PAYMENT OF CLINICAL FACULTY SERVICES TASK FORCE

2024-2025 COUNCIL OF DEANS

FINAL REPORT

AACP ANNUAL MEETING
JULY 21, 2025

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Committee Charges

1. Work with AACP Institutional Research and Effectiveness Team to review the data from the 2022 **Patient Care Models of Pharmacy Faculty Survey**.
    a. Create a process to enlist CEO Deans to Complete the **Patient Care Models of Pharmacy Faculty Survey** in 2024-2025 academic year.
    b. Identify exemplary Practice Plans that colleges and schools of pharmacy have implemented for their clinical faculty.
2. Assess barriers to CMS **"incident-to-billing"** by pharmacists among the 12 Medicare Administrative Contractors (MAC) and propose ways to address these barriers.
3. If CMS plans to move toward a **"value-based payment"** system by 2030, how might the academy address quality-based metrics that will provide pharmacists with the ability to understand, analyze, and expand quality control outcomes Associated with drug therapy across all healthcare sectors.
4. Discuss how **faculty contracts** may be constructed in the future given these changes above.

Task Force Members

First Name	Last Name	Title	School/College	State
John	Gums*	Executive Associate Dean	University of Florida	Florida
Thomas	Dowling**	Assistant Dean	Ferris State	Michigan
Donald	Godwin	CEO Dean	University of New Mexico	New Mexico
Paul	Gubbins	Associate Dean	University of Missouri-Kansas City	Missouri
Mark	Munger	Associate Dean	University of Utah	Utah
Thomas	Wadsworth	CEO Dean	Idaho State University	Idaho
Kristin	Wiisanen	CEO Dean	Rosalind Franklin	Illinois
Craig	Henchey***	Associate Instructor	University of Utah	Utah

*Chair **Vice-Chair ***Guest member

The committee would also like to recognize the assistance and support of the following individuals. ***Rose Williamson*** *at the University of New Mexico College of Pharmacy for her time and effort in capturing all committee meeting minutes.* ***Samantha Battaglia*** *from the University of Florida College of Pharmacy for her assistance in scheduling all meetings, communication between the committee and outside consultants, and her management of the Google Docs site serving as a repository for all references and information generated by the committee.*

Committee Accomplishments

The committee had its inaugural meeting during the **July 2024** AACP Annual Meeting in Boston. The task force reviewed the charges by Dr. MacKinnon: The committee discussed and agreed that a revised survey is needed based on the specificity of the charges. The intention is to use this data to guide further discussions and to have an evidenced-based product deliverable early on that has the potential to be publishable by the task force. We agreed to review the latest version of the 2022 Patient Care Payment Models of Pharmacy Faculty Survey and make comments and edits to existing questions for group discussion at our next meeting. Dr. Munger will check with his leadership but was optimistic that his institution could provide analysis support on the data generated from the updated survey. We agreed that for the next 2 months, we would meet approximately every 2 weeks to facilitate the completion of the revised survey and distribute it to the member colleges and schools. Thereafter, we agreed to meet monthly.

During **August and September 2024**, the committee focused on creating a revised survey that was designed to be shorter, be in alignment with the current charges for the committee, and capture data from as many of the member schools/colleges as possible regardless of whether they were actively engaged in billing models for services by clinical faculty.

In **September 2024**, the committee hosted guest Mary Ann Kliethermes, Pharm.D., the Director of Medication Safety and Quality in the Office of Advancement at ASHP and a nationally recognized expert in reimbursement for pharmacy clinical services. Key takeaways from Dr. Kliethermes's discussion are itemized below:

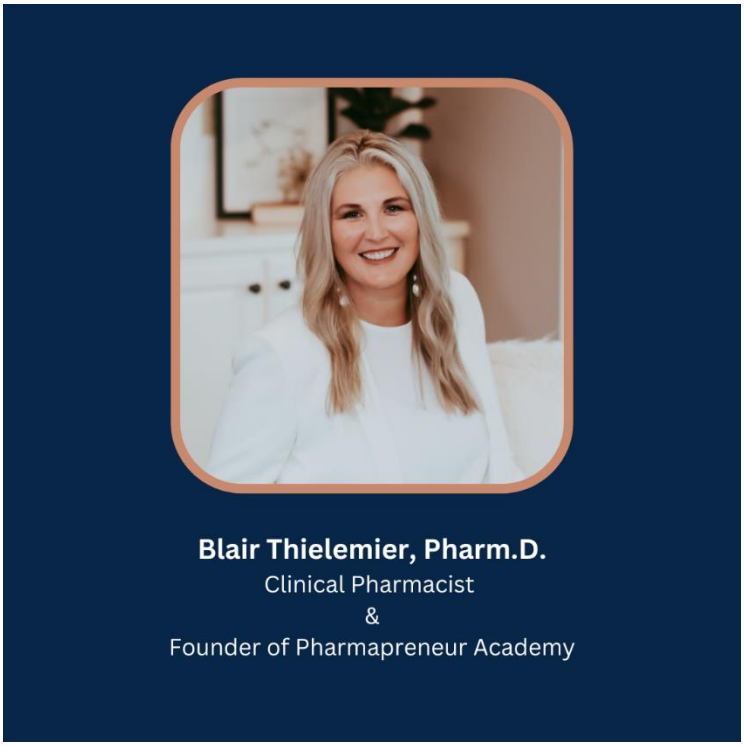
- Important questions to ask before a COP/SOP begins to explore clinical revenue from faculty services.
    - Is your COP/SOP connected with a health center and if so, is it part of a system?

    - Regardless of whether the COP/SOP is connected to a health center, what is the payer mix of the patients that are being served by the faculty members' practice?
        - Typical payer mixes include 30-40% Medicare; 40-50% Private insurance, and the remaining is public aid.
- Changes that may be occurring for 2025
    - Telehealth will be coded at the equivalent of a 99212 (not for pharmacists) but the 99211 code will be extended for audio and video patient interactions.
    - New G-codes for Team-based care models
    - 1:1 chronic disease = $10.00
        - Greater than or equal to 2 chronic diseases = $50, like CCM but with no time limit and could be done on the same day that the patient sees the physician for another reason since all these new codes are only dropped monthly.
    - Dual eligible patients = $100.00
    - New code (preventive) for Atherosclerosis Management
        - Will be an "add-on" code to 99211.
- Discussed the concept of "billing literacy" to be part of the TF's recommendations.
- Value (potential) of having a designated faculty member become certified in medical billing and coding.
- Overview of available codes

Medicare Fee-for-Service Pharmacist Revenue Options Based on Practice Site

Provider Office	Hospital Outpatient	Pharmacy
Incident to; established patient	Facility Fee	MTM
CCM, Complex CCM	CCM, Complex CCM	CCM, Complex CCM
TCM	TCM	TCM
Wellness visit	DSMT, MDPP	DSMT, MDPP
DSMT, MDPP	MTM	RPM
MTM	Wellness visit	PCM
RPM	RPM	
PCM	PCM	
CGM	CGM	

MTM = Medication Therapy Management
CCM= Chronic Care Management
TCM= Transitions of Care Management
DSMT= Diabetes Self-management Training
MDPP= Medicare Diabetes Prevention Program
RPM= Remote Patient Monitoring
PCM= Principal Care Management
CGM= Continuous Glucose Monitoring

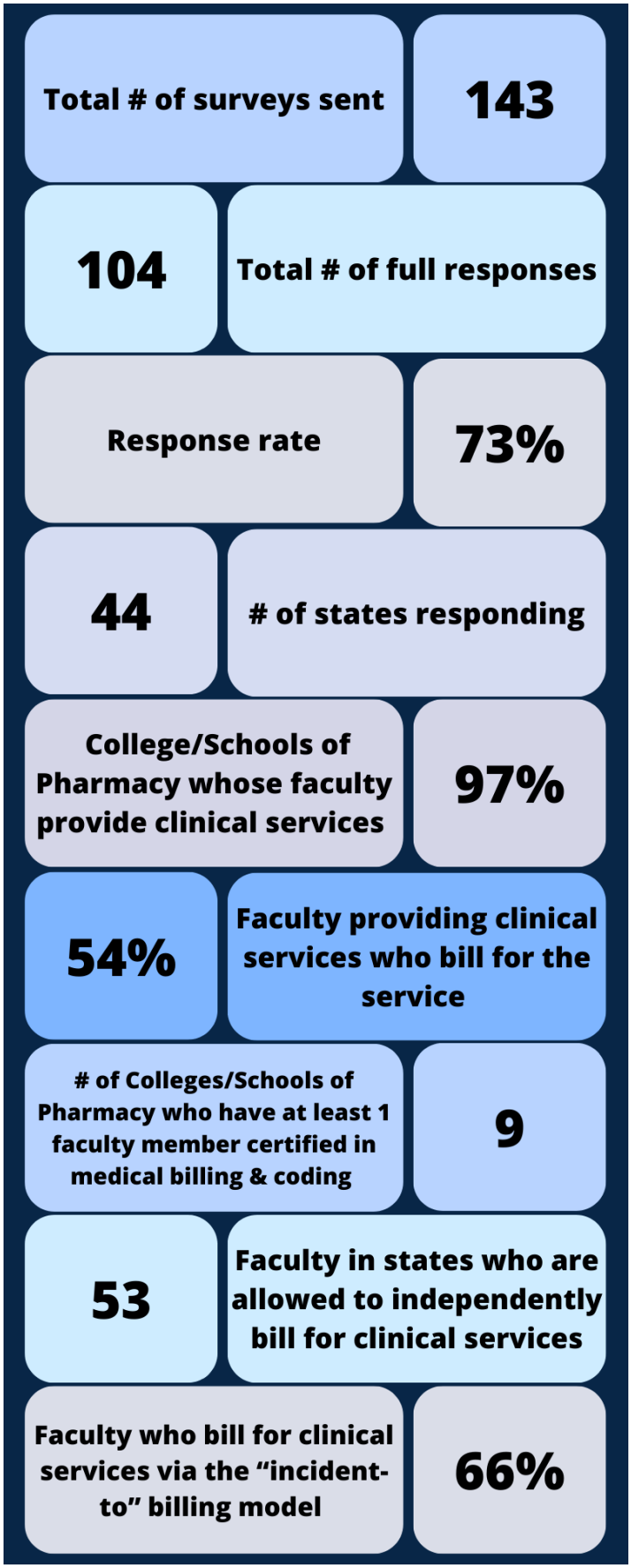


In **October 2024**, the committee hosted guest Blair Thielemier, Pharm.D. Blair is a clinical pharmacist and founder of the Pharmapreneur Academy which collaborates with individuals and organizations to expand their pharmacist-led medical billing and value-based billing models. Key takeaways from Dr. Thielemier's comments are itemized below:

- Pharmacist NPI (National Provider Identification) number.
- Clinical faculty becoming credentialed with specific payers in their state.
- Opportunities for clinical faculty including care coordination services.
- Opportunity for incentive payments from CMS for improved quality of care to outpatient clinics.
- Any SOP/COP wanting to start or increase reimbursement for clinical services needs to consider a marketing or promotional strategy.
- Consideration for clinical faculty to develop a "scorecard" that would be quality-focused to support value-based reimbursement.
- Discussion around taking advantage of opportunities where an organization may be self-insured.

