REPORT OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Virginia Medicaid Pharmacy Benefit Manager Study (2025 Appropriation Act, Item 292.MM.2.)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 8

COMMONWEALTH OF VIRGINIA
RICHMOND
2025

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/343-0634 (TDD)

December 1, 2025

MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor of Virginia

The Honorable Don Scott
Speaker, Virginia House of Delegates

The Honorable Scott A. Surovell
Majority Leader, Senate of Virginia

Members of the Virginia General Assembly

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: VA Medicaid Single Pharmacy Benefit Manager (PBM) Study

This report is submitted in compliance with Item 292.MM.2. of the 2025 Appropriations Act which states:

The evaluation provides a comprehensive assessment of potential benefits, cost savings, and implementation considerations associated with transitioning to a single pharmacy benefit manager (PBM) model. The study includes an in-depth review of Virginia's Medicaid pharmacy program, an analysis of PBM contracting strategies in peer states, and a data-driven evaluation of dispensing fees and both short and long term costs. The final report presents projected implementation and ongoing costs, anticipated savings, recommended dispensing fees, an implementation timeline, and additional recommendations to enhance the administration of Medicaid pharmacy benefits. The report will be submitted to the Governor and the General Assembly by December 1, 2025. Any unexpended balances for the purposes specified in paragraph MM.1. and MM.2. which are unexpended on June 30, 2025, shall not revert to the general fund but shall be carried forward and reappropriated in fiscal year 2026.

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CJR/wrf

Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Virginia Medicaid Pharmacy Benefit Manager Study

BACKGROUND

The Department of Medical Assistance Services (DMAS) currently operates a Medicaid pharmacy carve-in model, whereby each of the five Cardinal Care MCOs contract with a pharmacy benefit manager (PBM). In 2025, the General Assembly passed HB 2610 requiring DMAS to contract with a single third-party PBM for all Medicaid populations.

STUDY METHODOLOGY

DMAS engaged Myers and Stauffer to conduct the single PBM study required by HB 2610.

Stakeholder Engagement

Provider organizations and medical associations were surveyed, and formal interviews conducted representing DMAS and other state agencies, provider and pharmacy organizations, legislators, managed care organizations (MCOs), and other DMAS vendors.

National Scan Research

State leaders were interviewed and research was conducted into the following states' pharmacy benefit models: Kentucky, Louisiana, Mississippi, Ohio, New York, West Virgina, and Washington.

Data Analysis

Available data was analyzed to inform the overall study, including review of dispensing fees, potential short-term and long-term costs of implementing a single PBM contract, and comparison of Virginia net pharmacy spend per member to other comparable states with managed care delivery systems.

SINGLE PBM CONTRACTING OPTIONS

Option 1: Implement a Single PBM Contract with MCOs Maintaining Risk.

Option 2: Implement a Single PBM Contract with State Maintaining Risk and Single PBM Paid by MCO.

Option 3: Implement a Single PBM Contract with PBM Operating as a pre-paid ambulatory health plan (PAHP).

Option 4: Implement a Managed Care Carve Out.

IMPLEMENTATION CONSIDERATIONS

Implementation Timeline

The following general 18-month implementation timeline for a single PBM contract is recommended.

Issue RFP or Other Procurement Vehicle
Early January 2026

Proposals Due
Early March 2026

Proposal Evaluations and Award
March-April 2026

Contract Award and Protest Period
May-June 2026

Contract Implementation
July 2026-June 2027

Additional Considerations

- MCO dispensing fees were found to be much lower than FFS, and these dispensing fees are much lower than typical pharmacy costs to dispense drugs.
- HB 2610 did not provide funding to support increases in pharmacy reimbursement. This change would need additional legislative action.
- DMAS has several competing priorities that may impact implementation including implementation of:
  - The Fiscal Agent Services core module of DMAS' Medical Enterprise System.
  - Requirements resulting from H.R. 1.
- Implementation and ongoing operation and oversight of the single PBM is projected to require 7-8 additional DMAS staff.
- Should bid protests or lawsuits be filed resulting from the single PBM procurement, implementation dates may be impacted.

TRANSPARENCY AND ACCESS COMPARISON

Myers and Stauffer conducted an analysis of access to community retail pharmacies in Virginia. We found that an estimated 160 Virginia zip codes (17.7%) are classified as pharmacy deserts for Medicaid members.

FISCAL IMPACTS SUMMARY

Period	Description	Estimated Fiscal Impact
Year 0	6-month procurement and 6 months of implementation activities	An initial cost of $6.2 million – $9.6 million.
Year 1	Additional 6 months of implementation activities and 6 months of single PBM contract operations	Potential cost of $6.1 million to savings of $1.6 million.
Years 2+	Full 12 months of single PBM operations.	Potential savings of $10.2 million – $22.1 million.

FISCAL IMPACTS

Cost/Savings	Description	Assumptions and Caveats	Estimated Cost Impact
Single PBM Administrative Fee	Fees for PBM services for both fee-for-service (FFS) and MCO populations.	• Based on other states' PBM pricing, adjusted for DMAS program and timeline. Depends on service scope, reporting needs, and vendor integration.	$16.4 – $20.5M annual cost after single PBM implemented
FFS PBM Administrative Fees	Total estimated administrative fees paid by DMAS for FFS PBM services	• Based on invoice totals provided by DMAS.	$6.1M annual cost until full single PBM implemented
Single PBM Implementation Fee	One-time design, development, and implementation (DDI) cost for system configuration, business rule translation, benefit design alignment, and testing.	• Based on PBM DDI fees like those experienced in other states.	$1.5M – $2.5M one-time cost
DMAS Full-time Equivalent (FTE) Staff	Permanent staff expansion to oversee PBM operations and maintain performance monitoring.	• Assumes 3–4 pharmacists, 2 data analysts, 1 appeals coordinator, and 1 rebate manager.	$925K – $1.1M annual cost
Temporary DMAS Implementation Resources	Limited internal resources for transition activities, testing, data validation, PBM platform integration with Medicaid Management Information System (MMIS) and Medicaid Enterprise System (MES) modules, and financial process alignment.	• Assumes 5–6 temporary FTEs for 24 months. • Roles may include internal system integration consultant, financial consultant, and business consultant.	$1.8M – $2.5M per year for the first two years
External Implementation Support	Consultant services to assist DMAS with project management, Request for Proposal (RFP) and contract development, readiness reviews, stakeholder engagement, and post-implementation stabilization.	• Assumes 24 months of engagement covering procurement through post-implementation stabilization. • Provides subject matter expertise and staff augmentation while DMAS onboards new internal staff.	$1.8M – $2.1M per year cost for the first two years
System Integration and Related Vendors	Enhancements and change orders to the MMIS and related vendors to implement the single PBM interfaces, testing, and reporting functions.	• Assumes required changes will result in a change order and additional costs to DMAS.	$3.4M – $5.9M one-time cost over a two-year period.
MCO Supplemental Rebates Removal from Capitation Rates	Reflects the loss of MCO-retained rebates currently built into MCO capitation payments.	• Assumes DMAS may not recover equivalent supplemental rebate value under a single PBM model as MCOs.	$21.8M annual cost
MCO PBM Administrative Fees	Total estimated administrative fees paid by the MCOs for PBM services	• Based on information from DMAS's actuary.	$31.1M annual savings after single PBM implemented
FFS PBM Administrative Fees	Total estimated administrative fees paid by DMAS for FFS PBM services.	• Based on invoice totals provided by DMAS.	$6.1M annual savings after single PBM implemented
Rebates Savings	Increased supplemental rebate revenue generated through single preferred drug list (PDL).	• Accounts for 6-month collection lag on rebate payments. • Assumes 15%-20% of lost MCO supplemental rebates achievable.	$3.3M – $4.4M annual savings starting in Year 2.
Utilization Management (UM) Cost Offset and Other Efficiencies	Administrative savings from consistent UM criteria, reduced duplicative MCO pharmacy operations, and additional UM efforts.	• Reflects long-term savings from unified utilization management efforts and other program efficiencies. • Assumes savings equivalent to 0.5%-0.75% of total MCO pharmacy expenditures.	$6.6 million to 9.9M savings during Year 1. $13.2 million-$19.7 million annual savings after single PBM implemented

MYERS AND STAUFFER LC

VIRGINIA DEPARTMENT OF
MEDICAL ASSISTANCE SERVICES

Virginia Medicaid Pharmacy Benefit Manager Study

December 1, 2025

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Executive Summary

Introduction

The Department of Medical Assistance Services (DMAS, Department, or State) administers Medicaid services for more than 1.7 million Virginians — approximately 90% of whom are enrolled in Virginia's Medicaid managed care program, Cardinal Care.[1] The remaining members are served through the fee-for-service (FFS) delivery system, most of whom are temporarily enrolled there prior to transitioning to one of five Cardinal Care managed care organizations (MCOs). DMAS uses a pharmacy carve-in model under which each MCO is responsible for the Medicaid pharmacy benefit and contracts with a pharmacy benefit manager (PBM) for administration of those benefits. DMAS also contracts with a PBM to manage the FFS pharmacy benefit and other pharmacy administration activities.

Nationally, state Medicaid programs, including DMAS, are working to address concerns about the Medicaid pharmacy benefit that extend to transparency in pricing, increasing costs, and member access to medications. Pharmacy closures have also become increasingly common, raising concerns about patient access to essential medications and pharmacy services. To address these concerns, states have implemented initiatives such as establishing single preferred drug lists (PDLs), prohibiting spread pricing, and most recently, several states have implemented a new single PBM contracting strategy. The figure below depicts Virginia's key efforts beginning in 2018 to address these concerns.

Virginia Medicaid Pharmacy Initiatives

2018	2020	2020-21	2021	2022	2025
Common Core Formulary (CCF) Established CCF that applies to FFS and Cardinal Care. MCOs' PDLs must include all drugs on the CCF. MCOs may opt to cover additional drugs.	**Spread Pricing** HB 1291 passed prohibiting spread pricing in Medicaid MCO contracts and required MCOs and their PBMs to operate under pricing models reflecting true cost of prescription drugs.	**Required Reporting** HB 30 and HB 1800 passed requiring MCOs to report drug reimbursement costs and PBM changes to DMAS on a quarterly basis.	**Prescription Drug Cost Data** HB 2007 authorized DMAS to require wholesale distributors to submit prescription drug cost data if information from carriers, PBMs, and manufacturers proved insufficient.	**Data Sharing** Senate Bill (SB) 428 required carriers and PBMs to provide real-time prescription cost and coverage information to members and prescribers, including cost-sharing obligations and PA requirements delivered in accessible format within electronic prescribing or health record systems.	**Single PBM** HB 2610 and Item 292.MM of the Appropriations Act passed requiring DMAS to contract with a single PBM for all Medicaid members by July 1, 2026.

Virginia House Bill (HB) 2610 requires that MCOs must contract with and use the DMAS contracted single PBM. Additionally, as required by HB 2610, DMAS engaged an independent consultant, Myers and Stauffer LC (Myers and Stauffer) to design and conduct a comprehensive evaluation of the potential benefits, cost savings, and implementation considerations associated with utilizing a single third-party administrator to serve as the pharmacy benefit manager (PBM) for all Medicaid pharmacy benefits. In

[1] In State Fiscal Year 2024, Cardinal Care had 1,681,090 members and 147,456 were enrolled in the FFS delivery system.

the following, we provide high-level findings and key information from our PBM study. Comprehensive findings can be found in our full report to DMAS.

Approach

Myers and Stauffer conducted the PBM study, inclusive of the following components:

Assessment of Virginia's Medicaid Pharmacy Program
Conducted research and stakeholder interviews to understand the current delivery of Virginia's outpatient Medicaid pharmacy benefit and gain stakeholders' perspectives of potential impacts of implementation of changes to the current model. Additionally, conducted the data analyses described below specific to the Medicaid pharmacy benefit and access to pharmacies across the Commonwealth.

Review of Other States' PBM Contracting Strategies
Researched other states' PBM contracting strategies and identified states that have implemented changes to their Medicaid pharmacy delivery models in the past five years. Research focus areas included understanding of the various models used by states, review of payment arrangements and cost data, collection of data on access and pharmacy deserts, and managed care pharmacy activities. The review included interviews of select state leaders to identify successes, challenges, and lessons learned in their implementation and operations of their pharmacy delivery models.

Data Analysis
Analyzed available data to inform the overall study, including review of dispensing fees, potential short-term and long-term costs of implementing a single PBM contract, and comparison of Virginia net pharmacy spend per member to other comparable states with managed care delivery systems.

Options Analysis and Recommendations
Based on overall findings identified from our research, stakeholder engagement, and analyses, as well as our industry experience, we identified single PBM contracting options and their respective costs and benefits. This analysis included identification of best practices in PBM contracting to include in a Request for Proposals (RFP) for a single PBM and recommendations for any required changes to Virginia law to enable the most efficient and effective pharmacy delivery system possible.

