Pharmacists as Providers in Ohio – A Statewide Implementation Summary and Operational Best Practice

Stuart Beatty, PharmD, MPAL, BCACP, FAPhA

Dean and Professor
Ohio Northern University
Raabe College of Pharmacy

E. Michael Murphy, PharmD, MBA

Senior Advisor for State Government Affairs
American Pharmacists Association

Assistant Professor of Pharmacy Practice
The Ohio State University College of Pharmacy

Cory P. Coffey, PharmD, MS, BCACP, BCPP

Manager of Pharmacy Services
OSU Physicians, Inc.

Assistant Professor – Practice
OSU Department of Internal Medicine

Financial Disclosures

Our speakers declare that they have not had a relevant affiliation or financial arrangement with any ineligible companies that may have a direct interest in the subject matter of this continuing pharmacy education activity within the past 24 months.

Additionally, members of the District 4 Planning Committee and NABP staff involved in the planning of this activity do not have any current affiliation or financial arrangement with any ineligible companies that may have a direct interest in the subject matter of NABP's CPE program within the last 24 months.

AI Disclosure:

Artificial intelligence was not used for any component of this continuing education presentation.

Objectives

- Outline the utilization rates and structural differences of pharmacist medical billing across practice settings.
- Summarize best practices to maximize the financial and operational impact of pharmacist provider status at practice sites.
- Discuss strategies to overcome implementation barriers by pharmacists.

Payment for pharmacists' services

Programs across the country and barriers to implementation



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Where are the policy levers* to pay pharmacists for services?

	Percent of US Population	Federal Policy	State Policy	Private Sector Policy
Employer (self-funded, estimated)	30.6%	✓	✗	✓
Medicaid	20.4%	✓	✓	◐
Employer (fully insured, estimated)	18%	✓	✓	✓
Medicare	14.8%	✓	✗	◐
Uninsured	8.2%	✗	✗	✓
Non-Group	6.6%	✓	✓	✓
Military	1.3%	✓	✗	✗

✓ = Can directly establish or require a payment pathway
◐ = Limited or conditional plan/contract authority
✗ = No general direct payment authority

*These are alternative, not cumulative, pathways. One actor may establish payment without action at every other level.

Sources: KFF 2024 total-population coverage and KFF 2024 Employer Health Benefits Survey

ECAPS has advanced in the House

H.R. 3164: Ensuring Community Access to Pharmacist Services Act

MAY 21, 2026

Ways and Means Committee approval

Committee version: Main Street Pharmacy Access Act

SEPTEMBER 15, 2026

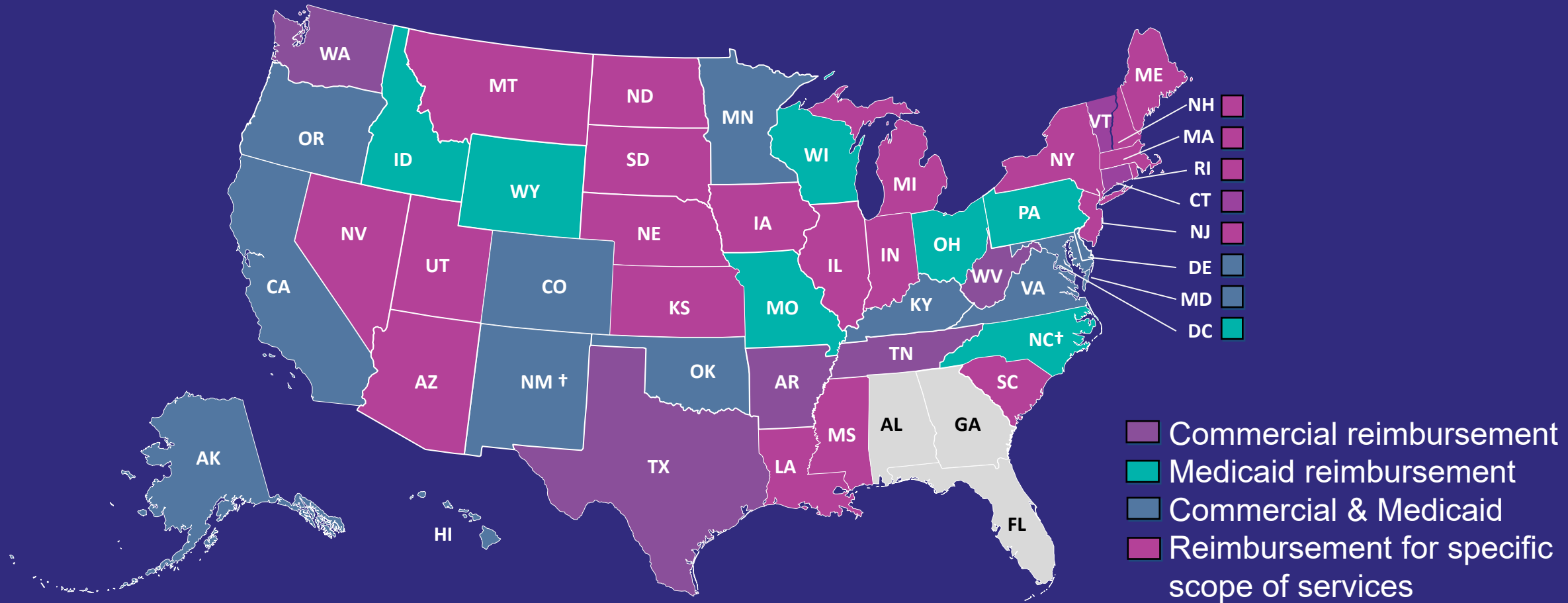
Energy and Commerce Health Subcommittee hearing

The hearing included H.R. 3164 among Medicare payment proposals.

Proposed Medicare Part B payment for specified infectious-disease services within state-authorized scope.

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Payment for Pharmacists' Services in the States*



Updated July 2026

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

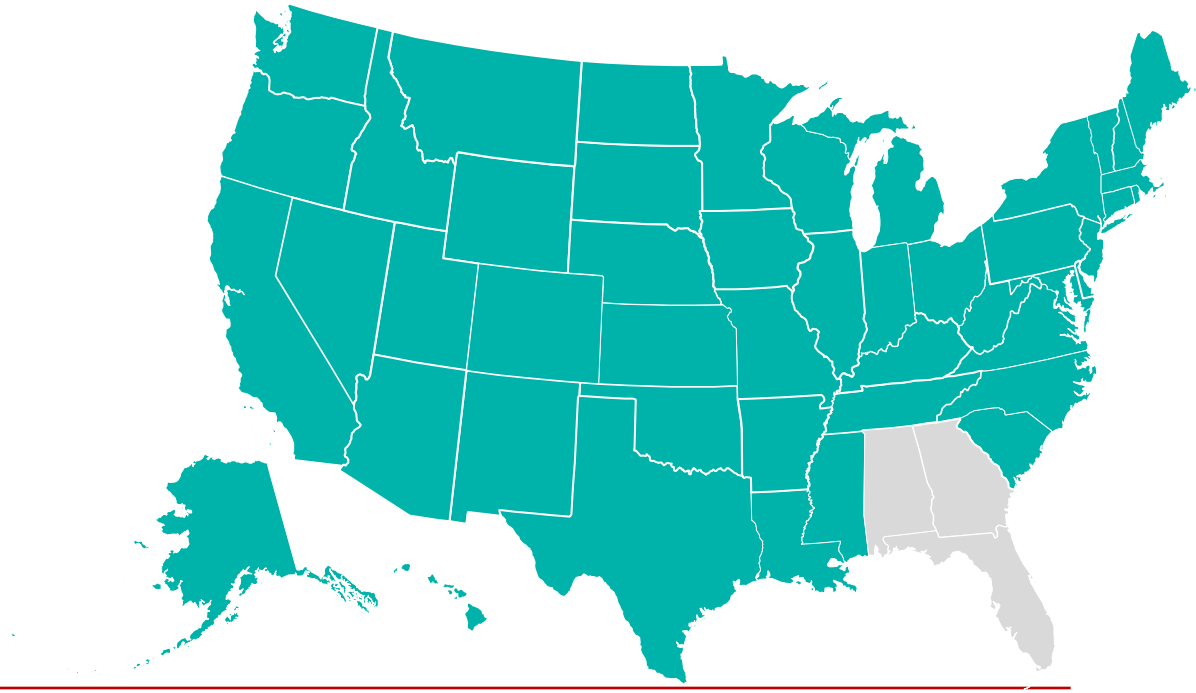
†Pharmacist reimbursement for a broad scope of services is largely tied to the requirement of being an advanced practice pharmacist

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Trends in payment for pharmacists' services in the states

- Currently, states can add pathways to pay for pharmacists' services for **~45% of the population**
- With the passage of ECAPS, certain states may see coverage expand to **~59.8% of the population**
- Despite broad availability of programs, there have been reports of limited participation
- Significant implementation barriers remain