In addition to hosting guest experts to provide insights to the committee, the committee made the final edits to the survey in October 2024. In early November 2024, the survey and cover letter were reviewed by the University of Utah IRB and deemed not to require formal IRB approval. The survey was initially sent out to 143 member institutions of AACP on **November 5, 2024**. The final version of the approved cover letter and new survey, "*Understanding Pharmacist Practice Models in Academic Pharmacy"*, respectively, are attached to this report as Appendix A & B.

Final Survey Results: Abbreviated



On **December 12, 2024,** the committee discussed and agreed on the following:

- Dr. Godwin will support the committee before the COD business meeting at the 2025 Interim Meeting in Houston to provide the verbal update.
- Three sub-committees were created to focus on the remaining charges of the committee: 1) "Incident-to billing"; 2) Value-based care models; and 3) Faculty contracting. Each sub-committee will retain some time on future committee agendas to update the whole committee on its progress. Each sub-committee will develop a stand-alone report which prior to the AACP 2025 Annual meeting will be added to the final report from the task force.

Task Force Accomplishments in 2025

The task force finalized their efforts on the national survey to Colleges and Schools of pharmacy and began the process of creating abstracts for potential presentations at the AACP annual meeting.

In addition, each sub-committee developed a stand-alone report summarizing their work and recommendations which has been rolled into the final report provided to the organization and the chair of the COD.

The task force has been productive around potential scholarships and dissemination of our findings and recommendations.

- A total of 2 abstracts have been submitted to AACP for consideration as possible poster presentations. One focused on the College/School of Pharmacy (C/SoP) survey results and the other focused on the primary recommendations from each of the three sub-committees: Value-based payments, Faculty contracting, and Incident-to-billing.
- The task force submitted 2 abstracts to AACP for consideration as a poster presentation at the 2025 Annual Meeting. One of the two submissions was accepted. The abstract entitled ***"Underutilized Revenue Source: Clinical Faculty Patient Care Services are Underutilized in Colleges of Pharmacy"*** **will be presented as a poster at the 2025 Annual Meeting.**
- Finally, the task force took the initiative to work collaboratively to develop two unique manuscripts for potential publication. The first focuses on the C/SoP survey, the methodology, results, and discussion and is being prepared and targeted for submission to the *Journal of the American College of Clinical Pharmacy* (JACCP). The second manuscript is a commentary from the task force to CEO deans and C/SoP on the opportunities that exist around compensation for clinical services from C/SoP faculty and recommendations as to how those C/SoP can initiate or grow their activities in this arena. This manuscript is being prepared for submission to the *American Journal of Pharmaceutical Education* (AJPE).

Two members of the task force was invited by District 6-8 of the National Boards of Pharmacy (NABP) to present to their organization in October of 2025 in St. Louis, MO on the topic of compensation for clinical faculty services at C/SoP.

The task force also discussed and agreed that the concept of generating compensation from services provided by faculty is an evolving one with almost constant change and increasing opportunities. To this end, the task force feels that this topic deserves consideration by AACP to be moved to a standing committee status.

The task force also supports enhancing the COD mentorship program to include information for CEO deans on revenue compensation for clinical services when applicable or the creation of a consultancy through the organization where C/SoP and/or CEO deans can access more one-on-one mentorship on how to best increase their revenue through this mechanism. The CEO mentorship program is a valued and proven toolkit to assist Colleges and Schools of Pharmacy. CEO deans that choose to initiate or grow their commitment to faculty compensation for clinical services should have that specific tool available to them.

Respectfully,

Members of the Payment for Clinical Faculty Services Task Force

2024-2025

Appendix A: Survey Cover Letter

8701 Watertown Plank Road
Milwaukee, WI 53226

MCW
PHARMACY SCHOOL

Office of the Dean
School of Pharmacy
pharmacy@mcw.edu

October 2024

Dear CEO Deans:

As chair of the Council of Deans (COD), one of my priorities for the 2024-2025 year is to grow the awareness, resources, and implementation of Colleges and Schools of Pharmacy to increase their ability to generate revenue from clinical services that their faculty are providing. As many of you know, the current practice is highly variable among our member colleges and schools. Likewise, academic pharmacy programs will need to identify, revenue sources beyond tuition to remain viable in our dynamic education environments.

To this end, I charged the COD **Payment of Clinical Faculty Services Taskforce** to create a *Patient Care Payment Models of Pharmacy Faculty Survey.* Previous work of the 2021-22 Strategic Engagement Committee and published scholarly works by members of this task force, laid the foundation for this effort. This survey is intended to identify best practices currently in place and to assist colleges and schools who want to pursue this model in the future. Providing access to resources and advice on how to implement a successful revenue-generating faculty service model.

I am asking you to please pass this request on to your one faculty or administrators who is best equipped to answer questions on your current faculty practice service model. If you currently have a reimbursement model in place the survey should take about 15-20 minutes to complete. If you don't have a revenue-generating program, I ask that you still compete the survey. In that case it will only take 1-2 minutes of time.

This is the direct link to the survey:

This effort would not be possible without the task force members who worked diligently on the survey, listed below. I am ever grateful to their contributions to this necessary work in the academy.

Sincerely,

George E. MacKinnon III, PhD, DMSc (*Hon*), MS, RPh, FASHP, FNAP
Founding Dean School of Pharmacy
Professor Pharmacy, Family Medicine, and Institute for Health & Equity
Medical College of Wisconsin
Chair Council of Deans, American Association of Colleges of Pharmacy (AACP)

AACP Payment of Clinical Faculty Services Taskforce

Thomas Dowling	Ferris State University
Donald Godwin	University of New Mexico
Paul Gubbins	University of Missouri-Kansas City
John Gums	University of Florida
Mark Munger	University of Utah
Thomas Wadsworth	Idaho State University
Kristin Wiisanen	Rosalind Franklin University

Appendix B

Survey: Understanding Pharmacist Practice Models in Academic Pharmacy

Question 1

You are being invited to participate in a survey of pharmacy practice department chairs and clinical affairs administrators. The ideal person to ask to contribute to the survey would be a faculty or staff member with understanding of payment models or value-based health systems and knowledge of which faculty are involved with those systems. Please answer each question to the best of your ability.

There are no anticipated risks in participating in this survey. The survey will ask for the name of your School/College, however that information will be kept separate, and there will be no link between the name of the institution and the responses to the survey questions. School/College names are only used to allow the investigators to approach Schools/Colleges who have not responded seeking their participation. You may decide to stop participating at any point before submitting your questionnaire, however, after the survey is submitted, your entries can no longer be modified, and the investigators cannot remove our entries.

For participation, your School/College will be given access to the aggregate data from the survey to track what activities and trends are occurring nationally.

Question 2

Name of School/College of Pharmacy: (This information will be kept separate from all other survey information provided)

Question 3

What is the position of the person completing the survey?

Question 4

In which state or states US is your School/College located:

1	☐ Alabama	2	☐ Alaska	3	☐ Arizona
4	☐ Arkansas	5	☐ California	6	☐ Colorado
7	☐ Connecticut	8	☐ Delaware	9	☐ District of Columbia
10	☐ Florida	11	☐ Georgia	12	☐ Hawaii
13	☐ Idaho	14	☐ Illinois	15	☐ Indiana
16	☐ Iowa	17	☐ Kansas	18	☐ Kentucky
19	☐ Louisiana	20	☐ Maine	21	☐ Maryland
22	☐ Massachusetts	23	☐ Michigan	24	☐ Minnesota
25	☐ Mississippi	26	☐ Missouri	27	☐ Montana
28	☐ Nebraska	29	☐ Nevada	30	☐ New Hampshire
31	☐ New Jersey	32	☐ New Mexico	33	☐ New York
34	☐ North Carolina	35	☐ North Dakota	36	☐ Ohio
37	☐ Oklahoma	38	☐ Oregon	39	☐ Pennsylvania
40	☐ Puerto Rico	41	☐ Rhode Island	42	☐ South Carolina
43	☐ South Dakota	44	☐ Tennessee	45	☐ Texas
46	☐ Utah	47	☐ Vermont	48	☐ Virginia
49	☐ Washington	50	☐ West Virginia	51	☐ Wisconsin
52	☐ Wyoming	53	☐ Other		

Question 5

Are any of your pharmacist faculty members providing clinical services within any of the health care settings listed below?

- Academic Health Center (in-patient)
- Academic Health Center (out-patient clinics)
- Community-based hospitals
- Community pharmacies
- Federally Qualified Health Centers (FQHCs)
- Indian Health Service
- Group physician practice
- Telehealth services
- Veterans Affairs (VA)

Question 6

Do any of your School/College pharmacist faculty members bill for any of the above clinical services?

- Yes
- No

Question 7

List the total number of faculty in the pharmacy practice/clinical department (pharmacist and non-pharmacists)

Question 8

List the total number of **pharmacist practice faculty** in the pharmacy practice/clinical department

Question 9

List the proportion of pharmacist practice faculty in your department that (on a scale of 1-6, 1=0%, 2=1-20%, 3=21-40%, 4=41-60%, 5=61-80%, 6=81-100%):

1) **Spend more than 50% of their time in direct patient care activities** (Patient Care is defined as the delivery of services by a licensed pharmacist to a patient in an acute, ambulatory, or telehealth environment where there is a direct intersection between the pharmacist and the patient. For the purpose of this survey, this does NOT include population management or data analytics.)

2) Have **split-funded positions** (i.e. faculty has 2 employers or < 1.0 FTE paid by the School/College of Pharmacy)

3) Are **practicing under a CPA** (Collaborative Practice Agreement or CPA is a legal document establishing a relationship between a pharmacist and collaborating physician(s) or independent prescriber that allows or authorizes pharmacists to conduct specified patient-care services.)

4) Have some of their FTE is **financially supported by an MOU or a flat-fee service contract** (Memorandum of Understanding or MOU is a formal agreement between 2 or more parties used to establish an official partnership.)