Findings

In the following, we provide a summary of our findings related to stakeholder engagement, access to pharmacy services, single PBM contracting models, other states' experiences, reimbursement, and our estimate of fiscal impact of transitioning to a single PBM model.

Stakeholder Engagement

During stakeholder engagement, we received feedback with major themes as summarized in *Table 1*.

Table 1: Common Themes of Comments and Perspectives of Virginia Stakeholders

Theme	Comments and Perspectives of Virginia Stakeholders
Single PBM Design	Stakeholders recommended consideration for the following in single PBM design: • Greater transparency into the management of PBM activities, including their financial arrangements and operations. • Strong and enforceable contract language that holds the single PBM accountable to DMAS for performance. • More efficient and streamlined processes that replace multiple processes and requirements for each of the MCO's PBMs.

Theme	Comments and Perspectives of Virginia Stakeholders
	• Strong focus on ensuring continuity of care and care coordination during the transition and in ongoing operations. • Ensure data systems are considered and build to support timely access to prescription drug utilization information. • Strong DMAS oversight and monitoring of the single PBM operations and performance.
Financial Considerations	• Pharmacy reimbursement, particularly dispensing fees, were reported to be low, and stakeholders expressed a desire for dispensing fees for MCO claims to be more aligned with the FFS dispensing fees. • Pharmacy deserts and pharmacy closure rates, especially among independent and rural pharmacies, were reported to be in part due to low reimbursement rates. • Transition to a single PDL inclusive of all drug classes may result in savings. • A concern about the lack of transparency regarding rebates collected by the MCOs, dispensing fees and reimbursement amounts paid by the health plans and their PBMs and encouraged our attention to these during our study
Access to Pharmacies	• Closure of independent pharmacies and rural pharmacies are a growing concern for access to services. • Mail order pharmacy may not be a solution for all individuals and their needs. • The administrative burden on pharmacies to comply with the rules of five MCO PBMs creates a hardship and may be contributing to unwillingness of pharmacies to contract with the MCOs.

Access to Pharmacies

Our research and review of access to pharmacy services in Virginia resulted in the following key findings.

- Pharmacy deserts in Virginia are not confined to rural communities but also exist in urban neighborhoods, often where populations are low income, uninsured, or rely heavily on public health coverage, such as Medicare or Medicaid.
- 14.2% or 261,624 Medicaid members live in zip codes without a pharmacy; however, not all of these zip codes would be considered a pharmacy desert.
- 160 Virginia zip codes (17.7%) are pharmacy deserts for Medicaid members.
- The percentage of residents living in zip codes without pharmacies is nearly identical for both Medicaid and non-Medicaid populations, highlighting pharmacy deserts as a systemic issue impacting all demographics.

Single PBM Contracting Models

We identified and classified single PBM contracting strategies into the four major contracting models shown in *Table 2*. Each model may have a multitude of variations in its design and operations.

Table 2: High-Level Overview of Single PBM Contracting Options

Single PBM Contracting and Payment Option	Party that Procures Single PBM Contract	Source of Funds for Single PBM Remuneration	Who Compensates the Single PBM?	MCO Agreement with Single PBM?[2]
MCO At-Risk	State (zero-dollar contract	Capitation rate	MCO	Yes
MCO Non-Risk	State	State (provides MCOs with administrative fee funds)	MCO (passes through funds received from State)	Yes
Carve-Out Pre-paid Ambulatory Health Plan (PAHP)	State	State (capitation rate or non-risk based payment)	State	Yes
Pharmacy Carve-Out	State	State	State	No contract

Other State Experiences

Myers and Stauffer researched PBM contracting strategies used by state Medicaid agencies with an emphasis on seven state programs that illustrate a diverse range of Medicaid PBM contracting strategies. Specifically, we studied Medicaid pharmacy programs and interviewed their leaders in Kentucky, Louisiana, Mississippi, Ohio, New York, West Virginia, and Washington. These states collectively demonstrate that while the structure of Medicaid pharmacy models vary by state, common themes emerge for desired features, including transparency, administrative alignment, rebate maximization, pharmacy network stability and access, and PBM accountability. Additionally, recommendations from these states regarding the implementation of their PBM solutions provide insight for DMAS' consideration as it works to implement the single PBM model and are incorporated into our recommendations.

Reimbursement

Funding Allocation

HB 2610 did not allocate funding for pharmacy reimbursement changes.

While funds were not allocated for changes in pharmacy reimbursement as a result of HB 2610, a review of Virginia MCO's pharmacy reimbursement was included in the legislative language for this study. Myers and Stauffer analyzed four categories of MCO pharmacy claims: brand non-specialty, generic non-specialty, brand specialty, and generic specialty drugs. These categories have varying impacts on ingredient reimbursement and average dispensing fees as they make up a different proportion of the total MCO pharmacy claims. However, we made the following general observations regarding averages of each.

[2] In addition, traditional contracts, written agreements with MCOs may include non-contractual agreements, such as service agreements, memorandums of understanding, letters of intent, or letters of agreement to outline intentions, objectives, roles, expectations, and any other requirements that will align the participating parties on their purpose and desired outcomes.

- Chain versus Independent Pharmacies
  - Ingredient cost reimbursement was approximately equal except for branded specialty drugs which were reimbursed higher for independents.
  - Independent pharmacies received higher dispensing fees versus chains except for branded specialty drugs.
- Related-Party Pharmacies versus Non-related Pharmacies
  - Ingredient cost reimbursement was approximately the same except for specialty brands and specialty generics which were both reimbursed higher for non-related party pharmacies.
  - Dispensing fees varied with branded drugs, non-specialty generic drugs, and specialty generic drugs had higher dispensing fees for non-related pharmacies while related-party pharmacies received higher dispensing fees for specialty branded drugs.
- Rural versus Urban Pharmacies
  - Branded drugs and specialty generic drugs had approximately the same ingredient cost reimbursement; rural pharmacies received higher reimbursement for branded specialty drugs; and urban pharmacies received higher reimbursement for generic drugs.
  - Urban pharmacies had higher average dispensing fees for generic non-specialty and generic specialty drugs. Rural pharmacies received higher dispensing fees for branded specialty drugs. There were nominal differences in dispensing fees for brand non-specialty.

MCO pharmacy claims were found to carry much lower dispensing fees than FFS, and these dispensing fees are much lower than typical pharmacy costs to dispense drugs. An ingredient cost reimbursement analysis comparing FFS to MCO reimbursement was not conducted but should be considered in tandem with dispensing fees should legislative funding for outpatient reimbursement changes be made available in the future.

Estimated Fiscal Impact

There are many decisions to be made by DMAS regarding the single PBM program contracting model and design features. These decisions as well as how the model is operationalized will significantly affect the fiscal impact the single PBM will have on the Virginia Medicaid program. Our research shows that each state that has transitioned to a single PBM contract has done so from various unique starting points, and reports of projected savings have varied across and sometimes within these transitions.

Based on our analysis, the estimated fiscal impact of transitioning to a single PBM results in initial implementation costs over an 18-month period consisting of a 6-month procurement period and 12-month contract implementation period. Potential savings would begin in Year 1 during the first six months of the contract being operational followed by full savings potential beginning in subsequent contract years. The estimate of savings are reflected in *Table 3*.

Table 3: Fiscal Impact Summary by Period

Period	Description	Potential Estimated Fiscal Impact*
Year 0	6-month procurement and 6 months of implementation activities	An initial cost of $6.2 million to $9.6 million.
Year 1	Additional 6 months of implementation activities and 6 months of single PBM contract operations	Potential cost of $6.1 million to savings of $1.6 million during continued implementation and transition to operations.
Years 2+	Full 12-month periods of single PBM operations	Potential savings of $10.2 million-$22.1 million annually.
***Total Funds**		

The range in these estimates largely represents the unknowns related to the decisions DMAS will need to make during the design of the single PBM model, the results of the procurement process, and how the model is operationalized.

Recommendations

DMAS has a relatively short timeline to procure the single PBM and have a contract in place by July 1, 2026, as legislatively required. We recommend DMAS consider the following steps:

- Select a single PBM model and make design decisions leveraging this report and the options analysis.
- Determine a procurement strategy. Begin development of a procurement document and contractual service level requirements.
- Identify staffing needs as well as any external consultant needs and begin onboarding resources.
- Assess competing initiatives within the Department and how the single PBM implementation may be impacted or impact those other initiatives.
- Establish a comprehensive project management approach inclusive of a detailed implementation workplan, project governance, communications, and change management approach.
- Set expectations with stakeholders that funding to support reimbursement increases was not allocated under HB 2610.

We recommend DMAS consider the following high-level timeline for transition to the single PBM model:

- **Model and Design Decisions:** December 31, 2025.
- **Issue RFP:** Early January 2026.
- **Proposals Due:** Early March 2026.
- **Proposal Evaluations and Award:** March-April 2026.
- **Contract Award and Protest Period:** May-June 2026.

- **Contract Implementation:** July 2026-June 2027.
- **Contract Go-Live:** July 1, 2027.

Conclusion

Implementation of the single PBM model required under HB 2610 continues Virginia's historical efforts to improve transparency and efficiency of PBM operations impacting the Medicaid population. As DMAS plans for transition to the single PBM model, it has an opportunity to achieve various program improvements, but to do so will require thoughtful planning, detailed implementation activities, and comprehensive ongoing oversight and compliance monitoring.

Potential program improvements when transitioning to a single PBM model include the following:

- Decreased administrative burden for pharmacy providers.
- Administrative savings from efficiencies and economies of scale with PBM administrative fees being paid to one PBM versus each of the five MCO PBMs.
- Greater transparency and oversight of the Medicaid related PBM activities and ensuring compliance with state and contractual requirements.
- Greater DMAS control over utilization management and consistent application of utilization management initiatives and requirements.
- Potential for DMAS to collect additional supplemental rebates, including expanding supplemental rebate program to currently "open" classes on the CCF.

To realize the above potential improvements when implementing a single PBM model, Myers and Stauffer recommends the following are necessary.

- Ample time dedicated to single PBM model design, implementation, systems testing, and go-live readiness review.
- Hiring of additional staff and resources who will be dedicated to supporting the PBM contract implementation and ongoing operations.
- Diligence in establishing a comprehensive procurement vehicle, as well as contracting requirements and service agreements, to clearly identify roles and responsibilities across DMAS, the single PBM, and MCOs and to ensure accountability. This includes review and amendment of Cardinal Care MCO contracts.
- Safeguards to protect members' access and continuity of services during the transition period.
- Data exchange mechanisms to ensure each MCO has real-time or near real-time access to pharmacy claims and drug utilization data for its assigned members.
- Consideration of the impact of the single PBM implementation on other vendors from both an operational perspective and any additional costs that DMAS may incur from these vendors.

- Assessment of the multiple competing priorities and initiatives of the Department, including the Fiscal Agent Services (FAS) procurement and implementation, and the interdependencies and resource requirements.
- Development and deployment of a communication strategy that encompasses all affected stakeholders and keep them informed and solicits feedback throughout the process.
- Monitoring of actual savings and strategic use of savings, if realized, to maintain or improve access.
- Ongoing actuarial analysis and monitoring of the impact on the single PBM on the MCO capitation rates as this is a significant source of savings.

Finally, this study is comprehensive in nature, providing insights from Virginia stakeholders and other states' pharmacy leaders, data and financial considerations, and options and recommendations for single PBM contracting in Medicaid programs. However, as acknowledged throughout this report, there are countless decision points that DMAS must consider in determining the single PBM program design, contracting strategy, and implementation. Further, transitioning to a single PBM will not independently resolve all PBM and pharmacy access issues. Time will be required to fully assess the true fiscal and operational impact of the single PBM, as well as any savings realized. This study should serve as a basis for DMAS' use as it moves forward in planning with the recognition that decisions are intricately related and will have overarching impacts on the best approach to moving forward and to cost and savings estimates presented in this report.

Time will be required to fully assess the true fiscal and operational impact of the single PBM and possible savings.

Introduction

In the 2025 Legislative Session, the Virginia Legislature passed House Bill (HB) 2610 and Item 292.MM of the Appropriations Act, which requires the Virginia Department of Medical Assistance Services (DMAS, Department, or State) to procure a vendor to administer all pharmacy benefits for Medicaid members, including those enrolled with a managed care organization (MCO). Specifically, HB 2610 requires the following:[3]

- By July 1, 2026, DMAS must select and contract with a single third-party administrator to serve as the State pharmacy benefits manager (PBM)[4] to administer all pharmacy benefits for Medicaid recipients, including those enrolled in an MCO.
- Each managed care contract that DMAS enters or renews shall require the MCO to contract with and utilize the State PBM to administer all pharmacy benefits for the MCOs enrolled Medicaid recipients.
- The PBM contract shall include the following:
    - Establish the State PBM's fiduciary duty owed to DMAS.
    - Require the use of passthrough pricing.
    - Require use of the common formulary, reimbursement methodologies, and dispensing fees negotiated by DMAS.
    - Require transparency in drug costs, rebates collected and paid, dispensing fees paid, administrative fees, and all other charges, fees, costs, and holdbacks.
    - Prohibit the use of spread pricing.

