A Business Model Framework to Scale Pharmacy-Delivered Clinical Services

An NCPDP Foundation-Sponsored White Paper

SUMMIT HEALTH ADVISORS

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Purpose

This white paper, prepared by Summit Health Advisors and Point-of-Care Partners (POCP) with support from the NCPDP Foundation, explores business models for reimbursing pharmacists for clinical care in community settings. The goal of this paper is to identify barriers that have prevented the widespread adoption of pharmacist-delivered services and recommend viable ways to help scale pharmacist clinical care nationwide in the near term.

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Acknowledgments & Methodology

This white paper was prepared by Summit Health Advisors and Point-of-Care Partners (POCP) as a result of a grant award from the NCPDP Foundation.

The National Council for Prescription Drug Programs (NCPDP) is a not-for-profit, ANSI-accredited standards development organization committed to improving patient safety and health outcomes through enhanced data exchange and interoperability. The NCPDP Foundation advances this mission by funding projects that align with its strategic initiatives: expanding the role and value of the pharmacist, increasing patient access to care, enhancing patient safety and empowering coordination of care and innovation.

The purpose of this project and grant funding was to explore business models for reimbursing pharmacists for clinical care, particularly in community settings. The goal of this project is to identify viable reimbursement approaches, assess how current or future NCPDP standards can support them, and provide insights that help advance scalable pharmacist-delivered clinical services.

Our work builds on the 2024 award-winning NCPDP Foundation-funded white paper–*Pharmacy Interoperability: A Comprehensive Assessment of the Current Landscape* and the efforts of national, multi-stakeholder initiatives designed to advance pharmacists' clinical services, such as the Sequoia Project and Pharmacy Health IT Collaborative, among others. However, our white paper takes a uniquely regional, near-term and economic-focused approach to enabling pharmacist clinical services at scale. Without aligned and effective economic incentives, even the most advanced policy frameworks, data standards and technology platforms will struggle to achieve widespread adoption. The analysis and recommendations in this paper are focused squarely on solving the business model challenge: the key to unlock volume and transform promising pilots into durable, scalable solutions.

To inform this analysis, the project team employed a mixed-methods research approach:

- Literature Review: We reviewed 15 peer-reviewed articles, industry reports and relevant policy analyses to establish an evidence base for pharmacist-delivered services and reimbursement models.
- Key Informant Interviews: We conducted more than 30 interviews with senior leaders across the healthcare ecosystem, including representatives from:
  - Two U.S. federal agencies
  - Four health plans
  - Three pharmacy benefit managers
  - Five national or regional pharmacy chains
  - Three independent pharmacies
  - Four pharmacy associations
  - Four technology providers
  - Five independent pharmacy experts

These discussions provided rich, real-world insights into opportunities and barriers facing advanced pharmacy practice.

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Executive Summary

The United States (U.S.) faces a convergence of provider shortages, rising healthcare costs, and worsening clinician burnout. These challenges underscore the need to fully leverage all qualified health professionals. Pharmacists (doctors of pharmacy since 2003) exist in many practice settings and could help to alleviate these issues, with community pharmacists being among the most accessible, frequently visited and highly regarded, yet they remain underutilized.

The past two decades have seen repeated efforts to expand the role of community pharmacists in healthcare delivery. Some payers have begun reimbursing pharmacists for more complex clinical services. These programs have demonstrated meaningful results: improved access, reduced unnecessary acute care utilization, relieved overburdened clinicians, and strengthened continuity of care. Patients, health plans and the healthcare system benefit profoundly as a result.

However, despite success in certain regions, these initiatives have not scaled in meaningful, sustainable fashion. The primary obstacles are not technical. While challenges like technology adoption, connectivity and interoperability exist, other provider types have overcome similar hurdles to scale clinical programs and secure reimbursement. The greater barriers for pharmacists providing clinical services are structural, rooted in business and operational realities.

Two interconnected challenges stand out as the greatest and most foundational barriers to scale:

1. **Health plan fragmentation** and resulting variability in coverage, reimbursement, credentialing and contracting policies.
2. **Low patient volume** for pharmacist-delivered clinical services that prevent meaningful investment.

These create a network effects "cold start" problem. Without consistent coverage and streamlined contracting, pharmacies cannot attract enough patients to make operational investments worthwhile. Without adequate patient volume, health plans cannot see impact at the scale required to justify further investment in pharmacy infrastructure.

To break this cycle, a clear and unified business model framework for health plans is needed: one that allows pharmacists to deliver a set of prioritized, reimbursable clinical services across multiple health plans within a region. Such a framework must include alignment on scope of pharmacist practice, agreed-upon reimbursable services, streamlined enrollment and credentialing processes, and standardized billing and outcomes tracking.

This white paper recommends creating nimble, action-oriented **Pharmacy Health Alliances for Reimbursable Medical Services** ("PHARMS" or "alliances") in key regions. Each alliance would bring innovative regional health plans and pharmacies together to address:

1. **Service Prioritization:** Identify two to three pharmacist services per region with the greatest potential for early, repeatable patient volume.
2. **Reimbursement & Contracting:** Align codes, billing and contracts to ensure services generate sustainable revenue and can scale beyond pilots.
3. **Credentialing & Enrollment:** Streamline processes for pharmacist credentialing, enrollment and plan directory inclusion.
4. **Technology & Workflow:** Create standardized workflows and infrastructure to deploy services quickly and consistently.
5. **Metrics & Value Demonstration:** Define shared outcomes and return on investment (ROI) models to measure and communicate value.

The approach is intentionally small-scale and focused at first, targeting a limited number of committed stakeholders to drive early wins, then expanding once the business model is proven. Each alliance must be tailored to local market dynamics, patient needs, plan priorities and pharmacist capabilities.

By building shared frameworks in regions where momentum already exists, we can accelerate adoption, unlock patient volume, and realize the full clinical and economic potential of pharmacists in the U.S. health system.

What We Heard From the Experts

This white paper is grounded in insights from more than 30 interviews with senior leaders across the healthcare ecosystem, including national and regional pharmacies, health plans, PBMs, technology vendors, and policymakers. These conversations revealed which aspects of pharmacist-led care are working today, and which barriers are preventing widespread scalability.

Key Area	What's Working Today	What Barriers Persist
Health Plans & PBMs	Contracting between health plans and pharmacies; investing in scalable billing and credentialing systems; using pharmacists to meet Medicaid quality goals; promoting services through member tools and networks.	Fragmented enrollment and credentialing; inconsistent payer requirements; pilots fail from weak alignment across lines of businesses and plans. PBMs lack agency to drive innovation.
Credentialing & Provider Status	State pilots (e.g., Ohio Medicaid) show value of centralized credentialing; some momentum for national provider recognition, though progress remains slow.	No standard credentialing; lack of national provider status blocks billing and payer participation; patchwork state policies.
Reimbursement Models	PBM-based payments for prescribing and adherence work well; employee health pilots show promise; some payer pilots are tied to HEDIS metrics.	Medical billing remains slow and inconsistent; few scalable payer frameworks for pharmacist care.
Pharmacy Operations	Emphasis on workflow fit, team-based care and real-time service prompts; growing use of test-and-treat, immunizations, and med sync.	Low patient volume; disconnected systems ("swivel-chairing"); limited ROI without reliable reimbursement.
Technology Integration	Gradual movement toward unified platforms linking dispensing, documentation, billing and payer data; interest in FHIR-based, interoperable tools.	Data silos persist; limited bi-directional exchange; few automated prompts for eligible patients.
Payer Alignment & VBC	Payers value pharmacist impact on quality and adherence; early inclusion in provider networks.	Minimal direct value-based contracts; attribution and incentive gaps persist.
Innovation Focus	Growth in chronic care, self-triage, and retail-based interventions; more pharmacy–manufacturer pilots.	Efforts remain siloed and regional; outcome data and interoperability gaps slow spread.
Collaboration	Emerging partnerships among pharmacies, payers and tech vendors to pilot scalable models.	Persistent fragmentation and misaligned incentives across stakeholders.

