Pharmacy Wrap May 2026

The latest talent related US pharmacy news

PHARMACY WRAP

John Muchka

Managing Partner - Executive Search
262-490-1766
john.muchka@hudsontalent.com

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Content

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Recent Themes Roundup

Cannabis rescheduling creates new pharmacy implications, after the DOJ and DEA formally moved state-licensed medical marijuana into Schedule III in April, triggering new DEA registration timelines and raising questions about future pharmacy dispensing models. [jdsupra.com]

Claims accuracy and payment integrity in focus, following new research showing frequent pharmacy claims errors that often go undetected for over a year under traditional PBM audit models. [finance.yahoo.com]

DEA steps up enforcement against retail pharmacies, issuing an Immediate Suspension Order in early April against a Tennessee pharmacy for alleged Controlled Substances Act violations, reinforcing the agency's tougher stance on diversion and compliance in 2026. [dea.gov]

Independent pharmacists lobby Congress in Washington, urging lawmakers to extend PBM reforms beyond Medicare Part D to Medicaid, Tricare, and federal employee plans during April's NCPA "fly-in." [hmenews.com]

PBM economics under renewed scrutiny, with April commentary highlighting specialty pharmacy "steering," spread pricing, and profit shifting within vertically integrated groups—issues increasingly relevant for both chain and independent pharmacies. [drugchannels.net]

PBM reform gathers pace nationally, with April seeing increased scrutiny of vertically integrated models. FTC settlements, new federal reporting requirements under the Consolidated Appropriations Act (CAA) 2026, and state-level action are reshaping reimbursement and transparency expectations for pharmacies. [pharmaceut...mmerce.com], [psca.org]

Tennessee passes sweeping PBM legislation, banning common ownership of PBMs and pharmacies. CVS Health warned the law could trigger over 100 store closures and significant job losses, while state lawmakers argue it will level the playing field for independents. The law is expected to face legal challenge and could become a national test case. [wkrn.com], [msn.com]

Walgreens accelerates store closures in April, continuing its multi-year downsizing strategy as reimbursement pressure, theft, and lower front-of-store sales persist. Community groups warn of reduced access to pharmacy services, particularly in urban and lower-income areas. [msn.com]

Pharmacy Fun Fact

Aspirin lost its name in the U.S. because of World War I

"Aspirin" was originally a trademarked brand name owned by Bayer, not a generic drug. But during World War I, the U.S. government seized Bayer's American assets as enemy property under wartime law. In 1919, Bayer's U.S. trademark for Aspirin was auctioned off and soon after, American courts ruled that "aspirin" had become a generic word in the United States.

That's why in the U.S., aspirin is generic, but in Germany and many other countries, Aspirin® is still a protected Bayer trademark

