Submitted electronically to PatientsOverPaperwork@cms.hhs.gov

January 17, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Request for Feedback on Scope of Practice

Dear Administrator Verma:

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on its request for feedback on scope of practice under Executive Order (EO) #13890 on *Protecting and Improving Medicare for Our Nation's Seniors*. NCPA represents America's community pharmacists, including 22,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care settings.[1] Together, our members represent a $76 billion healthcare marketplace, employ 250,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits these comments on behalf of both community and long-term care independent pharmacies.

NCPA commends CMS for evaluating Medicare regulations that require more stringent supervision than existing state scope of practice laws, or that limit health professionals from practicing at the top of their license. Although CMS' request for feedback specifically identifies physician assistants (PAs) and Advanced Practice Registered Nurses (APRNs), NCPA brings CMS' attention to burdensome requirements that also limit pharmacists from practicing at the top of their professional licenses and education. Like other medical professions, the pharmacy profession has evolved from a dispensing and product reimbursement-based industry to a profession with the training and patient relationships to provide outcomes-based services and participate in care coordination efforts.[2]

[1] *NCPA 2018 Digest* (2018).
[2] Troy Trygstad, *Payment Reform Meets Pharmacy Practice and Education Transformation*, 78 North Carolina Med. J. 3 at 173-176 (May-June 2017), *available at* http://www.ncmedicaljournal.com/content/78/3/173.full.pdf+html.

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As CMS implements the EO intended to reduce clinical burdens and improve patient care to enable providers to spend more time with patients, NCPA emphasizes pharmacists are the most accessible health care providers and provide care and services in a wide variety of practice settings in communities across our nation. Ninety-one percent (91%) of Americans live within five miles of a community pharmacy[3] (with extended hours allowing broad access to a health professional). This number includes underserved patient populations and geographic areas with few other healthcare providers (healthcare deserts). Convenient access to a healthcare professional is particularly essential for patients with chronic diseases, behavioral health conditions, or medication-use challenges. In fact, 71% percent of all health care spending is on patients suffering from multiple chronic diseases. These patients represent 83% percent of all prescriptions filled.[4]

Pharmacists are intensively trained health care professionals with the ability to provide medication management services, including interventions for safe and effective drug use and chronic disease education and management, as well as smoking cessation counseling, health and wellness screenings, preventive services, and immunizations.[5] NCPA emphasizes that pharmacists undergo a minimum of six years of comprehensive undergraduate and professional education. They receive clinical training in disease state management, training in the interpretation of lab data, and get hands-on clinical assessment of patients with co-morbidities. Pharmacists learn to distinguish when it is appropriate for patients to self-treat and when disease states require physician referral. However, due to statutory and regulatory barriers such as references to "provider," "eligible professional," or similar terms that do not include pharmacists in their definition, pharmacists are often an underutilized health care resource. In order to move toward CMS's goal towards value with an emphasis on increasing access through coordinated, team-based care delivery CMS must eliminate barriers that exclude/prohibit pharmacists and other nonphysician practitioners from providing team-based patient care services at the top of their respective licenses and education, and within their legal state scope of practice.

Accordingly, NCPA recommends CMS employ its regulatory discretion, similar to efforts the agency has previously applied for chronic care management (CCM) and transitional care management (TCM) services to remove barriers (e.g., direct vs. general supervision) preventing highly qualified providers, like pharmacists, from being fully utilized and integrated onto patient care teams. We strongly urge CMS to take similar regulatory actions to implement the EO to maximize the use of pharmacists practicing at the top of their profession. Specifically, as CMS develops policies around Medicare services, we strongly urge the agency consider how to better incorporate highly qualified providers like pharmacists beyond those listed in 1848(k)(3)(B) of the social security act (SSA). Such actions would alleviate many of the current restrictions preventing pharmacists from providing patient-care services and increase pharmacists' inclusion on patient care teams and in value-based delivery models.

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[3] NCPDP Pharmacy File, ArcGIS Census Tract File, NACDS Economics Department.
[4] *Id*.
[5] *Exploring Pharmacists' Role in a Changing Healthcare Environment*, Avalere (May 21, 2014), *available at* https://avalere.com/insights/exploring-pharmacists-role-in-a-changing-healthcare-environment.

