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Clinical Value Optimization vs. Transactional Price Navigation

A framework for rethinking pharmacist roles in medication affordability

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WHERE THIS TALK FITS

Pharmacy keeps circling one question.

AUTHORITY

Pharmacists as providers

Who is authorized, and who pays?

WORKFORCE

The pharmacy technician role

Who can take on more?

PRACTICE

Test-and-treat services

What does top-of-license work look like?

> Underneath all three: which work belongs to whom, and who pays for it?

A LESSON FROM IDAHO

Authority alone did not create provider status.

Authority

Standard-of-care regulation gave pharmacists broad diagnostic and prescriptive authority.

Payment gap

Pharmacists could enroll as ordering, referring and prescribing providers, but not as rendering providers.

The 2025 fix

“What, not who” billing, rendering enrollment, and payment at midlevel-provider rates.

“Legal authority alone does not guarantee functional provider status.”

Adams, JAPhA 2026

Adams and Chopski, JAPhA 2020; Adams, JAPhA 2026; Idaho HB 110 (2025)

THE PROBLEM

Patients are asked to navigate prices on their own.

43%

of U.S. adults did not take a medicine as prescribed in the past year because of cost

Up to 41%

of records for the 20 common generics studied had an out-of-pocket payment above the discount-card price; highest for uninsured and deductible-phase patients

The usual advice is “talk to your pharmacist.” That advice covers two very different kinds of work.

Sources: KFF, updated April 30, 2026; Patel, Len, Shah, Vaidya, Ann Intern Med 2023

THE PROBLEM · WHAT IS COMING

Coverage changes will add to the load.

Jan 2027

Medicaid work requirements begin for expansion adults: 80 hours a month of work, school or service, unless exempt

700,000

Ohioans enrolled in Medicaid expansion, approximately; requirements apply to nonexempt adults

Up to 356K

fewer Ohio expansion enrollees projected in 2028, including six-month redeterminations (highest scenario)

Some will reach the counter uninsured or between coverage, where our 2023 data show out-of-pocket overpayment is highest.

H.R. 1 (2025); Health Policy Ohio, July 2026; Urban Institute, March 2026; Patel et al. 2023

TWO CONVERSATIONS

Two conversations, filed under the same job.

ABOUT 45 MINUTES

A $4,000-a-month biologic

Reviewing history, evidence and formulary to judge whether a biosimilar is appropriate, then working it through with the prescriber.

ABOUT 5 MINUTES

A common generic

Comparing three discount websites and the copay to find the lowest price for a drug already prescribed.

Grouping them hides the value of the first and normalizes the inefficiency of the second.

THE FRAMEWORK

Every affordability task answers one of two questions.

TIER 1 · CLINICAL VALUE OPTIMIZATION

Which therapy is right for this patient?

TIER 2 · TRANSACTIONAL PRICE NAVIGATION

What is the lowest price for the therapy already chosen?

The test: does the task require clinical evaluation of therapeutic alternatives, or price comparison of the same therapy?

THE FRAMEWORK

Two dimensions separate the tiers.



Adapted from Vaidya, JAPhA 2026

TIER 1

Clinical value optimization: choosing the right therapy

TASKS THAT NEED CLINICAL JUDGMENT

- Biosimilar or interchange evaluation for a specific patient
- Cost-effectiveness consultation with prescribers
- Deprescribing, whatever the drug costs
- Appeals that need a clinical justification

> Classify the task, not the drug. Eligibility checks and paperwork for a chosen biologic are Tier 2.

WHO

Pharmacist with relevant clinical training

PATIENT SAVINGS (ILLUSTRATIVE)

About $100 to $1,000 per year

TODAY

Largely unreimbursed; no standard training

Illustrative range from Vaidya, JAPhA 2026, Table 1

IN PRACTICE

Clinical value optimization in practice

KAISER PERMANENTE

90%

biosimilar adoption in 2 months for three oncology biosimilars in 2019; about $140 million in drug savings

THREE COMMERCIAL PLANS

94%

of 504 Humira patients on a biosimilar within 3 months of a formulary change

ASHEVILLE PROJECT

$1,200+

lower total direct medical costs per patient per year ($1,200 to $1,872) with community pharmacist diabetes care

Each had a clinical owner, prescriber engagement, and a payer or system that kept the savings. These programs did not evaluate the two-tier framework.

