Redefining Pharmacy Practice: The Next Gen Rx.

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Disclosure to Learners

Dr. Magaly Rodriguez de Bittner, faculty for this CE activity, has no relevant financial relationship(s) with ineligible companies to disclose.

“The Colegio de Farmacéuticos de Puerto Rico is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.”

Provider Number: 0151

OBJECTIVES

1. **Identify** emerging opportunities and technology trends transforming pharmacy practice.
2. **Recognize** shifting consumer/patient expectations toward patient-centric, accessible, and personalized pharmacy services.

OBJECTIVES

3.Discuss regulatory, workforce, and financial challenges influencing the evolution of pharmacy practice.

4.Describe innovative models and future directions for expanding pharmacists' roles and value in patient care.

5.**Explain** the importance of appropriate compensation mechanisms for sustaining advanced pharmacy services.

Outline

- Emerging Trends/ Opportunities/Technology
- Consumer/Patient Expectations
- Current Landscape in Pharmacy and Health Care
  - Regulatory/Workforce/Financial
  - Innovative Care Models and Future Directions
- Compensation challenges and Opportunities/ Sustainability
- Actions/Steps/Roadmap

Why Pharmacy Must Transform

Key drivers:

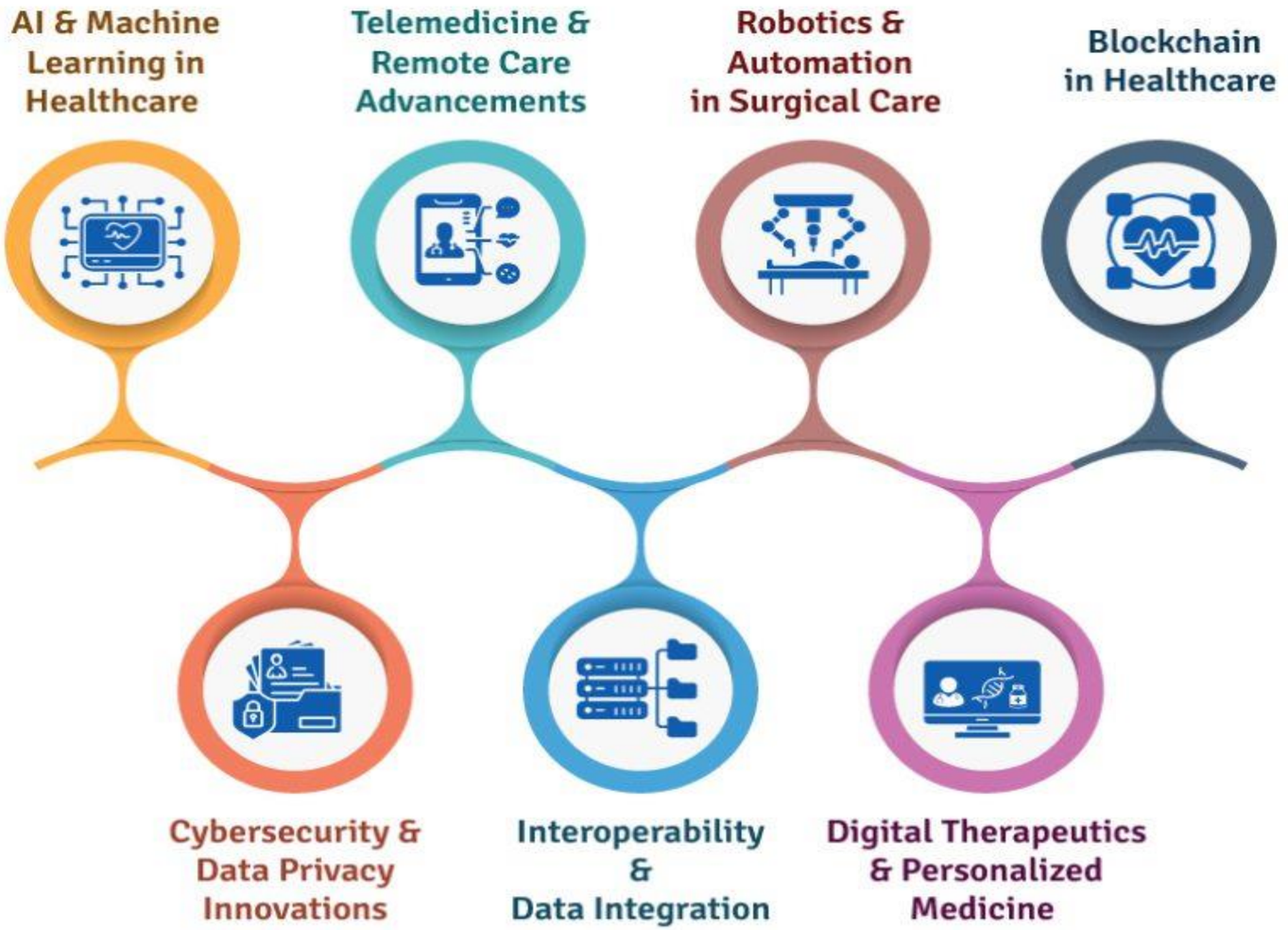
- Digital health acceleration
- Technology/AI
- Workforce challenges/shortages
- Chronic disease burden
- Consumer demand for convenience
- Value-based care pressures
- Health Care cost
- Outdated/Unsustainable Business Model

The landscape of healthcare delivery is rapidly evolving, driven by accelerating advancements in digital health, artificial intelligence (AI), automation, and personalized medicine.

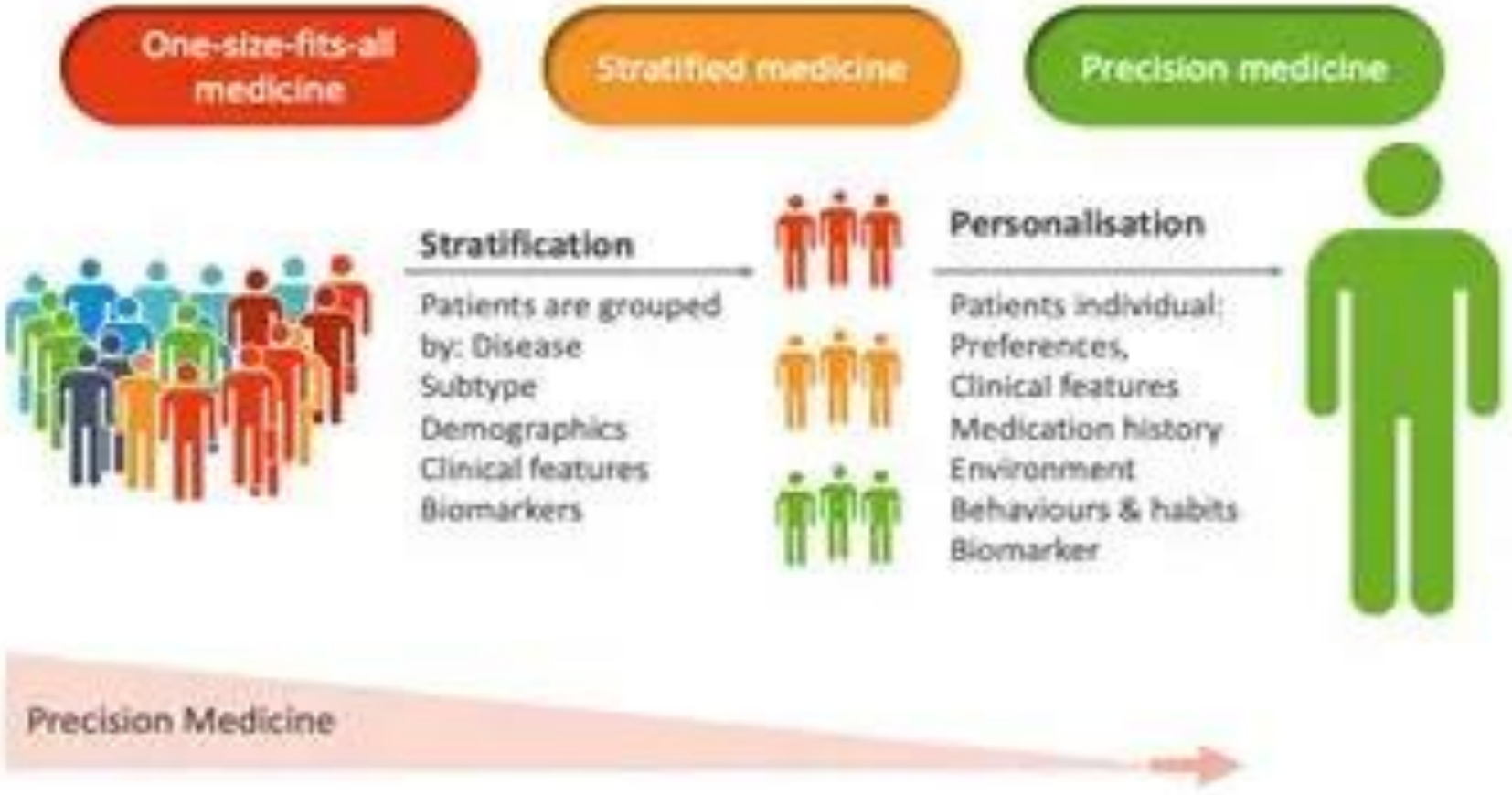
Technology: Digital health tools reshaping practice

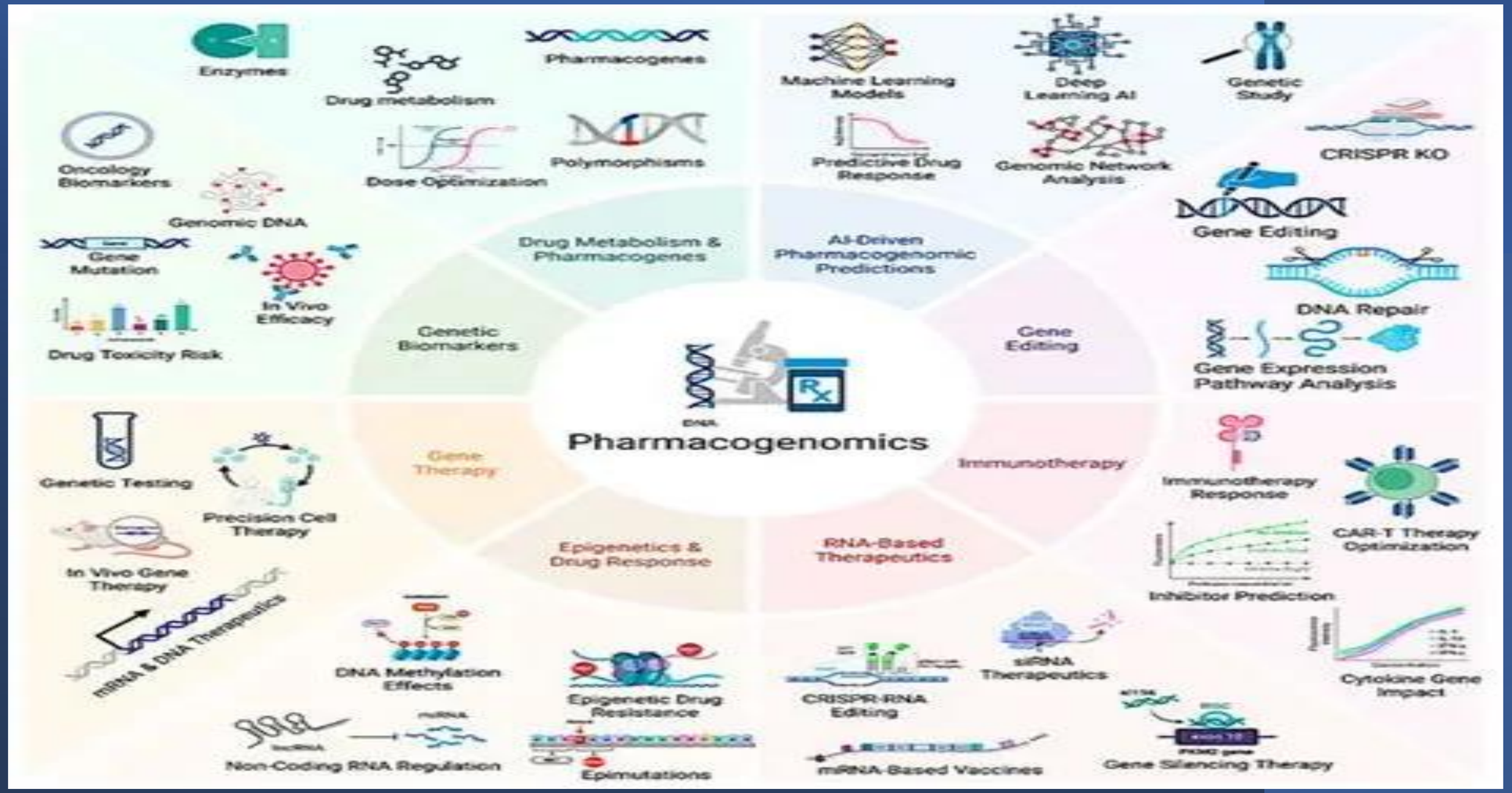
- Telepharmacy &virtual counseling
- Remote monitoring platforms
- Mobile health apps
- Digital therapeutics
- E-care coordination

Top 7 Healthcare Technology Trends for 2024



PRECISION MEDICINE




Pharmacogenomics
Drug Metabolism & Pharmacogenes
AI-Driven Pharmacogenomic Predictions
Gene Editing
Immunotherapy
RNA-Based Therapeutics
Epigenetics & Drug Response
Gene Therapy
Genetic Biomarkers
Enzymes
Drug metabolism
Pharmacogenes
Oncology Biomarkers
Dose Optimization
Polymorphisms
Genomic DNA
Gene Mutation
In Vivo Efficacy
Drug Toxicity Risk
Machine Learning Models
Deep Learning AI
Genetic Study
Predictive Drug Response
Genomic Network Analysis
CRISPR KO
Gene Editing
DNA Repair
Gene Expression Pathway Analysis
Genetic Testing
Precision Cell Therapy
In Vivo Gene Therapy
mRNA & DNA Therapeutics
DNA Methylation Effects
Epigenetic Drug Resistance
Epimutations
Non-Coding RNA Regulation
CRISPR-RNA Editing
siRNA Therapeutics
mRNA-Based Vaccines
Immunotherapy Response
CAR-T Therapy Optimization
Inhibitor Prediction
Cytokine Gene Impact
Gene Silencing Therapy


Future Pharmacy
AI

Pharmacy professionals must be prepared to integrate innovative tools such as telepharmacy, AI-supported decision systems, precision medicine platforms, and automated dispensing technologies.

- Data privacy, cybersecurity risks, and public trust concerns are important considerations when integrating digital health and AI tools into pharmacy practice.

Pharmacists and Technician Role expansion

• Primary care • Chronic disease management • Preventive care • Digital therapeutics • Precision medicine • Integrated care teams

Consumer Demands/ Expectations

Convenience
Personalization
On-demand access
Digital engagement
Coaching & wellness support

Consumer demand is shifting toward convenience, personalization, and rapid access to care.

- Hybrid digital-physical pharmacy models
- Personalized care journeys
- Medication coaching
- Engagement through mobile platforms
- Trust-building communication


CARE MANAGER
SOCIAL WORKER
CARE TEAM
MEMBER
PCP
SPECIALIST
PHARMACIST
FLEXIBLE, INDIVIDUALIZED CARE PROGRAMS
REAL-TIME INTEGRATED DATA, ELECTRONIC MEDICAL RECORDS, CLAIMS, CARE PLANS

Cost of Non-Optimized Medication Use

$528 billion *wasted*

275,000 lives *lost*

For every **$1** *spent* on meds, **$1.55** *spent* *fixing* med issues

MEDICATION NON-ADHERENCE

75%

Medication Non-Adherence Rate

of people with a chronic medical condition

COSTS **$500 billion** of the entire U.S. healthcare spend every year.

Pharmacists are Accessible

89% of Americans live within **5 miles of a pharmacy.**[1]

340,000 pharmacists in the United States.

Pharmacy Deserts

- there are **15.1% more pharmacy locations** within low-income communities than physician practices, and[3]
- pharmacy locations offer **95.7% more operating hours than physician practice sites.**[4]

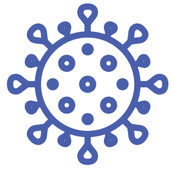
https://www.pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=BdS0HbVWDtw%3d

Pharmacists' Clinical Services

These are examples of services provided by pharmacists. There are many others beyond these.

- **Immunizations**

- **Cardiovascular disease**



- **Infectious disease**

- **Test-and-treat**

- **Women's health**

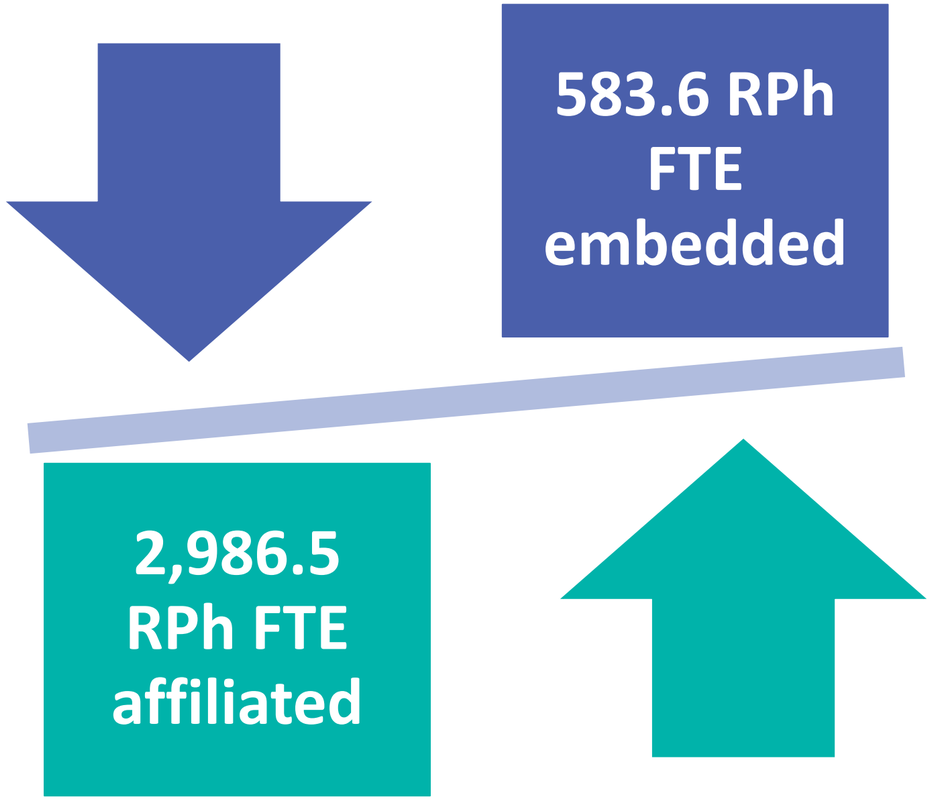
- **Tobacco cessation**

Mental and behavioral health

Research

Pharmacist's Role in Team-based Care

- Filling gaps in care, not just prescriptions.