Across these areas, two themes — **lack of patient volume** and **health plan fragmentation** — emerged as the primary barriers experts cited as limiting the scale of pharmacist-delivered clinical services.

Primary Barriers to Scale

Despite strong evidence from successful pilots and local programs (above), pharmacist-delivered clinical services have not yet scaled nationally in the U.S. Two primary interrelated barriers — health plan fragmentation and low patient volume — have created a "cold start" problem that stalls broader adoption.

1. **Limited Patient Volume and Lack of Investment Incentive for Pharmacies.** Most pharmacies lack the consistent patient demand or payer engagement needed to justify the upfront investment required for clinical service delivery. These investments often include staff training and role adjustments, upgrades to technology systems and data integration capabilities, workflow redesign, and even physical space modifications. With low initial reimbursement and uncertain demand, the business case for pharmacies is weak, creating a high-risk, low-return proposition. At the same time, health plans are reluctant to fund infrastructure or operational changes when service penetration remains low, perpetuating a "chicken and egg" cycle that limits adoption.

> *"There's really like a chicken and egg problem around investment. People don't want to invest in the technology until they see payoff, but without investment there's no payoff."*
>
> ~ Industry association executive

2. **Health Plan Fragmentation and Lack of Standardization.** Health insurers vary widely in what clinical services they express interest in from pharmacies; further exacerbating the challenge is that priorities tend to be different by line of business (e.g., Medicare Advantage, managed Medicaid, commercial, etc.) even within a single insurer. In addition, there are differences in how they recognize, credential and reimburse pharmacists for clinical services, with differences in credentialing requirements, scope-of-practice interpretations, billing codes, documentation standards and data exchange protocols. This patchwork of rules forces pharmacies to customize operations for each payer, increasing complexity and cost. Without a consistent set of requirements across plans and geographies, it is difficult to deliver services efficiently or at scale.

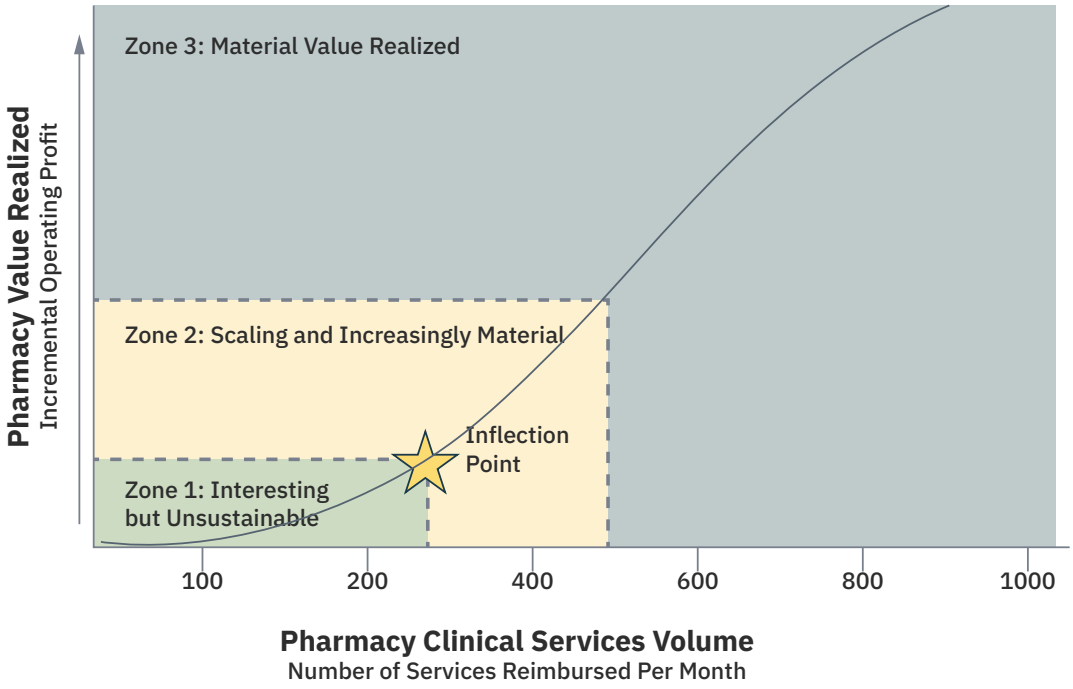
The two primary barriers to scaling pharmacist-delivered clinical services—limited patient volume and health plan fragmentation — are magnified by four structural obstacles across the system. **Reimbursement and contracting complexity** make it difficult to align incentives, preventing pharmacies from achieving the consistency and predictability needed to invest in services that drive scale. **Credentialing and enrollment delays** slow down even willing participants, adding administrative burden and contributing to a patchwork of uneven access across plans and regions. **Technology and workflow gaps** compound the challenge: without interoperable tools or standardized processes, it is harder to generate the service volume required for sustainability. **Outcomes measurement and ROI demonstration** remain essential but inconsistent, leaving plans hesitant to commit beyond pilots. Taken together, these four dynamics reinforce fragmentation and depress volume.

Minimum Volume Threshold for Sustainable Adoption

Scaling pharmacist-delivered clinical services is not a simple linear process — it follows a threshold adoption curve similar to what is seen in other network-driven healthcare innovations. Early on, patient volume is too low to justify the operational and financial investment required, but once a critical mass is reached, adoption accelerates rapidly and becomes self-sustaining.

The chart below illustrates the hypothetical financial contribution that clinical service offerings can produce for a pharmacy operator at different volume thresholds. This example is for a single pharmacy location and intended to be illustrative of a pharmacy doing industry average prescription dispensing volume and providing a mix of clinical services.

Illustrative Model: Clinical Services Volume Thresholds



Zone 1: Interesting but Unsustainable (<250 services per pharmacy per month)

At this stage, clinical services remain fragmented and dependent on isolated pilots or grant funding. Pharmacists' confidence in providing the services remains low because it is not being done frequently. Pharmacists and pharmacies struggle to maintain dedicated clinical workflows because demand is too sporadic to support specialized staffing, consistent scheduling or standardized processes. Financial returns are minimal, creating little incentive for sustained investment.

