UCLA School of Law
Center on Reproductive Health, Law, and Policy

# Policy Brief

## Implementation Strategies for Pharmacist-Prescribed Contraception

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This policy brief summarizes recommendations from UCLA Law's Center on Reproductive Health, Law, and Policy (CRHLP) to maximize and overcome common barriers to implementation of existing state laws authorizing pharmacists to prescribe hormonal contraception. Our aim is to increase access to contraception through robust implementation of expanded scope of practice at pharmacies—a convenient location where a growing number of patients may seek contraceptive care now that at least one formulation of oral contraceptive pill is available over the counter.

Our recommendations are tailored to stakeholders working in the 29 states that have already adopted laws, protocols, or standing orders that permit pharmacists to prescribe hormonal contraception, which may include additional formulations of the pill, as well as the patch, the ring, and the shot. These recommendations may also be useful to those advocating for new laws in additional jurisdictions.

We offer recommendations within six interrelated domains where action is needed to fulfill the potential of expanded scope of practice: reimbursement, compliance, workflow, training, liability, and demand. These recommendations are based on our own analysis, informed by the perspectives of a range of stakeholders, including chain pharmacy executives, public and private payer executives, government officials, researchers, scholars, and advocates. We gained stakeholder perspectives through qualitative interviews and a multi-day in-person convening funded by Arnold Ventures. Our work is also informed by previous studies focused on capturing the perspectives of pharmacists.

# 1. REIMBURSEMENT

## AVAILABILITY OF REIMBURSEMENT

### The Challenge

Stakeholders consistently cite reimbursement challenges as the most significant barrier to full implementation. They report that reimbursement for clinical services (time spent assessing, counseling, and educating patients, and method initiation and management, as opposed to the dispensing fee a pharmacy charges when a prescription is filled) is not available from many payers. To enable reimbursement for services, public and private payers must recognize pharmacists as providers and establish reimbursement processes.

### Recommended Solutions

- **Medicaid officials in states that have successfully implemented reimbursement should develop and disseminate model state plan amendment language and model language for Medicaid MCO contracts to recognize pharmacists as Medicaid service providers.** Medicaid plans are well positioned to have the greatest impact on access. Pharmacist-initiated contraception is poised to offer the greatest benefits to patients who lack easy access to primary care or OB-GYN providers. Such patients are more likely to be low-income and therefore more likely to be Medicaid enrollees. Additionally, recognition by Medicaid plans can be an effective encouragement for private payers to follow suit. Sharing model state plan amendment (SPA) language with agencies in other states can decrease the administrative lift for overburdened Medicaid agencies, while encouraging uniformity across states.
- **Advocates should develop and disseminate model state "any willing provider" (AWP) laws that provide for pharmacist prescribing services.** AWP laws typically limit the ability of private health plans or Medicaid MCO plans to exclude from their network providers who are authorized by state law to provide the applicable service and are willing to accept the health plan's terms and conditions. Most states have some form of AWP law in place, but the scope and substance of these laws varies considerably. Carefully crafted model AWP state legislation or amendment language that allow for the full scope of pharmacists' prescribing services would go a long way toward fulfilling the potential of expanded scope of practice to increase access to care.
- **Researchers should build an even stronger evidence base.** Stakeholders identified that payers and policymakers require undeniable evidence that pharmacists practicing independently can provide safe, competent, and cost-effective contraceptive care. While data supports expansion of pharmacist scope of practice, some stakeholders reported difficulty finding usable data. Stakeholders identified that future research is needed regarding patient and population-level outcomes, return on investment for payers, and the link between contraceptive access and maternal health (especially for state Medicaid reimbursement). Quantitative research is needed to establish the actual costs, revenues, and financial impact of reimbursement for pharmacist-prescribed contraception.

