MILKEN INSTITUTE

July 2025

Advancing Health Through Expanded Access to Pharmacy-Based Care

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Executive Summary

Pharmacies are accessible health-care destinations that are well-positioned to support disease prevention, management, and treatment. Despite their accessibility and the effectiveness of highly trained pharmacists, the US health system lacks sustainable mechanisms to integrate pharmacy-based health-care services at scale. Although many states have expanded pharmacists' scope of practice, significant regulatory and reimbursement barriers persist. The result is a fragmented system wherein pharmacy care teams, health plans, other providers, and community members must navigate a patchwork of policies that create inconsistencies in health-care delivery and ultimately impact health outcomes.

The US health-care system faces mounting challenges, with chronic diseases accounting for 90 percent of the nation's $4.9 trillion annual health-care expenditures.[1] A declining primary care workforce, projected to be short 87,150 primary care physicians by 2037, exacerbates these challenges.[2] With 90 percent of Americans living within five miles of a pharmacy and most people visiting their pharmacist more frequently than their primary care provider, pharmacies serve as critical access points for care. The pharmacist's role in the health-care system has been increasingly elevated, starting in the 1960s, when there were several key changes to hospital outpatient care delivery, and continuing through the early 2000s, when a doctorate degree was required for entry-level pharmacists and vaccinations were offered at community pharmacies in all 50 states.[3] The COVID-19 pandemic is a demonstration of pharmacists' capacity to rapidly expand services at a nationwide scale to meet the public's dynamic needs, administering more than 340 million COVID-19 vaccines and providing access to testing and treatments across communities.

Although pharmacies have demonstrated promise to improve health outcomes and control health-care costs, pharmacists remain underutilized across the health-care system because of federal and state policy barriers. A patchwork of differing state policies has led to fragmented service implementation and access. Even in states where policies expand authorities for pharmacy-based health-care services, unclear reimbursement pathways have limited uptake. Pharmacists remain without a direct billing pathway to provide health-care services under Medicare Part B, and opportunities in Medicaid are limited and vary state by state. This complicated policy landscape has caused pharmacies and health plans to use fragmented, non-interoperable systems with varying standards, codes, and data methods, complicating efforts to scale partnerships.

To drive sustainable and scalable access, stakeholders must address several interrelated challenges to accelerate reimbursement for pharmacist-provided health-care services. First, **redefining the value proposition** of pharmacy-based health-care services to reflect

the existing body of literature, which demonstrates pharmacies' effectiveness in providing these services, will help to strengthen buy-in from key decision-makers. At the same time, **aligning on a prioritized set of health-care service interventions** that pharmacists are best positioned to provide—both now and in the future—will help to expand partnerships and increase awareness among advocates and consumers.

This report identifies 13 current pharmacy-based health-care service areas grouped into three categories that warrant increased focus: (1) chronic disease, (2) mental and behavioral health, and (3) routine reproductive and sexual health services. These areas of need are highly prevalent and costly to the health system. Leveraging pharmacists' accessibility and position as highly trusted health-care providers, these service areas build on existing pharmacy workflows and complement the services that pharmacists already provide. To ensure that services are effectively implemented across diverse pharmacy settings, **addressing infrastructure barriers**, such as credentialing, reimbursement mechanisms, workflow integration, and billing, will be critical. Finally, **navigating the complex policy landscape** remains essential, because federal and state regulations that dictate both pharmacists' scope of practice and reimbursement for the care they provide are woefully inconsistent.

This report explores these opportunities in depth, outlining both short- and long-term strategies to facilitate expanded access to pharmacy-based health-care services. It builds on efforts to catalyze pharmacist-provided Food Is Medicine care, which are hindered by limited payment mechanisms for pharmacist-provided health-care services. By addressing policy and implementation barriers, partners throughout the health ecosystem can unlock the full potential of pharmacies as essential public health champions.

Introduction

The US health system is at a major inflection point. Despite spending significantly more on health than other developed countries, the United States continues to experience worse health outcomes, with Americans living the shortest lives and facing the highest rates of avoidable deaths. Six in 10 Americans have at least one preventable chronic disease, most commonly heart disease, cancer, diabetes, obesity, or hypertension, with 90 percent of the nation's $4.9 trillion in annual health care expenditures for people with chronic and mental health conditions.[4] Prevalence rates and the costs of chronic disease are only continuing to grow, with the costs related to cardiovascular disease alone projected to top $2 trillion by 2050. With this soaring demand for services and their associated costs, the US health-care system is struggling to deliver value in improving people's lives.

The recently released Commonwealth Fund report, titled *Mirror, Mirror 2024*, compares health system performance in 10 countries on access to care, care process, administrative efficiency, equity, and health outcomes. The findings paint a dim picture of the US health system's performance, which ranks last overall.[5] Lack of affordability is driving many people to forgo doctor visits and thereby miss testing, treatment, and follow-up. Compared to their counterparts in most other countries, people in the US are more likely to report that they do not have a primary care physician or place of care and have more limited options for treatment outside of regular office hours.[6] Lack of access to routine care is a risk factor for recurrent hospital admissions, which places an additional burden on individuals and the health-care system.[7]

The shortcomings of the primary care system exacerbate these issues: chronic disinvestment in primary care in the US has resulted in national shortages of primary care physicians, especially in rural areas, with a projected deficit of approximately 87,150 physicians by 2037.[8] The acquisition of primary care practices by private equity investors is further disrupting the ecosystem with uncertain consequences for care access and quality. Often the first line of defense in managing chronic disease and preventable hospital visits, primary care is essential. Yet, with existing shortages, most primary care physicians lack the time to deliver all the preventive and chronic disease services needed.

To fill these gaps, other providers such as physician associates, nurse practitioners, community health workers (CHWs), and pharmacists are stepping in, helping to ease strain on the system while lowering costs for the health-care system. In addition, pharmacist-provided health-care services not only are typically less expensive than other care venues, including primary care, but also help to avoid the costs associated with unnecessary emergency room visits.[9]

Located within five miles of 90 percent of Americans, pharmacists have long been key health access points. They are highly trained in clinical care and effective in supporting disease prevention, management, and treatment. They do much more than dispense medicines—they conduct health screenings, provide disease education and management support, administer immunizations, and advise on the safe and effective use of medications. Most people visit their pharmacist more frequently than their primary care physician: A study of 11 million Medicare beneficiaries found that those with multiple chronic conditions paid their pharmacists an average of 13 visits per year and their primary care provider an average of 7 visits per year. The difference was almost twice as large in rural communities and among individuals with multiple comorbidities.[10]

Pharmacies most recently demonstrated their ability to provide effective community-based health care during the COVID-19 pandemic. Government policies were revised to support pharmacists' ability to provide hundreds of millions of care interventions. In response, pharmacies built a workforce and workflow in record time to close care gaps. Many states have solidified these temporary changes into permanently expanded authorities that enable vaccine administration to children and adults, but they have not directed reimbursement for pharmacist services, nor has the federal government. Introduced bipartisan legislation, the Ensuring Community Access to Pharmacist Services Act (H.R. 3164), would expand Medicare Part B coverage for select pharmacist services, including testing and initiating treatment for common illnesses, such as influenza, respiratory syncytial virus, and streptococcal pharyngitis, in alignment with existing state scope-of-practice laws, and would allow coverage of pharmacist services during public health emergencies.[11] In tandem with navigating these federal and Medicare policies, there is an opportunity for advocates to harness this momentum and expand access to pharmacy-based health-care services through state policies and other incremental changes.

However, state policies regarding reimbursement for pharmacists' time providing health-care services are limited and inconsistent. According to a 2022 Ask Your Pharmacist survey, most pharmacists (81 percent) want to expand their health-care services beyond immunizations, but nearly 85 percent said they receive only partial or no payment for additional services. Yet other providers, such as physician associates and nurses, are reimbursed for their time regardless of whether they provide diagnostic or other services or products during a visit. As the authorities governing pharmacist-provided health-care services expand, policies regarding reimbursement remain underdeveloped, especially because pharmacists are not recognized as providers under Medicare Part B.[12]

Pharmacists have highlighted as problematic the primary focus on the transactional dispensing of medication in the current reimbursement model. And, even here, reimbursement for medication is below cost, making it increasingly difficult for chain and independent retail pharmacies to keep their doors open. Because pharmacies are one of the most frequently and easily accessed sources of care and health management, establishing a model wherein pharmacists can operate at the top—and breadth—of their education and training and are appropriately valued is paramount to improving health.

Pharmacies have sounded the alarm on the financial viability of the current medication-dispensing reimbursement models mediated by pharmacy benefit managers (PBMs). A PBM manages prescription drug benefits for insurance companies, employers, and Medicare Part D sponsors, acting as the intermediary between insurance companies and pharmacies to negotiate prices, maintain drug formularies, and process prescription claims. PBMs are currently attracting considerable critical attention from policymakers, including in a 2023 letter to PBMs and insurance plans in which the Centers for Medicare & Medicaid Services (CMS) reported hearing "an increasing number of concerns about certain practices by some plans and PBMs that threaten the sustainability of many pharmacies, impede access to care, and put increased burden on health care providers."[13] For example, retail pharmacies report that PBMs are reimbursing pharmacies below their cost to fill prescriptions, especially in Medicare, ultimately harming beneficiaries in the process.[14]

This report provides insights and recommendations for health plans, pharmacies, and other key partners to accelerate expanded access to pharmacy-based health-care services. The 35 recommendations discussed below were developed from extensive research, interviews, and roundtable discussions with key leaders across the ecosystem.

Methodology

Starting in July 2024, Milken Institute's Public Health team examined the barriers to and opportunities for expanded access to pharmacy-based health-care services. This research began with a review of the peer-reviewed literature, white papers, and case studies to understand the policy and implementation landscape. This landscape review informed 30 semi-structured discussions with a diverse range of leaders representing national and regional pharmacies, health plans, other provider networks, technology infrastructure, and policy (see Acknowledgements).

12
National + Regional Pharmacies

12
Health Plans + Other Providers

8
Infrastructure + Policy Leaders

Qualitative thematic coding analysis was applied to the 30 interviews to identify key themes and inform a 30-person roundtable discussion in Washington, DC. This roundtable solidified the final recommendations, with peer review from a select group of diverse stakeholders. The findings in this report reflect the challenges and opportunity areas that emerged from the landscape review, discussions, and roundtable. They are intended to synthesize actionable policy and implementation recommendations to facilitate and accelerate increased access to pharmacy-based health-care services as a strategy to improve health across communities.

Research Findings

The distillation and analysis of qualitative research yielded 68 codes ranging from policy and regulatory barriers to examples of partnerships and payment models to the need for standardization and identification of various health-care service offerings. These codes were then grouped into four overarching themes regarding opportunities to fill gaps and drive scalable and sustainable system-level change:

1. **Redefining the value proposition:** How might stakeholders drive scalable and sustainable access to more health-care services at pharmacies while they navigate incremental legislative progress?
2. **Prioritizing health-care service offerings now and in the future:** What are the key pharmacy-based health-care services best positioned for expansion?
3. **Identifying infrastructure barriers for standardization and streamlining:** What are the implementation challenges that pharmacies, health plans, and other collaborators must overcome to implement more health-care services in pharmacies and facilitate payment for these services?
4. **Navigating the policy landscape:** What federal and state laws and regulations are affecting the scope and governance of pharmacy-based health-care services?

