, Oklahoma, Pennsylvania
Pathology, laboratory, or diagnostic panel codes	Colorado, Indiana, Nevada, New York, North Carolina, Texas, Utah

[1] Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011. Available at: https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf

[2] Murphy EM, Rodis, JR, Mann HJ. Three ways to advocate for the economic value of the pharmacist in health care. Journal of the American Pharmacists Association. August 2020. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1544319120303927

We strongly recommend the Department of Health consider including CPT codes included in Table 1 and relevant pathology, laboratory, or diagnostic panel codes to ensure patients are able to receive necessary monitoring for tests including, but not limited to, hemoglobin A1c, HIV, hepatitis B & C, influenza, lipid tests, renal function tests, sexually transmitted infections, strep throat, RSV and other current and future relevant point of care tests.

Additionally, we are concerned with the lack of valuation for the 99607 CPT code. Currently, the pharmacist schedule limits medication therapy interactions to 15-minute increments, which may not be an adequate amount of time for pharmacists to provide a comprehensive medication review and recommendations depending on the complexity of the patient's medication regimen. We strongly recommend the inclusion and valuation of 99607 to allow pharmacists adequate time to provide care to their patients.

Minimizing Barriers and Ensuring Equitable Access to Pharmacist Services

APhA is concerned with drafted changes to 7 AAC 120.110(c) that includes the following language that limits pharmacist encounters with their patients to "*not more than once each 30-day period for a recipient,*". Placing this arbitrary restriction on how frequently a patient can receive care from their pharmacist raises two potential problems. The first problem is that this restriction goes against the intent of the legislature to increase access to pharmacist provided patient care services by placing an arbitrary limit on patients receiving care from their pharmacist. Additionally, the intent of the legislation was to treat pharmacists the same as other health care professionals. Based on our review, we cannot find comparable restrictions being placed on other providers, such as physicians, advanced practice nurse practitioners, and physician assistants. APhA recommends the Department of Health implement the legislation as intended without these arbitrary restrictions that discriminate against pharmacists and limit patient access to care.

The second problem is that this restriction could result in patients not receiving needed care in a timely manner. Take the following situation as an example, a patient may have a scheduled appointment with their pharmacist to review their blood glucose, diabetes medications, and for the pharmacist to provide recommendations and interventions to get the patient to their goal hemoglobin A1c. The pharmacist is able to bill for their time in providing these services to this patient. However, two weeks later, the patient is having flu-like symptoms and goes back to their pharmacist to receive a CLIA-waived flu test and if necessary, treatment for the flu. Under the rules as currently written, their pharmacist would not be able to provide them with these services as it has been less than 30-days. It is inequitable, unfair, and unreasonable to think that these services can be provided for free by pharmacists, thus the pharmacist is forced to refer the patient to another provider. This could result in unnecessary and expensive trips to urgent care, the emergency department, and potentially hospitalizations. Another example may be the need for a patient on insulin for diabetes may need to receive follow up care within 30-days of an appointment to ensure they are not experiencing potentially dangerous adverse effects, such as low blood sugar. There are numerous additional examples of where a patient *may* need to see their pharmacist more frequently than once every 30-days for new or follow-up care. APhA recommends the removal of this barrier to patient care that will limit patient access to care and potentially result in unnecessary urgent care visits, emergency department visits, and hospitalizations.

Recognizing pharmacists as providers in RHCs and FQHCs

Pharmacists in all practice settings provide highly valuable services, and these services are important in maintaining the health of patients especially for underserved communities receiving care in rural health clinics (RHCs) and federally qualified health centers (FQHCs). To ensure appropriate access and sustainability of these clinics, we recommend allowing pharmacists in all practice settings, including RHCs and FQHCs, the ability to enroll as medical providers with Alaska Medicaid and be reimbursed for their patient care services. In RHCs and FQHCs, we recommend that prospective payment system (PPS) rates be updated for the inclusion of the pharmacist provider type, that patient encounters with pharmacists in RHCs and FQHCs trigger a payment of the PPS rate, and that the Alaska State Medicaid Manual be updated to include pharmacists as providers that can provide primary care services in RHCs and FQHCs. If necessary, APhA recommends the submission of an additional amendment to the Alaska Medicaid State Plan to include pharmacists as billable providers in RHCs and FQHCs. Other states have submitted state plan amendments[3] (SPA) to allow pharmacists to bill for similar services, and we would encourage the Department of Health to take similar steps.

We greatly appreciate the Department of Health's work to quickly implement this law. Along with recommendations provided by the Alaska Pharmacists Association, we believe, with the recommended changes that we've highlighted, Alaskans will have greater access to the numerous patient care services provided by pharmacists. Thank you for your time and consideration of our comments. If you have any questions or require additional information, please don't hesitate to contact E. Michael Murphy, PharmD, MBA APhA Advisor for State Government Affairs by email at mmurphy@aphanet.org.

Sincerely,

E. Michael Murphy, PharmD, MBA
Advisor for State Government Affairs
American Pharmacists Association

cc: Brandy Seignemartin, PharmD, Executive Director,Alaska Pharmacists Association

[3] State Plan Amendment #: 21-0009. Available at https://www.medicaid.gov/medicaid/spa/downloads/OH-21-0009.pdf