## ADMINISTRATIVE BURDENS OF CREDENTIALING AND BILLING

### The Challenge

To be reimbursed for clinical services, pharmacists must be credentialed by public payers and enrolled by private payers as providers. The current process is burdensome to pharmacies, as each pharmacist must go through credentialing with each plan, including multiple Medicaid Managed Care Organizations (MCOs) and other private plans. Further, to bill payers for clinical services provided by pharmacists, pharmacies must acquire and train pharmacists on the type of billing system that medical providers use, which is a different system with different billing codes than pharmacies are currently using. Payers are also burdened, as they must update their benefit coding to allow pharmacists to bill for the codes they will be using. The specter of these administrative burdens discourages payers from entering this space.

### Recommended Solutions

- **Payers should streamline credentialing.** First, payers could implement group credentialing by outsourcing to third parties; MCOs already do group credentialing of physicians, but it does not yet appear to be widespread in pharmacy practice or by public payers. Second, state agencies could support standardization of the credentialing processes and requirements across Medicaid as well as for private payers, which would lessen the administrative burden and allow pharmacists to go through the same process for a larger number of health plans. Third, payers could offer credentialing reciprocity for Medicaid enrollment—recognizing any pharmacist who has been enrolled as a Medicaid provider as having satisfied the requirements for the private payer as well.
- **Pharmacies and payers should address administrative staffing needs.** Addressing the administrative burden of credentialing requires that both pharmacies and payers have dedicated staff and resources to become acclimated to the credentialing and billing process.
- **Payers and pharmacies should take steps to make billing codes and software accessible to pharmacists.** Stakeholders agree that it is preferable for pharmacists to use existing billing codes rather than for payers to create new codes specifically for pharmacists. However, statutory language and industry practices among payers may preclude pharmacists from using existing diagnostic codes. Additionally, pharmacists must become familiar with new billing codes and software. Outsourcing to billing agencies, centralizing processes within chain pharmacies, and using clearinghouses, which interface between pharmacy and medical billing systems, are ways to decrease the administrative burden that pharmacists experience related to billing.

## ADEQUACY OF REIMBURSEMENT RATES

### The Challenge

Pharmacists are reimbursed at lower rates than other providers (typically 75-85% of rates for physicians performing the same services) for both drug dispensing and clinical services, where available. Additionally, pharmacists need to be able to bill for time spent counseling patients regardless of whether that patient leaves with a prescription contraception method, just as physicians who see sick patients but do not prescribe a drug can still bill for the visit. Current reimbursement rates are so low that pharmacies may only break even or even suffer a loss when providing clinical services. Due to low rates, pharmacies may determine it is not worth expanding capacity to provide contraceptive prescribing.

### Recommended Solutions

- **Payers should take steps to ensure rate adequacy and should consider payment parity.** Medicaid should lead the way in ensuring that reimbursement rates are adequate to incentivize provider participation and guarantee meaningful access (rate adequacy), as private payers are unlikely to reimburse at higher rates (compared to physicians or other providers) than public payers. Some stakeholders called for pharmacists to be reimbursed at the same rate as physicians (known as "clinician-blind reimbursement"), although other stakeholders expressed that legislation to mandate this may be opposed by physicians who fear that uniform reimbursement will ultimately lower their rates while increasing rates for pharmacists and other non-physicians.
- **Medicaid officials should conduct state-level cost of dispensing studies.** One component of Medicaid reimbursement for drug dispensing is the "ingredient cost," which is determined by state Medicaid agencies in accordance with federal regulations—specifically, the ingredient cost is based on the "actual acquisition cost" (AAC) of a drug. State Medicaid agencies can calculate AAC using multiple methods, subject to Centers for Medicare and Medicaid Services (CMS) approval through the SPA process, and one such method is a state cost of dispensing study, wherein states survey pharmacies to produce an up-to-date estimate of the cost of dispensing Medicaid fee for service drugs.