Question 10

At your School/College of Pharmacy, do you have any faculty or staff members that are certified in medical billing and coding

- Yes
- No
- I don't know

Question 11

Does your College/School collect revenue from any of the following sources? (select all that apply)

- Medicaid (Medicaid is a joint federal and state program that gives health coverage to some people with limited income and resources.) (1)
- Medicare (Medicare is federal insurance for anyone age 65 or older, and for some people under 65 with certain disabilities or conditions.) (2)
- Private Insurance (Private health insurance is a contract between the patient and a private health insurance company that mandates the insurer pay some or all of the patients medical expenses as long as the patient pays their premium) (3)
- Flat Rate Contract (Flat rate contracts are a pricing model where the price or cost of a service is a single, fixed fee, regardless of how much resources or time are used) (4)
- Off-set revenue (Off-set revenue is funding provided, usually through an agreement or memorandum of understanding (MOU) by a medical partner to cover the time and services of a clinical pharmacist. This type of funding is typically directly calculated based on the estimated amount of time or FTE that the clinical pharmacist will spend provided the services.) (5)
- Other (6)
- None of the above (7)

Question 12

Does your state allow pharmacists to independently bill the state health plan when rendering healthcare services within their state defined scope of practice?

o Yes (1)

o No (2)

o I don't know (3)

Question 13

In your state, which payers recognize pharmacists for payment? (Select all that apply)

▢ Medicaid (1)

▢ Medicare (2)

▢ Private Insurance/Commercial (3)

▢ Other (4)

▢ None of the above (5)

Question 14

In which of the following areas do faculty provide billable services? (Select all that apply)

▢ Acute Care Management (1)

▢ Annual Wellness Visits (AWV) (2)

▢ Chronic Care/Disease Management (CCM) (3)

▢ Evaluation and Management (E&M) (4)

▢ Immunizations (5)

▢ Medication Therapy Management (MTM) (6)

▢ Pharmacogenomic or Personalized Medicine (7)

▢ Test and Treat (or Point of Care) (8)

▢ Transitions of Care (TOC) (9)

▢ Other (10)

▢ None of the above (11)

Question 15

Do you have any clinical faculty who bill for incident-to-billing services as defined by Medicare? (Incident-to billing allows non-physician providers (NPPs) to report services as if they were performed by a physician. This often requires a collaborative practice agreement (CPA).)

o Yes (1)

o No (2)

o I don't know (3)

Question 16

Please check all the Evaluation and Management (ENM) service levels used for incident billing at the following levels. (Check all that apply)

☐ services at a Level 1 (99211) (1)

☐ services at a level 2 (99212) (2)

☐ services at a level 3 (99213) (3)

☐ services at a level 4 (99214) (4)

☐ services at a level 5 (99215) (5)

☐ None of the above (6)

Question 17

What is the approximate gross yearly revenue for your School/College resulting from all patient care activities ($/year)? (Please estimate if not fully known)

Question 18

Please provide a basic description of your clinical services billing model.

Question 19

What are or were the main barriers to generating revenue from clinical services for your faculty at your School/College?

Sub-committee Report on "incident-to" billing

Payment of Clinical Faculty Services Taskforce
"Incident-to Billing" Subcommittee

Charge

Assess barriers to CMS "incident-to billing" by pharmacists among the 12 Medicare Administrative Contractors (MACs) and propose ways to address these barriers.

Qualifications and Definitions

This report focuses only on "incident-to" billing models as they pertain to CMS Medicare Part B. It is possible to bill "incident-to" through other payers but each payer would need to be contacted individually to inquire about their willingness to participate. The official definition of "incident-to" from CMS is those services that are furnished incident-to physician professional services in the physician's office. The physician's office can be a free-standing office, an outpatient clinic, a hospital outpatient clinic, or a patient's home. In 2014, CMS responded to an official query from the American Academy of Family Physicians (AAFP) and confirmed for AAFP that if all statutes and regulations are met for "incident-to," a physician may bill for services provided by a pharmacist. To be consistent with CMS guidelines, incident-to services to be consistent with CMS guidelines must be part of the patient's normal course of treatment and must only be offered as a follow-up visit to an initial physician visit that sets up the plan for incident-to services moving forward. Therefore, incidents to services can only be provided to established patients and are not recognized as initial visits for new patients. For pharmacists engaged in incident-to-service delivery, it is recommended that such services and visits **do not** occur on the same day that the patient sees their physician. "Incident-to" billing by the physician for services provided on the same day of a physician visit will typically be denied. Three types of supervision defined by CMS are: general, direct, and personal. "Incident-to" services must be billed by the physician under direct supervision meaning that the billing provider must be in the office or building but not the exam room. Any individual providing services to a patient in an incident-to model is referred to as *auxiliary personnel*. Per CMS, to be eligible for "incident-to" billing, the *auxiliary personnel* must in some way be an expense to the provider or the provider's practice. This can be accomplished via direct contracting, or leasing, or the physician or practice may hire their own pharmacist. In addition to physicians, CMS recognizes nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives as non-physician providers (NPP) for "incident-to" billing. However, if an NPP is the billing provider, the "incident-to" reimbursement will be 85% of the physician's rate. A summary of the criteria to provide "incident-to" services in an outpatient physician office or a hospital-based outpatient clinic are provided in **Figure 1**.

Figure 1: Criteria for Incident-to Billing

CRITERIA	PHYSICIAN OFFICE SERVICES	HOSPITAL OUTPATIENT SERVICES
DIRECT SUPERVISION	✓ BY AN ELIGIBLE PROVIDER WITHIN THE SUITE OR OFFICE SPACE	✓ ELIGIBLE PROVIDER IS PRESENT ON CAMPUS WHERE SERVICES ARE PROVIDED OR PRESENT WITHIN THE OFF-CAMPUS DEPARTMENT
ESTABLISHED PATIENT	✓	✓
COMMON TO PROVIDER'S SERVICES	✓	✓
SERVICE INTERGRAL THROUGH INCIDENTAL OF ELIGIBLE PROVIDER'S SERVICES	✓	✓
SERVICES COMMONLY FURNISHED AND APPROPRIATE FOR PROVISION IN PHYSICIAN'S SERVICE LOCATION	✓	✓
MEDICALLY NECESSARY, AUTHORIZED AND DOCUMENTED SERVICE	✓	✓
ELIGIBLE PROVIDER MAINTAINS SUBSEQUENT SERVICES AT A FREQUENCY THAT REFLECTS ACTIVE PARTICIPATION IN PLAN OF CARE	✓	✓
RELATIONSHIP BETWEEN AUXILLIARY PERSONNEL AND ELIGIBLE PROVIDER	✓ FINANCIAL RELATIONSHIP	✓ EMPLOYEE RELATIONSHIP
STATE SCOPE OF PRACTICE SUPPORTS SERVICES PROVIDED	✓	✓

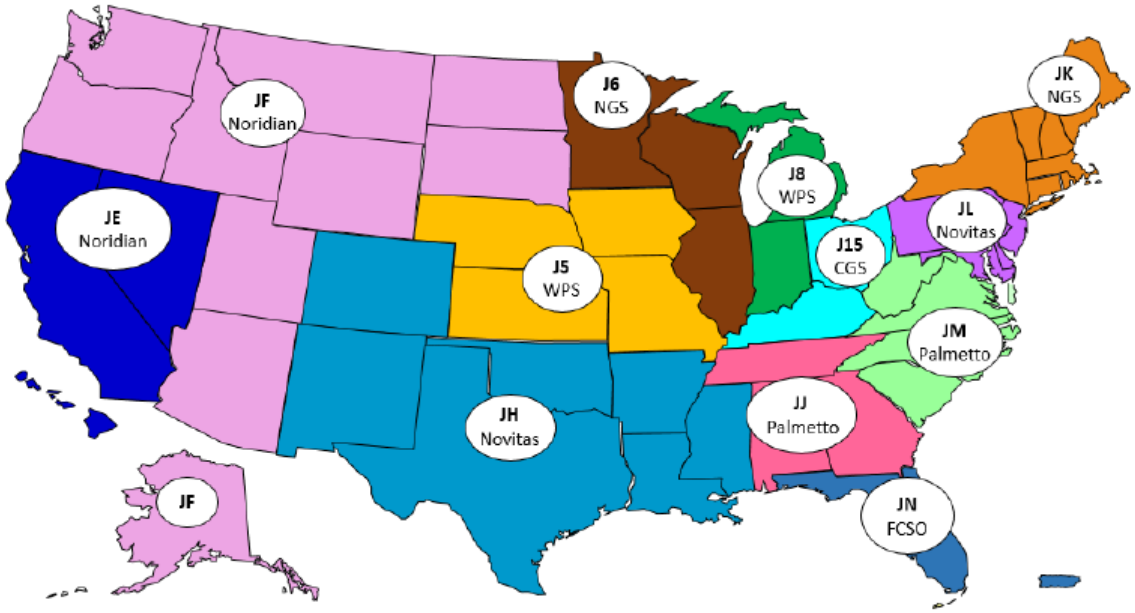
Introduction

One of the primary barriers to "incident-to" billing is a basic understanding of who can provide incident to services, and at what levels. Inherent within the barriers is a common misconception regarding "incident-to" billing that according to CMS, "incident-to" billing **by** a pharmacist for Evaluation and Management (E&M) service is restricted to Level I or 99211. Pharmacists are currently excluded by CMS as a recognized billing provider; therefore, they are unable to bill independently for any E&M service provided beyond Level 1. However, since the task force's charge reads, "Assess barriers to CMS "incident-to billing" by billing providers for services provided by pharmacists," then opportunities and some challenges can be explored. The following will focus on barriers and benefits for recognized billing providers to bill "incident-to" for services provided by the clinical faculty and provide colleges and schools of pharmacy some recommendations to begin or expand their own "incident-to" billing models.

The evolving clinical role of pharmacists in healthcare has become increasingly significant in improving patient outcomes and managing the rising cost of care. One mechanism through which pharmacists can be reimbursed for clinical services is through the **incident-to billing** provision under Medicare. Incident-to billing allows non-physician providers, such as pharmacists, to be reimbursed for services provided as part of a physician's plan of care. While this provision has the potential to significantly expand the range of clinical services that pharmacists can provide, its implementation faces numerous barriers. This report explores both the benefits and challenges of expanding clinical pharmacy services through the incident-to billing provision in Medicare.

Medicare Administrative Contractors (MAC's)

A Medicare Administrative Contractor (MAC) is a private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. Currently, there are 12 A/B MACs and 4 DME MACs in the program that process Medicare FFS claims for nearly 51% of the total Medicare beneficiary population, representing approximately thirty-four million Medicare FFS beneficiaries. This report focuses only on the 12 MACs that provide claims processing for Medicare Part B since that is the part of Medicare where the "incident-to" billing resides.



A/B MAC Jurisdictions

In Fiscal Year 2023 (FY2023), the MACs served more than 1.2 million healthcare providers who are enrolled in the Medicare FFS program. In FY2023, the MACs processed more than 1.1 billion Medicare FFS claims, including approximately 192 million Part A claims and 950 million Part B claims, and paid out approximately $431.5 billion in Medicare FFS benefits. Each college or school of pharmacy with clinical faculty engaged in "incident-to" billing will be dependent on their regional MAC for decisions related to whether a submitted service code will be covered. As will be discussed later in this report, there is no assumed uniformity in how MACs process "incident-to" claims for service between one MAC and another. Beyond that, there can be discordance even within a given MAC on how they process an "incident-to" claim from one-time point to another. For example, the decision that physicians may bill for services provided by a pharmacist in an "incident-to" model rendered by CMS in 2014 is not uniformly accepted by all MACs. One would assume since the MACs are regional contractors working for CMS they would align their decisions for reimbursement of services with CMS at the federal level. However, this is not the case as regional MACs retain significant autonomy from CMS in how they determine what is covered or not. National pharmacy organizations advocating for pharmacist reimbursement for services provided are not enthusiastic about pitting CMS against one of its regional MACs resulting in a maintenance of final decision authority sitting

primarily at the regional MAC level. Working with your respective billing and compliance departments, it is important for all schools and colleges of pharmacy to establish a line of communication with their MAC especially as it pertains to services provided under the Medicare Part B section.

As part of the work and research that went into developing this report, a Qualtrics survey was sent to all 12 MAC's in the United States that provide Medicare Part B services for CMS (see below). Each respective MAC was asked if a recognized billing provider (i.e. physician) would submit a claim for reimbursement of E/M services above Level 1 that were provided by a clinical pharmacist under a CPA and if those services were within the respective states scope of practice for pharmacy, would that MAC reimburse the physician for the service rendered. Below are the responses received broken down by the individual 12 MACs in the U.S.

