August 18, 2026

Submitted electronically to the Centers for Medicare & Medicaid Services Healthcare Advisory Committee

Dear Members of the Healthcare Advisory Committee:

On behalf of American Association of Psychiatric Pharmacists (AAPP) thank you for the opportunity to provide comments to the Healthcare Advisory Committee (HAC) as it develops recommendations to improve the United States healthcare system. We encourage the Committee, as part of its examination of healthcare access and workforce challenges, to consider opportunities to better utilize psychiatric pharmacists to expand access to high-quality mental health and substance use disorder care.

About AAPP

AAPP is a professional association of nearly 3,000 members who envision a world where all individuals living with mental illness, including those with substance use and neurologic disorders, receive safe, appropriate, and effective treatment. Members are specialty pharmacists, and most are Board-Certified Psychiatric Pharmacists (BCPPs) who specialize in psychiatry, substance use disorders (SUDs), and psychopharmacology. With a significant shortage of mental health care professionals, psychiatric pharmacists offer another resource to improve outcomes for patients with psychiatric conditions and SUDs.

Psychiatric Pharmacists Are an Underutilized Behavioral Health Workforce

The United States continues to face significant challenges ensuring timely access to mental health and substance use disorder services. As policymakers consider ways to strengthen the behavioral health workforce, it is important to make full use of healthcare professionals who already possess specialized expertise in caring for individuals with psychiatric and substance use disorders.

Psychiatric pharmacists are pharmacists with specialized training and experience in the use of medications to treat psychiatric and substance use disorders. Many are BCPPs and practice as members of interdisciplinary healthcare teams in hospitals, clinics, and other care settings.

Psychiatric pharmacists provide comprehensive medication management (CMM), working collaboratively with patients and other members of the healthcare team to ensure that medications are administered and taken appropriately. Their expertise is particularly valuable for patients with complex medication regimens, co-occurring medical and psychiatric conditions, treatment-resistant conditions, or medications that require careful monitoring.

Meaningfully integrating psychiatric pharmacists into behavioral healthcare teams can increase the capacity of physicians and other behavioral health practitioners while providing patients with specialized medication expertise as part of coordinated, team-based care.

Federal Policy Increasingly Recognizes Pharmacists as Part of the Solution to Behavioral Health Workforce Challenges

The Administration has already recognized the opportunity to better utilize pharmacists to address behavioral health workforce shortages and barriers to care.

In June 2026, CMS, the Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly issued a Dear Colleague Letter encouraging states to consider greater use of pharmacists to expand access to medications for opioid use disorder (MOUD).[1] The agencies identified workforce shortages, geographic barriers, and restrictive scope-of-practice laws as impediments to treatment and highlighted appropriately trained and licensed pharmacists as one means of expanding access.

Importantly, the agencies recognized that the value of pharmacists extends beyond initiating treatment. The Dear Colleague Letter notes that patients with opioid use disorder frequently have co-occurring physical and behavioral health conditions treated with medications and highlighted the therapeutic value of pharmacists' direct involvement in ongoing patient care. The agencies further recognized pharmacists' ability to work with patients and other members of the clinical care team to assess treatment progress and the role of medications in recovery.

CMS has also encouraged states, through its Rural Health Transformation Program, to empower pharmacists as essential clinical partners in rural communities, including through incentives and payment models that support pharmacist prescribing and expanded clinical responsibilities.[2] Together, these policies reflect the Administration's recognition that better utilizing the pharmacy workforce can help address gaps in access to care.

We strongly support that principle and encourage the Committee to consider how it can be applied more broadly to psychiatric pharmacists and the patients they serve.

Medicare Payment Policy Impedes Access to Behavioral Health Services

Despite the growing recognition of pharmacists' clinical contributions, psychiatric pharmacists are not recognized as Medicare practitioners who can directly bill for the patient care services they provide. This can leave healthcare organizations without a sustainable mechanism for

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[1] Administration for Children and Families, Substance Abuse and Mental Health Services Administration, & Centers for Medicare & Medicaid Services, *Dear Colleague Letter on Expanding Access to Medications for Opioid Use Disorder Through Pharmacist State Scope-of-Practice Flexibility*, DCL 06182026 (June 18, 2026), available at https://acf.gov/cb/policy-guidance/dcl-expanding-access-medications-opioid-disorders-pharmacist-flexibility

[2] Id.

supporting psychiatric pharmacist-provided CMM, even when incorporating a psychiatric pharmacist into the care team would improve access to needed behavioral health services.

Unfortunately, this disconnect hinders federal efforts to make better use of the pharmacy workforce. While CMS and its federal partners are encouraging policies that expand pharmacists' clinical responsibilities to help address workforce shortages and improve access to behavioral healthcare, Medicare payment policy limits healthcare organizations' ability to integrate specially trained psychiatric pharmacists into patient care.

Medicare allows physicians to bill Medicare Part B for services provided by pharmacists when supervised by a physician, known as billing “incident-to” the physician. However, pharmacist patient care services provided incident-to a physician or nonphysician practitioner are limited to reimbursement for the lowest level E/M code (99211), eliminating the ability for care teams to bill incident-to for complex services that would generally be reimbursed under the higher level E/M codes (99212 – 99215) and which pharmacists are licensed by states to provide within their scope of practice, either independently or through collaborative practice. Psychiatric pharmacists are not ancillary staff performing tasks delegated by physicians; but rather act as direct patient care providers on interdisciplinary care teams. Like other specialists such as psychologists, dietitians, or physical therapists, psychiatric pharmacists often manage patients’ complex conditions. This interferes with team-based care by restricting physicians’ ability to bill for the full scope of services across all levels of medical decision-making provided by members of the care team incident-to the physician.

In short, we believe federal payment policy should reinforce, and not impede, the Administration's efforts to integrate the pharmacy workforce to improve access to care.

Recommendations

We encourage the HAC to recommend that CMS build upon their recent efforts to better utilize pharmacists by examining federal recognition and reimbursement policies that limit Medicare beneficiaries' access to patient care services provided by qualified psychiatric pharmacists.

Specifically, the Committee should consider recommending policies that:

1) **Recognize psychiatric pharmacists as an important component of the behavioral health workforce** and incorporate their services into federal strategies to improve access to mental health and substance use disorder services;

2) **Support Medicare coverage and payment for CMM services** provided by appropriately qualified psychiatric pharmacists as members of collaborative healthcare teams;

3) **Examine Medicare provider-recognition and reimbursement policies** that limit the ability of psychiatric pharmacists to be reimbursed for patient care services including:

a) Clarifying that physicians and health care facilities have the authority to bill for all levels of E/M services provided by a psychiatric pharmacist practicing within their scope of practice while under supervision of such a physician;

b) Requesting Congress designate clinical pharmacists as Qualified Health Providers under Medicare; and

4) **Promote interdisciplinary models of behavioral healthcare** that fully integrate the specialized expertise of psychiatric pharmacists into patient care.

Ultimately, removing unnecessary barriers to psychiatric pharmacist-provided care would build upon the Administration's existing efforts to address workforce shortages through thoughtful use of the pharmacy workforce and would allow Medicare beneficiaries to benefit more fully from the specialized expertise psychiatric pharmacists bring to behavioral healthcare teams.

Conclusion

Thank you for your consideration. We welcome the opportunity to provide additional information regarding the role of psychiatric pharmacists and CMM in improving care for individuals with mental health and substance use disorders.

If you have any questions, please do not hesitate to contact me at bschimenti@aapp.org or our Health Policy Consultant, Laura Hanen at lahanen@venable.com.

Sincerely,

Brenda K. Schimenti
Executive Director