Experienced Hires Trading Places

Name	New Role	Previous Role	Location
Andre Sloan	Director of Pharmacy Operations | 340B Strategy, Compliance & Oversight at RAO Community Health	Pharmacist/Strategic Business Consultant	North Carolina
Brandon L. Keith	Director, Clinical Solutions Pharmacist (MID) at McKesson	Manager, Specialty and Clinical Pharmacy Services at The GW Medical Faculty Associates	Maryland
Constencse Sirmans	Director of Pharmacy at InnovAge	Market Director of Pharmacy at Reunion Rehabilitation Hospitals	Colorado
Eintou Ford	Pharmacy Director, Home Infusion at Amerita, Inc	Health Services Pharmacist at Walgreens	Colorado
Emily Kyrargyros	National Director of Regulatory Adherence, Pharmacy Care Services, Genoa Healthcare at Optum	Regional Director of Pharmacy Operations at Genoa Healthcare	Massachusetts
Hayley Y. Park	Senior Vice President, Chief Pharmacy Officer at Blue Shield of California	Vice President, Pharmacy Operations and Services at Kaiser Permanente	California
Kent D. Wangsness	Senior Director at Avera Health	Senior Director at UnitedHealth Group	Minnesota
Kevin Curry	Executive Director, Pharmacy Strategy at Plenful	Clinical Pharmacy Director at Elevance Health	Colorado
Lanh Dang	Director of Specialty Pharmacy at Baptist Health	Ambulatory Pharmacy Supervisor at UF Health Jacksonville	Florida
Melissa Farley	Vice President, Pharmacy at The US Oncology Network	Vice President Provider Experience & Engagement at Evolent	Colorado
Nick Capote	Executive Director | Ambulatory and Specialty Pharmacy Services at Boston Medical Center (BMC)	Director | Oncology, Infusion, and Investigational Drug Pharmacy Services at UCSF Health	Massachusetts
Nicole Robert	Director Operations at Option Care Health	Associate Director, Pharmacy Retail at Banner Health	Illinois
Raed Ahmed	Director of specialty pharmacy at Cedars-Sinai	Director Of Pharmacy Services at Saban Community Clinic	California
Sharmarke Mohamed	Director of Pharmacy at Uptown Community Health Center (Uptown CHC)	Director of Pharmacy at CommonSpirit Health	Colorado
Steve DeLaO	Director of Pharmacy Operations at Round Rock ISD	Paediatric Pharmacist at Dell Childrens Medical Center of Central Texas	Texas
Sulbha Pai	Director pharmacy at Florida Medical Center	Pharmacy Manager Inpatient at Vanderbilt University Medical Center	Florida
Tina Moen	Chief Pharmacy Officer at Colibri Healthcare at Colibri Group	Founder & Principal at Triple M HealthTech Consulting	Colorado

M&A & Funding

Community Health Systems Acquires Majority Stake in Surgical Institute of Alabama
Community Health Systems has acquired a majority interest in the Surgical Institute of Alabama, significantly expanding its ambulatory surgery footprint. The deal advances CHS's shift toward lower cost outpatient care while deepening physician relationships and strengthening surgical capacity in a key regional market.

H2 Health Acquires Advanced Physical Therapy
H2 Health has acquired Advanced Physical Therapy, adding six clinics in the Little Rock area and entering the Arkansas market. The acquisition supports H2's strategy of disciplined regional expansion and clinic level densification across the rehabilitation services sector.

Megansett Partners Acquires TLC Private Home Care
Megansett Partners has acquired TLC Private Home Care, a nurse led in home care provider in Massachusetts. The transaction establishes a platform investment in the growing home-based care sector, supported by favourable demographics and rising demand for clinically led care at home.

National HealthCare to Acquire 35 Facilities from NHI for USD560m
National HealthCare Corporation is acquiring 35 senior care facilities from National Health Investors for USD560 million, consolidating ownership of assets it already operates. The deal enhances NHC's strategic control while allowing NHI to recycle capital and rebalance its portfolio.

Orlando Health to Acquire RMC Health System
Orlando Health has agreed to acquire RMC Health System in Alabama, expanding its regional footprint and referral network. The transaction is expected to support capital investment, operational stability and improved access to care in Northeast Alabama.

Superior Health Holdings Acquires Chant Healthcare
Superior Health Holdings has acquired Chant Healthcare, expanding into Oklahoma with a full continuum of home health, homecare and hospice services. The acquisition strengthens Superior's regional presence and supports continued growth in home-based care.

Wellmore and The Village for Families and Children Plan to Merge
Not for profits Wellmore and The Village for Families and Children plan to merge, creating a scaled behavioural health provider serving around 30,000 families annually. The merger aims to expand access, improve service integration and meet rapidly growing demand.

Witham Health Services Plans to Merge with Parkview Health
Witham Health Services has signed a non-binding agreement to merge with Parkview Health, seeking long term sustainability and expanded services. The proposed merger reflects continued consolidation among community hospitals partnering with larger regional systems.

Zócalo Health Raises USD15m Series A
Zócalo Health has raised USD15 million in an oversubscribed Series A round to scale its tech enabled, community based primary care model. The funding will support national expansion focused on serving high need populations through a value-based care approach.