Zone 2: Scaling and Increasingly Material (~500 services per pharmacy per month)

Reaching this level of consistent patient demand allows pharmacies to integrate services into their daily operations. Clinical workflows become predictable, staff competencies increase through repetition and the technology and documentation processes begin to pay efficiency dividends. Payers start to see more consistent outcomes data, which can justify expanding reimbursement and network participation. Operational breakeven for the pharmacy has been exceeded, financial returns are material and profitability increases, thus increasing ability for pharmacies to participate in more use cases and deal with looming MFP changes that will impact revenues starting in 2026.

Zone 3: Material Value Realized (>500 services per pharmacy per month)

ROI becomes visible for health plans through improved quality metrics, reduced medical costs and stronger member engagement. At this point, clinical services are no longer experimental; they are embedded into the pharmacy's business model and, further, represent a profitable growth avenue on which pharmacy operators can rely on. Economies of scale emerge as fixed technology and training costs are spread across more encounters, staffing is optimized and payer relationships are more easily replicated across geographies. Further, increased patient awareness of pharmacy services at this stage will only compound utilization.

> *"Most pharmacies don't have front office staff, they don't have schedulers, they don't have billers, they don't have the capital to invest. They're not willing to take on the risk."*
>
> ~ Pharmacy technology executive

Without deliberate action to push the market past the inflection point, most programs remain stuck at low volume. Concerted coordination between payers and pharmacies at the local level is required to drive this early momentum.

Illustrative Model: Health Plan Adoption

The table below illustrates how health plan participation in a regional initiative can drive alignment on clinical services. The model is based on insights derived from expert interviews, with illustrative numbers (based on research and analysis of industry data), to demonstrate how increasing membership can be associated with demand for pharmacy-delivered clinical services.

	Zone 1: Interesting But Unsustainable	Zone 2: Scaling and Increasingly Material	Zone 3: Material Value Realized
Health Plans Participating	1 to 2 health plans	3 to 6 health plans	8 to 11 health plans
Participating Lines of Business	Medicaid	Medicaid, Medicare Advantage, ACA Exchange	Medicaid, Medicare Advantage, ACA Exchange, Fully-insured Commercial
Total Member Population	270,000 to 540,000	1,650,000 to 3,300,000	3,670,000 to 5,041,000
Services Reimbursed	Immunizations	Immunizations Test and treat Gaps in care closure	Immunizations Test and treat Gaps in care closure Comprehensive medication reviews
Total Monthly Pharmacy Clinical Services Delivered	18,250 to 32,000	355,300 to 711,200	882,200 to 1,211,800
Pharmacies Participating	600 to 800	1,600 to 2,200	2,600 to 2,800
Services Per Month Per Pharmacy	30 to 40	220 to 325	400 to 432

The Need for a Unified Business Model

Overcoming the cold start problem and enabling clinical services at scale require a shared business model framework between payers and pharmacies, including:

- Agreed-upon service scope aligned with pharmacist licensure
- Standardized credentialing and enrollment processes
- Consistent reimbursement structures and billing workflows
- Unified outcomes measurement

Such alignment can reduce operational friction, enable multipayer participation and build the critical patient volume needed for momentum.

Core Recommendation: Pharmacy Health Alliances for Reimbursable Medical Services (PHARMS)

This paper recommends establishing multiple **action-oriented regional alliances to advance pharmacist-delivered clinical services at scale**. These alliances build upon local initiatives and partnerships where success has been realized to fill the gap between isolated pilot programs and regionally scaled market adoption. To achieve this, each alliance should collectively address and align on the five **Core Focus Areas** to drive patient volume, improve service sustainability and overcome the fragmentation that currently limits impact.

Further, these alliances should function as living labs, rapidly testing, refining and validating scalable models. Lessons learned should be shared across regions to accelerate progress and expand the size of regional programs. Outcomes, frameworks and case studies should be published to guide national adoption and scale beyond early innovators and adopters.

Driving Near-Term Impact

Scaling pharmacist-led care requires pragmatism and action. Postponing progress until the ideal future state can be achieved will only delay patient impact, market adoption and the sustainable business models needed for long-term success.

The following principles should guide efforts to drive more immediate impact.

- **Start with Fee-for-Service:** Full value-based care adoption will take time. Fee-for-service (FFS) models provide a viable on-ramp to build volume, prove value, and establish payer-pharmacy relationships today.
- **Interoperability Is Not a Gate:** Seamless data exchange is a long-term necessity, but it should not be a prerequisite for health plans to contract with pharmacies. Early partnerships can prove the model while interoperability is advanced and implemented over time.
- **Focus on Health Plans:** Pharmacy benefit managers (PBMs) play an operational role, but health plans have the agency advance pharmacist clinical services, as they are responsible for designing provider networks and administering the medical benefit.
- **Think Regionally First:** Healthcare is local. National coalitions are often cumbersome and move slowly; real traction comes from solving for regional market dynamics and then expanding from those successes.

Why a Regional Focus

Healthcare is inherently local, so that is where change should take root. Regional alliances should leverage existing systems, trusted relationships and proven pharmacy champions to accelerate adoption. This approach avoids the inertia that often stalls large national coalitions, focusing instead on hyper-local alignment around shared incentives and geography-specific needs. By concentrating efforts within defined regions, alliances solve the "cold start" problem, achieve the service density needed to make models viable, and create momentum that can scale nationally. As seen in other healthcare transformations, such as e-prescribing – now used by approximately 92% of prescribers and mandated in 35 states — national success grew from strong regionally focused efforts. See the Appendix for a case study on how national infrastructure and regional initiatives helped pave the way for e-prescribing adoption.

Alliances Structured for Efficiency and Impact

PHARMS are designed for speed and impact, with a streamlined structure that keeps decision making close to the work, focuses on committed participants and prioritizes rapid, measurable progress.

- **Initial Scope and Launch Strategy:** Each regional alliance should begin in areas where there's already momentum — whether that's strong pharmacy leadership, engaged health plan partners, demonstrated pilot success or early funding commitments. By focusing on regions where stakeholders are motivated and local conditions are favorable, the alliances can hit the ground running, build credibility and expand from proven success stories.

- **Leadership and Facilitation Model:** Governance of each alliance should be shared between pharmacy and health plan leaders, ensuring joint accountability and alignment. To maintain neutrality and operational agility, a third-party facilitator, such as an independent convener or intermediary, should manage logistics, stakeholder coordination and the iterative adaptation of models across regions.
- **Engaged Membership and Commitments:** Membership in each alliance should be limited to pharmacies and health plans that are already invested in advancing clinical services or are willing to make a defined commitment. This ensures the alliances maintain momentum, avoid distraction and collectively work toward scalable, financially sustainable models.

Five Core Focus Areas

To unlock the full potential of pharmacist-delivered clinical services, regional alliances must align around a shared set of priorities that directly drive patient volume: the lifeblood of sustainability and scale. Fragmentation across stakeholders, service types and operational approaches dilutes impact; coordinated alignment creates the momentum needed for market transformation.