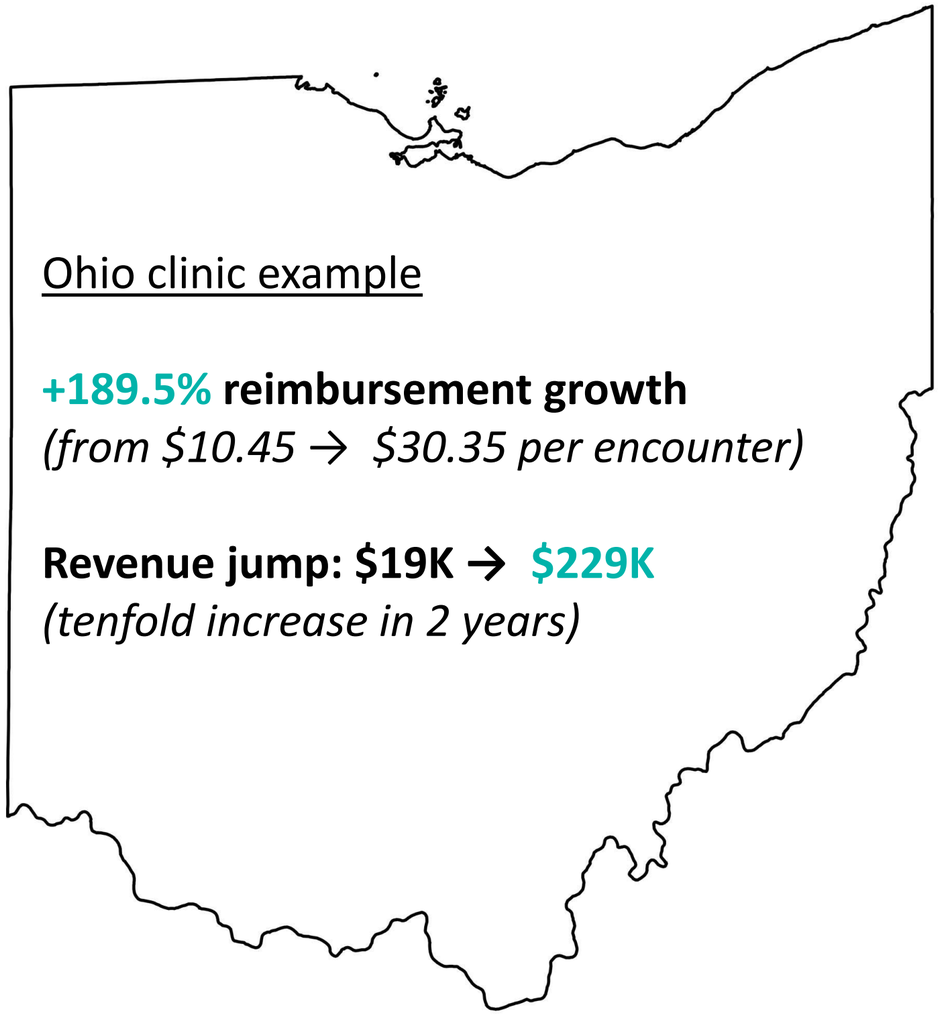
Underutilizing pharmacists already associated with clinics

Economic Value of Pharmacists

Asheville Project: **$725 direct savings; $1,230 indirect savings**

Pharmacist-led diabetes program: **$74,906 savings in a free clinic annually**

Pharmacist services: **$4.81 return per $1 invested**



Ohio clinic example

+189.5% reimbursement growth
(from $10.45 → $30.35 per encounter)

Revenue jump: $19K → $229K
(tenfold increase in 2 years)

Center for Innovative Pharmacy Solutions (CIPS)

University of Maryland School of Pharmacy

The Center for Innovative Pharmacy Solutions (CIPS) is a national leader in the development of **novel patient care** and **business solutions** to health problems

CIPS responds to urgent needs in the health care landscape with strategic action and generates health care models with **improved patient outcomes** and **cost savings**.

P3

PATIENTS

PHARMACISTS

PARTNERSHIPS

The Maryland P³ Program: A Collaborative Effort to Improve Outcomes and Reduce Costs

AHRQ HEALTH CARE INNOVATIONS EXCHANGE
Innovations and Tools to Improve Quality and Reduce Disparities

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

MARYLAND

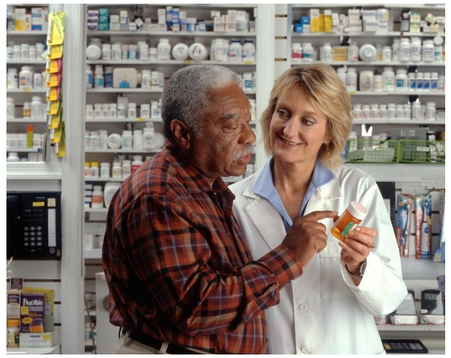
APhA FOUNDATION

Health Care Innovations in Maryland

PINNACLE AWARDS

recognized by the following entities

The P^3 Program's® Goals



Identify, Prevent, & Solve Drug-Related Problems

Improved Beneficiary Health; Reduced Health Care Costs, Absenteeism, Increased Patient Satisfaction, & Productivity

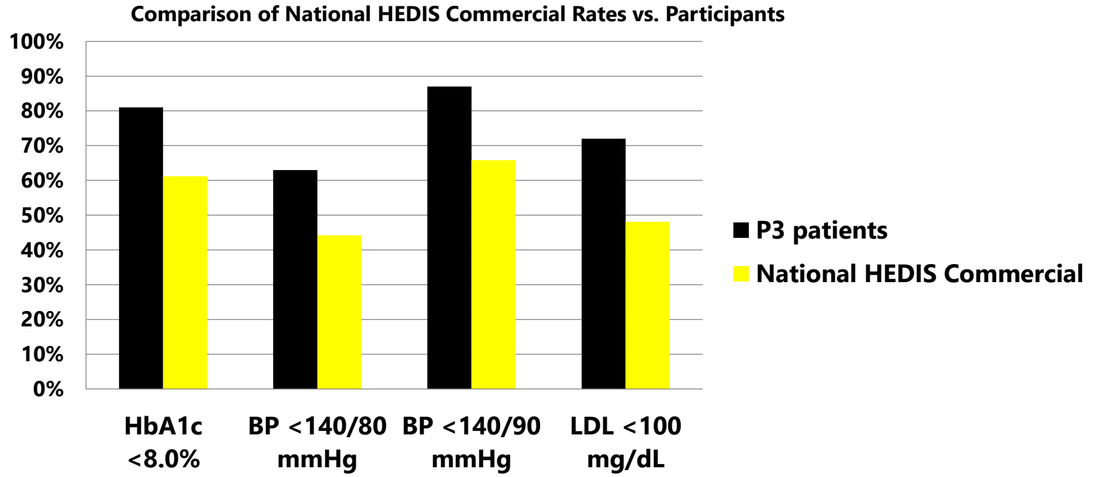
Guidance In Medication Adherence, Lifestyle Changes, & Disease Self-Management Knowledge And Skills; Improved Health.

The Maryland P^3 Program: Diabetes Care

Problem: Skyrocketing diabetes costs; medication and guideline adherence; self-management; critical issues for health plans, employers and physicians' practices; HEDIS measures STAR ratings

Solutions: **1) Self-Insured Employers Program:** coaching as health benefit with waived co-pays medications and supplies
2) Quality Care Network: integrated in case management to improve performance metrics
3) Health Plan Disease Management: integrated in the health plan benefit program

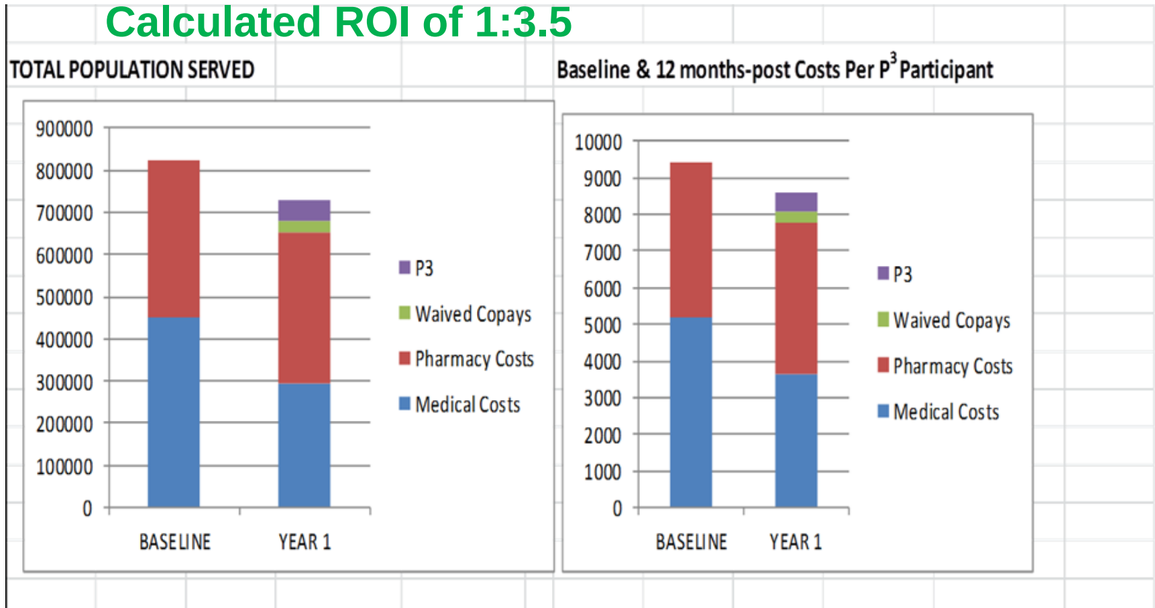
Outcomes: ⇧ patient and provider satisfaction: 98% participant retention rate; ⇩ medication-related conditions hypoglycemia and hypotension; ⇧ medication adherence and persistence



Comparison of Pre- and Post- Total Participant Costs

Comparison of Pre- and Post- Average Per Participant Cost

Calculated ROI of 1:3.5



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journal homepage: www.japha.org

EXPERIENCE

Clinical effectiveness and cost savings in diabetes care, supported by pharmacist counselling

Magaly Rodriguez de Bittner, Viktor V. Chirikov, Ian M. Breunig, Roxanne W. Zaghab, Fadia Tohme Shaya*

a b s t r a c t

Objective: To determine the effectiveness and cost savings of a real-world, continuous, pharmacist-delivered service with an employed patient population with diabetes over a 5-year period.

Setting: The Patients, Pharmacists Partnerships (P^3 Program) was offered as an "opt-in" benefit to employees of 6 public and private self-insured employers in Maryland and Virginia. Care was provided in ZIP code matched locations and at 2 employers' worksites.

Practice description: Six hundred two enrolled patients with type 1 and 2 diabetes were studied between July 2006 and May 2012 with an average follow-up of 2.5 years per patient. Of these patients, 162 had health plan cost and utilization data. A network of 50 trained pharmacists provided chronic disease management to patients with diabetes using a common process of care. Communications were provided to patients and physicians.

Practice innovation: Employers provided incentives for patients who opted in, including waived medication copayments and free diabetes self-monitoring supplies. The service was provided at no cost to the patient. A Web-based, electronic medical record that complied with the Health Insurance Portability and Accountability Act helped to standardize care. Quality assurance was conducted to ensure the standard of care.

Evaluation: Glycosylated hemoglobin (A1c), blood pressure, and total health care costs (before and after enrollment).

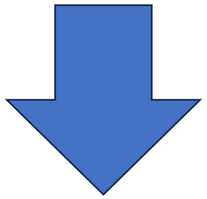
Results: Statistically significant improvements were shown by mean decreases in A1c (-0.41%, P <0.001), low-density lipoprotein levels (-4.7 mg/dL, P ¼ 0.003), systolic blood pressure (-2.3 mm Hg, P ¼ 0.001), and diastolic blood pressure (-2.4 mm Hg, P <0.001). Total annual health care costs to employers declined by $1031 per beneficiary after the cost of the program was deducted. This 66-month real-world study confirms earlier findings. Employers netted savings through improved clinical outcomes and reduced emergency and hospital utilization when comparing costs 12 months before and after enrollment.

Conclusion: The P^3 program had positive clinical outcomes and economic outcomes. Pharmacist-provided comprehensive medication therapy management services should be included as a required element of insurance offered by employers and health insurance

http://dx.doi.org/10.1016/j.japh.2016.08.010

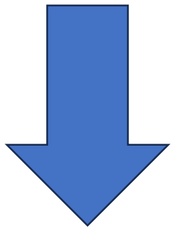
P^3 Program cost savings

COST SAVINGS



$ 2,136 per participant

ED/HOSPITALIZATIONS



22% REDUCTION

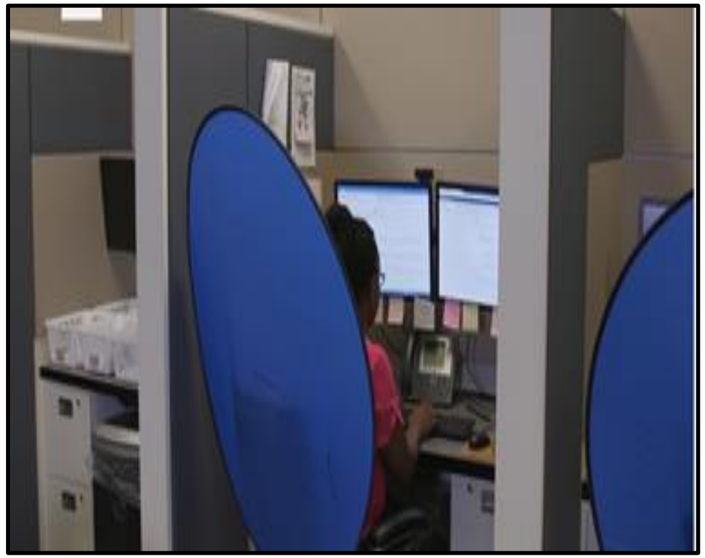
AVERAGE ROI

2.5:1

EVERY **$1** SPENT

Clinical Programs: The ***PreventionLink Program***

- The ***PreventionLink Program from*** *the Prince George's Department of Health with a grant from the Center for Disease Control* brings together stakeholders in chronic disease care.
  - Shared goal; reduce burden of diabetes, hypertension, and stroke
  - Focus on underserved areas in four (4) southern Maryland counties.
  - Telehealth CMM to aprox 50 primary care practices
  - Developed e-referral and documentation system within CRISP across all practices
  - Collaborating with community pharmacies-Giant, CPSEN, independent pharmacies and Prescribe Wellness.



Medication Adherence Program

Description:

Pharmacists will work with the patient to identify resources for patients with complex medication profiles so they receive individualized counseling to identify and resolve barriers to medication adherence such as packaging/medication synchronization at pharmacies preferred by the patient.

Criteria:

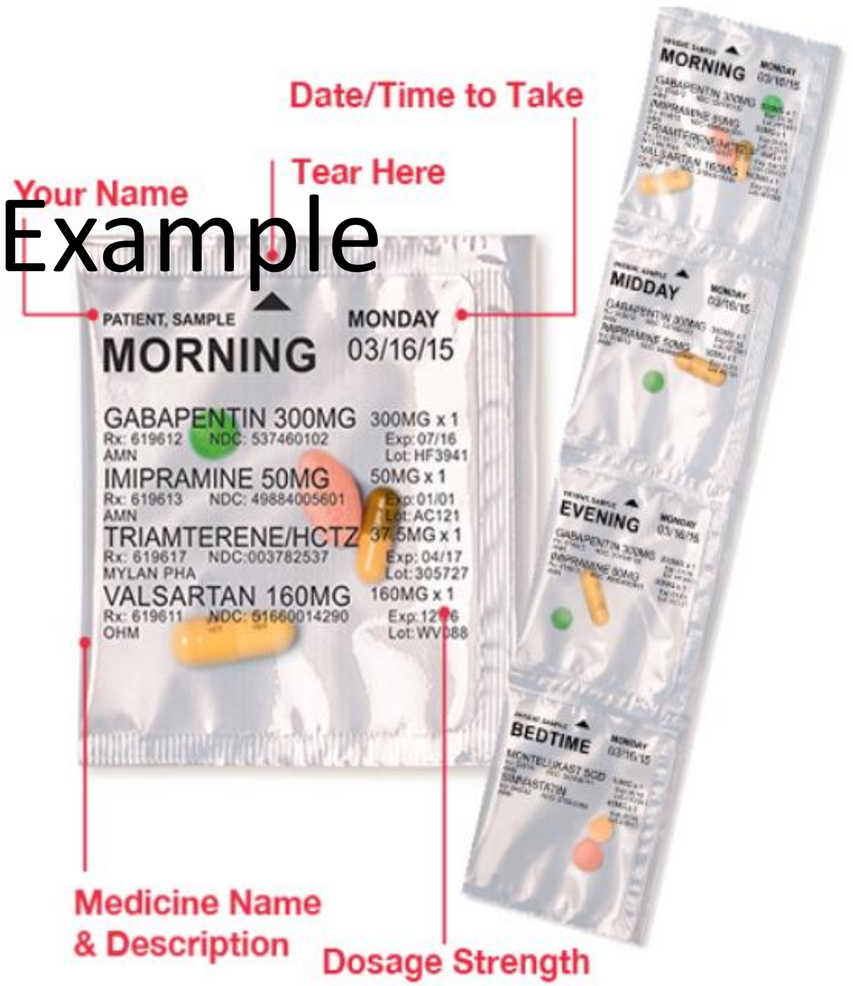
- Patients on 4 or more chronic medications and/or at risk for non-adherence.