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

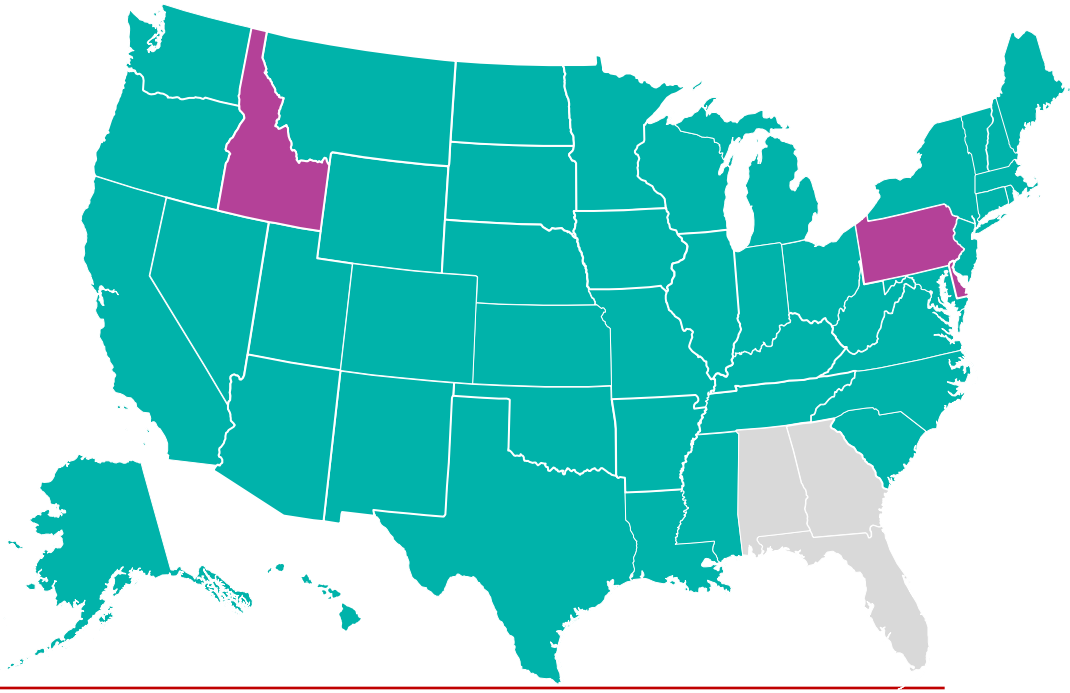


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Three state pathways are making payment operational

- **Delaware:** A Medicaid state plan amendment added pharmacists as providers; covered services are paid at 100% of the physician fee schedule.
- **Idaho:** Enrollment and claims-system changes moved pharmacists from ordering/referring to rendering providers; configured codes pay at 85% of the Medicaid fee schedule.
- **Pennsylvania:** Enrollment and billing guidance opened medical-benefit billing; pharmacists can generate billable encounters in FQHCs and RHCs.
- **Takeaway:** Implementation may live in a SPA, provider manual, fee schedule, or claims edit, not only in legislation.

State payment examples



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Why coverage authority does not automatically produce participation

- **Enrollment and contracting friction:** Lengthy credentialing, separate payer processes, and unclear taxonomy requirements.
- **Coverage and billing restrictions:** Limited codes, referral requirements, and inconsistent rules across payers and settings.
- **Claims-system barriers:** Pharmacists may not be recognized as rendering providers, producing rejected or denied claims.
- **Weak financial viability:** Reimbursement may not cover pharmacist time, supplies, administrative work, or billing costs.
- **Practice infrastructure gaps:** Limited staffing, medical-billing technology, clinical data access, referral pathways, and denial-management expertise.
- **Scope of practice:** Inefficient ability for pharmacists to provide care

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Determining standard of care status

SOC is not one binary variable

1. **Disciplinary standard** – how the board evaluates professional conduct.
2. **Interpretation rule** – whether unprohibited services are permitted within competence and SOC.
3. **Full-practice language** – whether statute expressly includes broad functions such as assessment, testing, and prescribing.

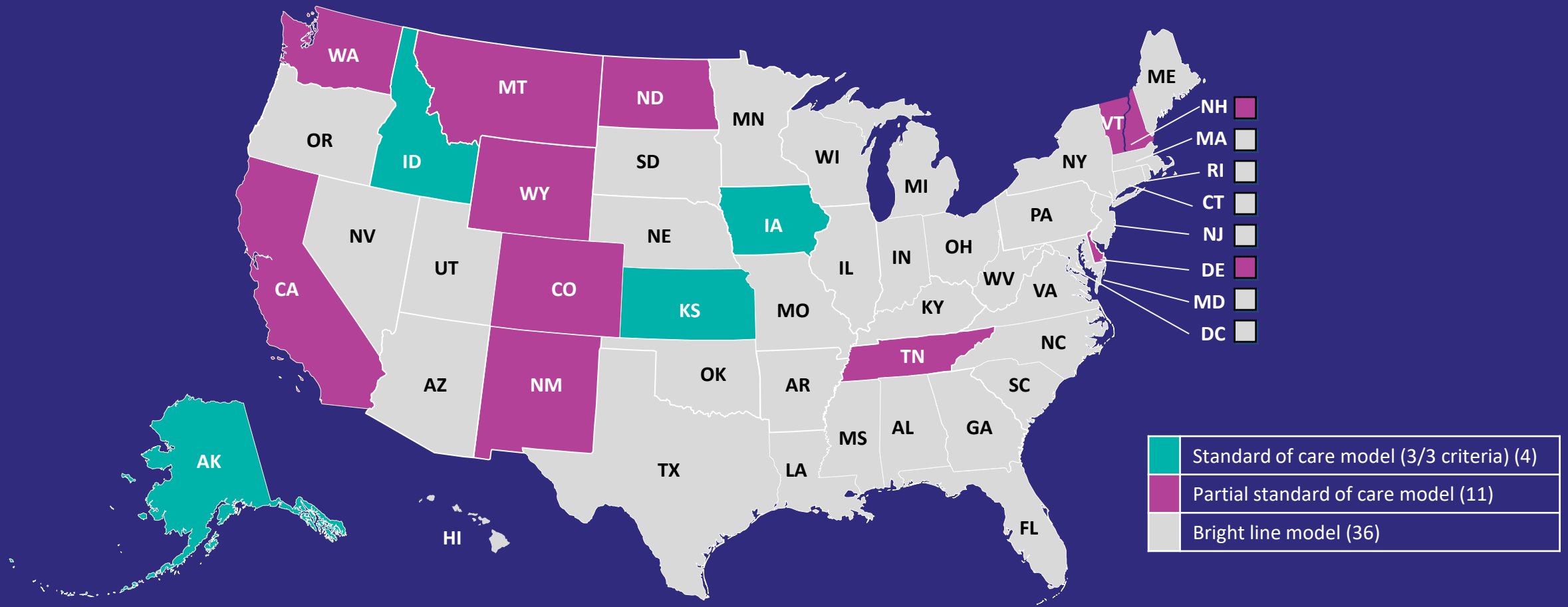
Then validate the constraints

- **Carve-outs and exceptions**
  - board rules
  - effective dates
  - implementation dependencies

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Pharmacist Practice Regulatory Models

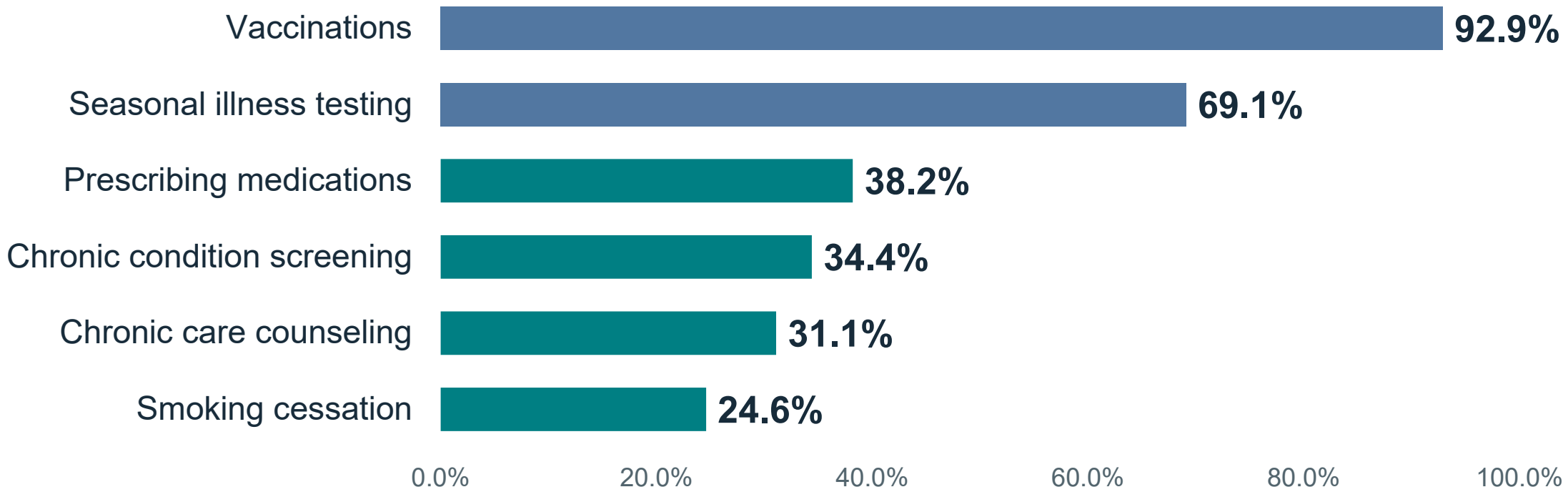


Updated Aug. 2026
Source: APhA Analysis of State Policies; Jennifer Adams, PharmD, EdD, FAPhA, FNAP

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Patient demand may be another barrier

Services respondents recognized pharmacists could provide



395 respondents answered this item in a 405-adult convenience sample in Columbus, Ohio.