The following sections delve into each of these themes and key questions and provide recommendations for key stakeholders. Together, they capture how the landscape needs to shift in both small and large ways to facilitate expanded access to pharmacy-based health-care services.

Redefining the Value Proposition

How might stakeholders drive scalable and sustainable access to more health-care services at pharmacies while they navigate incremental legislative progress?

In a health-care landscape with rising chronic disease rates and physician workforce shortages, pharmacists are well-positioned to fill gaps and address challenges. However, the health-care ecosystem has been slow to leverage and reimburse the pharmacist to operate at the top and breadth of their training to provide direct patient care. This section describes how pharmacists have filled critical care gaps for decades and highlights opportunities to strengthen buy-in among key decision-makers, demonstrate value through existing structures, and prioritize impact areas.

Strengthening Buy-In

For decades, pharmacists have demonstrated their ability to innovate and address public health challenges. For example, in the Asheville Project in 1997, pharmacists were trained in a diabetes certificate program, reimbursed for the care they provided to patients with diabetes, and ultimately decreased both A1C levels and medical costs.[15] The 2009 H1N1 influenza pandemic, alongside the COVID-19 pandemic, also underscores the effectiveness of pharmacies in stepping up to advance population health and reduce health-care spending.[16] However, on a pharmacy-by-pharmacy scale, many remain in the early days of piloting programs with health plans or establishing agreements to offer health-care services beyond immunizations.

Efforts to scale programs are hindered by the tension between building the evidence needed to validate impact and making the initial investment to build the evidence. Many health plans want evidence of success for their specific populations before agreeing to scale a program. Similarly, many pharmacies may hesitate to establish a new program before they receive payment or have even secured a health-plan partner.

Although health-care service partnerships with employers, pharmaceutical companies, and philanthropies are becoming more common, high-quality evaluations of return on investment (ROI), which are needed to bolster confidence in pharmacy-based health care, are few in number. The literature includes case studies that describe the benefits of pharmacy-based health-care services, but review articles have highlighted the lack of rigorous study design in ROI analyses.[17] Building out a body of research with more rigorous study designs would help to identify the pharmacy services and interventions that are both the most impactful on health outcomes and have the highest ROI.

Achieving this aim requires mutual partnership between pharmacies and health plans because neither alone has a complete data set. Health plans have access to member care utilization and outcome data that identify specific high-cost drivers and enable collaboration with a pharmacy to measure related health outcomes. Further, this research must focus on a generalizable population, preferably a large population in several different study locations, and measure both treatment and control groups (compared to most of the current literature's before-and-after study design). An interviewed health economist suggested that the ideal study design would leverage the infrastructure of a health plan that operates in two different states, one that has expanded access to pharmacy-based health-care services and one that does not allow for pharmacy-based health-care services. This approach would enable a robust difference-in-difference comparison and result in meaningful data that health plans could use to determine the true impact of pharmacy-based health-care services for their populations.

Beyond research evidence, securing buy-in to develop current programs wherein pharmacists are paid for providing health-care services involves establishing trust with health plan leadership. In many current cases, leadership buy-in was facilitated by having a pharmacist in a leadership position serving as an internal champion. In other cases, a

track record of success in other domains increased leadership's confidence in piloting pharmacy-based health-care services. For example, one interviewed health plan had proved its ability to assume risk responsibly through previous projects using purposeful guardrails, robust monitoring processes, and transparent key performance indicators. This background positioned the health plan to pilot a program to pay pharmacists for their time and cognitive services related to diabetes and hypertension. The health plan is tracking the program closely to understand what services are being offered, to whom, and with what outcomes, so that it can nimbly adjust the program to serve patients better and improve care delivery. This balancing act—weighing initial investment risk within the buy-in process—can be part of an ongoing effort to ensure long-term sustainability and scalability of pharmacy-based health-care services.

Because pharmacies are among the most accessible points of care in the US, public health should establish a model whereby pharmacists can practice at the top, and breadth, of their education and training—and are appropriately valued for these services. Without such a model, access gaps will widen, particularly in communities already experiencing pharmacy closures. Between 2010 and 2020, nearly a third of US retail pharmacies closed, disproportionately affecting neighborhoods with large Black and Latinx populations and those with higher rates of Medicaid and Medicare beneficiaries.[18] These closures create additional barriers for communities to access health services, maintain medication adherence, and stay healthy. For example, a 2019 study in *JAMA Network Open* found that people with cardiovascular disease were significantly less adherent to their prescription medications when their pharmacy closed.

Health plans are recognizing the need to build creative partnerships to bolster pharmacy business longevity and better serve their members. An interviewed health plan explained that it was inspired to expand its health-care service partnerships with pharmacists after attending a local community board of pharmacy meeting during which pharmacies discussed business pressures. As University of California, Berkeley professor Jenny Guadamuz, PhD, shared in *The Nation's Health*, "advocating for these policies that ensure pharmacies don't close, especially not disproportionately in marginalized neighborhoods, is the number one thing that public health practitioners can think about doing."[19]

Recommendations:

- Leverage evidence-based outcomes from past collaborations and pilot programs to demonstrate clearly the impact of pharmacy-based health-care services and strengthen alignment with health plans for scalable partnership models.
- Develop robust monitoring processes and transparent key performance indicators so that the outcomes of pilot projects can be effectively measured. Publicly publish the outcomes to provide evidence for other stakeholders seeking to gain buy-in.
- Invest in robust research methods, including control studies, to demonstrate further the economic benefits of pharmacist-provided health-care services to support future reimbursement opportunities.

Key stakeholders: pharmacists, pharmacy leadership, and health plans

Demonstrating Value Through Existing Structures

Many pharmacies are demonstrating their ability to deliver community-based care effectively within—and around—existing pathways and authorities. Communities already rely on pharmacy teams to support medication adherence, chronic disease management, and preventive health care. Many states have expanded pharmacists' authority to provide services such as administration of long-acting injectable medications, prescriptions for routine health needs (e.g., hormonal contraceptives, antivirals for common respiratory conditions), tobacco cessation support, and point-of-care diagnostic testing.

However, despite expanding scopes of practice, evidence of improved health outcomes and savings, and growing buy-in, progress is often stymied by the lack of a standardized reimbursement structure for these services. Many programs still depend on temporary pilots or one-off contracts that require pharmacies to prove their value before securing compensation. Furthermore, many pharmacies are navigating a fragmented policy landscape that complicates scaling of bespoke models across geographies. Without a consistent reimbursement model, even successful programs may struggle to scale.

Navigating a Fragmented Policy Landscape

Pharmacy care teams must navigate a patchwork of policies that lack clear regulatory standards and vary by state. Pharmacies, health plans, and health systems alike are working to address these challenges by leveraging pharmacy-based health-care services in both pilots and at a broader scale with services such as medication therapy management (MTM) and other medication adherence services. The evolution of MTM is one example of leveraging Medicare as a path toward wider access. Once MTM was required under Medicare Part D, Medicaid and commercial plans followed suit by creating payment mechanisms for this service.

However, many initiatives often lack scalable reimbursement structures to account for substantial investment of pharmacist time. Without federal recognition of pharmacists as health-care providers under Medicare Part B, creating a standardized reimbursement model for other pharmacist-provided health-care services at a national level remains a challenge.

Many pharmacy chains operate across multiple states and therefore must manage disparate rulings on pharmacist authorities and payment for services. They must also comply with the unique requirements and preferences of each health plan. The resultant inability to establish an organization-wide standard diminishes their efficiency. In addition, this patchwork complicates their advertising efforts, which limits customer awareness and demand.

Further, authorities are often defined by treatment category. Within these categories, there are additional specifications by state; for example, many states specify that pharmacists can only prescribe self-administered hormonal contraceptives or only emergency contraceptives.

Some states, such as Idaho, have enacted independent authorities that allow pharmacists to prescribe medications as they deem fit, within certain broad guardrails established by the state legislature and overseen by the state board of pharmacy. Although Idaho provides the most sweeping example, several other states have enacted statutes that define pharmacists' scope of practice based on a "standard of care" model. Here, pharmacists must act consistently with their education, training, and experience and within the accepted standard of care provided in a similar setting by a "reasonable and prudent pharmacist."

However, most states with expanded authorities do not define reimbursement. As of spring 2025, 19 states had policies that directed Medicaid payment of certain pharmacist-provided health-care services, and 13 states included provisions for commercial insurance.[20] Even in these states, uptake of and payment for these services remain slow, which continues to limit impact and scalability.

This challenging situation extends beyond pharmacists to include the entire pharmacy team. Pharmacy technicians are increasingly assuming roles that support health-care services by collecting information, conducting outreach, contacting other health-care providers, performing medication reconciliation, helping with MTM, providing basic information, and administering certain vaccinations and point-of-care tests. By performing these nondiscretionary activities, pharmacy technicians free up pharmacists' time to focus on interventions that require their clinical expertise and judgment.

Pharmacy technicians can also be cross-trained as CHWs, who are frontline public health workers with intimate knowledge of their communities and help individuals navigate care systems. Payment pathways for CHWs continue to evolve, but they are largely funded by grants. To fully realize the impact of the full pharmacy care team, sustainable reimbursement pathways are needed to recognize and support the contributions of the entire pharmacy team.

Creative Pathways to Provide Care and Receive Reimbursement

In response to this fragmented landscape, pharmacies are establishing creative, although often temporary, models to provide care and demonstrate value. For example, many pharmacy teams use broad protocols and collaborative practice agreements (CPAs), which were allowed in all 50 states as of August 2023. CPAs create formal relationships between pharmacists and other providers (typically physicians or nurse practitioners) to allow pharmacists to deliver broader services than those allowed within a pharmacist's independent authority, as defined by state scope of practice. Expanded services leveraged under CPAs often include chronic care management, refill authorizations, and formulary management under the oversight of the collaborating provider.[21]

Although CPAs do not ensure direct pharmacist reimbursement, interviewed thought leaders described them as facilitators toward expansion of service offerings and payment. When an overseeing provider bills for services provided by pharmacists, the gaps and challenges posed by direct pharmacist billing can be mitigated. This interim arrangement

enables current service delivery while building a case for sustainable pharmacist payment models in the long term.

Other pharmacy stakeholders have opted for unconventional paths to reimbursement, taking on financial risk to demonstrate the impact of a program and build the case for reimbursement. Some examples include establishing pilots that demonstrate a program's benefit before contracting with a health plan, partnering with a pharmaceutical company on a suite of related medication-adherence services, or layering care-gap closure interventions with existing pharmacy workflow. One interviewed regional drugstore that developed successful health plan relationships summarized this tension: "We're trying to find very creative ways to continue to maintain our access to communities until we can get to a day where we're paid properly for what we're doing on the pharmacy dispensing side, but we can also get paid properly for what we're doing on the care delivery side as well. It's a challenge." Pharmacies that have taken less traditional approaches have reported that payment is not always guaranteed, but such approaches reflect a growing willingness among all partners to innovate, as well as highlight the pressing need for formal payment mechanisms to support service delivery.

