

# Optimizing Pharmacist Provider Roles: *Insights from the Pennsylvania Pharmacist Provider Summit*



Pennsylvania  
Pharmacists  
Association



PA Pharmacists  
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## **Table of Contents**

|                 |      |
|-----------------|------|
| Overview        | 2    |
| Introduction    | 3    |
| Sessions        | 4    |
| Key Findings    | 5-6  |
| Recommendations | 6-11 |
| Conclusions     | 12   |
| Special Thanks  | 13   |
| References      | 14   |

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## Overview:

The 2025 PPA Pharmacist Provider Summit brought together pharmacists, payors, and healthcare leaders to address barriers and opportunities for pharmacist-led care. Key findings highlight challenges in Medicaid enrollment, credentialing, and reimbursement, as well as opportunities to enhance patient outcomes through collaborative care, innovative payment models, and integration into primary care teams.

Pennsylvania is facing a growing crisis in pharmacy access. Across the Commonwealth, patients are experiencing limited access to pharmacies due to closures, particularly in rural and inner-city communities, where geographic and socioeconomic barriers compound the problem. These gaps reduce timely access to medications, patient counseling, and other essential services, worsening health disparities.

Medication mismanagement, adherence issues, and lack of timely access to pharmacists contribute to millions of dollars in avoidable healthcare costs each year. Pharmacists are uniquely positioned to help address challenges through direct patient care, medication management, and collaborative care models.

Importantly, mail order pharmacies and telehealth services are not driving these access issues. The problem stems from local pharmacy closures and inadequate access to in-person pharmacy care, which disproportionately impacts vulnerable populations.

Other barriers include difficulties with Medicaid enrollment, credentialing, and reimbursement for pharmacist-led services. Expanding pharmacist-led care and integrating pharmacists into primary care teams can improve patient outcomes, reduce costs, and help ensure equitable access to essential pharmacy services across Pennsylvania.

This document provides actionable recommendations to streamline operational processes, support pharmacist-led services, and align policy reimbursement priorities.

## Introduction:

Pharmacists play a critical role in healthcare quality, accessibility, and outcomes. Expanded scope of practice, including immunizations, point-of-care testing, wellness programs, chronic disease management, and preventative care services position pharmacists as essential members of interprofessional care teams. As of March 1, 2024, Pennsylvania pharmacists have Medicaid provider status in the state, and many have enrolled and become credentialed by health plans. However, pharmacists in the Commonwealth continue to face operational, legislative, and reimbursement challenges that limit the delivery of patient-centered care.

In September 2025, an inaugural statewide summit was held in Harrisburg, Pennsylvania. The event brought together stakeholders in pharmacy from across the state and nation representing multiple areas of pharmacy practice:

- Academia
- Clinically integrated pharmacy networks
- Legislative advocates
- Managed care organizations
- National pharmacy association representatives
- Pharmacists representing community pharmacy, health system, ambulatory care and FQHCs
- State agency representatives

The intent of the summit was to discuss the evolving role of pharmacists as providers and explore opportunities to expand pharmacist-led services across the state.

The PPA Pharmacist Provider Summit opened with an inspiring keynote delivered by Randy McDonough, President of the American Pharmacists Association. His address, titled *From Practice Transformation to Disruption*, set the tone for an engaging and forward-thinking event. The address explored how current healthcare trends are reshaping independent pharmacies and influencing their role in patient care. Randy McDonough highlighted the evolving landscape of community pharmacy, noting significant challenges such as declining reimbursement rates and increasing regulatory complexity. At the same time, he emphasized emerging opportunities, including expanded clinical services and integration into value-based care models. This shift has driven a fundamental transformation from a product-focused approach to a patient-centered model where pharmacists deliver personalized care, manage chronic conditions, and collaborate within interdisciplinary teams to improve health outcomes.