General Regulatory Actions for CMS to Better Incorporate Pharmacists into Agency Programs, Services and Benefits

To assist CMS to accomplish the stated goals of the EO, NCPA respectfully submits the following general regulatory action recommendations:

- Leverage pharmacists' expertise broadly under Medicare;
- Expand service models utilizing pharmacist-provided patient care services using CMS Innovation Center data;
- Attribute and understand the contributions of pharmacists to the health outcomes of Medicare beneficiaries; and
- Implement a general supervision requirement vs. direct supervision for services delivered by highly trained pharmacists (see below).

Implement a general supervision requirement vs. direct supervision for services delivered by highly trained pharmacists

To expand on our recommendation regarding general and direct supervision, NCPA urges CMS to consider a general supervision requirement for services delivered by highly trained pharmacists, to help facilitate coordinated care. For example, evaluation and management (E/M) services under "incident-to" arrangements between pharmacists and physicians and Annual Wellness visits could be delivered using general supervision. Further, there are other Medicare services where pharmacists' scope of practice in the state/private sector are increasing access to care (opioid risk assessment, opioid antagonist training, telehealth services, tobacco cessation services, oral contraceptive services, etc.). CMS recently granted increased flexibility to physician supervision for other non-physician practitioners, physician assistants (PAs), and PA services.[6] Similar to PAs who may provide a broader array of services than those currently covered by Medicare Part B, as stated above, recent changes in the practice of pharmacy have resulted in pharmacists practicing more autonomously, like nurse practitioners (NPs) and clinical nurse specialists (CNSs), as members of care teams that often consist of physicians, nonphysician practitioners, and other health professionals. These changes have resulted in an increasing number of states updating scope of practice laws for pharmacists (e.g., pharmacist prescribing for tobacco cessation, hormonal contraceptives, naloxone, vaccine access, etc., under statewide protocols and collaborative practice authority (CPA)).[7]

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[6] *Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies Final Rule*, CMS, 84 FR 62568 (Nov. 15, 2019), *available at* https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other.

[7] Scope of Practice Resources, NASPA (2019), *available at* https://naspa.us/restopic/scope/.

Specific Regulatory and Policy Recommendations for CMS to Better Incorporate Pharmacists into Agency Programs, Services and Benefits

To assist CMS to accomplish the stated goals of the EO, NCPA respectfully submits the following specific recommendations for regulatory, subregulatory, policy, practice, and procedural changes:

- Clarify physicians and other qualified practitioners can bill for "incident-to" services provided to Medicare beneficiaries by pharmacists at levels higher than evaluation and management (E/M) Code 99211;
- Allow for pharmacists to be data-waived providers for buprenorphine;
- Clarify the ability of pharmacies to provide diabetes self-management treatment (DSMT) services (see below);
- Include advances in pharmacist-provided patient care services that are in state scope of practice laws in Medicare rulemaking, services and programs (see below);
- Increase MAT and counseling at the pharmacy level under Medicare Part B (see below); and
- Incorporate and/or test an alternative model at the innovation center in rural and medically underserved areas/populations (MUAs/Ps) focused on optimizing medication use and health outcomes as part of coordinated care delivery by using pharmacists (see below).

Clarify the Ability of Pharmacies to Provide Diabetes Self-Management Treatment (DSMT) Services

In CMS' CY 2017 Physician Fee Schedule (PFS) Proposed Rule, NCPA appreciated CMS's recognition of pharmacists as instructors "who actually furnish DSMT services…"[8] Yet, CMS then stated that pharmacists do not qualify to enroll in Medicare as certified providers, as that term is defined at section 1861(qq)(2)(A) in the Social Security Act, and codified in CMS regulations at § 410.140 as approved entities. However, § 1861(qq)(2)(A) states that DSMT services can be provided by "certified providers," which include "individual[s]" who meet "quality standards established by the Secretary…" "...for furnishing these services." While pharmacists and their services are not listed under § 1861 and therefore, are not eligible to directly bill for DSMT services, accredited pharmacies are able to provide such services upon meeting certain requirements.