Additionally, the Bill requires DMAS to engage an independent consultant to evaluate implementation of the PBM contract, including potential benefits, cost savings, and implementation costs. The Commonwealth Appropriation Act Item 292.MM.1 and 292.MM.2 requires the evaluation to include:

- Analysis of financial efficiencies, improved transparency, and the impact on patient access to pharmacy services, including community critical access pharmacies.
- Timelines and cost for both implementation and ongoing operation and maintenance.
- A detailed assessment of the implementation costs associated with transitioning to a single PBM model in comparison to the projected cost savings identified in the independent evaluation to ensure fiscal accountability.

[3] HB 2610 (2025) ; HB 1600 (2025)
[4] Some states use the term "Pharmacy Benefits Administrator, or PBA. We use the terms interchangeably in the report. See Appendix A for definitions.

- A review of fee-for-service (FFS) and managed care pharmacy dispensing fees and recommendations for adjustments necessary to maintain adequate pharmacy participation and patient access.

DMAS must report its findings, including projected implementation and ongoing costs, anticipated cost savings, recommended pharmacy dispensing fees, timeline for implementation, and any other recommendations for improving the administration of Medicaid pharmacy benefits to the Governor and the General Assembly by December 1, 2025.

As a result, DMAS contracted with Myers and Stauffer LC (Myers and Stauffer) to design and conduct a transparent PBM study. Myers and Stauffer has worked with DMAS for more than 32 years on numerous Medicaid initiatives during this tenure as DMAS' accounting and audit consultant. This experience includes Medicaid financing consulting and assisting with responses to the Centers for Medicare & Medicaid Services (CMS) and inquiries from the Office of Inspector General. Throughout our work with DMAS, we have extensive knowledge of Virginia's Medicaid data and access to additional data to inform our analyses for this PBM study. In addition to our DMAS experience, we have supported states across the country and the federal government with reviews and audits, including those of PBMs, rebate vendors, and pharmacy reimbursement methodologies. Myers and Stauffer meets the legislative requirements that DMAS engage an independent consultant with direct experience advising Medicaid fraud control units and working with states that have established a single PBM for their Medicaid program. We are not nor have we been engaged by any Virginia Medicaid MCO or by any PBM contracted with a Virginia Medicaid MCO.

Myers and Stauffer's PBM study is inclusive of the following components:

Assessment of Virginia's Medicaid Pharmacy Program
Conducted research and stakeholder interviews to understand the current delivery of Virginia's outpatient Medicaid pharmacy benefit and gain stakeholders' perspectives of potential impacts of implementation of changes to the current model. Additionally, conducted the data analyses described below specific to the Medicaid pharmacy benefit and access to pharmacies across the Commonwealth.

Review of Other States' PBM Contracting Strategies
Researched other states' PBM contracting strategies and identified states that have implemented changes to their Medicaid pharmacy delivery models in the past five years. Research focus areas included understanding of the various models used by states, review of payment arrangements and cost data, collection of data on access and pharmacy deserts, and managed care pharmacy activities. The review included interviews of select state leaders to identify successes, challenges, and lessons learned in their implementation and operations of their pharmacy delivery models.

Data Analysis
Analyzed available data to inform the overall study, including review of dispensing fees, potential short-term and long-term costs of implementing a single PBM contract, and comparison of Virginia net pharmacy spend per member to other comparable states with managed care delivery systems.

Options Analysis and Recommendations
Based on overall findings identified from our research, stakeholder engagement, and analyses, as well as our industry experience, we identified single PBM contracting options and their respective costs and benefits. This analysis included identification of best practices in PBM contracting to include in a Request for Proposals (RFP) for a single PBM and recommendations for any required changes to Virginia law to enable the most efficient and effective pharmacy delivery system possible.

For ease of access, *Table 4* is provided as a "report roadmap" and demonstrates alignment between each report section and the specific requirements in HB 2610 and Items 292.MM.1 and 292.MM.2 of the Appropriations Act.

Table 4: Report Section Locations for PBM Study Requirements

Study Requirements	Report Section
Evaluation of Potential Benefits of Single PBM	Single PBM Contracting Options
Evaluation of Potential Cost Savings of Single PBM	Financial Considerations for Implementing a Single PBM
Implementation Considerations	Recommendations and Considerations
Analysis of Financial Efficiencies	Financial Considerations for Implementing a Single PBM
Analysis of Improved Transparency	Single PBM Contract Design Considerations
Analysis of Impact on Patient Access	Transparency and Access Comparison
Cost for Implementation and Operations	Potential Costs and Assumptions for Implementing a Single PBM
Timeline for Implementation	Best Practices in PBM Contracting
Review of FFS and MCO Dispensing Fees	FFS Program Comparison

Background

DMAS is the state agency responsible for administering Medicaid services for more than 1.7 million Virginians — approximately 90% of whom are enrolled in the Commonwealth's Medicaid managed care program, Cardinal Care. The remaining members are served through the FFS delivery system, most of whom are temporarily enrolled there prior to transitioning to an MCO in the Cardinal Care Program. DMAS contracts with the following five Cardinal Care MCOs: Aetna Better Health of Virginia, Anthem Healthkeepers Plus, Humana Healthy Horizons in Virginia, Sentara Community Plan, and UnitedHealthcare.

The Cardinal Care Program operates statewide, and MCOs are at full risk for providing health care coverage for their Medicaid members. Each MCO subcontracts with a PBM to administer the pharmacy benefit for their members, therefore, multiple PBMs support the Cardinal Care Program. Additionally, DMAS contracts with Prime Therapeutics (Prime) as its PBM. Prime provides utilization management and service authorization (SA) functions for pharmacy services for FFS members, claims adjudication, rebate administration, and formulary management services, including development of the preferred drug list (PDL), also referred to as the Common Core Formulary (CCF), that is used for both FFS and MCO pharmacy programs.

Nationally, state Medicaid programs have been working to address concerns about the Medicaid pharmacy benefit that extend to transparency in pricing, increasing costs, and member access to medications. Pharmacy closures have become increasingly common across the United States, raising concerns about patient access to essential medications and pharmacy services. These closures affect both chain and independent pharmacies, though independent pharmacies are disproportionately affected.[5] One of the most pressing consequences of this trend is the emergence of "pharmacy deserts"— communities that lack adequate access to pharmacies. This pattern of limited access highlights a growing public health concern that extends to Virginia, where pharmacy access challenges have also been documented.[6]

In response to challenges regarding transparency, cost, and access, several states have implemented a new single PBM model for administering the pharmacy benefit. Medicaid agencies have traditionally provided the pharmacy benefit through their FFS or managed care delivery systems, or a combination of the two. Most states with Medicaid managed care delivery systems operate under a similar pharmacy "carve-in" model to Virginia although states may provide some or select pharmacy services to members as a "carve-out" FFS benefit.[7] Although each state has unique requirements of their contracted health plans and/or PBMs, generally, state Medicaid pharmacy program models can be described as follows:

- ***Pharmacy Carve-In Model:*** As of July 2024, 42 states and Washington, D.C., including Virginia, had comprehensive, risk-based contracts with one or more health plans to provide care to at

[5] Gudamuz et. al., *More US Pharmacies Closed Than Opened In 2018–21*, Health Affairs (2024).
[6] Joseph Boyle, et al., *Characterizing pharmacy deserts and designing a model to minimize inequities in pharmacy distribution in Virginia*, JAPhA (Apr. 2025).
[7] KFF, *Inclusion of Pharmacy Benefits in Medicaid MCO Contracts* (2019).

least a portion of their Medicaid members. Thirty-one of these states include the pharmacy benefit in managed care contracts.[8] This model is commonly referred to as a pharmacy carve-in model. While there may be programmatic variations within a carve-in model, often under this approach, health plans are at risk for the cost of providing the benefit, which is typically administered by the health plan in conjunction with the MCO's subcontracted PBM vendor.

When a health plan contracts with the PBM, there is no direct contractual relationship between the state Medicaid agency and the PBM. PBMs acting on behalf of MCOs are not automatically bound by the same federal or state Medicaid pharmacy reimbursement requirements as the FFS program, and they will often negotiate reimbursement rates directly with pharmacies and set proprietary maximum allowable costs (MACs).[9] Similarly, these PBMs generally negotiate dispensing fees, which are also not subject to federal requirements requiring the reasonableness and sufficiency of those dispensing fees to cover the cost to dispense the drug. As a result, many industry experts have noted that the price paid for drugs for Medicaid members is not always transparent.[10] Recently and through the use of CMS-approved state directed payment (SDP) programs, states have taken measures to increase transparency including requiring health plans to pay pharmacies at a calculated acquisition cost and/or the same dispensing fees as those used in the FFS delivery system.[11]

- ***Single PBM Models:*** In recent years, some states have adopted a newer approach to PBM contracting in which the state Medicaid agency selects one PBM to serve all health plans. Three single PBM contracting approaches can generally be categorized as the following:
    - *Single PBM: MCO At-Risk.* The Medicaid agency procures the single PBM and requires each health plan to contract directly with the single PBM. The State sets the overall policies the single PBM must follow for those policies all pharmacy claims processed; however, the health plans remain at risk for the provision of the pharmacy benefit. The PBM uses the State's Medicaid enrolled pharmacies as the provider network. Kentucky and Louisiana have implemented this single PBM approach.
    - *Single PBM: MCO Not at Risk.* The Medicaid agency requires MCOs to contract with the single PBM; however, they remove the pharmacy benefit risk from the MCO capitation payment rate. Instead, the State pays the MCO separately for pharmacy claims and the MCO maintains a separate bank account of those funds to pay the pharmacy benefit manager. Mississippi has implemented this approach.
    - *Prepaid Ambulatory Health Plan (PAHP).* The single PBM is solely contracted with the state Medicaid agency and operates as a PAHP, which provides the pharmacy benefit to all members enrolled in the managed care program. The health plans are not at risk for the pharmacy benefit. States electing this option must seek CMS approval of a 1915(b)

[8] Hinton and Raphael, *10 Things to Know About Medicaid Managed Care*, KFF (2025).
[9] Dolan and Tian, *Pricing and Payment for Medicaid Prescription Drugs*, KFF (2020).
[10] Ge Bai et al., *Medicaid Managed Care Programs' Contracts for Generic Drugs are Inefficient*, Health Affairs, (2019).
[11] CMS, State Directed Payment; Gattine, Reck, & Lanford, *State Strategies to Lower Drug Prices: New Legislative and Medicaid Models* NASHP (2021).

waiver and communicate information in the waiver application, such as how the model will not limit member access to services and identify any excluded populations.

Ohio operates its single PBM model under an approved 1915(b1)(b4) waiver. During an interview, the State indicated that the single PBM must contract with all state-enrolled pharmacies willing to accept the single PBM's contractual terms and conditions, thereby promoting increased access to pharmacy providers. Ohio excluded the following populations from the PAHP model: Medicare dual-eligible individuals, residents of nursing facilities, residents of intermediate care facilities for individuals with intellectual disabilities, individuals enrolled in other managed care programs, individuals who participate in a home and community-based waiver, and Medicaid members during any retroactive eligibility period. Under the PAHP model, CMS required Ohio to explain how the single PBM will coordinate with MCOs to ensure Medicaid members have access to needed medications.

The PAHP single PBM model is intended to provide the state Medicaid agency with more control over the pharmacy benefit while maintaining transparency and adequate pharmacy reimbursement.

- ***Pharmacy Managed Care Carve-Out Model:*** In contrast to the carve-in model, under a pharmacy carve-out model, states exclude some or all of the pharmacy benefit from health plan contracts and administer the benefit through the Medicaid FFS delivery system. Many states using this model contract with one PBM to support the Medicaid agency with management of the benefit for all Medicaid members (i.e., FFS and MCO populations). States that have used this carve-out approach for many years include Missouri, Tennessee, West Virginia, and Wisconsin. California, and more recently, New York, transitioned to this model and both manage the pharmacy benefit exclusively within their FFS programs.

