State Health Agencies' Role in Implementing Pharmacist-Prescribed Contraception

Report Summary:
State health agencies (SHAs) play a pivotal role in expanding access to contraception by supporting the implementation of pharmacist-prescribed contraception (PPC). From policy leadership and aligning reimbursement systems to convening stakeholders and raising public awareness, they help bridge the gap between policy and practice. By addressing barriers around payment, workforce readiness, and regulatory mechanisms, SHAs lay the groundwork for sustainable and equitable contraceptive access.

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Table of Contents

Introduction 1

Mechanisms That Expand Pharmacist Roles in Contraceptive Access 2

- Collaborative Practice Agreement 2
- Standing Orders 3
- Statewide Protocol 3
- Standard of Care 3
- The Role of State Health Agencies 4

Payment for Services 4

- Legislative Solutions 5
- Medicaid Reimbursement 5
- Commercial Insurance Coverage 5
- The Role of State Health Agencies 6

Workforce, Education, and Consumer Awareness 7

- Workforce Development 7
- Pharmacy and Regional Champions 8
- Educa on and Consumer Awareness 8
- The Role of State Health Agencies 9

Conclusion 9

- Citations 10

Introduction

States are increasingly exploring pathways that utilize pharmacists to facilitate greater access to contraception. According to the National Association of Chain Drug Stores, about 90% of Americans live within five miles of a pharmacy. This is critical as millions of Americans live in areas where access to contraception is limited. One article found that between 17% and 53% of each state's population live in a contraceptive desert,[1] with a contraceptive desert being defined as a "county where the number of health centers offering the full range of methods is not enough to meet the needs of the county's number of women eligible for publicly funded contraception." Barriers to contraception in the United States are pervasive, with one national survey reporting that 29% of women who tried to obtain hormonal contraception had difficulties in accessing the initial prescription or refills. To address these barriers, numerous states have implemented policies focused on PPC.

> **Note: Throughout this report, we will use "pharmacist-prescribed contraception (PPC)" as a general term to describe approaches that expand contraception access through services provided by pharmacists.** States may vary in the terminology they use to describe these services. While some PPC legislation aligns the services with traditional prescriptive authority, others use terms such as "furnishing" to describe a similar scope of services delivered under specific protocols or through collaboration with another health care provider.

PPC programs allow pharmacists to prescribe and dispense contraception without needing the patient to go to a doctor's office. PPC has been shown to be a safe and effective way to increase access to contraception,[2] while reducing cost. As of June 2025, 35 states and Washington, D.C., have passed legislation that permit pharmacist-prescribed contraception; however, these laws are in various states of implementation.

Passing a policy that legalizes PPC is just the first step; implementing PPC can be difficult due to a variety of policy, administrative, clinical, and logistical barriers. A diverse set of public health agencies, private entities, and health care professionals must work collaboratively to successfully implement a PPC program that meets the needs of pharmacists, patients, and the wider community. This is increasingly challenging to accomplish with limited staff capacity, resource constraints of public health agencies, and competing priorities in clinical settings. These implementation barriers have resulted in underutilization of PPC programs, which then contributes to increasing gaps in contraceptive care, negative personal and public health outcomes, and reduced access to reproductive services.

This report identifies three primary barriers to successful PPC implementation and explores related actionable solutions:

1. **Mechanisms That Expand Pharmacist Roles in Contraceptive Access:** States employ four distinct pathways to utilize pharmacists under PPC programs. These pathways vary in how they grant authority for pharmacists to support contraception access, the level of autonomy provided in service delivery, as well as the policy and regulatory processes a state must follow after legislation is passed to implement these mechanisms.

2. **Payment for Services:** Financial sustainability in the form of adequate payment for services is essential to the viability of PPC programs. Collaboration with state agencies and public and private payers is necessary to address barriers to payment and identify streamlined solutions.

3. **Workforce, Education and Consumer Awareness:** Proper workforce development and educational initiatives ensure that pharmacists are equipped with the knowledge and skills to deliver PPC services effectively and communicate available services to a wide audience. Both consumers and health care providers must understand the role of pharmacists in contraceptive care to ensure successful utilization of PPC programs.