Benefits:

- Improved medication adherence

Next Steps:

- Provider and/or case manager can refer patients to the pharmacist for enrollment.



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P^3 Clinical Outcomes for Co-Pay Program Participants

Diabetes Clinical Marker A1c	At Baseline* (N=158)	During Program* (N=197)
Average A1c	7.6	7.5
A1c <7 %	38.0%	42.7%
A1c 7-7.9%	31.0%	32.7%
A1c 8-8.9%	14.6%	11.6%
A1c >/=9	16.5%	13.1%

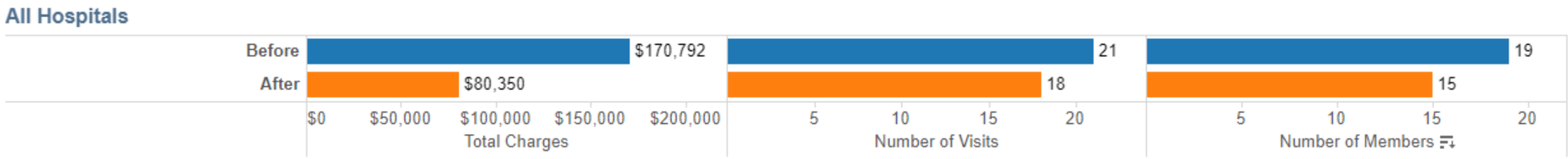
HTN Clinical Marker	At Baseline* (N = 131)	During Program* (N=195)
Mean Systolic BP	133	133
Mean Diastolic BP	79	79
BP <140/90	66%	71%

Clinical Goal is to obtain a A1c < 7 % per American Diabetes Association guidelines
Clinical Goal is a BP <140/90 mm/Hg

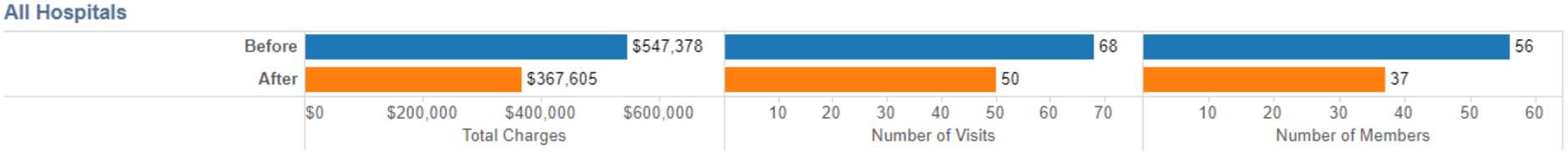
- **Estimated savings for UMMS Employee plan:**
  - **For each 1% reduction in A1c a savings of $1,169 per patient is estimated****

Pre-Post Analysis: Co-Pay Waiver Program

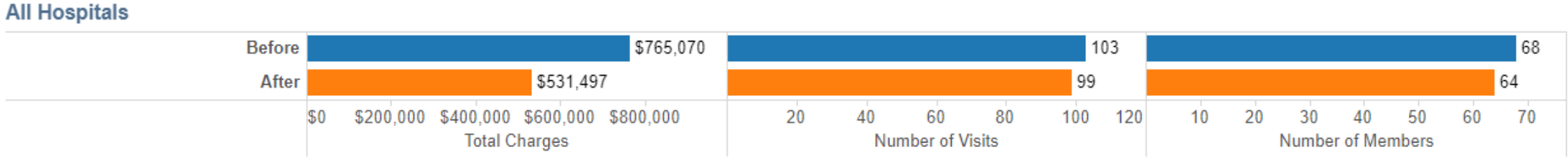
1 Month Pre/Post: 398 members available for analysis, 32 members with visits



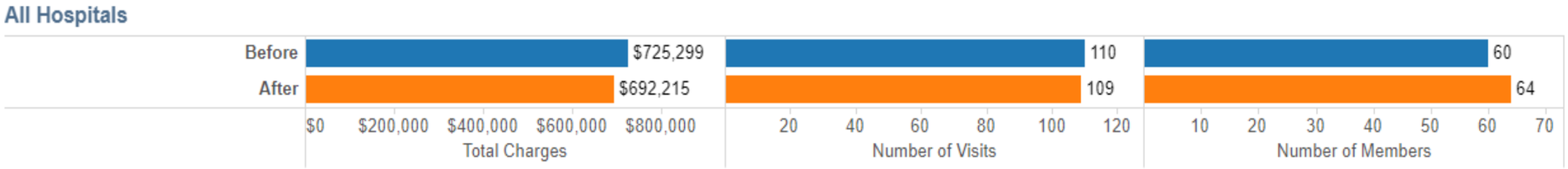
3 Month Pre/Post: 379 members available for analysis, 78 members with visits



6 Month Pre/Post: 343 members available for analysis, 108 members with visits



12 Month Pre/Post: 199 members available for analysis, 92 members with visits



UMB SOP eHealth Center

- **Transition of Care Programs**
  - University of Maryland Prince George's Hospital Center
  - UMMC MIH Program

- **Chronic Disease Management**
  - Prince George's Department of Health
  - Self-Insured employees from McCormick with clinical and economic outcomes
  - Average savings $1,000 per employee per month in diabetes management

- **COPD-Telehealth Medication Management**
  - Virtual clinic and mobile monitoring for COPD patients on the Eastern Shore

- **UMMS Quality Care Network (350 primary care physicians and 150,000 patients)**
  - Disease state management program for UMMS employees (diabetes and hypertension management)
  - Complex case management for high risk patients
  - Transition of care medication reconciliation
  - Medication management for specialty drugs and patients with chronic diseases

Training the next generation of health care providers-residents and students- how to deliver optimal and effective telehealth services

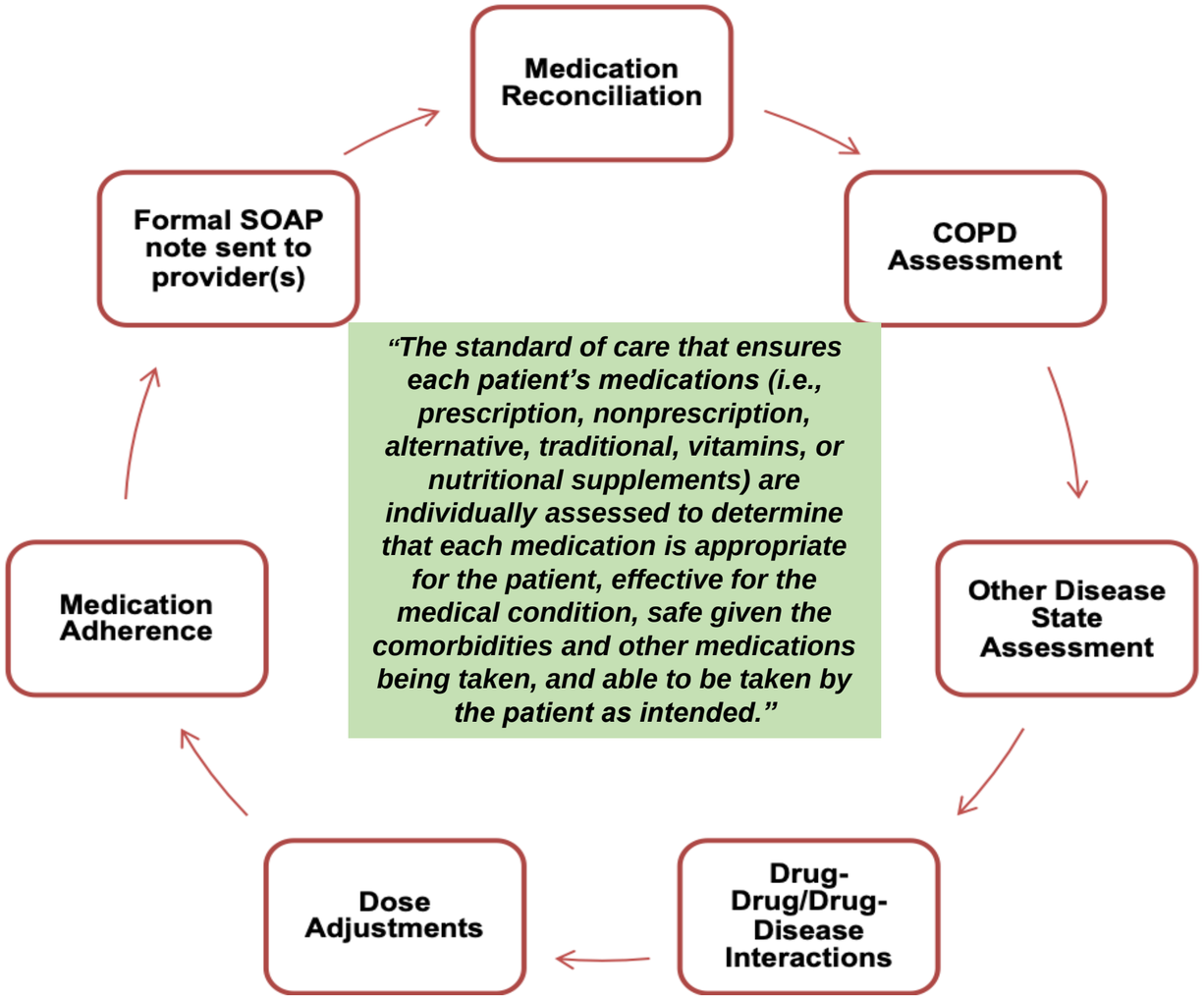
Clinical Programs: Mobile Integrated Health (MIH)

Service to West Baltimore Community

Paramedic/Nurse/Pharmacist at the patient's home

Winner of the *2020 Patty Brown Innovation Award from Chesapeake Regional Information System for our Patients (CRISP)..*

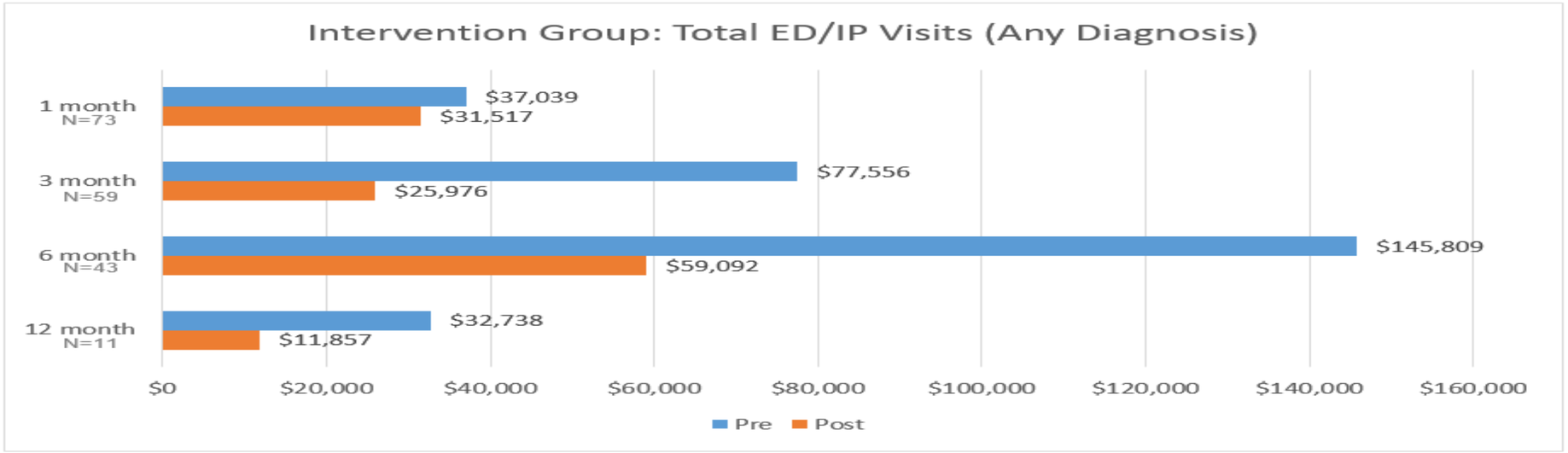
P^3 Comprehensive Medication Therapy Management COPD

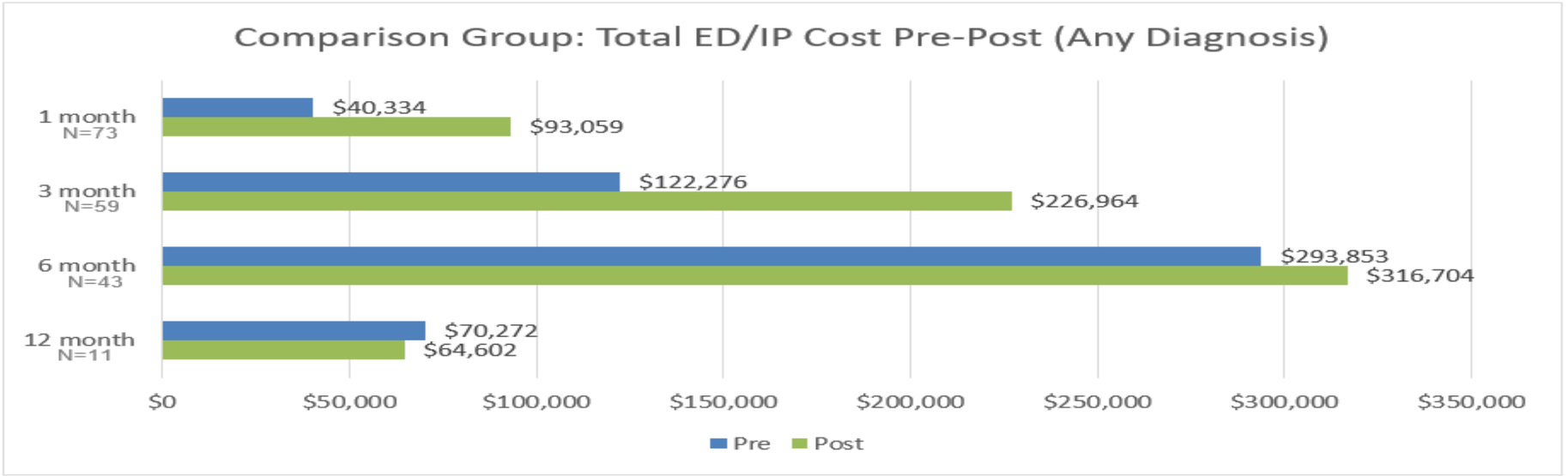


"The standard of care that ensures each patient's medications (i.e., prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended."

- COPD Assessment Test (CAT)
- Inhaler Use
- Self Reported Medication Adherence
- Influenza/Pneumococcal Vaccinations

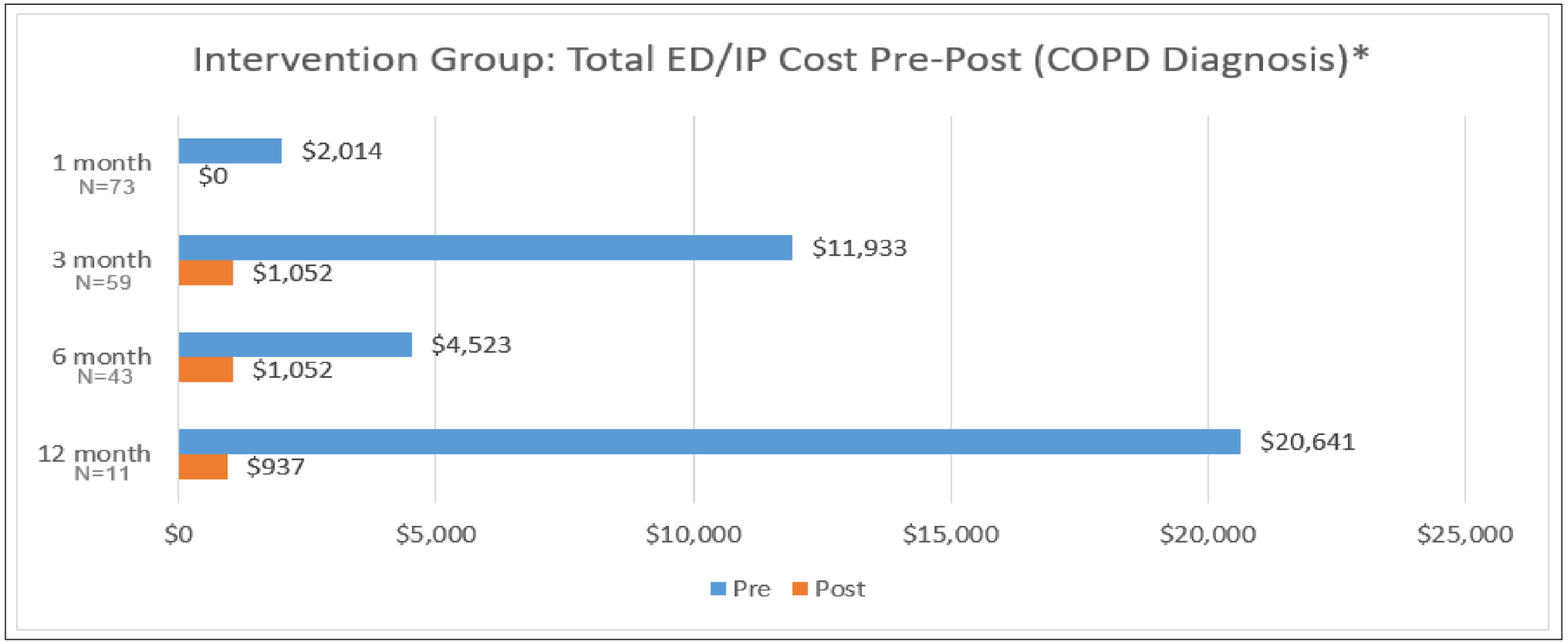
COPD Telehealth-Pre-Post Panel Analysis (CRISP)





COPD Telehealth Visits-Results

Reduce hospitalizations inpatient and ER visits (where COPD is the primary diagnosis) in patients who complete the intervention by a pharmacist, compared to the same patient 6 (12) months prior to enrollment.



