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Implementing Pharmacist Contraceptive Prescribing: A Playbook for States and Stakeholders

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Implementing Pharmacist Contraceptive Prescribing: A State and Advocacy Playbook

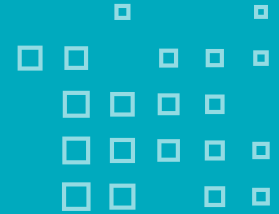


Table of Contents

Introduction	5
State Authorization of Pharmacist Prescribing	6
Pharmacist Prescribing Laws	6
Policy Considerations in Crafting Statewide Protocol Legislation	9
State Legislative Dynamics	11
State-Based Policy Change: Spotlight on Bold Futures	12
Strategies to Assure Effective Implementation	14
Stakeholder and Community Engagement	14
1. Engage Providers, Pharmacists, and Community-Based Organizations Early and Often	14
2. Design Consumer Outreach Plans to Ensure Awareness of Pharmacist Prescribing	15
3. Establish a Centralized Registry of Pharmacists Certified to Prescribe Contraceptives	17
Payment	17
4. Ensure Pharmacists Are Paid for Contraceptive Prescribing Services	17
5. Develop a Cross-payer Toolkit for Pharmacist Credentialing, Enrollment, and Billing as Providers	18
6. Increase Pharmacy Dispensing Fees	19
Pharmacist Training	19
7. Offer a Range of Pharmacist Training Programs	19
8. Partner with Local Schools of Pharmacy to Incorporate Contraceptive Prescribing Certification Programs	20
9. Provide Pharmacist Prescribers with Family Planning Referral Resources	20

Promoting and Supporting Pharmacist Uptake21

 10. Collaborate with Multi-Location Pharmacies21

Data Analysis21

 11. Assess Family Planning Provider Availability to Craft Pharmacist and Consumer Engagement Initiatives21

 12. Assess Contraceptive Access22

Medicaid Strategies23

 13. Clarify Balance Billing Restrictions for Pharmacists23

Medicaid Managed Care Strategies24

 14. Clarify Freedom of Choice of Provider Protections24

 15. Incorporate Pharmacist and Member Engagement, Billing Requirements in MCO Contract25

Appendix26

Endnotes27

Introduction

More than 19 million individuals in the United States lack meaningful access to birth control within their communities.¹ Low-income women, women of color, and individuals from other historically marginalized communities have been shown to have greater difficulty in accessing reproductive healthcare generally and contraception in particular.² These problems are tied to several factors, including cost barriers or lack of insurance as well as the clinician requiring a clinic/doctor visit, challenges in obtaining a clinic appointment (often tied to the absence of a regular doctor/clinic relationship), or difficulty traveling to the clinic.³ Authorizing pharmacists to prescribe and dispense contraceptives is one strategy states can deploy to increase contraceptive choice and access and at the same time address health disparities.⁴

The early experience of states that have implemented pharmacist prescribing policies demonstrates that such policies increase contraceptive access and choice. In Oregon, for example, almost three-fourths of Medicaid-enrolled patients who were prescribed contraception by pharmacists did not have a prescription for a contraceptive in the preceding 30 days—suggesting they were either entirely new users of contraception or experienced a lapse in contraceptive use.⁵

In a 2019 study of four states with contraceptive prescribing laws, women who were prescribed contraceptives by a pharmacist as opposed to a clinician were younger, had less education, and were more likely to be uninsured.⁴ Pharmacist prescribing may help address access disparities particularly for Black women⁶ and people living in rural communities⁷ because both of these populations are likely to live closer to a pharmacy than a physician's office.

In addition, the pharmacy counter may be a preferred access point for some consumers. Individuals who have obtained pharmacist-prescribed contraceptives report high levels of satisfaction and note, in particular, the convenience of obtaining care at the pharmacy.⁸

Recognizing these benefits, more than a dozen states have passed legislation to allow pharmacists to prescribe contraceptives (see page 8 for an overview of state legislation).^{9,10} These states' experiences show that successful pharmacist contraceptive prescribing initiatives require thoughtful design and implementation and realistic execution timelines. The purpose of this playbook is to provide state policymakers and other stakeholders with legislative, regulatory, reimbursement, and operational strategies to effectuate pharmacist prescribing and thereby increase access to contraception.

The **medical community** recognizes many methods of contraceptives as safe enough for complete over-the-counter access (an even less-regulated model for contraceptive delivery that would require **federal action**), and the Centers for Disease Control and Prevention (CDC) has **emphasized** that most contraceptive methods can be initiated without physical examinations or laboratory tests.

State Authorization of Pharmacist Prescribing

State professional scope of practice laws typically limit the responsibilities of pharmacists to dispensing prescriptions authorized by other providers (e.g., physicians, advanced practice providers). For that reason, authorizing pharmacist prescribing of contraception often requires legislation to expand pharmacists' scope of practice. Once legislation is passed, regulations and subregulatory guidance are essential to the effective implementation of the new authorities. This section of the playbook describes the legislative authority states adopt to enable pharmacist prescribing of contraceptives.

Pharmacist Prescribing Laws

State legislation authorizing pharmacist prescribing of contraceptives generally takes one of three forms:

- **Laws that authorize pharmacists to independently prescribe contraceptives (statewide protocol laws).** The term “statewide protocol” refers to a legislative framework that specifies the conditions under which pharmacists are authorized to prescribe a specified medication or category of medications—in this case, contraceptives.¹¹ Statewide protocol laws allow pharmacists to independently prescribe and dispense contraceptives. Typically, a combination of authorizing legislation and subsequent regulations establish training and certification standards that pharmacists must meet to become contraceptive prescribers. These authorities also set out the prescribing process that pharmacists must follow (e.g., requiring pharmacists to screen individuals seeking contraceptives for selected medical conditions).
- **Laws that authorize statewide standing orders** permit a state health officer (e.g., a health department official) to authorize, via a standing order, pharmacists to prescribe contraceptives without having to first obtain a physician (or other prescriber) order, so long as they meet any training requirements established by the state.
- **Laws establishing collaborative practice agreement authority** authorize pharmacists to prescribe and dispense contraceptives under a collaborative practice agreement (CPA) with an otherwise authorized prescriber. There are two forms of CPAs. Population-based CPAs are the more expansive form of CPA, and they are more commonly used to provide preventive services, including contraceptives. In this model, CPAs allow pharmacists to provide services to any patients who meet the criteria specified in the CPA. The other, more limited form are patient-specific CPAs, which allow pharmacists to provide services to patients who meet certain criteria, as agreed to by the authorized prescriber and pharmacist and documented in the CPA. These criteria may, for example, limit pharmacist prescribing to individuals who are already established patients of the authorizing provider.¹²

State regulators' ability and willingness to authorize pharmacist scope of practice changes without legislative authority varies across the country. State leaders and other stakeholders seeking to advance pharmacist prescribing should assess the most effective pathway in their respective states.