SHAs and their partners are central to the exploration of these barriers and proposed strategies. SHAs play a pivotal role in the successful implementation of PPC. As regulatory authorities, they may help develop and oversee policies that define pharmacist roles in contraceptive access and ensure alignment with best practices. They also serve as conveners, bringing together stakeholders such as Medicaid programs, pharmacy boards, and community organizations to address barriers and streamline implementation efforts. By leveraging their expertise and leadership, SHAs can promote equitable access to PPC services, support sustainable funding models, and contribute to the education of pharmacists as well as the public to maximize the reach and impact of PPC initiatives.

By exploring these challenges and highlighting the role of SHAs in addressing them, this report aims to identify key findings from a landscape assessment of the field conducted by the Association of State and Territorial Health Officials (ASTHO) in the fall of 2024. The findings of this report guide the capacity building and technical assistance work that ASTHO is providing through their Implementation of Pharmacist Prescribed Contraception Learning Community, which launched in April 2025.

Mechanisms That Expand Pharmacist Roles in Contraceptive Access

Successful PPC implementation often requires changes to jurisdictional law or policy that supports pharmacists playing a more active role in contraceptive care. The type of change will vary based on the pathway that is pursued and the existing laws and policies of that jurisdiction. States utilize four pathways to enable pharmacists to support expanded access to contraception.

Collaborative Practice Agreement

A Collaborative practice agreement (CPA) enables pharmacists to enter into a formal agreement with another health care provider who has prescriptive authority. A CPA for contraception allows pharmacists to furnish contraception only if they individually enter a CPA with another health care provider. Through a CPA, a pharmacist can provide specific clinical services outside of their standard scope of work, although the clinical services that pharmacists can offer via a CPA vary from state to state. Although CPAs are a feasible pathway for PPC programs and have been components of clinical practice for years, having each pharmacist enter a CPA with another health care provider can be administratively burdensome for both providers.

Nebraska law allows pharmacists to enter into CPAs with practitioners who have independent prescribing authority, and describes the scope, and required content and notice for the CPA.

Standing Orders

Standing orders allow pharmacists to dispense specific medications based on precise clinical guidelines. A state may pass legislation that permits PPC through use of a statewide standing order and direct a state agency to develop a standing order outlining the parameters. PPC standing orders, generally written and signed by the SHA's medical director, are statewide agreements that allow pharmacists to dispense certain contraceptives without a prescription from the patient's health care provider under specific circumstances.

In 2023, New Jersey enacted S275 to allow pharmacists to provide self-administered hormonal contraceptives via a standing order. The law also requires that the state Board of Pharmacy and Board of Medical Examiners develop standardized protocols and procedures that specifies what those protocols must contain, including a requirement for a patient questionnaire as well as specific counseling and referral requirements.

Statewide Protocol

Statewide protocols permits pharmacists to prescribe and dispense specific medications in a manner that is consistent with requirements set forth by the state's licensing body (usually the state board of pharmacy). Statewide protocols resemble standing orders but do not require partnership with a health care provider (like a SHA medical director) with prescriptive authority. However, statewide protocols may need to be continuously updated as clinical guidelines change.

New Mexico uses statewide protocols to permit PPC, and the Board of Pharmacy has issued a protocol for pharmacist prescribing of hormonal contraception.

Standard of Care

Standard of care expands the practice of pharmacy to align with the model physician's use. Rather than legislation or a state board of pharmacy spelling out what pharmacists can or cannot do for individual drugs or conditions, pharmacists use their own professional judgement to determine what a reasonable intervention would be that aligns with the standards of patient care. Within this mechanism, pharmacists have independent prescriptive authority for a certain range of clinical conditions and classes of medications. Idaho is one of the few states using a standard of care model to expand the definition of pharmacy practice. State law has evolved in Idaho in recent years to define the practice of pharmacy as including the prescribing of drugs and devices.

Expanding pharmacists' standard of care allows for the most flexibility and autonomy for pharmacists to prescribe contraception. However, few states are utilizing this model as it requires a coordinated shift amongst stakeholders to understand and accept pharmacists' expanded scope of practice.