*Please note that number of patients within each time period's analysis does change based on their enrollment date and availability of claims data in CRISP.

COPD Telehealth Visits-Results

Achieve an average rating between satisfied or highly satisfied by patients completing one or more e-health visits during the project period

Program Satisfaction:

- Did you Feel that all of your concerns were addressed during the telehealth visit?
- Did you feel the telehealth visit was more convenient than a face-to-face visit?
- Would you like to have a telehealth visit in the future?

Technology Satisfaction:

- How complicated was it to use the audio-visual connect for your telehealth visit?
- Did you have difficulty hearing or seeing your provider during the telehealth visit?
- Did you experience technical problems during the telehealth visit?

Total Mean Satisfaction Score

84%

Highly Satisfied

Total Mean Satisfaction Score

94%

Highly Satisfied

Integration = Innovation

- Pharmacist integration = better care + better ROI

Access

- 50% of clinics have pharmacies, but few integrate pharmacists and their services

Quality

- Pharmacists boost HEDIS scores and close care gaps

Team-based care

- 77% of patients agree that pharmacists are integral to their care team

Immunizations by Pharmacists

- Pharmacies increase access to vaccines across the lifespan
- More than 400,000 pharmacists, student pharmacists, and 100,000 pharmacy technicians are trained to administer vaccines
- More than 60,000 pharmacies provide vaccinations

COVID-19 vaccine doses

- **300+ million in pharmacies**
- More than half of all C19 in U.S.

From December 2020 – January 2023[1]

https://www.pharmacist.com/Practice/COVID-19/The-Essential-Role-of-Pharmacy-in-Response-to-COVID-19/Infographic

RSV vaccine doses

- **9.7 million in pharmacies**
- 0.3 million in medical offices

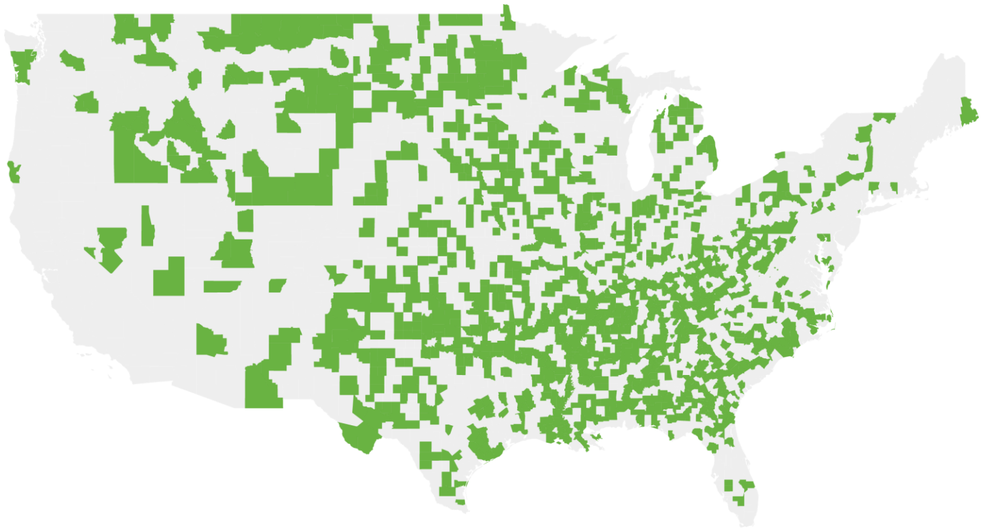
From Aug 2023 – March 2024[2]

https://www.cdc.gov/vaccines/imz-managers/coverage/rsvvaxview/adult-vaccinations-administered.html

Pharmacy's potential to expand primary care

- In December 2023, **62.9% of U.S. counties had less than one PCP for every 1,500 residents**, creating a relative PCP shortage.
- **65% of counties with a PCP shortage** have **high or medium pharmacy availability.**[1]

Counties with high/medium opportunity for pharmacists to address shortages



Note: Alaska, Hawaii, Puerto Rico and other U.S. territories not displayed but included in analysis

Highest-population counties with high/medium pharmacy opportunity

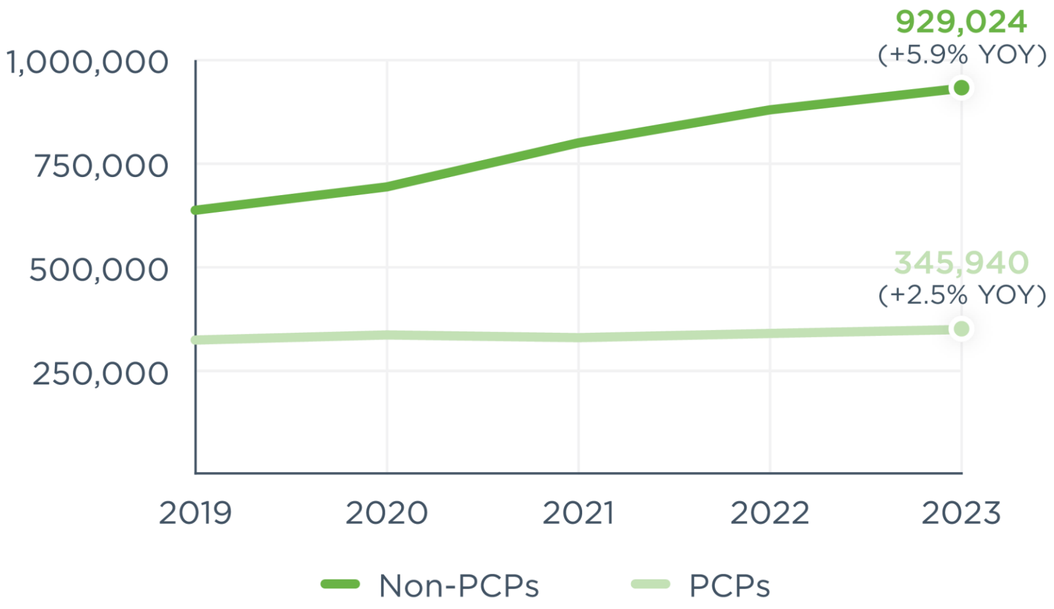
1	Hudson, NJ	6	Madison, MS
2	Shelby, AL	7	Bradley, TN
3	Carolina, PR	8	Marshall, AL
4	Morgan, AL	9	Sevier, TN
5	Robeson, NC	10	Guaynabo, PR

Source: Surescripts 2023 National Progress Report.

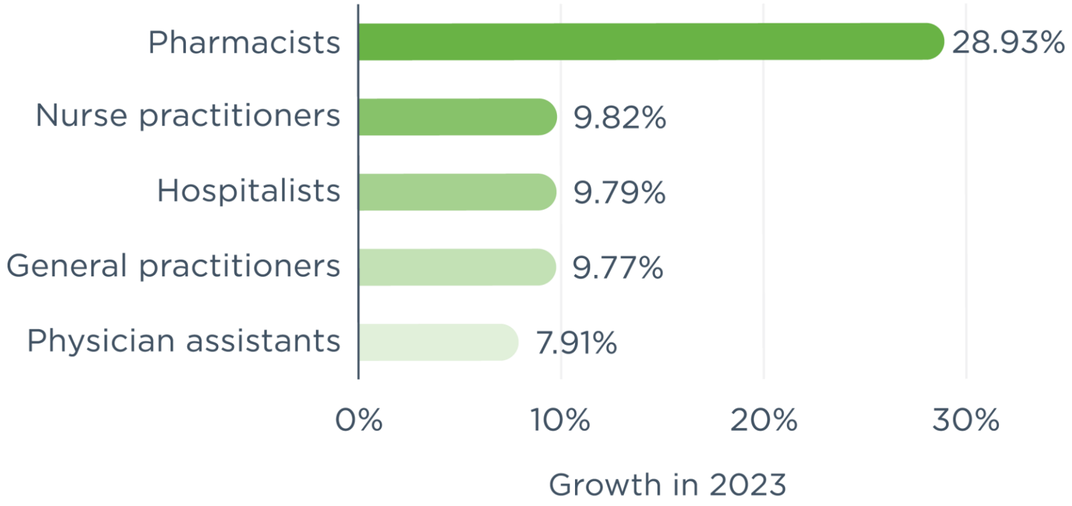
Shifting care team responsibilities

- The average annual growth rate for non-PCP e-prescribers was 10% in 2023, compared to just 1.7% among PCPs.

E-prescribers on the Surescripts network



Roles with fastest growth in e-prescribers

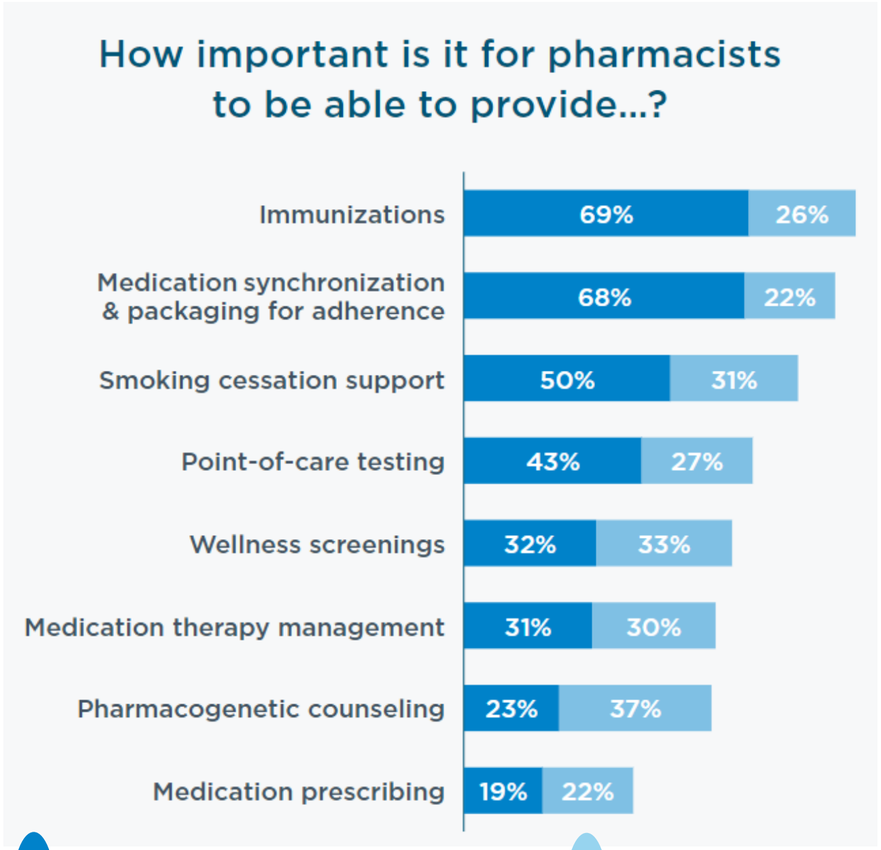


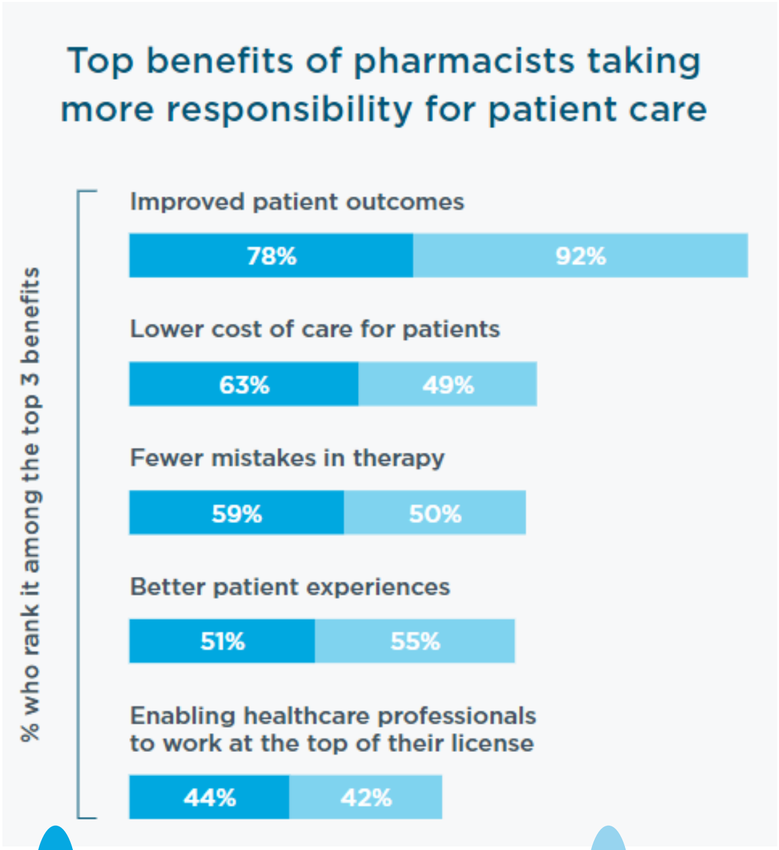
Note: Includes only prescriber types with at least 5,000 e-prescribers on the network

Source: Surescripts 2023 National Progress Report.

Provider Perspectives on Care Team Evolution

- In a survey of more than 500 providers, 9 in 10 support team-based care





Source: Surescripts, “Data Brief: Prescribers & Pharmacists Look for More Collaboration & New Technologies to Improve Care,” August 2023.

Lack of Coverage for Pharmacist Services

- Pharmacist-provided services are *intermittently* included as a covered benefit for patients

Limited access to services	Underutilization of pharmacists' skills	Fragmented care
Reduced medication adherence	Increased healthcare costs	Missed opportunities for patient care initiatives

Perspectives from Health Insurers

Key messages

- Eight interviews conducted with representatives from different health plans
- All agreed there is an opportunity to further include pharmacists as members of the care team
- Opportunity to contribute to care gap closures
- Existing partnerships show value, but struggle to scale

Key levers to advance partnerships:

Consistent scope of practice across states

Bi-lateral information exchange

Evolved reimbursement models & billing mechanisms

Robust networks of pharmacists & staff

Appropriate measurement & reporting

surescripts

American Pharmacists Association

- The American Pharmacists Association (APhA) is the first-established, largest, and most diverse national professional association representing pharmacists, pharmaceutical scientists, student pharmacists, and pharmacy technicians in the United States and is the only organization advancing the entire pharmacy profession.

SCIENCE AND PRACTICE

Journal of the American Pharmacists Association xxx (2023) 1–13

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ELSEVIER

APhA

FEATURE

Optimizing patient outcomes: Health plans and pharmacists summit: Meeting proceedings

E. Michael Murphy*, Anne Burns

ARTICLE INFO

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ABSTRACT

Objective: To convene a group of experts to define the value pharmacists provide to health plans, barriers to covering pharmacists' patient care services, and scalable solutions to cover pharmacists' services, specifically in the medical benefit.

Methods: The American Pharmacists Association (APhA) convened 31 experts, including physicians and pharmacists representing health plans (HPs) and pharmacist practitioners (PP) or organizations representing PPs for a strategic summit on May 16 to May 17, 2022, in Washington DC and Arlington, VA. A presummit survey was conducted to identify participants' perspectives on the value proposition of pharmacists and barriers to coverage for services. Day 1 of the summit featured a keynote presentation focused on the current state of coverage for pharmacists' care. The second day included a framing session on the future of pharmacist-provided services and the results of the presummit survey; four panel presentations on innovative HP program coverage; three breakout sessions to gather participant feedback on their experiences; and a final session prioritizing action items into an initial timeline of goals. A postsummit survey was fielded to rank feasibility and importance of opportunities and next steps for advancing coverage of pharmacists' services.

Result: In general, there appeared to be consensus throughout the summit on the need to expand payer programs covering patient care services provided by pharmacists and the importance of continued collaboration between PPs and HPs to increase patient access to care. Participants highlighted a need for legislative and regulatory changes at the state and federal level for the expansion of some programs; however, there were many opportunities to expand programs without the need for public policy changes.

Conclusion: The summit was a groundbreaking meeting between PPs and HPs that provided the foundation for collaboration and expansion of programs covering pharmacists' patient care services under the medical benefit. Key takeaways from the summit focused on the need for scaling programs; establishing mutually beneficial programs for patients, PPs, and HPs; and the need for partnership and flexibility from PPs and HPs as programs continue to establish and expand.

Background

Financial coverage for pharmacists' time and expertise in the delivery of patient care services is critical for the creation of scalable, sustainable services profession-wide that meet patients' health and wellness needs. While pharmacists are well-positioned in knowledge, expertise, and accessibility to address increasing barriers and disparities for patients to obtain optimal health care, the ability for pharmacists to meet this need is hindered by the widespread lack of coverage for services provided.[1,2]

Common financial models for pharmacists' patient care services include fee-for-service (FFS) payment from a variety of payers, value-based payments, blended FFS/value-based payments, direct contracting with an employer, and patient self-pay. Depending on how payers recognize their providers, pharmacists either bill directly for their services or in the case of Medicare Part B and some other payers, a physician or other

Disclosure: The author declares no conflicts of interest or financial interests in any product or service mentioned in this article.