Medicare Part B Medicare Administrative Contractors Survey

MAC	MAC Designation	Qualtrics Response
Noridian	JE	No response
Noridian	JF	No response
Novitas	JH	No response
WPS	JS	No response
NGS	J6	No response
WPS	J8	No response
Palmetto	JJ	No response
FCSP	JN	No response
Palmetto	JM	Will pay if all requirements in the Medicare Policy Manual Chapter 15, Section 60 are adhered to. We utilize state practice acts to determine if pharmacists are practicing within their scope, including if they are being utilized to provide services via incident-to physician services.
CGS	J15	CGS complies with all CMS regulations, rules, and guidance, the incident-to guidelines are outlines in the following resources. CGS allows pharmacists to bill incident-to a physicians service where allowable by state scope of practice.
Novitas	JL	No response
NGS	JK	No response

Clearly, with only 2 of 12 responses (17%), the MAC middleman between services rendered and reimbursable claims remains a challenge. It is difficult to know how "to play the game" when the rules are not shared. The persistent variability including between what CMS authorizes and individual MAC's allow, the variability among MAC's in what they will allow, and the variability within an individual MAC for what they will allow at time 1 versus time 2, plus the apathy associated with working with pharmacy providers operating in a compliant "incident-to" model remains one of the most significant overall barriers to increasing revenue from pharmacist-provided clinical services.

Barriers to "Incident-to" Billing by Pharmacists

The following is an in-depth list of published barriers to "incident-to" billing by a recognized billing provider for clinical services provided by a pharmacist.

- **Not recognized as a health care provider at the federal level**
    - This is the primary barrier for pharmacists to bill directly for E&M services above accepted Level 1 (99211)
- **Time and workflow**
    - Depending on the type of service provided, supervision by a CMS-approved billing provider is required. Each pharmacist-delivered service or visit also requires physician attestation that they were in the building at the time the service was delivered (direct supervision). Without careful consideration, this may potentially upset provider workflow and productivity.
- **Facility and staff resources**
    - Since clinical faculty will be providing direct patient care service, there needs to be adequate facility support.
- **Required pharmacist education**
    - Pharmacists need to be appropriately trained to participate in direct patient care services and depending on the state they may be required to obtain certification in collaborative practice agreements (CPA's) before engaging in the service.
- **Company or management support, namely billing and compliance**
    - The biggest barrier to the expansion of "incident-to" service billing. Billing and compliance offices are historically very conservative and averse to approving any activity that in their opinion may increase fiscal liability and potential for audit.
- **Compensation**
    - Reimbursable compensation for low-level visits is often not adequate to offset the costs associated with providing the service or doing the billing.
- **Patient awareness of services**
    - Many patients are unaware that pharmacists working in collaboration with their primary care physician (PCP) or specialist can provide direct services to them if is authorized by the physician via a CPA.
- **Complex billing procedures**
    - It is imperative that all required documentation and criteria for "incident-to" billing be complete and accurate. Without proper training and experience, these procedures can be complex.
- **Inadequate training for pharmacists on billing and coding**
    - Few pharmacists receive any formal instruction either in school or after on regarding the proper avenues for how to use "incident-to" billing to expand and sustain service models.
- **Payer resistance**
    - Some payers may be hesitant to reimburse for appropriately documented "incident-to" services if the process is not well established in the area or considered a standard of care.

- **For E&M services, physicians or recognized billing providers must provide the initial patient care service**.
    - Billable clinical services by pharmacists are only allowed for follow-up visits after an initial evaluation is made.
- **Not typically applicable to community pharmacies**

- While the delivery of E&M services may not be feasible in most community pharmacy environments, community pharmacists in such settings can take advantage of other billing codes that are approved to be used directly by pharmacists or require only general supervision by a billing provider.

Additional Challenges When Attempting Reimbursement Through the "Incident-to" Model

1. **Restrictive Requirements for Incident-to Billing**
   One of the primary barriers to expanding clinical pharmacy services through the incident-to billing provision is the restrictive nature of Medicare's requirements. Under the incident-to rule, the services provided by non-physician providers must be rendered under the direct supervision of a physician and as part of a treatment plan developed by the physician. This means that pharmacists can only bill for services if they are working within the context of a physician's plan of care and under a physician's supervision. Direct supervision requires that the supervising billing provider be in the facility but not in the room with the patient at the time the service is rendered. This limitation excludes many independent clinical services that pharmacists could provide autonomously, including E&M level 1 service (99211) for established patients, direct patient counseling, and disease management in settings outside of a physician's practice.

2. **Lack of Standardization and Scope of Practice**
   Another significant barrier is the variability in the scope of practice for pharmacists across different states and healthcare systems. The incident-to provision requires that the services pharmacists provide be consistent with their scope of practice, but this scope is not uniformly defined nationwide. While some states allow pharmacists to prescribe medications, adjust drug regimens, and engage in more direct patient care, others impose more restrictive practices. Without uniformity in the laws governing the scope of pharmacy practice, the ability for pharmacists to bill for services in all states remains inconsistent, limiting the national impact of expanded pharmacy services and making it essentially impossible to develop a "one-size-fits-all" set of recommendations.

3. **Financial and Administrative Challenges**
   The administrative complexity of the incident-to billing system presents a challenge. Billing through the incident-to provision requires extensive documentation to show that the pharmacist's services are part of the physician's treatment plan and that the physician is directly supervising the services. This can be burdensome for pharmacists and healthcare providers, especially in settings where pharmacists may not be fully integrated into a physician-led team. Additionally, reimbursement rates for pharmacists' services under Medicare may not fully reflect the value of their contributions, potentially disincentivizing pharmacists and providers from pursuing incident-to billing.

4. **Resistance from Traditional Healthcare Providers**
   Some physicians and other healthcare providers may resist expanding the role of pharmacists in direct patient care due to concerns over professional boundaries, financial competition, or unfamiliarity with the role of pharmacists in clinical settings. The integration of pharmacists into physician-led care teams requires a shift in the traditional healthcare model, which may not be welcomed by all providers. This resistance can delay efforts to expand pharmacy

services and hinder the establishment of collaborative practice agreements that would allow pharmacists to work more closely with physicians.

5. **Regulatory and Legislative Hurdles**
   Legislative action is often required to expand the role of pharmacists, including allowing them to bill directly under incident-to provisions in Medicare. This requires changes to federal and state laws, which can be slow and difficult to implement. While there is growing recognition of the value pharmacists bring to healthcare, the process of changing Medicare policy and state regulations can be challenging due to competing priorities and political interests. Furthermore, achieving consensus among stakeholders, including physicians, insurers, and patient advocacy groups, can be a prolonged process.

State-Based Initiatives

One of the issues that makes standardizing recommendations for pharmacists more successful in "incident-to" billing is the variability from state to state. Since "incident-to" billing is built on the premise of collaborative practice and collaborative practice agreements (CPAs), each state may have unique rules and regulations as to how pharmacists and billing providers can partner with a CPA. All fifty states allow for CPAs between pharmacists and billing providers but the specific requirements for pharmacists to participate differ from state to state. The other core principle to maximizing "incident-to" billing for services provided by pharmacists is the state's scope of practice laws for pharmacists. This varies widely from one state to another and therefore can alter or dictate the depth of clinical services that a pharmacist can achieve within the CPA. Lastly, for Medicare patients, all reimbursement requests are funneled through the respective Medicare Administrators Contractor (MAC) for the state in which the service was provided. There are a total of 12 MACs that service the United States and Puerto Rico. Unfortunately, there is a lack of uniformity in how one MAC manages an "incident-to" billing request compared to another. It is not unusual for there to be inconsistency from one reimbursement request to another even within the same MAC at different time points. The lack of standardization for how MACs respond to "incident-to" billing requests from recognized billing providers for services provided by a pharmacist adds another layer of complexity to the process and makes it difficult to provide national recommendations to Schools and Colleges of Pharmacy on how they can maximize the services provided by their respective clinical faculty.

As of 2024, several U.S. states recognize pharmacists as healthcare providers for certain in-state medical services, allowing them to provide a broader range of clinical services beyond dispensing medications. The recognition of pharmacists as healthcare providers has been growing, particularly in areas like immunizations, medication management, and chronic disease management. Some states have adopted laws or regulations that allow pharmacists to provide patient care services directly, and these states often have expanded scopes of practice for pharmacists.

Some states currently recognize pharmacists as providers for state-run health plans (i.e., Medicaid, etc.). A list of those states with specifics for each is provided in **Appendix A.**

Collaborative Practice Agreements (CPAs)

In many states, pharmacists can enter into **Collaborative Practice Agreements** (CPAs) with physicians or other healthcare providers. This allows pharmacists to take on some aspects of patient care, such as adjusting medication regimens, managing chronic diseases, and more.

National Level Efforts

There have also been efforts at the federal level, including advocacy for pharmacists to be recognized as healthcare providers for Medicare and Medicaid, which would expand their ability to provide services like disease management and medication therapy management for these populations.

Overall, the recognition of pharmacists as healthcare providers is growing across the country, especially as they play an increasingly key role in improving access to care, especially in underserved areas. However, the specific services they are authorized to provide depend on state laws and regulations, which are continually evolving.

The Rules of Supervision

As mentioned previously, when considering pharmacists as auxiliary personnel working under a CPA the three types of supervision recognized by CMS are: general, direct, and personal. For "incident-to" services, only the general and direct types of supervision play any significant role. A College or School of Pharmacy may or may not have the relationships with CMS-recognized billing providers to take advantage of building reimbursement models requiring direct supervision of the clinical pharmacist. In this case, general supervision services may be a better fit and are typically the type of services pursued by independent community pharmacists pursue who do not practice in an environment where there is a recognized provider on the premises. Below is a list of various codes associated with specific types of clinical services arranged by the required level of supervision of the pharmacist to conduct those services. Chronic Care Management (CCM) is the most common type of clinical service provided by pharmacists that requires only a level of general supervision to be compliant.

Table 1: Clinical Pharmacy Service Options and the Required Level of Supervision

Specific Code	Service Description	Required Supervision
CPT 99211	Established patent	Direct
APC 5012, HCPC G0463	"Facility Fee"	General
CPT 99490,99439,99487,99489	Chronic Care Management	General
CPT 99426,99427	Principle Care Management	General
HCPC G0438, G0439	Annual Wellness Visits	Direct
CPT 99453-99458	Remote Physiologic Monitoring (RPM)	Direct
CPT 95249-95251	Continuous Glucose Monitoring	Direct
CPT 99406,99407	Tobacco Cessation Counseling	Direct

Benefits of "incident-to" billing beyond Level I by billing providers

There are several benefits to the billing provider (typically the physician), the billing provider's practice, and the patient from the implementation of "incident-to" billing models from clinical services provided by pharmacists.

