

November 10, 2025

The Honorable Chuck Grassley  
United States Senate  
135 Hart Senate Office Building  
Washington, D.C. 20510

The Honorable Ben Ray Lujan  
United States Senate  
498 Russell Senate Office Building  
Washington, DC 20510

**RE: Request-for-Information on Pharmacists Providing Chronic Care**

Dear Senators Grassley and Lujan:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in the United States. **We strongly urge Congress to make pharmacists billable providers and be able to generate a qualifying visit for CHCs to continue to best serve our patients.**

For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, behavioral health, pharmacy, vision, and other essential health services in every type of community. This includes over 10 million rural residents (at least 1 in 5 and up to 1 in 3), more than 20 million (at least 1 in 3) in poverty, and more than 6 million (at least 1 in 5) uninsured people. Powered by dedicated and committed staff (nearly 330,000 FTEs), CHCs serve at least 1 in 10 Americans and up to 1 in 7<sup>1</sup> yet account for only 1% of total U.S. healthcare spending, saving Medicaid and Medicare billions annually by reducing costly emergency, inpatient, and specialty care.<sup>2</sup> Research suggests that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.<sup>3</sup>

In addition to medical services, CHCs provide dental, behavioral health, pharmacy services, and other “enabling” or support services that facilitate access to care for individuals and families in medically underserved communities, regardless of insurance status or ability to pay. NACHC maintains its role as the national voice for CHCs and believes that high-quality primary health care is essential in creating healthy communities. The collective mission and mandate of NACHC and the 1,512 CHCs around the country is to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

In 2024, more than 70 percent of CHCs reported primary care physician, nurse, or mental health professional shortages.<sup>4</sup> Thus, pharmacists have the opportunity, as billable providers, to continue

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<sup>1</sup> <https://www.weitzmaninstitute.org/the-hidden-patient-base/>

<sup>2</sup> Volerman A, Carlson B, Wan W, Murugesan M, Asfour N, Bolton J, Chin MH, Sripipatana A, Nocon RS. Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in health centers vs non-health centers. *BMC Pediatr.* 2024 Feb 8;24(1):100. doi: 10.1186/s12887-024-04547-y. PMID: 38331758; PMCID: PMC10851548. <https://pubmed.ncbi.nlm.nih.gov/38331758/>

<sup>3</sup> <https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf>

<sup>4</sup> <https://www.commonwealthfund.org/press-release/2024/new-survey-over-70-percent-community-health-centers-face-critical-staff>

playing a vital role in the delivery of comprehensive care at CHCs, from dispensing medications to providing patient education and chronic disease management. As some of the most accessible health professionals, pharmacists are often on the front lines of patient care, helping patients understand their treatments, manage conditions like diabetes or hypertension, and stay adherent to medications. Although pharmacists in all 50 states are now authorized to administer vaccines, the scope of their authority varies significantly by state, including which vaccines can be administered, to which age groups, and the ability to delegate authority. Some states also permit pharmacists to prescribe medications, often contingent on collaborative practice agreements with other licensed providers.

As you consider legislation to expand the role of pharmacists in Medicare, NACHC urges you to consider the unique role and needs of pharmacists working at CHCs. Any legislation to make pharmacists a billable Medicare provider must include an update to § 1861(aa)(1)(B) of the Social Security Act to ensure the nearly 4,000 pharmacists at CHCs are included. Pharmacists at CHCs serve a population with limited care options and complex chronic health needs, and this language would protect these seniors' access to care.

We appreciate your consideration of our response, which focuses on questions 3, 4, and 5 from the RFI.

**I. What role do rural health clinics (RHCs) and federally qualified health centers (FQHCs) play in improving pharmacy services under Medicare in rural and underserved areas?**

Across the country, CHCs are integrating pharmacy services into primary care services to create seamless access for patients. With workforce shortages across the country, pharmacy staff play a vital role in providing comprehensive, whole-person care that directly improves the health of rural and underserved patients served by CHCs. In addition to medication access, they collaborate on patients' medication plans, vaccine choices, evaluate the effectiveness of treatment, provide patient education, and improve access to reimbursement. Pharmacists embedded within CHCs can help manage chronic diseases such as diabetes, heart failure, chronic obstructive pulmonary disease (COPD), hypertension, and hyperlipidemia. They also help provide anticoagulation monitoring and management, smoking cessation programs, and chronic pain management to patients.