Pharmacies have proved their ability to provide high-quality, accessible care. However, without clear and sustainable reimbursement pathways, that care remains vulnerable. Solutions such as CPAs and risk-based partnerships can help to fill short-term gaps, but they are not substitutes for comprehensive payment models that reflect the value of pharmacy-based services. As pharmacies work within and around current structures, policymakers, health plans, and health systems must invest in reimbursement strategies that support scalability and ensure that pharmacists can remain a reliable access point for care. The alignment of policy, payment, and practice is essential to realizing the full potential of pharmacy-based health-care services to improve health for communities and promote efficiencies in our health-care system.

Recommendations:

- Explore alternative payment models and partnerships to sustain pharmacist-provided health-care services, including demonstrating pharmacy value through partnerships with pharmaceutical companies, employers, or public health agencies.
- Leverage existing mechanisms that can help to enable payment, such as CPAs, to fill gaps in payment for pharmacist-provided health-care services, while continuing to advocate for independent authority pharmacy-practice laws and corresponding payment parity for direct pharmacist billing (see "Policies of Focus").

Key stakeholders: pharmacy leadership, non-pharmacist providers, and health plans

Prioritizing Rural Impact Opportunities

As the policy landscape continues to evolve, pharmacists can expand their health-care service offerings by prioritizing areas in which health plans would most benefit. Geographic areas with patient access challenges, for example, present a valuable opportunity for pharmacists to close care gaps. Landscape research and interviews repeatedly identified rural communities as underserved because pharmacists may be the only or one of a few health-care providers. A 2016 brief from the US Department of Health and Human Services reported that while 19 percent of the US population lives in rural areas, only 9 percent of US physicians practice in these regions.

Further, in many communities, pharmacies may be the only provider available without an appointment or outside traditional office hours, which is an especially critical consideration for those who work during traditional business hours or individuals with transportation limitations. In addition, adults living in non-metropolitan areas are on average older than the urban population, have lower incomes and higher poverty rates, and report poorer health status and higher rates of major chronic conditions.[22] Finally, public policies have been shifting incentives to provide care in rural, underserved communities. Several interviewed thought leaders emphasized that the most efficient way to activate pharmacies as frontline care providers—and to ensure that they are paid for their services—is to start with rural populations.

Pharmacists are already poised to, and in many cases, already offer expanded services in rural geographies to fill care gaps. One interviewed national mass-merchant pharmacy mentioned that for many people in rural areas, pharmacies are the most accessible places to receive care: "On the testing and treatment in the rural areas, especially where we operate, we're seeing greater than 70 percent of our visits happen after 5 p.m. or on a weekend. The only alternative would have been an urgent care or an ER in some of our communities, which is absolutely the highest cost of care." Further, they realize cost-savings for both patients and the health-care system at large by diverting unnecessary emergency room visits. Re-emphasizing the pharmacist's value proposition in rural areas, where the primary care physician shortage is amplified and patients are already seeking care from other health-care providers, is a valuable opportunity to improve health outcomes while demonstrating the importance of pharmacy-based health-care services.

Recommendations:

- Prioritize the establishment of health plan–pharmacy partnerships that leverage pharmacist-provided health-care services in rural communities where access to providers is limited.
- Engage and partner with policymakers to embed rural health priorities in national and state initiatives, ensuring that pharmacists are empowered to deliver care in underserved regions through clear policy support and aligned incentive mechanisms.
- Strengthen relationships with rural health-care leaders to generate buy-in across additional key stakeholder groups.

Key stakeholders: rural health advocates, rural community health centers, pharmacy leadership, health plans, and policymakers

Prioritizing Pharmacy-Based Health-Care Service Offerings: Now and in the Future

What are the key pharmacy-based health-care services best positioned for expansion?

A key goal of this research project was to home in on a core set of pharmacy-based health-care services that should be prioritized for expansion, standardization, and ultimately reimbursement. Interviewed thought leaders described the key services that pharmacies are best positioned to offer, what health-care service offerings are working well now, and which specific services should be the primary collective focus for acceleration. This process involved comparing the service offerings deemed by pharmacies to be of highest interest to those deemed by health plans to be most valuable for the populations they serve. This section examines the intersection of those perspectives to frame potential opportunities for future payment arrangements and ROI.

Current Health-Care Service Offerings

A wide variety of health-care services are already being delivered in pharmacies. The **analysis and thematic coding of interviews revealed 12 health-care service codes varying in specificity, reach, and scalability.** Services related to chronic disease management were most frequently mentioned. Immunizations were also frequently mentioned, although thought leaders were prompted to focus on services other than immunizations because widespread authority and clearer reimbursement pathways already exist for them.

Interviews also explored the implementation and reimbursement processes for the services offered. Many services are offered on a cash payment basis, although examples of partnerships with health plans for reimbursement exist. Within these partnerships with health plans, services are reimbursed via fee-for-service arrangements based on each individual encounter, coupled with a bonus payment based on a specific care gap being closed or outcome achieved. These arrangements are not necessarily standardized across service offering or replicated within every geographic area covered by the same retail pharmacy.

The current literature does not capture an exhaustive list of health-care services being offered in pharmacies or of reimbursement arrangements. Therefore, health stakeholders and advocates lack an awareness of the full breadth of service opportunities in pharmacies, which trickles down to consumers.

> ***It takes a good bit of effort to make patients aware that these services are available to them, but in all the cases where members have interacted with these services, the feedback is outstanding, and you know we've diverted emergency room visits. But it is one of the things that you know, continually working on ways to make the public more aware of the services being available to them.***
>
> ***—Health plan leader***

This lack of awareness is compounded by considerable variation in the maturity of offerings across pharmacies, with some pharmacies still designing services and others delivering services in well-established partnerships. In addition, inconsistency in health plans' implementation of pharmacy-based health-care services challenges efforts to raise awareness among the public.

Interviewed thought leaders emphasized the need to approach these services in the broader context of closing care gaps. Such an approach involves understanding what services individuals and communities are not accessing through existing care pathways or populations where health plans are struggling to reach their members. These care gaps are where plans have the greatest incentive to directly partner with pharmacies. For example, one interviewed regional pharmacy chain collaborates with Medicare Advantage plans to capture data from patients who are already filling prescriptions but may be experiencing care gaps, such as being overdue for a hemoglobin A1C test.

On the plan side, one interviewed national plan described its collaboration with pharmacists in four states to measure hemoglobin A1C and blood pressure to impact their Healthcare Effectiveness Data and Information Set (HEDIS)-related gaps in care. Here, pharmacies not only have reached an unprecedented number of members, but also have addressed other gaps at the same time, such as eye exams, foot exams, and food insecurity. This plan shared how "historically a barrier has been even when pharmacists had the regulatory scope of practice to do specific clinical services, there was no way to connect the value from the pharmacy into the system that impacted the health plans. Adherence to HEDIS measures is one way to connect that value."

Quality measures also play an important role in shaping the list of health-care services to prioritize. As one thought leader explained, "Look at HEDIS and Medicaid Core Sets. It's usually what somebody's being held accountable for where their gap is." An interviewed pharmacy explained it is "increasingly seeing health plans viewing pharmacies as an access point that can help close additional gaps in care. And the majority of these are being driven by the quality metrics that the payers have." This sentiment was echoed by health plan stakeholders as their areas of accountability.

The Healthcare Effectiveness Data and Information Set is a tool used by greater than 90 percent of US health plans to measure performance on important dimensions of care and service. The Centers for Medicare & Medicaid Services requires Medicare plans and Medicaid Managed Care Organizations to use HEDIS measures. These measures are used to rate the performance of Medicare Advantage and Part D drug plans through star measures. Additionally, the Medicaid and Children's Health Insurance Program (CHIP) Core Set is a set of measures designed specifically for state Medicaid and CHIP programs by CMS to measure the national quality of care for beneficiaries, as well as to monitor performance at the state level and ultimately improve quality of care.

Some measures overlap between HEDIS and the Medicaid Core Set because both aim to ensure high-quality care. For example, measures such as follow-up after mental health hospitalization and preventive screenings may appear in both sets, but their reporting context differs. The recommended priority health-care service opportunities detailed in this report have significant overlap with existing HEDIS measures and Medicaid Core Sets that could be further leveraged. Since 2017, CMS has been working to unify quality measures across traditional Medicare, Medicare Advantage, Medicaid, and CHIP coverage, Marketplace plans, and CMS Innovation Center models through its Meaningful Measures 2.0 initiative and development of a "Universal Foundation" of quality measures that streamlines data, reduces burden, and improves interoperability.[23] In addition to aligning a standard set of quality measures, this work would help plans and pharmacies to align on priority quality measures for focused pharmacy impact.

Table 1 presents the 13 pharmacy-based health-care service areas that were identified during our analysis, examples of current reimbursement arrangements for each service area, and the related quality measures.

Table 1: Current Pharmacy-Based Health-Care Service Offerings

Category	Services	Reimbursement Arrangement Examples	Related Quality Measures
Chronic Disease Screening	• Screenings: hemoglobin A1C, glucose, blood pressure, lipids, height, waist circumference, and weight • Annual wellness visits • Colorectal cancer screening kits • Evaluating potential comorbidity indications such as chronic kidney disease	• Cash payment • Direct contracts with health plans (Medicaid and commercial) • Medicare Part B with a supervising approved Medicare Part B provider ("incident-to" billing) • Direct contracts with pharmaceutical companies • Free screening days • Direct contracts with employers	**HEDIS** • A1C Control • Blood Pressure Control • Colorectal Cancer Screening • Kidney Health Evaluation for Patients with Diabetes **Core Set** • Colorectal Cancer Screening • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Adherence and Medication Therapy Management (MTM)	• General medication adherence evaluations and barrier review • Medication review post-hospital discharge • Refill management • Comprehensive Medication Review (CMR): review and consultation of medications (including prescriptions, over-the-counter medications, herbal therapies, and dietary supplements) that is intended to aid in assessing medication therapy and optimizing patient outcomes	• Direct contracts with health plans (Medicaid and commercial) • Direct contracts with pharmaceutical companies • Medicare Part D: patients with chronic conditions and high costs are eligible for an annual CMR • Direct contracts with employers	**HEDIS** • Care for Older Adults – Medication Review • Medication Adherence for Diabetes Medications, Hypertension (RAS antagonists), and Cholesterol (Statins) • MTM Program Completion Rate for CMR • Statin Therapy for Patients with Cardiovascular Disease • Statin Use in Persons with Diabetes **Core Set** • Adherence to Antipsychotic Medications for Individuals with Schizophrenia • Antidepressant Medication Management