- The billing provider retains the work relative value unit (wRVU) for the visit. This is important since many billing providers (i.e., physicians) are incentivized based on their productivity measured by their total wRVUs compared to a target wRVU established by their employer. Since the physician retains the wRVU for the visit, they increase their likelihood of exceeding their target wRVU for the year through participation in "incident-to" billing with pharmacists.
- Most electronic medical record (EMR) systems allow for the recognition of a secondary provider. Listing the clinical pharmacist as the patient's secondary provider allows the system's billing process to track the activities and subsequent revenue attached to those activities delivered by the pharmacist for a group of patients. These provide healthcare institutions with an extremely specific mechanism to track the increased productivity of the physician or medical practice from the "incident-to" services provided by the pharmacists.
- Once established, the physician and pharmacist can work independently both at the top of their licensure to provide the highest possible quality of care to the patient. This has a direct impact on the quality of care that each patient receives.
- Once established, expansion of "incident-to" billing services will increase the access to care between patients and physicians. This will decrease the waiting times for new and established patients to get an appointment, contribute to individual physicians hitting CMS quality targets, and increase overall patient satisfaction throughout the practice.
- Through the expansion of "incident-to" billing practices, more of the medication management-based patients can be shifted to the clinical pharmacist. This has the potential to reduce prescriber liability by making sure patients are on the right drug, the right dose, and the right frequency and to screen for any potential drug-drug interactions.

More on Select Benefits of "Incident-to" Billing Models

1. **Enhanced Access to Care**
   Expanding services through incident-to provision can significantly increase access to care, especially in underserved and rural areas. Pharmacists often work in community settings, hospitals, and clinics, but many are in areas where physician shortages persist. By allowing physicians to bill Medicare for clinical services provided by a pharmacist under a CPA, patients can receive essential healthcare services from a broader range of providers. This is particularly crucial in areas where physicians are scarce, enabling pharmacists to alleviate some of the workload on primary care physicians and extend care to a greater number of people.

2. **Improved Patient Outcomes**
   Pharmacists are highly trained in medication management, which is central to the treatment of chronic conditions such as diabetes, hypertension, heart disease, depression, and others. When pharmacists can directly interact with patients through incident-to billing, they can engage in medication therapy management (MTM), monitor therapeutic outcomes, and provide counseling on proper medication use. These interventions are shown to improve

patient adherence, reduce medication errors, and optimize therapeutic regimens. Studies have shown that pharmacist-led interventions can reduce hospitalizations and emergency visits, contributing to improved long-term health outcomes and reducing total healthcare costs.

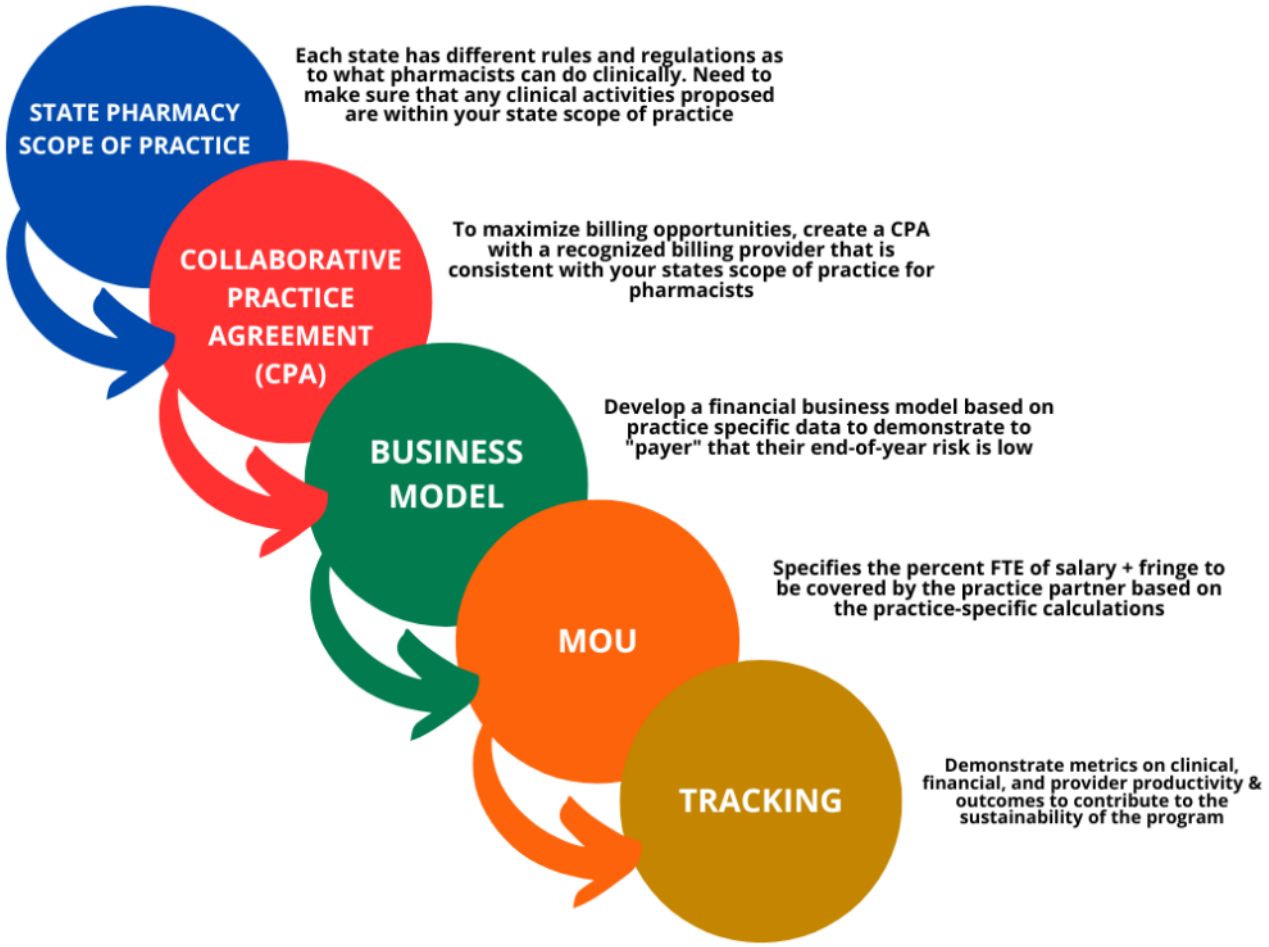
3. **Cost Savings**
   By expanding the scope of services through incident-to billing, Medicare could realize substantial cost savings. Pharmacists can provide preventive care services such as immunizations, medication management, and disease management, which reduce the need for more costly interventions like hospitalizations or emergency care. Research has indicated that clinical pharmacy services result in cost savings by preventing adverse drug events, reducing hospital readmissions, and avoiding unnecessary tests or treatments. Additionally, by preventing medication-related issues, pharmacists help improve medication adherence, which leads to more efficient and effective treatment, lowering healthcare costs.

4. **Better Integration into the Healthcare Team**
   When pharmacists are recognized as providers under the incident-to provision, they become integral members of the healthcare team, collaborating with physicians, nurses, and other healthcare professionals. This multidisciplinary approach has been shown to enhance patient care coordination, leading to better management of chronic diseases and complex medication regimens. Collaboration between pharmacists and physicians ensures that patients receive comprehensive care, with pharmacists providing expertise in pharmacotherapy and physicians focusing on broader aspects of diagnosis and treatment.

Recommendations for Schools and Colleges of Pharmacy

The following recommendations are provided for Colleges and Schools of Pharmacy to consider if they wish to begin or expand their “incident-to” billing model for clinical faculty services. (**See Figure 2**)

Figure 2: Algorithm to Establish "Incident-To" Billing Models



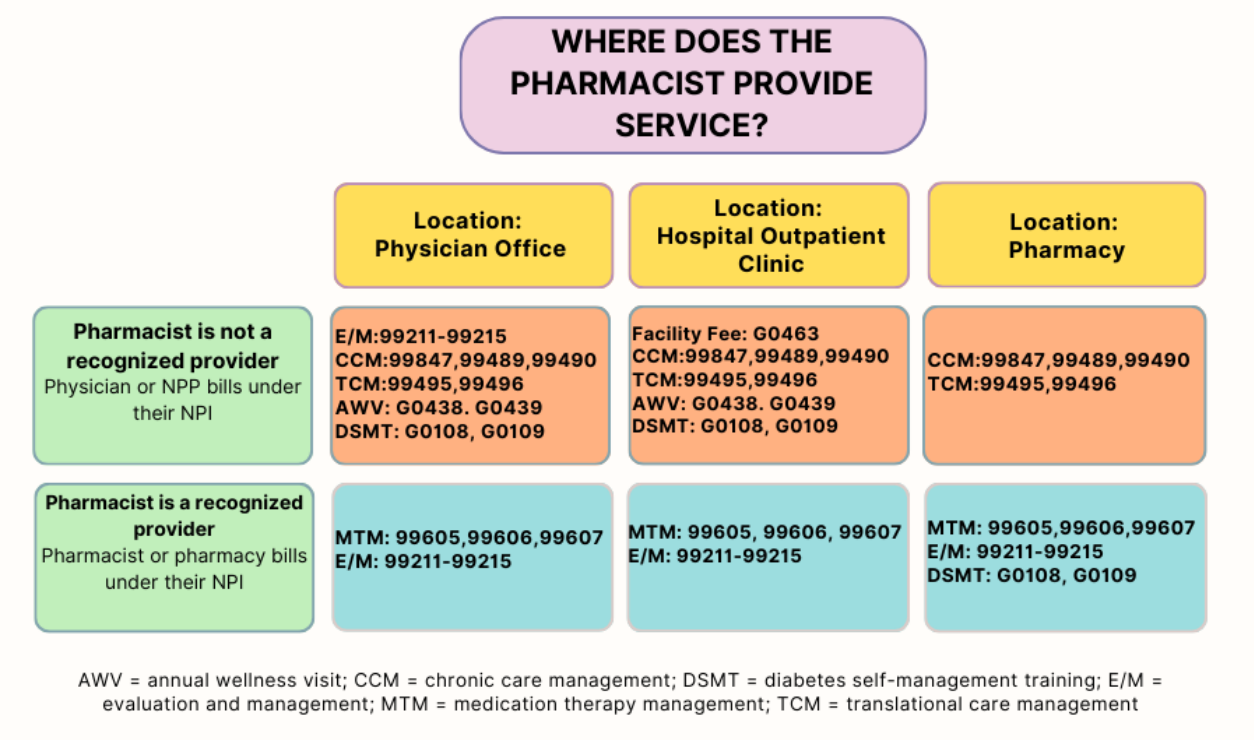
1. Colleges or Schools of Pharmacy should strongly consider supporting one to two clinical faculty to become certified as medical billers and coders **(See Appendix B).** Certification can be accomplished via virtual classes and exams in less than 12 months. The cost for the training and exams as well as any continuing education requirements to maintain certification should be provided by the College or School of Pharmacy, under a professional development grant program. Since for most institutions, the number one barrier to implementation of incident-to billing is the institution's own billing and compliance department (see barriers section), having a certified biller and coder within the clinical faculty department of the school or college will change the narrative with the billing and compliance group. Discussions will switch from “Can we….?” to “When can we….?.” If they know that you know, there is significantly less push-back for implementation, and billing and compliance become more of a partner than a barrier. It is recommended that faculty who practice in the ambulatory or outpatient arena be considered for this certification since most of the “incident-to” billing opportunities will emerge from outpatient services provided by faculty.

