Washington D.C. Pharmacy Association

APhA American Pharmacists Association
For Every Pharmacist. For All of Pharmacy.

November 11, 2024

[submitted electronically via: DHCFPubliccomments@dc.gov]

Melisa Byrd
Medicaid Director
Department of Health Care Finance
441 4th Street, N.W.
9th Floor
Washington, DC 20001

Dear Ms. Byrd:

The Washington DC Pharmacy Association (WDCPhA) and American Pharmacists Association (APhA) would like to thank Mayor Muriel Bowser and the Department of Health Care Finance (DHCF) for their quick work implementing the Mayor's Order 2024-115 to establish coverage of Medication Therapy Management (MTM) services for Medicaid beneficiaries. WDCPhA and APhA appreciate the opportunity to provide comments to support the coverage of pharmacists' services in DC.

WDCPhA and APhA are generally supportive of the proposed changes to DCMR 2716 and 2799 and believe it will increase access to MTM services provided by pharmacists and share the following recommendations to ensure beneficiaries have optimal access to pharmacist provided MTM services:

- WDCPhA and APhA recommend ***against*** the inclusion of a limit of number of visits that patients can have per year to receive MTM services. Patients, pharmacists, and their healthcare providers should have autonomy to determine the number of visits a patient may need based on the specific needs of the patient and medical necessity. Placing this arbitrary restriction on how frequently a patient can receive care from their pharmacist can lead to health care problems not being addressed which could potentially result in unnecessary urgent care visits, emergency department visits, and hospitalizations.
- WDCPhA and APhA recommend the DC Medicaid MTM program align with eligibility requirements of the Medicare Part D MTM program. Notably, the Medicare Part D MTM program does not place a limit on the number of visits a patient can have with their pharmacist per year. Additionally, CMS places the limit on "eight Part D drugs being the maximum number of drugs a Part D plan sponsor may require as the minimum number of Part D drugs that a beneficiary must be taking" to be eligible for MTM services.[1] WDCPhA and APhA urge DHCF align the number of medications a patient must be prescribed to be eligible for MTM services with the Medicare Part D MTM program.
- Currently, the DC Medicaid fee schedule lists 99605, 99606, and 99607 as being reimbursed at $0.00.[2] These rates will need to be updated prior to the program being rolled out. For reference, the

[1] CMS. Contract Year 2025 Part D Medication Therapy Management Program Guidance and Submission Instructions. Published May 6, 2024. Available at: https://www.cms.gov/files/document/memo-contract-year-2025-medication-therapy-management-mtm-program-submission-v050624.pdf.
[2] https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload

California and Minnesota rates of these codes are included below for consideration as DC Medicaid is valuing the codes:

	California[3]	**Minnesota**[4]
99605	$43.00	$52.00
99606	$43.00	$34.00
99607	$32.00	$24.00

In addition to MTM, pharmacists provide numerous other services as authorized under their scope of practice. WDCPhA and APhA urge DHCF cover all services within pharmacists' scope of practice to ensure that Medicaid beneficiaries can access all services provided by their trusted community pharmacists.

Due to the fact that the services pharmacists will be providing are within DC pharmacists' scope of practice there is expected to be minimal fiscal impact from this change as demonstrated by comparable programs established in other states. For example, Oregon, identified in their fiscal legislative analysis that the creation of a similar program that would permit pharmacists to engage in the practice of clinical pharmacy and provide patient care services to patients would have "minimal expenditure impact on state or local government."[5]

Substantial published literature clearly documents the proven and significant improvement to patient outcomes[6] and reduction in health care expenditures[7] when pharmacists are optimally leveraged as the medication experts on patient-care teams. The expansion of programs that increase patient access to health care services provided by their pharmacist in DC is aligned with the growing trend of similar programs in other states, such as: California, Colorado, Idaho, Kentucky, Minnesota, Missouri, Nevada, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and others. In states where such programs have already been implemented, health plans are recognizing the value of the pharmacist and investing in the services they provide to capitalize on the positive therapeutic and economic outcomes associated with pharmacist-provided patient care services.[8]

As the most accessible healthcare professionals, pharmacists are vital providers of health care, especially for those living in underserved and remote communities. Patient access to pharmacist-provided care can address health inequities while reducing hospital admissions, increasing medication adherence, and decreasing overall health care expenditures by recognizing and covering the valuable health care services pharmacists provide, similar to DC's recognition of many other health care providers.

WDCPhA and APhA recommends that DHCF consider the following recommendations when expanding the coverage of pharmacists' services under DC Medicaid.

