July 21, 2026

Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

Submitted via http://www.regulations.gov

Re: CMS–2449–P; Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (RIN 0938–AV69)

Dear Administrator Oz:

The National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA) appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments" (CMS–2449–P).

NACDS and NCPA support CMS' goal of promoting Medicaid fiscal integrity, transparency, and accountability. Medicaid payment arrangements should be consistent with efficiency, economy, quality of care, and access for Medicaid beneficiaries. NACDS and NCPA also recognizes CMS' concern that certain state directed payments (SDPs) and targeted fee-for-service (FFS) supplemental payments may not always be sufficiently connected to access, quality, or Medicaid program objectives.

Given the essential role of pharmacies and pharmacists in improving healthcare access and quality, CMS should ensure that the final rule does not inadvertently restrict state flexibility to reimburse pharmacies and pharmacists for Medicaid-covered services. Community pharmacies are among the most accessible healthcare destinations, including for Medicaid beneficiaries. Notably, states are increasingly leveraging pharmacies to expand access to healthcare services, including testing and treatment for common illnesses, immunizations, chronic disease screening, contraceptive access, tobacco cessation support,

HIV prevention, substance abuse disorder treatment, medication therapy management, medication adherence services, and other pharmacist-provided services. As states increasingly expand pharmacists' scope of practice, CMS should clearly distinguish broadly available payment methodologies for pharmacies and pharmacists from the targeted payment arrangements addressed in this rulemaking.

NACDS and NCPA Recommendations

NACDS and NCPA respectfully urge CMS to finalize the rule with the following clarifications and modifications:

I. **CMS should preserve state flexibility to reimburse pharmacies and pharmacists appropriately for Medicaid-covered services, while still preventing abusive or non-transparent payment arrangements.**

II. **CMS should confirm that standard Medicaid pharmacy benefit reimbursement is outside the scope of the proposed SDP and FFS targeted-payment limits.**

III. **CMS should protect state flexibility to reimburse pharmacist-provided healthcare services beyond services related to dispensing medications.**

IV. **CMS should clarify that payment methodologies available to all qualified and willing pharmacies or pharmacists are not "targeted" merely because they apply to pharmacies, pharmacists, or pharmacy-based services.**

V. **CMS should provide a practical methodology for Medicaid-covered pharmacy and pharmacist services that have no exact or reasonably comparable Medicare payment rate.**

VI. **CMS should clarify how the managed care SDP limits apply to pharmacy and pharmacist services, including value-based, quality incentive, and access-related arrangements in Medicaid managed care.**

VII. **CMS should make clear that the final rule is intended to address specific fiscal integrity concerns, not to limit appropriate state innovation in pharmacy-based care.**

VIII. **CMS should clarify that recognizing pharmacists as Medicaid providers, establishing provider-type-specific billing rules, or requiring appropriate enrollment and credentialing does not make payment methodologies targeted**.

Discussion

I. **NACDS and NCPA support CMS' goal of Medicaid fiscal integrity, but the final rule should avoid unintended consequences for pharmacy access.**

CMS proposes to modify payment limits and related requirements for Medicaid managed care SDPs and to establish new limits for certain targeted Medicaid FFS payments. CMS explains that SDPs and targeted payments can advance access and quality when designed appropriately but may raise fiscal integrity

concerns when payments are not sufficiently connected to Medicaid program goals or when payment arrangements reward providers based on financing structures rather than access or quality.

NACDS and NCPA support CMS's focus on payment transparency and program integrity. However, CMS should ensure that prescription drug reimbursement and pharmacist-provided healthcare services are not inadvertently subjected to a regulatory framework designed primarily for fundamentally different supplemental payment arrangements used by hospitals, academic medical centers, nursing facilities, physicians, and other practitioners.

Community pharmacies are not merely points of medication dispensing. They are accessible healthcare destinations that Medicaid beneficiaries rely upon for medication access, immunizations, accessing testing and treatment for common ailments, preventive and wellness care, health screenings, counseling, adherence support, and other services. Many Medicaid beneficiaries face transportation barriers, primary care access challenges, workforce shortages, and delays in obtaining routine preventive services. Pharmacies can help states address those barriers quickly and cost-effectively.

The final rule should therefore preserve state flexibility to reimburse pharmacies and pharmacists appropriately for Medicaid-covered healthcare services, while still preventing abusive or non-transparent payment arrangements.

II. CMS should clarify that standard Medicaid pharmacy benefit reimbursement for medications is outside the scope of the rule.