## Summit Agenda:

Keynote Address: The Role of the Pharmacists in Healthcare Transformation

**Randy McDonough, PharmD, MS, BCACP, BCPS, FAPhA** | President, American Pharmacists Association

Session #1: Interprofessional Collaboration: Pharmacists and Physicians Collaboration to Improve Patient Outcomes

**Autumn Stewart-Lynch PharmD, BCACP, BC-ADM, CDES** | Professor of Pharmacy Practice Duquesne University School of Pharmacy (Ambulatory Care)

**Alex Rothey, PharmD** | Co-Owner Hilltop Pharmacy, Pittsburgh, PA (Community Pharmacy)

**Garrett Sipes, Pharm.D.** | Pharmacist Keystone Health Pharmacy (FQHC)

Session #2: Expanding Pharmacists-Led Services Through Medicaid

Presentation: Understanding the Pharmacist's Scope and Payment in Pennsylvania

**Rick Seipp, PharmD** | President, Value Drug Company

**Nicole Hasson, PharmD** | Director of Pharmacy Strategy, Value Drug Company

Panel Discussion: Bridging the Gap in Provider Status Adoption with Perspectives from Other States

**Shannon Steele, RPh, MSc** | Community Program Manager CareSource Ohio

**Mark Pilkington, BS, MS** | Executive Director, Pharmacy Profiles

**Eric Yarnell** | Vice President, Pharmacy, Highmark Wholecare

**Emily Katz** | PA Medicaid Managed Care Organizations, Consultant

Session #3: Case Studies: Successful Pharmacist Integration Strategies

**Michael Murphy, PharmD, MBA** | Advisor for State Government Affairs, American Pharmacists Association

**Cody Clifton, PharmD** | Director of Practice Transformation and Clinical Programs, CPESN

Session #4: Breakout Sessions – Identifying Barriers & Opportunities for pharmacy collaboration in Pennsylvania

- Session 1: Overcoming Barriers to Medicaid Enrollment & Credentialing
- Session 2: Maximizing Reimbursement & Sustainable Service Models
- Session 3: Pharmacy-Health Plan Partnerships for Expanded Services
- Session 4: Overcoming Legislative & Payor Barriers for Pharmacy Services in PA

## Key Findings:

### 1. Medicaid Enrollment & Credentialing Barriers

Pharmacists in Pennsylvania hold Medicaid provider status as midlevel practitioners. To bill MCOs, they must first become providers, then complete credentialing through CAQH and contracting with each payer, processes that typically take 90-180 days and vary by payer type (facility, specialty, ancillary).

Eligible services include immunization, point of care testing (COVID-19, flu, RSV), wellness programs, preventive care, and disease management. Limitations include no independent test to treat prescribing, and POCT restrictions. Coverage varies by place of service (in-person, at-home, telehealth) and the One Big Beautiful Bill (OB3) may increase administrative workload.

Operational challenges include variable payer requirements, special certifications, limited understanding of pharmacist services, and scaling issues in larger organizations. Streamlining efforts such as coordinated credentialing, centralized guidance, and consolidating the process can reduce barriers and improve efficiency.

### 2. Maximizing Reimbursement & Sustainable Business Models

Breakout discussions highlighted that pharmacy teams face challenges with reimbursement for clinical services with limited financial incentives. Sustainable payment models should account for patient complexity, time investment, and documentation requirements. Ideal approaches include per-patient fees or value-based contracts that balance effort and outcomes, ensuring services such as diabetes education, blood pressure screenings, and wellness programs are financially viable for pharmacies.

### 3. Health Plan and Healthcare Professional Partnerships

Breakout sessions highlighted strategies for expanding pharmacy services through collaboration with health plans, physicians, and community partners. Pharmacists serving underserved populations emphasized starting small, focusing on high-impact services, and integrating social determinants of health (SDOH) support with appropriate reimbursement. Assigning patients a “home” pharmacy and improving follow-up processes were noted as key to effective care.

Partnerships with employers and health plans can help overcome reimbursement

barriers, while local relationships and consistent service offerings increase patient engagement and access. Local, independent pharmacies are often better positioned to build and maintain strong relationships with providers on behalf of their patients, supporting continuity of care. In contrast, large retail pharmacies may face challenges related to corporate structures and operational expectations that can limit the ability to deliver more personalized, relationship-driven services. The expansion of telehealth further enhances collaboration by enabling timely, virtual communication between pharmacists and providers, improving care coordination and continuity, particularly for patients in underserved or remote communities. Overall, success depends on aligning pharmacist services with community needs, standardizing practices, and fostering stronger connections between pharmacies, health systems, and payors.