Michel D, Murphy EM, Shaw Ojeda M, Hill EG. Pharmacists through a public lens: Understanding trust, role recognition, and support for prescribing.

Low awareness can coexist with receptivity

Patient demand remains an implementation question to test

12.2%

reported a pharmacist service beyond vaccination or dispensing in the previous 12 months

49 of 403 respondents

91.2%

were comfortable with pharmacists independently prescribing medicines for seasonal illnesses

344 of 377 respondents

Programs can test clear service descriptions, visible coverage and costs, and an easy way to book.

Michel D, Murphy EM, Shaw Ojeda M, Hill EG. Pharmacists through a public lens: Understanding trust, role recognition, and support for prescribing.

Boards and colleges can support implementation

Priorities for District 4

Boards of pharmacy

Review administrative requirements for a clear patient-safety benefit.

Consider updating regulatory model to align with standard of care.

Colleges of pharmacy

Teach billing and service operations alongside clinical care.

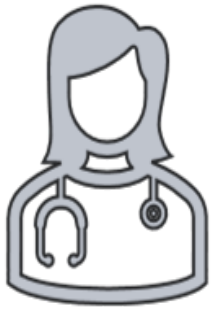
Build experiential partnerships that deliver and measure paid clinical services.

Shared measure of progress: patients served, claims paid, administrative time, and safety.

Ohio Implementation

Pharmacist Provider Status – Ohio

Ohio Senate Bill 265 in the 132nd General Assembly was signed into law in January 2019



Pharmacists as Providers

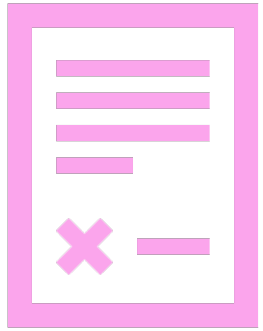


Permitted Insurer Coverage

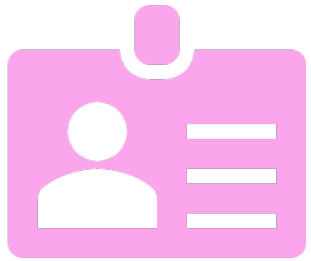


Pilot Programs *Without a Mandate*

Pharmacist Provider Status – Ohio



Pharmacists can sign up for Medicaid ID number



Pharmacists can enroll with Medicaid and MyCare plans



Pharmacists can bill for services if all rules met (finalized Jan ’21)

ORC 5160-8-52

- Payment may be made to pharmacist:
  - Scope of practice
  - Medically necessary
  - Has order issued by practitioner with prescriptive authority
  - Meets following criteria:
    - Managing medications under consult agreement
    - Administering immunizations
    - Administering medications

http://www.registerofohio.state.oh.us/pdfs/5160/0/8/5160-8-52_PH_FF_N_RU_20210107_1605.pdf

ORC 5160-8-52

- Additional rules
  - Payment may be made for telehealth services
  - Managed Medicaid plans may pay for services outside of criteria listed if they choose
  - Payment will be 85% of Medicaid maximum amount for each code
    - Equivalent to ANP, PA
  - No separate payment made for pharmacist services in facility, emergency department, or inpatient psychiatric facility

http://www.registerofohio.state.oh.us/pdfs/5160/0/8/5160-8-52_PH_FF_N_RU_20210107_1605.pdf



If you build it, he (they) will come

Health Affairs Scholar, 2026, 4, 1–8
https://doi.org/10.1093/haschl/qxag126
Published: 21 May 2026
Research article

Health Affairs Scholar OXFORD
EMERGING & GLOBAL HEALTH POLICY

Pharmacist participation as providers in Ohio Medicaid: an analysis of claims, services, and billing patterns, 2021-2025

E. Michael Murphy [1,2]*, Stuart J. Beatty [3], Macarius M. Donneyong[1], Henry J. Mann [1]

[1]Division of Pharmacy Practice and Science, The Ohio State University College of Pharmacy, Columbus, OH 43210, United States
[2]Government Affairs, American Pharmacists Association, Washington, DC 20037, United States
[3]Raabe College of Pharmacy, Ohio Northern University, Ada, OH 45810, United States
*Corresponding author: Division of Pharmacy Practice and Science, College of Pharmacy, the Ohio State University, 500 W. 12th Ave, Columbus, OH 43210, United States. Email: murphy.981@osu.edu

- All pharmacist-submitted claims from 1/21/17 to 1/17/25
  - Number of pharmacists that have submitted claims
  - Frequency and types of ICD and CPT codes
  - Total reimbursement paid by Medicaid

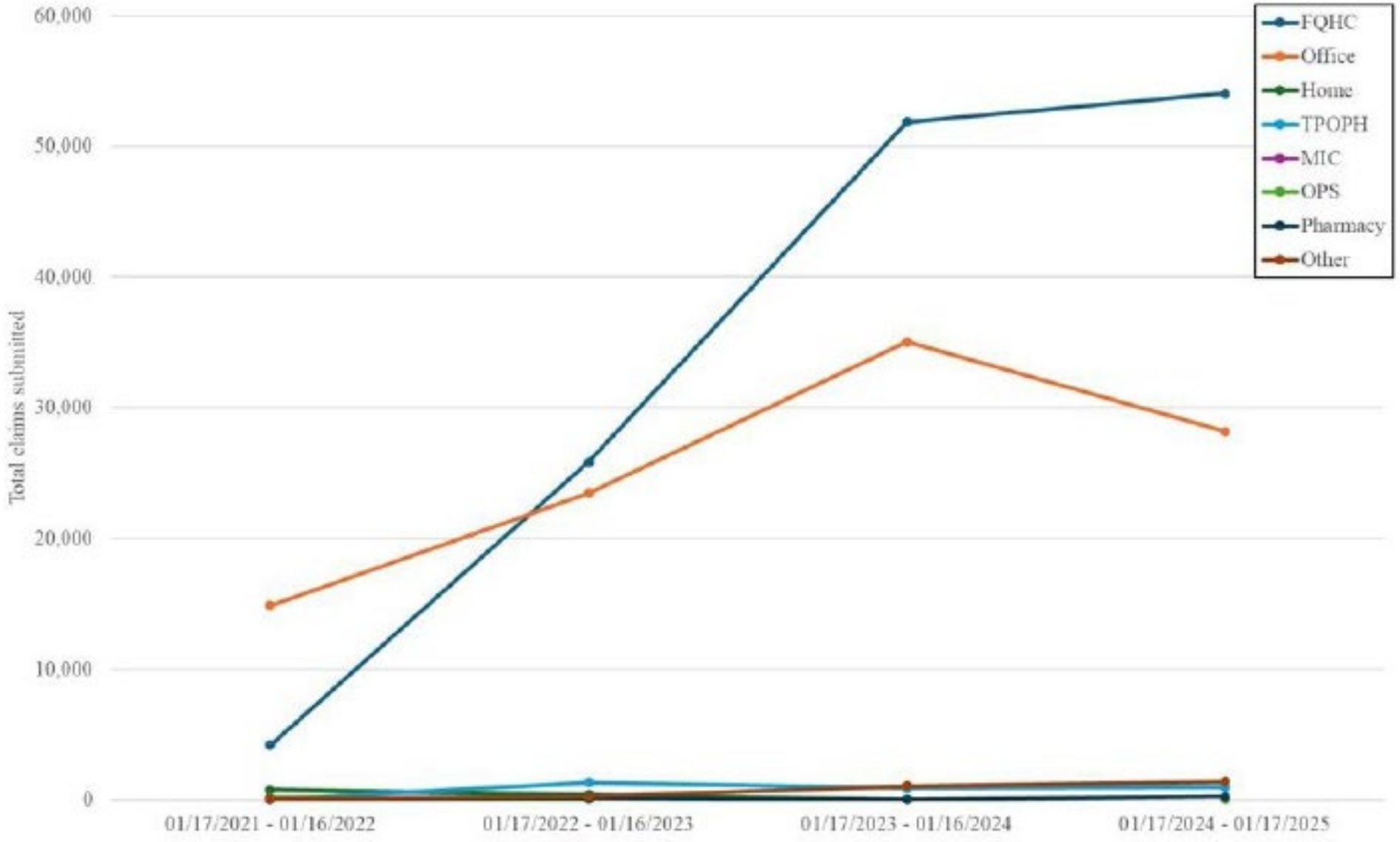
Ohio Medicaid Analysis

Table 1 Submitted pharmacist claims by place of service January 17, 2021 to January 17, 2025.