The **Five Focus Areas** represent the core levers where alignment is essential:

1. **Service Prioritization:** Define two to three high-priority pharmacist services with the highest strategic and operational value in each region, ensuring focus on offerings most likely to generate early, repeatable patient volume.
2. **Reimbursement & Contracting:** Align billing codes, Current Procedural Terminology (CPT) structures and contracting models so that services generate sustainable revenue and can expand beyond initial pilots.
3. **Credentialing & Enrollment:** Standardize and simplify the credentialing, enrollment and directory processes for pharmacist participation in health plans.
4. **Technology & Workflow:** Establish consistent workflows and shared infrastructure so services can be implemented quickly and uniformly, enabling scale without reinventing the wheel at pharmacy.
5. **Metrics & Value:** Develop shared outcome measures and ROI models to track, validate and communicate value to stakeholders; inform selection of additional services to incorporate; and support the transition to value-based care.

By aligning on these five areas, each alliance creates a clear, coordinated pathway from local pilots to market-wide adoption, turning early regional wins into sustainable national impact.

Please see the Appendix for a more comprehensive breakdown of the purpose, objectives and key workstreams proposed to mobilize each Focus Area.

Conclusion & Key Takeaways

The path to scaling pharmacist-delivered clinical services is within view, but requires deliberate, collective and focused action. Evidence from decades of pilots proves that pharmacists can improve access, outcomes and cost effectiveness. Yet wide-scale adoption remains stalled because of two structural challenges:

1. Health plan fragmentation in coverage, credentialing, contracting and reimbursement.
2. Insufficient patient volume to justify operational investment and demonstrate sustainable ROI.

These barriers reinforce each other, creating a "cold start" problem that limits both plan engagement and pharmacy incentives. The solution is not more pilots or isolated technology fixes; it is a unified, regionally focused business model framework that can be used to scale multiple service lines in one geography and build the foundations to expand to other geographies.

The PHARMS model provides the collaborative structure to develop and operationalize these frameworks. By aligning committed stakeholders — health plans and pharmacies — around five core focus areas (services, reimbursement, credentialing, workflow and metrics), regional alliances can rapidly:

- Prioritize scalable services to meet local population needs
- Standardize reimbursement, contracting, credentialing and workflows to reduce friction
- Build the patient volume necessary to cross sustainability thresholds
- Demonstrate ROI that compels expansion to additional services and regions

The call to action: Health plans and pharmacies must work together, committing to building a shared foundation through a practical regional approach. The opportunity is immediate and actionable. By starting where success has been demonstrated and stakeholders are engaged, we can transform fragmented progress into durable system change.

It is time we utilized pharmacists to their fullest scope and potential. The proposed PHARMS model can help move pharmacists from the periphery to the core of care delivery, bringing measurable benefits to patients, providers, payers and the healthcare system at large.

Appendix

Appendix

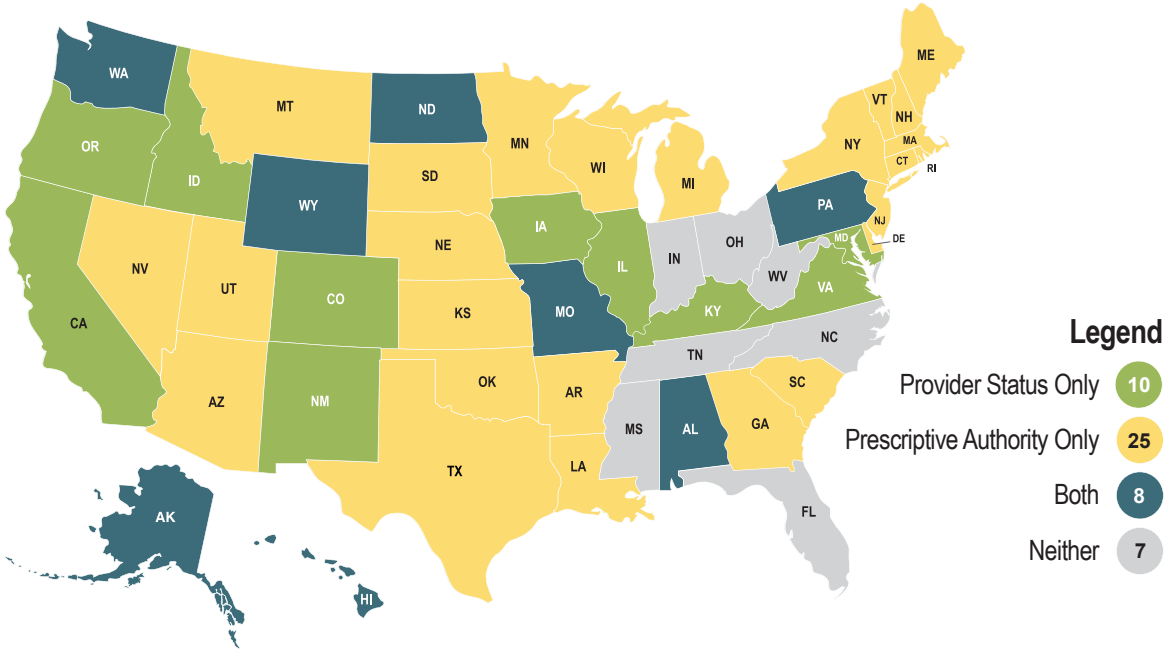
The Evolution and Impact of Expanded Pharmacist Scope of Practice in the U.S.

As the U.S. healthcare system grapples with widespread provider shortages, rising healthcare costs and escalating burnout among physicians and nurses, there is growing urgency to leverage the full capabilities of all qualified healthcare professionals.

Pharmacists are well suited to fill these gaps and support the rest of the clinical team in providing high-quality patient care. Pharmacists (doctors of pharmacy or PharmDs) receive significantly more focused education and training in medication-related therapeutics than physicians, physician assistants or nurse practitioners. While medical, physician assistant (PA) and nurse practitioners (NP) programs cover pharmacology as part of broader medical curricula, PharmD programs devote the majority of their professional training – typically four academic years following pre-professional studies – specifically to the safe, effective and evidence-based use of medications. This includes in-depth coursework in pharmacokinetics, pharmacodynamics, pharmacogenomics, drug interactions, adverse effect management and clinical therapeutics across all disease states, along with extensive experiential rotations in diverse patient care settings.

Further, community pharmacists are accessible in nearly every neighborhood and highly trusted by patients. On average, patients visit a pharmacy between two and 10 times more often than they see a primary care provider, making pharmacists one of the most readily accessible, yet underutilized, members of the healthcare team. (JAMA; Accenture) Expanding their clinical role offers a high-leverage solution to improve access, reduce unnecessary acute care utilization, relieve pressure on overloaded providers and enhance care continuity—particularly for patients with chronic conditions or those in underserved communities. Importantly, pharmacist-provided clinical services are best focused on use cases in which their training and expertise uniquely position them to support and augment the broader care team, complementing rather than duplicating the work of other providers.

Over the past three decades, the role of community pharmacists in the United States has undergone significant transformation. Once seen primarily as dispensers of medications, pharmacists are increasingly recognized as integral members of the healthcare delivery team, providing services such as chronic disease management, preventive care, medication optimization and acute illness triage. Today, pharmacists have provider status in 18 states and prescriptive authority in 33 states, with 8 states where pharmacists have both provider status and prescriptive authority.



Map illustrates the states in which pharmacists have provider status and or prescriptive authority.