Hypertension and Heart Health	• Screenings: blood pressure and lipids • Blood pressure monitoring • Statin initiation and adherence • Atrial fibrillation identification and referral • Integrated management programs including improving medication adherence, lifestyle coaching • Referral to dietitians for nutrition counseling • Medication change recommendations • Tobacco cessation assessments, counseling and prescribing	• Cash payment • Direct contracts with health plans (Medicaid and commercial) • Direct contracts with pharmaceutical companies • Direct contracts with employers • Grant funding	**HEDIS** • Beta-Blocker Treatment • Blood Pressure Control • Medication Adherence for Diabetes Medications, Hypertension (RAS antagonists), and Cholesterol (Statins) • Statin Therapy for Patients with Cardiovascular Disease **Core Set** • Controlling High Blood Pressure • Medical Assistance with Smoking and Tobacco Use Cessation
Diabetes	• Screenings: hemoglobin A1C and glucose • Integrated management programs including blood sugar measurement, medication adherence, lifestyle coaching, pneumonia immunization, foot and eye exams • Setup and ongoing counseling for continuous glucose monitors • Statin initiation and adherence • Referral to dietitians for nutrition counseling • Insulin titration support • Medication change recommendations • Kidney function monitoring	• Cash payment • Direct contracts with health plans (Medicare and commercial) • Direct contracts with pharmaceutical companies • Direct contracts with employers • Grant funding	**HEDIS** • A1C Control • Diabetes Care - Eye/Feet Exam • Kidney Health Evaluation for Patients with Diabetes • Medication Adherence for Diabetes Medications, Hypertension (RAS antagonists), and Cholesterol (Statins) • Statin Use in Persons with Diabetes • Vaccination Status **Core Set** • Diabetes Care for People with Serious Mental Illness • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications • Adult Immunization Status

Respiratory	• Screenings: pulmonary function test • Asthma management including inhaler education, refill monitoring • Medication change recommendations • Chronic obstructive pulmonary disease support, including "rescue packs" for exacerbations and pneumonia immunization • Tobacco cessation assessments, counseling and prescribing	• Direct contracts with health plans (Medicaid and commercial)	**HEDIS** • Vaccination Status **Core Set** • Asthma in Younger Adults Admission Rate • Asthma Medication Ratio • Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • Adult Immunization Status • Medical Assistance with Smoking and Tobacco Use Cessation
Immunization	• Administration of recommended vaccines including flu, COVID-19, respiratory syncytial virus (RSV), pneumococcal pneumonia, shingles, measles/mumps/rubella (MMR), human papillomavirus (HPV), and tetanus/diphtheria/pertussis (Tdap) • Review travel agenda and recommend related immunizations • Education and counseling, risk assessment	• Direct contracts with health plans (Medicaid and commercial) • Medicare Part B (pneumococcal and influenza vaccines, COVID-19, hepatitis B for high-risk individuals) • Medicare Part D (all other vaccines) • Cash payment	**HEDIS** • Vaccination Status **Core Set** • Adult Immunization Status
Testing and Treatment for Routine Illnesses and Infections	Clinical Laboratory Improvement Amendments–waived tests for: • Infectious diseases including influenza, streptococcus, COVID-19, and RSV • Skin conditions and fungal infections including mild acne, vaginal candidiasis, and tinea infections • Minor, uncomplicated viral and bacterial infections including urinary tract infection, allergic rhinitis, and herpes zoster	• Cash payment • Direct contracts with health plans (Medicaid and commercial) • Direct contracts with pharmaceutical companies	**HEDIS** • Vaccination Status **Core Set** • Adult Immunization Status

Health-Related Social Needs	• Centers for Medicare & Medicaid Services–approved assessments on social needs and aging in place, social determinants of health screening and referral • Food Is Medicine including food delivery with medication delivery and products and education to support nutrient depletion related to pharmacology therapies • Medication reconciliation post-hospital discharge and referral to social or community health workers as needed • Pharmacy technicians cross-trained as community health workers to do in-home visits for fall risk assessments	• Direct contracts with health plans (Medicaid and commercial) • Grant funding	**HEDIS** • Care for Older Adults – Medication Review • Fall Risk Management
Reproductive Health	• Hormonal contraceptive consultation and prescribing • Hormonal labs	• Cash payment • Direct contracts with health plans (Medicaid and commercial)	**Core Set** • Contraceptive Care
Sexual Health	• Sexually transmitted infections take-home kits	• Cash payment • Direct contracts with health plans (Medicaid and commercial)	**Core Set** • Chlamydia Screening in Women Ages 21 to 24
HIV	• HIV testing • Preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) consultation and prescribing	• Cash payment • Direct contracts with health plans (Medicaid and commercial)	**Core Set** • HIV PrEP and PEP

Mental Health	• Mental health screening (e.g., PHQ-9, GAD) • Pharmacogenomic testing • Administration of injectable medications for people with schizophrenia	• Cash payment • Direct contracts with health plans (Medicaid and commercial)	**Core Set** • Adherence to Antipsychotic Medications for Individuals with Schizophrenia • Diabetes Care for People with Serious Mental Illness • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications • Screening for Depression and Follow-Up Plan
Behavioral Health	• Tobacco cessation support including prescribing for nicotine replacement therapies • Naloxone access/prescribing • Opioid use disorder support: screening, referrals, medication titration support and adherence	• Cash payment • Direct contracts with health plans (Medicaid and commercial)	**Core Set** • Initiation and Engagement of Substance Use Disorder Treatment • Medical Assistance with Smoking and Tobacco Use Cessation • Use of Pharmacotherapy for Opioid Use Disorder

Source: Milken Institute, CMS, National Committee for Quality Assurance (2025)

In the context of understanding opportunities for future expansion, it is first necessary to look at current policy feasibility. Authorities for each of the services highlighted in the table above vary greatly by state as highlighted in the policy and reimbursement landscape. Test-and-treat and HIV care are examples that show the range of authorities. For a more complete exploration of pharmacy-based health-care service authorities, please visit the companion Interactive Authorities Explorer Map.

Current Testing and Treatment Policy Context

Seventeen states have enacted legislation allowing pharmacists to independently provide test-and-treat services for common health conditions—without requiring a collaborative practice agreement (CPA) or prescription. These services typically involve Clinical Laboratory Improvement Amendments (CLIA)–waived tests, which are low-risk diagnostic tests approved by the Food and Drug Administration for home use. Examples include tests for influenza, strep throat, and urinary tract infections. The federal authorization of CLIA-waived point-of-care testing by pharmacists during the COVID-19 pandemic led to a significant increase in the number of community pharmacies becoming CLIA-waived test sites—rising by greater than 90 percent between 2019 and 2021.[24] Although the authorities are in place for pharmacies to offer these services, payment arrangements remain limited. Because of the lack of widespread reimbursement, the majority of test-and-treat services at pharmacies are paid for out of pocket by individuals.

Pharmacists in six states (Arkansas, Colorado, Delaware, Idaho, Iowa, and Kansas) have some type of direct prescribing authority that covers test-and-treat services. Seventeen additional states have some form of delegated prescribing authority or CPA. Nine states (California, Colorado, Connecticut, Hawaii, Illinois, Michigan, North Carolina, New Mexico, and Virginia) specifically enacted point-of-care testing and treatment authority for pharmacists. However, four states (California, Montana, New Mexico, and North Carolina) require that pharmacists obtain additional training and certification for these services, yet fewer than 10 percent of the licensed pharmacists in these four states have completed this additional certification.[25]

Current HIV PrEP and PEP Policy Context

Pharmacists in several states have the authority under state law to prescribe HIV preexposure prophylaxis and postexposure prophylaxis. Many cite that the expansion of pharmacist authority began as early as 1993 in New Mexico with the goal to combat the HIV/AIDS epidemic by allowing pharmacists to prescribe HIV PrEP and PEP. These medications play a critical role in preventing HIV transmission, with PrEP reducing the risk of infection by up to 99 percent when taken as prescribed, and PEP serving as an emergency treatment to prevent HIV infection within 72 hours of exposure. Currently, at least 21 states allow pharmacists to prescribe PrEP and/or PEP, expanding access to these essential preventive treatments.

The specific scope of authority varies by state—some permit pharmacists to initiate and continue PrEP therapy, while others allow only short-term dispensing until a patient can see another prescriber. States such as California, Colorado, Nevada, and Oregon have implemented some of the most comprehensive pharmacist-prescribing laws for PrEP and PEP. California also has requirements for Medi-Cal (California's Medicaid program) and private insurance companies to cover PrEP and PEP when prescribed by a pharmacist without needing prior authorization or step therapy requirements. However, in many states, barriers such as insurance reimbursement limitations, certification requirements, and patient awareness continue to impact pharmacists' HIV prevention efforts.

Recommendations:

- Conduct peer-reviewed research to develop a comprehensive list of health-care services currently provided by pharmacists, as well as existing reimbursement models.
- Disseminate the holistic list of current and potential pharmacy-based health-care services to health advocates, employers, health plans, and social service organizations to increase awareness of the availability of these services.
- Leverage in-store signage, social media, health plan communications, and other creative distribution channels in partnership with community-based organizations to increase consumer awareness and demand.

Key stakeholders: health plans, health providers, pharmacies, pharmacy advocacy organizations, and researchers

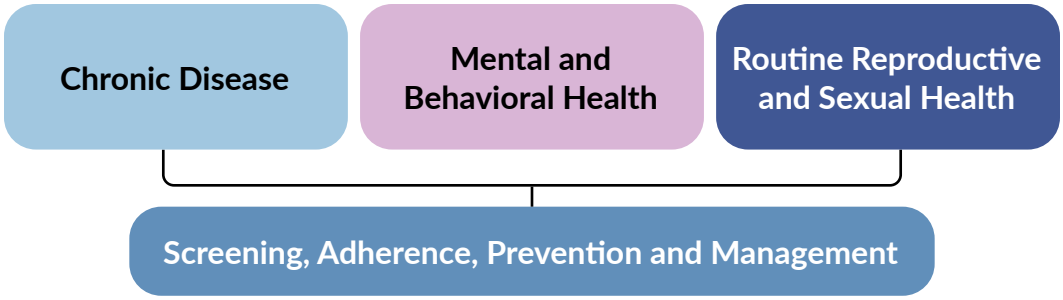
- Continue aligning on a standard set of priority quality measures across Medicare and Medicaid services for focused health-plan and pharmacy collaboration. For example, this could involve expanding the Universal Foundation Set.

Key stakeholders: CMS, National Committee for Quality Assurance, Medicare, and Medicaid health plans

Enhanced Opportunities for the Future

The narrowed set of core pharmacy-based health-care service areas that are most appropriate for focused expansion and future reimbursement (**Figure 1**) can be grouped into three categories: (1) **chronic disease**, (2) **mental and behavioral health**, and (3) **routine reproductive and sexual health**. Within each category, the services can be subcategorized by one of three impact areas: screening, adherence, and prevention and management. Because pharmacists are becoming increasingly accessible providers of community-centered care, reimbursement models must recognize their time and clinical expertise to ensure that those services are broadly available and sustainable.