Place of service	Total claims submitted		Claims paid, *n* (%)[a]	Claims denied, *n* (%)[a]	Payment made ($)	Payment denied ($)
FQHC	135 892	96.7%	117 778 (87)	18 114 (13)	2 498 217	857 779
Office	101 548		86 329 (85)	15 219 (15)	1 758 610	711 099
Home	1206		1009 (84)	197 (16)	58 077	20 431
TPOPH	3231		1814 (56)	1417 (44)	44 620	63 716
MIC	164		146 (89)	18 (11)	8141	1275
OPS	282		246 (87)	36 (13)	7297	1930
Pharmacy	460	0.19%	368 (80)	92 (20)	7076	3755
Other[b]	2793		1665 (60)	1128 (40)	14 123	54 154
Total	245 576		209 355 (85)	36 221 (15)	4 396 161	1 714 139

Health Affairs Scholar 2026; 4:1-8

Ohio Medicaid Analysis



Health Affairs Scholar 2026; 4:1-8

Ohio Medicaid Analysis – Diagnoses

Diagnosis Category	ICD 10	Total number of claims
Type 2 diabetes mellitus	E11	138,379
Special exam without complaint	Z01	19,080
Essential (primary) hypertension	I10	15,582
Nicotine dependence	F17	8,058
Type 1 diabetes mellitus	E10	6,861
Viral hepatis	B18/B19	5,246
Opioid related disorders	F11	3,992

Health Affairs Scholar 2026; 4:1-8

Ohio Medicaid Analysis – Billing

Category	CPT Code	Total claims submitted
Office/outpatient visit	99202-99214	77,241
Risk factor reduction/behavior change intervention	99401-99404	9,869
Telephone services	99441-99442	9,519
Immunization administration	90471, 0001A, 0011A, 0012A, 0071A	1,788
Continuous glucose monitoring	95250-95251	1,731
Clinic visit/encounter	T1015	25,171

Ohio Medicaid Implementation Takeaways

- Pharmacist implementation is not automatic or immediate
- Most implementation occurring at team-based settings
- Encounters tend to be for chronic disease management and are largely face-to-face

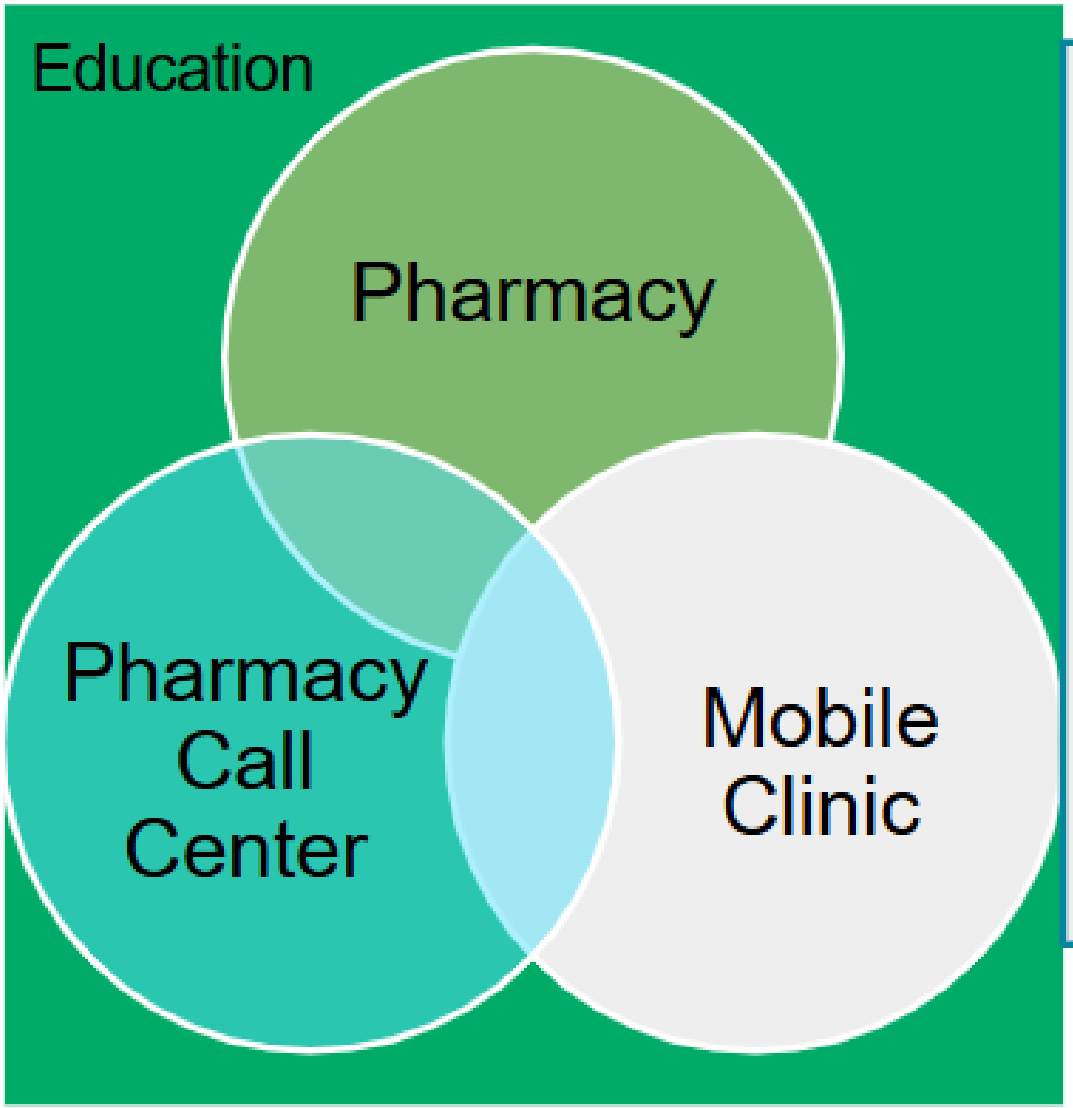
Pharmacists can get paid!

Pharmacists can fill primary care gaps!

Health Affairs Scholar 2026; 4:1-8

- Adherence packaging
- Employer contracts (e.g., pass through)
- Utilize med sync programs
- Market primary care / urgent care services
- Long-term care contracts

- Telehealth follow-up for pharmacy and mobile clinic (e.g., RPM, adherence)
- Payor contracts (e.g., gap closure)



- Pharmacy delivery to rural areas
- Bill for clinical services and establish primary care model
- Expand employer contracts
- Affiliate with health-systems for specialist
- Track outcomes to establish rural healthcare best practices



HealthWise



Go the distance.

Ohio Implementation – Best Practice

Pharmacists as Providers in Ohio: A Statewide Implementation Summary and an Operational Best Practice



Cory P. Coffey, PharmD, MS, BCACP, BCPP
Manager of Pharmacy Services
OSU Physicians, Inc
Director, PGY1 Ambulatory
The Ohio State University College of Pharmacy

October 15, 2026
11:15 AM
NABP/AACP District IV

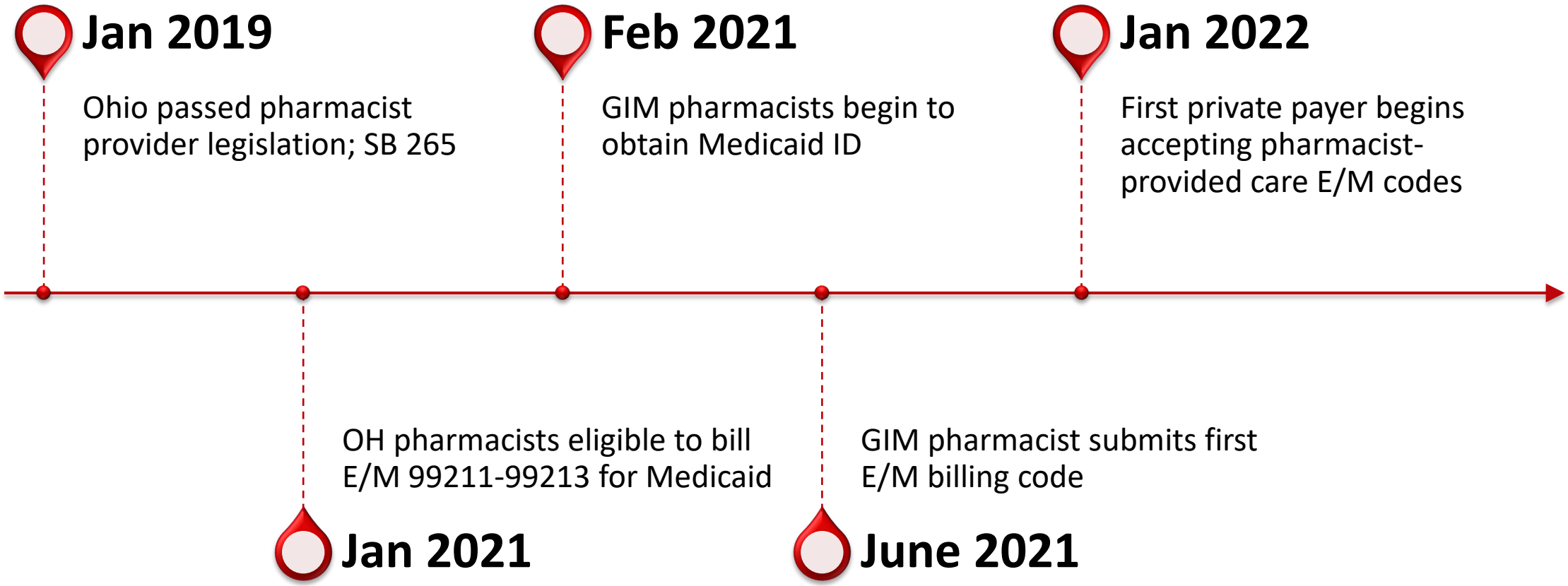
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Ohio Provider Status



