November 11, 2022

Doug Jacobs, MD, MPH
Chief Transformation Officer
Centers for Medicare & Medicaid Services

RE: Get the Medications Right Institute (GTMRx) follow-up from meeting on 11/3/2022 with Katherine Capps and Dr. Michael Barr

Dear Dr. Jacobs:

Thank you for your time and attention on Thursday, 11/3/22. Michael Barr and I truly appreciated your comments and questions in response to our overview and recommendations about comprehensive medication management (CMM) services. We hope the materials provided were helpful.

During our meeting, three ideas surfaced to advance CMM and team-based, interprofessional care. We identified one additional approach during a GTMRx policy meeting later that same day.

1. Include CMM as an eligible service for Chronic Care Management (CCM) codes.
2. Review/modify prior guidance regarding incident-to billing under FFS for CMM services provided by a clinical pharmacist.
3. Convene a listening session and/or roundtable to help CMS identify opportunities for advancing CMM services.
4. Review options for CMS to develop and advance a mandatory model that includes CMM services.

<u>Include CMM as an eligible service for Chronic Care Management (CCM) codes</u>

Pharmacists qualify as clinical staff and can be delegated services for incident-to billing including CCM, Principal Care Management (PCM), and Annual Wellness Visit but the levels of medical decision making are still limited. Clinical pharmacists could contribute critically important support to Chronic Care Management (CCM) if CMM was included as an eligible service and pharmacists were authorized to bill incident-to for moderate to high complexity CCM. Given that CCM is focused on patients with 2+ chronic conditions (or PCM for a single, high-risk disease) the broader use of well-defined CMM services would be expected to significantly improve care and reduce CMS expenditures. CMS should allow moderate to high complexity CCM services be billed incident-to a physician by clinical staff, including clinical pharmacists.
Barriers to clinical pharmacists providing CCM services:

- In an FAQ from CMS in August 2022 it states that any medical decision making in moderate to high complexity CCM must be done by the billing practitioner personally. This eliminates the opportunity for the clinical pharmacist to offer CMM and is a lost opportunity to support the care team.[1]
- Levels 2 through 5 E/M visits (CPT codes 99212-99215) qualify as a comprehensive E/M visit for CCM purposes but clinical pharmacists are not authorized to perform them.
- Billing CPT code 99490 (+/-) add on code 99439 is not sustainable to be performed by a clinical pharmacist because the reimbursement is so low. This 20 minutes of clinical staff time per month does not equal the work performed by clinical pharmacists providing CMM services.

<u>Review/modify prior guidance regarding incident-to billing under FFS for CMM services provided by a clinical pharmacist</u>

We request clarification on incident-to billing for clinical pharmacists. In 2014, the American Academy of Family Physicians requested guidance from CMS and received a letter from then Administrator of CMS, Marilyn Tavenner (March 25, 2014) in response which read:

> "…you ask that we confirm your impression that if all the requirements of the "incident to" statute and regulations are met, a physician may bill for services provided by a pharmacist as "incident to" services. We agree."

However, the 2021 Physician Fee Schedule provided contradictory guidance. In apparent support of incident-to billing are these statements:

> "…pharmacists fall within the regulatory definition of auxiliary personnel under our regulations at §410.26. As such, pharmacists may provide services incident to the services, and under the appropriate level of supervision, of the billing physician or NPP, if payment for the services is not made under the Medicare Part D benefit. This includes providing the services incident to the services of the billing physician or NPP and in accordance with the pharmacist's state scope of practice and applicable state law. [page 84592 Federal Register/Vol. 85, No. 248 (12/28/2020)]
>
> …we have long used the term ''auxiliary personnel'' to describe the individuals who may provide services incident to the professional services of a physician or practitioner who is authorized by law to bill Medicare for their services. The regulation defines the term as any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner) and meets other stated rules, including licensure rules imposed by the State in which the services are

[1] **Frequently Asked Questions About Practitioner Billing for Chronic Care Management Services.** Division of Practitioner Services, CCM FAQs, August 16, 2022

being furnished. This Medicare Part B framework applies to any individual working with the billing physician or other practitioner to provide services on an ‘‘incident-to’’ basis, for example, a physician assistant, medical assistant, nurse, pharmacist, administrative assistant or others, whether they have a clinical role or not."