2. CEO Deans of Colleges or Schools of Pharmacy should form consortiums with other Colleges or Schools of Pharmacy in their respective MAC and lobby their MAC together. Doing so could potentially mitigate one source of persistent variability, specifically that which occurs within an individual MAC for what they it will allow at time 1 versus time 2. Forming such consortiums would ensure consistent messaging so that the MAC administrator would not be hearing from individual Colleges or Schools of Pharmacy or individual clinical faculty seeking to bill. Rather the MAC would hear from multiple Colleges or Schools of Pharmacy representing a critical

mass of pharmacy clinicians and covered lives using one voice that could be applied over the entire jurisdiction.

3. While pharmacists can bill Level 1 (99211) for "incident-to" services, it is typically not justified when the cost of delivery care is factored in. Most institutions will assess the college or school with a fee that could include various overhead charges including front office staff, rooming, and taking vitals on patients, and even a cost to submit the bill. These so-called costs per visit or CPVs can easily wipe out any reimbursement from CMS for a Level 1 visit by a pharmacist. Since reimbursement for 99211 codes is so low, the net after accounting for costs is typically a loss for the college or school. Therefore, colleges and schools of pharmacy are encouraged to pursue E&M "incident-to" billing for clinical pharmacy services at only Level 3 (99213) or higher. Level 3 billing compliance is easily met with almost every patient that the clinical pharmacist sees. Billing in this model will be based on complexity and not time. **(See Figure 3)**

Figure 3: Typical Codes Used for Outpatient Billing of Clinical Pharmacy Services (Fu and Cavanaugh, 2019).



AWV = annual wellness visit; CCM = chronic care management; DSMT = diabetes self-management training; E/M = evaluation and management; MTM = medication therapy management; TCM = translational care management

4. While Level 1 (99211) reimbursement for E&M services is available for pharmacists, it is unlikely that a sustainable service will be fundable from only Level 1 billing. Therefore, colleges and schools of pharmacy must re-think the possible payers for clinical faculty services. As discussed earlier in this document, physicians and/or physician groups have much to gain by partnering with clinical pharmacists in addition to the benefit derived by their patients. Clinical faculty should recognize that the physician or group practice is another potential payer. This is accomplished by modeling the business plan for the group and then entering a Memorandum of Understanding (MOU) or Management Service Agreement (MSA) with the practice. Under this model, the physician practice agrees to cover the salary + fringe for a percent FTE of the

clinical faculty member up front. This percentage is arrived at by showing the practice plan how physician billing for clinical pharmacy services, under a CPA, can "repay" the practice. These practice-specific financial models typically include a variety of data types including, the percentage of Medicare patients in the practice, the number of Medicare patients eligible for annual wellness visits (AWVs), the number of admissions and discharges for patients in the practice to help judge potential for transition of care billing, and the number of patients based on disease states and medication lists that would qualify based on complexity for a Level 3 or Level 4 visit. Through this financial projection, it is possible to demonstrate to the practice that any financial commitment it would make up front to a percent FTE of a clinical faculty member will be low-risk since the practice will make that back based on the extra "incident-to" billing it will do from the pharmacy services. This is a crucial component of the total program since many physicians are already convinced of the impact pharmacy can have on the quality of patient care and are only restricted by not having a clear plan on how to adopt those services in a cost-neutral model or better. By using practice-specific data, the college or school can demonstrate to the practice that is possible for a "win-win-win" opportunity. The patient wins because they get two clinicians practicing at the top of their licensure, get better and quicker access to their providers, and end up on the lowest number of medications with the least number of interactions. The physician wins since their liability for prescribing goes down, their patients are happier and more likely to stay with the practice, and they have an opportunity to increase their productivity without a significant increase in workload. Finally, the school or college of pharmacy wins since they can use the encumbered salary & fringe that they would have had to spend on the faculty and reinvest it.

Conclusion

Expanding the clinical services provided by pharmacists through the incident-to billing provision under Medicare offers significant benefits, including enhanced access to care, improved patient outcomes, and cost savings. Pharmacists can play an integral role in managing chronic diseases, preventing adverse drug events, and promoting medication adherence, all of which contribute to better healthcare outcomes. However, several barriers to this expansion must be overcome, including restrictive billing requirements, variations in state scope of practice, financial and administrative challenges, resistance from other healthcare providers, and the need for legislative changes. Addressing these barriers will require a concerted effort from policymakers, healthcare providers, and pharmacists to create a more integrated and effective healthcare system that leverages the full potential of clinical pharmacists in improving patient care. Nonetheless there are strategies that colleges or schools of pharmacy can consider if they wish to pursue or expand their "incident-to" billing model for clinical faculty services.

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Appendix A: States that allow Pharmacists to serve as billing providers for in-state services

1. **Arizona**: Arizona has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

2. **Arkansas:** Pharmacists in Arkansas can prescribe medications, order lab tests, and provide vaccinations. They can also serve as primary care providers for patients under the Arkansas Advanced Practice Pharmacist (APP) program.

3. **California**: California allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

4. **Colorado**: Pharmacists in Colorado can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

5. **Connecticut:** Pharmacists in Connecticut can prescribe medications, order lab tests, and provide vaccinations. They are also allowed to serve as primary care providers for patients with certain chronic conditions.

6. **Delaware**: Delaware has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

7. **Hawaii**: Pharmacists in Hawaii can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

8. **Idaho**: Idaho allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

9. **Indiana**: Pharmacists in Indiana can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

10. **Iowa**: Pharmacists in Iowa can prescribe medications and provide vaccinations. Iowa also has a program that allows pharmacists to serve as primary care providers for patients under the Iowa Advanced Practice Pharmacist (APP) program.

11. **Kansas**: Kansas allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

12. **Kentucky**: Pharmacists in Kentucky can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

13. **Maine**: Maine has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

14. **Maryland**: Pharmacists in Maryland can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

15. **Massachusetts:** Massachusetts allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

16. **Michigan**: Pharmacists in Michigan can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

17. **Minnesota**: Minnesota allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

18. **Nevada**: Nevada has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

19. **New Hampshire:** New Hampshire allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

20. **New Mexico:** Pharmacists in New Mexico can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

21. **North Carolina**: North Carolina allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

22. **North Dakota**: Pharmacists in North Dakota can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

23**. Ohio:** Ohio has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

24. **Oklahoma**: Oklahoma allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

25. **Oregon**: Oregon has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

26**. Pennsylvania**: Pennsylvania allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

27. **Rhode Island:** Rhode Island has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

28. **South Carolina**: South Carolina allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

29. **South Dakota**: Pharmacists in South Dakota can prescribe medications and provide vaccinations. They are also allowed to work in community health clinics and provide primary care services.

30**. Tennessee**: Tennessee allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

31**. Texas:** Texas has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

32. **Utah**: Utah allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

33. **Vermont**: Vermont has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

34. **Virginia**: Virginia allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

35. **Washington**: Washington has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

36. **West Virginia:** West Virginia allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

37. **Wisconsin**: Wisconsin has expanded the role of pharmacists in patient care. Pharmacists are allowed to prescribe medications, order lab tests, and provide vaccinations.

38. **Wyoming**: Wyoming allows pharmacists to prescribe medications and provide vaccinations. Pharmacists can also serve as primary care providers for patients with certain chronic conditions.

Appendix B: How pharmacists can become certified in medical billing and coding through AAPC

Certified Professional Coder (CPC):

1. **Enroll in a training program.**
    - Formal education prepares you for the exam. The AAPC offers a self-paced CPC preparation course that takes 4 to 8 months to complete (starting at $2699).

2. **Become an AAPC member.**
    - You will need to be a member to schedule the exam.

3. **Pass the exam.**
    - The exam has one hundred questions and takes four hours to complete. You will need to score at least 70% to pass (exam cost $399).

4. **Earn your title.**
    - Depending on your experience, you will receive either the CPC or CPC-A (Certified Professional Coder – Apprentice) designation.

5. **Maintain certification.**
    - You will need to earn continuing education units (CEUs) to maintain your certification.
    - You can expect to receive your exam results within 7-10 business days.

Certified Professional Biller (CPB):

1. **Enroll in a training program.**
    - You can take an AAPC medical billing training course to prepare for the exam (starting at $1495). The course covers topics such as:
        - Healthcare introduction
        - Health insurance models
        - Legal and regulatory considerations
        - Physician-based insurance claims
        - Coding manuals

2. **Become an AAPC member.**
    - Create an account on the AAPC website to access the exam registration system.

3. **Pass the exam.**
    - The exam is 135 multiple-choice questions and must be completed in four hours. You can take the exam at a testing center or online (the exam costs $399).

4. **Maintain certification.**
    - To maintain your certification, you must maintain your AAPC annual membership and earn forty continuing education units (CEUs) every two years.

Combo CPC & CPB:

1. **Enroll in a training program.**
    - Self-paced and virtual instructor-led course options for both CPC and CPB training (starting at $3799).

2. **Become an AAPC member.**
    - You will need to be a member to schedule the exam.

3. **Pass the exam.**
    - Each exam must be taken individually (4 hours each; Regular costs apply).

4. **Maintain certifications.**
    - You will need to earn continuing education units (CEUs) to maintain your certifications.

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May 2025

"Value-Based Model" Subcommittee

Payment of Clinical Faculty Services Taskforce

Charge

If CMS plans to move toward a "value-based payment" system by 2030, how might the academy address quality-based metrics that will provide pharmacists with the ability to understand, analyze, and expand quality control outcomes associated with drug therapy across all healthcare sectors?

Qualifications and Definitions

Healthcare payment models are under two primary options, Fee-for-Service (FFS) and/or Value-Based Care. Understanding the differences between these models is important for providers, pharmacists, and patients.[1]