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Burks K, et al. A systematic review of outpatient billing practices. *SAGE Open Medicine*. 2022;10. doi:

Shifting Pharmacist-Provided Care Model

Pre-provider status

- Incident-to billing
- Non-scheduled care model
- “Extra” support in office setting

Post-provider status

- E/M billing (99211-99214)
- Scheduled visit model
- Integrated pharmacist referral process

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Results

Pharmacist Encounters Per Year – Billable and Non-Billable (N = 14416)

Encounter Type	2020	2021	2022
Office Visit	573	275	1021
Telehealth	883	3486	5250
Electronic Consult	377	488	251
*Other**	30	714	1068
Total Encounters	1863	4963	7590

*Other includes anticoagulation monitoring, documentation that occurred outside of a scheduled visit, within the secure electronic patient portal, or as part of the refill process that required intervention

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Results

Payor Demographics of Pharmacist Encounters (N = 14416)

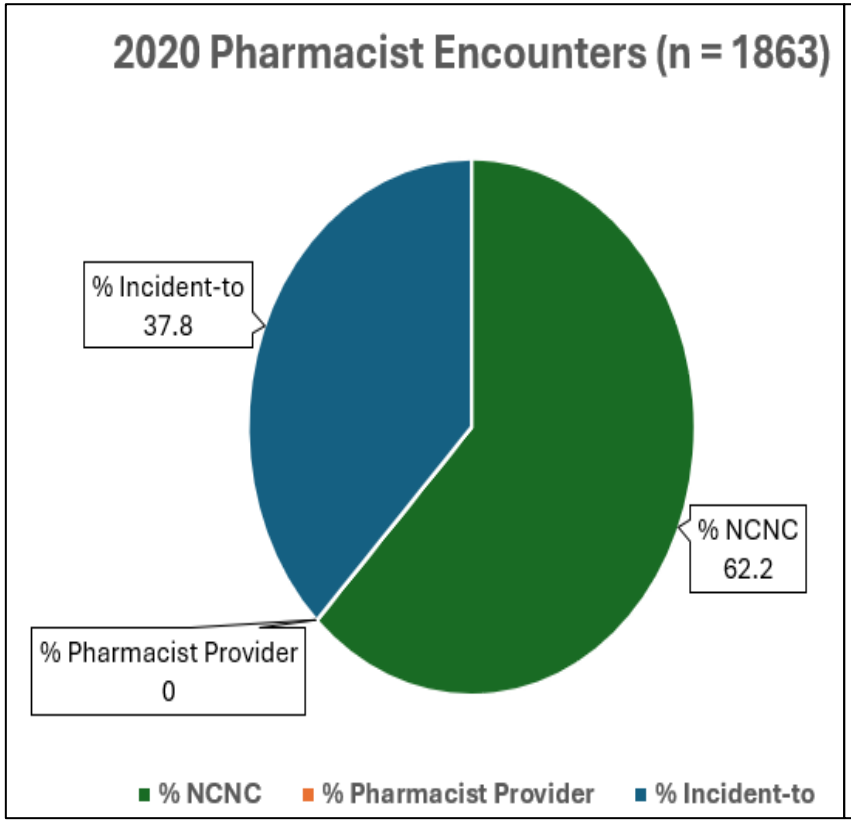
Insurance Type	2020 (n = 1863)	2021 (n = 4963)	2022 (n = 7590)
Medicaid	27.4%	19.5%	28.6%
Medicare	36.1%	35.2%	30.1%
Dual Medicare/ Medicaid	3.3%	3.8%	5.1%
Private	18.2%	34.6%	33.1%
Self-pay	15%	6.9%	3.1%

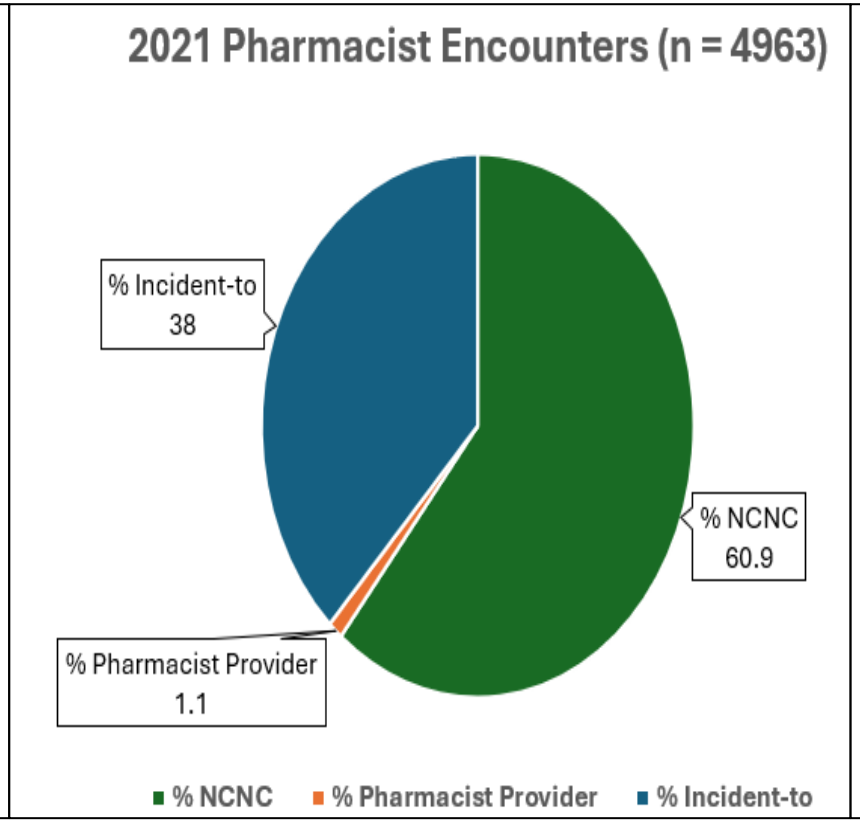
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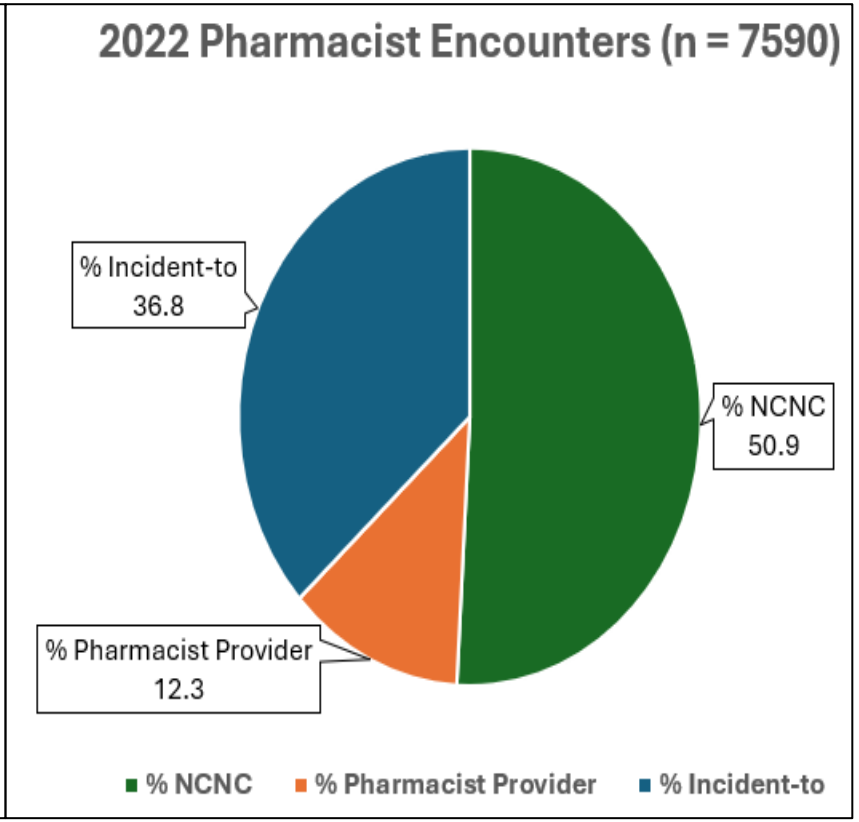
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Results

