AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

August 14, 2025

The Honorable John Thune
511 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Mark Warner
703 Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Leader Thune and Senator Warner:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, we write to express our opposition to the *Ensuring Community Access to Pharmacist Services (ECAPS)* Act (S. 2426), which would permanently expand Medicare by reimbursing pharmacists for certain types of patient care that have historically only been allowed by a physician.

We wholeheartedly agree that Congress must advance additional policies to better support the needs of our nation's seniors, especially those in rural areas – however, we caution against this approach. The AAFP does not believe it will meaningfully improve access to care but instead risks disruptions to whole-person continuous primary care delivered by trained primary care clinicians. We are concerned that unintended consequences such as fragmented care, misdiagnosis, additional costs, and time to a patient to correct an incorrect care plan could occur. We appreciate the inclusion of new language to highlight the importance of physician-pharmacist collaboration, but the proposal still promotes and incentivizes delivery of direct patient care beyond the appropriate scope for a pharmacist.

Pharmacists are integral to the delivery of comprehensive health care. A pharmacist's unique role and training ensures the safe, effective, and appropriate use of medications. However, pharmacists do not receive robust training to diagnose conditions nor to provide a care plan that goes beyond the administration of medications to treat a condition. Additionally, a recent survey of U.S. voters showed that 95 percent said it is important for a physician to be involved in their diagnosis and treatment decisions.[i]

We acknowledge the expanded and critical role pharmacists played during the COVID-19 public health emergency after receiving additional federal authority, such as the ability to administer COVID-19 testing and vaccines. The pandemic showed that it may be necessary and appropriate to temporarily allow some expanded responsibility during times of crisis, but this should not be seen as a universally appropriate approach to other conditions, such as strep throat, respiratory syncytial virus (RSV), and the flu. We also remain concerned by the bill's broad language that allows pharmacists to "address a public health need related to a public health emergency."

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Our principal concern with S. 2426 is patient safety. Pharmacists frequently lack access to a patient's full medical records and have limited training on patient history, physical exams, differential diagnoses, and testing, meaning they would be granted the ability to provide medical treatment without the critical knowledge needed to make informed and appropriate decisions for each individual patient. Pharmacists do not possess the skills, training, experience, or knowledge needed to provide comprehensive medical care, health maintenance, and preventive services for a range of medical and behavioral health issues. Many patients, especially seniors who have a higher prevalence of chronic conditions, require follow-up care and management services that primary care physicians are appropriately trained to provide.

A negative diagnostic test does not negate the need for further evaluation or treatment. However, Medicare beneficiaries who receive a negative test result from a pharmacist may not seek additional diagnostic or treatment services from their primary care physician, which could lead to untreated conditions and adverse outcomes. Pharmacists do not have access to requisite technologies, such as an x-ray, or the training to perform additional services, such as listening to a patient's lungs, that are necessary to ensure that the patient is not suffering from an acute condition beyond a negative strep, RSV or COVID test. In addition, given the lack of two-way communication between pharmacists and physicians, seniors could be subject to duplicative testing (and thus, increased costs) while the physician is diagnosing the actual cause of illness.

Again, we acknowledge the vital role that pharmacists play in providing comprehensive care to most patients and fully support a collaborative and team-based health care model.[ii] Although pharmacists should not independently diagnose, they are qualified to deal with issues of medication use, medication tolerability, patterns of medication use, assessment of therapeutic response, and dosing adjustments. It is clear however that patients are best served when their care is provided by an integrated practice care team led by a physician. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients.[iii]

Instead of promoting fragmented delivery of services, Congress should be prioritizing the delivery of comprehensive, whole-person primary care by passing policies that strengthen the primary care workforce at all levels. Allowing pharmacists to test for COVID-19 and to provide additional vaccines during the public health emergency was a band-aid solution to a systemic problem: primary care physicians face numerous hurdles when it comes to providing comprehensive, continuous patient care, especially to the most vulnerable populations and during times of crisis.

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Congress should advance health care workforce reforms that strengthen primary care education and training, encourage primary care physicians to work in underserved and rural communities, and ensure that Medicare payments for primary care services are sufficient and stable. In addition, given the constant uncertainty regarding Medicare Part B funding, we must acknowledge that adding pharmacists to the list of Part B providers would have a significant fiscal impact and only further destabilize Medicare payment for physicians and other Part B clinicians. This continued erosion of finite resources could jeopardize the ability of family physicians and others to deliver care to all the Medicare beneficiaries in their community who need it.

While we appreciate the intent behind S. 2426, the unintended consequences of this bill could be incredibly detrimental to the state of our nation's primary care system and the quality of care patients receive. We urge Congress to instead focus on policies that strengthen and invest in a patient's relationship with their usual source of care.

Thank you for your consideration of our concerns with S.2426. If you have questions, please contact Megan Mortimer, AAFP's Manager of Legislative Affairs, at mmortimer@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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[i] Protect Access to Physician-led Care | AMA (ama-assn.org)
[ii] Joint Principles of the Patient-Centered Medical Home (aafp.org)
[iii] pcmh_evidence_report_2019_0.pdf (thepcc.org)

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