APhA
American Pharmacists Association

January 8, 2025

[Transmitted electronically by e-mail]

Dawn Redman
Office of Acquistion Servies
Centers for Disease Control and Prevention
Department of Health and Human Services
Attention: ICATT-2025-0001
1600 Clifton Road
Atlanta, GA 30333

RE: Request for Information – Enhancing Pharmacy Countermeasures in Independent Pharmacies

Dear Ms. Redman,

The American Pharmacists Association (APhA) is pleased to submit comments via the request for information on *Enhancing Pharmacy Countermeasures in Independent Pharmacies.*

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including but not limited to 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.

Pharmacists and pharmacy personnel practicing in independent pharmacies regularly deliver health services to those in under-resourced populations and communities. Lessons learned and improvements from the last pandemic can facilitate independent pharmacists providing vaccines, testing, and therapeutics to underserved communities. Improving the following policies/regulations would improve pharmacists' ability to provide countermeasures:

- Equitable reimbursement - Reimbursement for services provided by pharmacists should be on par with other health care providers (i.e., payment parity).
- Medicare coverage - The lack of coverage under Medicare Part B for pharmacists inhibits the coverage of patient care services delivered by pharmacists. While the PREP Act authorities enacted during the last pandemic increased pharmacists' and pharmacy personnel's authorities, it did not require equitable coverage and reimbursement of these services.
- Streamlined documentation procedures – Pharmacists practicing in independent pharmacies need efficient platforms and mechanisms to document and exchange

patient-specific information with other health care entities and should not be required to input via multiple software systems. Inequitably, other health care entities are eligible for grant funding to acquire platforms that allow efficient data input and exchange. Independent pharmacies are often excluded from these funding mechanisms and therefore, are required to manually input and send patient information individually to primary care offices, health departments, and other health care entities. Independent pharmacies should be eligible for these funding mechanisms.

- Fair access to federal contracts – During the previous pandemic, federal contracts were either favorably awarded to large chains with little consideration to independent pharmacies or issued through third parties who required unrelated services as part of the contracts for independent pharmacies.
- Pharmacists can provide countermeasures anywhere, not exclusively in a traditional pharmacy setting, therefore reimbursement should not be coupled with a physical location.

1. Capabilities and Infrastructure

a) Is the following a comprehensive in describing the needed capabilities/infrastructure to provide pharmacy countermeasures (vaccines, testing, and therapeutics) to under-resourced populations/communities? If not, please provide and describe the additional capabilities and infrastructure required.

Appendix A describes appropriate capabilities and infrastructure requirements yet the following needs to be added and addressed:

- Reimbursement and funding
    - Billing/reimbursement information and processes
    - Financial incentives for incorporating countermeasure services into workflow
    - Reimbursement and regulation to allow for one-on-one opportunities such as home visits for home-bound patients
    - Established funding for countermeasures that account for dispensing fees versus only administration fees
    - Additional acquistion costs and waste disposal plans for personal protective equipment
    - Credentialing of pharmacists to bill under medical benefit for services, counseling, testing, etc.
    - Authority for pharmacists to provide services and bill for reimbursement outside of a physical pharmacy location
    - Ability to mass invoice an external payor for underinsured and uninsured instead of individual claims
    - Implement systems that allow pharmacists to bill independently for evaluation and management (E/M) services, comparable to physicians and other primary care professionals
    - Standardize billing codes for pharmacist provided services across payor types
- Communication and documentation
    - Establish telehealth platforms that extend clinical services to frontier or rural populations where physical pharmacy locations are scarce

    - Create no cost regional or state level communication methods across pharmacies
    - Decrease multiple documentation and duplicative efforts (e.g., pharmacists must log into software system for lab reporting and then must access a separate software for health department reporting)
- Additional capabilities and infrastructure
    - Separate community engagement and local marketing as they are independent activities
    - Establish policies that support coordinated care through the pharmacy as a care hub
    - Relax state requirements that must be adhered to during a pandemic (e.g., pharmacists providing CLIA-waived tests must follow state requirements and can be subjected to disciplinary action)

b) Please provide a summary of your capabilities and infrastructure that could support strategies to enhance public health response capacity, improve the efficiency of medical service delivery to rural populations, and enable pharmacies to operate as a more cohesive group.