Even though chronic diseases more commonly afflict CHC patients than the general population, because of CHC's model of care, these diseases are more effectively managed. For instance, a growing number of CHC patients have diabetes. Between 2022 and 2023, the overall CHC patient population increased by 3%, while the number of individuals with diabetes rose by 6%, totaling 3,273,700 patients. Yet, the percentage of CHC patients with uncontrolled diabetes fell from 32% in 2021 to 29% in 2023.<sup>5</sup> Pharmacists are deeply involved in both point-of-care A1C testing and the long-term monitoring of diabetes control, as well as the monitoring of other chronic conditions.

In fact, more than half of CHC pharmacists offer some form of chronic disease management.<sup>6</sup> They may order labs, adjust therapies under collaborative practice agreements (CPAs), and coordinate with the healthcare team to ensure the best possible patient care. CHC pharmacists also provide essential preventive care, including health education, blood pressure and A1C checks, cholesterol and glucose screenings, fall-risk screenings, and immunizations for influenza, pneumonia, and shingles. They

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<sup>5</sup> [https://www.nachc.org/wp-content/uploads/2025/05/2025-UDS-Chartbook\\_Final-05.13.25.pdf](https://www.nachc.org/wp-content/uploads/2025/05/2025-UDS-Chartbook_Final-05.13.25.pdf)

<sup>6</sup> Internal NACHC assessment data (53%).

conduct Point-of-Care Testing (POCT) for diabetes through Clinical Laboratory Improvement Amendments (CLIA) waived A1C tests, as well as flu and strep tests, directly in the clinic or pharmacy. These quick tests allow pharmacists to make immediate therapeutic decisions, conduct patient education, and perform same-day medication adjustments. For rural and underserved areas, these tests serve as a lifeline, especially for A1C testing, as this may be the only consistent testing available between primary care visits.

Another key preventive service pharmacists provide is conducting Annual Wellness Visits (AWVs). Given pharmacists' close relationship with their patients and their deep understanding of their medication regimens, they are well positioned to conduct AWVs, which help them develop and update a personalized prevention plan based on a patient's health status and risk factors. Pharmacists conducting AWVs also free up primary care providers to attend to other patients while providing convenience to patients. These preventive services are particularly important for seniors and are often more accessible through pharmacies than physician offices in rural areas.

Beyond dispensing medication, pharmacists in CHCs also provide comprehensive medication management (CMM), including addressing the issue of polypharmacy, which is the use of five or more medications concurrently. Polypharmacy is especially common in older adults with chronic conditions and can lead to an increased risk of adverse drug interactions, medication non-adherence, and potential hospitalization. Pharmacists reconcile patient medications, deprescribe, and educate patients on their prescription drugs to decrease those risks and added costs to our already strained health care system. According to an internal NACHC assessment, 69% of pharmacists in CHCs provide medication therapy management (MTM)<sup>7</sup> to help patients get the most benefit from their medications, ensuring they are safe, effective, and advancing the patient's health goals. Additionally, CHC pharmacists play a key role in reviewing and aligning patients' medications during the transitions between the hospital, facility, and home, which are high-risk for older adults. Post-discharge medication reconciliation and early follow-up help reduce re-admissions, while also improving communication and coordination among care teams.

Additionally, rural initiatives are increasingly positioning pharmacists as core members of interdisciplinary care teams as the industry faces a national workforce shortage. Pharmacists are coordinating medication home-delivery programs for patients in "pharmacy deserts" and providing tele-pharmacy services to ensure rural patients have access to their prescriptions. They help patients use remote patient monitoring (RPM) devices, such as those that track blood pressure, glucose, and other metrics, between office visits to enable early intervention and therapy optimization for rural seniors. As essential members of the care team, pharmacists in CHCs continue to transform pharmacy services under Medicare, improving access, enhancing chronic disease management, and ensuring high-quality, patient-centered care for rural and underserved communities.