As of Sept. 30, 2025, 14 jurisdictions offer PPC via a statewide protocol, eight states via a standing order, eight states via a CPA, and six states via expanding pharmacists' standard of care.

The Role of State Health Agencies

By supporting evidence-based policy and convening stakeholders, SHAs can play an important role in supporting implementation of PPC from inception to PPC's full implementation.

Supporting Legislation and Regulatory Development

Often, SHAs are asked for feedback on legislation for health-related topics in their jurisdiction. In some cases, SHAs can champion proposed legislative changes in the form of statewide working groups, education to legislators, and overall development of key resources. For states seeking to advance implementation of PPC, SHAs can support policy development that expands pharmacy scope of practice or PPC legislation that is evidence-based and informed by best practices in the field. SHAs can take an active role in the development of regulations, statewide protocols, standing orders, or collaborative practice agreements to ensure they align with best practices and promote broad implementation and success of PPC programs. For example, they can ensure regulations use language that is easily adaptable to future clinical updates and avoid requirements for care that are not centered on best clinical practice.

Convening Stakeholders

SHAs are well-positioned to build relationships across pharmacy associations and stakeholders, payers, and community-based organizations. This is due to their central role in public health governance, access to comprehensive health data, and established networks that facilitate collaboration for improving health outcomes and addressing community needs. SHAs can assemble stakeholders to provide feedback on proposed legislation, and support the development of regulations, statewide protocols, standing orders and/or collaborative practice agreements.

For example, members of the Division of Public Health in Delaware – in partnership with ASTHO – convened an interdisciplinary stakeholder workgroup to draft the state's PPC regulations. Utilizing the diverse perspectives from the workgroup, the state's promulgated regulations were both grounded in best practice and aligned with key stakeholders' priorities. The goals of these regulations are to streamline implementation and build buy-in for the state's approach to PPC programing.

Payment for Services

Pharmacists and other key stakeholders regularly identify payment for services as a key barrier to widespread implementation and uptake of PPC programs. Many pharmacists report resistance to participating in PPC without mechanisms in place that would reimburse pharmacists for all relevant services – specifically, the cost for the counseling and assessment services in addition to the cost of the medication and a standard dispensing fee.

In addition, pharmacists have raised concerns about the reimbursement rates for services and a need for them to be on par with those paid to other health care providers. To accomplish this, jurisdictions must employ a blend of legislative, Medicaid, and commercial insurance strategies, and communicate them widely to pharmacists and consumers.

Legislative Solutions

Embedding payment requirements for PPC services into state legislation can create a stable foundation for sustainable programs. In 2019, Maryland enacted HB 613 becoming one of the first states to pass PPC legislation that included reimbursement mechanisms within the initial legislation. PPC legislation can address reimbursement barriers in a variety of ways. For example, some states, including Washington (SB 5557), Tennessee (HB 0405), and West Virginia (SB 787), have advanced laws mandating that certain health plans enroll pharmacists as medical providers – which is an essential step towards reimbursement for the clinical services provided as part of PPC.

Additionally, these laws may require certain health plans in the state to provide clear information to pharmacists and enrollees about the availability and coverage of PPC services, addressing knowledge gaps that can impede access and utilization. Such measures not only secure funding but also reduce administrative confusion, making it easier for pharmacists to participate fully in PPC programs and for patients to utilize them.

Finally, legislative language may specify whether pharmacies are permitted to charge consumers directly for the services associated with PPC (such as the counseling fee). This is typically done in the form of a flat fee charged to consumers. If states opt to prohibit charging consumers directly in this way, as measure of consumer protection, the need for specific reimbursement mechanisms in PPC legislation is heightened to ensure pharmacists are paid for their time and services provided. It remains best practice to always include language about reimbursement and payment for services in PPC legislation.