Yearly Growth of Percent of Pharmacist Provider Encounter Billing





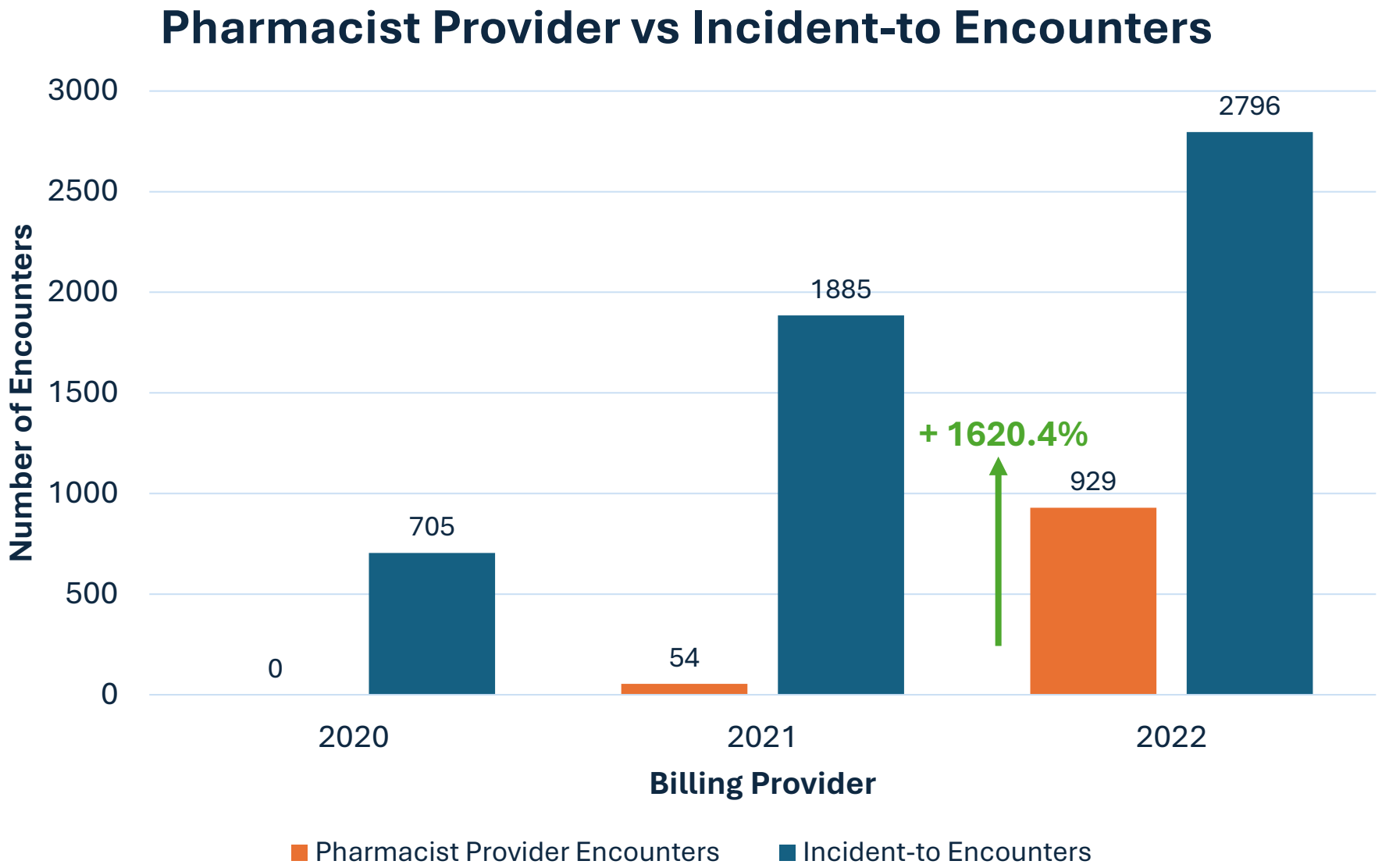


NCNC = no charge for service

Incident-to = service provided by auxiliary personnel under physician's supervision; billed under physician's NPI

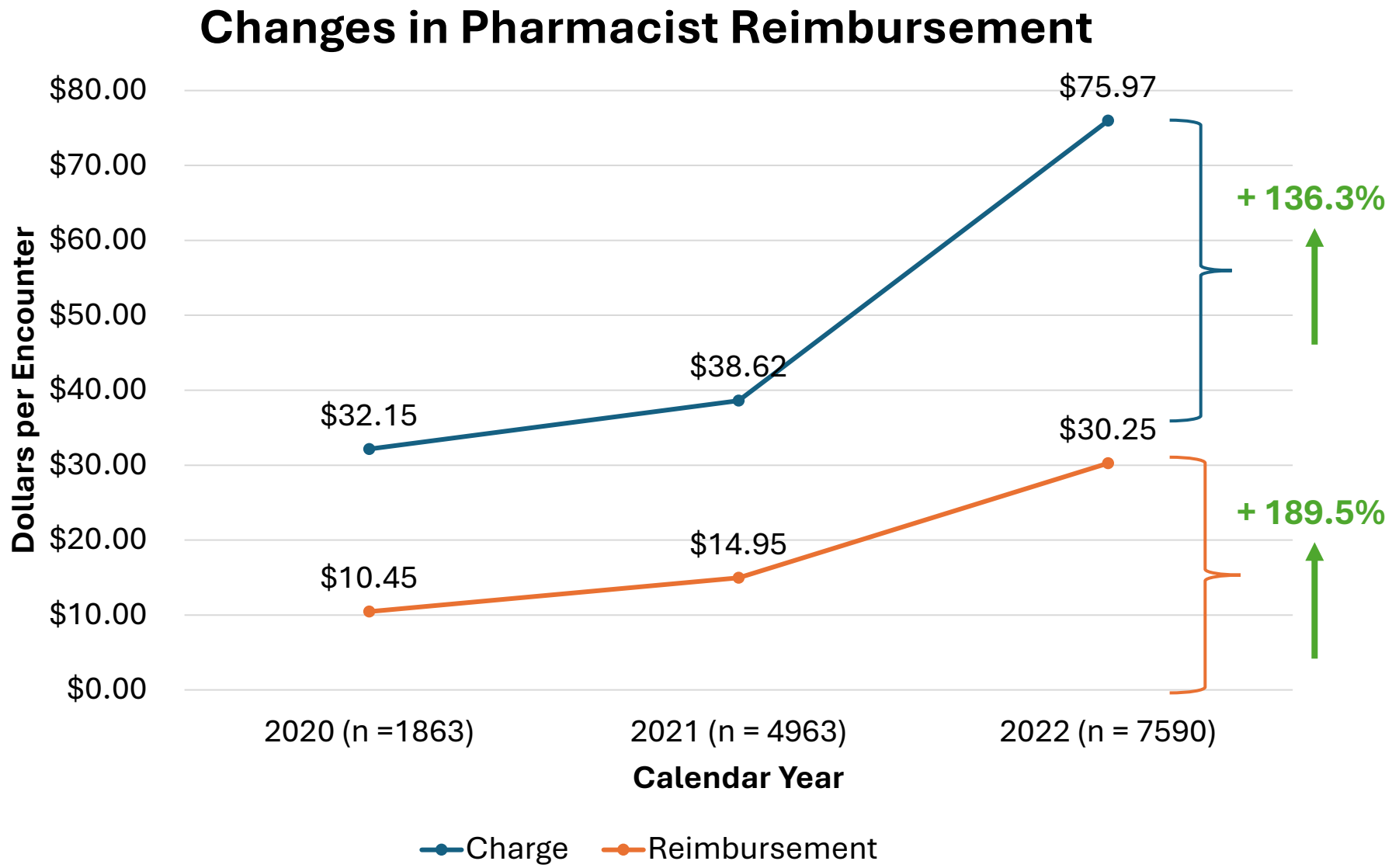
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Results



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Results



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Ongoing Changes

Engagement of Medical Director of Ambulatory Services

Spring 2024

Summer 2024:

Revisit 99214 processes; *GIM pilot*

Switch to **MDM** instead of strictly time-based billing; *GIM pilot*

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Training and CQI

Billing workshop conducted

- Provided by GIM Managing Pharmacist and GIM Director of Operations

Several mini-training sessions for GIM pharmacists ongoing internally

- Case simulations
- Encouraged discussions with discrepancies

Open communication with compliance for pilot

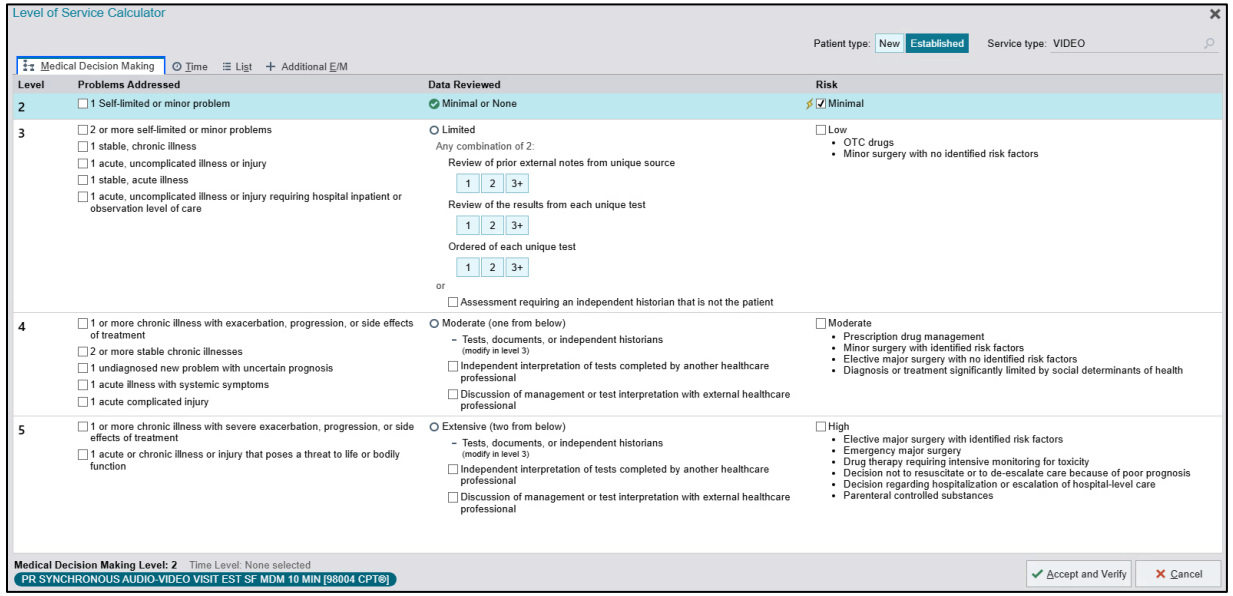
- PharmD proactive request to audit billing pilot results