Pharmacists also assist seniors in navigating the rules of Medicare Part D plans and overcoming medication access barriers. They are key actors in streamlining prescription management for patients. Pharmacists coordinate refill schedules and manage insurance requirements to ensure all medications are available, thereby reducing patient confusion and missed doses. They also identify medications that can be converted to 90-day supplies to reduce pharmacy visits and improve adherence. Additionally, pharmacists collaborate with nearby dispensing pharmacies to prevent treatment interruptions.

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<sup>7</sup> Internal NACHC survey data.

Pharmacists are also key educators, helping patients understand all the nuances of their conditions. They go through a rigorous curriculum and training while in pharmacy school. In many cases, pharmacists tend to have more training in certain disease states than providers, some of these include diabetes, hypertension, heart failure, COPD, hyperlipidemia and nutrition. They help bridge gaps in health literacy by explaining medications in understandable terms and providing ongoing education, given their close relationships to their patients and their caregivers.

While it has been established that pharmacists do much more than just dispensing medications, CHC pharmacists connect patients to affordable, accessible medications through the 340B program. The 340B program allows CHCs to get discounted outpatient drugs, so that CHC pharmacists can discount the medications patients receive and further invest the savings right back into patient care. CHC pharmacists also connect patients to manufacturers' Patient Assistance Programs (PAPs) that provide free or low-cost medications to low-income patients, as well as prescription discount programs, where the CHC itself offers or works with a third-party to get even more savings for patients on certain medications. CHCs utilize a sliding fee discount that adjusts costs based on a patient's income and household size, ensuring that no one is denied services due to an inability to pay. CHCs must also establish systems for eligibility determination and offer full discounts to individuals at or below 100% of the Federal Poverty Level (FPL).

## **II. How does regulatory red tape reduce the care that pharmacists can perform?**

Pharmacists are trained and qualified to provide a wide range of patient care services, are easily accessible, and often have longstanding relationships with the communities they serve. However, several regulatory restrictions can drastically decrease their effectiveness and ability to provide services.

**Pharmacy Benefit Managers (PBMs) Practices.** PBMs have, for years, engaged in discriminatory contracting practices against CHC pharmacies, solely because they participate in the 340B program. Such practices pose a threat to the sustainability of smaller, community-based pharmacies, particularly in rural areas. Currently, there is no recourse when PBMs and insurers treat 340B pharmacies differently or lower their reimbursement for specific medications because of the pharmacy's 340B status. To address this concern, Congress should consider legislation like the *PROTECT 340B Act* (H.R. 2534 in the previous Congress) to prevent these discriminatory business practices. This legislation creates much-needed protection against insurers and PBMs' repurposing CHC 340B savings to compensate for lost revenue, which has increased significantly over the last few years due to a lack of statutory protections.

**Incident-to Billing Hurdles.** Most notably, under Medicare, pharmacists can currently bill only for services performed under a physician's supervision ("incident to"), meaning a physician must be physically present or directly involved to bill for these services. This limits a pharmacist's ability to provide independent care and can discourage CHCs from integrating pharmacists into care teams because reimbursement can be complex and limited. By granting pharmacists provider status under Medicare, these essential providers can have more flexibility and be appropriately reimbursed for the services they already provide. This change would also alleviate the burden on an increasingly burnt-out healthcare workforce.

**Varying State Pharmacist Authorities.** Additionally, the varying authority across states for pharmacists to prescribe, order labs, or provide care can create confusion. Even when states expand pharmacist authority (e.g., prescribing antivirals or vaccines), Medicare does not always update its reimbursement policies to match, creating a regulatory mismatch. A federal determination on

pharmacists' authorities that establishes uniformity without restricting what states currently allow in expanded scopes could also alleviate the burden on the primary care workforce and enable pharmacists to provide more services to their communities.

**Lack of Reimbursement for Specific Services.** There are barriers to fully utilizing and being able to receive adequate reimbursement for certain frequently provided services, especially under Medicare Part D. For instance, many Medicare Part D Medication Therapy Management (MTM) programs are narrow in scope and eligibility, often limited to patients with at least three chronic disease states and multiple medications.<sup>8</sup> Pharmacists also cannot be reimbursed for chronic disease management or preventive care services under Part D, even though these services improve outcomes and reduce costs. Individual plans determine their own vendors for these services, and not all pharmacists can access these vendors or participate in contracts to provide MTM. With nearly 70% of CHC pharmacists providing MTM, their reimbursement for participating in these programs is crucial to improving health outcomes for Medicare beneficiaries.