This evolution has been catalyzed by policy shifts at the federal and state levels, payer interest in value-based care, persistent primary care gaps and a growing body of evidence demonstrating the clinical and economic impact of pharmacist-delivered services.

> *"If we engage pharmacists in delivery of healthcare services for patients, this is going to improve health for all."*
>
> ~ Health plan executive

The Value of Pharmacist-delivered Clinical Services

A critical and often overlooked factor in scaling pharmacist-delivered clinical services is the unique connection between health plans and pharmacies. Unlike other care settings, pharmacies sit at the intersection of medication access, patient engagement and data visibility, while health plans control benefit design, reimbursement and performance incentives. It's this interdependence that makes alignment between the two indispensable: pharmacies can't reach sustainable volumes without plan alignment and plans can't optimally achieve their goals without leveraging the pharmacist's reach and trust. Our ultimate recommendation centers on strengthening this partnership because it's the linchpin for moving beyond pilots to truly scalable, system-level impact.

For health plans, these services translate to improved outcomes through higher Healthcare Effectiveness Data and Information Set (HEDIS) scores and Star ratings and better chronic disease control, along with cost savings from fewer hospitalizations, emergency room (ER) visits and avoidable complications. They also drive member engagement by meeting patients in familiar community settings. For pharmacies, scaling clinical services creates new revenue streams beyond dispensing, strengthens their clinical identity through recognition as providers in value-based care models, and builds patient loyalty by deepening trust and retention.

For more details on the unique value proposition for health plans (by business line) and pharmacies (by type), please see The Value Proposition for Health Plans and Pharmacies.

> *"The pharmacist value prop is a pretty good one. We can do it more convenient than urgent care and we can do it cheaper than urgent care."*
>
> ~ National pharmacy chain executive

Proven Models of Care and Outcomes

Across the country, pharmacist-delivered clinical services have been implemented successfully in a variety of settings, addressing diverse patient needs. From chronic disease management to point-of-care "test and treat" and preventive immunization campaigns, the evidence consistently shows improved patient outcomes, reduced avoidable utilization and strong returns on investment.

The section below (Successful Use Cases and Their Business Models) outline six proven pharmacist-led models of care that have demonstrated success in regions across the country. These use cases include: 1) Chronic disease management; 2) Medication therapy management; 3) Preventive care and immunizations; 4) Point-of-care test and treat ; 5) Transitions of care; and 6) Gaps in care.

Together, these use cases illustrate a growing toolbox of pharmacy interventions that can be tailored, combined and scaled to improve outcomes and efficiency across the healthcare continuum.

The Value Proposition for Health Plans and Pharmacies

The value proposition differs for plans and pharmacies depending on a plan's line of business (e.g. Medicaid, Medicare Advantage, commercial, etc.) and a pharmacy's ownership model (e.g. independent, chain, etc.). As a result, the clinical services, or use cases, most relevant and impactful will vary both across and within these organizations.

Health Plans

For health plans, the value of pharmacist-delivered services varies by line of business. Medicaid programs focus primarily on access and cost containment, whereas pharmacists can help to reduce avoidable utilization and improve reach in underserved communities. Medicare Advantage plans prioritize quality performance, with pharmacists able to play a direct role in driving adherence, improving outcomes, and influencing Star ratings. Commercial plans emphasize member experience and convenience, where pharmacists can enhance satisfaction, promote engagement, and contribute to healthier, more productive populations.

Line of Business	What They Value Most	High-Value Pharmacist Use Cases
Medicaid	Cost containment, access in underserved areas, avoidable ER use reduction	• Chronic disease management • Opioid management • Tobacco cessation
Medicare Advantage	Quality ratings (Star ratings, HEDIS), adherence, risk adjustment accuracy	• Comprehensive medication reviews • Personalized medication action plans • Adherence monitoring
Commercial (Employer & Individual)	Convenient access, member experience, productivity	• Point-of-care test & treat • Gap in care closures • Chronic disease management
Commercial FFS	Differentiation, service offerings, patient satisfaction	• Point-of-care test & treat • Preventive care and immunizations • Gaps in care closures

Note: *Traditional Medicare (FFS) is not included above as it does not designate pharmacists as providers, and therefore is not viable for a short-term innovation (as is the aim of this paper).*

Pharmacies

For pharmacies, the value depends on the ownership model. Independent pharmacies that provide clinical services can benefit by diversifying revenue streams and building stronger patient loyalty. Large pharmacy chains can leverage pharmacists' services to deliver standardized clinical offerings at scale, strengthening partnerships with payers and enhancing their role in care delivery. Health system pharmacies focus on care integration, where pharmacists reduce readmissions, support population health goals and extend the reach of clinical teams managing complex patients.

Pharmacy Value by Ownership Model

Pharmacy Type	What They Value Most	High-Value Pharmacist Use Cases
Independent	Revenue diversification, local patient loyalty, payer leverage	• Chronic disease management • Medication therapy management • Preventive care and immunizations
Chain	Scale, standardization, payer partnerships	• Point-of-care test & treat • Preventive care and immunizations • Gaps in care closure
Health System	Integration, reduced readmissions, population health	• Transitions of care • Medication therapy management • Preventive care and immunizations

Because the value of pharmacist-delivered services varies by plan and pharmacy, pilots often remain confined to a single program. Achieving scale requires alignment across regional stakeholders to create shared priorities and sustain impact.

Successful Use Cases and Their Business Models

Chronic Disease Management

Program Description: Chronic disease management programs are typically employer-sponsored, pharmacist-led care for diabetes, asthma, hypertension and lipids. In addition, these disease states also enable pharmacists to provide remote patient monitoring services, which already have established CPT codes for reimbursement. In the Diabetes Ten City Challenge (DTCC), community pharmacists provided scheduled coaching, medication optimization and guidelines-based follow-up to 573 adults with diabetes across 10 cities. In the Asheville Project, the initiative included education by a certified asthma educator and regular pharmacist follow-ups (reimbursed for MTM), with 207 asthma patients and 12 pharmacies.

> *"Where we have pharmacists in clinic, it's been much easier to work with those clinics, especially to tackle pharmacy-related measures [chronic disease quality measures]. They're definitely more effective in terms of managing that population."*
>
> ~ Health plan executive

Business Model & Flow of Funds: These models were typically employer funded through value-based benefit design: employers waived or reduced copays for chronic medications/supplies and paid pharmacists (often through a contracted pharmacy network) for documented coaching encounters. Medication spend often rose modestly (through better adherence), but was offset by lower medical claims (fewer ER visits and hospitalizations), yielding a net savings to the employer health plans. DTCC explicitly aligned financial incentives among patients (reduced out-of-pocket costs), pharmacists (service fees) and employers (lower total cost of care).