# 2. REGULATORY COMPLIANCE

## The Challenge

The burden of navigating a complex and varied regulatory landscape across states was identified by stakeholders as one of their chief concerns, particularly for pharmacies and payers who operate across multiple states. States can expand pharmacist scope of practice through several mechanisms, including a statewide protocol, standing order, or collaborative practice agreement, all of which have downstream regulatory impacts. Overly prescriptive regulatory requirements that are often included in state statutes or other protocols authorizing pharmacist prescribing make compliance more difficult for stakeholders operating in multiple states. It also gets in the way of chain pharmacies' preference to create company-wide policies and procedures that can apply to all locations.

## Recommended Solutions

- **State lawmakers and regulators should simplify state regulation of pharmacist scope of practice with broader and more general grants of authority and harmonization across states where possible.** Prescriptive state rules and the practice of expanding scope of practice for specific services should be replaced with a standard of care model that grants pharmacists the ability to prescribe within their scope of practice as determined by the profession. An intermediate step toward a total standard of care model is to grant pharmacists scope of practice in broad categories, without clinical or service specifics (e.g., pharmacists may prescribe "medications for which a diagnosis is not required"). In state contexts in which deregulation is not feasible, state regulations should be made less prescriptive, such as removing age restrictions or not listing out specific methods of contraception but using the language of "self-administered methods" to allow for flexibility if additional methods are approved. Harmonization across states would also reduce burdens and make broad implementation more feasible.
- **Advocates and researchers should create a toolkit for state legislatures and agencies with a range of alternative options for removing regulatory burdens and harmonizing remaining regulations.** By providing a menu of model or template policy language to effectuate pharmacist-prescribed contraception in the most efficient and streamlined way—from less prescriptive models to more prescriptive models—and explaining the impact of each option, a toolkit would enable state legislatures or regulators to make informed choices that suit their political climate and constituent needs.
- **Advocates and researchers should create a stakeholder engagement playbook.** A playbook would provide stakeholders operating in state legislative or regulatory bodies with the data needed to advocate for pharmacist provision of clinical services, help identify the groups needed to build a successful coalition (including non-pharmacy stakeholders such as other medical professionals and "pharmacy champions" in other industries), and advise on how to successfully engage different types of stakeholders, all of whose buy-in is needed.

# 3. LIABILITY CONCERNS AMONG PHARMACISTS

## The Challenge

Prior research indicated that concerns about liability was a top concern for pharmacists and a barrier to prescribing. However, the stakeholders we interviewed, particularly chain pharmacy executives, expressed confidence that existing liability coverage is sufficient for pharmacists to prescribe hormonal contraception, indicating a gap in understanding between individual pharmacists and executives.

## Recommended Solutions

- **Advocates and pharmacies should raise awareness among pharmacists about existing liability insurance protections.** The gap in understanding between pharmacists and pharmacy executives should be addressed through training and education. Advocates, particularly those working with pharmacist associations, can support this awareness-raising effort.

# 4. TRAINING

## The Challenge

Both prior literature and many of our stakeholders indicated that pharmacists may not initially feel comfortable prescribing hormonal contraception, while others expressed that pharmacists already have the ability to safely provide contraceptive care based on existing training required for their licenses. Many expressed discontent with state-mandated trainings; in particular, chain pharmacy executives said that they prefer to develop training in-house as part of rolling out the service, but that their ability to offer a single training was inhibited by differing training requirements amongst the states.

## Recommended Solutions

- **State regulators should minimize and harmonize mandatory training requirements. Stakeholders generally agreed that state-mandated training requirements are unnecessary to ensure patient safety and inhibit implementation.** Rather than require and legislate the specifics of trainings, states should (as they do for other health care providers) rely on the standards of care learned during pharmaceutical clinical education as well as professional ethics regarding continuing education as sufficient to ensure patient safety with respect to hormonal contraception. States with existing training requirements in legislation or regulations should be encouraged to remove or minimize those requirements through legislative or regulatory processes, while states currently developing their policies should rely on the education already happening in pharmacy schools today rather than requiring additional training.
- **Advocates and pharmacies should take steps to increase policymakers' trust in and knowledge of pharmacists' ability to provide expanded services.** Stakeholders spoke of a need to reinforce confidence in pharmacists by educating policymakers on pharmacists' core competencies (including provision of medications like hormonal contraception) and providing data demonstrating their expertise and the benefits of expanding scope of practice.