However, elsewhere, in response to questions about whether a pharmacist can bill incident-to a physician for office/outpatient E/M visit codes (CPT codes 99202 – 99215), the language [page 84593] in the final rule includes:

> "As commenters noted, pharmacists could be considered QHPs by some other payers who provide for their direct payment. We do not consider them such because there is no Medicare statutory benefit allowing them to enroll, bill and receive direct payment for PFS services. As such, pharmacists are not among the physicians and QHPs that can furnish and bill for the 2021 office/outpatient E/M visit codes, because levels two through five are by definition only performed and directly reported by physicians or QHPs. For example, when time is used to select visit level, only the time of the physician or QHP is counted. By definition, these codes cannot be furnished and billed as ‘‘incident to’’ services; therefore, they cannot be used to report services consisting of time spent solely by a pharmacist working ‘‘incident to’’ the services of a billing physician."

It seems the guidance written specifically in response to a question about the ability of pharmacists to directly bill E/M codes has been conflated with the positive intent for clinical pharmacists to provide services that physicians/QHPs could bill as "incident to" and has severely limited the ability of CMM to be supported under FFS billing. Pharmacists can bill in the marketplace in several states and this definition is not a part of the AMA guidance. Therefore, we request further clarification and ask that clinical pharmacists can bill established patient visit codes at a higher-level incident-to. The only allowable E/M service that is reimbursable incident-to does not match the time or complexity for the clinical assessment, plan, implementation, monitoring, and documentation necessary for a pharmacist to provide CMM.

We believe E/M codes 99212-99215 most accurately align with the complexity of services required when CMM is delivered by a clinical pharmacist on the care team. We urge you to clarify that physicians may bill 999212-99215 for CMM provided by a pharmacist incident-to that physician or identify and alternative code that could be billed incident to for such purpose (Existing CCM, TCM and MTM codes do not meet the needs of delivering this service).

<u>Convene a listening session/roundtable to help CMS identify opportunities for advancing CMM services</u>

CMM is under-recognized and often confused with the more limited medication therapy management (MTM) program under Part D. We believe that a CMS listening session and/or round table discussion, especially if coupled with clarification of incident-to billing and CCM eligibility, could significantly advance the awareness and understanding of CMM and hopefully

lead to broader adoption. We would welcome the opportunity to co-develop such an approach with CMS.

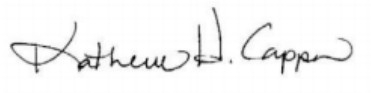
Review options for CMS to develop and advance a mandatory model that includes CMM services

Current and previous CMMI models have tested CMMI implementation in primary care: Comprehensive Primary Care Plus (CPC+), Primary Care First, and the Maryland Primary Care Program. Each of these three models included two tracks, and in all three of them, Track 2 practices are required to provide more enhanced care delivery approaches to better support patients with complex needs. Notably, Track 2 practices are required to provide CMM to patients receiving care management and in transitions of care who are likely to benefit. In CPC+, Track 2 practices were expected to increase the comprehensiveness of care delivered, and they were compensated by the Comprehensive Primary Care Payments that should increase the amounts they would have received from fee-for-service payments. This incentive aligns well with CMM, which is inherently comprehensive in its process of care.

Informed by lessons learned from CPC+, Primary Care First, and the Maryland Primary Care Program continue to require CMM implementation in Track 2 practices. Similar to CPC+, Track 1 practices have the option to implement CMM services, which some do, but it is not required. We encourage CMS to consider future mandatory models that include CMM services, and we believe that CMM implementation should be required in high value care delivery models.

Again, thank you again your time last week. We look forward to exploring these ideas with you and the CMS team. We will reach out shortly to schedule a follow-up telephone conversation. In the interim, please feel free to reach out to me at kcapps@gtmr.org or 703-394-5398.

Sincerely,



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