#### 4. **Legislative and Operational Barriers**

Pharmacists face legislative challenges including lack of full provider recognition, scope-of-practice limitations, and lab licensing restrictions. Advocacy efforts such as “Hill Days” or Legislative Fly-ins, multi-disciplinary partnerships with prescribers and insurers, and targeted legislation are key to addressing these barriers.

Operational challenges include limitations in billing systems, staffing, training, workflow, physical space, and data collection. Strategies to overcome these include streamlined credentialing and licensing, enhanced billing infrastructure, updated workflows, staff training, and guidance documents. Collaboration across pharmacy associations, medical societies, and payors, along with consistent advocacy and demonstration of pharmacists’ value, is essential to align policies and expand sustainable pharmacist-led services.

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## **Recommendations:**

### **1. Streamline Medicaid Enrollment & Credentialing**

Pharmacies and pharmacists should be able to enroll and become credentialed with Medicaid and Managed Care Organizations (MCOs) quickly, consistently, and with minimal administrative burden. The outcome looks like predictable timelines, uniform requirements across payors, and fewer administrative hurdles, so patients get timely access to pharmacist-delivered care, and pharmacies can spend more time on clinical services.

- a. Standardize credentialing processes across MCOs – create a uniformed application packet and checklist accepted by all MCOs. Establish clear service-level agreements

and reciprocity for credentialing across plans when the pharmacist's credentials are already verified.

- i. Example: A pharmacy that hires a new clinical pharmacist submits one consolidated application. Every Medicaid MCO accepts the same packet, eliminating duplicative forms.
- b. Centralize training and resources for pharmacy staff to reduce administrative burden
  - i. Create a state-supported resource hub with plain-language guidance, short training modules, template forms, and live office hours to help front-line staff.
    - 1. Example: Pharmacy team member uses a standardized checklist from the resource hub to complete enrollment update, avoid back and forth with the different MCO portals.
- c. Encourage payors to recognize full scope of pharmacist services, minimizing exceptions and duplicative paperwork
  - i. Update billing policies to clearly list pharmacist-delivered services and allow pharmacists to bill under their own NPI where applicable.
    - 1. Example: Washington State Pharmacist Provider Status Under Washington's ESSB 5557, commercial health plans are prohibited from excluding pharmacists from their provider networks. This requires payors to update their billing manuals to explicitly list pharmacists as eligible providers for specific Current Procedural Terminology (CPT) codes. For instance, a pharmacist managing a patient's anticoagulation therapy bills the insurer directly using their NPI, rather than folding the cost into a "facility fee" or pharmacy "dispensing fee." This shift reduces administrative barriers by standardizing the credentialing process and ensuring that pharmacists are not subjected to unique, burdensome reporting requirements that do not apply to other providers.
    - 2. Recommendation: Pennsylvania should seek to adopt a pharmacy standard of care legislation to ensure pharmacists can bill under their own NPI where applicable.

In 2024, the state of Iowa passed the pharmacy Standard of Care (SOC) legislation, enacted through House File 555. This legislation is crucial because it eliminates "regulatory lag" during public health shifts or medical advancements. Under the old prescriptive model, Iowa pharmacists were limited to a specific list of duties; if a new

vaccine or diagnostic test was developed, they could not provide it until the legislature manually updated the law or the Board of Pharmacy issued new rules.

Under the new SOC framework, pharmacists can exercise professional judgment to provide services—such as Point-of-Care (POC) testing for flu or strep and subsequent treatment—without waiting for legislative permission. This is vital for rural lowans who may live miles from a physician but have immediate access to a local pharmacist. By shifting the legal benchmark to what a “reasonably prudent pharmacist” would do, the law ensures that patient care evolves at the speed of clinical medicine rather than the speed of the legislative process.