Figure 1. Future Opportunity Areas for Pharmacy-Based Health-Care Services



Source: Milken Institute (2025)

Chronic Disease

Holistic health-care approaches services in the broader context of care gap closures and bundles chronic disease prevention, management, and treatment into a collective service offering. As discussed above, the supply of primary care providers is shrinking, health plans are incentivized to help their members better manage chronic diseases, and pharmacists have demonstrated success in providing chronic disease prevention and management services. The logical next steps, therefore, are to standardize and bundle these services (**Figure 2**) and expand payment mechanisms. In support of this evolution, recent evidence demonstrated that retail pharmacists leveraged in a value-based primary care arrangement helped patients achieve statistically significant reductions in systolic blood pressure and A1C, compared with matched controls.[26]

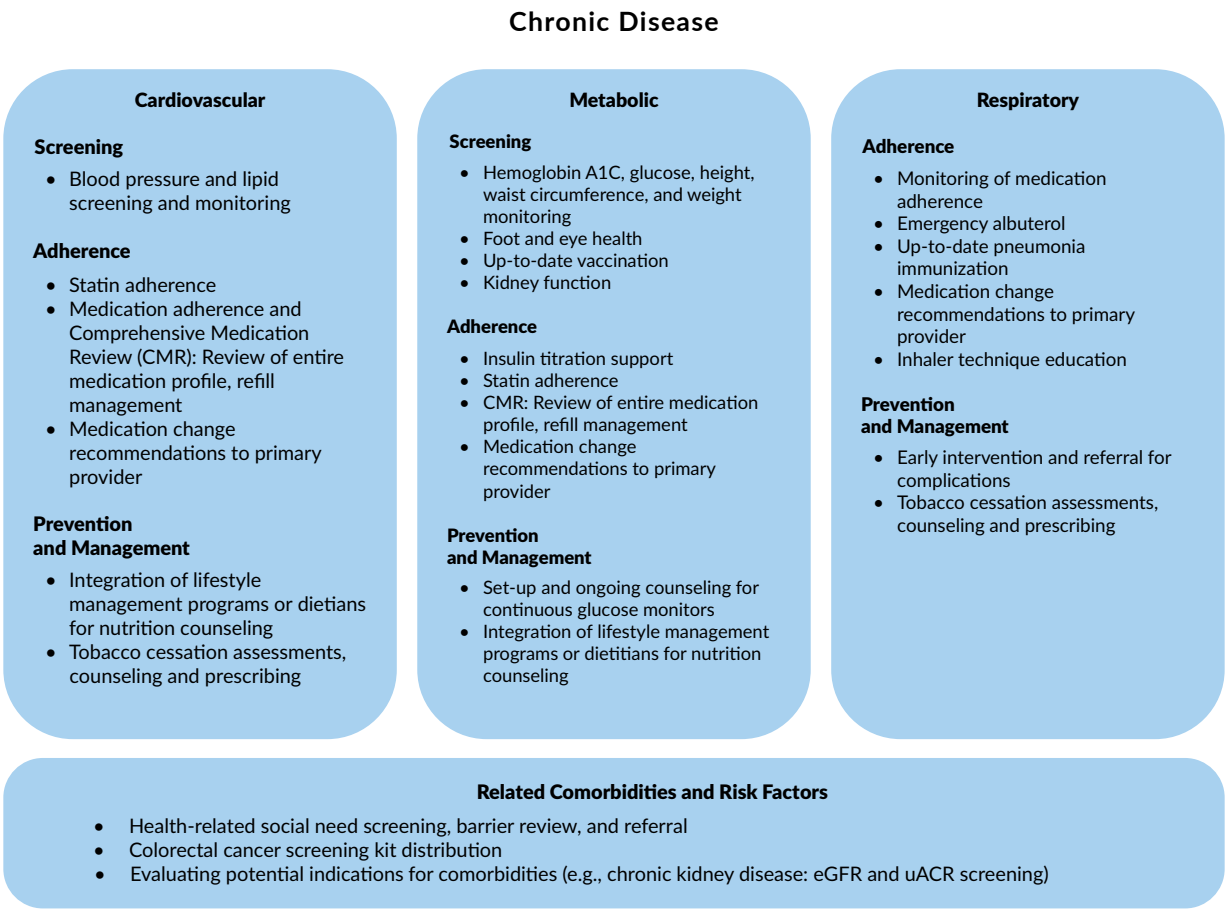
One key opportunity is to bundle these services into a cohesive offering termed "interventional chronic disease management" by some pharmacies. In this type of arrangement, pharmacists can augment the work of primary care by improving disease state control, optimizing medication use, and reducing hospitalizations. One interviewed pharmacy described a partnership with a health plan focused on the integration of chronic disease management into a longitudinal relationship workflow. The first interaction takes the form of a welcome visit, during which the pharmacist explains to the patient, "Each time we talk a little bit more about your diabetes just so that we're making sure you're getting the most out of your medications and that you're doing all the latest and greatest recommendations to take best care of yourself." This initial conversation establishes a level of trust that builds with each additional clinical intervention. Each time the patient goes to the pharmacy to refill a medication, they receive an in-pharmacy health-care service, such as an A1C test or an eye and feet exam, as prioritized by the pharmacist based on observations from the welcome visit. This approach enables the pharmacist to address not only the variety of care gaps the health plan would like to close but also the patient's priorities—while sharing the data back with the health plan.

Other pharmacies have attempted to establish a similar comprehensive model, but found limited success because their service package was specific to a certain plan or partner. In response, they transitioned to specializing in some of the building blocks of the programs, such as blood pressure and A1C management. During the roundtable, a thought leader explained how "pharmacies have holistic condition-management programs but the underpinnings of them are just a selection of multiple gap-closure needs." These gap-closure needs may be related not only to HEDIS or Core Set quality measures, but also to a specific high-cost need beyond the quality measure, such as chronic obstructive pulmonary disease exacerbation control.

Currently, many of these services are reimbursed sporadically or in limited partnerships. Pharmacy and health plan stakeholders coming together to align on a common core set of chronic disease management services would help standardize policy, reimbursement, and implementation while enabling bundling and program personalization. For this core set, this report, following an integrated systems approach, recommends services by disease/

condition area for future expansion. In 2024, 42 percent of Americans had two or more chronic conditions, and 12 percent had at least five. These facts emphasize the need to connect services across disease states and to bundle services for holistic care.

Figure 2. Future Focus Area: Chronic Disease Pharmacy-Based Health-Care Services



Source: Milken Institute (2025)

Screening: Chronic disease screenings are low-hanging fruit in terms of opportunities for standardization. These screenings relate directly to biometrics as well as the social needs that impact disease risk and management. Key thought leaders mentioned several screening services that are currently offered at scale: A1C, blood pressure, blood sugar (glucose), cholesterol, lung function, kidney function, height, weight, body mass index, and diabetes risk. In addition, pharmacists are employing screening tools for areas such as access to food, stable housing, transportation, ability to pay for medications, and caregiver needs. Health plans are interested in these areas to address the root causes of health gaps and are accountable for measuring these outcomes via quality measures (see the previous section on Current Health-Care Service Offerings).

Adherence: Pharmacists and pharmacy technicians are experts in medication adherence services intended to reduce the risk of adverse drug events, enhance appropriate

medication use, and optimize medication-related outcomes. Because a variety of terms are used to describe these services, stakeholders across the ecosystem called for standardizing terminology to improve alignment. Under the umbrella of "adherence" and "medication optimization services" are traditional Medicare Part D MTM, Comprehensive Medication Reviews, personalized action plans, adherence support, patient education, and collaboration with health-care providers.

Although studies consistently show that MTM programs reduce health-care costs associated with medication-adherence problems, a host of implementation barriers are impeding further expansion. MTM can be reimbursed by a third-party insurance company, but the monetary amount may not be equivalent to the amount of time invested by a pharmacist to complete a single MTM encounter. Sometimes direct partnerships with employers, pharmaceutical companies, or private insurance companies will pay for these adherence services. However, the compensation process can prove cumbersome, requiring individual contracts with individual pharmacy locations.

Prevention and management: Wraparound services related to chronic disease prevention and management include support for individuals to set up remote patient monitoring devices for weight, blood pressure, or blood glucose. Through a partnership with a health plan, one interviewed pharmacy helps individuals with uncontrolled diabetes set up continuous glucose monitors (CGMs) to help improve blood sugar control. As part of this CGM counseling, the pharmacy helps to identify early signs of chronic kidney disease. Many retail pharmacies also partner with chronic disease lifestyle management programs or in-house dietitians to help with nutritional counseling. As Food Is Medicine continues to scale, pharmacies, especially those in grocery or mass merchant store models, have a powerful opportunity to integrate with these interventions.

The Pharmacist's Role in Addressing Health Stigma

Pharmacists' accessibility and community trust make them well suited to support health needs when stigma may prevent people from seeking traditional care. In health, stigma refers to a negative attitude, belief, or stereotype associated with a specific health condition or behavior, for example, HIV, mental health, substance misuse, and contraception. Stigma is a well-documented barrier to healthy behaviors, care seeking, and adherence to treatment across a range of health conditions for individuals who experience, internalize, perceive, or anticipate stigma.[27] As a result, these individuals often seek care at later stages when prognoses are worse and health-care costs are significantly higher, which presents the opportunity for health plans to partner with pharmacies to expand services and both improve health-care outcomes and reduce health-care costs.

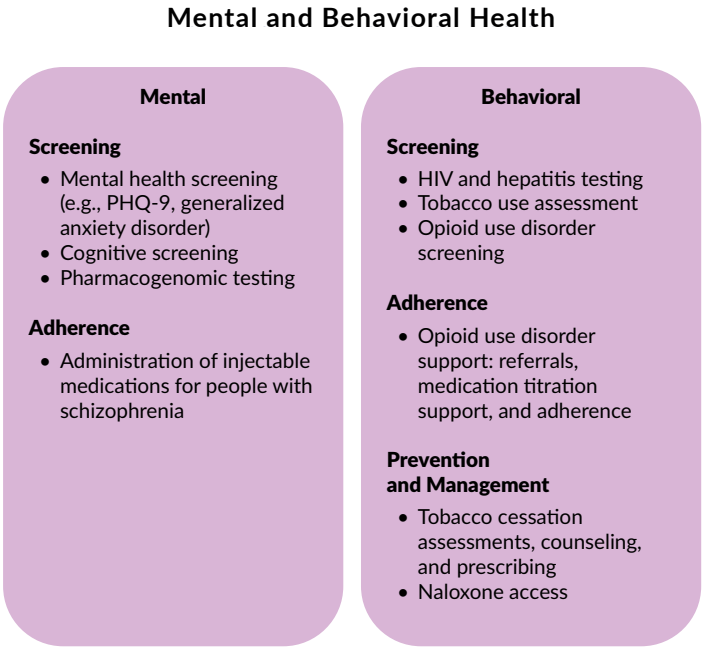
Mental and Behavioral Health

Mental health conditions affect nearly one in five US adults annually, yet barriers related to stigma, provider shortages, and access prevent many from receiving timely care.