To avoid uncertainty, NACDS and NCPA strongly urge CMS to clearly state in the final rule that standard Medicaid pharmacy benefit reimbursement for prescription drugs is not subject to proposed § 447.381 or the SDP payment-limit provisions. This clarification should include, at a minimum:

- reimbursement for covered outpatient drugs;
- ingredient cost reimbursement;
- professional dispensing fees;
- vaccine product reimbursement when paid through the pharmacy benefit;
- vaccine administration fees when paid through the pharmacy benefit;
- pharmacy benefit claims processing methodologies;
- state supplemental rebate arrangements;
- managed care pharmacy network reimbursement arrangements that are not SDPs; and
- other payment methodologies governed by Medicaid pharmacy-specific statutory and regulatory requirements.

Explicit clarification is necessary to avoid uncertainty regarding the applicability of this rule to pharmacy benefit reimbursement under the Medicaid program. The final rule should confirm that Medicaid

outpatient drug reimbursement requirements and pharmacy benefit payment policies remain unchanged. Any future modifications should be pursued through separate, pharmacy-specific rulemaking with notice to affected stakeholders.

III. CMS should protect states' flexibility to reimburse pharmacist-provided healthcare services, beyond medication dispensing.

NACDS and NCPA appreciate CMS' recognition that payment methodologies may appropriately reflect objective differences in provider qualifications and service requirements. At the same time, CMS should clarify that pharmacists should not be disadvantaged under Medicaid payment policies when furnishing the same covered service as another qualified practitioner. Where pharmacists provide the same Medicaid-covered service within their state-authorized scope of practice, CMS should direct states that reimbursement should be *no less* than the amount available to other qualified practitioners furnishing that same service. Importantly, CMS should allow states to retain flexibility to establish higher payment rates where appropriate to support access, workforce needs, quality objectives, or the unique value of pharmacy-based care.

States increasingly authorize pharmacists to furnish Medicaid-covered healthcare services. Depending on state law and Medicaid program design, these services may be reimbursed under the pharmacy benefit, the medical benefit, the preventive services benefit, the other licensed practitioner benefit, managed care arrangements, or other authorities. Where authorized by state law, examples include:

- immunization assessment and administration;
- point-of-care testing;
- test-and-treat services for common illnesses;
- medication therapy management;
- comprehensive medication management;
- medication adherence services;
- contraceptive prescribing;
- tobacco cessation services;
- HIV prevention services;
- chronic disease screening and management support; and,
- other public health and preventive services.

Payment methodologies for these services may appropriately account for pharmacist licensure, training, scope of practice, certification, protocol participation, standing orders, collaborative practice authority, CLIA certificate status, documentation requirements, reporting obligations, and service setting. Such

differences are legitimate features of Medicaid rate-setting and provider participation, not evidence of impermissible targeting.

IV. CMS should clarify that payments available to all qualified and willing pharmacy providers are not "targeted."

Proposed § 447.381 would apply where all or a portion of a Medicaid FFS payment is targeted to a subset of participating practitioners or providers furnishing the applicable Medicaid-covered service. NACDS and NCPA understand CMS' concern with payments directed to small subsets of providers in ways that may not be tied to access or quality. However, CMS should avoid defining "targeted" in a way that captures ordinary, broadly available provider-type-specific payment methodologies.

A state may reasonably establish a payment methodology for all qualified pharmacies or pharmacists that furnish a Medicaid-covered service. Such a methodology should not be considered targeted merely because it applies to pharmacy providers, pharmacist providers, or pharmacy-based services.

For example, a state should be able to establish a Medicaid payment methodology for pharmacist-provided immunization assessment and administration services, point-of-care testing, medication therapy management, or medication adherence services if all qualified and willing pharmacies or pharmacists that satisfy objective requirements may participate. The payment should not be considered targeted merely because not every Medicaid provider type furnishes the service or because only some pharmacies choose to enroll, credential, or submit claims.

This distinction is important for preserving state flexibility to design provider-type-specific payment methodologies that reflect the services actually furnished by different provider types.

V. CMS should provide a practical methodology for pharmacy and pharmacist services with no Medicare equivalent.

CMS proposes to use Medicare payment rates as a benchmark for certain targeted Medicaid payments, with state plan approved rates serving as the limit when no Medicare payment rate exists. NACDS and NCPA understand the administrative appeal of using Medicare rates where a comparable Medicare service exists. However, many pharmacist-provided Medicaid services do not have an exact or reasonably comparable Medicare payment rate.

This is a critical issue for pharmacy-based services. Medicare's coverage and billing rules do not always reflect Medicaid's broader benefit design or state-authorized pharmacist scope of practice. Services that Medicaid may cover through pharmacies or pharmacists — such as medication therapy management, point-of-care testing, test-and-treat services, blood pressure measurement, contraception services, HIV prevention services, or adherence interventions — may not map neatly to a Medicare Physician Fee Schedule code or other Medicare payment methodology.