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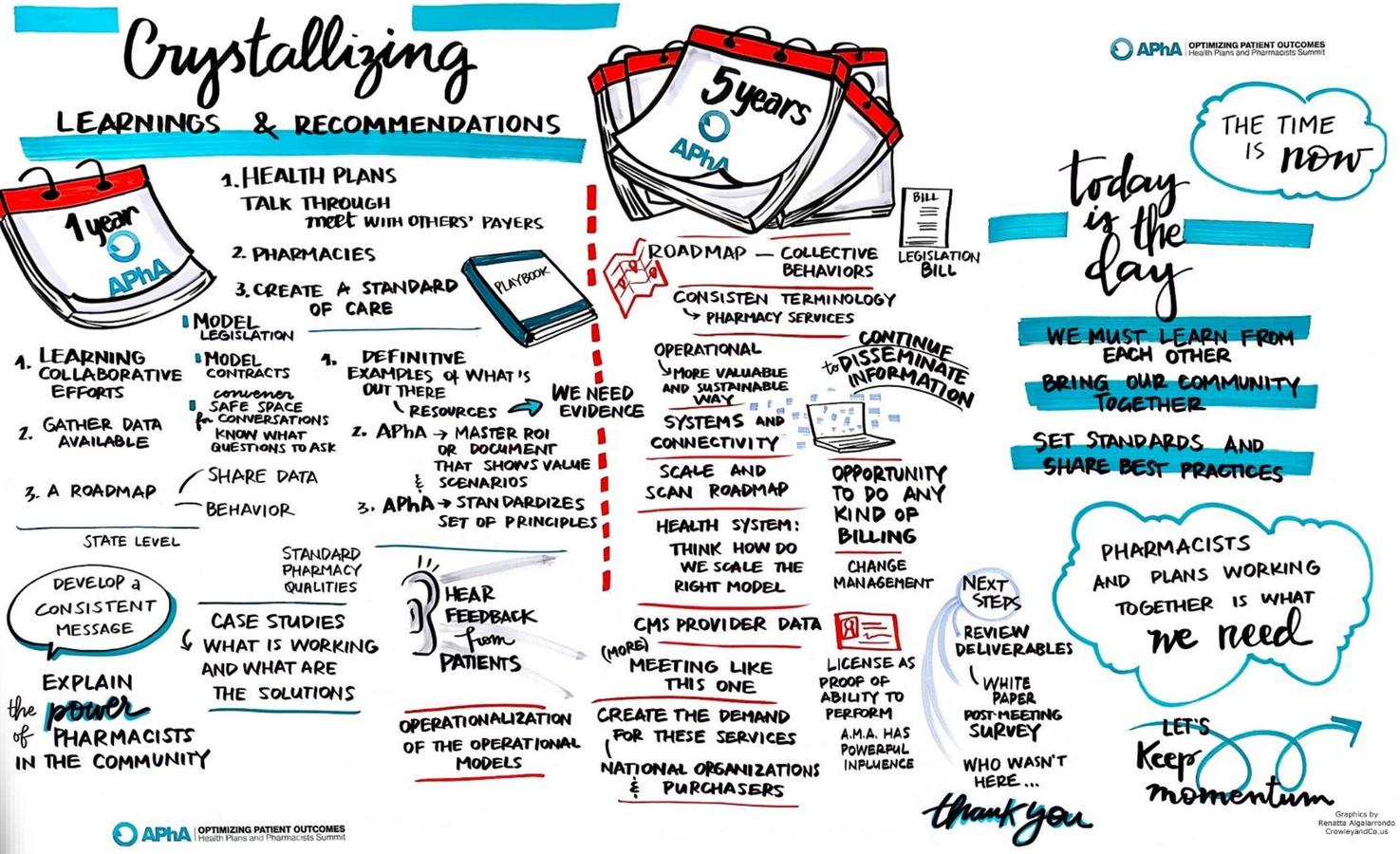


https://doi.org/10.1016/j.japh.2023.06.019

Policy in Action

- Federal and state level reform needed
  - Advocate for payment parity and insurance coverage to sustain and grow pharmacist integration.

Payment Journey for Pharmacists' Patient Care Services

- **Payers**
  - Medicaid programs
  - Commercial payer requirements
  - Commercial contracts and grants (various)
- **Payment models**
  - Fee for service
  - Value-based arrangements
- **Return on investment**
  - Decreased health care costs
  - Improved control of chronic conditions (e.g. diabetes, hypertension, asthma)
  - Decreased missed or nonproductive workdays
  - Average ROI $4:$1 for pharmacists' services

Medicare.gov
The Official U.S. Government Site for Medicare

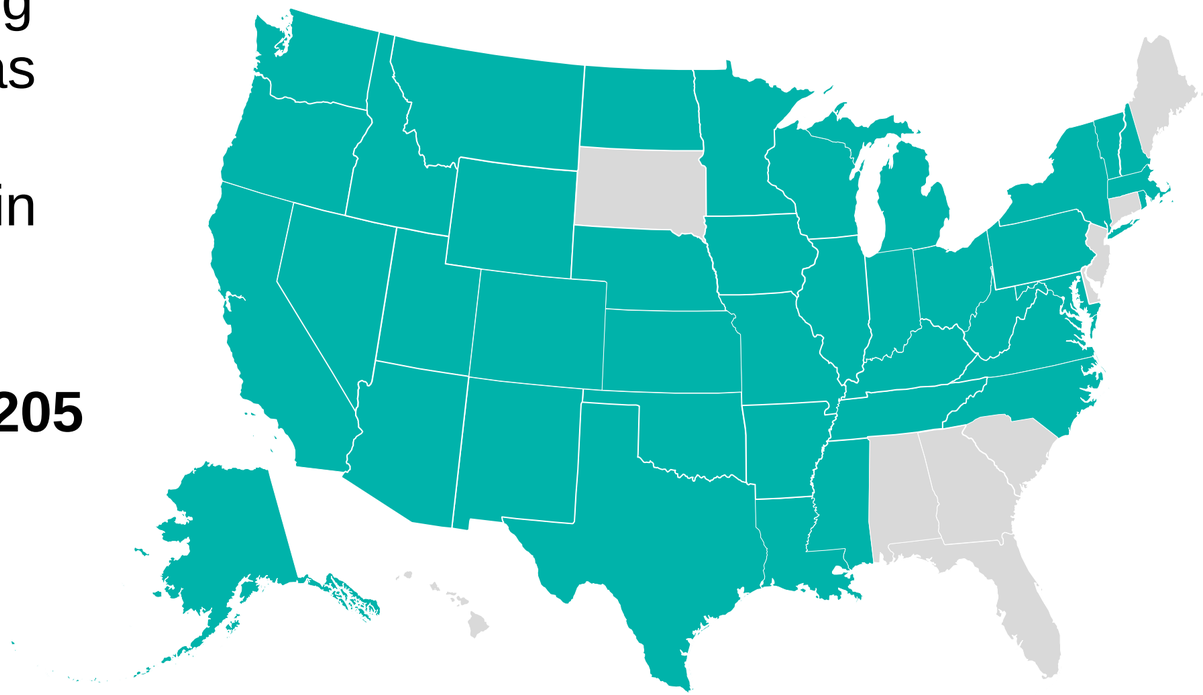
Lack of recognition of pharmacists' services for payment in Medicare Part B is a significant barrier to broader uptake in other payer markets.

- Pharmacy profession advocacy efforts to gain recognition

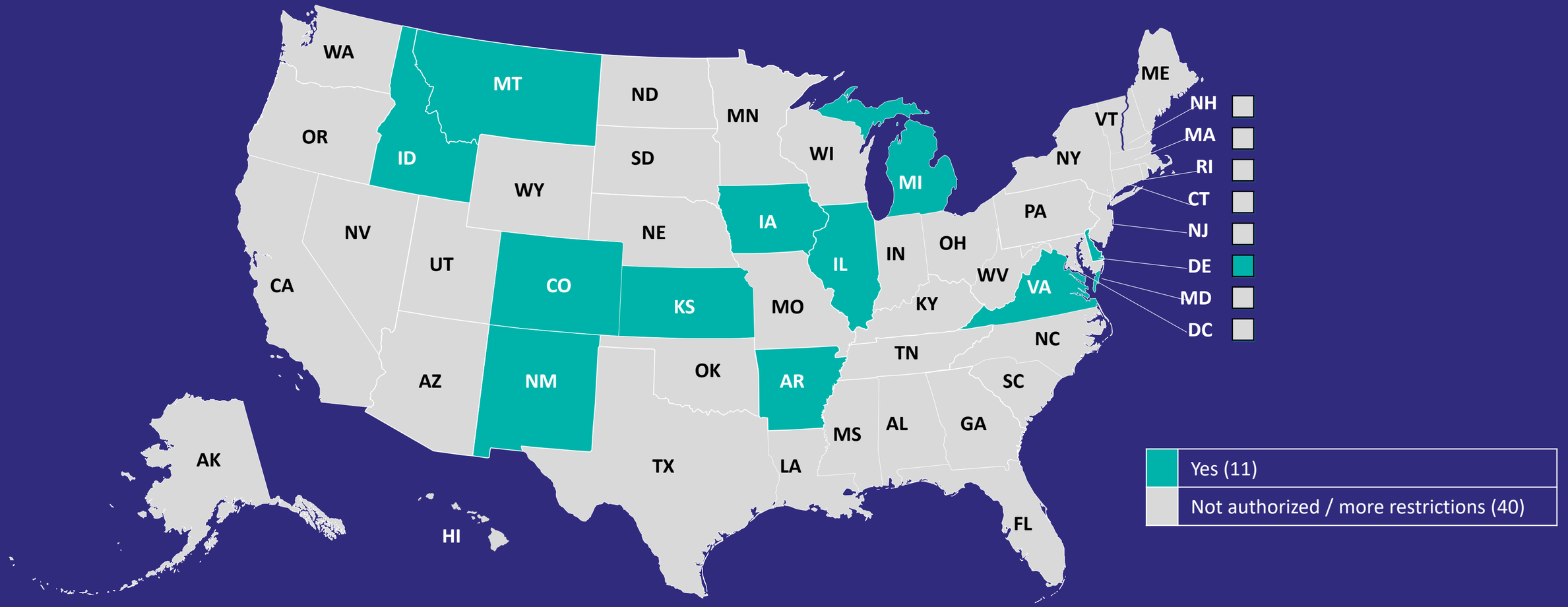
Trends in Payment for Pharmacists' Services in the States

- Payment for services under Medicaid and commercial health plans
  - State medical assistance programs submitting state plan amendments to add pharmacists as **other licensed practitioners**
- Integrating pharmacists into established models in the **medical benefit**
  - CMS 1500 claim form
  - Billing HCPCS codes: **Commonly 99202-99205 & 99211-99215**
- Variability in scope of reimbursable services

States where at least one service is being covered by Medicaid or a commercial plan

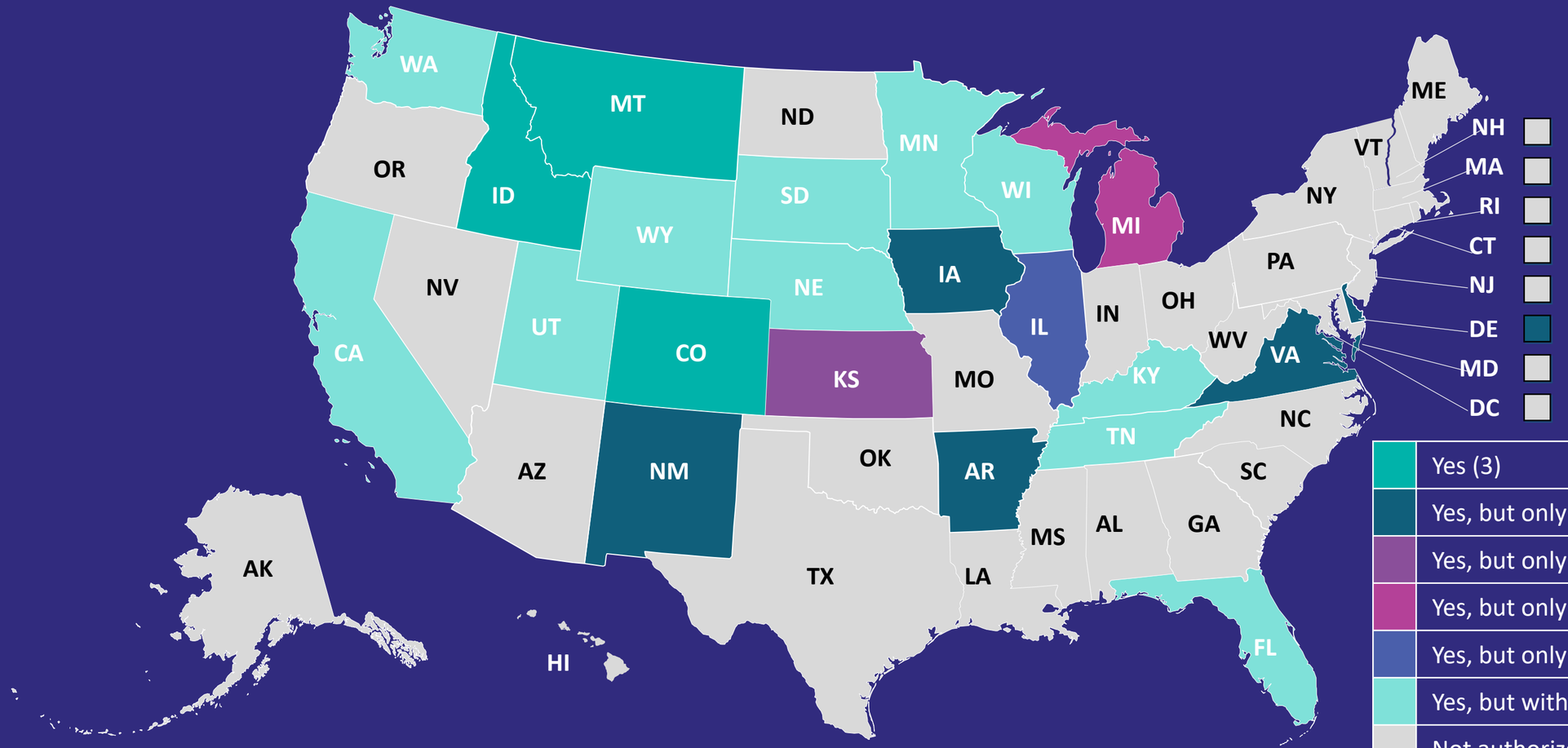


Can pharmacists test and treat for minor ailments via prescriptive authority or statewide protocol?



Minor ailments that pharmacists can test and treat for vary between states. They include, but are not limited to, influenza, Group A Streptococcus Pharyngitis, COVID-19, lice, and skin conditions, including ringworm and athlete's foot.

Can pharmacists test and treat for COVID–19, influenza, respiratory syncytial virus, or streptococcal pharyngitis via prescriptive authority, statewide protocol, or other means?*

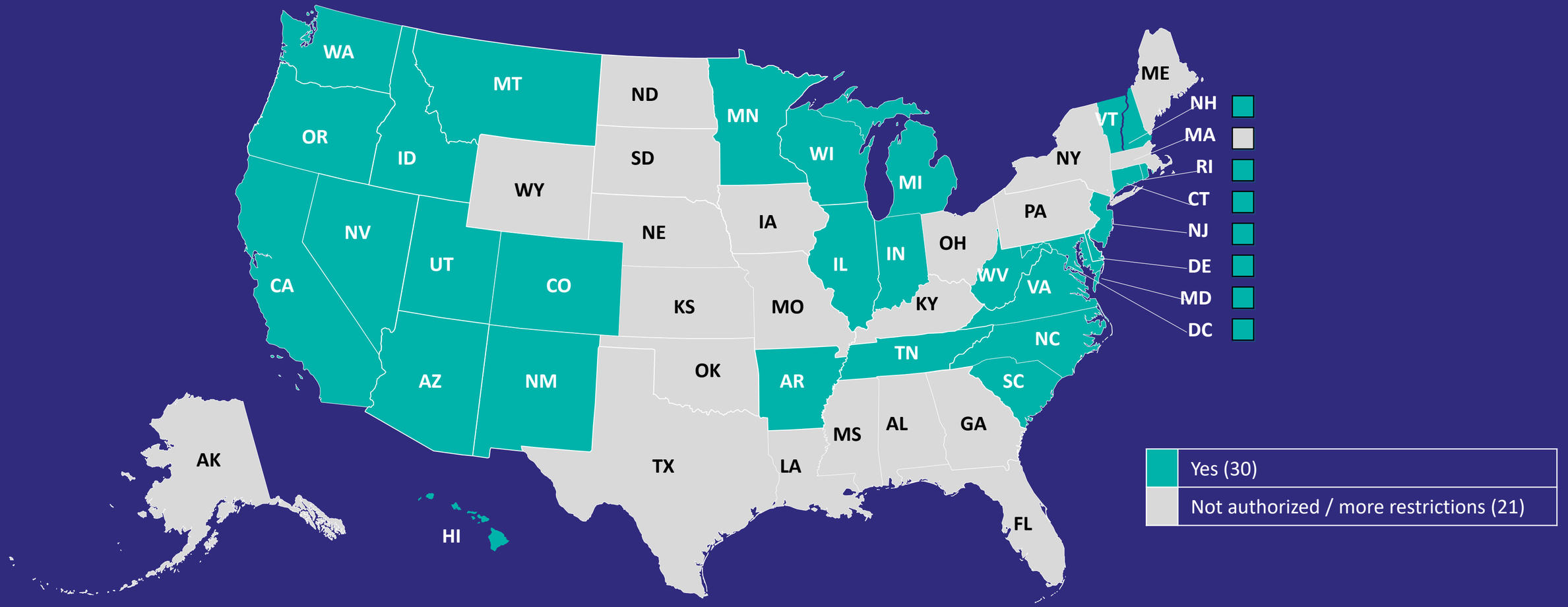


Yes (3)
Yes, but only COVID-19, strep, & influenza (5)
Yes, but only strep & influenza (1)
Yes, but only COVID-19 & influenza (1)
Yes, but only COVID-19 (1)
Yes, but with prescriber collaboration* (11)
Not authorized / more restrictions (29)

*Limited to collaborative practice agreements or prescriber protocols that allow multiple patients and do not require past prescriber-patient relationship
Last updated: December 2023