Perhaps due to this conflicting language, pharmacists continue to experience barriers to providing DSMT services, as there is a lack of awareness that accredited pharmacies *can* bill for DSMT services and that pharmacists *are* recognized DSMT instructors. For example, it took one community pharmacy nine months to receive a National Provider Identifier (NPI) to bill for DSMT services primarily because of processor assertions that a pharmacy should only be requesting an NPI for Part D services. Policies that allow a pharmacist to be an instructor for an accredited DSMT pharmacy but not sign the billing paperwork for DSMT services is inconsistent with CMS' intent to increase accessibility of these services

[8] *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017*, CMS, 82 FR 33950 (July 15, 2016), *available at* https://www.federalregister.gov/documents/2016/07/15/2016-16097/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions.

to patients. In many cases, the pharmacist is the most accessible health care provider in a community and may be the sole instructor for DSMT.

Because this inconsistent language was not clarified in the CY 2017 final PFS rule or subsequent rules, we ask CMS to address in EO #13890 the ability of pharmacists and pharmacies to provide DSMT services. We also believe additional education and training materials for staff, as well as stakeholders, about the DSMT program and its benefits would help increase awareness regarding pharmacists' role in providing these services. This would additionally address concerns expressed in the CY 2017 proposed rule, that "claims have been rejected or denied because of confusion about the credentials of the individuals who furnish DSMT services," and help address the "issues that may contribute to the low utilization of these services." Lastly, NCPA asks CMS to clarify that a DSMT accredited pharmacy *can* bill for services without sign-off from a Part B DSMT accredited provider—a position reinforced by the fact that CMS and national accreditation organizations (NAOs) allow pharmacists to be DSMT certified instructors.

Include Advances in Pharmacist-Provided Patient Care Services that are in State Scope of Practice Laws in Medicare Rulemaking, Services and Programs

When pharmacist practitioners partner with physicians and other health care professionals they streamline and improve care, but regulations and policies that lag-behind state scope of practice laws add extra barriers that limit patient access to care. When state laws and regulations expand, it is important that federal regulations adapt to allow health care practitioners to contribute fully to patient care. Lack of CMS coverage of pharmacist-provided care services, rigid supervision requirements and unclear coverage policies for incident-to services create unnecessary layers of complexity for health care providers and patients. As explained below, pharmacists have prescribing authority in most states, are trained to perform assessments and monitor and manage medications and diseases.

Collaborative Practice Agreements

Currently, forty-eight (48) states grant pharmacists the ability to practice collaboratively in some capacity with other health care providers with prescribing authority in most states and training to perform assessments and monitoring and managing medications and diseases.[9]

Pharmacist Prescribing

Forty-three (43) states now permit pharmacist prescribing as part of CPAs. However, several states limit collaborative practice agreements to inpatient settings only or allow only the modification of medication regimens (thus, not the initiation of a medication). In addition, pharmacist scope of practice has expanded by states authorizing pharmacists to prescribe medications via statewide protocols and other

[9] *See Advancing Team-Based Care Through Collaborative Practice Agreements,* Centers for Disease Control and Prevention (2017), *available at* https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf.

mechanisms. Pharmacists are addressing unmet patient needs by performing assessments and prescribing medications(s) for minor ailments or public health needs. NCPA believes the ability to initiate a medication in an outpatient setting is a prerequisite to leveraging pharmacist prescriptive authority to meet health care needs in a scalable manner.

Pharmacist Prescribing Based on the Results of a Point-of-Care Test for Strep or Flu

There has been a growing interest in pharmacist prescribing based on the results of a point-of-care test for strep or flu.

- Idaho pharmacists are allowed to prescribe products to treat strep/flu pursuant to a point-of-care test. There is no state-mandated protocol, but pharmacies must develop and utilize an evidence-based protocol. The regulations went into effect in the summer of 2018.
- Kentucky's Board of Pharmacy has approved what they call statewide protocols that include strep and flu. Because their authority requires a doctor to sign off on a pharmacist *using* the protocol, it's actually more of a collaborative practice/standing order authority.

Beyond statewide authority, many states (ID, IL, MI, MN, MT, NE, NM, ND, OK, SD, TN, UT, VT, WA, WI) have CPA authority broad enough to allow pharmacists to prescribe pursuant to a point-of-care test. Overall, 17 states would be able to implement a test-and-treat program in some capacity.[10]

For Medicare, a pharmacy may possess a CLIA Certificate of Waiver so that they may expand patient access to CLIA-waived tests and improve public health. For example, patients may come to a pharmacy with a Certificate of Waiver to obtain a CLIA-waived point-of-care (POC) test for an infectious disease. One recent study involved pharmacists in three states, where pharmacists in waivered pharmacies worked with a physician under a collaborative practice agreement to help identify patients for an influenza POC test and subsequent identification and management of patients who tested positive for influenza.[11] This type of model helps earlier identify patients with infectious conditions as several of those screened did not have a primary care provider or were seen outside of regular clinic office hours. However, the ability to recoup both the costs associated with the CLIA-waived test and the pharmacist's time is essential for these models to advance but are a significant barrier currently.[12]

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[10] *Pharmacist Prescribing: "Test and Treat,"* NASPA (Feb. 8, 2019), *available at* https://naspa.us/resource/pharmacist-prescribing-for-strep-and-flu-test-and-treat/.

