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Nov. 10, 2025

The Honorable Senator Chuck Grassley
135 Hart Senate Office Building
Washington, DC 20510

The Honorable Senator Ben Ray Luján
498 Russell Senate Office Building
Washington, DC 20510

Re: Request-for-Information on Pharmacists Providing Chronic Care

Senators Grassley and Luján,

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments on the important role of community pharmacists in rural and underserved communities, and opportunities to strengthen their role to improve health care for seniors.

NCPA represents America's community pharmacists, including 18,900 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 (LTC) settings. Together, our members employ 205,000 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 LTC independent pharmacies.

1. What role do pharmacists perform in providing chronic care services, especially for seniors in rural and underserved areas?

Medication Therapy Management (MTM) in Part D

As medication experts, community pharmacists are critical to helping patients stick with and get the most out of their prescription drugs. Yet so much more can be done to improve medication adherence and achieve better health outcomes at lower overall costs. That is where medication therapy management, or MTM, services can play a vital role. NCPA believes that prevention is the best medicine, and whether it is catching a medication error before it leads to a hospitalization or effective chronic disease management, MTM services present an opportunity to improve patient care while providing greater efficiencies within the healthcare system.

NCPA opposes further broadening coverage of MTM services without increasing payment to pharmacies, as doing otherwise will create an "unfunded mandate" on pharmacy. It is crucial that Part D plans increase payment for these services, as the existing payment rates are insufficient for pharmacies. If low payments continue, pharmacists will not invest the time in providing MTM services. Part D plans should recognize the role and value of the pharmacist and what they provide for MTM services and compensate them accordingly.

Furthermore, MTM payments should be commensurate with the care and expertise provided to the patient, not based on generating additional revenue for the plans and the PBMs. NCPA opposes Part D plans utilizing MTM to generate cost savings, such as formulary management tools that arbitrarily seek to move patients to the PBM's preferred formulary medication or transitioning to an extended-day supply of medication. Often patients that qualify for MTM are not ideal candidates for extended-day supplies, such as 90-day fills. Additionally, extended day supply can often lead to less clinically appropriate in-person, pharmacy-patient contact. MTM payments should emphasize the professional services and relationships that pharmacists provide to patients. MTM should not arbitrarily limit time and engagement with patients.

Additionally, NCPA supports Congress advising CMS to require Part D contracts to contain "any willing pharmacy" language to allow pharmacies to participate in MTM services. Such participation in MTM should be based on pharmacies' capacities and willingness to handle MTM cases. Plans should not be allowed to have performance scores, fees or payment withholds contingent on the number of MTM beneficiaries a pharmacy has.

Diabetes self-management training (DSMT)

NCPA recommends that Congress ask CMS to address challenges for pharmacists and pharmacies to deliver diabetes self-management training ("DSMT") services. Diabetes is a growing epidemic in this country, and community pharmacists are key in managing the disease. We appreciated CMS' recognition of pharmacists as instructors "who actually furnish DSMT services...," in the CY 2017 PFS proposed rule.[1] Section 1861(qq)(2)(A) of the Social Security Act states that DSMT services can be provided by "certified providers," which include "individual[s]" who meets "quality standards established by the Secretary..." "...for furnishing these services." While pharmacists and their services are not listed under §1861, accredited pharmacies are able to provide such services upon meeting certain requirements.

Our members continue to experience barriers to providing DSMT services due to 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 9 months to receive an NPI to bill for DSMT services primarily because of MAC assertions that a pharmacy should only be requesting an NPI for Part D services. In addition, our members have had claims rejected when submitting bills from a DSMT accredited pharmacy because a pharmacist signed the billing paperwork and not a Part B DSMT certified provider.[2] Policies that allow a pharmacist to be an instructor for an accredited DSMT pharmacy, but not sign the bills for DSMT services is illogical and inconsistent with CMS' policies and aim to make such services more accessible 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. Furthermore, when pharmacists inquire about DSMT billing

[1] CMS. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017. 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.

[2] See §1848(k)(3)(B) and 1842(b)(18)(C). Available at: https://www.ssa.gov/OP_Home/ssact/title18/1848.htm.

problems to CMS or MACs, staff are not often aware of pharmacists' and pharmacies' roles in DSMT. This was not clarified in the CY 2017 final PFS rule or subsequent rules. **Accordingly, we request that CMS clarify that pharmacists and pharmacies can provide DSMT services. We also ask CMS provide education and training materials for staff and information for patients and other stakeholders about the program and its benefits.** This acknowledgement and awareness will address concerns expressed in the CY 2017 PFS proposed rule, that "claims have been rejected or denied because of confusion about the credentials of the individuals who furnish DSMT services," and will help address the "issues that may contribute to the low utilization of these services." **We also ask 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.**