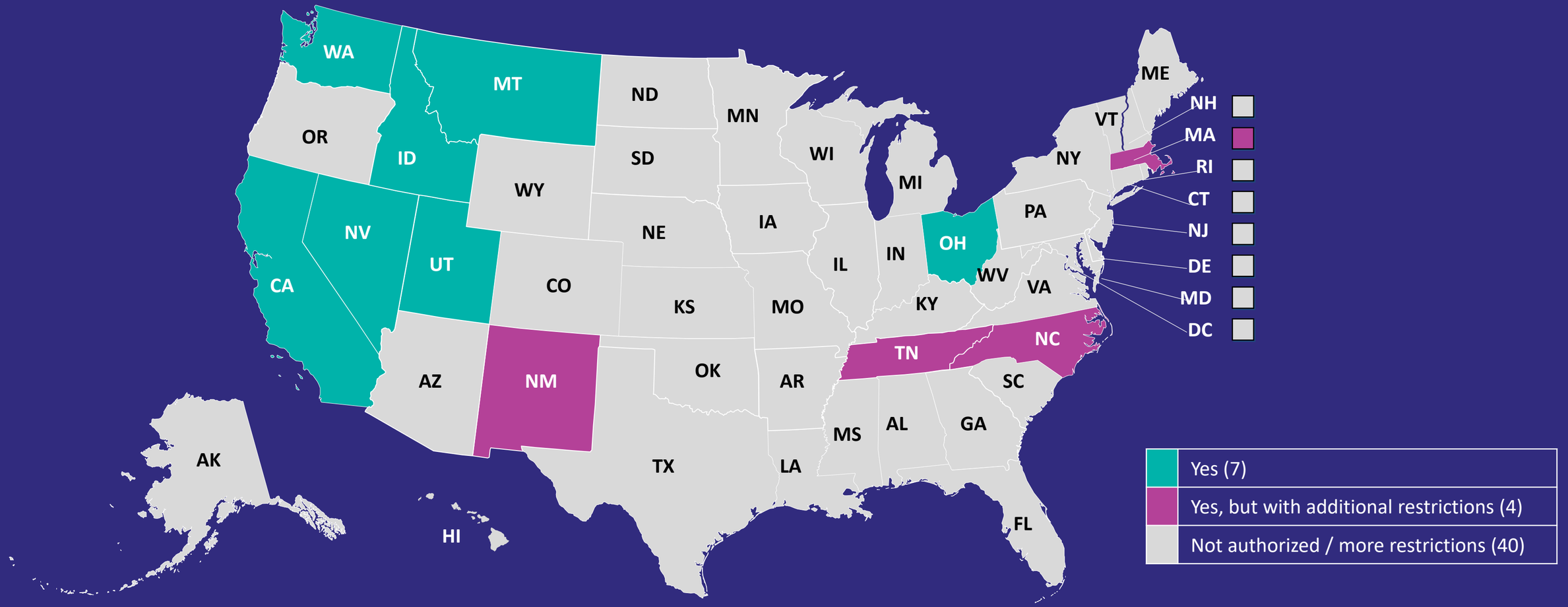
APhA

Can pharmacists furnish hormonal contraceptives via prescriptive authority, statewide protocol, or other means?



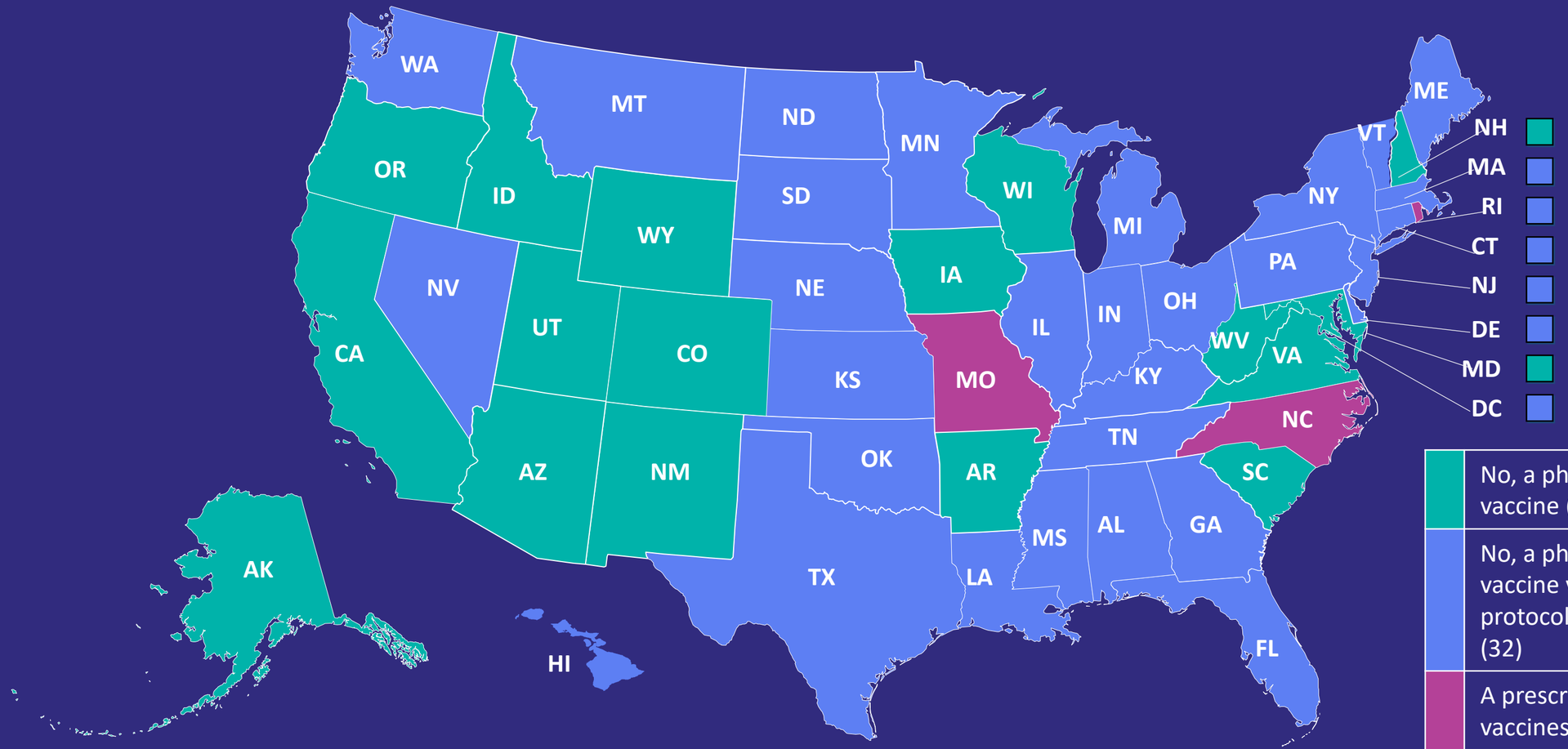
Ability to furnish via provider specific collaborative practice agreement not included

Can pharmacists furnish medications for opioid use disorder (MOUD) via prescriptive authority, statewide protocol, or collaborative arrangement?



Updated May 2024

Does a patient need a prescription for a pharmacist to administer a vaccine on the adult immunization schedule?

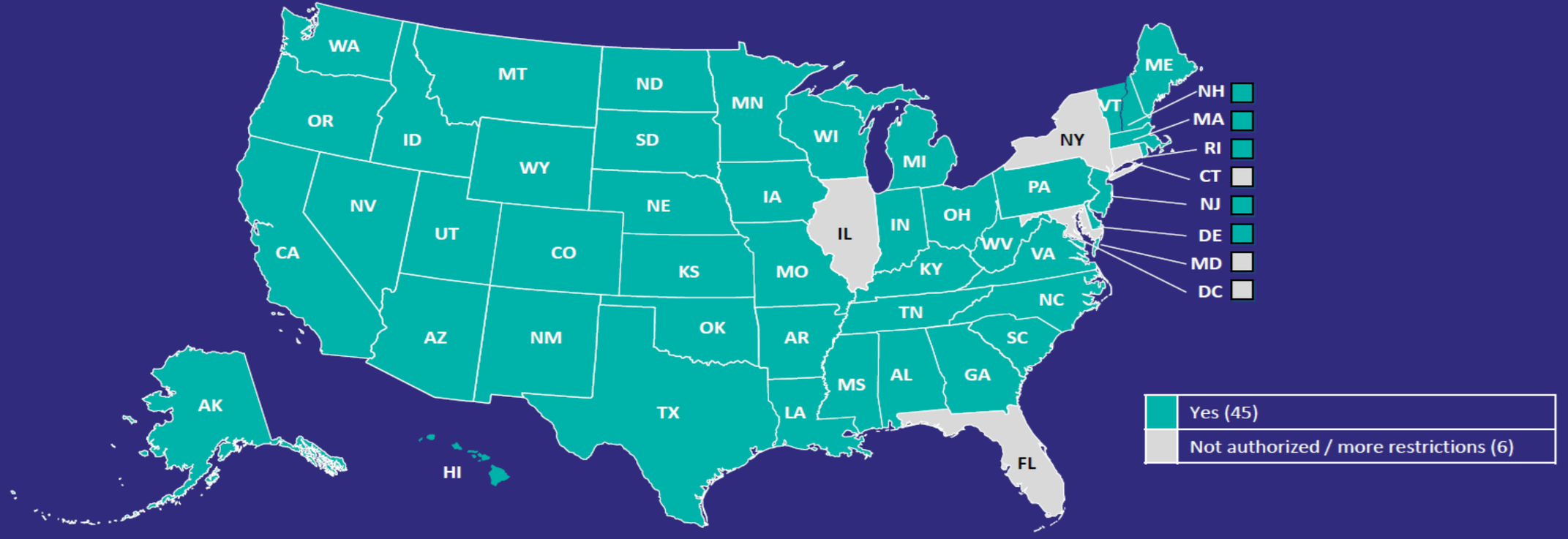


NH
MA
RI
CT
NJ
DE
MD
DC

	No, a pharmacist can prescribe the vaccine (17)
	No, a pharmacist can administer the vaccine via a prescriber approved protocol or non-patient specific order (32)
	A prescription is needed for certain vaccines, ages, or circumstances (2)

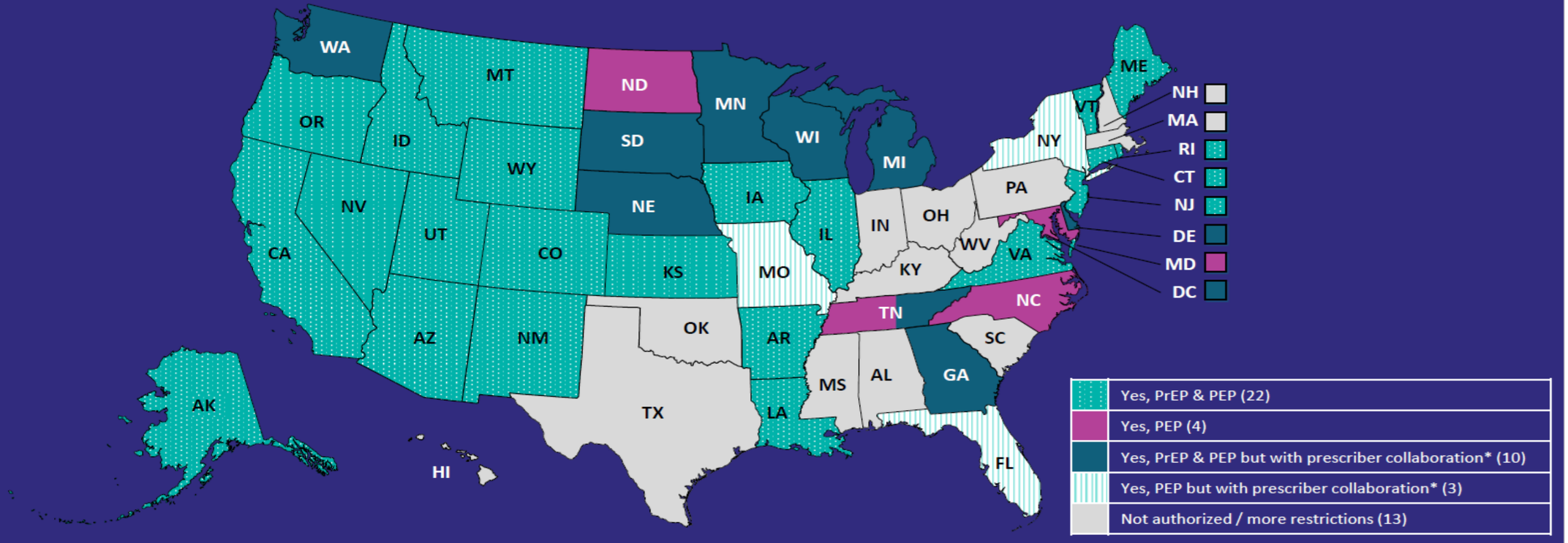
APhA

Can pharmacists administer injectable medications for the prevention of HIV?



Updated Aug. 2026
Source: APhA Analysis of State Policies; NASTAD Pharmacists' Authority to Initiate PrEP and PEP and Engage in Collaborative Practice Agreements

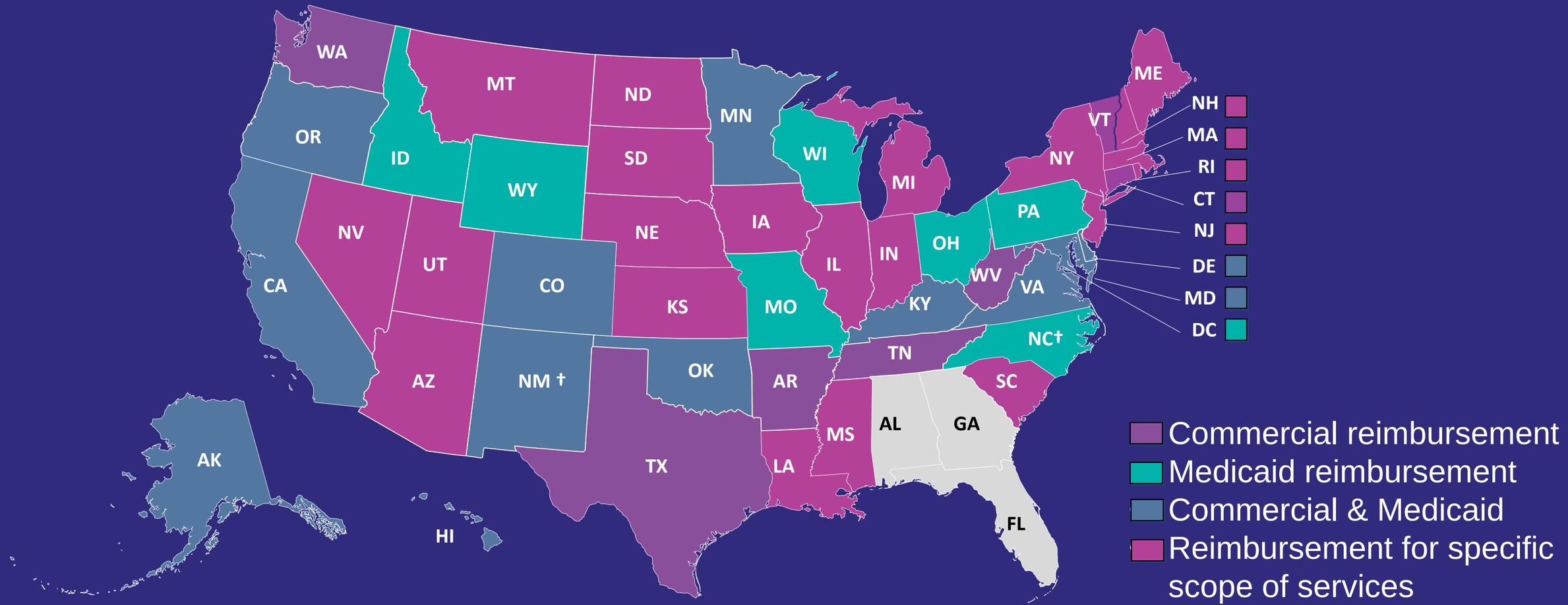
Can pharmacists furnish HIV PrEP/PEP via prescriptive authority, statewide protocol, or other means?



Updated July 2026

*Limited to collaborative practice agreements or prescriber protocols that allow multiple patients and do not require past prescriber-patient relationship

Payment for Pharmacists' Services in the States*



Updated July 2026

*Examples of states where pharmacists are receiving reimbursement for a broad or narrow scope of their patient care services. Not intended to be a comprehensive representation.