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[3] https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates?page=1&tab=rates

[4] https://mn.gov/dhs/assets/mhcp-fee-schedule_tcm1053-294225.pdf

[5] FISCAL IMPACT OF PROPOSED LEGISLATION Measure: HB 2028 A. Seventy-Eighth Oregon Legislative Assembly – 2015 Regular Session. Available at https://olis.oregonlegislature.gov/liz/2015R1/Downloads/MeasureAnalysisDocument/28866.

[6] 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

[7] 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

[8] CareSource Launches Pharmacist Provider Status Pilot. Published August 4, 2020. Available at https://www.caresource.com/newsroom/press-releases/caresource-launches-pharmacist-provider-status-pilot/

Reimbursement under the Medical Benefit

WDCPhA and APhA recommend that all services within a pharmacist's state scope of practice be covered under the state Medicaid program aligned for equitable treatment with how all other health care professional services are covered. Pharmacists should be the recognized provider type who orders, renders, administers, and bills for services under the medical benefit using current procedural terminology (CPT) codes used by other health care professionals (physicians, advanced practice registered nurses, physician assistants, etc.) providing outpatient services. Pharmacists' services should be covered in all outpatient settings and should not be limited to a specific place of service (POS) code. These "services" are distinct from the "dispensing," of medications and should ***not*** be reimbursed under the pharmacy benefit.

In order to add pharmacists as providers under the medical benefit, Medicaid programs can submit a state plan amendment (SPA). Other states have submitted SPAs to add pharmacists as providers under the medical benefit without any legislative changes.[9] Appendix A provides a SPA template for DHCF to consider submitting to CMS. Below are specific considerations that WDCPhA and APhA recommends when submitting a SPA.

Recognition of pharmacists as other licensed practitioners

In order to add pharmacists as providers under the medical benefit, Medicaid programs can submit a SPA within attachment 3.1-A 6.d. to add pharmacists as other licensed practitioners (OLPs), in accordance with 42 CFR § 440.60. Attachment 3.1-B would also need to be amended under 6.d. to add pharmacists as OLPs if the state participates in the medically needy program.

Coverage of pharmacists' services

Some Medicaid programs include a payment methodology for all OLPs within their state plan. To ensure that services rendered by pharmacists are a covered benefit, an amendment may be needed within attachment 4.19-B.

At a minimum, it is essential that evaluation and management office or other outpatient services codes 99202-99205 and 99211-99215 be included on the fee schedule as these codes appropriately describe the most common services pharmacists will be providing to patients. The inclusion of 99202-99205 and 99211-99215 on the pharmacists' fee schedule is aligned with how many other state Medicaid plans are implementing their pharmacist provider programs.

The following list details of WDCPhA and APhA's recommended set of CPT codes that reflect the complexity and time for various pharmacist patient care services. 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.[10,11] 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 DC patients, WDCPhA and APhA strongly recommends that DHCF adopt the inclusion of this set of CPT codes for pharmacists' services in the Medicaid program:

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[9] https://www.medicaid.gov/medicaid/spa/downloads/DE-24-0008.pdf

[10] 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

[11] 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

- Immunization Administration for Vaccine/Toxoids: 90460-90474
- Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: 96372
- Office or Other Outpatient Services: 99203-99205, 99212-99215
- Counseling Risk Factor Reduction and Behavior Change Intervention: 99401-99402, 99406-99407

Many of the CPT codes included in the list above are recommended because they are aligned with codes many other state Medicaid programs are including on pharmacists' fee schedules, they are comparable with codes that other healthcare professionals utilize and appropriately describe pharmacist patient care services. As an example, the Nevada Department of Health and Human Services Division of Health Care Financing and Policy, in drafting rules for the implementation of Senate Bill 190[12] and Senate Bill 325[13] has proposed allowing pharmacists to bill many of the codes included above, including, but not limited to 99203-99205 and 99212-99215. WDCPhA and APhA strongly recommends DHCF consider including these CPT codes to ensure patients can receive necessary pharmacist care services while aligning with other states' implementation of similar policies.

In addition to these codes, it is imperative that necessary CPT codes for the administration of all Clinical Laboratory Improvement Amendments of 1988 (CLIA)-waived tests are added to the pharmacists' fee schedule. Additionally, it is necessary that the reimbursement of CPT-codes for CLIA-waived tests be at parity for other provider types, to ensure pharmacy providers are not under-reimbursed for the cost of point-of-care tests administered at the pharmacy.