# 5. WORKFLOW AND STAFFING

## The Challenge

Many studies have indicated that time and staffing issues are main barriers to implementation. Our stakeholders echoed these findings, expressing concern that pharmacists would feel overwhelmed by adding a new service and that pharmacies need to figure out workflow processes to ease burdens on busy staff. (While the whole of pharmacy staffing issues is a bigger issue than our project could address, it should still be mentioned as it was identified as a main barrier to implementation.) Increasing staffing for the sole purpose of offering contraception prescribing is not viable as demand is currently low and difficult to predict; simultaneously, variability in staffing and availability of pharmacist-prescribed contraception makes it difficult for patients to know whether or when the service will be available. Thus, staffing and patient demand (see next section), must be considered together.

## Recommended Solutions

- **Lawmakers and regulators should enable pharmacies to leverage pharmacy technicians more effectively.** Pharmacy technicians should be included in as many steps as possible to help to alleviate broader staffing constraints facing pharmacies. Policymakers should ensure that state statutes and regulations are not written in a way that excludes the participation of pharmacy techs (for example, by requiring licensed pharmacists to take patient blood pressure). Policymakers should also address state laws mandating a minimum pharmacist-to-technician ratio, as restrictive ratios exacerbate staffing shortages and limit pharmacists' ability to practice at the top of their licenses.
- **Pharmacies should facilitate staff specialization and make more efficient use of specialized staff.** Sharing of specialized pharmacists across multiple locations could also help alleviate staffing pressure, while publicizing the prescribing pharmacist's schedule on a centralized schedule will allow patients to know when and where these services are available.

# 6. PATIENT DEMAND

## The Challenge

Lack of consistent patient demand was a frequently identified barrier to robust implementation. This lack of demand is understood to stem from lack of awareness, rather than lack of desire for the service. As mentioned above, there is a mutually reinforcing relationship between workflow and staffing issues and patient demand issues: as long as implementation is not widespread, word will not spread to the general public and patients who are aware will be reluctant to rely on a service that is not consistently available. Stakeholders described a hesitancy to mount public awareness campaigns until the service is readily available at a significant number of pharmacies.

## Recommended Solutions

- **Pharmacies and advocates should leverage the Opill moment to generate more consistent consumer demand and address related workflow issues.** Retail pharmacy chains should provide signage in the aisle where Opill is located, indicating that pharmacists are available to prescribe other methods and, if applicable, that pharmacists can write prescriptions for Opill to allow patients to use insurance benefits to cover the costs. States who have not already done so should issue standing orders or statewide protocols for OTC contraception, so that pharmacists can issue prescriptions at the point of sale, ensuring Medicaid coverage, as recently recommended by CMS.
- **Advocates, pharmacies, and payers should raise public awareness of contraceptive options available at pharmacies by securing funding for awareness campaigns and integrating information into existing programming at high schools, colleges, and universities.** At least one state has successfully implemented this recommendation. They disseminated a logo and branding kit for pharmacies across the state with consistent imaging that will signal to patients where the service is available. An additional model is to create a centralized directory of pharmacies offering the service that includes scheduling information (following a model used for COVID vaccines); however, some stakeholders raised concerns about the sensitive nature of the service and possible backlash against providers listed in a public-facing directory of this kind. Stakeholders also pointed to the recent NHS “Pharmacy First” campaign aimed at raising awareness of and building public trust in community pharmacists’ ability to provide care relating to specific needs.

## KEY TAKEAWAYS

We're optimistic about the potential to fully implement existing state laws and ensure that pharmacists are available to provide contraceptive care in their communities. Collaboration among regulators, stakeholders, researchers, and advocates is a particularly important factor in successful implementation. Collaboration on one or more of the recommendations we've shared could pave the way for cooperation on additional steps that will protect and expand access to contraception. This is a unique moment in time where pharmacies' potential can be harnessed to generate significant healthcare solutions. Pharmacies are important sites for healthcare, and we are hopeful that empowering them in this area will lead to growth in the reproductive space and beyond.