## 2. Expand Sustainable Payment Models

Pharmacists need reliable, fair reimbursement that recognizes both patient outcomes and the professional effort invested by pharmacists. Effective payment approaches create predictability for staffing, enable investment in team-based care, and align incentives across providers and payors.

- a. Fair reimbursement for dispensing plays a crucial role in building a sustainable business model for pharmacies to exist, especially in rural and underserved areas; in addition, it enables the pharmacy to expand into provider-enhanced reimbursed services. Policy makers suggest that implementation of a transparent “Cost-Plus” model, such as NADAC plus a fair market professional dispensing fee, ensures that a pharmacy’s fees cover actual operational costs while maintaining drug price transparency. This approach not only recognizes the professional effort and outcomes of pharmacists but also allows them to focus on medication optimization. Improved medication management can significantly reduce the most expensive costs in healthcare, such as hospitalizations and emergency room visits, ultimately leading to better patient outcomes and cost savings.
- b. Implement value-based contracts that reward both clinical outcomes and pharmacist effort.
  - i. Design contracts that tie bonuses to meaningful outcomes (e.g., blood pressure control, A1c improvement, medication adherence) and include activity-based recognition for time spent on complex care (care coordination, counseling, monitoring).
    1. Example: A pharmacy receives a performance payment for achieving hypertension control targets in its panel and a

supplemental payment for documented care coordination hours for patients with multiple chronic conditions.

- c. Develop per-patient fees based on service complexity and time invested that align with physician reimbursement models.
  - i. Introduce tiered per-member-per-month fees or visit-based payments calibrated to service intensity (brief check-in, standard visit, complex care management). Mirror existing physician reimbursement structures to facilitate consistency across settings.
    - 1. Example: A patient requiring monthly diabetes monitoring and medication optimization is assigned a “complex tier” with a higher per-patient fee; a stable patient receives a lower tier fee tied to quarterly touchpoints.
- d. Support pilot programs that demonstrate cost savings and quality improvement from pharmacist-led interventions.
  - i. Launch pilots with clear inclusion criteria, defined measures, and an independent evaluation plan. Focus on high-cost, high-need populations
    - 1. Example: A 12-month pilot funds pharmacist-led medication reviews for dual-eligible beneficiaries, tracking reductions in hospitalizations and total cost of care, with a pathway to convert the pilot into a permanent benefit.

### 3. Strengthen Collaborative Care & Integration

Better integration with physicians, health systems, and health plans ensures coordinated care and closes gaps more quickly. When pharmacies have access to shared health information and clear referral pathways, patients experience seamless care, fewer duplicative tests, and more timely interventions.

- a. Promote interprofessional communication through shared EHR access, e-care plans, and telehealth collaboration.
  - i. Provide secure, role-appropriate EHR access for pharmacists, enable e-care plans that are visible to all team members, and support telehealth consults between pharmacists and prescribers. Establish standardized documentation templates to streamline communication.
    - 1. Example: A pharmacist documents an updated medication list and home BP readings in the shared record; the primary care physician sees the note in real time and co-signs the plan via e-consult.
- b. Identify high-impact services tailored to local community needs, including underserved populations.
  - i. Use local data to prioritize services

1. Example: A community pharmacy in a transportation-limited area runs a mobile clinic for diabetes checks and medication synchronization, aligned with the local health department's outreach calendar.
- c. Develop frameworks for partnerships between pharmacies, health systems, and health plans to enhance patient-centered care.
  - i. Create memoranda of understanding, data use agreements, and shared protocols for referrals, follow-up, and care transitions. Define roles, performance metrics, and funding mechanisms
    1. Example: A health plan contracts with a network of pharmacies to manage post-discharge medication reconciliation within 72 hours, reducing readmissions and improving patient satisfaction scores.

#### 4. Advocate for Legislative & Policy Changes

Modernizing statutes and regulations ensures pharmacists can practice within their full scope of practice and be reimbursed for the care they already provide. Clear policy frameworks reduce ambiguity for payors and providers and accelerate access for patients.