  Additionally, some states carve out one or more drug classes or certain subsets of high-cost drugs from their managed care contracts to be paid as a FFS benefit. As of 2023, 19 states had a partial carve-out of the pharmacy benefit.[12]

  Most carve-out states contract with a PBM to administer specific components of the benefit, though the State may maintain certain administrative functions internally (e.g., enrollment of pharmacy providers). A carve-out model allows the state Medicaid agency to maintain more control over the pharmacy benefit, which may result in greater oversight of reimbursement rates and rebates and ultimately increase transparency.[13]

In addition to, or in concert with, the above PBM models, some states have leveraged various federal authorities (i.e., waivers, State Plan amendments [SPAs], or state directed payment [SDP] programs) to further customize their outpatient pharmacy delivery and reimbursement system. As DMAS

[12] Gifford, Lashbrook, & Payne, *State Approaches to Managing the Medicaid Pharmacy Benefit*, HMA (2024).
[13] Gattine, Reck, & Lanford, *State Strategies to Lower Drug Prices: New Legislative and Medicaid Models* NASHP (2021).

contemplates its program design for the single PBM model, consideration for the required federal authorities will be necessary. For example:

- ***SPAs:*** Through SPAs, States provide CMS with information about the reimbursement methodologies they want to use for all types of drugs (i.e., brand name drugs, generic drugs, 340B covered entities, etc.) dispensed to the State's FFS Medicaid members, including the professional dispensing fee (PDF) determined through cost of dispensing surveys. When approved, the State can choose to apply the methodologies to drugs dispensed for managed care members as well.

  For example, North Carolina passed legislation which required a minimum pharmacy reimbursement methodology set at 100% of the Medicaid FFS methodology.[14] Other States such as Iowa, Kentucky, and Mississippi have also established minimum reimbursement methodologies which align closely with Medicaid FFS rates.[15, 16, 17] For "local pharmacies," which generally includes independent pharmacies, Louisiana requires Medicaid MCO payments that are at least equal to the FFS reimbursement rate.[18]

- ***Section 438.6(c):*** Some states use the authority under Section 438.6(c) to adopt a minimum fee schedule for MCO paid claims consistent with its FFS reimbursement methodology. For example, Kentucky established a managed care minimum fee schedule and indicated that the fee would be incorporated in its MCO capitation rates through a risk-based rate adjustment (Single PBM: MCO At-Risk Model).[19]

In the following sections, this report provides detailed information about our methodology to conduct this study, Virginia's current Medicaid pharmacy benefit, examples of other states' pharmacy delivery approaches, and options and recommendations for DMAS' consideration as it plans for implementation of a single PBM model. Please see *Appendix A* for a glossary of acronyms and definitions for pharmacy-specific terms used throughout our report.

[14] Session Law 2025-69.
[15] Iowa Senate File 383
[16] KRS 304.17A-595
[17] https://medicaid.ms.gov/pharmacy/pharmacy-reimbursement/
[18] Louisiana RS 46:460.36
[19] Kentucky Section 438.69(c) Preprint (2023).

PBM Study Methodology

The following presents the study methodology for the Virginia and national landscape scan and data analysis. We also provide a summary of limitations and assumptions. Please see *Appendix A* for a glossary of acronyms and definitions of pharmacy-specific terms used throughout our report.

Assessment of Virginia's Medicaid Pharmacy Program

Myers and Stauffer's assessment of Virginia's Medicaid pharmacy program is based on a mixed-methods approach that integrates a statutory and regulatory review, peer-reviewed research, stakeholder input, and quantitative data analysis, described in detail later in this section. Enrollment and program structure information were drawn from DMAS and/or federal reporting sources to establish the size and composition of the Commonwealth's Medicaid program. To assess the current pharmacy delivery system, including the carve-in model and associated formulary policies, Myers and Stauffer reviewed official DMAS guidance, provider bulletins, and public documentation on the CCF and related governance structures, such as the Pharmacy & Therapeutics (P&T) Committee and the Drug Utilization Review (DUR) Board.

To capture the policy context, Myers and Stauffer conducted a legislative and regulatory scan of relevant Virginia statutes enacted between 2018 and 2025. This included an examination of bills addressing PBM oversight, transparency requirements, spread pricing, and real-time benefit tools. The statutory review focused on how each measure incrementally reshaped the administration of Medicaid pharmacy benefits and its relevance to the mandated transition to a single PBM model.

Finally, Myers and Stauffer incorporated evidence from recent peer reviewed literature and National Community Pharmacy Association data to understand emerging trends in pharmacy access, particularly the identification of pharmacy deserts across urban, rural, and suburban communities in Virginia.

To complement this research, we conducted stakeholder engagement to solicit detailed perspectives on the Commonwealth's current Medicaid pharmacy program and recommendations to consider for the transition to a single PBM. We conducted a survey focused on provider associations, as well as 18 formal interviews representing DMAS and other state agencies, provider and pharmacy organizations, legislators, MCOs, and other DMAS vendors. We coded and analyzed perspectives gathered from stakeholder engagement activities to highlight themes and practical considerations relevant to the single PBM transition. See *Appendix B. Stakeholder Engagement* for a full listing of stakeholders who received outreach and participated in this study, and details of stakeholder feedback received are in the *Summary of Findings from Virginia Stakeholder Engagement* section of this report.

Collectively, these data sources and perspectives, combined with analysis of other data and information described below, were leveraged to provide an assessment of Virginia's Medicaid pharmacy landscape and to identify key implications for members, providers, and policymakers for consideration during single PBM implementation.

Review of Other States' PBM Contracting Strategies

Myers and Stauffer conducted research to gain the perspectives of and distill lessons from other state's Medicaid programs and their administration of the Medicaid pharmacy benefits for managed care members. Based on our research and with input from DMAS, we focused on the following seven study states Kentucky, Louisiana, Mississippi, New York, Ohio, Washington, and West Virginia. Our overarching rationale for our final selection of study states is as follows:

- Five of these states have changed their Medicaid pharmacy and/or PBM services within the last five years.
- Four states have implemented single PBM models similar to the model DMAS is legislatively mandated to implement but each with differing features and considerations.
- Two states operate carve-out pharmacy programs that provide alternative models to both Virginia's current carve-in model and a single PBM model and provide additional insights and lessons learned.
- One state operates a pharmacy carve-in model and has begun efforts to introduce value-based payments.
- We prioritized states that shared characteristics with Virginia, including rural provider networks and Medicaid managed care enrollment exceeding 75% of total membership; however, exceptions were made based on specific features of each individual program.

The resulting sample offers an informative, geographically diverse, and policy-relevant cross-section of state Medicaid pharmacy models.

For each state, we developed a summary of key features based on our review of primary and secondary source documentation, interviews with state leaders, and the features of each program. Additionally, we include information based on our internal subject matter experts' (SMEs) experience and expertise supporting Medicaid pharmacy programs. Primary data included information, such as legislative reports, pharmacy audit findings, Medicaid SPAs, PBM and MCO contracts where available, and supplemental rebate programs. We conducted semi-structured interviews with Medicaid pharmacy directors or interim pharmacy directors and pharmacists across the seven study states. We coded and analyzed interview themes to identify implementation challenges, stakeholder perspectives, and policy outcomes.

Through this methodology, Myers and Stauffer developed state summaries that include both policy structure and practical implementation detail, as well as lessons learned and recommendations from other states' program leaders for DMAS to consider in planning and implementation of a new PBM model.

Data Analysis Methodology and Limitations

For Virginia, Myers and Stauffer received final paid FFS and MCO pharmacy claims and monthly enrollments for state fiscal year (SFY) 2023 through SFY25 from DMAS. DMAS provided data regarding administrative fees paid by the MCOs to the PBMs for SFY23 and SFY24. We also obtained publicly

available state Medicaid drug utilization and expenditure data, as well as state Medicaid enrollment data from the CMS website for the comparable states in the national landscape scan. The following analyses were performed utilizing the data compiled.

Per Member Per Month Comparison

The per member per month (PMPM) comparison was completed by taking the state Medicaid expenditures by SFY and dividing them by the SFY 12-month average Medicaid enrollments. The Virginia PMPM analysis utilized the pharmacy claims data and enrollment numbers provided by DMAS. All other comparable states' PMPM calculations utilized Medicaid expenditures and enrollment from the CMS website. The data analysis section of this report cites specific locations where Myers and Stauffer obtained the information to calculate PMPM.

Data Limitations

The PMPM could not be broken down by FFS and MCO as the Medicaid enrollment data available did not possess these designations for comparable states. Additionally, there were pending updates to the CMS website's presentation of Kentucky Medicaid pharmacy expenditures for the first half of calendar year (CY) 2024, thus Myers and Stauffer was unable to calculate a PMPM cost for SFY24 for Kentucky. Finally, publicly available state Medicaid expenditures are only available through CY 2024 through the CMS data website. This caused Myers and Stauffer to only be able to provide PMPM analysis on the first half of SFY25.

DMAS MCO Pharmacy Reimbursement Analysis

We performed an analysis of the MCO pharmacy reimbursement from the claims data provided by DMAS. This analysis compares the ingredient amount paid by the MCO to the Medi-Span drug compendia average wholesale price (AWP) per unit. AWP is the published list price for a drug sold by wholesalers to retail pharmacies and non-retail providers. It is similar to a sticker price and is used as a starting point for negotiation in commercial contracts often used for Medicaid managed care reimbursement. The results are expressed in terms of the discount or percentage below the AWP per unit. The comparison was made only by National Drug Codes (NDCs) that had pricing available within the Medi-Span drug compendia. The average dispensing fee paid was also analyzed.

The ingredient price and dispensing fee analysis was broken down by the following components.

- **Brand versus Generic NDC.** Brand and generic NDCs were designated by a team of pharmacists within Myers and Stauffer. This designation was made based on a review of various indicators in published drug compendia, the CMS Covered Outpatient Drug (COD) file, and Food and Drug Administration (FDA) databases.

  It should be noted that health plans and PBMs provide their own designation for brand and generic. Myers and Stauffer utilized our internal designation to create uniformity across the health plans in Virgina Medicaid for direct comparison.

- **Specialty versus Non-Specialty NDCs.** It should be noted that health plans and PBMs provide their own definition of specialty for specialty and non-specialty drugs. Myers and Stauffer

utilized an internal designation to create uniformity across the health plans in Virgina Medicaid for direct comparison.

- **Chain versus Independent.** Chain versus independent designation was obtained through the National Council for Prescription Drug Programs (NCPDP).
- **Related Party versus Non-related Party.** Related party pharmacy designation was determined by a manual review that considered pharmacy name and industry knowledge of known relationships and mergers and acquisitions.
- **Urban and Rural.** The urban versus rural designation was performed only for pharmacies residing in the state of Viriginia using the CMS designation by zip code available in the Zip Code to Carrier Locality File. Pharmacies from surrounding states that may serve Virginia Medicaid members were not included in the analysis.

FFS Program Comparison

Myers and Stauffer compiled publicly available data from CMS for a comparison of the FFS reimbursement methodology for Virginia and the landscape scan states. We relied on the accuracy and completeness of the state reimbursement information published by CMS to conduct our review.[20]

Administrative Costs

Myers and Stauffer utilized the MCO PBM administrative fee data provided by DMAS by SFY and divided it by the number of claims with a final status of paid in the DMAS provided pharmacy claims data to get the administrative cost per prescription for Virginia Medicaid by health plan and SFY. Myers and Stauffer also scanned publicly available information to obtain the services provided by the PBM or state vendor for each comparable state Medicaid program.

Data Limitations

A review of administrative fees paid by DMAS to each MCO's PBM for SFY25 is under review and not available at the time of this report's publication. The lack of publicly available information regarding administrative fees and services provided by PBMs to other state Medicaid programs did not allow Myers and Stauffer to compare Virginia Medicaid administrative fees to other comparable states.

[20] *Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State*.

Environmental Scan

In the following sub-sections, Myers and Stauffer presents background information about key aspects of the Medicaid outpatient drug program, including relevant legislation and regulations. This information provides critical context to support understanding of discussions throughout the report.

Next, we present findings from our assessment of Virginia's Medicaid pharmacy program, including a summary of stakeholder engagement and an analysis of the Commonwealth's reimbursement and dispensing fees. Finally, we present findings from a review of other states' Medicaid PBM contracting strategies.

Federal Regulations

Outpatient prescription drug coverage is an optional benefit that all state Medicaid programs have elected to provide.[21] If the drug's manufacturer has entered into a Medicaid rebate agreement with the Secretary of the U.S. Department of Health and Human Services, states are generally required to provide access to all prescription medications unless otherwise excluded under the Social Security Act.[22] States are allowed to use utilization management strategies, such as prior authorization (PA) to drive appropriate and cost-effective utilization of covered outpatient drugs (CODs). States are required to define their pharmacy reimbursement methodology in their State Plan, which is an agreement between the State and the federal government regarding the administration of the Medicaid program. The reimbursement methodology defined in the State Plan applies to FFS paid claims and not MCO paid claims unless the State has otherwise implemented such requirements. The 2016 CMS CODs Rule, discussed later in this report, sets expectations for the reimbursement of both ingredient cost and dispensing fees for FFS paid claims.