NACDS and NCPA urge CMS to avoid a rigid approach that would undervalue or discourage pharmacist-provided services simply because Medicare does not cover or pay for the service in the same way. Where there is no exact or reasonably comparable Medicare payment rate, states should retain flexibility to

establish payment methodologies using reasonable evidence that the rate is economical, efficient, and sufficient to ensure access.

NACDS and NCPA recommend that CMS establish a clear pathway for states to demonstrate that no reasonable Medicare equivalent exists and to support an alternative Medicaid payment methodology. CMS should not require states to force an artificial crosswalk to Medicare codes where doing so would not reflect the actual Medicaid-covered service.

VI. CMS should clarify the application of managed care SDP limits to pharmacy services beyond medication dispensing.

CMS proposes to revise the Medicaid managed care SDP framework and ultimately apply payment limits more broadly to services covered under SDPs. NACDS and NCPA urge CMS to clarify how these provisions apply to pharmacy and pharmacist services in Medicaid managed care.

Many Medicaid beneficiaries receive benefits through managed care. Pharmacy services may be administered by Medicaid managed care organizations, subcontractors, pharmacy benefit administrators, or other arrangements. In addition, states may seek to promote pharmacy-based clinical services, quality incentives, medication adherence programs, vaccine access initiatives, or other access-related programs through managed care contracts.

CMS should make clear that ordinary managed care pharmacy network reimbursement arrangements are not SDPs merely because they involve payment terms for pharmacy providers. CMS should also clarify that managed care quality incentives or value-based arrangements involving pharmacies or pharmacists remain permissible where they are tied to objective access, quality, outcomes, or performance criteria and otherwise comply with applicable Medicaid managed care rules.

These clarifications are necessary because pharmacy providers may otherwise face uncertainty about whether state or plan initiatives to improve medication access, vaccination rates, adherence, or public health outcomes are subject to new payment caps or documentation burdens.

VII. CMS should avoid policies that could undermine Medicaid access to pharmacy-based care.

Medicaid beneficiaries rely heavily on pharmacies for timely access to care. Pharmacies are open evenings and weekends, located in urban, suburban, and rural communities, and often provide walk-in access without an appointment. For many beneficiaries, pharmacies are the most convenient and accessible point of care.

CMS should not finalize policies that make states reluctant to reimburse pharmacists for services that improve access and reduce avoidable higher-cost care. NACDS and NCPA urge CMS to make clear that the final rule is intended to address specific fiscal integrity concerns, not to limit appropriate state innovation in pharmacy-based care.

VIII. CMS should not apply the proposed rule in a way that creates new barriers to Medicaid provider enrollment for pharmacists.

In some states, pharmacists may need to enroll as Medicaid providers or rendering practitioners to furnish covered healthcare services beyond dispensing medications. NACDS and NCPA support efficient, program-integrity-focused enrollment processes. However, CMS should avoid creating payment policy uncertainty that discourages states from enrolling pharmacists or recognizing pharmacies as sites of care for Medicaid-covered services.

CMS should clarify that recognizing pharmacists as Medicaid providers, establishing provider-type-specific billing rules, or requiring appropriate enrollment and credentialing does not make payment methodologies targeted. Such actions are necessary for Medicaid program integrity and beneficiary access.

Conclusion

NACDS and NCPA appreciate CMS' efforts to strengthen Medicaid fiscal integrity and transparency. NACDS and NCPA support appropriate guardrails to ensure Medicaid payments are connected to access, quality, efficiency, and program integrity. However, CMS should ensure that the final rule does not inadvertently restrict standard Medicaid pharmacy reimbursement or discourage state efforts to reimburse pharmacies and pharmacists for accessible, high-value Medicaid-covered services.

Community pharmacies are critical access points for Medicaid beneficiaries. As states continue to address provider shortages, public health needs, chronic disease burdens, medication adherence challenges, and access barriers, pharmacies and pharmacists must remain available partners in Medicaid care delivery. CMS can advance fiscal integrity while preserving state flexibility to use pharmacies and pharmacists to improve access and outcomes. For these reasons, NACDS and NCPA respectfully urge CMS to finalize the rule with the pharmacy-specific recommendations and clarifications described above.

NACDS and NCPA appreciate the opportunity to comment and look forward to continued engagement. Should CMS have any questions or need further information, please do not hesitate to contact Kayla McFeely, NACDS Senior Vice President, Health & Wellness Strategy and Policy, at kmcfeely@nacds.org or Ronna Hauser, PharmD, NCPA Senior Vice President, Policy and Pharmacy Affairs, at ronna.hauser@ncpa.org.

Sincerely,

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National Association of Chain Drug Stores

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NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 155,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit NACDS.org.

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 235,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Please visit NCPA.org.