- a. Pursue provider status recognition for pharmacists in all payor systems.
  - i. Pharmacists are increasingly delivering care that aligns with the standard of care<sup>1</sup> in primary and chronic disease management. Recognition as providers ensures that pharmacists can be reimbursed for services that are already evidence-based and widely accepted in clinical practice.
    1. Update state law and Medicaid policy to explicitly recognize pharmacists as billable providers for defined clinical services. Align plan policies so pharmacists can enroll, credential, and bill under their own identifiers where appropriate
      - a. Example: Pharmacists are listed alongside physicians, nurse practitioners, and PAs as eligible providers for chronic disease management codes, enabling direct reimbursement for documented visits.
- b. Expand scope of practice to include lab testing and test-to-treat authority where safe.

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<sup>1</sup> The standard of care (SOC) in health care regulation and law refers to the expected level of practice provided by a reasonable and prudent professional with similar qualifications in a similar situation. A standard of care (SOC) model is a flexible regulatory framework that allows pharmacists to practice at the top of their abilities, adapting to changes in their skills and patient needs without needing constant legislative approval for specific services.

- i. Pharmacists should be authorized to order and interpret routine lab tests, such as HBA1c for diabetes monitoring, when clinically indicated. Expanding test-to-treat authority would allow pharmacists to close gaps efficiently and safely.
  - 1. Authorize pharmacists to order and interpret routine labs (e.g., A1c for diabetes monitoring, lipid panels) and to initiate/select therapy under protocol for specific conditions with guardrails: accredited training, CLIA-waived testing, quality assurance, and data reporting to the patient’s primary provider.
    - a. Example: A pharmacist conducts an A1c check during a medication review, updates the care plan, and works with the prescriber to intensify therapy when indicated, closing a gap without requiring a separate appointment.
- c. Engage in multidisciplinary advocacy with insurers and medical societies to secure reimbursement pathways.
  - i. Build coalitions that include medical, nursing, and health plan stakeholders; present shared priorities (access, quality, cost reduction) and scalable payment models. Use pilots and measurable outcomes to support permanent coverage decisions.
    - 1. Example: A joint task force recommends a statewide care management benefit delivered through pharmacies for hypertension, backed by pilot results and aligned quality metrics.

## Conclusion

Pharmacists are integral to advancing patient care, optimizing medication use, and supporting value-based healthcare models. Through the Pharmacist Provider Summit, stakeholders across practice settings, payers, policy, and academia reached consensus that current scope of practice limitations prevent pharmacists from fully contributing to patient care and system efficiency. The Cicero Institute's *2025 Policy Strategies for Full Practice Authority* report reinforces this conclusion, demonstrating that enabling pharmacists to practice under a standard of care framework expands access to timely, high-quality services while maintaining accountability and patient safety.

Summit discussions highlighted that expanding pharmacist scope must be paired with clear pathways for implementation, including standardized credentialing, integration into team-based care, and sustainable reimbursement mechanisms. These priorities align with the goals of the [Rural Health Transformation Program](#), which emphasizes workforce optimization, innovative care delivery models, and improved access in rural and underserved communities. Participants identified pharmacists as essential partners in achieving these goals through services such as chronic disease management, medication optimization, test and treat models, and telehealth-enabled care.

By addressing legislative, operational, and payment barriers in parallel, policymakers and healthcare leaders can unlock the full potential of pharmacists as accessible providers and advance a more equitable, efficient, and sustainable healthcare system.

## Special Thanks

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**Summit Attendees:** Brandon Antinopoulos, Michael Baer, Terri Cathers, Matthew Cippel, Cody Clifton, John DeJames, James Drennen, Gregory Duran, Elizabeth Grassmyer, Kelsey Hake, Janet Hart, Nicole Hasson, Emily Katz, Sally Kozak, David LaTorre, Margie Lydon, Rob Maher, Randy McDonough, Courtney McMahan, Michael Murphy, Charlotte Nazar, Mark Pilkington, Kurt Proctor, Ron Raymond, Alexandria Rothey, Richard Seipp, Deron Shultz, Garrett Sipes, Ryan Smith, Thomas Snedden, Sydney Stawarz, Shannon Steele, Autumn Stewart-Lynch, Rebecca Taylor, Gail Weidman, and Eric Yarnell.

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