Nationally, prescription drug expenditures continue to rise due to a variety of factors, including ongoing development of new, high-cost drugs and therapies and increased utilization. According to the Kaiser Family Foundation (KFF), prescription drugs account for approximately 6% of total Medicaid spending and net spending (spending after rebates) on Medicaid prescription drugs is estimated to have increased by 72%, from $30 billion in FY 2017 to $51 billion in FY 2023, likely driven by the emergence of new high-cost specialty drugs.[23] To address these rising costs, as well as concerns about transparency in drug pricing and access to services, states and the federal government have worked to implement cost containment efforts. For example, the *Misclassification of Drugs, Program Administration and Program Integrity Updates Under the Medicaid Drug Rebate Program Final Rule*[24] made enhancements to support proper rebate collection and clarified that both the ingredient cost and PDF under Medicaid FFS must be based on pharmacy-established cost data. Another example is passage of the *American Rescue Plan Act (ARPA)*, which included a provision lifting the cap on the total amount of rebates that Medicaid could collect from manufacturers that raise drug prices more quickly than the increase in the Consumer

[21] Social Security Act § 1905(a)(12).
[22] MACPAC, *Prescription Drugs*.
[23] Williams et al., *Recent Trends in Medicaid Outpatient Prescription Drugs and Spending*, KFF (2024).
[24] 89 FR 79020 (2024).

Price Index for All Urban Consumers (CPI-U) over time.[25] As a result, drug manufacturers have made a series of changes to avoid increased rebates, including voluntarily lowering drug prices or discontinuing drugs and in limited cases, terminating participation in the Medicaid Drug Rebate Program (MDRP). Yet another example is the *CMS Covered Outpatient Drugs (COD) Rule (CMS-2345-FC)*,[26] which made additional changes to the drug rebate program but importantly requires state Medicaid FFS programs to base ingredient reimbursement on the actual acquisition costs (AAC) of the drug and a PDF that reflects the true cost of pharmacist's professional services and costs associated with the dispensing of drug products to members. This rule also requires states to evaluate the sufficiency of both the ingredient cost and PDF reimbursement and its potential impact of access to services when proposing changes to either component.

Virginia's Current Medicaid Pharmacy Program

DMAS currently administers the Commonwealth's Medicaid pharmacy benefit through a "carve-in" model. Under this system, Virginia's five MCOs are at risk for the pharmacy benefit, and each engages its own PBM to manage a wide range of pharmacy functions, including network management, claims processing, partial formulary development, utilization management, clinical programs, rebate management, regulatory reporting, and coordination with medical care. Additionally, DMAS contracts with Prime for the FFS pharmacy benefit and other pharmacy management support.

In 2018, the Commonwealth established a CCF that applies to both FFS and Cardinal Care members and includes preferred drugs in designated therapeutic drug classes that are on the PDL.[27] MCOs' PDLs must include all drugs on the CCF, and MCOs cannot place additional restrictions on drugs that are in these designated classes. MCOs may opt to customize PDL placement and utilization management strategies for brand or generic drugs not included on the CCF.

The central aim of the CCF is to ensure access to clinically effective, safe, and cost-effective medications by categorizing drugs within select therapeutic classes as "preferred." Preferred drugs generally do not require a SA (or PA) except in cases where specific clinical or utilization criteria apply (e.g., long-acting opioids, hepatitis C therapies, growth hormones). Non-preferred medications typically do require an SA. The CCF undergoes periodic updates based on decisions made by DMAS' P&T Committee and the DUR Board. Provider bulletins and member notices detailing these updates are regularly published, outlining changes to preferred or non-preferred status and any new SA criteria.

In recent years, the Virginia Legislature has taken significant steps to modify the administration of the Medicaid pharmacy benefit and to strengthen oversight of PBMs. Most recently, in 2025, the General Assembly passed HB 2610 requiring DMAS to contract with a single third-party PBM by July 1, 2026 as described in more detail in the *Introduction* section of this report.[28] This legislation represents a shift away from the current multi-PBM "carve-in" model in which each MCO contracts with its own PBM

[25] MACPAC, *Medicaid Payment for Outpatient Prescription Drugs* (2018).
[26] 42 CFR Part 447 (2016)
[27] Medical Society of Virginia, *Medicaid Common core Formulary "Quick List" for Physicians* (2019).
[28] HB 2610; SB 875

toward a centralized approach intended to improve transparency, standardize benefit administration, and enhance accountability in how prescription drug benefits are delivered to Medicaid members.

The Commonwealth's path to this address PBM oversight has been shaped by a series of legislative measures designed to increase transparency, protect consumers, and regulate PBM practices.

- **HB 1177/Senate Bill (SB) 933 (2018):** Ensured that pharmacy contracts allow providers to inform members about more affordable therapeutic alternatives, dispense lower cost equivalents, and provide limited delivery services.[29]
- **HB 1291 (2020):** Prohibited spread pricing within Medicaid managed care contracts, requiring MCOs and their PBMs to operate under pricing models that reflect the true cost of prescription drugs rather than allowing PBMs to retain the difference between payer reimbursement and pharmacy payment.[30]
- **HB 30 (2020) and HB 1800 (2021):** Required all MCOs to report the following information to the Department on a quarterly basis for all pharmacy claims: the amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its PBM.[31]
- **HB 2007 (2021):** Authorized DMAS to require wholesale distributors to submit prescription drug cost data if information from carriers, PBMs, and manufacturers proved insufficient.[32]
- **SB 428 (2022):** Required carriers and PBMs to provide real-time prescription cost and coverage information to members and prescribers. This includes cost-sharing obligations and PA requirements delivered in an accessible format within electronic prescribing or health record systems.[33]

Collectively, these DMAS and legislative actions reflect Virginia's ongoing efforts to strengthen oversight of PBMs, promote transparency, and improve member experience.

Summary of Findings from Virginia Stakeholder Engagement

In addition to the above research and data analyses, Myers and Stauffer facilitated stakeholder engagement activities to solicit detailed perspectives on the Commonwealth's current Medicaid pharmacy program, insight into coordination, and recommendations to consider for the transition to a single PBM. Please see *Appendix B. Stakeholder Engagement* for a listing of interview participants and survey respondents.

[29] HB 1177/SB 933 (2018)
[30] HB 1291 (2020).
[31] Annual Pharmacy Liaison Committee and Drug Utilization Review Board Report FY 2021; Annual Pharmacy Liaison Committee and Drug Utilization Review Board Report FY 2020
[32] HB 2007 (2021).
[33] SB 428 (2022).

While the interviews were tailored for each stakeholder audience, questions across stakeholders were generally designed to gather input on strengths and opportunities in Virginia's current Medicaid pharmacy benefit management model and specific to the FFS and MCO PBM programs currently in place. In addition, questions were designed to identify key differences between the Department's administration and oversight of the FFS and MCO PBM programs. We also requested input on recommended approaches and considerations for DMAS for design and implementation of a single pharmacy benefit model. While each stakeholder group provided varying perspectives, common themes emerged regarding Virginia's potential transition to a single PBM and are presented in the following sections.

Stakeholder Engagement

Provider organizations and medical associations were surveyed and 18 formal interviews conducted.

Approximately 630 unique responses were received.

Stakeholder Feedback: Design Considerations for Transition to Single PBM

Virginia stakeholders provided common themes for DMAS's consideration when designing and implementing a single PBM model. Stakeholder recommendations focused on transparency, efficient and streamlined processes, care coordination, data systems and data sharing, and DMAS oversight. Below is a summary of comments provided by stakeholders for these design considerations.

- **Address Transparency.** Throughout interviews, stakeholders emphasized the need for MCOs to provide transparency into the management of their PBMs' financial arrangements and operations. They noted that in the absence of formal contract agreements between DMAS and the PBMs, DMAS must obtain PBM data through the MCOs. The DMAS pharmacy team noted that at times challenges have been incurred in accessing MCO PBM data, even citing denials of data requests, which have necessitated formal mandates.

  Legislators that were interviewed offered that increasing transparency using a single PBM is rooted in Virginia's HB 2007 — a prescription drug price transparency law enacted in 2021. One legislator also noted the need to address the lack of transparency into MCO PBM administrative fees and rebates within the current system. A desire for greater transparency in DMAS' efforts to track drug costs within the pharmacy benefit was also raised.

- **Efficient and Streamlined Processes.** The current structure of the pharmacy benefit has varying appeals, SA, and drug utilization processes across the five MCOs' PBMs. Stakeholders generally appreciated the prospect of the single PBM mandate to streamline operations and improve efficiency. Providers raised concerns regarding the various SA processes they must navigate and are advocates for the single PBM model to simplify administrative processes. Providers offered that reducing administrative burden could enable them to allocate more time to patient care.

  Legislators acknowledged their understanding of the importance of establishing a streamlined SA process, but some also reported they have not received significant concerns from citizens about the current processes. Alternatively, MCOs reference experiences in other states where difficulties are reported to have occurred with timely SA determinations or other inefficient processes under a single PBM model, and they are concerned about potential adverse outcomes associated with these issues. Despite streamlining administrative burden for providers, MCOs

caution there will be an increased administrative burden on the state agency (e.g., additional monitoring and oversight requirements).

- **Care Coordination.** Some stakeholders were concerned about potential impacts to care coordination due to the potential lack of transparency in pharmacy data and/or real-time access to pharmacy utilization data. They also referenced a past DMAS transition of members to a new MCO contract which they felt needed greater transparency, communications, and greater efforts to preserve continuity of services. Stakeholders believed that transparent and consolidated data would improve not only care coordination, but also DMAS' oversight of the program. DMAS team members also acknowledged the importance of ensuring that MCOs have access to DMAS data systems to minimize care coordination disruptions during the transition to the new model.

- **Data Systems.** MCOs stated a strength in the current model is each MCO's ability to address pharmacy claims promptly. Having a real-time or near real-time view into pharmacy claims activity is important to the MCOs for a number of internal activities, as well as care coordination and case management. Some stakeholders are concerned potential challenges may arise when developing the single PBM model that would impede timely access to pharmacy claims data, such as real-time access by the MCOs and their care coordinators or case managers to claims data in the single PBM system.

  Currently, MCOs are contractually obligated to share claims data with DMAS. However, several stakeholders are concerned that a single PBM would disrupt data sharing between DMAS and the health plans. The DMAS Managed Care and Operations team recommended a thorough review of data integration with the MCOs and DMAS before implementation to overcome potential barriers MCOs may face in care coordination.

  MCOs also raised potential concerns that regulatory reporting challenges may become more complex under single PBM models, as data is not separated by MCO which could lead to bundled reporting that reduces transparency.

- **DMAS Oversight.** Provider associations referenced the need for enhanced DMAS oversight, coordination, and communication with any PBM transition. They indicated DMAS should improve communications to providers in areas, such as changes to FFS reimbursement schedules, conditions for drug coverage, and PDL decisions. They also expressed a need for additional education about Medicaid provider enrollment processes as pharmacists sometimes struggle to understand how to enroll. They believe the transition to a single PBM could reduce member confusion that occurs when transitioning between various health plans, which typically happens when a member re-enrolls in Medicaid or a new MCO is onboarded. A DMAS representative acknowledged the need to ensure access to data, documentation, and details necessary to support DMAS oversight of the single PBM.

  Stakeholders recommended DMAS take a more active role in oversight and compliance and establish greater accountability of the MCOs, PBM, and other current vendors, as well as the new single PBM vendor. Stakeholders also recommended that DMAS and the single PBM ensure proper communication with provider and other stakeholders. Finally, stakeholders offered that

DMAS should establish an oversight process to minimize or prevent disruptions in care and avoid member and provider confusion during the transition to the single PBM.

Stakeholder Feedback: Financial Considerations

While HB 2610 does not impact pharmacy reimbursement and no legislative funding was provided to change pharmacy reimbursement, stakeholders consistently raised this topic. Due to the number of comments received from stakeholders, we have included their feedback below. However, we suggest DMAS work closely with stakeholders to clarify the legislation and steps that would be necessary for an increase in pharmacy reimbursement to be considered.

During the stakeholder interview process, many stakeholders shared concerns with the current reimbursement, dispensing fee, and rebate structure. Several independent providers noted that drug coverage, outside the CCF, varies across the five MCOs' PBMs, causing an administrative burden as well as a financial burden to stock medications due to inconsistent coverage. While some providers suggest that a single formulary or PDL could reduce costs, MCOs indicated the current model provides them with an opportunity to be competitive in the market by differentiating their drug coverage from their competitors. Provider associations expressed that they believe a single PBM could help to alleviate the financial issues community pharmacies face in rural areas through increased reimbursement and a unified formulary.

A summary of financial consideration feedback received from stakeholders is provided in the following.