**Uneven State Credentialing Requirements:** Pharmacists are often excluded from CMS's provider enrollment systems. Unfortunately, this means that even if a payer wants to contract with a pharmacist, there is no straightforward process to do so, which affects inclusion in Medicare Advantage or Accountable Care Organization (ACO) networks and limits pharmacists' participation in value-based care. Credentialing with CMS would create a unified structure that can be reproduced across state lines, as most payors are regional or national companies. As previously mentioned, pharmacists often perform point-of-care tests (POCT) for A1C, flu, and strep. Still, they need CLIA waivers.<sup>9</sup> These are tests the FDA has determined to be so reliable that there is little risk of error, such as certain home-use glucose and pregnancy tests. Some states impose additional hurdles, such as extra forms, licensing requirements, or added fees. Even when pharmacists comply with both federal and state CLIA requirements, Medicare reimbursement for these tests is often limited or nonexistent. By streamlining these waivers and making pharmacists billable providers under Medicare, they can provide quality preventive care for their communities.

**Stark Law/Anti-Kickback Concerns with Collaborative Practice Agreements.** Collaborative arrangements between pharmacists and physicians, or between pharmacists and health systems, can raise concerns under federal fraud and abuse laws, making some partnerships legally complex or risky. For CHC pharmacists, both the Anti-Kickback Statute and Stark Law have implications, as any financial relationship between the pharmacy and referring physicians must comply with applicable "safe harbors" or "exceptions," such as value-based arrangements or bona fide employment.<sup>10</sup> Recent updates to these laws better support value-based care and risk-sharing models, allowing for more coordinated and legally compliant collaboration.<sup>11</sup> Further clarification is needed so that CHC physicians are more likely to collaborate with pharmacists for improved whole-person care. However, even when pharmacists collaborate with physicians, the services that can be billed to Medicare are limited by available reimbursement codes.

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<sup>8</sup> <https://www.cms.gov/files/document/memo-contract-year-2022-medication-therapy-management-mtm-program-submission-v-043021.pdf>

<sup>9</sup> <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/cliaback.pdf>

<sup>10</sup> <https://www.pharmacytimes.com/view/changes-to-stark-and-the-anti-kickback-statute>

<sup>11</sup> <https://www.bakerdonelson.com/regulatory-sprint-understanding-the-impact-on-the-stark-law-anti-kickback-statute-and-value-based-arrangements#:~:text=Both%20final%20rules%20are%20effective,data%20used%20to%20verify%20outcomes.>

**Confusing Billing Codes.** Billing codes are often unavailable or inappropriate for the specific patient care services for which pharmacists are trained, such as comprehensive medication management. New or clarified billing codes for medication-focused, pharmacist-led chronic disease management would greatly improve reimbursement for the care pharmacists provide.

**Impending 340B Rebate Model Pilot Program.** The current shift within the 340B program to a rebate model for 10 drugs is a departure from decades of past practice. A rebate model approach would significantly increase upfront costs for CHCs and jeopardize patient care. Additionally, it would create enormous red tape and burden on CHC pharmacists to comply with manufacturer plans, with no guarantee of receiving a rebate for the drugs purchased. A recent NACHC assessment of the field found that 47% of CHCs surveyed estimate needing to hire 0.5 to 1 full-time equivalent (FTE) to comply with the rebate pilot program, with another 36% estimate needing 1 to 2 FTEs and 7% estimate needing more than 2 FTEs. Additionally, the estimated cost to hire additional staff was reported anywhere between \$30,000 - \$200,000/year. In terms of administrative burden, 39% of CHCs estimate it will take their staff more than 20 hours to report 340B rebate claims to a third-party platform, 38% estimated 15 to 20 hours, 23% estimate 5 to 10 hours. CHCs are safety net providers operating on razor-thin margins. A sudden increase in upfront 340B prices will reduce the number of drugs CHC pharmacies can stock, make it incredibly difficult for CHCs to finance affordable medications at the pharmacy counter, and limit wraparound services essential to improve patient care. CHCs use the medications in the proposed rebate model to treat diabetes, stroke, heart disease, and other chronic conditions. This fundamental change to accessing 340B-priced drugs will likely impact CHC patients' access to care as well as trigger closures and layoffs due cash flow constraints.