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Knowledge Gaps Identified

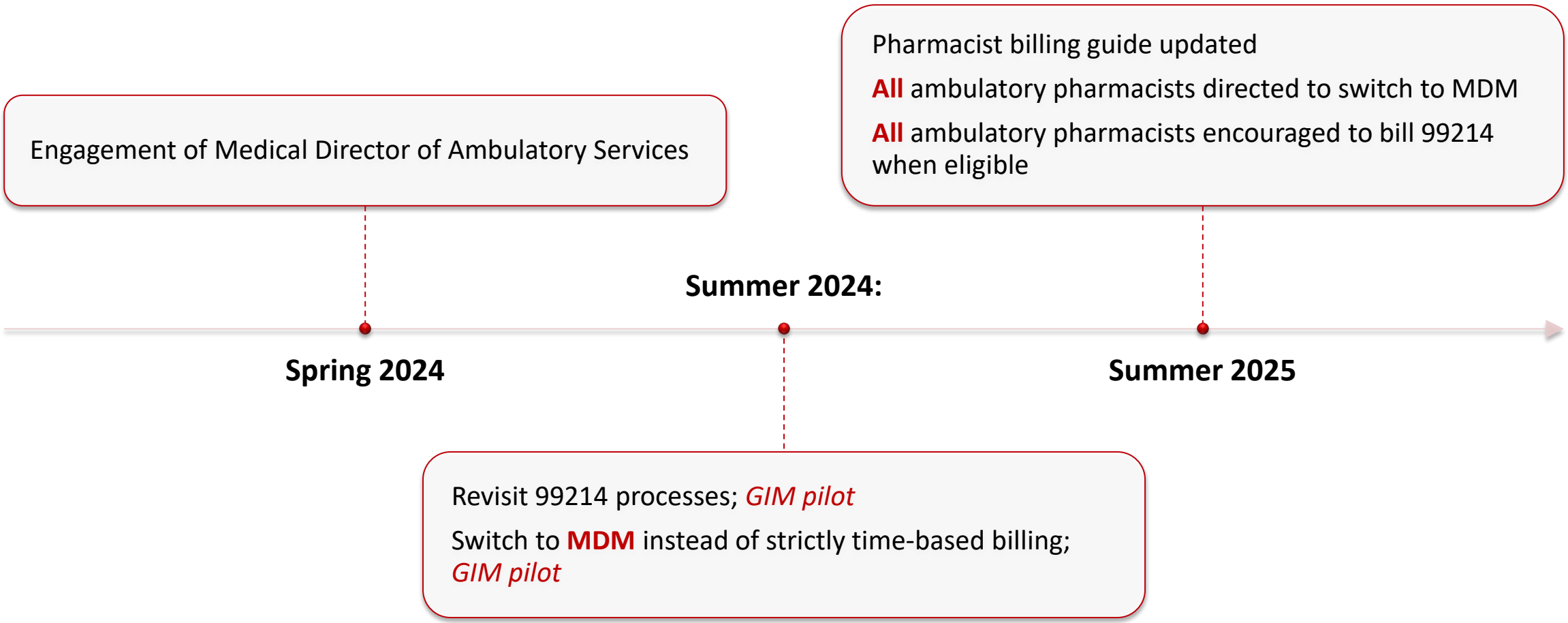
- Differentiating condition(s) complexity
- Fear of audit for higher level billing
- Time-based vs. complexity-based billing practices
- Compliance interpretation for pharmacists

Notes/other records reviewed today: PCP visit on *** reflecting the following changes for {SKHappointment description:40346} management: {SKH-therapy change:56146}
Discussion of care with other providers: {Careproviderdiscussion:56147}
Discussion of care with independent historian(s): {Independent historian:56148}
Additional labs/Procedures reviewed today (other lab results noted below): {OSU AMB OPRX Labs:23504}
Imaging reviewed today: {Imaging Review:56157}



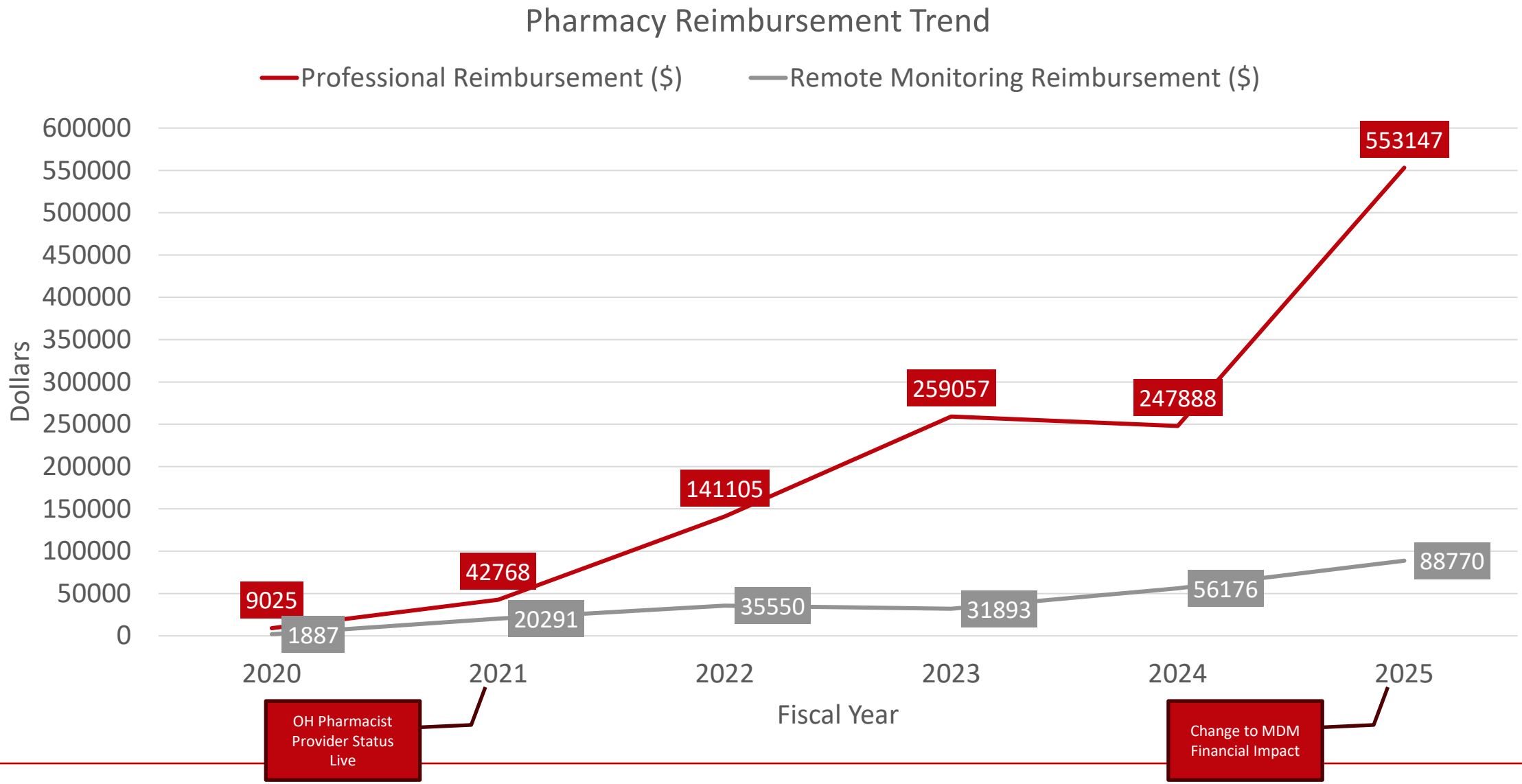
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Altering Institutional Practices



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GIM Pharmacist Reimbursement Progression