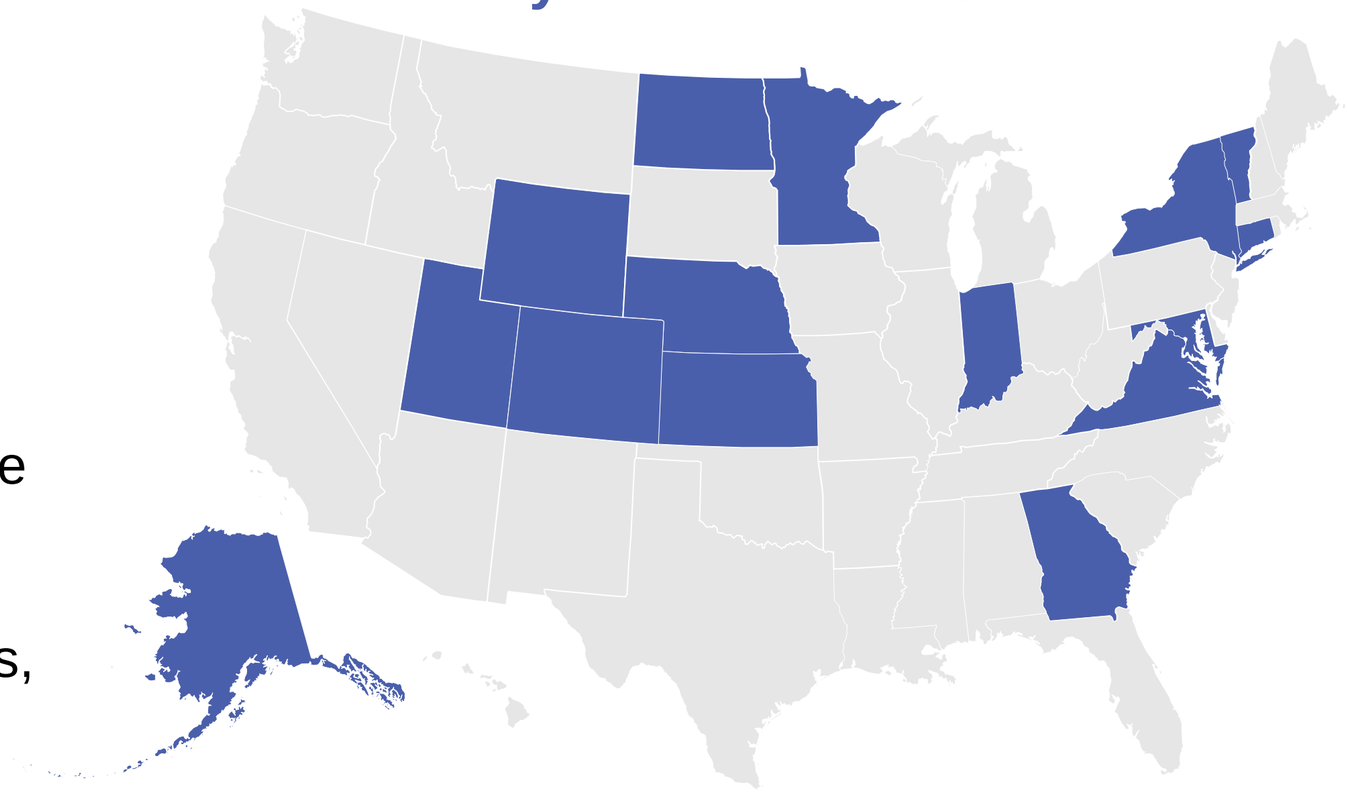
†Pharmacist reimbursement for a broad scope of services is largely tied to the requirement of being an advanced practice pharmacist

APhA

Scope of practice

- **2026 scope activity included:**
  - Vaccines and immunization standards
  - Contraception access
  - HIV PrEP/PEP
  - Tobacco cessation
  - Test-and-treat authority
  - Emergency refills
  - Collaborative practice modernization
  - Standard of care and broad prescriptive authority
  - Examples: WY SF 121, ND SB 2402, GA HB 1138, MD vaccine and CPA bills, NY vaccine standard bills, VA HB 232

Examples of 2026 Policy Advancements

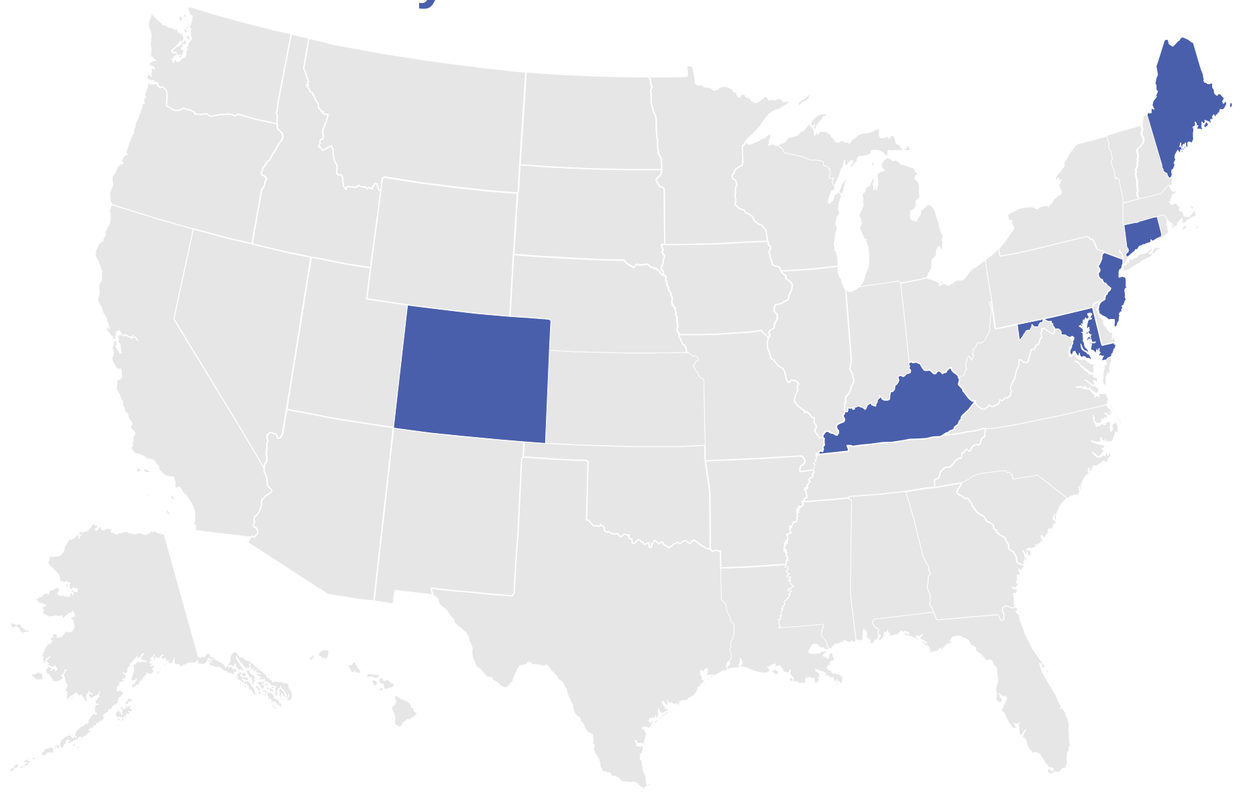


*Examples of legislative, regulatory, or policy advancements and not intended to be a comprehensive representation

Payment for services

- **Trends in payment bills:**
  - Coverage for pharmacist-provided clinical services
  - Prohibitions on denying coverage solely because the provider is a pharmacist
  - Medicaid and commercial plan reimbursement requirements
  - Payment tied to state-authorized scope
  - Growing connection between public health services and reimbursement
  - Examples: CO HB 26-1336, CT HB 5375, KY HB 3, MD SB 385 / HB 637, ME HP 1384

Examples of 2026 Policy Advancements



*Examples of legislative, regulatory, or policy advancements and not intended to be a comprehensive representation

Maryland Senate Bill 676 **Health Insurance - Reimbursement for Services Rendered by a Pharmacist**

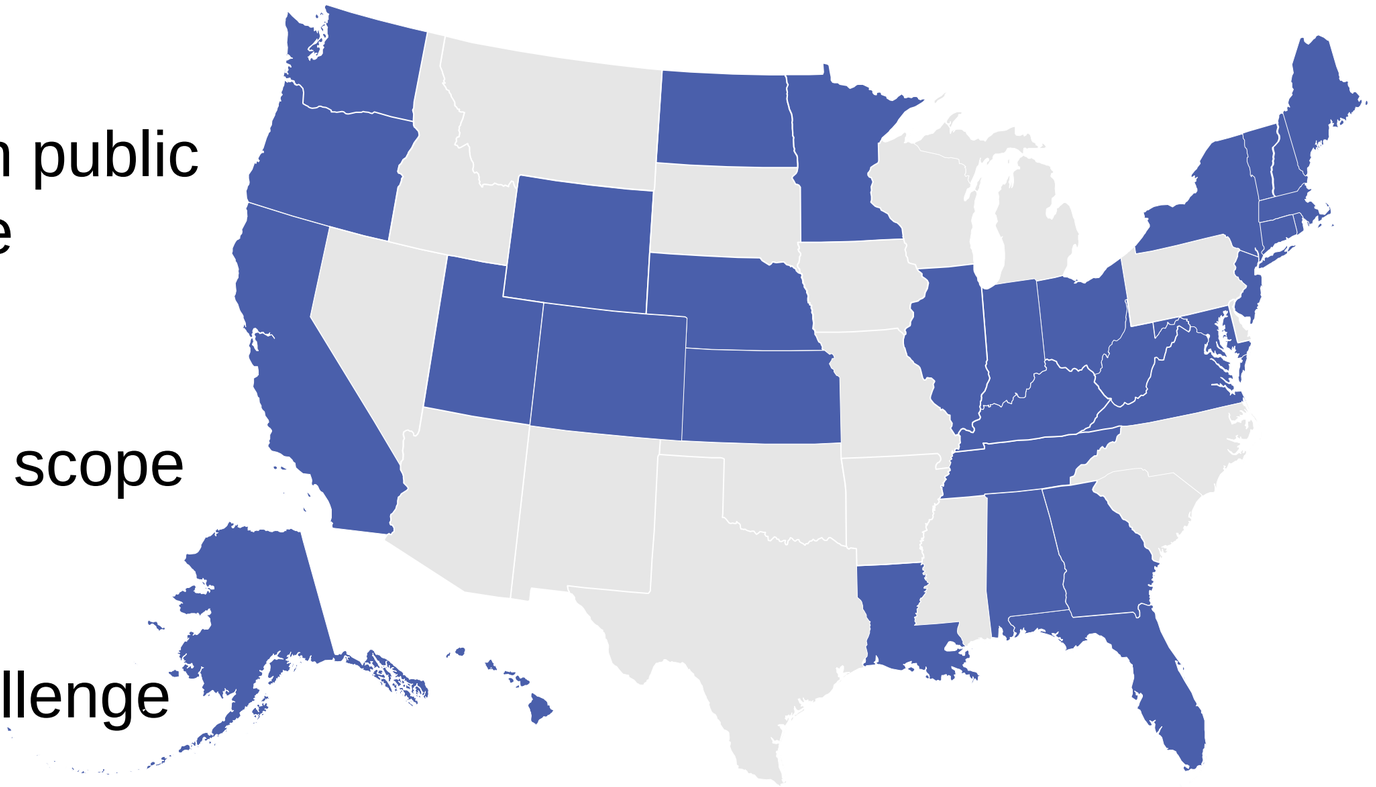
Pharmacist Payment for Services

- SB 678 - Health Insurance - Reimbursement for Services Rendered by a Pharmacist was passed by the General Assembly last week.
- The bill creates a pathway for pharmacists to be paid for providing their clinical services, regardless of practice setting. This is a big win for pharmacy in Maryland and will allow pharmacists to be paid by Medicaid MCOs and commercial payers, among others for their services outside the scope of PBMs

State Policy Update: 2026 Themes

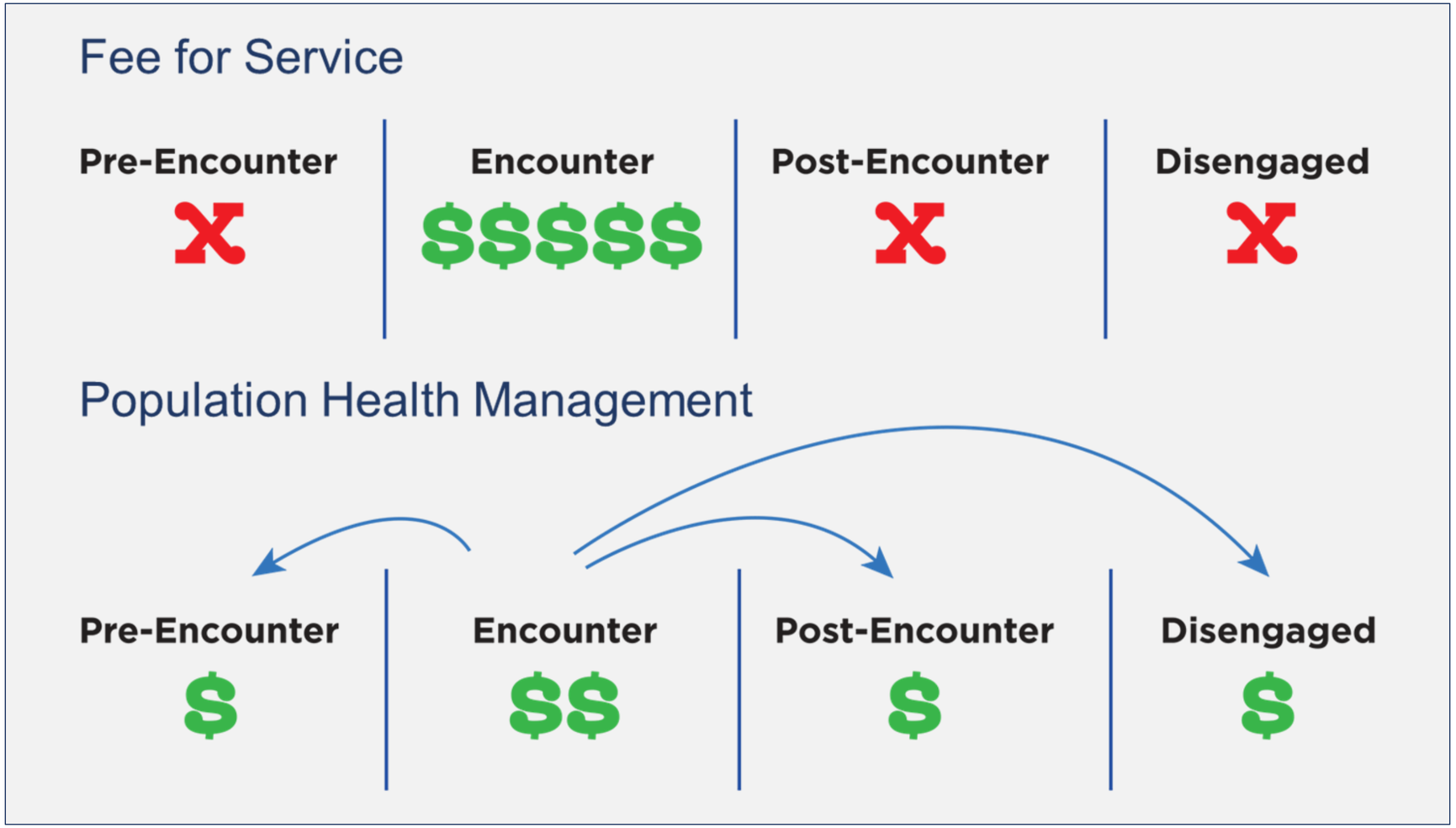
- PBM reform remained the highest-volume state policy area
  - >30 PBM bills enacted
- Scope bills increasingly focused on public health access and broader practice models
  - >20 scope bills enacted
- Payment policy is starting to follow scope expansion
  - 10 payment bills enacted
- Implementation is now the key challenge

Examples of 2026 Policy Advancements



*Examples of legislative, regulatory, or policy advancements and not intended to be a comprehensive representation

Value-Based Care/Population Health
Cost-Effective Care



Ensuring Community Access to Pharmacist Services Act (H.R.3164, S.2426), now the…..

Main Street Pharmacy Access Act

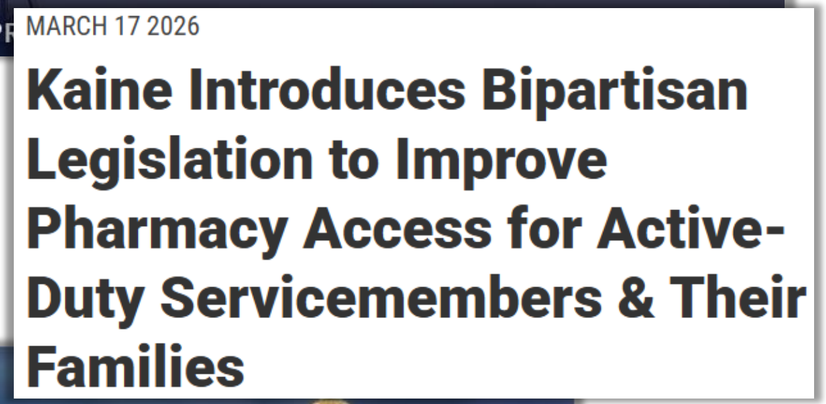
- What happened and what is next

- [x] **W&M Legislative Hearing**
- [x] **Ways & Means Markup (w/funding)**
- [ ] **Energy & Commerce, House Floor and Senate**

What's next?

Rx ACCESS Act (H.R. 6400 / S. 4106)

- Rep. Jen Kiggans (R-VA-1) and Sens. Tom Cotton (R-AR), Tim Kaine (D-VA)
- Addresses access, reimbursement, and audit concerns
- APhA-drafted audit language amendment added to NDAA FY27
- Aiming for data to prove network inadequacies and unfair reimbursement practices; rebid PBM contract



PBM Reform

- **Room for more?**
- **Included: Require "reasonable and relevant" Medicare Part D pharmacy contracts and payments. RFI (2027), Regulations (2028), Implementation (2029)**
- **Included: Delink PBM compensation from the cost of medications. RFI (2026)**
- **Included: Promote PBM transparency for both employers and patients in their prescription drug plans. (2028)**
- **Missing: Medicaid spread pricing**

Analysis of CMS's Standard-Setting Authority under Section 6223 of the Consolidated Appropriations Act, 2026

Prepared by Conor Sheehey, Director, Leavitt Partners

Memorandum Purpose

This memorandum was prepared on behalf of a coalition of pharmacy stakeholders in response to discussions with the Centers for Medicare & Medicaid Services (CMS) regarding implementation of section 6223 of the Consolidated Appropriations Act, 2026. The analysis is intended to assist CMS in evaluating the scope of its authority to establish and enforce standards governing "reasonable and relevant" pharmacy contract terms and conditions under Medicare Part D's any willing pharmacy requirements, including in the context of the Part D noninterference clause.

The memo analyzes the statutory text, legislative history, applicable rules of statutory construction, existing Medicare Part D precedent, and practical implementation considerations relevant to section 6223.

Executive Summary

Section 6223 of the Consolidated Appropriations Act, 2026 directs the Secretary of Health and Human Services to establish standards for "reasonable and relevant" contract terms and conditions under Medicare Part D's any willing pharmacy provisions. Congress included a "notwithstanding any other provision of law" clause to ensure that this authority operates without limitation from other potentially conflicting statutory language, including the Part D noninterference clause.