Sources: KP Institute for Health Policy, 2023; Navitus, 2025; Cranor, Bunting, Christensen, JAPhA 2003

TIER 2

Transactional price navigation: the lowest price for a chosen therapy

- Discount program lookup
- Copay vs. cash comparison
- Coupon eligibility screening
- Discount program matching

WHO

Trained technician or digital tool

SAVINGS (ILLUSTRATIVE)

About $1 to $30 per fill, out of pocket

Not simple work

Copay accumulators, deductible and out-of-pocket thresholds, and the downstream effects of copay assistance.

It needs trained staff and system support. It does not need doctoral clinical judgment.

Transaction savings: Patel 2023; Trish 2021; Van Nuys 2018

A NATIONAL ESTIMATE

Fewer than 1 in 20 fills, half of drug spending

SHARE OF PRESCRIPTION FILLS



Priority therapies (Tier 1 proxy): 4.4%

SHARE OF TOTAL DRUG SPENDING



$1,951 vs. $86 average cost per fill

Priority therapies: complex drug classes, over $1,000 a year in drug spend

Note: MEPS does not measure pharmacist activities

Vaidya and Patel. MEPS 2018 to 2023, 1.58 million fills; manuscript in preparation

THE BOUNDARY

The tiers overlap at the edges.

Price comparison of the same therapy

Clinical evaluation of alternatives

CLEARLY TIER 2

Copay vs. cash for a generic; assistance paperwork for a chosen biologic

MIXED ENCOUNTERS

Technician checks prices and coverage for a possible statin switch; pharmacist decides if it is appropriate

CLEARLY TIER 1

Biosimilar evaluation for a complex patient; interchange for treatment-resistant disease

Classify the task, not the drug. One encounter can hold both tiers: choosing the biosimilar is Tier 1; enrolling the patient in its copay program is Tier 2.

WHY IT MATTERS

The price navigation burden has three costs.

01

Misallocated expertise

Time spent on price lookups is time not spent on work that needs clinical training.

02

An undefined delegation layer

Technicians already help, but roles, training and escalation are unevenly defined and rarely measured.

03

A less visible problem

When pharmacists absorb price complexity quietly, payers, PBMs and program designers see less of it.

Vaidya, JAPhA 2026; PTCB Billing and Reimbursement Certificate

THE SUPERVISION QUESTION

Delegation changes the role, not the accountability.

TODAY

Pharmacists handle price questions one by one, between clinical tasks. Technicians often help, but scope and escalation are rarely written down.

WITH A TIER 2 PROTOCOL

Trained technicians own price navigation. The pharmacist sets the rules, handles escalations and takes the Tier 1 cases.

ESCALATION RULE

Escalate to the pharmacist when the solution would change therapy, or when cost raises an adherence or safety concern.

SEQUENCING

Scope, training and payment have to move together.

BOARDS

Scope

Who may do the work



COLLEGES

Training

Who is prepared to do it



PAYERS

Payment

Who pays for it

> In my view, payment is the binding constraint. But it is not sufficient on its own.
>
> Where should your state start?

GETTING PAID · OHIO'S EXPERIENCE

Ohio opened the payment door. Few pharmacists have used it.

1.96%

of about 13,700 employed Ohio pharmacists (268) billed Medicaid even once, 2017 to 2025

$4.4M

reimbursed on nearly 250,000 claims after implementation, more than 85% paid

0.19%

of claims came from community pharmacies; most came from FQHCs and physician offices

Billing was concentrated in integrated clinical settings; referral pathways and billing support may help expand participation.

Murphy, Beatty, Donneyong, Mann. Health Affairs Scholar 2026. Denominator: all employed Ohio pharmacists.

GETTING PAID · WHO SHOULD PAY

Pay where the savings land.

WHO MAY BENEFIT FROM A TIER 1 CONSULT

Health plan or PBM

Lower drug spend

Self-insured employer

Lower total cost of care

Patient

Lower out-of-pocket cost

System at risk

Integrated system or plan holding drug risk

WHO PAYS FOR IT TODAY

Usually the pharmacy or health system that employs the pharmacist. Whoever captures the savings should pay, or share them.