Billing barriers include requiring multiple National Provider Identifiers (NPIs) and multiple Provider Transaction Access Numbers (PTANs) that undoubtedly get crossed over in the background when trying to bill, resulting in incorrectly denied claims. Furthermore, the DSMT identifier is a sub-qualifier that is added on to a PTAN behind the scenes, so pharmacists are unable to track their status with their Provider Enrollment, Chain and Ownership System (PECOS) accounts nor can they easily track and reconcile DSMT claims that were billed with pharmacy designated PTANs that may be billing for other services as well. **That being said, CMS could ease barriers to DSMT access by allowing pharmacists working within an accredited program to be able to bill as a provider with their own NPI number.** NCPA believes that it is essential for pharmacies to maintain their accreditations, and we support pharmacists maintaining their accreditations even if CMS were to allow pharmacists to bill as a provider with their own NPIs.

We also strongly recommend that Congress ask CMS to clarify in the Medicare Benefit Policy Manual, Chapter 15, Section 300[3] that DSMT services are already permitted at pharmacies that meet CMS' and NAOs' requirements.[4] Moreover, to truly maintain the viability of DSMT programs, we have urged CMS to update the outdated terminology and design of the benefit. Our organizations also recommend CMS adopt the updated terminology defined in the 2022 Standards of Medical Care in Diabetes, "diabetes self-management education and support" or "DSMES." This terminology reflects the continuous support that diabetes patients need in managing their chronic condition as patients may require intensified re-education and self-management planning and support that often go beyond the current DSMT benefit. In addition, CMS should also consider allowing additional hours of DSMT for beneficiaries, similar to the

[3] See CMS. Medicare Policy Benefit Manual. Chapter 15, Section 300. May 22, 2022, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

[4] In accordance with § 410.144, a CMS-approved NAO may accredit an individual, physician or entity to meet one of three sets of DSMT quality standards: CMS quality standards; the National Standards for Diabetes Self-Management Education Programs (National Standards); or the standards of an NAO that represents individuals with diabetes that meet or exceed our quality standards. Currently, CMS recognizes the American Diabetes Association and the American Association of Diabetes Educators as approved NAOs, both of whom follow National Standards. Medicare payment for outpatient DSMT services is made in accordance with §414.63.

Medical Nutrition Therapy ("MNT") benefit, during the four critical times[5] identified in the Joint Position Statement of the American Association of Diabetes Educators ("AADE"), the American Diabetes Association ("ADA") and the Academy of Nutrition and Dietetics ("AND").[6] Investing in a more robust service for certain high-risk diabetes patients can help improve their quality of life and health outcomes, and prevent high-cost services and procedures.

Additionally, NCPA suggests that Congress ask CMS to allow pharmacists to order laboratory testing like a provider. This would allow pharmacists to track and affect DSMT outcomes more effectively. Having to request the physician to share A1C and lipids is often a barrier to care.

Continuous glucose monitoring (CGM)

Diabetes management is a necessary and growing service provided by community pharmacists, which is made possible by continuous glucose monitoring (CGM). CGM devices allow patients and providers to monitor glucose levels in real time and optimize medication usage and wellness practices. Diabetes management is a necessary and growing service provided by community pharmacy as pharmacy is the true gateway to care in the community. Patient access to CGM allows pharmacist to better coach and counsel their patients with diabetes. It illuminates patient adherence to their medications and allows for high personalization of recommendations.

It is important that CMS set a precedent for allowing pharmacists to bill for the device unit and the corresponding counseling of continuous glucose monitoring (CGM) in Medicare. We are aware of a number of private plans that cover the CGM device unit under the prescription benefit, while others cover it under the medical benefit. We are not aware of private plans that cover and reimburse for the counseling component. **NCPA urges Congress to ask CMS to expand access to needed diabetes services, specifically by covering CGM that is delivered by pharmacists and other qualified practitioners under direct or general (preferable) supervision.**

Annual Wellness Visit (AWV)

NCPA recommends that Congress advise CMS to allow AWVs to be delivered under general supervision. MA plans have been interested in partnering with community pharmacists to bridge their metrics gaps. As AWVs are currently only delivered in the office under direct supervision, general supervision would increase community pharmacist participation.

[5] The Joint Statement identified for critical times for allowing additional hours of DSMT: 1. New diagnosis of type 2 diabetes; 2. Annually for health maintenance and prevention of complications; 3. When new complicating factors influence self-management; and 4. When transitions in care occur.

[6] Powers, Margaret. Et. al. A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. Diabetes Self-management Education and Support in Type 2 Diabetes. 2015, available at: https://www.diabeteseducator.org/docs/default-source/practice/practice-resources/position-statements/dsme_joint_position_statement_2015.pdf?sfvrsn=0.