My Takeaway

The Push Towards a "Standard of Care" Model

STANDARD OF CARE PHARMACY: FROM PROTOCOLS TO PROFESSIONAL JUDGMENT

U.S. pharmacy practice is undergoing a structural and regulatory transformation. The movement toward a **"Standard of Care" (SoC)** model represents a shift away from prescriptive, permission-based rules toward a **competency- and accountability-based framework** grounded in professional judgment. Under this approach, pharmacists are regulated according to the level of care a reasonably prudent pharmacist with similar education and training would provide in comparable circumstances mirroring long-standing regulatory models used in medicine and nursing.
This transition is not philosophical alone. It is driven by workforce shortages, access gaps, economic pressure on community pharmacies, and a growing body of evidence demonstrating that pharmacists can safely deliver expanded clinical care. Increasingly, **the question is no longer whether pharmacists are capable of doing more, but whether the healthcare system can afford to underutilize them**.

WORKFORCE PRESSURES AND ACCESS GAPS

The urgency behind the SoC shift is data-driven. The **Association of American Medical Colleges** projects a U.S. physician shortage of **37,800 to 124,000 physicians by 2034**, with the most acute deficits in primary care. At the same time, approximately **76 million Americans** live in federally designated Primary Care Health Professional Shortage Areas (HPSAs). Similarly, while physician assistants and nurse practitioners have grown rapidly, supply has not kept pace with demand in underserved and rural areas

Pharmacists represent one of the most accessible and underleveraged healthcare workforces. There are **over 300,000 licensed pharmacists** in the U.S., the majority practicing in community settings, and nearly **90% of Americans live within five miles of a pharmacy**. Nearly eight in ten adults visit a pharmacy annually, often without an appointment. [bls.gov] [cvshealth.com] These access advantages stand in contrast to rigid regulatory frameworks that often prevent pharmacists from addressing routine clinical needs such as treating uncomplicated infections or adjusting chronic medications despite having the training to do so.

FROM COLLABORATIVE AGREEMENTS TO STANDARD OF CARE

Historically, pharmacist clinical services have been authorized through **Collaborative Practice Agreements (CPAs)** or service-specific statewide protocols. While CPAs can function effectively in integrated health systems, they create administrative friction, variability between states, and regulatory lag as practice standards evolve faster than statute.

Under a **Standard of Care** model, boards of pharmacy shift their focus from enumerating permitted tasks to **enforcing outcomes and professional accountability**. The **National Association of Boards of Pharmacy** defines standard of care as the level of care exercised by a prudent pharmacist with comparable education and experience in similar circumstances. [japha.org]. This framework allows pharmacists to initiate therapy, order laboratory tests, and manage treatment according to clinical guidelines provided their decisions meet accepted professional standards.

My Takeaway

The Push Towards a "Standard of Care" Model

STATE-LEVEL EVIDENCE AND EARLY ADOPTERS

Idaho is widely regarded as the national test case for SoC regulation. The state eliminated prescriptive "how-to" rules and instead empowered pharmacists to independently prescribe, order labs, and manage minor conditions under board-enforced standards of care. Importantly, early data show **no increase in adverse outcomes**, while regulatory enforcement authority remains intact. [japha.org]

By 2025, the **American Pharmacists Association** formally endorsed SoC-based regulation, arguing it aligns pharmacy oversight with other clinical professions. **California** followed with a major policy shift. Legislation enacted in 2025 (effective January 2026) transitioned multiple pharmacist-provided services including preventive care and vaccinations to a standard of care framework. The California Board of Pharmacy explicitly declined to issue prescriptive guidance, reinforcing pharmacist accountability for clinical judgment and staffing adequacy. [pharmacy.ca.gov]

A 2025 national analysis scoring states on pharmacist authority found a **national average of 4.1 out of 10**, while five SoC-oriented states achieved perfect scores demonstrating that broader authority can coexist with patient safety when enforced through professional standards rather than rigid rules. [cicero institute]