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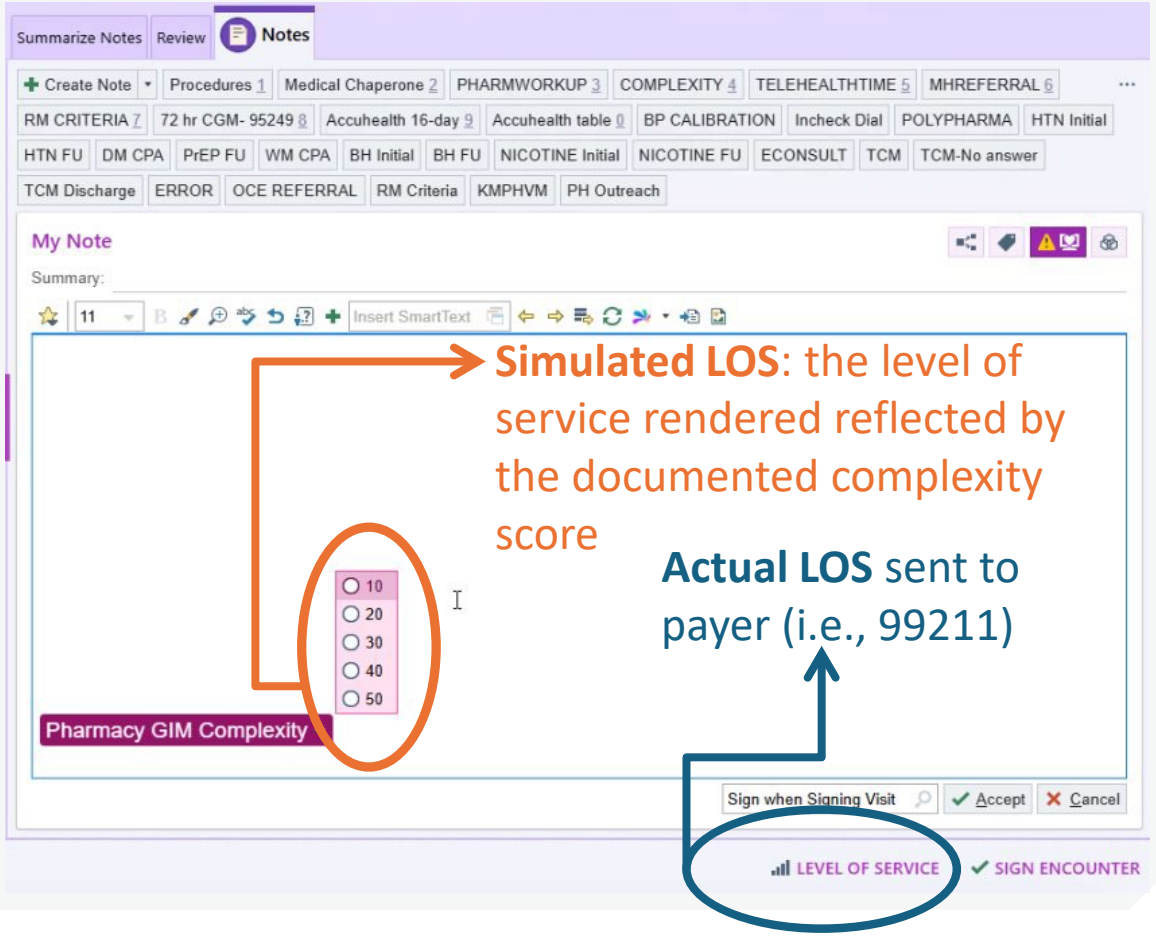


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Complexity Billing Tool

- Built within the EHR using a “Smart Element”
- Captures the level of MDM associated with the pharmacist’s service



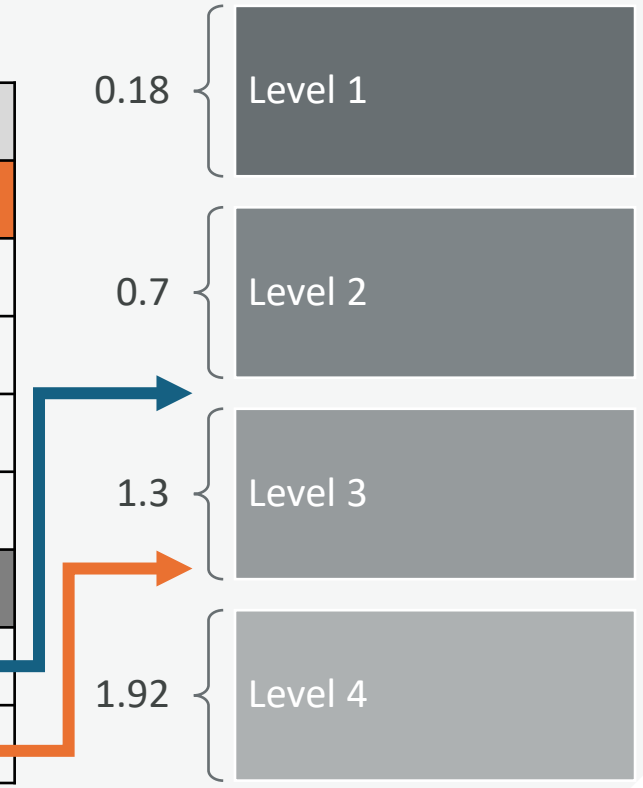
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Number of Visits by LOS (Actual vs. Simulated) (N = 5364)

Simulated LOS	Actual E/M Code Billed			
	99211	99212	99213	99214
Level 5			2 (<1%)	
Level 4	487 (22%)	21 (16%)	293 (10%)	127 (100%)
Level 3	1589 (72%)	75 (56%)	2612 (90%)	
Level 2	38 (2%)	37 (28%)		
Level 1	83 (4%)			

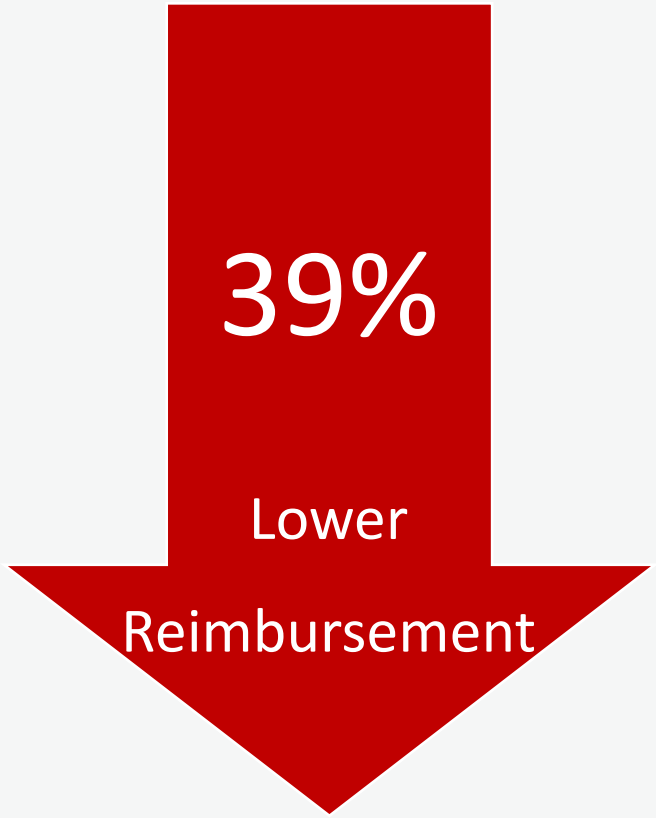
Actual vs. Simulated Estimated Pharmacist wRVU (N=5364)

E/M Code Billed	Number of Visits	wRVU	wRVU
		Actual	Simulated
99211	2197	0.18	1.38
99212	133	0.7	1.23
99213	2907	1.3	1.36
99214	127	1.92	1.92
Total **actual** wRVU			1.02
Total **simulated** wRVU			1.47



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Impact of Billing Limitations on Pharmacist Reimbursement



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Lessons Learned

Scaling of Services

- Pilot program for CQI
- Engage physician champion
- Look at the data to identify the need

Accurate Billing Practices

- Education is key
- Time-based vs complexity-based billing
- Periodically audit billing practices

Alignment with Compliance

- Involve compliance early
- Clarify risk tolerance of compliance
- Create documentation templates for easy compliance officer interpretation of E/M level



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Thanks to our OSUP Pharmacy Team!











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Posttest Question 1

Pharmacists from which of the following practice setting are LEAST likely to quickly begin billing for patient encounters?

A. FQHC

B. Primary care office

C. Chain pharmacy

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Posttest Question 2

Regardless of pharmacy setting, education on reimbursement strategy combined with a consistent approach to an identified population can cause billable pharmacist encounters to:

A. Increase

B. Decrease

C. Stay the same

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Posttest Question 3

Which of the following are barriers to pharmacist implementation of billable services?

A. State policies

B. Pharmacist credentialing

C. Pharmacy workflow

D. Patient expectation

E. All of the above

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Ease his pain

Questions?

Stuart Beatty, PharmD, MPAL, BCACP, FAPhA

s-beatty@onu.edu

Dean and Professor
Ohio Northern University
Raabe College of Pharmacy

E. Michael Murphy, PharmD, MBA

mmurphy@aphanet.org

Senior Advisor for State Government Affairs
American Pharmacists Association

Assistant Professor of Pharmacy Practice
The Ohio State University College of Pharmacy

Cory P. Coffey, PharmD, MS, BCACP, BCPP

cory.coffey@onumc.edu

Manager of Pharmacy Services
OSU Physicians, Inc.

Assistant Professor – Practice
OSU Department of Internal Medicine

Session Code

VX6M

1 contact hour (0.1 CEU)

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