2. How could pharmacist provider status for chronic care services improve access to care for seniors?

Many states allow pharmacists to provide chronic care services to seniors. According to the American Society of Health-Systems Pharmacists (ASHP), all 50 states, plus the District of Columbia and Puerto Rico, permit pharmacists to enter into collaborative practice agreements (CPAs) with physicians. CPAs enable pharmacists to engage in comprehensive medication management (CMM), including initiating, modifying, and/or discontinuing therapy regimens. Further, 30 states plus the District of Columbia permit pharmacists to independently prescribe at least one drug or device (not including vaccines).[7] Sixteen states permit pharmacists to independently order tests and treatments for COVID-19 and the flu,[8] while pharmacists in all 50 states may order and administer immunizations. Twenty-one states permit pharmacists to independently furnish drugs to prevent HIV infection.[9] Twelve states permit pharmacists to prescribe medications for opioid use disorder (MOUD),[10]while twenty-one states also permit pharmacists to prescribe drugs for tobacco cessation.[11] As to reimbursement for pharmacists' services, forty-four states require health plans and/or Medicaid to cover at least one clinical service from a pharmacist that is not directly tied to medication dispensing, and thirty-three states permit pharmacists to enroll as Medicaid providers.

Through these efforts, pharmacists have become critical practitioners, and have helped to close the care gaps, increased access to preventive care, helped manage conditions like diabetes and blood pressure, reduced unnecessary visits to emergency departments, and decreased hospital readmissions by providing transition of care support services post discharge.

4. How does regulatory red tape reduce the care that pharmacists can perform?

Pharmacists are unable to directly bill Medicare for their services, which limits the ability of pharmacists to practice within their scope of license as providing these services is not financially viable. **Therefore, we ask that Congress advise CMS to formally recognize pharmacists as providers to claim reimbursement under Medicare Part B.[12]** We additionally propose the following:

<u>CMS should reimburse pharmacist-provided opioid use disorder (OUD) services at OTPs</u>
Many pharmacists treat patients with opioid use disorder (OUD) at opioid treatment programs (OTPs). NCPA believes pharmacists can help meet treatment demands but their ability to do so is dependent, in part, on coverage frameworks that encourage better use of pharmacists. **Congress should advise CMS to acknowledge and reimburse pharmacist-provided patient care**

[7] AK, AR, AZ, CA, CO, CT, DE, HI, IA, ID, IN, KS, MA, MD, ME, MN, MO, MT, ND, NM, NV, OK, OR, RI, TN, UT, VA, VT, WV, and WY.
[8] AR, CA, CO, DE, IA, ID, IL, KS, MI, MT, NC, NM, NV, OR, VA, and WV.
[9] AR, CA, CO, CT, DE, IA, ID, IL, MD, ME, MN, MT, NC, NM, NV, NY, OR, RI, TN, UT, and VA.
[10] CA, CO, IA, ID, MA, MT, NC, NM, NV, OR, UT, and WA.
[11] AR, AZ, CA, CO, IA, ID, IN, MD, ME, MN, MO, MT, NC, ND, NM, OR, TN, UT, VA. VT, and WV.
[12] 42 U.S.C. 1395w-4.

services that can be provided through OTP programs. NCPA recommends CMS reimburse pharmacist-provided opioid use disorder (OUD) services at OTPs, and encourages CMS to implement policy changes that leverage pharmacists to deliver clinical care services for patients with opioid use disorder (OUD).

CMS should rescind the Medicare Part B requirement for a beneficiary's signature on a reimbursement claim

NCPA calls on Congress to advise CMS to rescind the Medicare Part B requirement for a beneficiary's signature on a reimbursement claim under 42 C.F.R. 424.32 and 42 C.F.R. 424.36 because it is outdated in today's era of electronic claim submission. Capturing a signature – both on paper and electronically – is administratively burdensome and not an effective deterrent for fraud and abuse.

42 C.F.R. 424.32 Basic requirements for all claims.
(a) A claim must meet the following requirements:
(3) A claim must be signed by the beneficiary or on behalf of the beneficiary (in accordance with § 424.36).

42 C.F.R. 424.36 Signature requirements.
(a) General rule. The beneficiary's own signature is required on the claim unless the beneficiary has died or the provisions of paragraphs (b), (c), or (d) of this section apply. For purposes of this section, "the claim" includes the actual claim form or such other form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary.

* * *

(c) Who may sign if the beneficiary was not present for the service. If a provider, nonparticipating hospital, or supplier files a claim for services that involved no personal contact between the provider, hospital, or supplier and the beneficiary (for example, a physician sent a blood sample to the provider for diagnostic tests), a representative of the provider, hospital, or supplier may sign the claim on the beneficiary's behalf.