The need to address these barriers was evident during several interviews. Yet, which specific pharmacy services are most feasible for doing so was less clear. One interviewed pharmacy asked, "Mental health. What does that mean to us? Just medication adherence for patients? Or does it mean keeping them out of an urgent situation? How? Where? That's where I think there's a lot of talk, but I'm not sure it's been really well defined. I do think that there is a need. The question is what can pharmacy do in those spaces to actually drive value or savings?"

There is a larger need across the health care system to improve access to effective support and resources for individuals experiencing mental health crises. Although mental health care tends to be siloed, pharmacies are ideally situated to provide critical support, particularly for screening and medication adherence services, including administration of long-acting injectables (LAIs). With an increased ability to refer individuals to other provider support systems, pharmacists could play an even greater role in responding to both acute and chronic mental health needs (**Figure 3**).

Figure 3. Future Focus Area: Mental and Behavioral Health Pharmacy-Based Health-Care Services



Source: Milken Institute (2025)

Screening: Pharmacies can play a vital role in screening for mental health conditions, including disorders such as generalized anxiety and depression, leveraging the Patient Health Questionnaire-9 (PHQ-9) tool, and conducting pharmacogenetic testing to better understand a person's response to medications such as antidepressants. Given the strong link between poor medication adherence and cognitive impairment, pharmacists are well-positioned to administer screenings for cognitive impairment and dementia at early

stages. In one study, community pharmacy staff asked older adults to participate in a self-administered 10-minute cognitive screening tool; 73 percent of the 425 individuals screened were referred to their primary care doctor for further evaluation based on screening results.[28] Greater than 80 percent of individuals screened reported it was their first cognitive assessment.[29] In addition to mental and cognitive health, pharmacists can screen for intersecting health behaviors such as tobacco and opioid use.

Adherence: Pharmacies can help to close the significant gaps in adherence to LAIs for people with schizophrenia, especially because many psychiatrists now practice via telehealth and therefore lack the ability to administer LAIs. "Doctor's offices don't want to do it... If I got the green light, I would set up an injection clinic tomorrow," shared one key thought leader, emphasizing the urgent need for pharmacist-led administration of antipsychotic medications. One interviewed pharmacy noted, "Physician prescribes the medication, and then it can actually be administered at the pharmacy... Some of our stores serve the schizophrenic population, and those folks were having to drive an hour each way to have their medication administered at their mental health clinic. It leads to poor adherence in an already non-adherent population." The fact that pharmacies are open during evenings and weekends further enhances patients' access to LAIs.

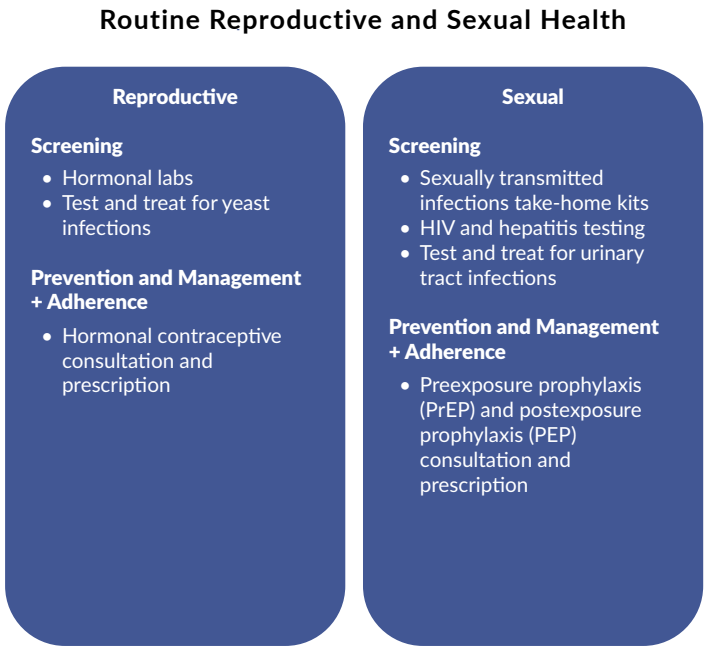
Prevention and management: Pharmacists can help to improve behavioral health through tobacco cessation counseling and prescribing, and through expanded access to medication (e.g., buprenorphine) and intervention for opioid use disorder. Despite the removal of the X-waiver, buprenorphine availability has not increased significantly. As one interview expert noted, "There's still the issue of reimbursement and clarifying the pharmacist's role." Research has started to describe the feasibility and effectiveness of pharmacy-based screening, brief intervention, and referral to treatment for opioid and substance use disorders.

Routine Reproductive and Sexual Health

Routine reproductive and sexual health services, including contraception access, sexually transmitted infection (STI) screenings, and PrEP and PEP consultations, are essential components of preventive care. Pharmacies are well-positioned to deliver these services (**Figure 4**), particularly in geographic areas facing provider shortages or when stigma and logistical barriers impact access. Several pharmacies are implementing models that cover contraceptive prescribing; on-site testing and treatment for STIs, yeast infections, and urinary tract infections (UTIs); and HIV prevention services. However, broader adoption is limited by inconsistent reimbursement pathways and the lack of coherent implementation protocols.

Expanding payment mechanisms and increasing public awareness of service availability would help pharmacies deliver routine reproductive and sexual health services in a standardized, scalable way. As with chronic disease management, bundling these services and integrating them into other health-care service workflows presents a key opportunity to improve access and outcomes.

Figure 4. Future Focus Area: Routine Reproductive and Sexual Health Pharmacy-Based Health-Care Services



Source: Milken Institute (2025)

Screening: Key thought leaders agreed that testing and treating for uncomplicated UTIs is an impactful and relatively easy-to-standardize pharmacy-based health-care service for future focus. About 60 percent of women and 10 percent of men in the US experience a UTI every year. Although they are not always related to reproductive health, UTIs can be highly stigmatized because of assumptions about hygiene and sexual behavior. Although a straightforward, uncomplicated UTI rarely leads to death, a complicated UTI can be life-threatening, particularly in vulnerable populations such as older adults or immunocompromised individuals. They can also result in significant health-care costs due to potential complications such as sepsis, prolonged hospital stays, and the need for more intensive treatment regimens.

One key thought leader shared one of their "top five reasons for a patient to be admitted to the hospital is an uncomplicated UTI that accelerated into a complicated one because they didn't get in to see their provider. If a pharmacist can just provide uncomplicated UTI medication to a patient, keep them out of the hospital, it reduces downstream costs." This urgency is compounded by the trend that many pharmacy testing visits occur when the only other source of care is urgent or emergency care: An interviewed regional pharmacy operating in many rural areas reported that greater than 70 percent of visits occur after 5:00 p.m. or on a weekend.

Adherence, prevention, and management: Pharmacists are uniquely positioned to offer contraception through both prescription-based and over-the-counter methods, helping to prevent unintended pregnancies and improve family planning. By preventing unintended pregnancies, pharmacies can reduce the total cost of care, including prenatal, delivery, and postnatal care, as well as the financial burdens on individuals and health-care systems. One pharmacist key thought leader shared, "There is an appreciation that receiving contraceptives from a pharmacist reduces major barriers for people who have been using the same type of contraception for a long time—they know what they want." For these individuals, pharmacies offer a convenient and accessible option for consistent contraception use.

Access to HIV care remains a critical component of public health, and pharmacies are increasingly playing a vital role in providing HIV prevention and treatment services, especially for underserved populations. Pharmacies now offer PrEP and PEP, two key medications that significantly reduce the risk of HIV transmission.

A major advantage of pharmacy-based HIV services is their low-stigma environment, which encourages individuals to seek care without fear of judgment. As one pharmacy key thought leader shared, "I think from a public health standpoint, pharmacy is going to be able to make a huge impact. With PrEP and PEP... We've already seen it with our HIV testing—people driving hours to be tested at our stores, not because they don't have a place to be tested, but because they don't have a non-stigmatized place to be tested. There's something to be said for walking into a [retail pharmacy] where people buy bananas and video games and you enter the same room we do flu shots in and walk out just like the person who got a flu shot." By further integrating pharmacists into the HIV care continuum, pharmacies can significantly reduce barriers to care, enhance adherence to HIV prevention medications, and lower health-care costs in the long run.

Recommendations:

- Forge a unified national framework among pharmacies, health plans, and community health advocates to prioritize a standard set of chronic disease, mental, behavioral, reproductive, and sexual health services (screening, adherence, prevention, and management) to create streamlined partnerships and payment mechanisms.
- Improve awareness of available services to improve community knowledge, demand, and access.

Key stakeholders: pharmacies, health plans, social services, and patient and public health advocates

Identifying Infrastructure Barriers

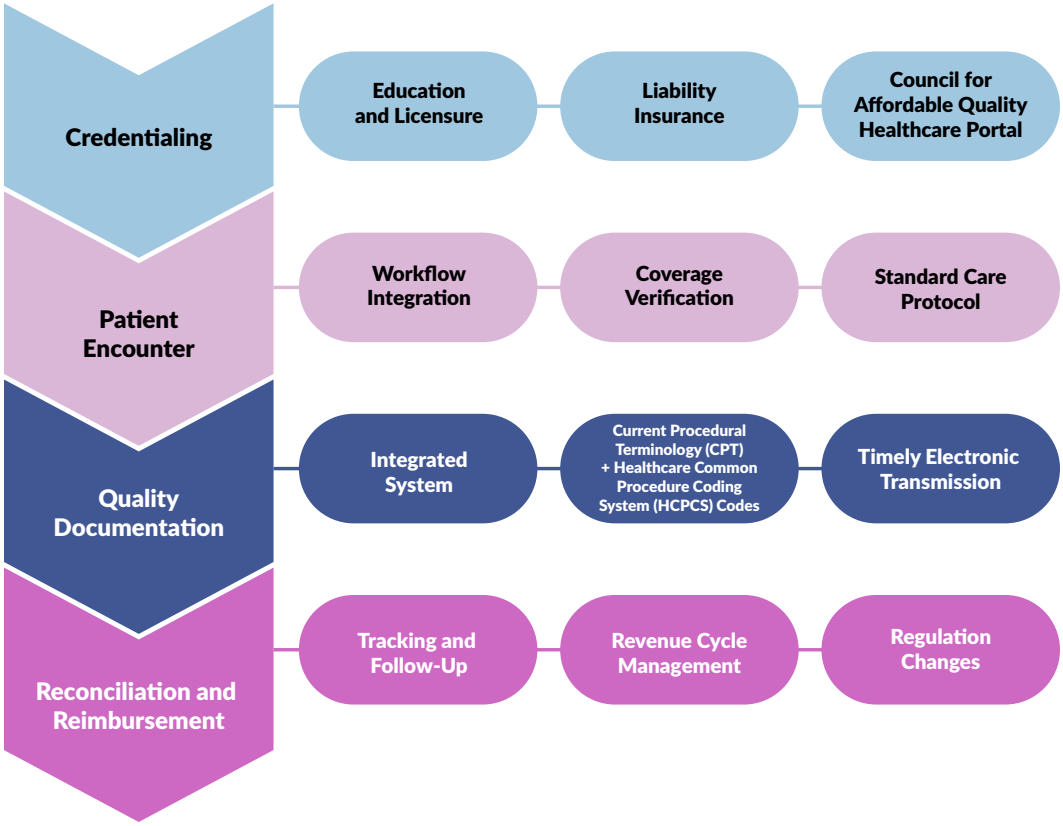
What are the implementation challenges that pharmacies, health plans, and other collaborators must overcome to implement more health-care services in pharmacies and facilitate payment for these services?