[11] ME Klepser, et al., *Effectiveness of a pharmacist-physician collaborative program to manage influenza-like illness*, J Am Pharm Assoc 56:14-21 (2016), *available at* https://www.ncbi.nlm.nih.gov/pubmed/26802915.

[12] *See* Burley, E., Klepser, S. & Klepser, M., *Opportunities for Pharmacists to Improve Access to Primary Care Through the Use of CLIA-waived Tests*, Michigan Pharmacists Association 52(2) (2014), *available at* https://www.michiganpharmacists.org/Portals/0/resources/poctesting/poctesting0414.pdf, last accessed, Dec. 27, 2019.

Naloxone

In regards to opioids, to help ensure that naloxone is on hand for life-threatening emergencies, all 50 states authorize pharmacists to dispense naloxone under statewide protocols and other mechanisms to prescribe an opioid antagonist.[13] The Centers for Disease Control (CDC) has acknowledged the ability for pharmacists to initiate or prescribe naloxone has contributed to significant reductions[14] in fatal overdoses (deaths) and also increases nonfatal overdoses (lives saved) seen in emergency department visits.[15] NCPA advocates for pharmacists to participate in wider distribution of naloxone under pathways approved by state regulatory boards. However, costs associated with these programs act as a deterrent for pharmacies' larger participation in the pathways. For example, counseling services that pharmacists provide when dispensing naloxone are not covered. Further, in some states, pharmacists must enter into collaborative practice agreements to provide naloxone, while some states require patient screening and counseling even though such services are not always eligible for reimbursement. NCPA urges CMS to allow pharmacists to directly prescribe naloxone to their patients, the least restrictive means to increasing access to naloxone.

Tobacco Cessation Aides

Currently, there are 12 states with statutes or regulations for pharmacist prescribing of smoking cessation aids, including Arizona, Arkansas, California, Colorado, Idaho, Indiana, Iowa, Maine, Missouri, New Mexico, Oregon, and West Virginia.[16] Community pharmacists are ideally positioned to make a difference with this challenging health issue both through the products they carry as well as the counseling services they provide.

Hormonal Contraception

Currently, there are 10 U.S. jurisdictions with statutes or regulations that allow pharmacists to prescribe contraceptives (without a CPA): California, Colorado, District of Columbia, Hawaii, Idaho, Maryland, New Mexico, Oregon, Utah, and West Virginia.[17]

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[13] *Pharmacist Prescribing: Naloxone*, NASPA (Jan. 17, 2019), *available at* https://naspa.us/resource/naloxone-access-community-pharmacies/.

[14] *Life-Saving Naloxone from Pharmacies*: *More dispensing needed despite progress*, CDC (Last reviewed Aug. 6, 2019), *available at* https://www.cdc.gov/vitalsigns/naloxone/index.html.

[15] Abouk, Rahi. et al., *Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose*, JAMA Intern Med. 179(6):805-811 (May 6, 2019), *available at* https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2732118.

[16] *Pharmacist Prescribing: Tobacco Cessation Aids*, NASPA (Nov. 22, 2019), *available at* https://naspa.us/resource/tobacco-cessation/.

[17] *Pharmacist Prescribing: Hormonal Contraceptives*, NASPA (May 24, 2019), *available at* *https://naspa.us/resource/contraceptives/*.

Despite pharmacists' expertise and expanding scope of practice, the inability to bill and receive adequate reimbursement for their services continue to create barriers to wider patient access to pharmacists' services throughout the health care delivery system. Accordingly, NCPA encourages CMS to consider advances in state scope of practice laws for health care practitioners, including pharmacists, when considering eligibility and coverage for patient care services and reflect this in the EO 13890 and other future rulemakings.