We request that CMS rescind these regulations which require a beneficiary's signature on a reimbursement claim in the Medicare program. This requirement was more appropriate when pharmacies were more regularly submitting paper claims, but is no longer viable today as pharmacies engage predominantly in real-time, electronic claims submission. It is unclear what, if anything, these rules do to protect the Medicare program from fraud or abuse, but these rules do substantially add to administrative burden on pharmacies, and delays in patient care.

Specific administrative burdens of the existing regulation include lost time attempting to mail a form to the beneficiary requesting signature and repeatedly following up seeking a response.

CMS should revise its interpretation of 42 CFR 424.57(c)(12) - Signature for In Person Pickup of Items

42 CFR 424.57(c)(12) - Signature for In Person Pickup of Items
Must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery. (The supplier must document that it or another qualified party has at an appropriate time provided beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively)

NCPA calls on Congress to advise CMS to revise its interpretation of this regulation, and instead interpret it to mean that a signature capture is not required for in person pickup. The federal regulation does not specifically state that signature must be captured to document proof of delivery. A supplier can rely on receipt of delivery confirmation from the carrier.

Requiring a signature for items that are picked up in person at a supplier is contrary to this regulation and unnecessarily burdensome, especially since a signature is not required for home delivery. Moreover, it is unclear how the signature requirement protects against fraud or abuse in the Medicare program, as a supplier has other forms of documentation it can produce for items picked up in person (electronic documentation of sales transactions, use of/form of payment collected for copayments, etc.) to document proof of delivery, similar to a third-party carrier delivery confirmation.

SAMHSA and DEA should rescind joint rules requiring pharmacists to verify the identity of patients filling prescriptions for buprenorphine to treat opioid use disorder (OUD) that were issued on the basis of a telemedicine encounter

42 CFR § 12.3 (b)(4) and 21 CFR § 1306.51 (b)(4) - Requirement for Pharmacists to Verify Identification of the Patient When Filling Prescriptions for Schedule III-V Medications

Congress should work with Substance Abuse and Mental Health Services Administration (SAMSHA) and the Drug Enforcement Administration (DEA) to rescind their joint rules requiring pharmacists to verify the identity of patients filling prescriptions for buprenorphine to treat opioid use disorder (OUD) that were issued on the basis of a telemedicine encounter – a requirement that perpetuates the stigma that individuals seeking OUD treatment can experience, thereby undermining the underlying purpose of the Final Rule to "increase patient access to legitimate medical treatment." Further, these requirements that impose burdensome, costly, and unworkable requirements on pharmacies were never properly noticed for public comment.

5. Are there other considerations that policymakers should account for in establishing pharmacist provider status?

Pharmacists as providers for opioid abuse services
Negative reimbursement pressure from insurers and pharmacy benefit managers and the inability of pharmacists to bill Medicare Part B as providers limits the positive impact pharmacists

can provide to help combat the opioid crisis. Pharmacists are key players in counseling treatment for SUDs and provide many opioid abuse services, such as drug management and referral to counseling treatment.

Due to independent pharmacists' expertise in medication management and frequent interaction with their patients, they are equipped to educate patients about their use of controlled substances. Further, independent pharmacists can alert patients to possible consequences and, if needed, begin to motivate them to take steps to change their behavior. Patients currently choose to seek medication-related services from their community pharmacist for many reasons, as they have established relationships with their community pharmacists. Allowing the beneficiary to seek these services from their pharmacist increases the odds that medication adherence will occur. **Therefore, we ask that Congress advise CMS to formally recognize pharmacists as providers eligible to furnish those opioid abuse reduction services in their scope of practice and claim reimbursement under Medicare Part B.**[13]

Additionally, the Drug Enforcement Administration's (DEA's) system for registration is antiquated because it prohibits pharmacists in some states from registering as medications for opioid use disorder (MOUD) prescribers — despite state laws specifically authorizing pharmacists to prescribe MOUD. The DEA's "Mid-Level Practitioners Authorization by State" table needs to be updated to recognize states that allow pharmacist prescribing of MOUD. We urge the DEA to update its online application and the Mid-Level Practitioners Authorization by State table to allow and include pharmacists in states permitting pharmacists to prescribe MOUD.

Conclusion

NCPA appreciates the opportunity to share comments on the important role of community pharmacists in rural and underserved communities, and opportunities to strengthen their role to improve health care for seniors. Please let us know how we can assist further, and should you have any questions or concerns, please feel free to contact me at steve.postal@ncpa.org or (703) 600-1178.

Sincerely,

Steve Postal, JD
Senior Director, Policy & Regulatory Affairs
National Community Pharmacists Association

[13] 42 U.S.C. 1395w-4.