Infrastructure is needed to actualize expansion of pharmacy-based health-care services and create opportunities to standardize and streamline payment and workflow systems. Even in states with enabling policies, uptake by pharmacies to offer these services has been limited by both the lack of reimbursement incentives and the additional infrastructure needed to drive implementation. In a recent survey of pharmacists by EnlivenHealth, 46 percent of respondents identified the largest barrier to expanding their health-care service offerings as being the lack of a medical billing solution that integrates seamlessly within their pharmacy workflow. Without the infrastructure and supportive technology, pharmacists are often unable to receive appropriate payment: more than a third of respondents are not compensated for the health-care services they provide, with more than half receiving only partial compensation.[30]

Although critical for sustainability and scaling, billing is only one aspect of the health-care service workflow. Efficient and sustainable implementation of services requires consideration and alignment of four distinct workflow phases: credentialing, the patient encounter, quality documentation, and reconciliation and reimbursement.

These phases and the relevant components for potential standardization are depicted in **Figure 5** below. Before delivering a service, the pharmacist must be credentialed to do so, which involves aligning education and licensure needs, verifying liability insurance coverage, and inputting data into a standardized provider data portal such as the Council for Affordable Quality Healthcare. To deliver the service to a patient, the service must be integrated into the pharmacy workflow, the patient's health insurance coverage must be verified efficiently and accurately, and clear guidelines or protocol around standard of care must be in place. Following service delivery, there must be an integrated system, clear and standardized billing codes and billing processes, and timely electronic transition of relevant, quality documentation. Lastly, to actualize reimbursement for services, there must be data reconciliation to ensure data are consistent and accurate, revenue cycle management, and alignment with regulatory changes to support long-term sustainability. This is the general workflow; the specifics of each process can vary between health plans, pharmacies, technology providers, or other partners.

Figure 5. Pharmacy-Based Health-Care Services Workflow



Source: Milken Institute (2025)

Currently, pharmacies and health plans use their own bespoke systems or various third-party platforms for one, several, or all of these workflow processes. Each uses different standards, codes, billing processes, definitions, and data transfer methods. Therefore, systems between pharmacies and health plans are not interoperable, and parties interested in partnering with different pharmacies often cannot scale across multiple pharmacies. An interviewed thought leader stated that all phases of the workflow would ideally integrate into one interoperable system, such as electronic medical records. As pharmacists continue to balance their initial investment risk with long-term scalability, understanding what systems and technologies need to be in place and standardized will position the ecosystem for success when supportive policies are eventually passed.

Standardizing Credentialing Across Health Plans

Thought leaders identified credentialing as a major opportunity for standardization. Credentialing is a process that organizations—such as employers, health plans, or networks—use to access and confirm the qualifications of health-care providers and thereby their eligibility for reimbursement. For pharmacists, this process validates their

qualifications, license, and practice history. However, no standard process for credentialing pharmacists exists, resulting in inconsistency in the frequency and method for verifying eligibility. For example, every health plan has its own set of rules, timelines, and processes for credentialing, which not only are administratively burdensome but also can last as long as 6–12 months. In addition, credentials are often assigned to a specific pharmacist at a specific location, so if the pharmacist switches locations even within the same chain, they would need to repeat the credentialing process. Further, many credentialing systems are not designed for the pharmacist specifically, so pharmacy teams encounter questions that do not apply to them and cannot be navigated in a standardized way.

> ***There's not a standardization for what the expectation is for pharmacist credentialing right at the front door. That makes it very challenging because so many health plans say you need to go through CAHQ, for example, and complete a credentialing packet. When you go through that credentialing process, there are questions within that process that do not apply to a pharmacist. Pharmacists don't have admitting rights at a hospital, so when you get to that question, you can't answer that question. And then it sets off multiple swirls within that system as far as being able to get through that process.***
>
> ***—Health plan leader***

Standardizing the process across credentialing bodies is one of the most effective ways to remove credentialing barriers. Rather than determining their own separate processes (many of which are not designed with pharmacies in mind), health plans can work with pharmacies to establish a set of questions and paperwork needed to verify the pharmacists' credentials. Interviewed health plans called for state guidance memos that could help direct this process. Ideally, the established credentialling process could align with those used by other health-care providers to emphasize pharmacists' analogous role in providing care.

Beyond standardizing credentialing, giving pharmacies the ability to mass credential the way they do for other types of licensing work would help streamline the process. For example, pharmacy teams could submit a single spreadsheet that provides information for all the pharmacists being credentialed rather than submitting for each individual pharmacist. Finally, credentialing pharmacists to their chain could eliminate the need to re-credential pharmacists if they change location or work across multiple locations, saving time and resources for both the pharmacy team and the health plan.

Recommendations:

- Standardize the credentialing process across health insurance providers and credentialing bodies to streamline the administrative burden for pharmacies and ensure consistency in verifying pharmacist qualifications, licenses, and practice history.
- Implement mass credentialing for pharmacies so that pharmacy teams can submit a credentialing request for multiple pharmacists at once.

- Credential pharmacists to pharmacy chains or organizations rather than individual locations to prevent the need for re-credentialing when one pharmacist moves between locations.
- Advocate for standardized, transparent credentialing guidelines from health plans and credentialing bodies to enable pharmacy teams to navigate requirements efficiently, ensure compliance, and avoid unnecessary delays.

Key stakeholders: pharmacy teams, health plans, and credentialing bodies

Integrating Quality Documentation with Billing

For pharmacists to practice at the top of their education and training, and to provide care to patients, the technology must be in place to support the documentation of patient encounters that can lead to payment. The current process requires extensive documentation on a shorter time frame than for many other providers.

Many pharmacies with health-care service partnerships are documenting patient encounters through roster billing, or what amounts to a simple spreadsheet that is submitted monthly to the health plan. Most health plans use evaluation and management coding to support medical billing, a system that uses current procedural terminology codes to represent the services provided by the health-care provider. These codes signal to the health plan the service provided and the reimbursement amount. However, prescription delivery systems in most pharmacies are not designed to support this type of coding. In addition, many of these codes are unfamiliar to pharmacists, who may only use a subset of them (such as billing for MTM) because they are not yet recognized as health-care providers by most health plans.

Integration of documentation within the billing system would streamline pharmacists' workflows, enabling them to simultaneously document and comply with the appropriate billing requirements for a given service in each state. Rather than leveraging separate documentation and billing codes, this integration would automatically tee up billing codes based on a pharmacist's documentation codes to ensure appropriate payment and compliance.

Some third-party technology vendors are already working with pharmacies to integrate the medical billing platform into the pharmacy dispensing system to supplement the existing pharmacy workflow, and pharmacists do not need to be trained on an entirely new system. These third-party platforms allow pharmacists to code and bill for encounters that are within their scope of practice but cannot be captured by the pharmacy dispensing system. The platforms collaborate with both pharmacies and health plans to ensure that the latter have the backend infrastructure to recognize these claims and reimburse pharmacies through whatever mechanism they have in place. By shifting the business model and overall incentives within the pharmacy to focus on comprehensive patient care, rather than medications alone, this type of platform integration drives the larger ecosystem toward valuing pharmacy-based health-care services.

Recommendations:

- Invest in technology that integrates documentation of patient encounters directly within the billing system so that pharmacists can document the health-care services they provide, ensure that appropriate medical billing codes are applied, reduce administrative burden, and improve workflow efficiency—all while ensuring appropriate payment.
- Align on consistent billing codes for pharmacist-provided health-care services.
- Ensure health plan readiness for billing integration so that health plans have the backend infrastructure to recognize and process claims from pharmacies that are submitted through integrated billing systems.
- Harmonize pharmacy documentation systems with local regulations so that pharmacists can more easily maintain compliance with billing codes needed to receive payment.

Key stakeholders: third-party platforms, pharmacy management system vendors, health plans, and pharmacy leadership

Ensuring Appropriate Reimbursement Structure to Pay for Cognitive Time

Pharmacies must have the appropriate payment structures in place to receive reimbursement for the care they provide. Many pharmacist-provided services are reimbursed through PBMs, which act as intermediaries between pharmacies, drug manufacturers, and health plans. Pharmacy claims are accepted or rejected in real time, and these claims are typically for a product (e.g., a medication or a vaccine) rather than a service (e.g., administration of the vaccine or management of the patient's condition). Medical claims, however, can take days to process and may be linked to a patient's other claims. In addition, pharmacy systems are not yet built for time-based billing or medical billing, which involves a different set of codes, processes, and timelines compared to billing PBMs and drug benefits.

Overcoming the current challenges with medical billing in pharmacies is essential to ensuring fair payment and treatment of pharmacies as health-care providers. As pharmacists continue to offer more health-care services, the ways in which they are paid must evolve as well. Providing cognitive services is very different from filling prescriptions, and for any other provider who is offering those services, PBMs do not mediate this interaction. As one interviewed pharmacy payment platform commented, "Pharmacists need to get recognized directly by the health plan for the value that they're bringing to the table and the value that they're bringing to the health plan's patients—the population health impact, but also the patient outcomes that they're directly impacting. And without that direct connection through the medical billing channel, that recognition won't be there; it's going to get lost in the PBM space, and it's going to look like prescription business, which it isn't."

Despite the fact that many pharmacies do not yet have medical billing systems in place, they emphasized the importance of disentangling payment for pharmacist-provided

health-care services from the PBM. This effort will involve developing closer relationships with health plans outside of the PBM.

For pharmacies to successfully and sustainably provide health-care services, they must make up-front investments in infrastructure and technology. In addition to outfitting pharmacy payment systems to support medical billing, pharmacy teams should consider revenue cycle management tools or systems that account for the delay in payment or the patient follow-up needed to resolve claims. One interviewed national pharmacy chain admitted to underestimating the importance of revenue cycle management to ensuring timely payment of claims, navigating the administrative burden, and accounting for the risk posed by delayed payment for services. Third-party vendors have stepped in to support pharmacies with medical billing and revenue cycle management.

Recommendations:

- Invest in upgrading pharmacy management systems to support medical billing so that pharmacists can properly document and receive payment for the health-care services they provide.
- Consider adopting revenue cycle management tools or systems to ensure timely payment, reduce the administrative burden on pharmacy teams, and navigate the challenges associated with delayed payment and patient follow-up that come with medical billing.
- Partner with third-party vendors to support billing, coding, and compliance with state-specific regulations and scope of practice laws.