Models that support pharmacists' response include: capability to remain open during natural disasters and public health emergencies; collaborating with payors that involve pharmacists providing countermeasures; pharmacists and pharmacy technicians dually trained as community health workers (CHWs) to provide vaccine hesitancy education, longitudinally (check in on insurance eligibility, perform social determinants of health (SDOH) screenings, and answer vaccine questions or access issues on monthly medication synchronization calls); providing home delivery and services including but not limited to vaccine administration, point-of-care testing, and emergency services; expanding pharmacy facility space to include private rooms for vaccine administration and testing; utilizing software systems that incorporate automated technology to assist with purchasing and reimbursement; and establishing and maintaining strong partnerships with community based organizations.

2. Existing Models and Services

There are several models that currently exist to provide the infrastructure services listed in the list above for independent retail and small chain pharmacies. These services are currently provided to independent pharmacies through a wide range of organizations.

a) What are the strengths and limitations of these existing models to provide the needed infrastructure to independent pharmacies for the provision of pharmacy countermeasures (defined as vaccines, testing, and therapeutics)?

Of existing models, most of the strengths pertain to product acquisition, regulatory compliance, and alignment with required documentation as guided by a pharmacy services administrative organization (PSAO) or a network of pharmacies (e.g., CPESN).

Limitations of existing models include: reliance on external third-party entities that charge additional fees; most of the models that exist do not include a focus on screening and addressing SDOH which can be a substantial barrier to public health crisis management that can be supported in large part by trained pharmacy teams; federal Medicare and state Medicaid

programs which do not cover pharmacists' services as a benefit and therefore, pharmacists are unable to serve population; federal programs necessitating specific reporting requirements that demand strict compliance by the end users without financial to support to offset administrative time and effort; no existing mechanism to electronically streamline medical billing for pharmacists' patient care services; state licensure regulations can be prohibitive in allowing pharmacy personnel to respond across state lines when they are geographically close or able to support via technology; scalability and capacity because of the limited number of staff (especially pharmacy technicians) - need support to do more or incentives for additional staffing or temporary staff (independent pharmacies often do not hire temporary staff) via grant programs (i.e., traveling nurses) and different levels of partnerships amoung state health departments.

b) What existing models could be expanded to reach other under-resourced populations and communities who may be challenged with the traditional offerings at pharmacies (i.e., Homebound, homeless, and rural populations) Please identify additional populations and describe the gaps in reaching them.

Expand current models of pharmacy technicians and delivery drivers who are dually trained as CHWs to provide insight, recommendations, and solutions for patient's living situation and SDOH considerations; incentivizing pharmacists for interventions or health equity incentives allows pharmacists and pharmacy personnel to reach more patients; utilizing mobile services out of mobile vans and clinics to reach challenged populations unable to get to a physical pharmacy location; partnership with community based organization working as a food pantry and staffing student pharmacists who were able to provide pharmacy services.

c) What challenges do independent pharmacies face in building or adopting the necessary infrastructure to expand their services to include medical health benefits, such as testing and medial assessments for the distribution of therapeutics (where authorized)?

Challenges that exist include widely variable state scope of practice regulations, with some states requiring pharmacists to partner with physicians via collaborative practice agreements to provide countermeasures such as vaccines, therapeutics, and diagnostic testing; balance of hiring additional staff support versus actual need during pandemic surges; lack of coverage of pharmacist services via medical billing; lack of strong relationship with state departments of health; high upfront costs with establishing infrastructure, technology, training staff, and facility upgrades that are urgently needed during a pandemic with limited abilities to access financing; and technology system upgrades such as implementing or integrating electronic health records, scheduling systems, and public health reporting tools.

3. Pharmacy and Medical Benefits

Providing testing, vaccines, and therapeutics may require independent pharmacies to contract with private insurance providers for both pharmacy and medical benefits.

a) Are contracts with insurance providers a component of the current infrastructure or are these contracts established by the independent pharmacies?

Within the current infrastructure, pharmacy coverage and medical coverage contracts are entered into by the individual independent pharmacy locations or via a network of pharmacies (e.g., CPESN) and vary state-by-state and per payor. Some payors may link a contract to a physical location versus an individual pharmacist, which poses challenges with credentialing and billing. Credentialing needed for payment is often burdensome to both the payor and individual pharmacist, pharmacy location, or both entities. There are disparities in reimbursement which may lower pharmacists' ability to participate in providing services. The pharmacy model should mirror models utilized by other primary care providers regarding coverage and payment parity under the medical benefit.

b) In what ways could federal support be provided to independent pharmacies to establish contracts with insurance providers for pharmacy or medical benefits?