CLINICAL AND ECONOMIC EVIDENCE

The clinical case for expanded pharmacist care is well established. A meta-analysis published in *JAMA Internal Medicine* found that pharmacist involvement in hypertension management reduced systolic blood pressure by **7–9 mmHg** compared to usual care. Pharmacist-led diabetes management programs consistently demonstrate **HbA1c reductions of 0.5–1.8 percentage points**.
Medication mismanagement costs the U.S. healthcare system an estimated **$528 billion annually**, driven by non-adherence, adverse drug events, and suboptimal prescribing.
University of North Carolina Eshelman School of Pharmacy

Medication Therapy Management (MTM) programs where pharmacists are central providers generate **returns on investment between 3:1 and 12:1**, reduce medication-related problems, and improve quality metrics. Community pharmacists account for roughly **22% of comprehensive medication reviews nationally**, particularly in face-to-face settings.
[NLM] [japha.org]

Pharmacist-led transitions-of-care programs reduce hospital readmissions by **up to 30%**, and in some populations, pharmacist-integrated care models are associated with **20–30% reductions in emergency department utilization**.

My Takeaway
The Push Towards a "Standard of Care" Model

SUSTAINABILITY, PAYMENT, AND PROVIDER STATUS

While SoC regulation expands what pharmacists **may do**, it does not guarantee payment for those services. Pharmacists remain excluded as providers under **Medicare Part B**, limiting their ability to bill directly for clinical care. Although **all but nine U.S. states** now mandate some form of pharmacist service reimbursement, payment pathways remain fragmented. Successful pharmacies often rely on complex combinations of billing codes, contracts, and grants, creating operational burden even as scope expands. [pharmacytimes.com].

As dispensing margins continue to erode due to PBM practices and below-cost reimbursement, SoC models are increasingly framed as a mechanism to support **diversification into clinical services** without requiring constant legislative updates for each new activity. [frierlevitt.com]

RISKS, ACCOUNTABILITY, AND WORKFORCE READINESS

Critics (most notably physician groups such as the AMA) argue that expanded pharmacist autonomy raises patient safety concerns and highlights differences in diagnostic training. Proponents counter that SoC models **increase accountability**, as enforcement is based on clinical judgment rather than box-checking compliance. There are also inconsistencies in pharmacist training pathways - while all pharmacists earn a PharmD, not all complete residencies or obtain board certification, raising questions about how "competency" is defined and enforced.

However, implementation depends heavily on workforce readiness. While all pharmacists earn a PharmD, not all complete residencies or obtain board certification. National academic bodies emphasize the need to align education, training, and continuing professional development with the expectation that comprehensive medication management becomes a default standard of care. [NLM]

Burnout is also a critical risk, recent studies show nearly **50% of pharmacists** report significant emotional exhaustion, and **43.9% of staff in large national chains** express reluctance toward expanded clinical roles due to lack of protected time and high dispensing volumes. [mdpi.com] Without staffing reform and payment alignment, expanded autonomy risks becoming an unfunded and unsustainable mandate.

CONCLUSION: ALIGNING REGULATION WITH REALITY

The movement toward a **Standard of Care** model in pharmacy is best understood as a **data-driven response** to access shortages, rising chronic disease burden, economic pressure, and demonstrated pharmacist impact on outcomes. Evidence from early-adopter states shows that SoC frameworks expand access without compromising safety, while national data reinforce the clinical and economic value pharmacists already deliver. Yet SoC alone is not enough. **Payment reform, provider recognition, workforce investment, and data infrastructure** must advance in parallel. The transition is ultimately less about expanding scope indiscriminately and more about aligning legal and economic frameworks with demonstrated professional capability.

My Takeaway

The Push Towards a "Standard of Care" Model

1 THE ECONOMIC IMPERATIVE

U.S. healthcare spending exceeds **$4.5 trillion** annually (nearly **18%** of GDP)

Non-optimized medication therapy costs the U.S. healthcare system over

$528 billion

each year

PHARMACIST-LED INTERVENTIONS DELIVER VALUE

MTM programs show ROI between **3:1–12:1**

Chronic disease management can reduce HbA1c by **0.5–1.5%** and improve BP control by **10–20 percentage points**

2 WORKFORCE & ACCESS PRESSURES

Up to **48,000** primary care physicians shortfall projected by 2034

300,000+ licensed pharmacists in the U.S.