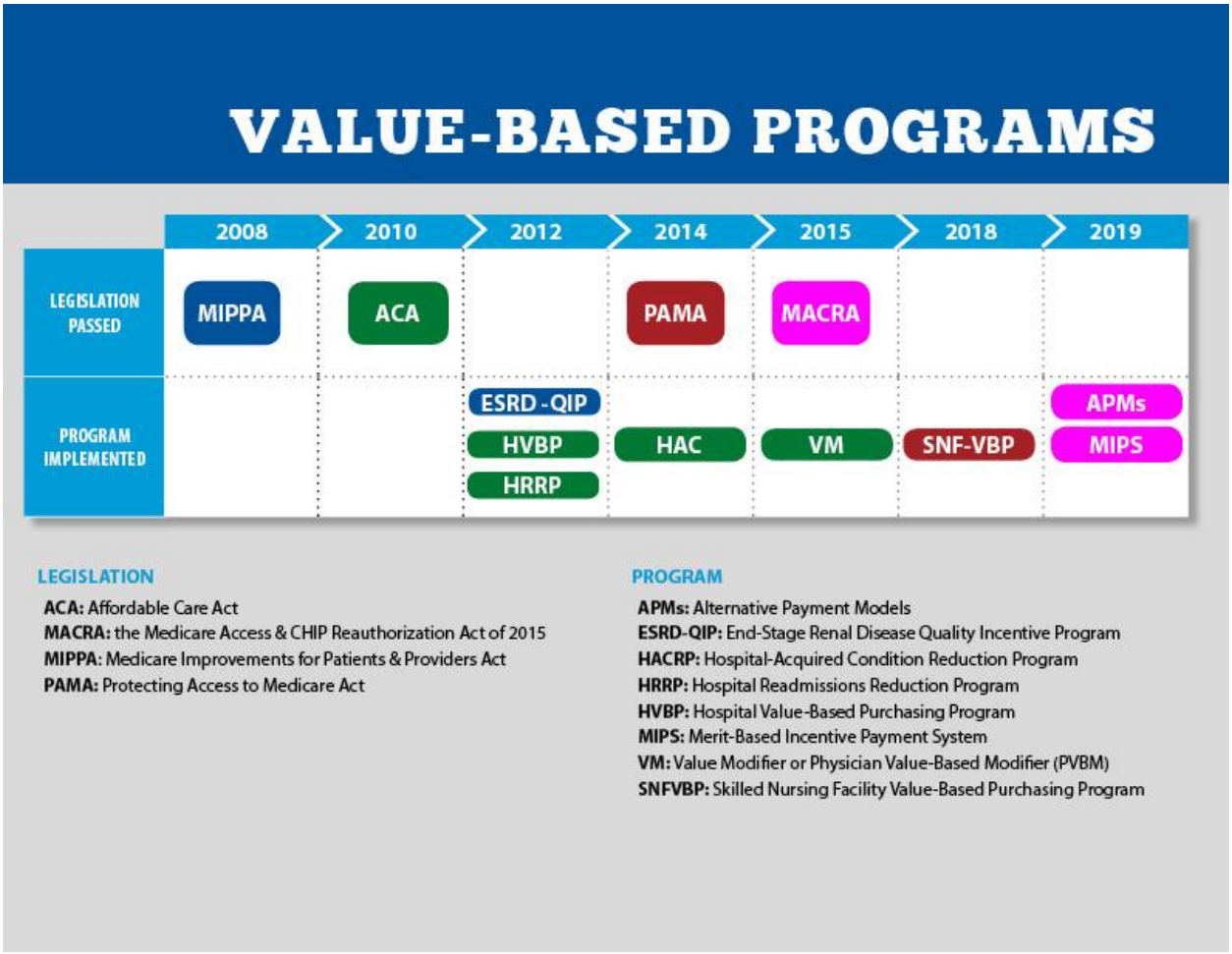
FFS and VBC represent a separate set of approaches to healthcare payment. Fee-for-service reimburses providers for each service rendered, while value-based care focuses on the quality and outcomes of care, rewarding providers for achieving positive patient outcomes and controlling costs. This shift encourages providers to prioritize prevention, coordination of care, and efficiency, leading to better patient experiences and potentially lower costs.

FFS providers are incentivized to deliver more services where higher volume usually leads to higher revenue. The primary focus is on quantity of services, rather than quality of care or patient outcomes. FFS leads to higher costs with fragmented care due to the volume-driven of the model.

VBC providers are paid based on quality and outcomes of the care they deliver, through a combination of capitation (fixed payments per patient) and pay-performance (PFP) incentives. Incentives are paid for preventing illness, coordinating care, and improving health outcomes. The focus is on delivery of the best possible care at the lowest possible cost. The potential advantage is lower costs, better patient outcomes, and a more coordinated, patient-centered approach to care.

The U.S. healthcare industry is currently in a transition phase from FFS to VBC payment models, due to greater focus on health and quality of care. Government and private payers are driving this transition. (Figure 1) VBC is being included across multiple models and programs including disease states, home-health, hospitals, providers, and skilled nursing facilities.

Figure 1: Timeline for Value-Based Programs



Introduction

The United States (US) has a population of over 340 million people[2], having one of the most complex healthcare systems in the world. The healthcare system is formed by intertwining relationships between providers, payers, and patients receiving care. The US healthcare system is in a constant state of evolution.

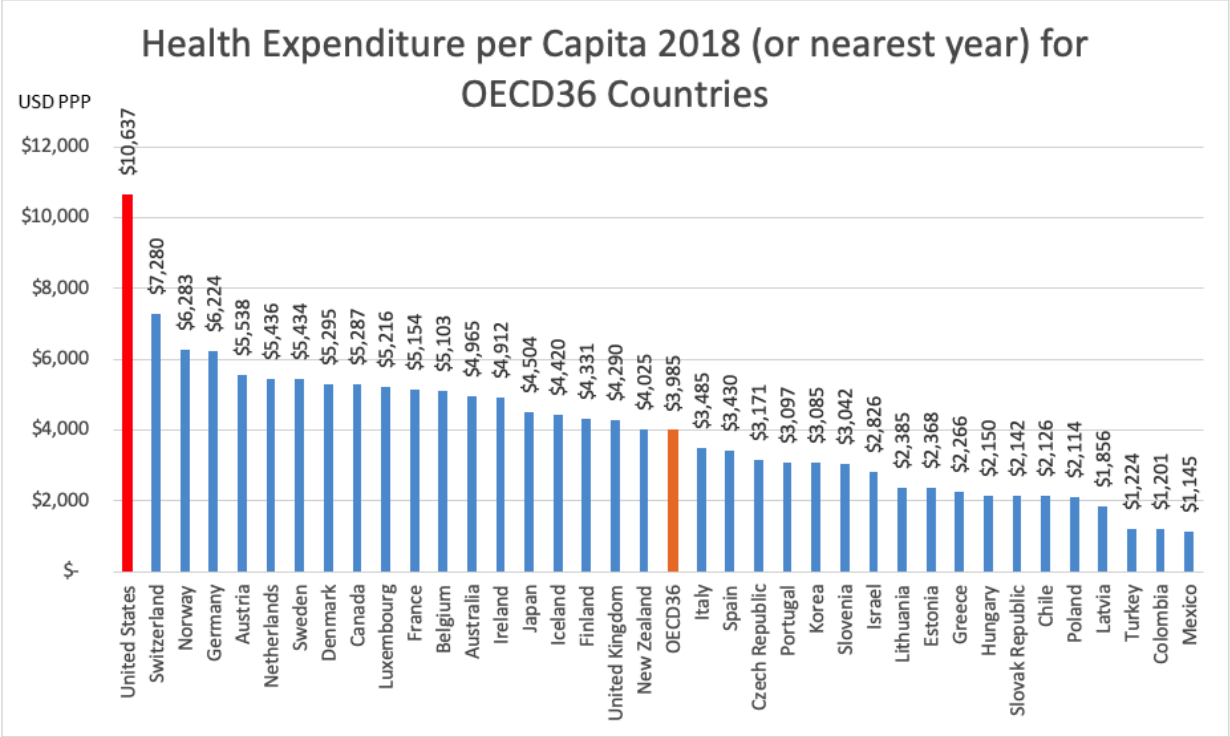
US Healthcare System Coverage

The US healthcare system does not provide universal healthcare. It is a mixed system of publicly financed government Medicare and Medicaid with privately financed market coverage. Out-of-pocket payments and market coverage are the primary means of financing and provision of healthcare. As of 2023, 92% of citizens have healthcare insurance coverage, at least part of the year. This equates to approximately 50% with private insurance through their employer, 20% on Medicaid, 14% of Medicare, and 2% on other public forms of insurance.[3]

At the individual spending level, patient healthcare financing often includes copayments (fixed cost for a medical service or product) or coinsurance (a proportion of the total cost of the medical service or product). Patients also often have a deductible specified amount of money that the insured must pay before an insurance plan will pay for healthcare—and premiums. These patient costs are considered "out-of-pocket" spending. The total out-of-pocket spending in 2019 was $406.5 billion[4]; which correlates to 2019 estimates of roughly $1240 per capita in out-of-pocket spend.[5]

Health Statistics

The United States is the third most populous country in the world, behind China and India, but has a population that is only about one-quarter of either of those 2 countries but spent $3.5 trillion on healthcare, or 16.9% of the gross domestic product (GDP), (more than any other country) in 2018.[6-7] Hospital care is the main driver of overall healthcare spending, accounting for 33% of 2017 healthcare dollars, physician and clinical services are second at 20%, and prescription drugs are third at 10%.[4] By disorder, the US spends $143.9 billion on diabetes, $108.6 billion on musculoskeletal disorders (joint pain and osteoporosis); $93 billion on oral disorders; and $80.7 billion on ischemic heart disease.[8]



Source: OECD Health Statistics 2018, WHO Global Health Expenditure Database.[20]

Healthcare spending is driven by utilization (the number of services used) and price (the amount charged per service). An increase in either of those factors results in higher healthcare costs. Despite spending nearly twice as much on healthcare per capita, utilization rates in the United States do not differ significantly from other wealthy OECD countries. Prices, therefore, appear to be the main driver of the cost difference between the United States and other wealthy countries with a significant portion of spending going towards administrative costs, rather than direct patient care. In fact, prices in the United States tend to be higher regardless of utilization rates.[9]

America's health outcomes are not any better than those in other developed countries.[10] The United States performs the lowest in life expectancy at birth among high-income countries, preventable deaths, infant mortality, and maternal mortality, among high-income countries. The US has the highest rates of obesity and diabetes; the highest rates of death from motor vehicle crashes, non-transportation injuries, and violence compared to other developed nations.

In conclusion, while the US healthcare system spends significantly more than other high-income countries, its overall health outcomes lag, particularly in areas like life expectancy, preventable deaths, and chronic diseases. [10] This is attributed to factors such as inequitable access, high administrative costs, and disparities in social determinants of health.

Value-Based Healthcare

VBC was originally developed in the Affordable Care Act (ACA), importing it into traditional Medicare.[11] The ACA set up accountable care organizations and the Center for Medicare and Medicaid Innovation (CMMI) to devise and evaluate new VBP models. To this end, the Medicare Access and CHIP Reauthorization Act (MACRA) began to set up VBC adoption by requiring *all* clinicians to

participate in VBC.[12] Current plans through CMS are to move all Medicare beneficiaries enrolled in accountable care organizations into VBC by 2030.[11]

In value-based arrangements, health care organizations are incentivized to meet goals. These goals typically aim to improve measures of quality, cost, and equity. If these goals are not met, organizations may forfeit bonuses or lose a portion of their payment from payers like Medicare, Medicaid, or commercial health insurers.

Quality.[13] The National Academy of Medicine has described a useful framework for quality in health care that can be used to hold providers accountable in value-based care models. Its components include:

> **Effectiveness:** care is based on evidence and is designed to get results
>
> **Efficiency:** providers do not use resources that are not needed
>
> **Equity:** care does not vary in quality based on personal characteristics such as race, gender, and income
>
> **Patient centeredness:** each patient's values, preferences, and needs are respected
>
> **Safety:** treatment does not cause harm
>
> **Timeliness:** treatment is available without long delays

Cost.[13] Health care providers may earn more or avoid penalties if they reduce or maintain costs. So, providers can reduce unnecessary use of high-cost forms of care like emergency department visits and inpatient admissions, they may share some of the savings they produce.

Equity.[13] Efforts to improve health equity aim to reverse practices and policies that have made it difficult for historically marginalized groups, especially people of color, to access and receive high-quality care. As a result, these individuals have had poorer health outcomes. Until recently, many value-based programs did not prioritize outcomes related to equity, but it is becoming more common for providers to receive financial incentives to ensure that high-quality care is accessible for communities of color, low-income populations, and more.