Outcomes:

- The Diabetes Ten City Challenge reduced average A1c from 7.5% to 7.1%, improved low-density lipoprotein (LDL) cholesterol and blood pressure, and generated annual savings of about $1,079 per patient. (Journal of the American Pharmacists Association)

- In Asheville, ER visits dropped from 9.9% to 1.3% and hospitalizations from 4.0% to 1.9%, with lower total asthma-related costs ($725/patient/year in direct costs and $1,230/patient/year in indirect costs), despite higher medication spend. (ScienceDirect)

Medication Therapy Management (MTM)

Program Description: MTM programs typically include comprehensive medication reviews, patient education and coordination with prescribers to ensure safe, effective and cost-efficient therapy. North Carolina's ChecKmedsNC (launched 2007) publicly funded MTM for Medicare Part D beneficiaries through the Health & Wellness Trust Fund; in 2010 it reached 11,671 members across 23,826 encounters. Minnesota's MTM program saw 34 pharmacists, mostly within integrated health systems and working closely with physicians, deliver services to 259 low-income patients with complex needs. (Oxford Academic, jmcp.org, communitypharmacyfoundation.org)

Business Model & Flow of Funds: Under Medicare Part D, plan sponsors pay pharmacies for comprehensive medication and targeted reviews, with savings accruing to the plan with lower medical and pharmacy claims. State Medicaid programs, like Minnesota, reimburse pharmacists directly for MTM encounters under defined codes/policies, while plans retain savings from reduced ER visits, readmissions and drug-related events. North Carolina's ChecKmedsNC used state grant dollars to pay pharmacies for MTM services delivered to Part D members. In most MTM arrangements, payments rarely reach the individual pharmacist who delivers the care. Instead, reimbursement is typically directed to the pharmacy (often a large chain) or a health plan that contracts the pharmacist at a fixed hourly rate. (jmcp.org, AJMC, communitypharmacyfoundation.org)

Outcomes:

- Minnesota Medicaid's MTM program saved an average $3,768 per patient annually and achieved a 12:1 return on investment. (AJMC; JMCP)
- North Carolina's ChecKmeds program saved $13.2 million in one year while improving medication adherence and patient satisfaction among Medicare beneficiaries. (AJMC)
- MTM participants experienced roughly 22% fewer hospital readmissions and 12% fewer emergency room visits compared with nonparticipants. (Frontiers in Pharmacology)

Preventive Care & Immunizations

Program Description: One of the earliest expanded roles for U.S. community pharmacists was vaccine administration. In the mid-1990s, community pharmacies began delivering adult vaccines (influenza, pneumococcal, zoster, COVID-19) and preventive screenings. By 2009, all 50 states allowed pharmacists to administer at least some vaccines. (AJMC)

Business Model & Flow of Funds: Pharmacies receive an administration fee plus vaccine product cost and payers realize avoided downstream medical costs from improved vaccination coverage. The financial incentive (vaccine margin and fees) has made immunizations a sustainable service in both chain and independent pharmacies. Medicare Part B reimburses influenza and pneumococcal vaccines and administration, while Part D covers zoster. Commercial insurance and Medicaid also reimburse pharmacist-administered vaccines. (School of Pharmacy)

Outcomes:

- A 2023 meta-analysis found pharmacist interventions increased adult vaccination uptake by ~51%. (Taylor & Francis Online)
- Increased vaccination coverage reduces preventable hospitalizations and delivers cost savings due to lower administration costs than physician offices. (Research in Social and Administrative Pharmacy)

Point-of-Care Test & Treat

Program Description: Point-of-care test & treat programs empower pharmacists to perform rapid diagnostic testing for select acute conditions, such as strep throat, influenza and urinary tract infections — directly in the pharmacy setting. By combining onsite assessment, testing and immediate initiation of appropriate therapy, these services improve timely access to care, reduce the need for separate clinic visits and help alleviate strain on primary and urgent care resources.

Business Model & Flow of Funds: Pharmacies bill a service fee (cash or payer-contracted rate) for the assessment and Clinical Laboratory Improvement Amendments (CLIA)-waived test, and dispense prescribed therapy through the pharmacy benefit; some programs also bill under the medical benefit through collaborative practice/provider status. Payers (or patients) fund the visit and test, with savings accruing by substituting lower-cost pharmacy visits for urgent care or ER visits. States such as Arkansas operationalize scope and protocol rules that enable clean billing and referral pathways.

Outcomes:

- In Washington state (large multichain study with 46 pharmacies), median total episode cost at traditional sites exceeded pharmacy care by $277.78. (Dove Medical Press)
- Care delivered in pharmacies for minor ailments cost a median $280 less per episode than care in primary care, urgent care or emergency settings. (ClinicoEconomics and Outcomes Research)

Transitions of Care

Program Description: Transitional care programs engage pharmacists to reconcile medications at hospital discharge, provide tailored patient education and coordinate timely follow-up to ensure therapy continuity. By preventing medication errors and closing gaps in care, these services help reduce avoidable readmissions and improve patient outcomes.

Business Model & Flow of Funds: Hospitals fund transitions of care services to mitigate Centers for Medicare & Medicaid Services (CMS) readmission penalties and improve quality. Accountable care organizations (ACOs) and health plans pay pharmacies through per member per month (PMPM) care-management fees, episode payments or per encounter contracts. Medications are billed under the pharmacy benefit, while service fees (medication reconciliation, adherence coaching, etc.) flow through hospital, plan or ACO agreements. Payers capture savings through lower 30- and 90-day utilization and hospitals benefit from avoided penalties and improved performance metrics.

Outcomes:

- Participation in Walgreens' WellTransitions® program was associated with a 46% reduction in unplanned hospital readmissions within 30 days of discharge. (AJMC)
- Hospital patients were about one-third less likely to be readmitted within 30 days and about one-quarter less likely within 90 days. (AJHP)
- Cambia Health Solutions' transitional care pharmacist model achieved a 2:1 return on investment, saving over $1,300 per patient.

Gaps in Care

Program Description: Gaps in care programs use pharmacist-led outreach to identify and close missed opportunities for recommended therapy, monitoring or preventive services, such as initiating statins in diabetic patients, adding angiotensin-converting enzyme (ACE) inhibitors in heart failure or updating overdue lab work. Using plan or EHR data, pharmacists proactively contact patients and coordinate with prescribers to address evidence-based care gaps which could otherwise increase risk of adverse events and higher downstream costs.

> *"We get a lot of data from our payer partners on open gaps...and we're doing a lot of great things together...transitions of care, med rec, immunizations, controlling blood pressure, controlling A1C."*
> ~ Multistate pharmacy executive

Business Model & Flow of Funds: Health plans and ACOs fund these programs through PMPM payments, care-gap closure incentives or performance-based contracts tied to quality metrics (e.g., Medicare Star ratings, HEDIS). Pharmacists may be embedded in health system care teams, contracted through community pharmacies or employed by PBMs. Savings accrue to plans through improved quality measure performance (driving higher bonus payments or avoiding penalties) and reduced acute care utilization from optimized therapy.

Outcomes:

- In a managed Medicaid population health initiative, pharmacist involvement was associated with a 74% care gap closure rate (versus 50% in control), meaning these patients were nearly three times more likely to have at least one care gap closed. (AJHP)
- A pharmacist-physician collaborative care model to support hypertension management resulted in lower program costs of over $100 and lower downstream medical expenditures of over $160 per patient. (JMCP)

Barriers Hindering Scalability of Use Cases

Scaling pharmacist-delivered clinical services is not a one-size-fits-all challenge, with each use case facing a unique mix of barriers. The table below maps the six clinical use cases against the four obstacles that most greatly impact patient volume and plan fragmentation.