Medicaid Reimbursement

Medicaid represents a critical funding stream for PPC services and can ensure vulnerable populations have equitable access to contraception. To bill Medicaid for all relevant PPC services, pharmacists need to enroll as Medicaid providers and obtain National Provider Identifier numbers. In managed care states, pharmacists must also be credentialed as providers by a state's managed care organizations (MCOs), and understand each MCO's billing protocols for PPC, adding administrative complexity cost and time for often low reimbursement.

Some states have addressed these challenges with innovative solutions. For example, Maryland designated specific codes for PPC, for pharmacists to bill Medicaid for contraceptive counseling and prescribing services in addition to dispensing. States can also make policy changes that specify minimum payment rates for Medicaid MCOs to reimburse pharmacists for their services. This type of tailored policy ensures that pharmacists are compensated not only for dispensing contraception but also for their consultation time, thereby acknowledging the full scope of their contributions to patient care.

Commercial Insurance Coverage

While reimbursement policies focused on state Medicaid programs are essential to ensuring equitable access to PPC programs, reimbursement from commercial insurers is essential to support financial viability. Commercial insurers often have higher reimbursement rates than Medicaid programs and encompass over 65% of the insured population. However, to be available to most commercially insured individuals, pharmacists need to be credentialed with multiple payers and navigate each plan's billing practices, which can be a significant administrative hurdle.

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Developing State Policies

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Educating Pharmacists on Billing and Credentialing Practices

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Collaborating with Stakeholders to Align Efforts

As conveners, SHAs can bring together critical stakeholders (e.g., Medicaid officials, state departments of insurance, managed care organizations, and leaders in the sexual and reproductive health/pharmacy fields) to address reimbursement related issues proactively and efficiently. These collaborative efforts can focus on identifying streamlined solutions for billing, coding, and credentialing, while fostering relationships between pharmacists and payers.

SHAs can also support appropriate parties to explore models for reducing administrative burdens, such as standardizing billing codes or simplifying the credentialing process across multiple payers. By aligning stakeholders around shared goals, SHAs ensure that financing reforms are both practical and sustainable, enabling pharmacists to deliver PPC services efficiently and equitably.

Workforce, Education, and Consumer Awareness

Numerous workforce, educational, and consumer awareness considerations impact the implementation of PPC. Many can be addressed through evidenced-based training programs, effectively utilizing the existing pharmacy workforce and workflows, support of provider or regional champions, and widespread awareness campaigns.

Workforce Development

Training

Most states with PPC laws require training for pharmacists to be permitted to prescribe contraception; however, the detailed requirements of these trainings vary widely across states. State legislation or regulation may dictate the core content, length, and frequency of PPC training. State policy might be as specific as identifying a training program pharmacists must complete (such as one through a state university or pharmacy association), or broader, identifying the number of hours the training should include or what standards it must meet. The varying training requirements from state to state can make it burdensome for chain pharmacies with locations across the country to train their pharmacists in a streamlined manner, while also adhering to various state requirements for PPC trainings.

Less granular requirements allow flexibility for pharmacists to receive training from a variety of sources. For example, the Maryland Board of Pharmacy has approved seven different trainings for pharmacists to use to be permitted to prescribe contraception. Similarly, to streamline implementation of PPC, numerous states have partnered with their schools of pharmacy to incorporate PPC training content into the school's curriculum. North Carolina and New Mexico have integrated PPC training content into their university schools of pharmacy curricula, ensuring that all students are able to provide PPC services upon graduation.

Pharmacy Technicians

Another workforce consideration is the role of pharmacy technicians in implementing PPC. Pharmacy technicians can be leveraged to relieve pharmacists' workload, especially when offering PPC. Overly prescriptive language in legislation can limit the use of pharmacy technicians in this area. While pharmacy technicians cannot prescribe contraception, they can partake in the patient screening process or assist with taking patient blood pressure if the legislation allows. Multiple pharmacies across different states report pharmacy technicians as a key component of implementation.[3]

Integrating PPC with Existing Workflows

One challenge to PPC implementation is uncertainty about how to integrate the service seamlessly into the pharmacies' existing offerings. Case studies with early adopters emphasized the importance of repurposing existing software and workflows. One chain pharmacy in Minnesota reported repurposing their existing software for scheduling online vaccinations appointments to include contraception visits, while another pharmacy in Colorado modeled their PPC visit workflow after their existing immunization workflow.[3]

Pharmacy and Regional Champions

Pharmacy and regional champions are integral to PPC uptake and implementation. In five case studies with early adopters of PPC across different states, three case studies specifically mention pharmacist champions as catalysts for the pharmacy locations to begin offering PPC services.[3] Pharmacist champions for PPC inspire on-the-ground utilization of the services, especially in the early implementation phase.