- **Reimbursement and Dispensing Fees.** Legislators shared that the mandate to move to a single PBM was driven, in part, by pharmacists' reports of poor reimbursement from MCOs/PBMs. Stakeholders, particularly provider associations, discussed challenges with Medicaid MCO reimbursement and dispensing fees that are contributing to an increasing number of counties without a pharmacy. They noted reimbursement differences in the managed care model between chain and independent pharmacies, which was reported to be a factor for the closures of independent pharmacies in rural areas. The Virgina Board of Pharmacy suggested that uniform reimbursement increases may not be fair to independent pharmacies, as chain pharmacies have greater buying power, and perhaps independents should be reimbursed higher than chains. However, one legislator shared that national pharmacy chains are refusing to accept low reimbursements from large MCO health plans which can create greater access issues. Additionally, stakeholders reported the MCO PBMs' dispensing fees are low than FFS resulting in pharmacies incurring losses, and low reimbursement becomes particularly problematic with high-cost specialty prescriptions.
- **Formulary Determinations.** Some stakeholders offered that movement to a single PDL inclusive of all drug classes, versus the current CFF, may result in savings. However, MCOs report that open classes under the CCF allow them to customize coverage of drugs, better meet members' needs, and customize utilization management strategies that result in more cost-effective spending.
- **Financial Comparisons.** The Virginia Association of Health Plans urged our consideration of covered populations in managed care when comparing pharmacy costs across different states,

as Virginia covers the aged, blind, and disabled population in managed care, whereas other states may not.

- **Transparency.** Some stakeholders shared concerns that there is a lack of transparency regarding rebates collected by the MCOs, dispensing fees and reimbursement amounts paid by the health plans and their PBMs, and they encouraged our attention to these during our study.

Virginia Pharmacy Access Considerations

Provider associations and legislative stakeholders in Virginia expressed support for transitioning to a single PBM model as one way to improve access. While not included in HB 2610, they relay this would be done largely by enhancing reimbursement methodologies. Movement to a single PDL was also envisioned to alleviate administrative burdens on pharmacies as well as prescribers.

- **Pharmacy Deserts.** Legislative stakeholders discussed the closures of independent pharmacies and the increased burden on remaining pharmacies to comply with multiple PBM requirements. Provider associations, such as the Virginia Community Pharmacists Association, highlight that many rural pharmacies have closed, including 18 pharmacies in Shenandoah Valley, exacerbating access issues, particularly for patients who rely on face-to-face interactions for their health care needs. One vendor emphasized the importance of providing timely and correct medications and advocates for the Commonwealth's focus on addressing access gaps in pharmacy desert areas. Additionally, there are concerns among stakeholders that if more independent pharmacies continue to close, patients will lose access to services that cannot be delivered via mail-order, such as immunizations.
- **Mail Order Services.** Some stakeholders suggested that mail order services are considered an efficient option to address rural access concerns. However, other stakeholders pointed out their significant concerns about mail order's reliability, especially regarding untimely drug delivery or that prescriptions could be left in conditions, such as heat, which could affect their stability. Concerns were also raised that mail order may not be a viable option for individuals who do not have a permanent residence or those experiencing homelessness. Stakeholders also voiced concerns over patient acceptance of use of mail order services and cautioned that this option may not fully address the access issues faced by rural and underserved populations.
- **Administrative Burden.** Several stakeholders suggested that working with many MCOs and their PBMs brings difficulty from an administrative standpoint and contributes to some pharmacies' reluctance to enroll in Medicaid and provide sufficient access for Medicaid recipients. They report a single PBM could alleviate administrative burden by allowing one PBM to control activities, such as PAs, appeals, and DUR processes. Some providers offered that the pharmacy network should include all pharmacies willing to enroll in Medicaid versus limiting opportunities for pharmacies to join the MCO PBM's provider network. Additionally, providers also offered that implementing a centralized credentialing process would significantly reduce administrative burden and streamline processes for provider enrollment.

Stakeholder Feedback: Single PBM Contract Considerations

Contract considerations were also raised by stakeholders who expressed that a strong contract with enhanced PBM accountability could address some of their concerns. They suggested that the structure of the contract is crucial in establishing PBM compliance with MCO and DMAS expectations, strengthening DMAS's oversight, and enforcing compliance with performance metrics. Stakeholders also recommended formally defining the term "critical access pharmacy", improving pharmacy network(s), establishing minimum reimbursement and dispensing fee structures, and implementing service-level agreements (SLAs) to create safeguards and drive PBM accountability.

Virginia Pharmacy Reimbursement and Dispensing Fee Analyses

As required by the legislature of this study, Myers and Stauffer conducted a variety of reimbursement and dispensing fee analyses for the DMAS pharmacy program. This analysis was performed to better understand MCO reimbursement levels and how these may contribute to pharmacy participation levels and ultimately member access to pharmacy services. Below is a summary of our findings.

DMAS had 63,780,005 MCO pharmacy claims totaling $8,033,394,336 in expenditures across SFY23 through SFY25. *Table 5* shows the total numbers of claims paid, the total amount paid, and the percentage change for each SFY. The number of MCO pharmacy claims declined over the three fiscal years; however, total expenditures increased.

Table 5: MCO Pharmacy Claims and Expenditures by SFY

MCO Pharmacy Claims and Expenditures by SFY				
SFY	**Total Number of Paid Claims**	**Percent Change in Number of Paid Claims**	**Total Amount Paid**	**Percent Change in Total Amount Paid**
2023	21,762,486		$2,544,710,253	
2024	21,236,497	-2.4%	$2,651,448,919	4.2%
2025	20,781,022	-2.1%	$2,837,235,163	7.0%
Totals	**63,780,005**		**$8,033,394,336**	

Myers and Stauffer analyzed four categories of MCO pharmacy claims: brand non-specialty, generic non-specialty, brand specialty, and generic specialty drugs. These categories have varying impacts on ingredient reimbursement and average dispensing fees as they make up a different proportion of the total MCO pharmacy claims. *Table 6* summarizes the ingredient reimbursement in terms of the average amount paid as a percentage of AWP and the average dispensing fee for each category across SFY23 through SFY25. Note AWP is the published list price for a drug sold by wholesalers to retail pharmacies and non-retail providers. It is similar to a sticker price and used as a starting point for negotiation for payments to retail pharmacies under many commercial PBM contracts, including those used by managed care plans. Average MCO PBM dispensing fees increased from SFY23 to SFY25 in all four categories. *Appendix C. Data Analysis Exhibits* details the pharmacy reimbursement for all three SFYs by category.

Table 6: MCO Pharmacy Reimbursement and Dispensing Fee SFY23 through SFY25

MCO Pharmacy Reimbursement and Dispensing Fee SFY23 through SFY25			
Drug Category	**Ingredient Reimbursement**	**Dispensing Fee**	**Volume**
Brand (non-specialty)	Paid approximately 79% of AWP each year.	Average increased from $2.00 to $2.32	9.27% of claims 35.98% of expenditures.
Generic (non-specialty)	Slight decrease in average ingredient paid as percentage of AWP from 14.43% to 12.75%	Average increased from $0.82 to $1.08	89.27% of claims 13.73% of expenditures.
Specialty (brand)	Paid approximately 78% of AWP each year.	Average increased from $1.91 to $3.34	1.10% of claims 47.49% of expenditures.
Specialty (generic)	Slight increase in average ingredient paid as percentage of AWP from 59.22% to 61.53%	Average increased from $2.02 to $2.57	0.35% of claims 2.79% of expenditures.

Chain versus Independent Pharmacy Reimbursement Analysis

During interviews, many stakeholders shared concerns with current reimbursement and dispensing fees for chain pharmacies versus independent pharmacies. Myers and Stauffer analyzed the ingredient amount paid as a percentage of AWP and the average dispensing fee for chain versus independent pharmacies for MCO pharmacy claims for three state fiscal years.

Table 7 provides a summary comparison for ingredient reimbursement in terms of the average amount paid as a percentage of AWP and the average dispensing fee paid between chain and independent pharmacies. Ingredient reimbursement was approximately the same for all categories except for specialty brand drug claims, which were reimbursed at a higher average amount paid as a percentage of AWP for chain pharmacies than for independent pharmacies. Chain pharmacies also received a higher average dispensing fee than independent pharmacies for brand specialty. All other categories had higher average dispensing fees for independent pharmacies than for chain pharmacies. See *Appendix D. Chain and Independent for* pharmacy reimbursement by category for SFY23 through SFY25.

Table 7: Chain Versus Independent Pharmacy Reimbursement and Dispensing Fee SFY23 through SFY25

Chain versus Independent Pharmacy MCO Reimbursement SFY23 through SFY25		
Category	**Ingredient Reimbursement**	**Dispensing Fee**
Brand (non-specialty)	Approximately equal across chains and independents.	Independent pharmacies received higher average dispensing fees.
Generic (non-specialty)	Approximately equal across chain and independents.	Independent pharmacies received higher average dispensing fees.
Specialty (brand)	Chains received higher ingredient reimbursement.	Chains received higher average dispensing fees.
Specialty (generic)	Approximately equal across chains and independents in most recent year.	Independent pharmacies received higher average dispensing fees.

Related versus Non-related Party Pharmacy Reimbursement Analysis

During interviews, many stakeholders shared concerns about transparency and current reimbursement and dispensing fees for related-party pharmacies versus non-related party pharmacies. Related parties often occur due to vertical or horizontal integration where a shared financial relationship exists among the parties (e.g., a pharmacy owned by a PBM or MCO). Myers and Stauffer analyzed the average ingredient paid as a percentage of AWP and the average dispensing fee paid to related and non-related party pharmacies for MCO pharmacy claims by state fiscal year.

Table 8 provides a summary comparison for ingredient reimbursement in terms of the average amount paid as a percentage of AWP and the average dispensing fee paid between related and non-related party pharmacies. Ingredient reimbursement was approximately the same for both brand and generic non-specialty categories. For SFY24 and SFY25 specialty brands and specialty generics were reimbursed at a higher average amount paid as a percentage of AWP for non-related party pharmacies than for related party pharmacies. Non-related party pharmacies had a higher average dispensing fee for brand non-specialty, generic non-specialty, and generic specialty claims. Related-party pharmacies had a higher average dispensing fee for brand specialty claims. See *Appendix E. Related Versus Non-Related Party* for pharmacy reimbursement by category for SFY23 through SFY25.

Table 8: Related Versus Non-Related Party Pharmacy Reimbursement and Dispensing Fee SFY23 through SFY25

Related versus Non-Related Party MCO Pharmacy Reimbursement SFY23 through SFY25		
Category	**Ingredient Reimbursement**	**Dispensing Fee**
Brand (non-specialty)	Approximately equal across all parties.	Non-related party pharmacies received higher average dispensing fees.
Generic (non-specialty)	Approximately equal across all parties.	Non-related party pharmacies received higher average dispensing fees.
Specialty (brand)	For SFY24 and SFY25 the average ingredient amount paid as a percentage of AWP was more than 4% higher for non-related party pharmacies than for related-party pharmacies.	Related party pharmacies received higher average dispensing fees.
Specialty (generic)	For SFY24 and SFY25 the average ingredient amount paid as a percentage of AWP was at least 11.50% higher for non-related party pharmacies than for related party pharmacies.	Non-related party pharmacies received higher average dispensing fees.

In-State Rural versus Urban Pharmacy Reimbursement Analysis

During interviews, many stakeholders shared concerns with current reimbursement and dispensing fees for urban pharmacies versus rural pharmacies. Myers and Stauffer analyzed the ingredient amount paid as a percentage of AWP and the average dispensing fee for urban versus rural pharmacies for MCO pharmacy claims for three state fiscal years. Urban versus rural designation was performed only for pharmacies located in Viriginia. CMS provides a designation by zip code for rural versus independent.

Table 9 provides a summary comparison for ingredient reimbursement in terms of the average amount paid as a percentage of AWP and the average dispensing fee paid between in-state urban and rural

pharmacies. Ingredient reimbursement was approximately the same for brand non-specialty and generic specialty. Ingredient reimbursement was slightly higher for urban pharmacies for generic non-specialty claims. Specialty brands were reimbursed at an approximately 5% higher average amount paid as a percentage of AWP for rural pharmacies than for urban pharmacies. Urban pharmacies had a higher average dispensing fee than rural pharmacies for generic non-specialty and generic specialty. Rural pharmacies had a higher average dispensing fee than urban pharmacies for specialty brand. There were nominal differences in dispensing fees for brand non specialty. See *Appendix F. In-State Urban Versus Rural* for pharmacy reimbursement by category for SFY23 through SFY25.

Table 9: In-State Urban Versus Rural Pharmacy Reimbursement and Dispensing Fee SFY23 through SFY25

In-State Urban Versus Rural Pharmacy MCO Reimbursement SFY23 through SFY25		
Category	**Ingredient Reimbursement**	**Dispensing Fee**
Brand (non-specialty)	Approximately equal between urban and rural.	Approximately equal between urban and rural in most recent year.
Generic (non-specialty)	Urban pharmacies received slightly higher ingredient reimbursement.	Urban pharmacies received higher average dispensing fees.
Specialty (brand)	Rural pharmacies received approximately 5% higher ingredient reimbursement.	Rural pharmacies received higher average dispensing fees.
Specialty (generic)	Approximately equal across urban and rural pharmacies in most recent year.	Urban pharmacies received higher average dispensing fees.