EXPANDING PHARMACIST ROLES IMPROVES ACCESS & OUTCOMES

Pharmacists significantly increased vaccination rates during COVID-19

Pharmacist-led care models reduced ED visits by **20–30%**

3 CLINICAL QUALITY & OUTCOMES

~20% of hospital readmissions are medication-related

Transitions-of-care programs can reduce readmissions by up to **30%**

In value-based care (ACOs), pharmacist integration is associated with:

- Improved chronic disease metrics
- Higher quality scores
- Reduced total cost of care

4 REGULATORY & POLICY MOMENTUM

Federal efforts toward pharmacist provider status (Medicare Part B)

Value-based care models (ACOs, bundled payments) incentivize team-based care

Many states expanded prescriptive authority & test-and-treat models

Lack of uniform federal recognition remains a barrier

5 TECHNOLOGY & DATA INTEGRATION

EHRs, claims data, & clinical decision support tools enable pharmacists to identify high-risk patients and improve outcomes

Predictive analytics can identify patients at risk of hospitalization or non-adherence

Integrated EHR access allows pharmacists to close care gaps in real time

Interoperability challenges—especially in community pharmacy—limit full participation.

6 BARRIERS TO ADOPTION

- Reimbursement misalignment (fee-for-service dominance)
- Operational constraints in retail pharmacy settings
- State-by-state regulatory variation
- Cultural and institutional inertia

These factors contribute to uneven adoption, with integrated health systems leading and community pharmacies lagging.

7 THE STRATEGIC DIRECTION

Pharmacy practice is evolving from product-focused to patient-centered and outcomes-driven.

TRADITIONAL MODEL	STANDARD-OF-CARE MODEL
Dispensing-focused	Outcomes-focused
Volume-based revenue	Value-based reimbursement
Isolated workflows	Integrated care teams
Reactive interventions	Proactive population health management

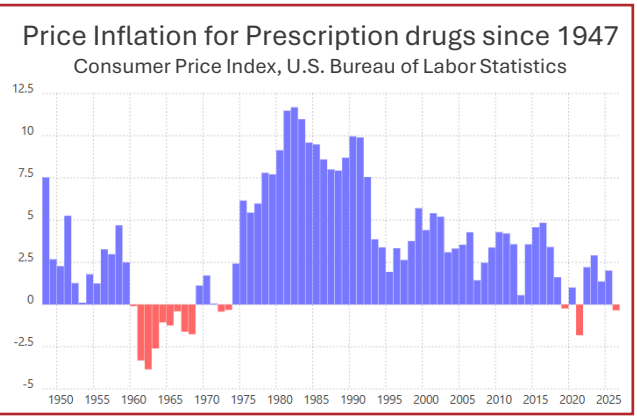
Health systems, payers, and pharmacy organizations are embedding pharmacists into population health strategies—especially for chronic disease and high-cost patients.

The debate is no longer whether pharmacists can do more.
It is whether the healthcare system can afford not to let them

Data Dive: The Impact of the Crisis in the Middle East on U.S. Medicine Prices

The crisis in the Middle East has created **measurable cost pressure** across pharmaceutical logistics, energy, and chemical inputs. However, **U.S. medicine prices have risen only modestly so far**, as pricing contracts, insurance structures, and high margins for branded drugs have absorbed most of the shock. Data indicates the **greatest exposure lies in generic drugs and hospital medicines**, particularly sterile injectables that depend on air freight and petrochemical-based materials. [aviationpros.com], [cbsnews.com], [officialdata.org]

According to the U.S. Bureau of Labor Statistics, price inflation for prescription drugs over the last few years has been around 2-2.5% [officialdata.org], **it was the early 80's that saw the biggest rises** 1982 (11.68%), 1981 (11.48%), and 1983 (10.98 %) – **could we be returning to these levels?**