As described in Figure 1 below, statewide protocol laws are the most straightforward and effective at improving contraceptive access. These laws permanently authorize pharmacists to independently prescribe and dispense contraceptives, avoiding the additional step of negotiating collaborative practice

Figure 1. Benefits and Limitations of Pharmacist Contraceptive Prescribing Laws

	Type of Law	Description	Benefits	Limitations
Least restrictive and most effective at increasing access	Statewide Protocol	Authorizes pharmacists to prescribe and dispense contraceptives consistent with protocols set forth by a state licensing body (e.g., Board of Pharmacy)	✔ Allows pharmacists to prescribe contraceptives to a wide range of patients	Statewide protocols do not have limitations relative to the other authorities described in this chart.
	Statewide Standing Order	Authorizes a state health official (e.g., the state Department of Health) to issue a statewide standing order allowing pharmacists to prescribe and dispense contraceptives	✔ Allows pharmacists to prescribe contraceptives to a wide range of patients	✘ Susceptible to administrative action (i.e., a future administration could undo the standing order and/or change the terms of the standing order without legislative approval)
	Collaborative Practice Agreement (Population-specific)	Authorizes pharmacists to prescribe and dispense contraceptives to any patient that meets broad population criteria specified by law and in the CPA	✔ Allows pharmacists to prescribe contraceptives to a wide range of patients	✘ Requires pharmacist to establish an agreement with an authorized prescriber
	Collaborative Practice Agreement (Patient-specific)	Authorizes pharmacists to prescribe and dispense contraceptives to individual patients that meet criteria agreed to by the pharmacist and the prescriber and specified in the CPA (such as the patient having an existing relationship with the prescriber)	✔ Allows pharmacists to prescribe contraceptives to at least certain patients	✘ Requires pharmacist to establish an agreement with an authorized prescriber ✘ Unlikely to create an access point for underserved patients (e.g., those without access to a family planning provider participating in a CPA with a pharmacist)
Most restrictive and least effective at increasing access				

agreements. Figure 2 below provides links to state laws that specifically authorize pharmacist prescribing of contraceptives (via a statewide protocol, standing order, or CPAs). Forty-nine states have enacted some form of CPA law that may permit contraceptive prescribing but does not specifically authorize contraceptive prescribing; the states included in Figure 2 have enacted laws that specifically authorize pharmacist prescribing of contraceptives via CPAs.¹³

Figure 2. State Laws Authorizing Pharmacist Prescribing of Contraceptives

Type of Law	State (Link to authorizing legislation)	
Statewide Protocol	California (Link)	Minnesota (Link)
	Colorado (Link 1 , Link 2) ^a	New Mexico (Link) ^b
	District of Columbia (Link)	Oregon (Link 1 , Link 2) ^c
	Hawaii (Link)	Vermont (Link)
	Idaho (Link)	Virginia (Link)
	Maryland (Link)	
Standing Order for Contraceptives	New Hampshire (Link)	West Virginia (Link)
	Utah (Link)	
CPA for Contraceptives	Tennessee (Link)	Washington (Link)

Other Resources:

- **Power to Decide** published an infographic and [overview](#) of pharmacist prescribing laws in all 50 states and D.C. That resource includes the states listed in Figure 2 as well as two states—Michigan and Montana—that have enacted laws authorizing CPAs that are not specific to contraceptives but under which at least one pharmacy has established a CPA with authorized prescribers to prescribe contraceptives.
- **Birth Control Pharmacist** published a [report](#) describing the current landscape of pharmacist contraceptive prescribing laws and state legislative approaches and experiences.

^a The Colorado General Assembly passed Senate Bill 16-135 ([Link 1](#)), which modified the definition of CPA to include statewide drug therapy protocols developed by identified state regulators, and House Bill 18-1313 ([Link 2](#)), which modified the definition of practitioner to include pharmacists participating within the parameters of a statewide drug therapy protocol (not specific to contraceptives). Under this authority, the Colorado State Board of Pharmacy issued a [statewide protocol](#) to allow pharmacists to independently prescribe hormonal contraceptive patches and oral contraceptives.

^b In 1993, New Mexico enacted The Pharmacist Prescriptive Authority Act (linked in the table), which granted prescriptive authority to pharmacists that obtain the required training and certification as “pharmacist clinicians,” based on regulations promulgated by the Board of Pharmacy in consultation with the Board of Medical Examiners and the New Mexico Academy of Physician Assistants. Under this authority, the New Mexico Board of Pharmacy in June 2017 promulgated [rulemaking](#) to grant contraceptive prescriptive authority to pharmacist clinicians.

^c In 2015, the Oregon State Legislature enacted House Bill 2879 ([Link 1](#)), which authorized pharmacist prescribing of the patch and oral contraceptives; in 2017, the Oregon State Legislature enacted House Bill 2527 ([Link 2](#)), which authorized pharmacist prescribing of injectable hormonal contraceptives.

Policy Considerations in Crafting Statewide Protocol Legislation

When crafting and negotiating legislation authorizing pharmacists to prescribe contraceptives, states and stakeholders will want to consider the following:

- **Payment for pharmacist services.** To encourage pharmacists to utilize the authority to prescribe, legislation can direct that Medicaid and health plans pay pharmacists for the time they spend prescribing the contraceptive method of choice to individuals. Without payment for this service, pharmacists are less likely to participate as pharmacist prescribers.¹⁴ Although payment policies may be adopted after legislation is enacted, addressing payment from the outset may promote more rapid implementation of payment policies by state regulators. In turn, clear payment pathways can encourage faster adoption among pharmacists. (For more information about implementing pharmacist payment policies, see page 17.)
- **Limits on charging consumers directly.** Particularly in states where pharmacist payment for contraceptive prescribing is not available, pharmacists may, where permissible, seek to charge consumers directly for the prescription (in addition to claiming reimbursement for the drug).^d Because charging patients can inhibit access, particularly for low-income women, prohibiting prescribing pharmacists from charging individuals with contraceptive coverage for prescribing services may be warranted.^e However, such a ban would only be advisable if coupled with pharmacist payment requirements so that pharmacists are compensated for their time. Implementing a ban on consumer payment without ensuring pharmacist payment may have the unintended effect of impeding access by limiting pharmacist participation.
- **Authorized contraceptives.** Most states with pharmacist contraceptive prescribing laws permit pharmacists to prescribe Food and Drug Administration (FDA)-approved self-administered hormonal contraceptives (e.g., the pill, patch, ring); other states also authorize injectable contraceptives, thereby allowing pharmacists to administer the birth control shot (known as Depo-Provera or Depo).^f States can maximize access to contraceptives and support contraceptive choice among individuals seeking contraceptives at the pharmacy counter by including (1) all FDA-approved self-administered contraceptives rather than only self-administered hormonal contraceptives and (2) FDA-approved injectable methods. Authorizing pharmacists to prescribe all FDA-approved self-administered

^d As described on page 23, federal Medicaid law prohibits Medicaid providers from charging Medicaid-enrolled patients for covered services.