Review of Other States' PBM Contracting Strategies

As indicated in our methodology, Myers and Stauffer researched PBM contracting strategies used by state Medicaid agencies. We narrowed our review to seven state programs that illustrate the range of Medicaid PBM contracting strategies used across the nation. Our findings are organized as follows:

- **States with Single PBM Contracts:** Kentucky, Louisiana, Mississippi, and Ohio.
- **States with Pharmacy Managed Care Carve-Out:** New York and West Virginia.
- **State with Pharmacy Managed Care Carve-In:** Washington State.

Table 10 provides high-level information for our study states and is followed by detailed summaries for each state pharmacy program.

Table 10: High-Level Overview of Study States

State	Approximate Enrollment (In millions)[34]	Percent Managed Care[35]	No. MCOs	Annual Drug Expenditure (SFY 24)[36]	Contracting Strategy	Legislatively Mandated?	Year Implemented
Virginia[37]	**1.7M**	**91%**	**5**	**$2,682,626,785**	**Carve-In**	**N**	**2018**

[34] Data.Medicaid.Gov, State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data (Aug. 2025). SFY24 is the average of monthly enrollment data published by CMS. Virginia enrollment data was provided by DMAS.
[35] The percent of total enrolled population in managed care is taken from the most recent available CMS dataset (2022).
[36] Unless otherwise noted, expenditure data was taken from Data.Medicaid.gov, *State Drug Utilization Data* (2023).
[37] DMAS Enrollment Report (Jul. 2024).

State	Approximate Enrollment (In millions)[34]	Percent Managed Care[35]	No. MCOs	Annual Drug Expenditure (SFY 24)[36]	Contracting Strategy	Legislatively Mandated?	Year Implemented
Kentucky	1.4M	90%	5	$2,282,511,779	Single Managed Care PBM FFS PBM	Y	2021
Louisiana	1.6M	85%	6	$2,552,949,064	Single Managed Care PBM[38] FFS PBM	N	2023
Mississippi	0.6M	43%	3	$642,154,317	Single PBA	N	2024
Ohio	2.8M	86%	7	$4,451,034,773	Single Managed Care PBM FFS PBM	Y	2022
New York	6.6M	74%	17	$10,150,657,088	Carve-Out	Y	2023
West Virginia	0.5M	79%	4	$860,990,429	Carve-Out	N	2017
Washington	1.8M	84%	5	$1,595,318,083	Carve-In	N	Early 2010s

These states collectively demonstrate that while the structure of Medicaid pharmacy models vary by state, common themes emerge for desired features: transparency, administrative alignment, rebate retention, pharmacy network stability, and PBM accountability. The experience of these states provides a practical foundation for DMAS to use in tailoring a PBM model design to best meet the needs of Medicaid members, pharmacies, and policy priorities.

Kentucky

The Kentucky Department for Medicaid Services (DMS) employed a pharmacy carve-in model through which multiple MCOs managed the Commonwealth's Medicaid pharmacy benefit prior to moving to its current single PBM model. Under the carve-in model, each MCO subcontracted a PBM to administer pharmacy benefits for its members. This model reportedly presented several challenges for the Commonwealth, including increased administrative burdens, varying PDLs, concerns over low reimbursement to independent pharmacies, and spread pricing. A study by the Kentucky Cabinet for Health and Family Services found that PBMs earned more than $123 million from spread pricing in 2018.[39]

Total Medicaid Enrollment (SFY 2024):
1,384,304
Annual Drug Expenditure:
$2,282,511,779
Pharmacy Contracting Strategy:
Single Managed Care PBM, FFS PBM

To address these issues, DMS implemented several initiatives over recent years, including implementation of a single PDL across the FFS and managed care delivery systems in January 2021. Additionally, the following legislative mandates over the past five years have significantly shaped Kentucky's Medicaid pharmacy program:

[38] Effective October 1, 2025, Louisiana transitioned back to a pharmacy carve-in model.
[39] Kentucky Cabinet for Health and Family Service Office of Health Data Analytics Department for Medicaid Services, Medicaid Pharmacy Opening the Black Box (2019).

- **SB 50 (2020):**[40] SB 50 required DMS to procure a single PBM to manage pharmacy benefits for all Medicaid MCO members and aimed to address administrative inefficiencies, pharmacy reimbursement issues, and spread pricing. SB 50 was designed to improve transparency, eliminate spread pricing, increase the Commonwealth's oversight and control over reimbursement and PDLs, and reduce costs by increasing rebates received by the Commonwealth while benefiting Medicaid members and independent pharmacies. The Bill also prohibited the single PBM from reducing payments to pharmacy providers for their services, imposing fees on pharmacies or Medicaid members without DMS approval, directing Medicaid members to specific pharmacies, mandating the use of mail order pharmacies, and establishing discriminatory reimbursement methodologies against pharmacies owned or contracted by a 340B covered entity.
- **SB 188 (2024):**[41] SB 188 included regulations over PBMs across all insurance markets and became effective for contracts on January 1, 2025. It requires PBMs and insurers to maintain adequate pharmacy networks and prohibits patient steering to ensure reasonable and fair access for individuals. SB 188 mandated annual reporting and oversight by the Insurance Commissioner and established a minimum dispensing fee of $10.64 per prescription for independent pharmacies (excluding chain pharmacies). The reimbursement model was also updated to include the National Average Drug Acquisition Cost (NADAC) plus a $10.64 dispensing fee to ensure fair payment and reflect the actual cost of dispensing.

Driven by legislation, strong advocacy from pharmacy providers, and a call for transparency in the MCO pharmacy benefit, DMS issued an RFP in 2020 and awarded a single MCO PBM contract to begin operations in July 2021.[42] DMS also maintains a separate "FFS PBM" contract to administer benefits for the FFS population and to provide other pharmacy management services. This FFS PBM contract was most recently procured and implemented in 2024. DMS awarded MedImpact as the PBM for both contracts.[43] Additionally, DMS also has a "pharmacy consulting services" contract for a vendor that provides procurement and PBM contract implementation support and assists DMS with ongoing oversight and subject matter expertise for its Medicaid pharmacy program.

DMS holds a no-cost contract with the single MCO PBM vendor. Under this arrangement, the Commonwealth does not directly pay the PBM for its services. Instead, the PBM contracts with each MCO and invoices the MCOs for the total cost of processed pharmacy claims. The MCOs are at risk for pharmacy services and are responsible for paying the PBM. Payments include the cost of pharmacy claims and PBM administrative fees, which are both included in the MCO capitation rates. Subsequently, the PBM reimburses the pharmacies for the cost of the dispensed medications.

The single MCO PBM manages the majority of PBM functions, while the MCOs retain responsibility for member-facing activities, such as pharmacy lock-in programs, communications, and case management.

[40] SB 50 (2020).
[41] SB 188 (2024).
[42] Note that the Kentucky DMS delayed the contract "go-live date" for one month due to ongoing implementation activities related to prior authorization transition/testing and call center readiness, and operations began August 2021.
[43] Kentucky CHFS, *Pharmacy Policy Branch* (2024).

MCOs also continue to have flexibility in retrospective DUR activities, allowing them to go beyond State and PBM requirements with approval. DMS provides extensive oversight of the PBM, working collaboratively with the PBM and MCOs to resolve identified issues, and assesses penalties on the PBM, when necessary. The MCO contracts do not allow the MCOs to assess penalties on the PBM. DMS retains that authority.

The FFS PBM supports DMS with management of the P&T Committee, PDL and rebates, and MCOs participate in P&T meetings as attendees. MCOs may provide recommendations for the PDL; however, they have limited influence over drug coverage decisions. With respect to rebates, Kentucky participates in the Sovereign States Drug Consortium (SSDC). The SSDC negotiates directly with manufacturers through Optum, while the FFS PBM synthesizes rebate data for DMS; however, the Commonwealth remains the final decision-maker. MCOs do not maintain any separate rebate arrangements.

DMS manages the pharmacy network, and pharmacies are not required to sign a separate agreement with the PBM. This model has streamlined the enrollment and contracting process for pharmacies compared to the previous model requiring separate MCO network contracting. Representatives from DMS Pharmacy Services indicated that the implementation of the single PBM model and streamlined pharmacy enrollment has had a positive impact on access to care. DMS stated the single PBM model has been linked to more consistent reimbursements and improved reimbursement rates, which have been advantageous for independent pharmacies.

In addition to the above findings from research and literature review of publicly available sources, Myers and Stauffer interviewed the Senior Director of DMS Pharmacy Services to obtain additional information about DMS' implementation of the single MCO PBM model. *Table 11* provides an overview of key comments and recommendations provided.

Table 11: State Leader Input on Kentucky's Single PBM Model Implementation

Issue Area	Key Considerations for a State Implementing this Model
State Goals for Implementing a Single PBM Model	• More consistent and streamlined provider network management. • Enhanced transparency in the pharmacy system. • Strengthened oversight and control over the PBM, including reporting requirements.
Successes Experienced by Kentucky	• Simplified provider enrollment; any eligible provider may participate unless restricted. • Complete elimination of spread pricing. • Strong collaboration between DMS and MedImpact allowing DMS to ensure transparency. • Positive feedback from pharmacy providers and members. • Streamlined prior authorization processes, which allowed providers to obtain and submit all necessary items within the MedImpact portal. • Enhanced communication and turnaround times for pharmacy inquiries.
Challenges Experienced by Kentucky	• The highly condensed timeline of approximately 5.5 months for implementation, spanning from contract signature to go-live, created significant strain. For example:

Issue Area	Key Considerations for a State Implementing this Model
	♦ Limited time for benefit setup, testing, and establishing operational details and processes. ♦ Internal agency staffing challenges, as DMS initially relied on 1-2 pharmacists, one policy analyst, and two business analysts who were supported by consultants. DMS added two pharmacists to the Pharmacy Services team in December 2021.
Recommendations	• Thoroughly assess PBM staffing capacity during procurement to avoid service disruptions. • Allow at least 18 months for transition to a single PBM model — from procurement to operations go-live. Allocate six months specifically for benefit setup and testing. ♦ Ensure sufficient agency staffing by hiring internally or engaging consultants to support the transition. Interviewee emphasized that ideally 3-4 pharmacists or 2-3 highly experienced technicians with one pharmacist supported by consultants, as well as a strong project manager, is necessary to manage a transition. ♦ Address small but critical operational details early (e.g., time zones, communication protocols). ♦ Include thorough information and data as part of RFP materials for bidders to best estimate staffing needs (e.g., volume of PA requests). • Plan for stakeholder engagement and clear communication to further support policy changes, such as PDL transitions.

In terms of the fiscal impact of the single PBM model, Kentucky offered that in CY 2021, total pharmacy PMPM costs decreased by 8.6%. DMS attributes this decrease to the implementation of SB 50 and the single PDL. During this time, rebates outpaced increases in MCO claim expenditures.[44] It is estimated that without this implementation, total pharmacy expenditures would have been an estimated $172.5 million higher in 2021 and $110.2 million higher in 2022. The continued growth in 340B utilization moderated overall savings during this period as 340B drug claims are excluded from rebates. Prior to implementation of SB 50, annual total pharmacy PMPM trends increased more than 10% each year for CY 2019 and CY 2020. Between CY 2018 and CY 2020, under MCO management, claim PMPMs increased by an average of 5.7%, while rebate PMPMs declined by 6.9%. This decline was primarily driven by increased 340B utilization and a shift by the MCOs to newly launched generics with lower rebates. However, in CY 2022, PMPM costs increased by 15.9%, which was attributed to MCO claim expenditures outpacing the increase in rebates from the single PDL. While rebates have increased year over year, overall pharmacy costs have also continued to rise in the Commonwealth.

Louisiana

The Louisiana Department of Health (LDH) operated a managed care carve-in model for its five MCOs and their subcontracted PBMs to manage the Medicaid pharmacy benefit prior to implementing a single

[44] Kentucky Cabinet for Health and Family Services, Single Pharmacy Benefit Manager (Sept. 2023).

PBM model. Additionally, LDH manages the FFS pharmacy benefit and contracts with the University of Louisiana Monroe, Magellan (now Prime), and DXC Technology (now Gainwell Technologies) to provide pharmacy administrative services.

Total Medicaid Enrollment (SFY 2024):
1,568,849
Annual Drug Expenditure:
$2,552,949,064
Pharmacy Contracting Strategy:
Single Managed Care PBM, FFS PBM

Under the previous carve-in model, Louisiana stakeholders — specifically independent pharmacies and advocacy groups — voiced significant concerns with this model. Stakeholders noted low reimbursement rates, spread pricing, and pharmacy steering among other concerns.[45] In response to these challenges, the Louisiana General Assembly enacted SB 239 (codified as Act 263) authorizing LDH to remove pharmacy services from managed care, or if found to be more effective and cost-efficient, to administer the pharmacy benefit through one or more PBMs.[46] Further, the Act required LDH to develop a comprehensive plan to administer the Medicaid prescription drug program. The Pharmacy Comprehensive Plan was published in 2020 and includes an analysis of single PBM and carve-out options, as well as a fiscal impact study.[47]

In 2023, LDH conducted a procurement and awarded a zero-dollar contract to Magellan (now Prime) to serve as the State's single managed care PBM. Prime managed the majority of PBM functions, including PAs, claims adjudication, DUR edits and point-of-sale (POS) edits, network management, pharmacy payments, operations of a pharmacy website and 24/7 call center, and standardized processing requirements.[48] The MCOs maintained responsibility for most member-facing activities, DUR escalations requiring secondary reviews, and reimbursement for medication therapy management (MTM). LDH maintained responsibility for management of the single PDL, oversight of P&T Committee and DUR Board, and rebate negotiations.