**Reduced Access to Medicare Reporting Portals:** Additionally, pharmacists currently have limited access to Medicare reporting portals, which restricts their ability to view patient clinical information and document care in a manner that qualifies for reimbursement or meets quality metrics. The lack of interoperability also limits their ability to deliver value-based care and adds an additional burden on physicians. Pharmacists can play a key role in a value-based care model, particularly in areas such as comprehensive medication management, transitions of care, and drug information and education, including switching patients to more affordable medications to reduce costs.<sup>12</sup> Their expertise in medication access, adherence, and optimization makes them valuable assets to the Value-Based Care team and can improve patient outcomes while reducing healthcare costs.<sup>13</sup> Expanding pharmacists' approved access to Medicare reporting portals would enable more effective collaboration with physicians and support better-informed, personalized care decisions, particularly for patients with complex or chronic conditions.

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

Pharmacists are essential members of the primary care team. We recommend policymakers consider the following actions to reflect that.

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<https://pmc.ncbi.nlm.nih.gov/articles/PMC10398252/#:~:text=The%20presence%20of%20pharmacists%20in,further%20advance%20the%20TOC%20process.>

<sup>13</sup> <https://www.chesshealthsolutions.com/2024/06/20/the-role-of-pharmacy-in-value-based-care/#:~:text=Disease%20State%20Programs:%20Medications%20are,improves%20adherence%20to%20treatment%20plans.>

**Leverage Existing Success Models Showing Improved Outcomes and Reduced Costs.** For instance, pharmacists at specific Indian Health Service (IHS), tribal, or urban (I/T/U) pharmacies can bill IHS and other programs, such as Medicaid, which may reimburse at an encounter rate for services. While they cannot bill Medicare directly, they can provide billable services under a physician's supervision. Other models within the Veterans Affairs allow pharmacists to bill and practice to the top of their license. One of the most prominent models is the Patient Aligned Care Team (PACT) model. A key player in this model is a clinical pharmacist, who focuses on comprehensive medication management (CMM)<sup>14</sup> and has prescribing privileges. Besides a clinical pharmacist, a primary care provider, a registered nurse care manager, and a licensed practical nurse or medical assistant and clerk, provide a coordinated care approach for patient care.<sup>15</sup> According to a VA study, sites with stronger PACT implementation generally achieved better results overall, including higher clinical quality scores, fewer emergency visits and hospitalizations, greater patient satisfaction, and lower staff burnout.<sup>16</sup>

**Include Pharmacists in Quality and Value-Based Care (VBC) Metrics (HEDIS, Star Ratings, CMS Quality Benchmarks).** Pharmacists play a vital role in advancing population health initiatives by emphasizing preventive care, reducing hospital readmissions, and managing chronic conditions. Through effective medication management, patient education, and ongoing disease monitoring, they help lower costly hospital visits and improve treatment adherence. These efforts can generate financial benefits through shared savings programs such as Medicare's Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program (MSSP),<sup>17</sup> both of which CHCs participate in. In partnership with their state PCAs and Health Center Controlled Networks (HCCNs), health centers across the country have already been actively engaged in Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program (MSSP). According to recent internal NACHC data, 83% of CHCs participated in at least one value-based pay contract.<sup>18</sup>

When care gaps are identified — such as medication adherence, statin use in diabetic patients, or vaccination status — pharmacists can implement targeted interventions aligned with VBC incentive contracts. Given the close ties between population health efforts and the Triple Aim – which focuses on improving patient experience, health outcomes, and reducing per capita healthcare costs – prioritizing population interventions, including those led by pharmacists, is a strong strategy to meet VBC metrics.

