February 5, 2024

Elizabeth Fowler, Ph.D., J.D.
Deputy Administrator and Director
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Patient Care Models Group
7500 Security Boulevard
Baltimore, MD 21244

Dear Director Fowler,

Thank you again for the opportunity to meet with the Center for Medicare & Medicaid Innovation's (CMMI) team to discuss recommendations on including pharmacists in the Making Care Primary (MCP) program and subsequent primary care models. To follow up on our discussion, we wanted to provide information related to pharmacists billing incident to physicians and nonphysician practitioners (NPPs) and thank the CMMI team for the information they shared during our January 17, 2024, meeting regarding pharmacists' involvement in the MCP program in the future.

As discussed, pharmacists' services are not covered for payment in Medicare Part B. In the Part B program, pharmacists are considered auxiliary personnel or clinical staff,[1] and some of their services are permitted by CMS to be billed by physicians and NPPs, under incident to physician or other practitioner service arrangements. Two CMS policies present barriers to pharmacist billing incident to physicians and NPPs, which hinder the ability to provide primary care services.

First, as detailed in the 2021 Physician Fee Schedule (PFS) final rule,[2] CMS categorizes pharmacists as "auxiliary personnel" or "clinical staff" and are not considered a "qualified health care professional" (QHP) due to there being no "Medicare statutory benefit allowing them to enroll, bill and receive direct payment for PFS services."[3] CMS also accepted Guideline Changes from a non-governmental entity that the lower-level evaluation and management (E/M) code 99211 is the only code available for time-based billing provided by clinical staff under Part B. The use of 99211 simply is not sustainable for clinical staff, such as highly trained pharmacists providing care to complex patients, who typically provide services with time commitments at the 99212-99215 levels, which essentially inhibits patients' access to high-quality team-based care that includes pharmacist-provided patient care services. Since these statements from CMS, physicians have been significantly challenged to utilize pharmacists to provide complex care services under an "incident to" relationship as E/M code 99211 reflects an average total time of 7 minutes. A growing number of state medical assistance programs, as approved by CMS through state plan amendments, include higher-level E/M office and other outpatient services codes on their pharmacist fee schedule.[4,5,6] For example, pharmacists can bill Colorado Medicaid using an extensive list of current procedural terminology (CPT) codes including the entire E/M office or other outpatient services code set, 99202-99215.[7]

---

[1] CMS. Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies. Published December 28, 2020. https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf. Accessed January 25, 2024.
[2] *ibid*
[3] *ibid*
[4] https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=139383
[5] https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT91.pdf 20
[6] https://portal.ohmits.com/public/Public-Information/Fee-Schedules/Code/RPH/Format/HTML
[7] https://hcpf.colorado.gov/pharm-serv

As APhA has emphasized in the past, it is not feasible that a pharmacist providing a 45-minute office visit to manage multiple chronic conditions and multiple medications for a Medicare beneficiary under an incident to arrangement with a physician would be limited to having the service billed as a Level 1 visit (99211), that only has an anticipated time commitment of 7 minutes—which has effectively eliminated any incentive and/or the ability for the majority of physicians/ NPPs and pharmacists to partner to provide complex health care services.

As CMS also stated in the 2021 final rule, "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." We recommend CMMI and the MCP model consider pharmacists as qualified healthcare practitioners (QHPs) and allow "auxiliary personnel" or "clinical staff" the ability to bill Medicare Part B 99202-99205 and 99212-99215 incident to physicians and NPPs that represents modern-day health care delivery to more accurately establish values for E/M services. Congress recently emphasized the following intention for federal funding at CMS regarding pharmacist-provided patient care services in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill, 2023 (H. Rept. 117-403):

> "Pharmacist-Provided Incident to Physician Services.—The Committee is pleased with CMS's recognition in the calendar year 2021 physician fee schedule (PFS) final rule (FR 84583) that ''pharmacists could be considered QHPs [qualified health care professionals] or clinical staff, depending on their role in a given service,'' and that ''new coding might be useful to specifically identify these particular models of care.'' However, the Committee remains concerned with current CMS PFS requirements restricting physicians' and nonphysician practitioners' (NPPs) utilizing pharmacists under incident to models to bill at the lowest E/M code (99211), with an estimated time commitment of 7 minutes. The Committee understands this restriction has diminished providers' engagement with pharmacists in team-based care models across the country. *CMS should consider how to ensure physicians and NPPs can optimize the use of pharmacists. The Committee encourages CMS identify mechanisms to attribute, report, and sustain pharmacists' patient care contributions to beneficiaries in the Medicare Part B program [emphasis added]."*

Second, CMS policy sets supervision requirements for auxiliary personnel to bill Medicare Part B incident to a physician or NPP. Historically, CMS required direct personnel supervision which entailed the auxiliary personnel "have a relationship with the legal entity billing and receiving payment for the services" and the physician or NPP be "present in the office suite and immediately available to provide assistance and direction throughout the time the [auxiliary personnel] is performing services".[8] During the COVID-19 pandemic, CMS changed the definition of "direct supervision" related to physicians' services "to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence."[9] This change in the definition of "direct supervision" is currently scheduled to expire on December 31, 2024, and CMS is considering permanently addressing the definition of "direct supervision" in rulemaking in the future. We urge CMMI through MCP and other primary care models to allow for virtual direct supervision of pharmacists when billing incident to physicians and NPPs.

---

[8] CMS. Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services. Issued December 21, 2023. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed January 25, 2024.

[9] CMS. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. Published November 16, 2023. https://www.govinfo.gov/content/pkg/FR-2023-11-16/pdf/2023-24184.pdf. Accessed January 25, 2024.

We greatly appreciate the CMMI teams' comments during our January 17, 2024, meeting and follow-up correspondence regarding the involvement of pharmacists in the MCP program. Specifically, plans to provide guidance that includes examples of how pharmacists can participate in the MCP program and that patient encounters with pharmacists will be eligible for payments of the prospective payment system (PPS). Our organizations would be happy to provide support to CMMI in developing and distributing information related to pharmacists' involvement MCP.

As was mentioned in follow-up correspondence on January 18, 2024, we appreciate that CMS will provide incentive payments of up to 60% above normal Medicare payments for achieving certain quality metrics, such as goals related to blood pressure control or lowering hemoglobin A1c levels in patients with Type 2 Diabetes Mellitus. Detailed in our November 9, 2022,[10] letter to the Department of Health and Human Services (HHS) regarding the HHS Initiative to Strengthen Primary Health Care, we provide several examples of published literature that documents pharmacists' impact on improving hypertension, diabetes, and other chronic condition outcomes.

Thank you again for meeting with our organizations. If needed, our organizations would welcome the opportunity to meet with you again to further discuss the topic of pharmacist billing incident to physicians and NPPs or pharmacists' involvement in CMMI primary care models. Please contact Michael Baxter, APhA Vice President, Federal Government Affairs at mbaxter@aphanet.org to schedule a meeting with us.

Sincerely,
American Pharmacists Association
Colorado Pharmacists Society
Minnesota Pharmacists Association
National Alliance of State Pharmacy Associations
New Jersey Pharmacists Association
North Carolina Association of Pharmacists
Washington State Pharmacy Association

[10] APhA. RE: Judith Steinberg, Senior Advisor, Office of the Assistant Secretary of Health, Department of Health and Human Services (HHS): HHS Initiative to Strengthen Primary Health Care. November 9, 2022. https://www.pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=VMpoQcGSMUA%3d. Accessed January 25, 2024.