Financial incentives.[13] Known as value-based payments; financial incentives are a key component of value-based care. These payments link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics. The structure of these payments varies widely, but factors may motivate providers include the following:

> **Upside and downside risk. Some models have upside-only risk** — providers gain revenue if they exceed expectations on quality, cost, or equity targets. Other programs also include downside risk — providers lose revenue if they fail to meet these goals. Some evidence suggests that models that include both upside and downside risk, also known as two-sided risk, may generate better outcomes, such as fewer hospitalizations. Although risk of revenue loss can be a strong motivator, two-sided risk may prevent risk-averse providers from joining a value-based program in the first place.

Prospective versus retrospective payments. Prospective payments are upfront payments to providers to manage care for a defined set of patients and procedures — and, in some cases, for a defined period. This type of payment referred to as "capitation" may create a stronger financial incentive for providers to lower the cost of care so they can retain more revenue.

The percentage of providers' revenue is tied to value-based payments. Evidence suggests providers are more motivated to change how they deliver care when more of their revenue comes from value-based payments especially since there is less administrative burden for providers.

Timing, size, and delivery of incentives. Providers are motivated by financial incentives offered to them directly in a timely manner. Incentives should be clearly linked to specific outcomes and large enough to be meaningful.

Nonfinancial incentives. Nonfinancial incentives in value-based care models offer greater flexibility to deliver the right care at the right time, which can contribute to providers' sense of purpose, mission, and professionalism.

Measurement. How health and hospital systems and individual clinicians are paid depends on how well they perform on measures of quality and safety, such as death rates or patients' ability to access timely care, as well as measures of equity and cost. To gauge providers' performance at one moment or over time, public and private health care entities and regulators collect and analyze data on specific measures.

Accreditation. CMS can require health care entities to adhere to the quality and safety standards set by certain third parties to participate in the Medicare or Medicaid programs such as Joint Commission accreditation for hospitals and health systems to receive Medicare or Medicaid reimbursement.

Regulation. Government agencies can create rules that encourage providers to meet specific standards of quality, equity, and cost-effective care.

Public reporting. Publicizing how well health care providers and health plans perform on certain measures can drive them to improve performance. For example, people can search Medicare.gov to find out the rate of complications for hip and knee replacement surgeries at a hospital. Alternatively, if they are looking to enroll in a particular Medicare Advantage plan, they may search the site to find out how members rate the plan.

Challenges to Value-Based Healthcare[14]

Financial Risk and Unpredictability: Providers face financial penalties if they do not meet benchmarks, potentially leading to unsustainable practices. The financial risks include unpredictable revenue leading to difficulty predicting and managing case flow and practice sustainability.

Implementation of new technology, training staff and adjusting workflows may be difficult and costly, especially in small practice settings.

Data Management and Reporting: Providers must track and report on a wide range of quality metrics, requiring robust systems and staff. Interoperability from sharing and integration data across systems is often challenging and can affect care coordination. Third-party data is often complex and requires contractual agreements.

Infrastructure and Resource Constraints: Many practices may struggle with staffing shortages, making it difficult to implement new processes and track patients. Many practices lack the technology, systems, and training needed to effectively manage population health and engage patients. Traditional workflows may need to be re-optimized, requiring significant changes and investment.

Changing Regulations and Policies: The healthcare landscape is constantly evolving, making it difficult to adapt to new rules and requirements. This point is more important now.

Benchmarking and Performance Metrics: Establishing appropriate benchmarks and understanding how they relate to clinical care can be challenging. This may be the most important with the greatest potential for differences in outcomes.

Patient Engagement: Engaging patients and involving them in their care plans can be difficult, especially for underserved populations.

Contract Clashing: Navigating complex contracts with different payers can be challenging.

Effect on Disparities: Value-Based Payments may inadvertently exacerbate health disparities if not carefully designed to address the needs of vulnerable populations.

Strategies for Pharmacists in Value-Based Healthcare[15]

The U.S. healthcare system continues a shift to value-based care with a focus on efficient, coordinated care that meets the needs of patients. Aligned with this shift, community pharmacy practice is transforming from product reimbursement and fee-for-service models to pay-for-performance models in which quality, value, and patient outcomes are measured and incentivized.

This care delivery transformation provides pharmacists opportunities to partner with payers and other healthcare stakeholders in delivering essential, high-quality, and cost-effective care. As our healthcare system transitions from fee-for-service to value-based care, pharmacies have expanded opportunities to sustainably partner with payers and other healthcare stakeholders in delivering essential, cost-effective care.

The pharmacy education academy should keep a watchful eye on the development of value-based care.

Currently, teaching and practicing value-based care on **medication adherence, medication safety, clinical status changes through medications** and **patient satisfaction** throughout the curriculum and how these clinical activities with an emphasis on tracking and measurement.

Another area of education should be focused on **transitions of care**. Teaching future pharmacists how to assess patients' medication lists, identify potential risks, and provide crucial information and education again with an emphasis on tracking and measurement of outcomes.

Education of students on how to measure value-based outcomes can be focused on a **SCORECARD including clinical outcomes including alignment with clinical guidelines (HEDIS quality measures), medication safety, patient satisfaction, medication efficiency, and financial factors**.[16-17]

In the dynamic landscape of healthcare, the concept of value-based care has emerged as a transformative force. Shifting the focus from quantity to quality, value-based care emphasizes the delivery of healthcare services that yield positive patient outcomes while reducing costs. The role of pharmacies will become increasingly pivotal. With their unique expertise, accessibility and patient-centered care, pharmacies have the potential to revolutionize the way healthcare is delivered and contribute significantly to the success of value-based care initiatives.[18]

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Subcommittee Report on Faculty Contracting

Payment of Clinical Faculty Services Taskforce
Toward Sustainable Models for Clinical Pharmacy Faculty Contracts

Introduction

As healthcare delivery continues to evolve toward value-based care, pharmacy education must adapt its faculty contract structures to support clinical engagement, revenue generation, and academic productivity. This report responds to the charge to explore how clinical pharmacy faculty contracts may be constructed in the future, considering funding and billing models as well as internal and external barriers to implementation. Insights are drawn from national practices and recent institutional examples.

I. Funding Models for Clinical Faculty

Current and emerging funding models vary in complexity and feasibility across institutions. Each model carries implications for faculty expectations, financial sustainability, and collaboration with healthcare partners.

1. **Split-Funded Positions**

    - These arrangements involve shared salary support between the College/School of Pharmacy (C/SOP) and the healthcare facility.
        1. individual positions where effort of individual position is split
        2. shared positions where the effort of the position(s) is split between individuals and the salary of position(s) are split between the organizations
    - While promoting joint ownership of faculty roles, they can be administratively complex and are often discouraged by university systems concerned about dual supervision or misaligned incentives.
    - For example, one institution noted that split funding was explicitly disallowed by their university and seen as problematic based on past practice plan challenges.

2. **Flat Fee Support**

    - The healthcare site pays a fixed amount to the C/SOP for faculty services.
    - Here, a bundled contract with a healthcare site may include multiple faculty practitioners based on time spent in the clinic.
    - An advantage of this model is that it simplifies budgeting and is especially useful where faculty effort is clearly defined and predictable.
    - However, this model does not take into account the billing revenue, which may exceed the flat rate contract.

3. **Percentage-Based Salary Support**

    - A portion of a faculty member's salary is reimbursed by the healthcare facility based on expected effort or outcomes through a management services agreement.
    - This model can better reflect the value provided by clinical services but may face institutional barriers, especially where practice plans do not exist or where full-time equivalents (FTEs) are tightly controlled.

4. **No Remuneration**

    - In this model, faculty practice at healthcare facilities without financial return to the C/SOP.
    - Although common, especially in educational partnerships, it results in significant loss of potential revenue and undervalues pharmacy services—one example described this as "giving away a ton of clinical pharmacy services for FREE."

II. Billing Models for Clinical Services

Billing models must reflect payer requirements, institutional capabilities, and faculty engagement in patient care.

1. **Healthcare Facility Bills and Retains Revenue**
    - This is the most prevalent model, particularly where pharmacists are embedded in interprofessional healthcare teams to provide clinical service in support of the C/SOP education mission.
    - It provides simplicity for the college but offers no financial return unless supplemented by a separate support contract.
2. **Revenue-Sharing Models**
    - Some institutions are exploring arrangements where clinical revenue is split between the healthcare site and the C/SOP.
    - One institution proposed a 70/30 split (site/college) based on the healthcare facility's administrative burden and estimated clinical billing of $35K per year.
    - While promising, revenue-sharing depends on payer recognition of pharmacist services, state specific regulations, and a clear contractual framework.
3. **C/SOP Bills Directly**
    - This approach offers the most financial autonomy but faces significant legal, regulatory, and infrastructure hurdles.
    - Without a practice plan or billing infrastructure, direct billing is often infeasible.

III. Barriers to Faculty Billing

Internal Barriers

- **Prohibition of Split Funding**: Some universities have policy-level resistance to shared financial models.
- **Absence of Practice Plans**: Colleges that lack a faculty practice plan struggle to accommodate or recognize revenue-generating clinical work, making it difficult to assign effort or incentivize faculty.
- **FTE Constraints**: When faculty are funded at 1.0 FTE with no flexibility for additional effort, it can be challenging to recognize clinical service billing as supplemental work.
- **Healthcare System Expertise:** Colleges need to be able to negotiate practice revenue contracts with the "C-Suite", as the scope of work is often outside of the pharmacy practice department.

External Barriers

- **Federal Restrictions**: CMS does not currently recognize pharmacists as billing providers under Medicare Part B, limiting direct reimbursement options.
- **State-Level Variability**: State laws differ widely regarding pharmacists' scope of practice and billing eligibility.
- **Administrative Overhead and Compliance**: Sites must manage credentialing, documentation, and audit risk, which may deter collaboration.

IV. Recommendations

To create sustainable, flexible, and equitable faculty contract models that reflect modern clinical realities, the subcommittee recommends:

1. **Adoption of Hybrid Funding Models**
    - Institutions should explore flat fee or percentage-based support contracts (i.e. a management service agreement) where split funding is not viable.
    - Clinical service fees should be set at reasonable market rates to meet payer, legal, and audit requirements.
2. **Development of Institutional Practice Plans**
    - Establishing a practice plan can formalize billing pathways, align faculty expectations, and enable recognition of clinical revenue as part of academic productivity.
3. **Policy Advocacy and Strategic Partnerships**
    - National advocacy for provider status and state-level engagement around scope of practice laws remain critical.
    - Strong contractual instruments (e.g. memoranda of understanding (MOUs), management service agreements) should clearly specify clinical responsibilities, revenue flows, and mutual benefits.
4. **Ensure Equity Across Faculty Roles**
    - Contract models must consider how revenue opportunities impact compensation equity, especially when limited to certain specialties or sites.
5. **Administrative Innovation**
    - Where direct billing is not feasible, institutions may use clinical service fees and shared revenue models to capture value without violating policy constraints.

Conclusion

Pharmacy schools are at a pivotal moment in aligning clinical faculty roles with healthcare system needs and reimbursement opportunities. By modernizing contract structures, building strategic partnerships, and addressing regulatory barriers, academic institutions can enhance the sustainability, recognition, and impact of clinical pharmacy faculty contributions.

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