^e Contraceptive coverage may include Affordable Care Act (ACA) compliant health plans and Medicaid, including Medicaid family planning coverage, which provide that contraceptives are available without cost-sharing. For more information about ACA versus non-ACA compliant plans, see The Commonwealth Fund's overview, [Non-ACA-Compliant Health Plans](#); for more information about Medicaid family planning plan's see Manatt's [Enhancing Access to Family Planning Services in Medicaid: A Toolkit for States](#).

^f Long-acting reversible contraception (intrauterine devices and the implant) must be inserted by a medical provider and therefore are excluded from pharmacist prescribing initiatives.

contraceptives—including those available over-the-counter, such as condoms and certain emergency contraceptive pills—helps ensure insurance coverage of such products.^{9,15} (For an overview of FDA-approved contraceptives, see page 26.)

- **Age restrictions.** Some state legislation makes pharmacist contraceptive prescribing available only to individuals 18 years of age or older. While these restrictions may in some cases reflect a legislative compromise, age restrictions exacerbate existing access disparities not only for adolescents seeking contraceptives, but also for individuals without necessary identification (who are disproportionately people of color, people with low incomes, people experiencing homelessness, transgender people, and undocumented immigrants).¹⁶
- **Training requirements.** Whether and how state legislation specifies the training requirements that pharmacists must complete to become pharmacist prescribers is another factor that will influence both implementation timelines and participation rates.
- **Timelines for regulatory bodies to implement policies.** To promote implementation momentum, legislation can establish timelines that state regulatory bodies (e.g., the Board of Pharmacy) must meet for issuing necessary rulemaking and guidance, approving the training programs pharmacists must complete, and/or implementing payment policies. Legislation should strike a balance between allowing regulatory bodies adequate time to undertake an effective implementation process and ensuring timely implementation.
- **Regulatory bodies and stakeholders involved in implementation.** Establishing an effective framework for pharmacist contraceptive prescribing policies requires the involvement of multiple stakeholders, including Boards of Pharmacy, medical boards, Medicaid agencies, state insurance regulators, and others. Boards of Pharmacy are commonly charged with implementing changes to pharmacists' scope of practice; legislation can require the Board of Pharmacy to engage:
 - Other state agencies, such as Medicaid and the department of insurance, which effectuate coverage policies.
 - The health department, which has oversight of Title X and state family planning programs, and is positioned to help Boards of Pharmacy implement pharmacist prescribing rules.
 - Pharmacy associations that can promote pharmacist awareness of the policy and connect pharmacists to training opportunities and information on becoming authorized prescribers.
 - Community-based organizations and advocates that can promote consumer awareness and represent consumer interests.

⁹ Because federal Medicaid match may only be available for prescription drugs, in many states contraceptives that are classified as drugs—such as levonorgestrel (Plan B®)—are covered only if they are prescribed. Similarly, private insurance plans may limit coverage of contraceptives to those that are prescribed.

- **Data collection and analysis requirements.** Establishing data reporting requirements in legislation will enable assessment of pharmacist and consumer uptake and, over time, can help ensure that the law is supporting improved access. For example, data can reveal whether pharmacist uptake is higher in certain communities than in others; this data can then be matched with Medicaid or other state data (e.g., family planning clinic utilization) and used to engage pharmacists and consumers in communities where access appears more limited. Today, few states assess pharmacist participation in contraceptive prescribing, and even fewer states assess consumer uptake.
- **Liability protections for pharmacists.** A recent, national study of community pharmacists' views about expanded access to contraception in pharmacies found that concerns about potential liability deter pharmacist participation—particularly in the South.¹⁷ Lawmakers could consider incorporating liability protections for pharmacists in pharmacist prescribing legislation.
- **Fiscal impact.** State budgets are strained due to COVID-19,¹⁸ making legislation that requires significant funding less likely to pass. However, laws authorizing pharmacist prescribing of contraceptives do not carry a high—if any—price tag. Most payers already are required by federal law to cover contraceptives without cost-sharing.¹⁹ The key change is to whom the payment is directed—a clinician or a pharmacist.

In 2017, the Centers for Medicare & Medicaid Services (CMS) issued [guidance](#) to states about pharmacist scope of practice changes as a means to improving access to certain drugs for Medicaid beneficiaries, highlighting ways states have modified pharmacy prescribing policies to increase timely access to naloxone (an opioid overdose reversal drug), initiate tobacco cessation treatments, and increase flu shot uptake. Most recently, pharmacists' scope of practice has been a consideration for policymakers responding to the COVID-19 pandemic. In reaction to growing concerns about dropping childhood immunization rates during the COVID-19 pandemic, the federal government and states have [acted](#) to expand pharmacists' scope of practice with respect to childhood immunization administration, and several states have included pharmacists as part of their COVID-19 vaccine distribution plans. State leaders and advocates can ensure contraceptives are among the drugs considered when assessing opportunities to improve access to care via pharmacies.

State Legislative Dynamics

Although model pharmacist prescribing legislation can and has served as a basis for legislative activity across the nation, states and stakeholders considering new authority will want to craft legislation that is responsive to the particular state's landscape.

In some states, legislators and regulators—and the stakeholders that inform their decision-making—may have concerns about whether expanding pharmacists' scope of practice is appropriate and safe. The scope of practice environment in their states will influence the perspective of policymakers, medical providers,

R Street published frequently asked questions to address common questions about the safety of pharmacist prescribing of contraceptives and a [guide for state legislatures](#).

and pharmacists considering broadening prescribing authority for pharmacists. For example, some states have long-established policies that allow pharmacists to prescribe a range of prescription drugs and devices, work in collaborative care teams to manage chronic conditions, and otherwise serve as an integral part of the patient care team. In these states, adopting statewide protocols may be less controversial—and require less education—than in states where pharmacists’ scope of practice is more limited.²⁰ State legislators and regulators may refer to the different types of laws enumerated in Figure 2 to understand which will be most effective in light of their state’s political dynamics.