Key stakeholders: pharmacy leadership, pharmacy management system vendors, and third-party technology vendors

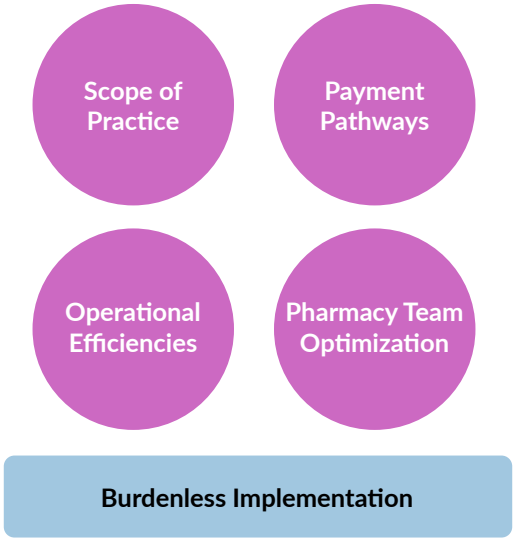
Policy Areas of Focus

What federal and state laws and regulations are affecting the scope and governance of pharmacy-based health-care services?

Expanding access to pharmacy-based health-care services requires addressing a range of implementation barriers at both the federal and state levels. Excessive administrative requirements, inconsistent state interpretations, and restrictive workforce policies create inefficiencies, limit the ability of pharmacies to deliver care, and prevent the use of scalable, sustainable models.

Stakeholders identified four policy areas of focus, shown in **Figure 6**, that are critical to scaling pharmacy-based care: scope of practice, payment pathways, operational efficiencies, and pharmacy team optimization.

Figure 6. Policy Areas of Focus for Scaling Pharmacy-Based Health-Care Services



Source: Milken Institute (2025)

Policy transformation cannot happen without a coordinated approach among all relevant stakeholders: federal and state policymakers, commercial and public plans (Medicare, Medicaid), pharmacy chains, independent pharmacies, and the rest of the health-care ecosystem. By streamlining scope of practice regulations, optimizing workforce policies, and securing sustainable payment models, pharmacy-based care can play a greater role in improving health outcomes.

Harmonize State Scope of Practice Rules for Public Health Services

Pharmacists' ability to provide health-care services depends on state regulations defining their scope of practice. State-level policy changes enable incremental improvements that can slowly but surely move the needle. State-level variation creates significant complexity, particularly as federal policies fluctuate. As one thought leader explained, "Now we will have every state interpreting and deciding what the patient pool is and we're going back to that... with the burden on a provider. How do they then manage and keep a spreadsheet of every different thing that can be done linked to the policy?"

In addition, regulatory requirements for pharmacists can be overly restrictive or overly onerous, limiting service access. For example, one interviewed pharmacist shared, "I couldn't give a flu shot because I didn't have a current CPR [certification], though I had [it] at one point in time. We're just overregulating ourselves." Scope of practice limitations must be addressed to maximize both pharmacists' contributions and community health.

Recommendations

- Standardize state scope-of-practice laws to allow pharmacists to independently manage patients for chronic and acute conditions, according to the standard of care.
- Remove unnecessary or unrelated implementation restrictions, such as certification requirements or additional training for services, especially when not required of other health-care providers, where appropriate.

Key stakeholders: state pharmacy boards, state legislatures, and pharmacy advocacy organizations

Address Federal and State Misalignment in Pharmacist Reimbursement

Once scope authority exists, sustainable payment models are necessary to expand health-care availability. At the federal level, CMS's lack of recognition of pharmacists as billable providers creates barriers for pharmacists delivering care services: "The challenge is the federal level, it's very confusing for a patient to navigate... When you go and you try to launch a new service and you have a large payer that maybe won't recognize you as a provider, even though the state does, or you have federal plans that don't recognize, it's really hard to communicate that to a customer."

However, some experts argue that establishing payment mechanisms first can accelerate expansions of scope of practice. As one key thought leader noted, "I would rather have the payment ready and then let the practice act catch up because that typically is easier when there's dollars that we know... it's going to be a viable, sustainable model." States where pharmacists can bill for services but have a limited scope of practice present key policy opportunities for advocacy and change. For example, Pennsylvania allows pharmacists to bill Medicaid services broadly, but their ability to provide care remains constrained.

Recommendations:

- Work with CMS and federal policymakers to secure recognition for pharmacists as billable providers under Medicare Part B, ensuring that they are recognized and reimbursed for delivering health-care services.
- Engage state Medicaid leaders to establish reimbursement pathways for pharmacists, with payment parity in alignment with other health-care providers, fostering consistent recognition of pharmacists' clinical role across state health-care systems.

Key stakeholders: Congress, CMS, state Medicaid programs, and pharmacy advocacy organizations

Remove Policy Barriers to Enhance Pharmacy Operational Efficiencies

Policies that support enhancing operational efficiencies can free up pharmacists' time to provide health-care services and enable them to shift capacity toward services that most support community health. Remote processing of prescriptions and central fill operations both improve retail pharmacy capacity and efficiency and reduce in-store workload. However, the regulations governing their use vary across states. Some states restrict pharmacists from reviewing and verifying prescriptions remotely and prevent pharmacy technicians from performing remote work, requiring in-person oversight at the dispensing pharmacy. Others prohibit or heavily regulate central fill arrangements, requiring prescriptions to be filled at the originating pharmacy.

One interviewed pharmacy explained, "We have two big central fill facilities that do a big majority of our prescriptions, but some of the [surrounding] state laws are not friendly to central fill... So we can't really alleviate some of that in-store work to free up the pharmacist to be out providing these other services."

In addition, the process of obtaining Clinical Laboratory Improvement Amendments waivers for pharmacies varies by state, creating inconsistencies that impact the ability to provide point-of-care testing and other health-care services. In some states, a corporate-level lab director can oversee multiple pharmacies, helping to streamline the process. In others, the pharmacy manager must be listed as the lab director, meaning that if the manager leaves, the pharmacy must undergo a re-approval process, which can take up to 30 days and thereby delay services.

Key thought leaders emphasized that this situation creates a lot of stop-start inconsistencies for individuals seeking what should be available services. Some states allow a single CLIA waiver for all locations within a chain, while others require separate waivers for each store, greatly increasing the administrative burden. Standardizing processes is key to enhancing operational efficiency, which enables pharmacists to serve patients better.

Recommendations:

- Allow pharmacists and pharmacy technicians to remotely process prescriptions across states.
- Remove restrictions on central fill operations to free up pharmacist time for health-care services.
- Standardize lab director requirements and remove undue restrictions to reduce disruptions when personnel changes occur.
- Create a single multi-site and multi-state CLIA waiver process for pharmacy chains.

Key stakeholders: state pharmacy boards, pharmacy advocacy organizations, state legislatures, CMS, and retail pharmacy chains

Reduce Restrictions to Maximize Skills of Pharmacy Technicians

Policies that govern the roles of pharmacy staff beyond the pharmacist, such as pharmacist-to-pharmacy technician ratios and technician duties, impact overall capacity to deliver health-care services. Some states impose strict pharmacist-to-technician ratios, limiting the number of technicians a pharmacist can supervise. These restrictions can hinder workflow efficiency and reduce the time that pharmacists have to provide health-care services. However, research indicates that rigid ratios do not necessarily improve patient safety; an interviewed thought leader emphasized that "some states are still pretty strict on pharmacist-to-technician ratios, and some states have totally abandoned it because studies show it's not really impactful." States that have eliminated these restrictions have found that pharmacists remain responsible for oversight, ensuring patient safety without unnecessary workforce limitations.

In addition, the ability of pharmacy technicians to support pharmacists varies widely across states. Technician authorities could include administering vaccines, administering CLIA-waived tests, accepting verbal prescriptions, transferring prescriptions, clarifying prescriptions or adding missing information, identifying patients for health-care services or vaccines, performing medication reconciliation, querying prescription drug monitoring programs, and performing final product verification.

For example, authorized in at least 12 states, technician product verification models, also known as "tech-check-tech," enable trained pharmacy technicians to verify prescription products to confirm that the prescribed drug matches the drug that was filled in the vial before dispensing to the patient. In most states, pharmacists are required to conduct this task, although the skills required are well within a pharmacy technician's abilities. This model has been shown to improve efficiency and enable pharmacists to focus on higher-value activities, such as MTM, chronic disease management, and immunization services. As one interviewed pharmacist explained, "In states where we have tech-check-tech, pharmacists can conduct drug utilization reviews remotely while technicians perform final product verification. This keeps workflow efficient while enabling clinical services."

Recommendations:

- Authorize pharmacy technicians across states to perform all duties within their skills and training, eliminating undue restrictions to maximize pharmacists' focus on patient care.
- Eliminate pharmacist-to-technician ratio laws that limit workforce efficiency.

Key stakeholders: state legislatures, chain and independent pharmacies, Pharmacy Technician Certification Board, and pharmacy advocacy organizations

Conclusion

Pharmacies have the potential to play a transformative role in addressing the United States' most pressing health challenges, offering accessible and effective health-care services to support disease prevention, management, and treatment. As the health-care system grapples with rising chronic disease rates and a declining primary care workforce, pharmacies are uniquely positioned to fill gaps in care. However, realizing the full potential of pharmacy-based services requires overcoming regulatory, reimbursement, and infrastructure barriers.

This report identified 13 current pharmacy-based health-care service areas within three key categories that warrant focused expansion and reimbursement: (1) chronic disease, (2) mental and behavioral health, and (3) routine reproductive and sexual health. Within these categories, service offerings are further grouped into one of three impact areas: screening, adherence, and prevention and management services. By narrowing the focus to these high-impact areas, stakeholders can ensure that pharmacy-based services address the most urgent health needs, while maximizing their potential to improve health outcomes across diverse populations.

To facilitate the sustainable integration of pharmacy-based health-care services, policymakers, health plans, pharmacies, and public health leaders must address several interrelated challenges. These challenges include understanding the value proposition of pharmacy-based health-care services, prioritizing key health-care interventions, standardizing implementation across settings, and navigating a fragmented policy and reimbursement landscape. Ultimately, the expansion of pharmacy-based health-care services requires coordinated efforts to align regulatory frameworks, create sustainable reimbursement mechanisms, and invest in infrastructure. By harnessing pharmacies as trusted and accessible health access points, stakeholders can create a more effective health-care system.

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Acknowledgments

The Milken Institute is grateful to the National Association of Chain Drug Stores for its support of the Institute's independent research to create this report. The entirety of the views included in this report do not represent those of the people and organizations mentioned below. The authors appreciate the time and valuable input from many experts across pharmacies, health plans, technology, health systems, policy, and advocacy who were consulted to inform this report. We are especially grateful to representatives from the following organizations:

AHIP

Albertsons Companies

Blue Cross and Blue Shield of North Carolina

Blue Cross Blue Shield Association

Blue Shield of California

CDC Foundation

Centene

CPESN

DocStation

EnlivenHealth

George Washington University School of Medicine

Health Dame

Health Net

Health Mart

Hy-Vee

The Kroger Co.

Meijer

National Academy for State Health Policy

National Consumer League

Northwell

Publix

RiteAid

Social Innovation Ventures

Thrifty White Health

UnitedHealth Group

US Office of Personnel Management

VillageMD

Walgreens

Walmart

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