Federal influence to establish and assure consistency in authority and coverage of pharmacists' services would be paramount. This requires partnership and collaboration between CDC and CMS to assure all patient populations (e.g., rural, urban, underserved) have equitable access to a pharmacist. It can support independent pharmacists by helping route to the proper channels and contacts for contracting or working around the "our network is closed" response. Pharmacies that are involved in supporting public health crisis management should be the highest quality pharmacies and not just those that were easiest to contract with to have a broad network.

4. Cost Structure and Incentives for independent pharmacy participation

a) Please describe potential methods for incentivizing independent pharmacy participation, beyond financial support, in the provision of pharmacy countermeasures (vaccines, testing, and therapeutics) to under-resourced populations and communities.

Potential methods for incentivizing independent pharmacists include:

- Care coordination services for pharmacy teams to support patient's getting to a service, scheduling a service, confirming questions/education, and follow-up.
- In rural or frontier areas include flexible internet hotspots, gas cards, or ability to use public spaces outside of the traditional pharmacy location and then bill for those services.
- Funding issued directly to the pharmacy for an attributed number of un-/underinsured patients to support them directly.
- Influencing value-based care and contracting for independent pharmacists; pay for higher quality of care and higher quality outcomes.
- Support training for community health worker-based solutions.
- Develop simplified processes for pharmacies to enroll in federal and state programs for countermeasure delivery, reducing administrative burden.
- Create centralized platforms for pharmacies to submit data on vaccinations, tests, and therapeutics, minimizing redundant reporting requirements.
- Assign dedicated public health coordinators to work with pharmacies in underserved regions to ensure successful implementation and support.

b) What infrastructure reimbursement capabilities can be developed or expanded to provide a cost structure to incentivize independent pharmacies to adopt the delivery of additional countermeasures to under-served communities?

Infrastructure reimbursement capabilities that can be developed include: granting financial support/incentive for pharmacies participating in EHRs; training pharmacists and pharmacy personnel on how to bill medical benefits and federally streamline the process; establishing equitable and predictable reimbursement for clinical services; providing guidance on a delivery model that is cost effective and with economic outcomes that are affordable to the underinsured or uninsured; employing a capitated fee approach where pharmacists receive a capitated fee each month to help coordinate countermeasure care.

5. Regarding independent pharmacy participation in programs implemented through federal government contracts.

a) What barriers exist to independent pharmacy participation in partnerships implemented through federal government contracts?

Several barriers exist that impede independent pharmacy participation which include awareness and communication of federal contracts; independent pharmacists engaged after other pharmacy employers, not simultaneously for countermeasure initiatives; excessive paperwork and administrative burden on smaller staffed locations; and federal contracts frequently involve slow reimbursement cycles, straining cash flow for independent pharmacies. In the case of the Bridge Access program, the federally approved contractor added non-negotiables to the contract which dissuaded independent pharmacists' participation.

b) What can be done to facilitate or incentivize independent pharmacy participation in such partnerships?

Decreasing the barriers to entry will help facilitate independent pharmacy participation in these partnerships which include streamlined contracting and realistic reporting; engaging in dialogue with independent pharmacy interested parties; issuing achievable expectations; offering pre-qualified participation pathways for pharmacies already credentialed under state Medicaid or federal programs like Medicare; ensuring timely reimbursement to mitigate cash flow issues; enhancing technology access such providing grants or subsidies for pharmacies to adopt required IT systems and data-sharing platforms; establishing incentives for federal agencies to engage independent pharmacies in rural and underserved areas.

6. Regarding sustainability,

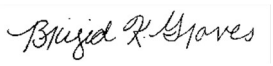
a) Describe the infrastructure that would support a sustainable program for delivery of services (vaccines, testing, and therapeutics) at independent pharmacies in under-resourced populations and communities absent of additional financial support. Please discuss potential strategies, partnerships, infrastructure, or innovations that could support long-term sustainability in these communities.

Potential strategies, partnerships, infrastructure, or innovations that can support long-term sustainability include: coverage of pharmacists' services under the medical benefit of all payor types; alignment of state scopes of practice and pharmacists authorities; collaboration with

health departments since health departments receive the funding and independent pharmacies have the access to patients; implementing and funding programs or offerings for un-/underinsured patients which do not require undue administrative burden; conduct regulatory reform for reimbursement models; and ensure federal grant dollars include pharmacists as a covered health care provider type.

Thank you for the opportunity to provide comments on this request for information on *Enhancing Pharmacy Countermeasures in Independent Pharmacies* and we look forward to continued collaboration. If you have any questions or require additional information, please contact me at bgroves@aphanet.org.

Most Sincerely,



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