State-Based Policy Change: Spotlight on Bold Futures

This overview of legislative action to enhance contraceptive access among individuals living in New Mexico was compiled by Bold Futures. In their words, “Bold Futures leads New Mexico-based reproductive justice work through policy change, research, place-based organizing, and



and culture shift by and for women and people of color in New Mexico. Bold Futures centers the lived experiences and expertise of those most impacted by an issue, engaging with people at the intersection of their identities. We work to build communities where all have what we need to make real decisions about our own bodies and lives, and all have room to live with respect and dignity.”

As a majority people of color and Indigenous state with many people who are poor, working class, and living in rural communities, New Mexico has emerged as a national leader in maintaining and growing access to sexual and reproductive healthcare. In particular, New Mexico has taken significant steps to expand access to contraception through a variety of innovative laws and policies, including an expansion of pharmacists’ ability to prescribe contraception and provide contraceptive counseling at pharmacy counters.

New Mexico has long supported access to a full range of reproductive healthcare, participating in Medicaid expansion and maintaining both family planning- and pregnancy-related Medicaid eligibility at 250% of the federal poverty level. Despite this broad coverage, patients often face significant wait times for primary care and even longer for specialty care. Although New Mexico is a leader in allowing advanced practice clinicians and other providers to practice at the top of their licenses, the state still needs more providers to meet its communities’ diverse needs.

With this backdrop, in 2017, New Mexico approved a pharmacy protocol that allows trained pharmacists to provide contraceptive counseling and prescribe all contraceptive methods available in a pharmacy setting, including those available over-the-counter.^h State law has long allowed pharmacists in New Mexico to prescribe and provide care in accordance with detailed protocols passed by the state’s Medical Board, Board of Nursing, and Board of Pharmacy. Examples of previously enacted protocols include tobacco cessation products, vaccines, naloxone drug therapy, TB testing, and emergency contraception.

The contraceptive prescribing protocol was the subject of many years of advocacy, but was ultimately made possible through a unique collaboration between Bold Futures, ACLU of New Mexico, and the New Mexico Pharmacists Association. Together, this multidisciplinary collaboration organized nurses, midwives, physicians, physician assistants, and other health professionals and influencers to voice their support to the relevant professional societies and each of the regulatory boards about how pharmacy prescribing could significantly improve access to contraception. More than 100 providers signed letters to their respective boards, and courageous representatives attended board meetings and debates to encourage the passage of this important policy.

Implementation of the protocol began soon after its passage. However, insurance policies that limit payment for clinical services provided by pharmacists created barriers to widespread participation. To address this challenge, New Mexico subsequently passed a law²¹ requiring insurers to reimburse clinical services provided by pharmacists at an amount similar to other licensed providers; implementation of this law is ongoing. Notably, in 2019, New Mexico enshrined the Affordable Care Act’s “no-cost” contraceptive coverage requirements in state law and expanded upon them in important ways by requiring insurers to cover contraception regardless of an enrollee’s gender, cover a six-month supply of contraception at one time, and cover over-the-counter contraceptive methods in addition to all other FDA-approved methods. This law was also the result of years of successful organizing and advocacy by local reproductive justice and reproductive health advocacy groups, including Bold Futures, the ACLU of New Mexico, Planned Parenthood, and others.



^h The protocol’s formulary includes hormonal contraceptive patches, hormonal vaginal rings, combined oral contraceptives, progestin-only oral contraceptives, emergency contraceptives, depot medroxyprogesterone acetate injection, and other FDA-approved contraceptive methods, including over-the-counter methods for which a prescription is sometimes required for insurance purposes. The protocol excludes contraceptive implants, intrauterine devices, or any methods that require surgical training and implantation.

Strategies to Assure Effective Implementation

This section of the playbook addresses strategies that state regulators charged with implementing pharmacist contraceptive prescribing policies can employ to maximize access. As described in the previous section, legislation may dictate implementation steps states must take; in other cases, legislation provides discretion to state agencies to implement the policy. State boards of pharmacy are most commonly charged with leading implementation and ongoing oversight of these policies, but the strategies described below could be implemented by any state regulators charged with leading implementation. Strategies specific to state Medicaid agencies are described in a separate section beginning on page 23.

Stakeholder and Community Engagement

1. Engage Providers, Pharmacists, and Community-Based Organizations Early and Often

Cross-agency collaboration between boards of pharmacy and other state agencies as well as outside stakeholders will enable more informed design decisions and more effective implementation.

Key Cross-Agency Design Questions

- Will sources of contraceptive coverage, including Medicaid and state-regulated commercial plans, cover contraception when prescribed by a pharmacist and reimburse pharmacist prescribers for screening and counseling individuals to whom they prescribe birth control?
- Are pharmacists in the state typically enrolled in Medicaid and commercial plans in the state as providers, and are they accustomed to billing payers for medical benefit services (and not just drugs) or, in order to receive reimbursement, will they need to become credentialed and enroll as providers with Medicaid and commercial plans? If the latter, what changes will Medicaid, Medicaid managed care plans, and/or commercial plans need to make to enable pharmacists to enroll as providers and adopt medical billing practices so that they can be reimbursed for contraceptive prescribing?
- What role should pharmacists play in the broader family planning delivery system? For example, in addition to prescribing contraceptives to consumers, should pharmacists provide consumers with information about where and how to access other reproductive health services not provided by pharmacists?

The remainder of this playbook touches on strategies for addressing each of these—and other—questions.

Boards of pharmacy also should consider ways to engage pharmacist organizations and consumer advocates as they begin to plan for implementation. Local pharmacy associations can help state agencies identify reservations pharmacists may have about becoming pharmacist prescribers (for example, they

may be unaware of how to bill Medicaid or contract with Medicaid managed care organizations (MCOs) as a medical benefit provider), and support outreach to pharmacists. Similarly, engaging consumer advocates can help policymakers design implementation strategies that effectively promote consumer awareness and understanding of the policies.

STATE EXAMPLES:

Maryland's pharmacist prescribing [legislation](#) required the Board of Pharmacy to consult several state agencies and provider and pharmacy stakeholder organizations in the development of regulations implementing the law. The Maryland Board of Pharmacy took the legislation a step further by (1) engaging key stakeholders not specified in the legislation, including the state Medicaid agency and department of insurance, and (2) hiring a third-party facilitator to support cross-stakeholder implementation planning meetings. The Board of Pharmacy, with the support of the facilitator, conducted five stakeholder working [sessions](#) between July 2017 and September 2017 to determine the design of Maryland's pharmacist prescribing program, prior to promulgating [proposed regulations](#) in February 2018.