Increase MAT and Counseling at the Pharmacy Level Under Medicare Part B

CMS' recently proposed rule[18] on the physician fee schedule and Medicare Part B payment implements section 2005 of the SUPPORT for Patients and Communities Act (SUPPORT Act) that expands Medication-Assisted Treatment (MAT) via a new Part B benefit category for opioid use disorder (OUD) treatment services furnished by an opioid treatment program (OTP). The SUPPORT Act provides for coverage of OUD treatment services and a bundled payment to OTPs for OUD treatment services furnished during an episode of care.

NCPA supports the increased usage of MAT and counseling at the pharmacy level under Medicare Part B. Advancing the pharmacist's role in MAT for OUD can help improve access and outcomes, while reducing the risk of relapse. In fact, pharmacists are already partnering with physicians to provide MAT. Currently, 48 states and the District of Columbia allow pharmacists to enter into collaborative practice agreements with physicians and other prescribers to provide advanced care to patients, including MAT. When such relationships form, pharmacists have taken the lead in developing treatment plans, communicating with patients, improving adherence, monitoring patients, identifying treatment options and performing tasks to alleviate the physician' burden.

Pharmacies providing MAT are even aiding city governments by partnering with local rehabilitation centers, physicians, and drug courts. For example, Alps Specialty Pharmacy in Missouri provides several services for patients receiving MAT including the following: (1) streamlining access to Vivitrol through insurance and financial support resources; (2) adherence support (timely refill/appointment reminders to ensure the injection is given on time); and (3) monthly Clinical Pharmacist Assessments to evaluate efficacy, safety, and adherence. A pharmacist at Alps manages 20-50 patients a month at any given time and offers these services to streamline patient access to treatment as well as help coordinate patient management.

[18] *Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other changes to Part B Payment; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals*, CMS, 84 Fed. Reg. 40, 482 (proposed Aug. 14, 2019).

By utilizing pharmacy/pharmacist-led program, CMS could witness the following benefits:

- Dedicated workflow and Patient Care Coordinators to help coordinate patient's insurance and billing;
- Less inventory burden on prescriber - Vivitrol is expensive and must be refrigerated. Having a pharmacy alleviate that burden by billing through prescription benefit is helpful;
- Access specialist - approval for Vivitrol can be time consuming. Patient Care Coordinators work at the pharmacy and can help navigate insurance benefits and prior authorizations as well as find financial resources for patients to make it accessible and affordable; and
- Flexible schedule for patients - walk in appointments are welcome for Vivitrol injections.

Although this program has shown to be successful for patients in Missouri, some insurance companies mandate that Vivitrol be filled under a "medical benefit," which limits pharmacists to assisting with billing/filling and forces prescriber offices to "buy and bill." Further, some insurance companies mandate that Vivitrol be filled through a specific mail-order pharmacy. This requirement prevents pharmacies from assisting with patient management. NCPA asks Congress to work with CMS to require plans to include opioid antagonist medications, such as Vivitrol, under a medical or pharmacy benefit.

Pharmacists have both the knowledge and experience to provide MAT; however, treatment is limited due to current regulatory barriers as stated above. Patients should be able to choose to seek these services from their community pharmacists. NCPA asks for clarification that healthcare professionals providing care under a SAMHSA-certified OTP may continue to provide care in accordance with their state law and thus, the care can be covered by Medicare Part B. We encourage CMS to consider ways in which community pharmacists can be utilized in expanding these MAT services.

Incorporate and/or Test an Alternative Model at the Innovation Center in Rural and Medically Underserved Areas/ Populations ("MUAs/Ps") Focused on Optimizing Medication Use and Health Outcomes as Part of Coordinated Care Delivery by Using Pharmacists

Currently, payment models that preclude participation from health care practitioners qualified to provide care have the unintended consequence of limiting access to care, including care in rural settings. Physicians and other health care practitioners are challenged to meet the growing demand for patient care services. According to the Association of American Medical Colleges (AAMC), the estimated shortage of physicians due to workforce aging, population growth and increased demand for health care services will range from 40,000 to 90,000 by 2025.[19] The effects of shortages will be exacerbated in rural communities which already struggle to meet patient needs.[20] One important mechanism physician practices can employ to greatly increase their capacity to meet patient demand is to use a coordinated,