**Ensure telehealth parity and coverage for virtual pharmacy visits.** Congress would need to explicitly include pharmacists in the list of eligible telehealth providers under Medicare,<sup>19</sup> given that CHCs are not currently included as distant site providers except for behavioral health/mental health

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<sup>14</sup> CMM is a holistic approach to patient medication management, looking at their entire patient, including their history, comorbidities, and preferences in collaborating with specific providers

<sup>15</sup> <https://www.va.gov/resources/your-va-primary-care-provider-and-PACT-team/>

<sup>16</sup>

<https://www.hsrd.research.va.gov/research/citations/pubbriefs/articles.cfm?RecordID=665#:~:text=The%20extent%20of%20PACT%20implementation,was%20observed%20for%20staff%20burnout.>

<sup>17</sup> <https://www.pharmacist.com/About/Newsroom/pharmacys-role-in-population-health#:~:text=Value%2Dbased%20care%20models%20and,the%20Medicare%20Shared%20Savings%20Program.&text=As%20gaps%20in%20care%20are.strategy%20for%20meeting%20VBC%20metrics.>

<sup>18</sup> 235 CHCs surveyed

<sup>19</sup> § 410.78 Telehealth services

services.<sup>20</sup> Additionally, it is crucial to have telehealth payment parity. Medicare currently reimburses CHCs for telehealth medical visits at less than half the rate (\$96) for in-person medical visits. Being able to bill at the Prospective Payment System rate for medical visits will bolster financial stability, improve cash flow, and ensure fairer compensation for telehealth services. Moreover, allowing pharmacists to be billable providers and distant-site providers would enable them to be reimbursed for services they already provide, including chronic care management (CCM), remote patient monitoring (RPM), and transitional care management (TCM).

**Implement national standards for Collaborative Practice Agreements (CPAs) and the privileging process.** As previously mentioned, each state currently defines what pharmacists are legally allowed to do (e.g., initiate therapy, prescribe under collaborative agreements, order labs). Some states allow prescriptive authority for specific conditions (e.g., tobacco cessation, hormonal contraception), but others do not. This inconsistency across states means that Medicare beneficiaries in some areas have less access to pharmacist-led care, which slows the expansion of the care model.

**Investment in Workforce Development Funding.** NACHC urges the Senators to consider sponsoring legislation like the bipartisan Health Workforce Innovation Act (H.R. 935) that would support innovative partnerships between CHCs and local community colleges, high schools, and Area Health Education Centers to grow the pharmacy workforce. Across the country, more than 84% of CHCs are providing hands-on, practical, and clinical health profession training in rural and underserved communities. In 2024 alone, CHCs provided pre- and post-graduate training to nearly 2,000 pharmacists. The evidence shows that when providers train in community settings and in rural and underserved areas, they are more likely to stay and practice in those areas.

In terms of pharmacy residency capacity, current graduates who want to practice in direct patient care roles are expected to complete pharmacy residency training, which is invaluable to advancing pharmacy education and further preparing the workforce for complex roles. Unfortunately, there is insufficient capacity to accommodate the number of pharmacy graduates seeking residency training. Demand for pharmacy residencies has been growing; for instance, the number of applicants rose from approximately 4,480 in 2013 to around 6,417 in 2022. The number of available positions also increased, but not at the same rate.<sup>21</sup> Several barriers exist to expanding residency capacity, including insufficient funding, difficulty in meeting accreditation standards, limited qualified practice sites, and a shortage of experienced preceptors and program directors.

Additionally, research shows that residency programs tend to cluster in large urban academic medical centers, while rural/underserved areas are underrepresented. Congressional investment in this could create a better pipeline for pharmacists to grow, especially in rural and underserved areas that desperately need these services. Furthermore, Medicare pass-through dollars do not fund Program Year 2 (PGY2) residency training programs.<sup>22</sup> Specialized PGY2 Pharmacy residency programs cannot receive reimbursement because the certification achieved is not recognized as a requirement to work

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<sup>20</sup> <https://telehealth.hhs.gov/providers/billing-and-reimbursement/medicare-payment-policies#:~:text=Interactive%20telecommunications%20system%20may%20also%20include%20two%2Dway%2C%20real%2Dproject%2C%20or%20in%20certain%20exemptions.>