In **New Mexico**, strategic efforts to increase access to long-acting reversible contraception (LARC) are coordinated through a [LARC Workgroup](#). The workgroup was convened and is facilitated by the reproductive justice organization Bold Futures and includes public health leaders, policymakers, clinical providers, and community members. Through [this model](#), New Mexico has made reproductive justice and patient-centered, culturally competent care a focus point of policymaking with respect to LARC.

2. Design Consumer Outreach Plans to Ensure Awareness of Pharmacist Prescribing

To promote consumer awareness of pharmacists' ability to prescribe contraceptives, state regulators charged with implementing pharmacist prescribing policies should consider partnering with community-based organizations, pharmacist associations, and other state agencies to develop consumer outreach campaigns. Such initiatives may include:

- Working with the public health department to incorporate messaging about pharmacy access to contraceptives in existing community outreach materials and websites with directories of family planning providers.
- Contacting local media organizations, or working with pharmacies to contact local media organizations, to publish stories about new access points.
- Encouraging and/or requiring health plans (including Medicaid managed care plans and commercial insurers) to incorporate lists of pharmacist prescribers of contraceptives in network information shared with enrollees.
- Distributing signage and/or window clings to pharmacists who are certified to prescribe contraceptives.

- Disseminating toolkits to pharmacist prescribers to encourage them to initiate conversations with individuals who are filling contraceptive prescriptions to make those patients aware that they may be able to receive a refill prescription from the pharmacist, if desired.
- Encouraging pharmacies that utilize text and phone reminders regarding refills to use these exchanges as opportunities to alert women prescribed a contraceptive that they can receive a refill prescription at the pharmacy (obviating the need for follow-up with a family planning provider).

Implicit bias can lead providers and pharmacists to offer contraceptives to certain patients, particularly low-income people and people of color, more frequently than to others and/or to encourage certain contraceptive methods over others. States, in partnership with community-based organizations, should consider disseminating educational materials for pharmacists about implicit bias in contraceptive prescribing and contraceptive counseling methods that promote individual autonomy and choice.

States and their partners will want to consider the best timing for implementing consumer outreach campaigns. States will want to strike the right balance between launching campaigns after some pharmacists have had a chance to receive the required training and enroll as prescribers (so that consumers can find a prescribing pharmacist) and implementing consumer outreach campaigns early because they can help drive demand and encourage pharmacist participation. Outreach campaigns that are coupled with information about which pharmacists currently prescribe contraceptives will help states strike that balance as programs develop (see Strategy 3 below).

STATE EXAMPLES:

North Dakota established a statewide pharmacy program called **ONE Rx** in response to the opioid epidemic; the program incorporated several pharmacist and consumer outreach initiatives. As the number of pharmacists participating in the program grew, the state stepped up its patient engagement efforts. For example, all participating pharmacists received a button to wear that read “Ask Me about Naloxone,” and window stickers that read “This Pharmacy is Taking Extra Steps to Ensure Safe Use of Opioid Medications.” Additionally, local television stations and newspapers interviewed ONE Rx team members and pharmacists about the services offered through ONE Rx.

Similarly, a private-public partnership in **Utah** disseminated a “Talk to Your Pharmacist” toolkit to support pharmacists starting a conversation about naloxone with patients who have been prescribed an opioid.

In several states, local news outlets have promoted the availability of contraceptives at pharmacies following the passage of legislation by featuring interviews with pharmacists, state regulators, and other stakeholders. For example, see local news coverage in **Idaho** and **Maryland**.

3. Establish a Centralized Registry of Pharmacists Certified to Prescribe Contraceptives

To ensure that women know which pharmacies and pharmacists are able to prescribe contraceptives, the state should consider publishing and regularly updating a list of participating pharmacies and pharmacists with the pharmacy hours. States can also encourage or require Medicaid and health plans to incorporate this information into their provider directories. Accurate, up-to-date state registries can augment other publicly available resources, such as birthcontrolpharmacies.com, which includes a directory of pharmacies that self-report prescribing birth control.

STATE EXAMPLE:

The **Utah** Department of Health publishes a [list](#), organized by city, of pharmacies where women may receive contraceptives without a prescription.

Payment

4. Ensure Pharmacists Are Paid for Contraceptive Prescribing Services

Pharmacists are more likely to seek certification to become contraceptive prescribers and, thereafter, to prescribe contraceptives if they are reimbursed for providing the service.¹⁴ Indeed, lack of payment is often cited as the most significant access barrier.²² Paying pharmacists for prescribing contraceptives helps overcome two common access barriers: (1) low pharmacist participation; and (2) pharmacists charging patients directly for prescribing services. It should be noted that federal Medicaid law prohibits charging Medicaid enrollees.ⁱ Ideally, state laws will specify that Medicaid and state-regulated commercial insurers must reimburse pharmacists for prescribing services and limit pharmacists' ability to collect payment for these services directly from consumers who have health insurance coverage. Where state law is silent, state Medicaid agencies and insurance regulators can take administrative action.

For Medicaid beneficiaries who are not enrolled in managed care, the state Medicaid agency may provide payment directly; for Medicaid beneficiaries who are enrolled in managed care, the state Medicaid agency can include pharmacist prescribing coverage requirements in their Medicaid managed care contracts and/or guidance. For individuals insured by state-regulated commercial plans, the state department of insurance could pursue multiple regulatory actions to ensure plans reimburse pharmacists for contraceptive prescribing. For example, state insurance regulators could require plans to meet provider network adequacy requirements related to contracting with pharmacists that are authorized to prescribe contraceptives. Regulators could also add or change requirements or guidelines for health insurance coverage in state model contracts (where state insurance regulators have such authority).

ⁱ Federal Medicaid laws generally prohibit Medicaid-enrolled providers from balance billing Medicaid-enrolled individuals once a provider has opted to bill and accept payment from Medicaid.

STATE EXAMPLES:

New Mexico [legislation](#), enacted in February 2020, requires Medicaid and state-regulated commercial plans to reimburse any participating provider that is a pharmacist certified to provide a prescriptive authority service (including, but not limited to, contraceptives) at the standard contracted rate that the plan reimburses any licensed physician, physician assistant, and nurse practitioner. The state is currently working to implement this requirement.

Maryland: Once they are credentialed and enrolled as Medicaid providers, pharmacist prescribers [may bill](#) Maryland Medicaid for the patient assessment that is required under Maryland’s law. The state designated two Evaluation & Management (E&M) patient codes for pharmacist use: 99201 (10-minute visit for a new patient) and 99211 (5-minute visit for an established patient).

