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Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1848–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings [CMS-1848-P]

Administrator Oz,

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services' (CMS') *Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings* proposed rule.

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. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits these comments on behalf of both independently-owned community and long-term care pharmacies.

Remote Monitoring (CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470)

In the proposed rule, CMS states:

> We are proposing to only allow payment for RPM or RTM services when furnished by clinical staff employed by the practice. To count the time spent by clinical staff providing aspects of RPM or RTM services, the clinical staff must be a direct employee of the practitioner or the practitioner's practice. If finalized, this will mean that for the purposes of billing Medicare, beginning January 1, 2027, the

> RPM and RTM codes could not be billed in cases where the service is not performed by clinical staff of the billing practitioner and will not allow contracting out to third-party companies. This does not mean the clinical staff must necessarily always be physically located within the practice, nor does it require that the beneficiary be on-site for the provision of remote monitoring services. Under our proposed revised policy, the time spent by clinical staff providing RPM or RTM services can be counted, provided that the clinical staff are under the general supervision of the billing practitioner, all other requirements of the ''incident to'' regulations at § 410.26 are met, and the clinical staff is a direct employee of the practitioner or the practitioner's practice. We are seeking comment on this proposal, specifically on how often third-party billing currently occurs and how this policy, if finalized, could impact access to remote monitoring services.[1]

Concerns with "clinical staff" and "direct employment" language. NCPA is concerned that the above language precludes pharmacists from providing RPM and RTM. Pharmacists are health care professionals with the education and training necessary to set-up and supply remote physiologic devices, provide patient education on use of the equipment and collect and interpret physiologic data. Pharmacies enrolled in Medicare Part B administer vaccines, dispense Part B drugs, supply DMEPOS and provide diabetes self-management training. Pharmacies enrolled in Part B should not be excluded from RPM setup, patient education and monitoring supplies. It varies by state, but pharmacist licensure may permit the pharmacist to do this independently or within a collaborative practice agreement (CPA) with a physician. Given that pharmacists do not have provider status, general supervision of a pharmacist by a physician under a CPA should be an allowed scenario reporting RPM codes for collection and interpretation of physiologic data.

Proposed policy would undermine CMS' RHT program. CMS has stood up a $50 billion Rural Health Transformation (RHT) Program, which is meant to help develop strategies for disease prevention and management, substance use disorder, and mental health care over the next five years. States will receive first-year awards from CMS, averaging $200 million within a range of $147 million to $281 million. In addition, CMS announced the formation of the Office of Rural Health Transformation within the Center for Medicaid and CHIP Services. NCPA worked with our partners to encourage the governors of all 50 states to leverage pharmacists in the programs and proposals when applying to the RHT program. To help states procure the required evidence-based data to support inclusion of pharmacy services in their RHT applications, NCPA launched a community pharmacy research library, which includes published papers, outcome metrics, payment and policy analyses, and implementation tools that can be cited in the state proposals. **CMS' proposed rule that puts the ability of some pharmacists to provide RTM and RPM in jeopardy would undermine the spirit of the RHT program and deny rural Medicare beneficiaries access to these services.**

[1] Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program. Fed Reg Vol. 91, No. 135, July 16, 2026. Page 43893.

NCPA supports greater participation by pharmacists in RPM/RTM services and worries that the proposed rule inadvertently excludes them. The current environment with devices locked into proprietary services needs to change. One scenario might be that CMS reimburse the medical device manufacturer to ship the device and supplies, while CMS reimburses set-up, patient education, collection and interpretation to provider and pharmacy PTANs. **NCPA therefore asks CMS to allow pharmacy PTANs to claim reimbursement for setup/education for RTM and RPM, and to explicitly allow pharmacists to work under general supervision for physicians to report RPM codes until such time pharmacists have Medicare provider status.**

Recognizing pharmacists as providers under Part B. The only way that pharmacists can currently provide RTM and RPM is with nominal services agreements with tech vendors, which are not ideal for patient service and efficiency. A better construct would be to allow for pharmacists to directly bill Medicare Part B. **Therefore, NCPA asks CMS to formally recognize pharmacists as providers eligible to furnish RPM and RTM services in their scope of practice and claim reimbursement under Medicare Part B.**

Allowing pharmacist reimbursement through a co-management fee**. An alternative solution to recognizing pharmacists as providers under Medicare Part B would be that CMS consider allowing pharmacists to be reimbursed for RPM/RTM through a co-management fee.** ACCESS to Pharmacy Care is a program that helps community pharmacies take advantage of the CMS ACCESS value-based care Medicare model. This NCPA program, powered by CPESN® USA in partnership with GamePlan Medical, a CMS ACCESS participant, provides a clear, simple, and scalable pathway for community pharmacies to participate in outcomes-based care. It also allows pharmacists to be eligible for a co-management fee.

Exclusion of 340B Acquired Units From Part D Rebatable Drugs

The proposed rule would require providers and suppliers that are covered entities as defined at 42 CFR 10.3 to submit to CMS certain data elements associated with each claim for units of a covered Part D drug billed to Medicare Part D and dispensed by such covered entity or its contractor(s) (such as contract pharmacies) for which a manufacturer provides a discount under the 340B Program to such covered entity to the Medicare Part D Claims Data 340B Repository beginning with claims with a date of service on or after January 1, 2027.

Contract pharmacies should not be required to identify 340B claims. **NCPA supports CMS not requiring contract pharmacies to identify 340B claims, and re-emphasizes the infeasibility of contract pharmacies identifying those claims either proactively or retroactively.** NCPA has found that the N1 transaction is not feasible as it is not adopted by pharmacy information systems. For details of NCPA's position, see our July 2024 comments to CMS' *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027*, as well as our March 2023 comments to CMS' *Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1860D-14B of Social Security Act, and Solicitation of Comments*.

340B interaction with MDPNP. An issue that our members continue to face is in regard to the interaction between the MDPNP and the 340B program. Pharmacies have alerted NCPA that Beacon MFP, acting on behalf of the manufacturers of MDPNP selected drugs is inappropriately rejecting MFP refund claims due to 340B status and subsequently denying good faith inquiries (GFI) by pharmacies that have no contract pharmacy relationships or have reasonable belief that a claim is not 340B-eligible. Lacking a contract pharmacy agreement, these pharmacies are not replenished with inventory purchased by the covered entity, nor trued up financially thus they are owed a refund from the manufacturer to effectuate MFP. Additionally, members that do have contract pharmacy agreements also report inappropriately rejected MFP refund claims due to 340B status and also report dissatisfaction with the GFI process. NCPA is advising our members to access their 835 remittance advice available in the Medicare Transaction Facilitator and review lines with Remittance Advice Remark Code (RARC) = N907 No refund because this claim has been identified as 340B-eligible with a ceiling price lower than the maximum fair price to identify any rejected MFP refunds. NCPA is also telling members that all the manufacturers with an MFP drug in 2026 use Beacon MFP to handle GFIs from pharmacies, but that they need to sign in or enroll to open a GFI. NCPA advises members that the first step to correct this is to use the Beacon MFP GFI process. If using the Beacon MFP GFI process does not correct MFP refund payment, NCPA is advising its members to use CMS' dispute form in the MTF. **That being said, this issue remains a long-standing and unresolved matter, and NCPA requests CMS to develop a permanent solution**.

NCPA thanks CMS for the opportunity to provide feedback, and we stand ready to work with the agency to offer possible solutions and ideas. 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
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National Community Pharmacists Association