GETTING PAID · HOW TO BILL

Potential payment and funding routes

FEE-FOR-SERVICE ROUTES TODAY

Medicare Part B

Not a recognized provider. Incident-to billing is conditional and may not cover it.

Part D MTM

Plan-paid medication reviews. 2026 cost threshold: $1,276.

Medicaid, commercial

Ohio and Idaho Medicaid pay pharmacists; Washington mandates some commercial coverage.

CONTRACT AND ORGANIZATIONAL FUNDING MODELS

Per member per month

A plan or employer pays a set fee for a panel of high-cost patients.

Shared savings

The pharmacist's employer earns a share of verified net savings.

Health-system budget

A consult service funded by the system that keeps the savings.

CMS CY2026 MTM memo; Ohio SB 265 (2019); Idaho HB 110 (2025); RCW 48.43.094; H.R. 3164, 119th Congress (2025)

GETTING PAID · MAKING THE CASE

What a health plan needs to see

1. **Target where spending concentrates**
   Priority therapies, under 5% of fills, carry half of drug spending. Start there.

2. **Estimate incremental savings**
   Compare against a credible comparator, using net prices and rebate data where available.

3. **Report cost avoidance separately**
   Prevented events and admissions are estimates. Label them that way.

4. **Subtract the cost of the service**
   Net savings and return per dollar, not gross savings.

5. **Speak the plan's language**
   Per member per month, member out-of-pocket cost, quality measures.

Savings vs. avoidance method: Mutnick et al., Am J Health-Syst Pharm 1997

GETTING PAID · SHOW THE MATH

One biosimilar consult, in a plan's terms

Line item (illustrative)	Value
Originator biologic, net cost per month	$4,000
Biosimilar, net cost per month (50% lower)	$2,000
Assumed average months on therapy, year one	10.8
Gross savings to the plan	$21,600
Pharmacist time, 2 hours at $150	$300
Net savings, year one	$21,300

$71

net savings per $1 of pharmacist time

At one tenth of the price gap: $1,860 net, about $6 net per $1.

One successful switch. A program return must count unsuccessful consults and overhead.

Illustrative inputs. Use plan-specific net prices; rebates can narrow the gap.

IMPLICATIONS

What people in this room can do

Boards of pharmacy

Put Tier 2 technician scope, training and supervision into rule. Keep Tier 1 consults clearly in pharmacist scope.

NABP and AACP

Carry shared tier definitions into model rules and curricular guidance, so states and schools mean the same thing.

Colleges

Teach billing, coding and net-savings documentation. Place students where pharmacists bill.

Employers and chains

Run Tier 2 through a technician protocol. Keep the loyalty value; change who does it by default.

Health systems

Stand up a Tier 1 consult service for high-cost therapies and track net savings from day one.

Payers

Pilot a per-member or shared-savings contract. Define the Tier 1 scope before billing starts.

WHAT COMES NEXT

From framework to measurement

Published

The two-tier framework

JAPhA 2026. Defines the tiers and sets out a research agenda.

Completed

A national estimate (MEPS)

Priority therapies: under 5% of fills, 51% of drug spending.

2018 to 2023; manuscript in preparation

Next

Claims-based studies

- Where spending concentrates in plan claims
- Whether Tier 1-targeted consults lower net spending and improve adherence
- Fill gaps and abandonment as coverage changes in 2027

Vaidya V. J Am Pharm Assoc. 2026;103488. doi:10.1016/j.japh.2026.103488

AN INVITATION

Three ways to work on this together

Data partners

Health plans, Medicaid managed care plans and employers with claims data

Curriculum partners

Colleges interested in teaching and assessing Tier 1 work

Boards

Open to piloting technician-led Tier 2 protocols

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DISCUSSION

Not more pharmacist involvement in affordability. Smarter, stratified involvement.

- In your state, what would it take for a technician to own Tier 2 work?
- Which should move first: scope, training or payment?
- Which payer in your state would pilot paying for a Tier 1 consult?

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