Hawaii [law](#) requires employer group health policies to reimburse pharmacists for “medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.” Following the law’s passage, the state’s largest insurer designated four E&M patient codes for pharmacist use: the same two codes Maryland implemented, plus 99202 (20-minute office visit for a new patient) and 99212 (10-minute visit for an established patient).

Note: Recent [research](#) from Oregon suggests that pharmacists may require approximately 15–20 minutes to complete a visit, in addition to time required to document the visit and dispense the prescription. When establishing payment policies, states will want to consider the most appropriate patient codes to utilize, based on this research and factors such as the level of assessment that state protocols require pharmacists to complete prior to prescribing contraceptives.

5. Develop a Cross-payer Toolkit for Pharmacist Credentialing, Enrollment, and Billing as Providers

Generally, pharmacists are reimbursed for the product they dispense (e.g., prescription drugs) plus, in some cases, a dispensing fee. As a result, pharmacists typically bill under the pharmacy benefit—and not the medical benefit. To receive payment for the time they spend prescribing the contraceptive, pharmacists must bill as providers. To do so, they must enroll in Medicaid; be credentialed by, and contract with, health insurance plans (including commercial and Medicaid plans, where applicable); submit medical claims; and use medical coding practices. States can distribute cross-payer credentialing, enrollment, and billing guides to ensure pharmacists understand how to bill for the services they provide.

STATE EXAMPLES:

Louisiana issued a LARC [billing and ordering guide](#) that describes how providers should bill Medicaid and Medicaid MCOs for LARC services and the cost of the device. Even long-standing providers of medical care can be met with challenges when seeking payment; looking to guides that simplify billing for traditional

providers of medical care will serve as a helpful starting point for states seeking to support pharmacists newly navigating medical billing.

Maryland established a one-stop [landing page](#) where pharmacists can access information about contraception training programs, enrollment in Maryland Medicaid, credentialing via the Maryland Insurance Administration, and all Maryland contraception prescribing forms (such as the self-assessment form a patient must fill out).

In **Washington**, the state pharmacy association developed a step-by-step “Get Started as a Medical Provider” [guide](#), including resources regarding contracting and credentialing, billing for patient care services, and addressing technology challenges that may impact billing.

6. Increase Pharmacy Dispensing Fees

Where the development of payment policies for pharmacist prescribing of contraceptives is delayed, states may want to consider temporarily increasing professional dispensing fees in Medicaid (and encourage other payers to do the same). Dispensing fees are additive payments, paid in addition to payment for the drug; in most state Medicaid programs, these fees typically range between \$9 and \$12 for each prescription.²³ The increased dispensing fee would apply when a provider prescribes and dispenses a contraceptive to reflect the additional services provided.

STATE EXAMPLE:

In 2014, **Illinois** established a \$35 dispensing fee for selected providers dispensing certain birth control methods; to receive this higher dispensing fee, pharmacists use certain billing code modifiers. The fee was implemented as part of a multi-pronged initiative to improve access to contraceptives. Although this specific example applies to family planning clinic providers (the dispensing fee is specific to drugs purchased via the 340B drug discount program), state Medicaid agencies and commercial payers can establish a similar payment methodology for pharmacists prescribing contraceptives.

Pharmacist Training

7. Offer a Range of Pharmacist Training Programs

In most states that have authorized pharmacist prescribing of contraceptives, pharmacists must complete training programs to become certified as contraceptive prescribers. State regulators can specify a single training program or a range of programs from which pharmacists may choose to obtain certification. Providing pharmacists with training options is likely to promote better uptake, opening the door for pharmacists to complete training programs at their pharmacy school, online, or through their employer.

STATE EXAMPLE:

The **Maryland** Board of Pharmacy has approved seven [contraception training programs](#) for pharmacists, including programs offered by the American Pharmacists Association, Birth Control Pharmacist, the Maryland Pharmacists Association, Oregon State University College of Pharmacy, TRC Healthcare, the University of Maryland School of Pharmacy, and Wegman's (a grocery store chain with community pharmacies that offer contraceptive prescribing).

8. Partner with Local Schools of Pharmacy to Incorporate Contraceptive Prescribing Certification Programs

States can increase the pipeline of available pharmacist prescribers by working with pharmacy schools to incorporate training programs into their curriculums. Indeed, pharmacists who are recent graduates are more likely to be interested in prescribing contraception than pharmacists who have been practicing for many years.¹⁷

STATE EXAMPLE:

As part of their curriculum, the **University of New Mexico College of Pharmacy** PharmD graduates [receive](#) the necessary training for all New Mexico prescriptive authorities, including contraceptive prescriptive authority.

9. Provide Pharmacist Prescribers with Family Planning Referral Resources

States may want to provide pharmacists with information about which providers offer family planning and other reproductive health services. There are several reasons providing additional information can benefit individuals seeking contraceptives at the pharmacy counter.

First, pharmacists are not able to prescribe and administer all forms of contraceptives; individuals who are interested in an intrauterine device or implant, for example, would need to see a clinical provider. Second, individuals without contraceptive coverage may prefer to receive contraceptives from a Title X clinic or other family planning provider that offers free/sliding fee discount schedules. Lastly, individuals who access contraceptives at the pharmacy counter may have other reproductive health needs, now or in the future (such as sexually transmitted infection testing and treatment). These informational materials could be coupled with information about coverage options for uninsured individuals (for example, information about what insurance coverage options for which they may qualify, including limited-Medicaid-benefit family planning programs where available).

STATE EXAMPLE:

The **Maryland** Board of Pharmacy includes a [list of family planning sites](#) among the [forms](#) that it provides to pharmacist prescribers. The list is organized by the county the site is located in and includes not only the family planning site addresses, but also contact names and phone numbers of individuals to contact regarding accessing services at the listed sites.

States also may leverage national resources—like Bedsider’s [clinic search tool](#).

Promoting and Supporting Pharmacist Uptake

10. Collaborate with Multi-Location Pharmacies

To ensure widespread pharmacy and pharmacist participation, states and their stakeholder partners may want to collaborate at the corporate level with large, multi-location pharmacies.

STATE EXAMPLE:

In **Oregon**, stakeholders worked collaboratively with insurance providers and pharmacies to establish pharmacist billing processes for contraceptives. This [initiative](#) began with Albertsons, which was the first Oregon pharmacy to bill Medicaid for pharmacist prescribing.