High-impact barriers (●) represent persistent, market-wide constraints to significant patient volume. Medium-impact barriers (●) are context-dependent, affecting patient volume in certain geographies or payer segments. Lower-impact barriers (●) exist but exert less influence on early stage volume.

Barriers Across Use Cases

	USE CASE			
	Reimbursement & Contracting Complexity	Credentialing & Enrollment Delays	Technology/ Workflow Gaps	Outcomes & ROI Needs
1 Chronic Disease Management	●	●	●	●
2 Medication Therapy Management	●	●	●	●
3 Preventive Care & Immunizations	●	●	●	●
4 Point-of-Care Test & Treat	●	●	●	●
5 Transitions of Care	●	●	●	●
6 Gaps in Care	●	●	●	●

To truly scale these services, initiatives must not only tackle individual obstacles but also drive standardization and alignment across use cases, avoiding the ongoing fragmentation that limits sustainable impact.

Five Core Focus Areas for PHARMS

1. Service Prioritization

Why This Is Needed

Pharmacists provide high-value clinical services, but there is a lack of aligned demand across health plans for a specific clinical service(s) for which they wish to pay for; oftentimes, there is a lack of demand even within a single health plan among its different lines of business. Where demand is not aligned, pharmacists cannot justify investments in technology, workflows and staff training required to scale these services. In short, there is no viable business case. Establishing a shared, regionally aligned set of priority pharmacist services – chosen for their strategic fit, proven success, operational feasibility, and potential to generate repeatable patient volume – will enable focused investment, consistent workflows and a stronger case for payer engagement.

Purpose & Objective

The regional alliances should define and implement a short list of two to three high-priority pharmacist-delivered services that align with payer quality goals, population health priorities and pharmacy capabilities. The objective is to create a clear, shared focus across participating plans and pharmacies, ensuring that resources are concentrated on services most likely to deliver measurable value, drive early patient uptake and be operationally feasible at scale. The alliances will work to validate demand, integrate these services into regional payer programs and establish the data and operational frameworks to support broader adoption.

Further, it is recommended that regions start with FFS reimbursement models to build early traction, measure results and refine workflows before layering in value-based or hybrid payment approaches. Outcomes from FFS delivery will help establish benchmarks and demonstrate clinical and financial performance needed to secure payer confidence and justify the transition to value-based models.

Key Regional Workstreams

Workstream	Phase 1 Foundation	Phase 2 Implementation & Scale
Reimbursable Services Prioritization	Identify and validate two to three high-value pharmacist services based on clinical impact, payer alignment, and operational readiness.	Align prioritized services with payer programs, quality metrics (e.g., HEDIS, Star ratings) and population health strategies.
Care Bundle Development	Develop standardized care bundles and protocols for each prioritized service.	Implement bundles in participating pharmacies; align with payer incentives and reporting requirements.
Standing Orders & Protocol Integration	Create model standing orders and scope-aligned protocols for prioritized services.	Integrate protocols into payer-approved workflows and ensure alignment with reimbursement and quality reporting systems.
Service Value & Outcomes Tracking	Define outcomes measures and operational key performance indicators (KPIs) for each prioritized service.	Collect, analyze and share regional results to demonstrate ROI and support payer scaling.
Reimbursement Model Focus	Recommend launching prioritized services under a FFS model to enable quick start-up, predictable payment and measurable early impact; document operational learnings.	Introduce value-based or hybrid payment models for services that demonstrate consistent quality and ROI; evaluate performance under both models.

2. Reimbursement & Contracting Standardization

Why This Is Needed

While pharmacists are authorized to deliver a growing range of clinical services, reimbursement remains inconsistent and fragmented across the medical and pharmacy benefits. Under the medical benefit, pharmacists face hurdles like lack of provider recognition, inconsistent CPT code usage and manual claims processes. Meanwhile, many services, such as immunizations, contraception and digital therapeutics, are already supported under the pharmacy benefit via National Council for Prescription Drug Programs (NCPDP) standards with real-time adjudication, but these workflows remain siloed from the medical billing systems used for most providers.

> *"Everybody's approach is different, the funding mechanisms are different, the mechanism by which you bill is different."*
>
> ~ National pharmacy chain executive

Compounding this challenge, contracting models for pharmacist-delivered services vary widely across payers, slowing adoption and creating operational inefficiencies. A sustainable regional model requires harmonizing both reimbursement and contracting practices, aligning service eligibility, documentation requirements, payment methods and contract structures. This allows local payers to integrate pharmacists into their existing networks, improve operational efficiency and enable long-term growth of pharmacist-delivered clinical services.

Purpose & Objective

The regional alliances should work to establish standardized, scalable reimbursement and contracting methods for pharmacist-delivered services. The effort will focus on aligning CPT and pharmacy benefit coding across participating payers, developing and testing billing workflows that fit existing pharmacy operations, creating shared documentation and ROI standards to demonstrate value, and establishing consistent contract language and structures that reduce administrative burden and enable repeatable service deployment. This work will be paired with targeted policy engagement and payer collaboration to achieve reimbursement parity in the region. The alliances will not directly process claims, negotiate individual rates or execute contracts on behalf of members but will provide the shared infrastructure, policy alignment and standardized frameworks needed for sustainable adoption.

Key Regional Workstreams

Workstream	Phase 1 Foundation	Phase 2 Implementation & Scale
CPT Code Recognition	Identify pharmacist-eligible CPT/HCPCS codes for priority services; validate with participating payers.	Align usage across regional commercial, Medicaid, and Medicare plans; monitor acceptance and adjust.
Billing Pathways (Medical & Pharmacy)	Document local use cases for pharmacy benefit billing (e.g., flu, contraception) and current medical benefit gaps.	Implement standardized medical benefit protocols and integrate eligibility/ adjudication checks with participating payers.
Billing Infrastructure Modernization	Assess gaps in local pharmacy electronic health record (EHR)/billing systems; define requirements for pharmacist billing support.	Deploy targeted health information technology integrations (e.g., 837P support) and train staff to ensure consistent workflows.
Contracting Standardization	Map current contracting approaches for clinical services; identify common terms and payer expectations.	Develop and implement a standardized regional contract template for participating pharmacies and payers.
Documentation & ROI Standards	Develop regional templates for care documentation and outcome tracking (e.g., adherence, A1c reduction).	Standardize reporting formats and share aggregated ROI data with payers and policymakers.
Standard Code Mapping & Tools	Publish CPT/NCPDP mapping for priority services; integrate into local pharmacy software.	Add structured clinical vocabularies (SNOMED, LOINC) and explore artificial intelligence-assisted documentation pilots.
Reimbursement Parity Advocacy	Build consensus among alliance members on parity targets (e.g., 85% of physician rates).	Engage with state agencies and payer executives to secure parity commitments or pilot agreements.

3. Credentialing & Enrollment Infrastructure

Why This Is Needed

Pharmacists are often excluded from health plan provider networks, not due to policy resistance but because of operational gaps in credentialing and enrollment systems. Without streamlined, consistent credentialing processes, pharmacists cannot be recognized as clinical providers at scale, undermining the ability to operationalize contracts or directory inclusion even where policy allows it.

