POLICY BRIEF
HEALTH CARE ACCESS

Tobacco Cessation
POLICY RESEARCH CENTER

Medi-Cal Reimbursement for Pharmacist-Provided Tobacco Cessation Services

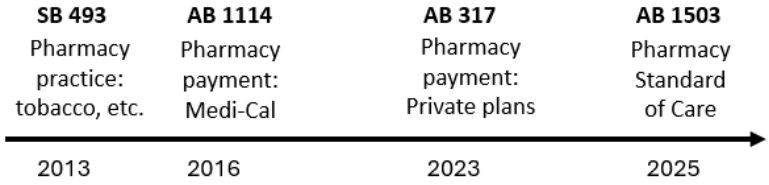
Community Pharmacy Enhanced Services Network (CPESN) California's Pharmacy Reimbursement Task Force, Robin Corelli, Chris Anderson, Elisa Tong

Background

California and the Department of Health Care Services (DHCS) have several complementary mechanisms to encourage pharmacies to treat tobacco use in the Medi-Cal population:

- ***Medi-Cal managed care plans are required to cover comprehensive tobacco treatment.*** This includes all medications approved by the Food and Drug Administration (FDA) for tobacco cessation.[1]
- ***Pharmacist-provided preventive services are covered benefits.*** Certain pharmacist-provided preventive services under SB 493,[2] including cessation counseling and furnishing nicotine replacement therapy (NRT), are covered benefits reimbursable at 85% of the Medi-Cal physician fee schedule. Dispensing medications is reimbursable through Medi-Cal Rx[3] while the clinical work of assessment, counseling, and furnishing NRT is reimbursable as a pharmacist services benefit (AB 1114, AB 317).[2]
- ***Pharmacists can furnish all FDA-approved tobacco cessation medications.*** As of January 2026, pharmacists can furnish NRT, varenicline, and bupropion under AB 1503.[4] The law operates under an accepted standard-of-care model, allowing pharmacists to select the appropriate therapy based on their professional judgment and qualifications.

Timeline of California Laws: Pharmacy Practice and Payment



The Case for Reimbursing Pharmacies for Providing Tobacco Cessation Services

Medi-Cal managed care plans should consistently reimburse pharmacies for tobacco treatment because:

- ***Reimbursement aligns financial incentives with public health policy and supports preventive services.*** California expanded pharmacists' authority in recognition of their ability to provide preventive care services, which besides treating tobacco includes immunizations, contraception, naloxone, HIV prevention care, travel medications, and medication-therapy management.[2,5,6] Clear reimbursement rules would align benefit design with scope-of-practice policy and reduce barriers associated with provider type or practice setting.[6] Preventive services require pharmacist and technician time, training, documentation, integration into pharmacy workflow, and patient follow-up. Pharmacies cannot be expected to provide these services consistently if they are only paid for medications dispensed.[7,8]
- ***Reimbursement advances health equity and helps close treatment gaps.*** Tobacco use and related disease disproportionately affect populations who experience barriers to health care, including people with low incomes or behavioral health conditions, and those who live in rural and underserved communities.[9] Pharmacy-provided services provide an additional, accessible point of care for these populations.[10,11] Most people who use tobacco want to quit, but few use both counseling and medication, which, when combined, provide the best chance of quitting successfully.[12] Pharmacies can screen for tobacco use during routine patient encounters, such as when administering vaccines.[13]
- ***Pharmacist-provided tobacco treatment is effective.*** Structured behavioral support delivered by community pharmacy personnel increases quitting compared with less intensive or usual pharmacy care.[14] Tobacco treatment is among the most valuable preventive interventions because it reduces future cardiovascular, pulmonary, cancer, pregnancy-related, and other health care costs.[15,16]
- ***Pharmacists reduce pressure on primary care systems.*** By providing preventive and medication-related services consistent with their training and scope of practice, pharmacists allow other providers to concentrate on diagnosis and more complex treatment.[10,17]

California's Community Pharmacies Report Inconsistent Reimbursement

CPESN CA is a network of over 100 independent pharmacies in California that provide enhanced clinical services. Qualitative studies with CPESN CA have found that while community pharmacies in California are able to implement pharmacist-led tobacco treatment, complex billing and reimbursement procedures are barriers to implementation and sustainability.[7,8]