Data Analysis

11. Assess Family Planning Provider Availability to Craft Pharmacist and Consumer Engagement Initiatives

By mapping the number of women of reproductive age against the supply of family planning providers in a given area, and/or measuring time and distance to family planning providers, states will identify contraceptive deserts and can target outreach to pharmacies in those areas.^{4,5} Women who do not live within proximity to family planning providers may be more likely to live near a pharmacy, or regularly use grocery stores or other retailers that have on-site pharmacies, making it easier for them to receive a contraceptive prescription at a pharmacy counter rather than a provider’s office. For example, using a 30-minute driving time threshold, a recent study found that 20% of North Carolina’s population and 35% of Texas’ population lacked or had poor access to the family planning services of a Title X-funded clinic.²⁴ States can close the access gap by targeting outreach efforts to pharmacies in areas with limited family planning provider options.

Even for women who have access to contraception through family planning clinics or other providers, pharmacist prescribing presents a convenient or preferred option for receiving a contraceptive prescription.²⁵ Additionally, pharmacist prescribing may help individuals avoid unwanted lapses in contraceptive adherence due to an expired refill.

12. Assess Contraceptive Access

To date, researchers have examined how pharmacist prescribing has increased access to contraceptives via point-in-time studies. States can best understand long-term contraceptive access by conducting ongoing analyses of contraceptive access. This information would enable states to target their outreach efforts in underserved areas or to assess whether changes to payment and other policies should be considered to improve pharmacist participation.

To assess the degree to which pharmacist prescribing of contraceptives has increased contraceptive access among consumers, states will want to consider the following data elements regarding individuals who have received a contraceptive prescription from a pharmacist:

- Consumer demographic information, including age, race, ethnicity, and income
- Consumer geographical information (e.g., home ZIP code)
- Consumer source of coverage (e.g., uninsured, Medicaid, commercial insurance)
- History of contraceptive use (e.g., did the individual have a contraceptive prescription in the past 30 days? 60 days?)
- History of receiving family planning services (e.g., did the individual receive any family planning service other than the pharmacist prescription in the past 365 days?)

Some of these data elements could be reported by pharmacists, but more robust analyses would require access to claims data. Depending on the availability of statewide claims data, states may need to limit these analyses to, for example, Medicaid-enrolled individuals.

To assess pharmacist participation, states should consider analyses of the following data points:

- Pharmacist prescriber demographic information, including age and race/ethnicity
- Employer type (e.g., whether the pharmacy is a chain or an independent pharmacy)
- Date pharmacist received state certification to prescribe contraceptives
- If the state has authorized multiple training programs, the specific training program utilized to receive pharmacist prescriber status
- If applicable, date pharmacist became enrolled as a provider for medical billing purposes (this may be limited to Medicaid or, if possible, also include commercial insurance data)
- Number of contraceptive prescribing visits completed by the pharmacist

Medicaid Strategies

In 2018, Medicaid covered 12.9 million women ages 15–44—20% of all women in this age group and 48% of women with incomes below the federal poverty line.²⁶ Not only is Medicaid critical to contraceptive access for low-income women, it also is essential to addressing disparities in access to contraceptive care among women of color; 31% of African American women ages 15–44 and 27% of Hispanic women ages 15–44 are enrolled in Medicaid.²⁶

As a result, state Medicaid leaders are critical to ensuring that pharmacy prescribing laws benefit low-income women, including women of color. Many of the strategies described in the preceding section are applicable to Medicaid. In particular, Medicaid will determine payment policies for pharmacist prescribing in Medicaid, and credential and enroll pharmacists as providers in the Medicaid program.

To ensure Medicaid beneficiaries have maximum access to pharmacist-prescribed contraceptives, state Medicaid agencies implementing new pharmacist prescribing laws will want to consider the strategies discussed above. For example, Medicaid agencies can help assure that pharmacist prescribing policies help improve access to contraceptives for Medicaid enrollees by paying pharmacists for their time spent prescribing (and not just dispensing); requiring managed care plans to contract with enrolled pharmacist prescribers; developing tailored communications and outreach strategies—in collaboration with stakeholder partners—to promote awareness; and regularly analyzing data to identify ongoing access gaps. This section describes Medicaid-specific strategies.

13. Clarify Balance Billing Restrictions for Pharmacists

Federal Medicaid laws prohibit Medicaid-enrolled providers from balance billing Medicaid-enrolled individuals once a provider has opted to bill and accept payment from Medicaid.²⁷ (Federal Medicaid law also prohibits states from imposing out-of-pocket costs, such as co-payments, coinsurance, or deductibles for all family planning services.²⁸) If the pharmacist is enrolled in and billing Medicaid for the prescription, the pharmacist may not charge the beneficiary any out-of-pocket costs, including the cost of prescribing the contraceptive.

To ensure pharmacists are aware of these restrictions and do not bill Medicaid beneficiaries directly for prescribing services, states can work with state boards of pharmacy and pharmacist associations to inform pharmacists about Medicaid requirements. Information could be distributed jointly by the Medicaid agency, the board of pharmacy, and/or the pharmacist association and could include comprehensive information about how to become credentialed and enrolled in Medicaid as providers and how to bill Medicaid and/or Medicaid MCOs for services provided.

Medicaid Managed Care Strategies

Over the past 30 years, managed care has become the dominant form of Medicaid service delivery; in 2018, more than two-thirds of the Medicaid population nationwide was enrolled in comprehensive managed care.²⁹ Thus, most Medicaid enrollees—and particularly people of reproductive age—receive their care through an MCO, making it critical that states consider MCO policies when implementing pharmacist prescribing.

14. Clarify Freedom of Choice of Provider Protections

Medicaid enrollees may receive family planning services from any Medicaid-enrolled provider, a policy known as “freedom of choice of provider.”^{30,31} This protection applies to beneficiaries who receive services through fee-for-service Medicaid or managed care and thus guarantees access to family planning providers regardless of whether providers are in the MCO’s network. It would also apply to pharmacists who are prescribing contraceptives.

States will want to ensure that both Medicaid managed care plans and pharmacist prescribers are aware of the policy and do not limit access to out-of-network pharmacists. States have differing policies with respect to whether Medicaid fee-for-service or the Medicaid MCO is responsible for paying an out-of-network family planning claim. Depending on which entity is responsible for paying the claim, out-of-network pharmacists seeking to bill Medicaid for contraceptive prescribing services may:

- Bill fee-for-service Medicaid for the service (this scenario applies if the state’s contract with MCOs “carves out” out-of-network family planning services from the MCO’s responsibilities); or
- Bill the MCO for the service (this scenario applies if the state’s contract with MCOs dictates that the managed care plan is responsible for reimbursing any Medicaid-enrolled provider for family planning services).