<sup>21</sup>

[https://www.accp.com/docs/positions/Commentaries/JACCP\\_JOURNAL\\_OF\\_THE\\_AMERICAN\\_COLLEGE\\_OF\\_CLINICAL\\_PHARMACY\\_-\\_2023\\_-\\_McFarland\\_-\\_Charting\\_a\\_new\\_path\\_forward\\_for\\_pharmacy.pdf](https://www.accp.com/docs/positions/Commentaries/JACCP_JOURNAL_OF_THE_AMERICAN_COLLEGE_OF_CLINICAL_PHARMACY_-_2023_-_McFarland_-_Charting_a_new_path_forward_for_pharmacy.pdf)

<sup>22</sup> 42 CFR § 413.85 - Cost of approved nursing and allied health education activities

in the specialty area by “industry norm.” CMS defines industry norm as more than 50% of hospitals in a random, statistically valid sample. If, in the future, the norm expands to require a PGY2 residency, these programs would also become eligible for Medicare reasonable-cost payment. PGY2 Ambulatory Care and Geriatrics residency programs are highly valuable training programs for pharmacists, especially as CHCs look to grow their workforce, but their expansion is limited by the current funding model. Congress could ensure that pass-through dollars could fund PGY2 residency training programs to ensure financial sustainability and expansion of these vital training programs.

**FTCA Coverage Clarification.** CHCs must meet specific requirements and maintain certain policies to qualify for Federal Tort Claims Act (FTCA) coverage – medical malpractice insurance that deems certain eligible CHC providers as federal employees. In some cases, pharmacists employed by or contracted with CHCs may also be deemed eligible for FTCA protection, but only when acting within their defined professional duties and the approved scope of the CHC’s project, such as dispensing naloxone.<sup>23</sup> However, the lack of clear federal guidance on FTCA coverage for pharmacists creates uncertainty that can limit how CHCs deploy pharmacy services to improve access and patient outcomes. To fully leverage pharmacists’ expertise in medication management, chronic disease support, and harm reduction, CHCs need clear, consistent federal guidance on FTCA eligibility and coverage for pharmacist-provided services. Clarifying this policy would not only protect providers but also expand patient access to lifesaving, comprehensive, team-based care.

**Allow Pharmacists to Register as Medications for Opioid Use Disorder (MOUD) Prescribers.** As medication experts, pharmacists are uniquely positioned to address the ongoing opioid crisis by assuming a more active role in directly initiating and managing MOUD. Responding to the opioid use crisis, which disproportionately has impacted rural and underserved communities, pharmacists have tried to step in due to an absence of OUD treatment providers. While the Mainstreaming Addiction Treatment (MAT) Act enabled pharmacists to reduce deaths due to overdose – a monumental step forward – more can be done to help pharmacists expand MOUD access. Specifically, several states have authorized pharmacists to prescribe MOUD. Unfortunately, these pharmacists face operational barriers to prescribing buprenorphine and other forms of MOUD because the DEA’s registration system prevents some pharmacists in some states from registering as MOUD prescribers. This is 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 pharmacists to prescribe MOUD. We urge Congress to prompt 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.

NACHC appreciates the opportunity to respond to this request for information on how CHC pharmacists already help older patients treat chronic diseases, especially in rural and underserved areas. We look forward to engaging with Senators Grassley and Lujan to make pharmacists billable Medicare providers to expand access for patients across the United States. If you have any questions, please contact Elizabeth Linderbaum, Director of Regulatory Affairs, at [elinderbaum@nachc.org](mailto:elinderbaum@nachc.org).

Sincerely,

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<sup>23</sup> [https://www.feldesman.com/ftca-protection-for-naloxone-prescribing-and-dispensing/#:~:text=Health%20centers%20must%20ensure%20that:%20\\*%20Pharmacy.program%2C%20acting%20within%20their%20scope%20of%20employment](https://www.feldesman.com/ftca-protection-for-naloxone-prescribing-and-dispensing/#:~:text=Health%20centers%20must%20ensure%20that:%20*%20Pharmacy.program%2C%20acting%20within%20their%20scope%20of%20employment)

A handwritten signature in black ink that reads "Joe Dunn". The signature is written in a cursive style with a large, looped "J" and "D".

Joe Dunn  
Chief Policy Officer