[19] *Physician Supply and Demand Through 2025: Key Findings*, Association of American Medical Colleges (2015), *available at* https://www.aamc.org/download/450420/data/physiciansupplyanddemandthrough2025.pdf.
[20] Petterson S.M., Phillips R.L., Jr., Bazemore A.W. & Koinis G.T., *Unequal Distribution of the U.S. Primary Care Workforce*, American Family Physician 87(11) (2013), *available at* http://www.aafp.org/afp/2013/0601/od1.html.

team-based, patient-centered approach to care and delegate appropriate clinical responsibilities to non-physician practitioners.[21] The American Medical Association (AMA) has already implemented modules for its members on embedding pharmacists into their practice and collaborating with pharmacists to improve patient outcomes.[22]

There are over 300,000 pharmacists in the U.S., many of whom are underutilized in their capacity to mitigate these unmet health care needs. As medications are becoming more complex and the population ages, optimizing patients' medications will be crucial under the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Therefore, recognizing the unique and essential contributions that pharmacists make on patient care teams is fundamental to sustaining new payment systems and models. As previously stated, pharmacists are critical to bending the Medicare cost curve by encouraging the delivery of high-quality, low-cost care. Improving the utilization of pharmacists on patient-care teams, particularly in rural and medically underserved areas will help address the need to provide care in rural settings and improve quality.

Leveraging pharmacists in rural health settings to provide patient-care services that are covered by Medicare Part B could help prevent rural pharmacies from closing while providing care in underserved areas. Rural pharmacy closures also impact hospitals, clinics, other care settings, medication adherence, patient safety and leave significant gaps in care to important services such as administering vaccines.[23,24,25,26] Therefore, NCPA urges CMS to carefully consider how pharmacists across all practice settings can be included in different aspects of Medicare in the interest of patient care and sustainability of the program.

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[21] Bodenheimer, T.D. & Smith, M.D. *Primary Care: Proposed Solutions to the Physician Shortage Without Training More Physicians*, Health Affairs (2013), *available at* https://doi.org/10.1377/hlthaff.2013.0234; https://www.ncbi.nlm.nih.gov/pubmed/24191075.

[22] *Embedding Pharmacists into the Practice - Collaborate with pharmacists to improve patient outcomes*, AMA Steps Forward (June 17, 2019), *available at* https://edhub.ama-assn.org/steps-forward/module/2702554?resultClick=1&bypassSolrId=J_2702554.

[23] Qato, D.M., Alexander, G.C., & Chakraborty, A., *Association Between Pharmacy Closures and Adherence to Cardiovascular Medications Among Older US Adults*, JAMA 2(4):e192606 (2019), *available at* https://www.ncbi.nlm.nih.gov/pubmed/31002324.

[24] Traynor, A.P., Sorenson, T.D. & Larson, T., *The Main Street Pharmacy: Becoming an Endangered Species*, Rural Minnesota Journal 2(1) (2011), *available at* https://www.ruralmn.org/wp-content/uploads/2011/03/The-Main-Street-Pharmacy.pdf.

[25] Bartch, S.M., et al., *Epidemiologic and Economic Impact of Pharmacies as Vaccination Location During an Influenza Epidemic*, Vaccine 34(46), 7054-7063 (2018), *available at* https://www.ncbi.nlm.nih.gov/pubmed/30340884.

[26] *Issues Confronting Rural Pharmacies after a Decade of Medicare Part D*, Rural Policy Research Institute & Rural Health Research & Policy Centers (2017), *available at* https://rupri.public-health.uiowa.edu/publications/policybriefs/2017/Issues%20confronting%20rural%20pharmacies.pdf.

Conclusion

NCPA greatly appreciates the opportunity to share with you our comments and suggestions on the request for feedback to include in the forthcoming regulation to implement EO #13890 on removing barriers to allow pharmacists to practice at the top of their license/profession. As stated above, when pharmacists collaborate with health care professionals, they improve patient care and outcomes. However, restrictive regulations hinder pharmacists' ability to continue providing this care at the federal level, especially when state laws are already ahead in expanding scope of practice. NCPA urges CMS to enhance coverage of pharmacist-provided care services and reevaluate strict supervision requirements as well as coverage policies for incident-to services. NCPA is committed to working with CMS and other industry stakeholders in promoting the Administration's effort to reevaluate Medicare regulations that limit health professionals from practicing at the top of their license.

Sincerely,

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National Community Pharmacists Association