Federal regulations require MCOs to include information in enrollee materials about enrollees’ freedom of choice of provider.³²

STATE EXAMPLE:

California issued [guidance](#) to its Medicaid managed care providers’ plans clarifying several family planning-related requirements, including freedom of choice of provider protections. The guidance clarifies that Medicaid managed care enrollees have the right to access family planning services through any qualified provider—meaning any provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medicaid provider, and is willing to furnish family planning services to an enrollee; this includes pharmacist prescribers. Similar guidance could be issued to both MCOs and pharmacists.

ⁱ This applies unless the state has received a waiver of “freedom of choice of provider” protections. For example, in January 2020, CMS approved [Texas’ Section 1115 waiver](#) for its Healthy Texas Women family planning program, allowing the state to exclude family planning providers from the program if they also provide abortion services.

15. Incorporate Pharmacist and Member Engagement, Billing Requirements in MCO Contract

In states where the majority of Medicaid-enrolled women of reproductive age receive care through an MCO, states may want to:

- **Require MCOs to provide information about pharmacist prescribing to pharmacists.** States may want to require MCOs to notify network pharmacists of the option to become enrolled as a contraceptive prescriber and the process to become credentialed and enrolled as an MCO provider and bill the MCO for contraceptive services (in addition to continuing to bill the MCO for contraceptive items).
- **Require MCOs to provide information to enrollees about the availability of pharmacy prescribing.** For example, states could require plans to include information about pharmacist prescribing in newsletters and member engagement materials, such as the member handbook and provider network directory.
- **Specify minimum payment rates.** States also can specify the payment rate(s) that MCOs must pay Medicaid-enrolled pharmacist prescribers for contraceptive prescribing. Where states dictate minimum payment rates, states often will base them on the Medicaid fee-for-service fee schedule.

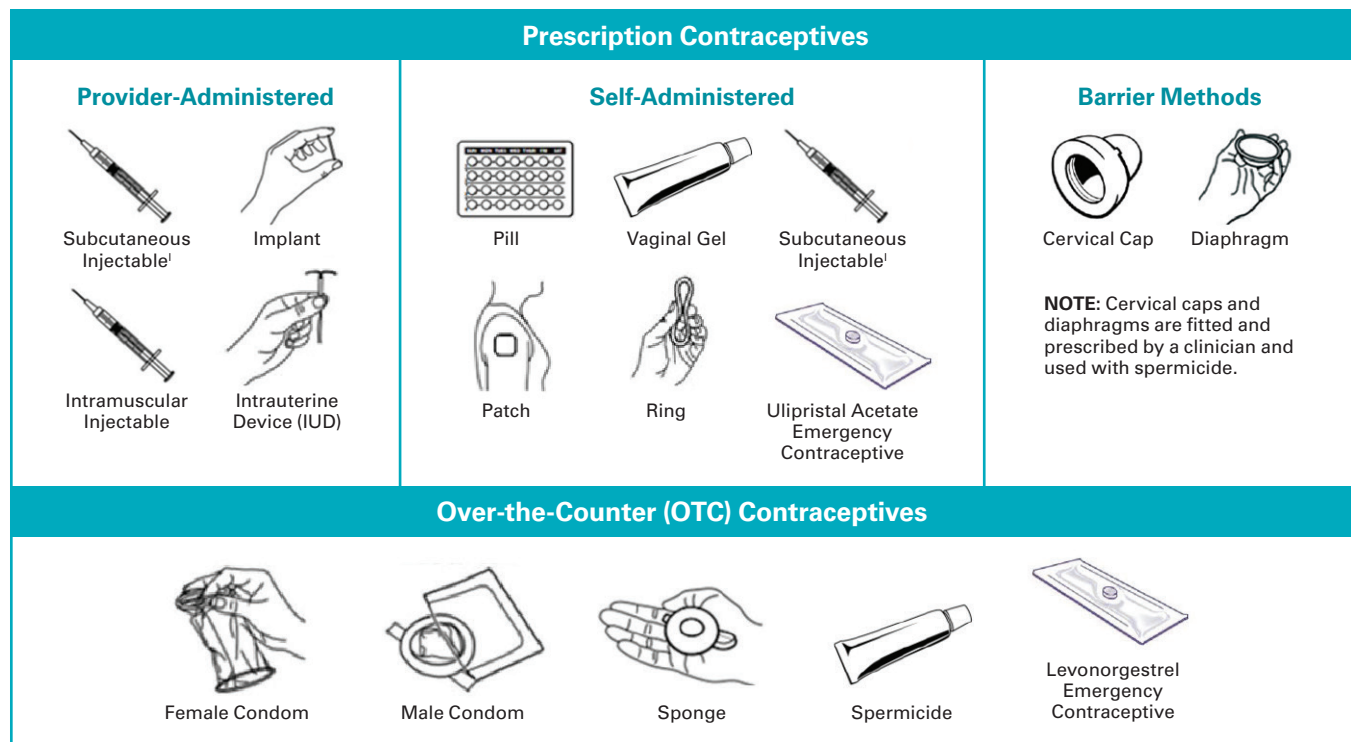
STATE EXAMPLE:

North Carolina's Medicaid [managed care contract](#) requires managed care plans to reimburse all in-network physicians and physician extenders (e.g., nurse practitioners and physicians assistants) no less than 100% of the Medicaid fee-for-service rate for the service or bundle, unless the PHP and provider have mutually agreed to an alternative payment arrangement. States could apply a similar policy specifically to family planning services, or a subset of family planning services (such as the E&M codes used by pharmacists) to assure adequate payment of pharmacists for contraceptive prescribing services.

Appendix

Figure 3 lists FDA-approved contraceptive products, organized by those that are only available with a prescription (including those that are provider-administered, self-administered, and barrier methods) and those that are available over the counter. Depending on whether state laws allow pharmacists to administer injectable contraceptives, pharmacists can play a role in ensuring access to all prescription contraceptives other than implants, intrauterine devices and cervical caps and diaphragms. These methods require a clinician to fit the individual for or insert the device. Pharmacist prescribing also can enhance access to over-the-counter contraceptives, if state law allows pharmacists to prescribe non-hormonal contraceptives. Because federal Medicaid match may only be available for prescription drugs, in many states over the counter contraceptives that are classified as drugs—such as levonorgestrel (Plan B®)—are covered only if they are prescribed.¹⁵ Many state Medicaid programs also require prescriptions to cover contraceptives that are not drugs (such as condoms, sponges, and spermicide), although federal Medicaid match is available for these products.³³

Figure 3. Types of FDA-Approved Contraceptives^{k,34}



^k Other forms of contraception not enumerated in Figure 3 include permanent sterilization (surgical and non-surgical), withdrawal, fertility-based awareness, and the lactational amenorrhea method.

^l Subcutaneous depot medroxyprogesterone acetate can be self-administered through “off-label” prescribing.³⁵

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