Pharmacy Health Information Technology Collaborative

Via Electronic Submission to: www.regulations.gov

July 7, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5331-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

> **Re: CMS-5331-IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for Skilled Nursing Facility Quality Reporting Program**

Dear Administrator Verma:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments regarding *CMS-5331-IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for Skilled Nursing Facility Quality Reporting Program.*

The Collaborative has been involved with the federal agencies, including the Office of the National Coordinator (ONC) and the Centers for Medicare & Medicaid Services (CMS), developing the national health information technology (HIT) framework since 2010.

Pharmacists provide essential services to Medicare patients through the Part D prescription drug benefit program and as part of team-based care models in Medicare Part A, B, and C programs. Additionally, pharmacists are users of telehealth and health IT, and in particular, e-prescription(eRx) and electronic medical record (EMR)/electronic health record (EHR) systems. The Collaborative supports the use of these systems, which are important to pharmacists in working with other health care providers to provide needed medications and transmit patient information related to overall patient care, transitions of care, immunization (historical and administered), immunization registry reporting, medication lists, medication allergies, allergy reactions, patient problem lists, smoking status, reporting to public health agencies, clinical decision support services/knowledge artifacts, drug formulary checking, and electronic prescribing.

The following are our comments regarding the *CMS-5331-IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for Skilled Nursing Facility Quality Reporting Program,* which concern the telehealth provisions of the interim final rule.

Payment for Medicare Telehealth Services

The Collaborative supports the use of telehealth for delivering clinical health and person-centered care, particularly in rural health areas, and especially during times of national, state, and local emergencies, such as the COVID-19 outbreak.

Pharmacists are a part of the health care management teams providing Medicare services and are also telehealth providers. The technology for exchanging COVID-19 information from a telehealth visit is available through pharmacy management systems. Telehealth enables pharmacists to connect with established health care management teams and patients, particularly when questions arise concerning medications prescribed or changes to medications, independent of geography. In many instances, especially in rural and underserved areas where telehealth would be invaluable, pharmacists are the first point of contact by patients and their caregivers.

Although Medicare routinely pays physicians and other health care providers and practitioners (e.g., social workers, dieticians; see 42 C.F.R. §410.73 and §410.134 respectively) for several kinds of services provided via interactive communication technology, the Collaborative and its members believe pharmacists should also be paid for the telehealth services they provide, especially during a public health emergency such as COVID-19. The Collaborative supports the efforts of the national pharmacy organizations for ensuring payments to pharmacists when billing for telehealth services.

The role of pharmacists in telehealth is expanding. Many types of medication management services (MMS)[1] provided by pharmacists are clinically appropriate for telehealth, including: medication therapy management, chronic care management (e.g., diabetes, hypertension), medication reconciliation, transitions of care, pharmacogenomics, interpretation of diagnostic tests and providing test results, and consultations with patients and health care providers.

Telehealth is a cost-saving option that can expand pharmacist-provided health care services to patients outside of traditional community pharmacy practice settings,

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[1] "Medication Management Services (MMS) Definition and Key Points," Joint Commission of Pharmacy Practitioners, https://jcpp.net/wp-content/uploads/2018/05/Medication-Management-Services-Definition-and-Key-Points-Version-1.pdf

while complementing existing pharmacy services and expanding access to the expertise of pharmacists. Telehealth and telepharmacy could also provide cost-savings for hospitals, particularly rural hospitals.[2]

B. Scope of Practice

The Collaborative notes CMS "clarifies explicitly that pharmacists fall within the regulatory definition of auxiliary personnel under our regulations at § 410.26," and the applicability to incident to pharmacist-provided patient care services. However, CMS does not clarify that physicians can bill for higher level pharmacist-provided evaluation and management (E/M) services. The complexity of most services delivered by pharmacists meets the requirements for physicians to bill at higher levels (E/M codes 99212-215). It is not logical that a pharmacist providing a 45-minute office visit to manage multiple chronic conditions and multiple medications for a complex 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 has an anticipated time commitment of five minutes. In addition, CMS has now relaxed supervision requirements to permit direct supervision of pharmacists providing E/M services by physicians via audio and video technology. Medicare beneficiaries can benefit from pharmacists providing many needed E/M services using a telehealth format to assist in the management of chronic conditions with physician supervision being administered by physicians and other practitioners via audio and video technology. Therefore, the Collaborative requests CMS expressly state in guidance or regulation that "incident to" services provided by a pharmacist can be billed at E/M codes 99212-215 commensurate with the services delivered under virtual physician supervision.

AA. Updating the Medicare Telehealth List

The Collaborative requests that pharmacy services provided by pharmacists using telehealth, particularly pharmacy services provided outside of inpatient settings, be added to the telehealth list. Currently, only one pharmacy service is included on the telehealth list: G0549 Telehealth inpatient pharmacologic management.

Although CMS states that it is "not codifying a specific process to be in effect during the PHE for the COVID-19 pandemic, we not that we could add services to the Medicare telehealth list on a subregulatory basis by posting new services to the web listing of telehealth services when the agency receives a request to add (or identifies through internal review) a service that can be furnished in full…to a beneficiary in a manner similar to the in-person service. We not that any additional services added using the revised process would remain on the list only during the PHE for the COVID-19 pandemic." In this regard, the Collaborative also asks CMS to consider making permanent any new pharmacy services that are added to the telehealth list.

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[2] Health IT News, January 2018, https://www.healthcareitnews.com/news/telepharmacy-rural-hospitals-provides-big-savings-quality-improvements

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       The Pharmacy HIT Collaborative comprises the major national pharmacy associations, representing 250,000 members, including those in pharmacy education and accreditation. The Collaborative's membership is composed of the key national pharmacy associations involved in health information technology (HIT), the National Council of Prescription Drug Programs, and 14 associate members encompassing e-prescribing, health information networks, transaction processing networks, pharmacy companies, system vendors, pharmaceutical manufacturers, and other organizations that support pharmacists' services.

       As the leading authority in pharmacy health information technology, the Pharmacy HIT Collaborative's vision and mission are to ensure the U.S. health IT infrastructure better enables pharmacists to optimize person-centered care. Supporting and advancing the use, usability, and interoperability of health IT by pharmacists for person-centered care, the Collaborative identifies and voices the health IT needs of pharmacists; promotes awareness of functionality and pharmacists' use of health IT; provides resources, guidance, and support for the adoption and implementation of standards driven health IT; and guides health IT standards development to address pharmacists' needs. For additional information, visit www.pharmacyhit.org.

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       On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on the *CMS-5331-IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for Skilled Nursing Facility Quality Reporting Program.*

       For more information, contact Shelly Spiro, executive director, Pharmacy HIT Collaborative, at shelly@pharmacyhit.org.

Respectfully submitted,

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