## SUMMARY OF RECOMMENDATIONS BY TYPE OF STAKEHOLDER (IN ORDER OF PRIORITY)

| **Recommendations for pharmacies** | |
|---|---|
| Reimbursement | Make billing codes and software accessible to pharmacists. |
| | Address administrative staffing needs. |
| Liability concerns | Raise awareness among pharmacists about existing liability insurance protections. |
| Workflow and staffing | Facilitate staff specialization and make more efficient use of specialized staff. |
| Patient demand | Raise public awareness of contraceptive options available at pharmacies through awareness campaigns and existing educational programming. |
| | Increase policymakers' trust in and knowledge of pharmacists' ability to provide expanded services. |
| | Leverage the Opill moment to generate more consistent consumer demand and address related workflow issues. |

| **Recommendations for private payers** | |
|---|---|
| Reimbursement | Streamline credentialing. |
| | Make billing codes and software accessible to pharmacists. |
| | Address administrative staffing needs. |

| **Recommendations for public payers** | |
|---|---|
| Patient demand | Raise public awareness of contraceptive options available at pharmacies through awareness campaigns and existing educational programming. |
| Reimbursement | Develop and disseminate model state plan amendment language and model language for Medicaid MCO contracts to recognize pharmacists as Medicaid service providers. |
| | Ensure rate adequacy and consider payment parity. |

| Recommendations for Medicaid officials | |
|---|---|
| Reimbursement | Conduct state-level cost of dispensing studies. |
| | Develop and disseminate model state plan amendment language and model language for Medicaid MCO contracts to recognize pharmacists as Medicaid service providers (for states that have implemented reimbursement). |

| Recommendations for state lawmakers | |
|---|---|
| Workflow and staffing | Enable pharmacies to leverage pharmacy technicians more effectively. |
| Regulatory Compliance | Simplify state regulation of pharmacist scope of practice with broader and more general grants of authority and harmonization across states where possible. |

| Recommendations for state regulators | |
|---|---|
| Workflow and staffing | Enable pharmacies to leverage pharmacy technicians more effectively. |
| Regulatory Compliance | Simplify state regulation of pharmacist scope of practice with broader and more general grants of authority and harmonization across states where possible. |
| Training | Minimize and harmonize mandatory training requirements. |

| Recommendations for researchers | |
|---|---|
| Reimbursement | Build an even stronger evidence base. |
| Regulatory Compliance | Create toolkits for state legislators and agencies that include alternative options for removing regulatory burdens and harmonizing remaining regulations. |
| | Create a stakeholder engagement playbook. |
| Liability Concerns | Raise awareness among pharmacists about existing liability insurance protections. |

| Recommendations for advocates | |
|---|---|
| Patient demand | Raise public awareness of contraceptive options available at pharmacies through awareness campaigns and existing educational programming. |
| | Leverage the Opill moment to generate more consistent consumer demand and address related workflow issues. |
| Reimbursement | Develop and disseminate model state “any willing provider” (AWP) laws that provide for pharmacist prescribing services. |
| | Build an even stronger evidence base. |

| Recommendations for advocates | |
|---|---|
| Regulatory compliance | Create toolkits for state legislators and agencies that include alternative options for removing regulatory burdens and harmonizing remaining regulations. |
| | Create a stakeholder engagement playbook. |
| Liability Concerns | Raise awareness among pharmacists about existing liability insurance protections. |
| Training | Increase policymakers' trust in and knowledge of pharmacists' ability to provide expanded services. |

## SOURCES

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## ABOUT THE CENTER ON REPRODUCTIVE HEALTH, LAW, AND POLICY (CRHLP)

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The UCLA Law Center on Reproductive Health, Law, and Policy is an independently funded think tank and research center developing long-term, lasting solutions that advance all aspects of reproductive justice and address the current national crisis of abortion access.

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