Likewise, regional champions can support wider implementation of PPC. North Carolina utilized pharmacies who implemented PPC early on as regional champions. These regional champions would focus on a specific area within the state and provide peer-to-peer technical assistance and troubleshoot implementation challenges for pharmacies who were beginning to offer PPC. Pharmacy and regional champions improve implementation of PPC through peer sharing and support.

Education and Consumer Awareness

Community education and awareness about PPC is critical to successful implementation. Education and awareness campaigns require a delicate balance – doing them too soon risks not enough pharmacists being able to offer services, which could confuse and turn away potential patients from seeking the service out in the future. However, if done too late, pharmacists may question the worth of offering the service with limited patient demand.

Partnering with diverse stakeholders early in PPC implementation establishes a strong network to promote program growth. In Oregon*, one pharmacy highlighted the importance of collaborating with the local health department and local sexual and reproductive health organizations to raise awareness of PPC. Pharmacies across the country have utilized multiple strategies to increase PPC awareness including promotion on social media, educational pamphlets, and window decals, and informing patients about the service when they are on their last refill of birth control, or purchasing EC. These strategies resulted in an increase in patient volume for the early implementors of PPC.[3]

Widespread consumer education campaigns can also help increase public awareness of PPC. Idaho and Maryland have found success in promoting PPC by partnering with local media to increase knowledge of the service. Similarly, public health departments in Utah and New Jersey manage online lists of pharmacies that offer PPC.

**access requires setting up an account*

The Role of State Health Agencies

SHAs are well-positioned to support training, education and awareness of PPC.

Supporting Policy Development

SHAs can guide policy development to remove barriers to PPC training for pharmacists, advising the use of broad language that does not put undue limitations on which training programs pharmacists can utilize. By advocating for broad policy language, SHAs can provide pharmacists with greater flexibility in completing PPC training, which can encourage more pharmacists to participate and expand access to PPC services.

Educating and Raising Awareness

State health agencies can use existing public health outreach campaigns to raise awareness and education about PPC. Additionally, SHAs can work with their local health agency counterparts to promote the service and aid in directing patients to pharmacies that offer PPC. Similarly, health agencies can utilize their websites to maintain a list of pharmacies offering PPC, making it easily accessible to consumers. By leveraging their role as a public health resource, SHAs can effectively raise awareness about PPC and ensure that both consumers and health care providers are informed about where and how to access these services.

Leveraging Partnerships

SHAs can leverage their partnerships across departments and agencies to align stakeholders and develop clear, consistent messaging on PPC. They can partner with Medicaid and encourage MCOs to share information on PPC with both pharmacists and enrollees. Additionally, health agencies can collaborate with universities and schools of pharmacy to include PPC as part of their curriculum. By utilizing their relationships with various stakeholders, SHAs can create unified messaging and promote education and awareness about PPC across key stakeholders such as health care providers, Medicaid, and academic institutions.

Conclusion

SHAs play a central role in bridging policy and practice for PPC. By shaping legislation and regulations, convening stakeholders, and promoting workforce development, SHAs can ensure that pharmacists are positioned to deliver contraception services safely, effectively, and sustainably. SHA leadership can help align reimbursement systems, pharmacy training, and public awareness efforts, creating the infrastructure needed for equitable access.

As this report highlights, successful PPC implementation requires coordinated action across policy, financing, workforce readiness, and consumer engagement. SHAs are uniquely positioned to lead this work, drawing on their authority, expertise, and partnerships to address barriers and leverage opportunities. By continuing to invest in these strategies, SHAs can expand contraceptive access and strengthen public health systems for the communities they serve.

Citations

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