> ***Partnership HealthPlan of California*** *is the only Medi-Cal managed care plan with a dedicated Policy and Procedure for pharmacy service payment.*[20] *The policy was established by Stan Leung, PharmD, Director of Pharmacy Services, and is a model for all health plans.*

From 2023 to 2025, 9 CPESN CA pharmacies have tracked 1,135 claims for pharmacy-provided preventive services in California and found that only about half (52.2%) were accepted by 27 different payers (e.g., Medi-Cal managed care plans, Medicare, independent physician associations).[18] Among the 19 payers other than Medicare, only 8 have paid any claims submitted by pharmacies to date. Claims were for new patient office visits (CPT 99202), established patient visits (CPT 99212), and Community Health Worker education by pharmacy technicians (CTP 98960). To reflect comprehensive pharmacy services, these claims included pharmacy services for immunizations (Z23), tobacco cessation (Z72.0), antipsychotics/mental health (F-codes), HIV and PrEP medications, Vivitrol (naltrexone), and others.

- The median percentage of claims accepted was:
    - 8.5% (range: 0−100%) by 18 payers for new patient office visits (n=713 claims)
    - 50% (range: 0−100%) by 19 payers for established patient office visits (n=583 claims)
    - 85% (range: 0−100%) by 3 payers for Community Health Worker education (n=23 claims)
    - 35% (range: 8−80%) across 6 diagnosis categories (n=1,135 claims)
- The top reasons for 121 denied claims were:
    - Payment documentation by the plan (46 remittance errors, 19 incorrect claim department routing) or pharmacy (17 place of service missing)
    - Confusion over correct payer (14 including forwarding to Independent Physician Associations)
    - Services not authorized (n=8)
    - Not payable under managed care contract terms (n=6)
    - Ineligible provider due to credentialing status (n=5) or member at time of service (n=3)
    - Duplicate claims (n=3)

CPESN CA pharmacies have worked with a DHCS analyst who has helped to improve reimbursement, but comprehensive policy and procedure is still needed, because:

- Only 4 Medi-Cal managed care plans have consistently paid CPESN CA pharmacies for enhanced services: Alameda Alliance for Health, Inland Empire Health Plan, Kern Family Health Care, and Partnership HealthPlan of California.
- 9 Medi-Cal managed care plans still have inconsistencies in payment and 9 do not have data for payment tracking.
- Credentialing of pharmacists as providers is only required by 2 Medi-Cal managed care plans.

These findings show that the main weakness in pharmacist-provided preventive services is not the absence of authority or nominal coverage, but that when pharmacists try to exercise their authority they encounter unclear billing pathways, inconsistent policy implementation, and insufficient operational guidance. Limitations of these data include that not every health plan and claim was tracked, pharmacy billing tracking systems have varying capacities, and not every CPESN CA pharmacy participated in data collection.

Legislation to Improve Implementation of Pharmacy Services

Assembly Bill (AB) 2565, currently under consideration for signing by the Governor, aims to ensure that Medi-Cal plans consistently recognize, cover, and reimburse pharmacist services already authorized under state law.[19] It would strengthen implementation of existing benefits by requiring DHCS to clarify plans' coverage and reimbursement obligations, ensure that pharmacist services are incorporated into provider manuals, billing and claims systems, and member coverage documents, hold plans accountable for

delegated entities, and take corrective action when plans fail to comply. Clarifying coverage and reimbursement expectations for the plans would greatly improve access to tobacco treatment.

In a separate analysis, California Assembly Health Committee staff found that pharmacist services were not specifically referenced in DHCS's master managed care contract or model Evidence of Coverage (EOC), or in the EOC/member handbooks of three plans reviewed by staff.[6] The committee subsequently called for DHCS to more clearly enumerate plans' obligations to cover these services.

Other ways to enhance access to pharmacy-provided preventive services include:

- Clarifying pharmacist and pharmacy technician roles as providers and community health workers, respectively, for billable services and education.
- Clarifying that furnishing any FDA-approved cessation medication, including NRT, varenicline, and bupropion, is billable as a pharmacist services benefit as a standard of care.
- Considering "standard of care" to include tobacco cessation counseling, even if no medication is dispensed.

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Contact us

tcprc@phmail.ucdavis.edu

https://tcprc.ucdavis.edu

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