Recognizing pharmacists as providers in FQHCs

Pharmacists in all practice settings provide highly valuable services, which are important in maintaining the health of patients especially for underserved communities receiving care in federally qualified health centers (FQHCs). To ensure appropriate access and sustainability of these clinics, WDCPhA and APhA recommends allowing pharmacists in all practice settings, including FQHCs, the ability to enroll as direct ordering, rendering, administering, and billing providers with Medicaid and be reimbursed for their patient care services. WDCPhA and APhA additionally recommends that pharmacists' services be applied to the prospective payment system and/or alternative payment methodologies for bundled payments provided to FQHCs. Other states have submitted SPAs that list pharmacists as other licensed practitioners to bill for similar services.[14]

Coverage of Pharmacists' Services in Managed Care Plans

WDCPhA and APhA also recommends that services provided by pharmacists be available to all beneficiaries including those enrolled with a managed care plan. In addition, WDCPhA and APhA encourages those services provided by pharmacists be applied to managed care plans' medical-loss ratio and their capitation rates. WDCPhA and APhA believes this will ensure equitable access to services provided by pharmacists across beneficiary groups.

When other state Medicaid programs have added pharmacists as a provider type, they have provided resources to support pharmacists navigating through the enrollment and credentialing process.[15] WDCPhA and APhA urge DHCF offer similar resources to support Washingtonian pharmacists.

[12] Nevada Senate Bill 190. Available at https://www.leg.state.nv.us/Session/81st2021/Bills/SB/SB190_EN.pdf
[13] Nevada Senate Bill 325. Available at https://www.leg.state.nv.us/Session/81st2021/Bills/SB/SB325_EN.pdf
[14] https://www.medicaid.gov/medicaid/spa/downloads/PA-24-0004.pdf
[15] https://www.papharmacists.com/page/PAProviderStatus_MA

WDCPhA and APhA greatly appreciates the work of DHCF to improve access to health care for Washingtonians. By ensuring Medicaid beneficiaries can use their medical benefit insurance to receive care provided by pharmacists, DHCF will successfully improve health equity and positively impact health and health care outcomes across DC. If you have any questions or require additional information, please contact Carolyn Rachel-Price, RPh, WDCPhA Executive Director by email at wdcpha@gmail.com and E. Michael Murphy, PharmD, MBA, APhA Senior Advisor for State Government Affairs by email at mmurphy@aphanet.org.

Sincerely,

Carolyn Rachel-Price, RPh
Executive Director
Washington DC Pharmacy Association

Michael Baxter, MA
Vice President, Government Affairs
American Pharmacists Association

Appendix A

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic- (which are otherwise included in the state p1an)

☒Provided: ☐No limitations ☒With limitations*
☐Not provided

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HFCA-Pub. 45-4).

☒Provided: ☐No limitations ☒With limitations*

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Other practitioners' services.

☒Provided: Identified on attached sheet with description of limitations, if any.
☐Not provided

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic

The following RHC services are covered by the Department of Medicaid in accordance with Sections 1905(a)(2)(B), 1905(l), and 1861(aa)(1) of the Social Security Act:

__ Medical services that are rendered by a pharmacist employed by or otherwise compensated by the RHC;

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

2.c. Federally-Qualified Health Center (FQHC) Services

The following FQHC services are covered and paid under the Prospective Payment System (PPS) by the Department of Medicaid in accordance with Section 1905(a)(2)(C) of the Social Security Act:

__ Medical services that are rendered by a pharmacist employed by or otherwise compensated by the FQHC;

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Other practitioners' services – 42 CFR 440.60

__ Licensed Pharmacist services
Licensed Pharmacists are covered under their scope of practice in accordance with state law.

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic- (which are otherwise included in the state p1an)

☒Provided: ☐No limitations ☒With limitations*
☐Not provided

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HFCA-Pub. 45-4).

☒Provided: ☐No limitations ☒With limitations*

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Other practitioners' services.

☒Provided: Identified on attached sheet with description of limitations, if any.
☐Not provided

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic

The following RHC services are covered by the Department of Medicaid in accordance with Sections 1905(a)(2)(B), 1905(l), and 1861(aa)(1) of the Social Security Act:

__ Medical services that are rendered by a pharmacist employed by or otherwise compensated by the RHC;

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

2.c. Federally-Qualified Health Center (FQHC) Services

The following FQHC services are covered and paid under the Prospective Payment System (PPS) by the Department of Medicaid in accordance with Section 1905(a)(2)(C) of the Social Security Act:

__ Medical services that are rendered by a pharmacist employed by or otherwise compensated by the FQHC;

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Other practitioners' services – 42 CFR 440.60

__ Licensed Pharmacist services
Licensed Pharmacists are covered under their scope of practice in accordance with state law.

State/Territory: _____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT

RATES

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Other practitioners' services – 42 CFR 440.60

__ Licensed Pharmacist services

The state Medicaid program reimburses for services provided by a licensed pharmacist operating within their scope of practice. Payment for services provided by licensed pharmacists is made in accordance with a fee schedule established by the department. All covered services are paid at the lesser of the provider's billed charges or the state maximum allowable for the procedures. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers. The agency's fee schedule is published at _____ and is effective for services provided on or after _____.