Logistics and Air-Freight Disruption

~35% of pharmaceuticals by value move via air freight, while **~90% of life-saving medicines and vaccines** depend on air cargo for speed and temperature control (IATA). [iata.org], [clinicaltrialsarena.com]

Global air cargo demand fell 4.8% in March 2026, with **Middle Eastern carriers down over 54%**, following conflict-driven disruptions at Gulf hubs such as Dubai, Doha, and Abu Dhabi (IATA). [iata.org], [arabnews.com]

US–Middle East air capacity dropped ~59%, sharply reducing belly-hold cargo capacity that pharmaceutical supply chains rely on. [aircargoweek.com]

Jet fuel prices rose **over 100% year-on-year**, pushing freight rates higher. [wwd.com], [iata.org]

Implication: Higher freight and insurance costs disproportionately hit generic and hospital medicines, where margins are thin and delivery flexibility is limited.

Energy and Petrochemical Input Costs

- Brent crude oil prices rose **50–60% after the war began**, reaching **$120–126 per barrel**, following attacks and shipping disruption in the Strait of Hormuz. [cbsnews.com], [eia.gov]
- The Strait of Hormuz normally handles **~20% of global oil** and **30–35% of seaborne crude trade**, making energy markets highly sensitive to the conflict. [worldbank.org], [eia.gov]
- **Naphtha**, a critical petrochemical feedstock used in plastics and pharmaceutical materials, surged **over 60%** and in some markets exceeded **$1,000 per ton**, nearly doubling pre-war prices. [coface.com], [markets.fi...ontent.com], [agbi.com]
- Analysts estimate **up to 5% of global ethylene capacity** has been shut due to naphtha shortages, affecting plastics used in IV bags, syringes, and blister packaging. [agbi.com]

Implication: Input cost inflation hits generics and hospital consumables first, often before patient prices rise

Data Dive: The Impact of the Crisis in the Middle East on U.S. Medicine Prices

Pharmaceutical Supply-Chain Exposure

Only **~4% of active pharmaceutical ingredients (APIs)** supplying the U.S. are manufactured domestically; **India (~50%) and China (~30%)** dominate API production (USP). [raps.org], [biohealthi...vation.org]

~90% of U.S. prescription volume is generic drugs, which rely heavily on overseas API supply. [pmc.ncbi.nlm.nih.gov], [biohealthi...vation.org]

USP and FDA analyses show that **geographic concentration** significantly increases the risk of shortages and cost pass-through under geopolitical stress. [accessiblemeds.org]

Implication: The U.S. is insulated from immediate shortages but exposed to targeted disruptions in essential medicines.

OBSERVED MEDICINE PRICE SIGNALS IN THE U.S.

Prescription drug prices rose **~2.0% between 2024 and 2025**, below overall CPI inflation (BLS). [officialdata.org]

Branded drug **net prices declined**, reflecting rebates and payer negotiations (IQVIA, BLS methodology). [bls.gov], [bls.gov]

In contrast, OTC and generic medicines have shown **greater volatility internationally**, with **20–30% increases** reported in some non-U.S. markets. [coface.com], [agbi.com]

IMPACT BY DRUG CATEGORY

Drug category	Impact level	Evidence
Generic drugs	High	Thin margins; API + freight exposure [agbi.com], [raps.org]
Hospital injectables	High	Sterile packaging, cold chain, plastics [coface.com]
Branded drugs	Moderate	High margins absorb shocks [bls.gov]
Biologics	Low–Moderate	Mostly U.S./EU made [iata.org]
OTC medicines	Moderate	Packaging and logistics costs visible [coface.com]

The crisis in the Middle East has clearly increased pharmaceutical input and logistics costs, but U.S. medicine prices have risen only incrementally so far. **The most credible risk is gradual price pressure and targeted shortages in generic and hospital-based medicines** if the conflict persists or escalates. [iata.org], [cbsnews.com], [officialdata.org]

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John Muchka
Managing Partner - Executive Search
262-490-1766
john.muchka@hudsontalent.com

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