Purpose & Objective

This initiative seeks to establish a standardized, scalable infrastructure to credential and enroll pharmacists across payer systems. Each alliance will develop shared frameworks, promote centralized and automated credentialing pathways and advocate for delegated credentialing models. It will not directly build or operate credentialing platforms but will convene stakeholders to define standards and support adoption among regional partners.

> *"Standardization is always a goal. The more that you can replicate, the easier it is to stand it up, the easier it is to expand and create quality controls."*
>
> ~ Health plan executive

Workstream	Phase 1 Foundation	Phase 2 Implementation & Scale
Standardized Credentialing Framework	Draft regional pharmacist credentialing policy; align with national best practices (e.g., APhA AQHA).	Secure payer agreement on framework; adopt in regional contracts and processes.
Delegated Credentialing Models	Identify and document existing best practices from local payers and networks.	Execute delegated credentialing agreements with participating payers; embed into workflows.
Centralized Credentialing Registry (Regional)	Define requirements for a shared, secure registry for participating pharmacies.	Launch regional registry; integrate with payer systems for credential validation.
Enrollment & Directory Automation	Collaborate with payers on a shared specification for enrollment and validation.	Implement automatic enrollment processes; ensure pharmacists are visible in payer/ provider directories.
Credentialing Pathways by Pharmacist Type	Map and document pathways for different pharmacy settings (retail, independent, health system).	Harmonize and embed pathways across all participating organizations.

4. Technology & Workflow Enablement

Why This Is Needed

Pharmacy workflows, including dispensing, documentation and billing, remain siloed from the rest of the care system. Without integration into EHRs, pharmacist-delivered care is often invisible to providers and nonbillable to payers. Pharmacies and their partners should work toward interoperability but should not be held to higher standards than other care providers before payment flows. Scalable care delivery requires pharmacy platforms that support documentation, communication and billing in a way that "plugs and plays" across pharmacy types, payer systems and geographies.

Purpose & Objective

The regional alliances should define the technical foundation needed for scalable pharmacy-based care, including interoperable platforms, standards documentation protocols and payer-aligned billing infrastructure. The alliances will not build or own technology but will establish functional and data exchange requirements, support real-world pilots and promote adoption of shared technical and workflow standards. Further it is recommended that regions begin with fee-for-service billing integration to enable rapid service launch and measurable early ROI, followed by the introduction of value-based and hybrid models for services that prove sustainable.

Key Regional Workstreams

Workstream	Phase 1 Foundation	Phase 2 Implementation & Scale
Core Platform Requirements	Refine and expand upon EHR-like requirements for pharmacy platforms, covering documentation, billing (with initial FFS focus) and scheduling.	Validate platforms through multisite pilots and prepare them for value-based care (VBC)-capable workflows.
Data Standards & Interoperability	Identify required standards (e.g., FHIR, SNOMED, LOINC, NCPDP eCare Plan) and align with payer and provider expectations.	Scale adoption across participating pharmacy networks and integrate into payer systems.

Workstream	Phase 1 Foundation	Phase 2 Implementation & Scale
Bidirectional Data Exchange	Define technical requirements for FHIR-based pharmacy–EHR exchange, starting with essential FFS billing-related data flows.	Expand to full real-time exchanges for referrals; labs; admission, discharge, and transfer (ADT) alerts; and care coordination under VBC arrangements.
Referral & Alerts Infrastructure	Design workflows that enable bidirectional referrals to and from pharmacists as well as discharge plans sent to pharmacy EHR software.	Fully integrate pharmacy referrals and alerts into payer/provider navigation systems (e.g., accountable care organizations [ACOs], managed care organizations [MCOs]).
Billing & Eligibility APIs	Define medical billing integration requirements (e.g., 837P, CPT mapping) and pilot real-time eligibility validation with payers, prioritizing FFS claims first.	Expand to include VBC metrics, risk-adjusted payment logic, and hybrid payment processing.
Payer–Pharmacy Data Flow	Promote payer acceptance of PeCP-compliant records and FHIR feeds for FFS payment verification.	Align PeCP data with Star ratings, HEDIS and VBC reporting, incentivizing documentation through bonuses or contractual performance metrics.

5. Performance Metrics & Value Demonstration

Why This Is Needed

Pharmacist-delivered services are often excluded from value-based care frameworks due to industry inertia and the lack of a historical track record for pharmacists as recognized providers. Without established performance benchmarks, shared metrics, or ROI models, payers lack the evidence needed to justify renewing or expanding contracts. The absence of standardized measurement also makes it harder for pharmacies to demonstrate their role in improving quality and lowering costs. Scalable investment requires transparent, aligned measurement systems that capture both the clinical and financial value of pharmacist interventions, starting with metrics that can be applied in fee-for-service arrangements and evolving toward full VBC integration.

Purpose & Objective

The regional alliances should aim to define standard performance metrics and outcomes reporting infrastructure to make the pharmacist's clinical impact visible to plans. This work should begin with a core set of quality and financial measures that can be applied to FFS reimbursement models to build early benchmarks and plan trust. Over time, these measures can be adapted to support value-based and hybrid payment models. The alliances should not collect or manage data directly but develop metric sets, ROI calculators, attribution frameworks, and reporting templates that participating pharmacies and plans can embed into their contracting and quality improvement processes.

> *"If there's a way for health plans to recognize that pharmacists can help move the needle on quality measures, that's going to help a lot."*
>
> ~ Industry association executive

Key Regional Workstreams

Workstream	Phase 1 Foundation	Phase 2 Implementation & Scale
Unified Quality & Outcome Metrics	Define core performance indicators (e.g., HEDIS, adherence, gap closures) suitable for FFS evaluation.	Align metrics with VBC frameworks (e.g., Star ratings, Medicaid quality plans) and integrate into contracts.
Attribution Protocols	Develop frameworks to attribute outcomes directly to pharmacist interventions in FFS services.	Test and formalize attribution standards for broader VBC and hybrid model use.
Outcomes Dashboards	Create templates for visualizing care gap closures, utilization changes and ROI from FFS programs.	Deploy dashboards in pharmacy HIT systems and embed them into payer/provider quality platforms.
ROI Modeling	Build pharmacy-specific ROI calculators (e.g., cost avoidance, A1c reduction) using FFS data.	Publish benchmarks and case studies to support contract renewals, expansions and VBC transitions.
Pharmacy VBC Contract Integration	Recommend performance metrics for future VBC contracts based on early FFS results.	Support payers in integrating pharmacy metrics into outcomes-based payment models.
Data Acceptance & Automation	Define required data elements for HEDIS and risk adjustment ingestion, starting with FFS claims.	Automate PeCP and structured pharmacy data transfers into payer quality systems for VBC reporting.

Links to Case Studies and Tactical Elements for PHARMS

1. Case Study for Pharmacists Expanded Scope of Practice in Canada
2. How we Define “Scale” for Pharmacist-Delivered Clinical Services
3. Case Study: How National Infrastructure and Regional Initiatives Helped Pave the Way for e-Prescribing Adoption