Need for PBM Reform: Vertical Integration

Vertical Business Relationships Within the U.S. Drug Channel, 2026

	BlueCross BlueShield	The Cigna Group	Centene Corporation	CVS Health	Elevance Health	Humana	UnitedHealth Group
Insurer ASO/TPA platform[1]	BlueCross BlueShield; luminare health[2]	cigna healthcare; Allegiance by Cigna Healthcare	Medicaid; wellcare; ambetter.	aetna; Meritain Health an aetna company	Anthem; Wellpoint; AmeriBen	Humana.	United Healthcare; UMR
PBM	Prime Therapeutics[3]	Express Scripts By Evernorth	Centene Pharmacy Services[8]	CVS caremark	carelon Rx[9]	Humana Pharmacy Solutions.	Optum Rx
GPO	synergie medication collective[4]	Ascent Health Services; Econdisc	—	zinc Health Services; Red Oak Sourcing	synergie medication collective[4]	—	EMISAR
Manufacturer	—	Quallent Pharmaceuticals	—	cordavis	—	—	nuvaila
Wholesale distribution	—	CuraScript SD By Evernorth	—	—	—	—	Optum Frontier Therapies
Specialty / Mail pharmacy	Prime Therapeutics Pharmacy[5]	Accredo By Evernorth; Express Scripts Pharmacy; Freedom Fertility By Evernorth; CarePathRx[6]	AcariaHealth Specialty Pharmacy	CVS specialty; Mail order pharmacy services	carelon Rx; BioPlus Specialty Pharmacy; A Carelon Company	CenterWell Specialty Pharmacy; CenterWell Pharmacy	Optum Specialty Pharmacy; Optum Frontier Therapies; cps[10]
Retail/LTC pharmacy	—	—	—	CVS pharmacy; Omnicare[11] a CVSHealth company	—	—	genoa healthcare; PHARMSCRIPT
Provider	—	Evernorth Behavioral Care Group; MD Live By Evernorth; VillageMD[7]	Community Medical Group; Magellan Health	CVS minute clinic; signifyhealth; Oak St. Health	carelon Health; carelon Behavioral Health	CenterWell Senior Primary Care; CenterWell Home Health; conviva Senior Primary Care	Optum

PBM = pharmacy benefit manager; GPO = group purchasing organization; LTC = long-term care; TPA = third-party administrator; ASO = administrative services only

1. Many large employers self-fund their health benefits and contract with ASO/TPA platforms for claims administration and network access.
2. Luminare Health (formerly known as Trustmark Health Benefits) was acquired by Health Care Service Corporation (HCSC) in October 2022 and now operates as an HCSC-owned third-party administrator. HCSC also holds an ownership stake in Prime Therapeutics.
3. Prime Therapeutics sources formulary rebates from—and has a 10% ownership interest in—Ascent Health Services, which is part of Cigna's Evernorth segment.
4. Synergie is a buying group focused on medical benefit drugs. Its primary owners are: Prime Therapeutics (40%); Elevance Health's CarelonRx (26.7%); and Evio Pharmacy Solutions (17.2%), which is itself owned by six Blue Cross Blue Shield health plans.
5. Prime Therapeutics Pharmacy was previously known as Magellan Rx Pharmacy. Some Prime clients can use Express Scripts for mail/specialty pharmacy services.
6. In 2023, Cigna's Evernorth Health Services acquired a 49% ownership interest in CarepathRx Health System Solutions, which assists hospitals and health systems with specialty pharmacy operations. In 2025, it acquired the remaining 51%, giving it full ownership of CarepathRx. in 2025, Evernorth also invested $3.5 billion for an undisclosed stake in Shields Health Solutions, the former Walgreens Boots Alliance subsidiary with a similar hospital-focused specialty pharmacy model.
7. In 2022, Cigna invested $2.7 billion for an estimated 14% ownership stake in VillageMD. Following Sycamore Partners' 2025 acquisition of Walgreens Boots Alliance, VillageMD is now a standalone private company. In 2024, Cigna determined that its investment in VillageMD was fully impaired and recorded a $2.7 billion loss.
8. Centene began outsourcing its PBM operations to Express Scripts in 2024. In 2023, Centene rebranded its Envolve Pharmacy Solutions pharmacy benefit subsidiary as Centene Pharmacy Services.
9. CarelonRx sources formulary rebates from—and has an undisclosed minority interest in—Zinc Health Services, which is a subsidiary of CVS Health.
10. In 2024, UnitedHealth Group acquired CPS Solutions, which provides specialty pharmacy services to hospital and health systems.
11. In May 2026, the U.S. Bankruptcy Court for the Northern District of Texas approved the sale of Omnicare to GenieRx Holdings LLC.

Source: *The 2026 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Exhibit 267. Exhibit does not illustrate every subsidiary business operated by each company.

DRUG CHANNELS INSTITUTE
An HMP Global Company

PBM Reform

2026 Addressing Structural Conflicts of Interest, Patient Safety, and Market Distortions by Pharmacy Benefit Managers

1. APhA supports structural, financial, and operational safeguards, **including separation requirements <u>where necessary,</u>** to address conflicts of interest between pharmacy benefit managers, insurers, pharmacies, and affiliated entities in the pharmaceutical supply chain.

2. APhA supports policies that prohibit pharmacy benefit managers, insurers, pharmacies, and affiliated entities in the pharmaceutical supply chain from using ownership relationships or vertically integrated market power to engage in patient steering, self-preferencing, discriminatory reimbursement, anticompetitive network design, or other practices that restrict patient choice, undermine pharmacy access, increase patient and total cost of care, or restrict access to clinically appropriate medications or interfere with pharmacist clinical judgement.

PBM Reform

2026 Addressing Structural Conflicts of Interest, Patient Safety, and Market Distortions by Pharmacy Benefit Managers

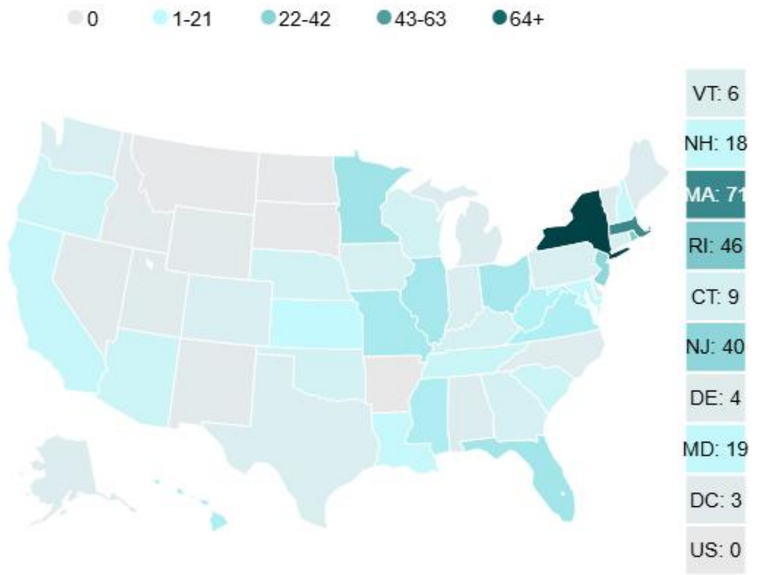
3. APhA supports enforceable structural remedies when vertically integrated ownership arrangements create conflicts of interest that harm patients, pharmacies, competition, or the delivery of clinically appropriate care.

4. APhA supports state and federal oversight, transparency, and enforcement authority to prevent anticompetitive and discriminatory business practices by vertically integrated pharmacy benefit managers, insurers, and affiliated entities

2026 EOY State Priorities

Advance state legislation

- **Expand scope of practice for pharmacists (Target 5 states)**
- **Support standard of care regulatory transition (Target 5 states)**
- **Expand payment for pharmacists' service programs**
- **Increase PBM transparency and accountability**
- **Improve pharmacy dispensing reimbursement sustainability**
- **Preparing for next vaccine respiratory season policy changes**
- **Preparing for 2027 state legislative sessions**



	Scope/ Payment	PBM Reform
Introduced	35 (+6)	108 (+2)
Considering	19 (-5)	9 (-2)
Passed	62 (+12)	42 (+5)
Failed	157 (+11)	195 (0)

The Political Landscape

- **Midterm elections**
- **The bill formerly known as ECAPS**
- **Health care packages and limited vehicles**
  - **Reconciliation 2.0, 3.0**
  - **End-of-year health care package**
- **RFK**
- **AMA, other barriers**
- **Implementing PBM reform**
- **What's next?**

Stay Informed!

APhA members receive a bi-weekly legislative and regulatory update with the latest news you need to know!

LEGISLATIVE AND REGULATORY UPDATE APhA

An exclusive benefit for APhA members *June 18, 2026*

Stay up to date on the laws and policies that affect your pharmacy practice.
Connect with us: APhAGovernmentAffairsTeam@aphanet.org.

News from federal agencies

APhA urges pharmacy integration in data exchange

Following a recent meeting with the HHS Office of the National Coordinator for Health Information Technology (ONC) at a listening session on clinical data exchange, APhA called on ONC and CMS to ensure pharmacists are fully included in interoperability efforts as essential members of the care team.

Read More

Workforce Transformation; Challenges

- Skill gaps in digital literacy
- Need for data interpretation skills
- **Burnout & staffing shortages**
- Expanding technician roles
- Technician competencies
- Foundational professional knowledge
- Quality assurance
- Value-based-Care
- Team-based Care

Key Takeaways

Health Care Transformation and Needs

Pharmacy is rapidly evolving.

Technology is central to future practice.

Consumer expectations demand accessibility & personalization.

Regulatory & reimbursement barriers must be addressed.

Pharmacists and technicians are essential leaders in future care models.

Cost of Non-Optimized Medication Use

$528 billion *wasted*

275,000 lives *lost*

For every **$1** *spent* on meds, **$1.55** *spent* *fixing* med issues

Pharmacists are Accessible

89% of Americans live within **5 miles of a pharmacy.**[1]

340,000 pharmacists in the United States.

- there are **15.1% more pharmacy locations** within low-income communities than physician practices, and[3]
- pharmacy locations offer **95.7% more operating hours than physician practice sites.**[4]

https://www.pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=BdS0HbVWDtw%3d

Integration = Innovation

- Pharmacist integration = better care + better ROI

Access

- 50% of clinics have pharmacies, but few integrate pharmacists and their services

Quality

- Pharmacists boost HEDIS scores and close care gaps

Team-based care

- 77% of patients agree that pharmacists are integral to their care team

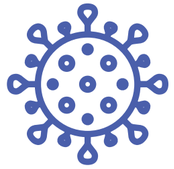

Future Pharmacy
AI

Pharmacists' Clinical Services

These are examples of services provided by pharmacists. There are many others beyond these.

- **Immunizations**

- **Cardiovascular disease**



- **Infectious disease**

- **Test-and-treat**

- **Women's health**

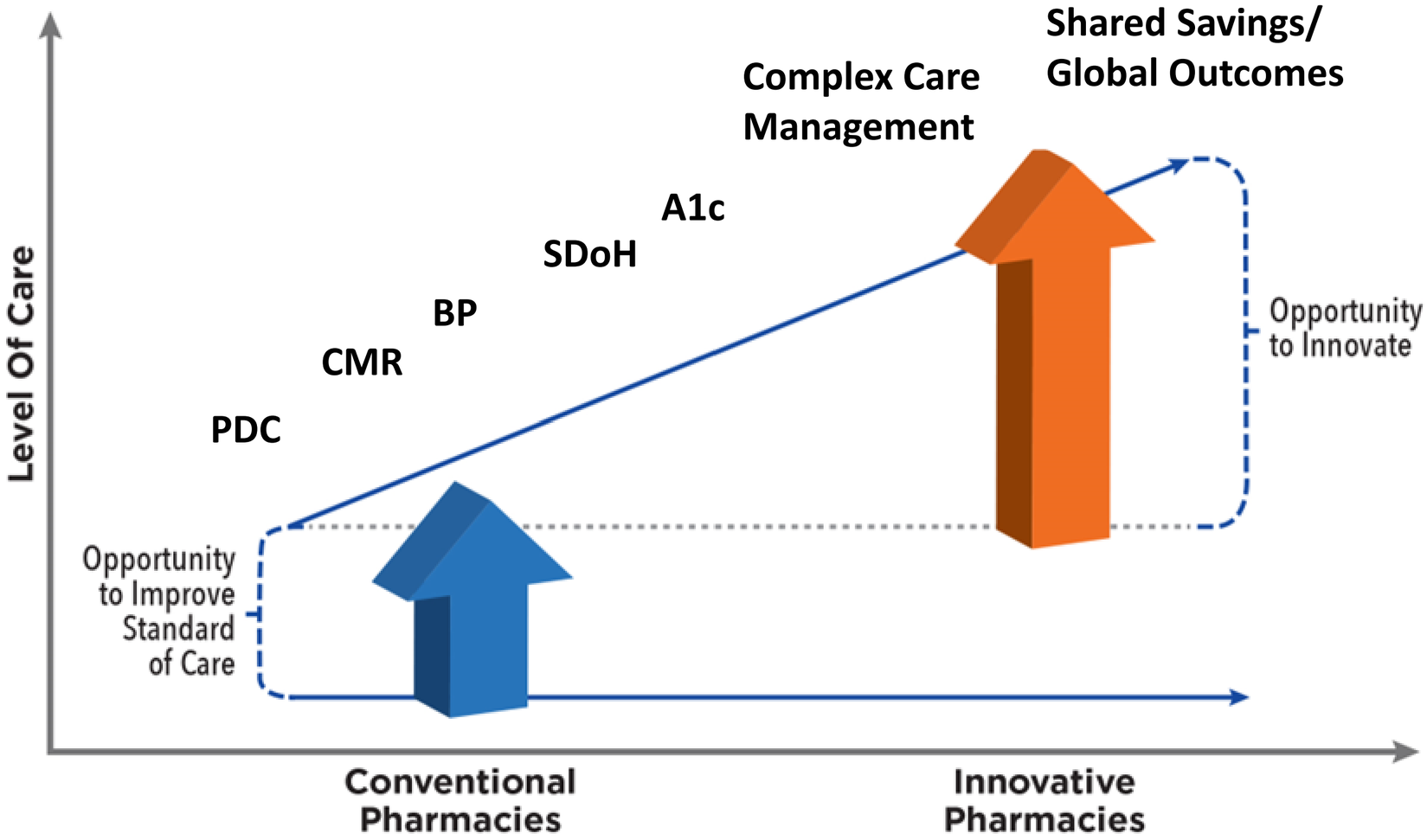
- **Tobacco cessation**

Mental and behavioral health

Research

The Pharmacy Profession View:

The Blue Pill or the Orange Pill?



Puerto Rico

Poster de la percepción de farmacéuticos y empleadores sobre el mercado laboral en Puerto Rico.

"Los hallazgos subrayan la importancia de desarrollar estrategias para fortalecer la fuerza laboral farmacéutica en Puerto Rico. La percepción de oportunidades limitadas de crecimiento profesional y los retos económicos resaltan la urgencia de promover la sostenibilidad de práctica de la profesión, ampliar la provisión de servicios clínicos y diversificar los escenarios de práctica. Estos resultados sirven como base para futuras iniciativas y políticas dirigidas a apoyar el desarrollo de la profesión."

Imagine the Future

- Let’s partner for impact.
- Build care teams that meet community needs.
- And make sure every patient has a pharmacist by their side. Personal Pharmacist

POST TEST

Which of the following emerging technologies is most likely to transform pharmacy practice by enhancing clinical decision-making and workflow efficiency?

A. Electronic Health Records
B. Artificial intelligence and data analytics
C. Manual pill counters
D. Robotic dispensing machines

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Rationale: A, C and D are in place and have improved pharmacy practice, it does not impact clinical decision making like artificial intelligence and data analytics does.

POST TEST

Patients increasingly expect pharmacy services to be more accessible through digital, virtual, and hybrid care models.

A. TRUE
B. FALSE

POST TEST

Patients increasingly expect pharmacy services to be more accessible through digital, virtual, and hybrid care models.

A. TRUE
B. FALSE

Correct Answer: True

Rationale:
Consumer demand is shifting toward convenience, personalization, and rapid access to care. Telepharmacy, mobile health platforms, and virtual counseling align with these expectations. Pharmacies that adopt these models can improve engagement and patient satisfaction.

POST TEST

Which barrier most significantly limits the expansion of advanced pharmacy practice across the United States and Puerto Rico?

A. Increased interest in clinical roles among pharmacists

B. Regulatory restrictions on pharmacist scope of practice

C. Widespread availability of telehealth technologies

D. Growing patient familiarity with digital tools

POST TEST

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A. Increased interest in clinical roles among pharmacists

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C. Widespread availability of telehealth technologies

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Rationale:
Variability in state laws and limits on pharmacists' authority—such as prescribing, ordering tests, or billing—hinder consistent expansion of advanced clinical services. Other factors, such as technology adoption, are more favorable. Regulatory change remains essential for practice transformation

POST TEST

Which strategy best supports sustainable compensation for pharmacists providing advanced clinical services?

A. Increasing the number of dispensing tasks performed

B. Advocating for provider recognition and compensation mechanisms

C. Eliminating documentation requirements

D. Reducing collaboration with physicians and nurses

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Correct Answer: B. Advocating for provider recognition and reimbursement mechanisms

Rationale:

Provider recognition enables pharmacists to be reimbursed for clinical services, which is critical for sustaining value-based and primary care models. Without payment structures, new services remain financially unsustainable. Advocacy is key to expanding practice authority and compensation pathways.

POST TEST

Data privacy, cybersecurity risks, and public trust concerns are important considerations when integrating digital health and AI tools into pharmacy practice.

A. True

B. False

POST TEST

Data privacy, cybersecurity risks, and public trust concerns are important considerations when integrating digital health and AI tools into pharmacy practice.

A. True

B. False

Correct Answer: True

Rationale:

Digital tools rely on sensitive patient health information, making privacy and cybersecurity essential. Breaches or misuse may undermine public trust and slow adoption. Pharmacists must understand these issues to implement technology safely and ethically.

Thank you
Gracias

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