Additionally, Louisiana implemented the following legislative initiatives, which have further shaped the management of the Louisiana Medicaid pharmacy benefit:

- **Louisiana Revised Statute (RS) 46:460.36 (2018):**[49] Defined "legacy Medicaid rate" as the lesser of (1) published Medicaid FFS rate for ingredient and dispensing cost; (2) the usual and customary (U&C) charge; or (3) the pharmacy's submitted charge. Defined "local pharmacy" as any pharmacy, domiciled in at least one Louisiana parish that contracts with an MCO or an MCO's contractor in its own name or through a pharmacy services administration organization and that has fewer than 10 retail outlets under its corporate umbrella. Created reimbursement requirement for MCOs mandating that local pharmacies be paid no less than the legacy

[45] Louisiana Department of Health Bureau of Health Services Financing, *Medicaid Pharmacy Comprehensive Plan* (2020).
[46] SB 263 (2019).
[47] Louisiana Department of Health Bureau of Health Services Financing, *Medicaid Pharmacy Comprehensive Plan* (2020).
[48] MagellanRx Management
[49] LA Rev Stat § 46:460.36 (2018).

Medicaid rate. In 2023, Louisiana amended its Medicaid State Plan to raise the maximum PDF to $11.81.[50]

- **Louisiana RS § 46:153.3 (2018):**[51] Required LDH to establish a single PDL inclusive of all covered therapeutic drug classes subject to PA.
- **Louisiana RS § 46:450.7 (2024):**[52] Allowed LDH to administer the pharmacy benefit under a carve-in or carve-out model. Prohibits contracted PBMs from engaging in spread pricing, buying or selling Medicaid recipient personal information, or patient steering.

In addition to conducting research into publicly available sources, Myers and Stauffer interviewed two LDH pharmacists to obtain additional information about LDH's implementation of the single PBM model. During this conversation, state leaders noted several challenges experienced during implementation and offered recommendations on lessons learned. One notable challenge came from difficulties with a lack of defined reimbursement rates for pharmacies not identified as "local pharmacies." As discussed above, a 2018 law created a statutory definition and reimbursement methodology for Louisiana pharmacies determined to be local pharmacies. Per contract requirements and state law, the single managed care PBM was to reimburse local pharmacies using the methodology outlined in statute; however, the contract was silent on how all other pharmacies were to be reimbursed leaving room for lack of transparency and consistency. State leaders recommended that if contracting with a single PBM, Virginia should be clear in the beginning about reimbursement methodology expectations.

State leaders additionally noted that though the single PBM is required to maintain an adequate network and adhere to state policies, including strict rules for out-of-state pharmacies, the single PBM tends to rely on its national network rather than meeting state-specific requirements. However, the network does include independent pharmacies and local providers, and LDH reported no significant or widespread issues with network adequacy. While one rural parish was identified as having only one or two pharmacies, state representatives are not currently aware of access problems rising to the level of a pharmacy desert.

In addition to the above findings from research and literature review of publicly available sources, Myers and Stauffer interviewed two LDH pharmacists to obtain additional information about the state's Medicaid pharmacy program. *Table 12* provides an overview of key comments and recommendations provided.

Table 12: State Leader Input on Louisiana's Single PBM Model Implementation

Issue Area	Key Considerations for a State Implementing this Model
State Goals for Implementing Single PBM	• Increased transparency. • Consistent and accurate PA reviews regardless of MCO. • Increase efficiency by having only one pharmacy billing source.

[50] Louisiana State Plan Amendment # 23-0024.
[51] LA Rev Stat § 46:153.3 (2024).
[52] LA Rev Stat § 46:450.7 (2024).

Issue Area	Key Considerations for a State Implementing this Model
Successes Experienced by Louisiana	• Smooth transfer of existing PAs, which were honored to original expiration dates and staggered to reduce disruption. • High compliance rate with the single PDL (97%), which was established prior to transition to a single PBM, providing stability and consistency. • Strong engagement with MCOs, pharmacies, providers, and advocacy groups during design and implementation.
Challenges Experienced by Louisiana	• A very short procurement and implementation timeline of about eight months caused difficulties, including incomplete or truncated readiness review and systems testing. • The structure of LDH's $0 contract with the single PBM limited LDH's ability to impose penalties; enforcement could only occur through MCOs, causing friction and challenges with thorough oversight. • Unclear delineation of responsibilities in contract created challenges between MCOs, the PBM, and LDH (e.g., PA denials, recall notices, escalated DUR/POS edits). • Confusion around member eligibility files and provider enrollment processes led to errors in enrollment and miscommunication between the PBM and providers. • Reimbursement issues occurred during the first month of operations, especially for chain pharmacies; independent pharmacies required protection by state law (FFS rates). • The PBM placed nearly all drugs on auto PA, including opioids and stimulants, against State preference.
Recommendations	• Consider alternative single PBM model where PBM operates as a PAHP independently of MCOs (i.e., the Ohio model). • Develop a strong and detailed RFP with sufficient time to address program design needs. • Allocate at least one year for implementation to allow thorough testing and readiness activities. • Ensure the State has direct authority to oversee and penalize the PBM, rather than relying on MCOs as intermediaries. • Clearly delineate roles and responsibilities in the contracts (e.g., PA denials, recall notices, DUR edits). • Finalize reimbursement policies and enrollment processes for both members and providers before go-live. • Document all decisions in writing. • Ensure internal staffing is sufficient and has programmatic knowledge and resources to manage the program.

Information is not publicly available about the fiscal impact of Louisiana's implementation of a single PBM; however, a 2023 report found that in fiscal year (FY) 2023, the single PDL program achieved nearly $143.7 million in savings, up from $102.8 million in FY 2022, driven by supplemental rebates and market shift savings.[53] Though the single PDL has demonstrated savings, Louisiana determined the single PBM model had not delivered the expected efficiencies and announced that effective October 1, 2025, pharmacy benefit management will be transitioned back to the MCOs. LDH emphasized that collaboration with frontline pharmacists and MCOs will be central to this transition. By requiring MCOs

[53] MagellanRx Management, *Louisiana Medicaid Preferred Drug List Program Overview and Results* (2023).

to again provide pharmacy management, LDH aims to create a more integrated approach to care, one that balances member access, cost control, and the long-term financial stability of the Medicaid program.[54]

Mississippi

Total Medicaid Enrollment (SFY 2024):
617,874
Annual Drug Expenditure:
$642,154,317
Pharmacy Contracting Strategy:
Single PBA

In Mississippi, prior to moving to its current single PBA model, pharmacy claims were carved in to the State's Medicaid managed care program, MississippiCAN (MSCAN), and coordinated care organizations (CCOs) subcontracted PBMs to manage the benefit. Mississippi uses a universal PDL for coverage decisions — an important feature created in 2017 to support the prior pharmacy benefit framework.

On July 1, 2024, the Mississippi Division of Medicaid (DOM) implemented a single PBA model.[55] During transition to a single PBA, the state reportedly experienced a seamless adjustment due to the model being built on existing infrastructure, and reimbursement methodology remaining consistent across the FFS and managed care delivery systems. Rather than issuing a single PBA RFP, DOM expanded an existing contract with Gainwell Technologies (Gainwell), which already served as the FFS fiscal agent and claims processor. As the single PBA, Gainwell also provides pharmacy claims processing and PA reviews for all members.[56]

Key features of Mississippi's single PBA model include:

- **Standardized reimbursement:** Mississippi has standardized its pharmacy reimbursement methodology across both the FFS and MSCAN programs.[57]
- **Electronic PA (ePA) system:** Gainwell conducts PAs through its DUR+ process, which is an ePA system with rules to drive consistency in an effort to reduce administrative burden.[58]
- **Streamlined billing:** The single PBA model aims to streamline billing for pharmacy providers and standardize claim processing across all programs ensuring uniform billing rules and reducing administrative complexity.[59] The managed care contracts require CCOs to pay the single PBA. Pharmacies submit claims to the PBA, which pays the pharmacies, and then invoices the CCOs, which reimburse the PBA using State-provided funds. In addition, timeline constraints are enforced where the CCOs must pay all PBA invoices on the business day following the CCO's receipt of the funds.[60]

[54] Louisiana Department of Health leadership announces key initiatives (2025).
[55] Mississippi Division of Medicaid, *Medicaid to implement single Pharmacy Benefit Administrator July 1, 2024*
[56] Ibid.
[57] Mississippi Division of Medicaid, Pharmacy Reimbursement.
[58] Mississippi Division of Medicaid Universal Preferred Drug List (version 2024).
[59] Ibid.
[60] Mississippi Medicaid Coordinated Care Contract with Magnolia Health Plan, Inc. (2024).

- **Simplified oversight processes:** By consolidating the benefit under a single PBA, DOM reduced the oversight and reporting requirements that had previously been necessary with multiple CCOs and their PBMs.
- **Participation in the SSDC:** DOM reports membership in the SSDC, a drug rebate program that negotiates for rebates that are in addition to those required under the federal rebate program.[61] The State, in consultation with the SSDC, may negotiate supplemental drug rebate agreements, which allows DOM to negotiate additional rebates for non-preferred drugs. These agreements are separate from federal rebates, which Gainwell oversees, and exceed the requirements of the national drug rebate program.[62]

In addition to research and literature review of publicly available sources, Myers and Stauffer interviewed DOM's interim Pharmacy Director to obtain additional information about the single PBA model. The implementation of the single PBA model did not require new staffing or major administrative restructuring, as DOM leveraged its existing staff and vendor relationships. DOM noted that there was minimal stakeholder engagement, and CCOs were cooperative in providing data to Gainwell and the agency. While DOM experienced minimal challenges, they recommended a full 12-18 months to implement a single PBM model to avoid delays. Overall, DOM shared a positive experience in transitioning to a single PBM model but emphasized the need for thorough PA review with coordination amongst stakeholders and multiple tests before launching. *Table 13* provides an overview of key comments and recommendations the state representatives provided.

Table 13: State Leader Input on Mississippi's Single PBA Model Implementation

Issue Area	Key Considerations for a State Implementing this Model
State Goals for Implementing Single PBM	• Reduction in administrative burden from streamlining requirements of multiple health plans under one single PBA. • DOM operated a universal PDL and required CCOs to pay the same reimbursement methodology as FFS prior to implementation of the single PBA. • Medicaid members and providers benefit from smooth transitions (e.g., PA grandfathering, fewer disruptions).
Successes Experienced by Mississippi	• Implementation with Gainwell described as largely seamless; leadership commended vendor performance. • Strong cooperation from CCOs during transition, including extensive meetings and testing. • Lessons learned from other states helped prevent similar problems. Grandfathering of PAs reduced provider and member friction.

[61] Sovereign States Drug Consortium
[62] Mississippi State Plan Amendment Attachment 3.1-A Exhibit 12a pg. 3

Issue Area	Key Considerations for a State Implementing this Model

Challenges Experienced by Mississippi	• Compressed timeline of approximately nine months for implementation.
	• Although some common PA transition challenges were avoided based on lessons learned from other states, merging systems had the following challenges:
	  ◆ Initially, DOM created a PA template that required each CCO to provide PA records to Gainwell's system. However, challenges persisted with template conversion and importing into a singular system. Enhanced coordination and testing efforts amongst DOM, CCOs, and Gainwell led to a smooth transition.
	  ◆ Grandfathering PAs avoided provider/member disruption but may have caused missed rebates.
	• Difficult to quantify fiscal impact.
	  ◆ DOM reported that an increase in pharmacy spend after single PBA implementation may be attributed to the following:
	  1. The lack of historical data.
	  2. The CCOs' PA requirements are comparatively less stringent than those of the single PBA.
	  3. Overall, there was an upward trend in the cost of pharmaceuticals. In addition, DOM began covering GLP-1s for obesity 12 months prior the single PBA implementation.
	• While the rebate process is a success, early operational issues with Gainwell affected rebate invoicing accuracy. After transition, there was difficulty in getting reliable encounter data into the rebate system, which led to over-invoicing.

Recommendations	• Allow a longer implementation period (12-18 months) to ensure sufficient time for system readiness, PA alignment, and testing. • Standardize PA processes and require vendor use of State-approved templates to avoid conversion burdens. • Closely monitor pharmacy spend to separate the impacts of the single PBM/PBA model from broader pharmaceutical cost trends. • Document and apply lessons learned from other states to avoid repeat pitfalls. • Maintain strong vendor oversight and clear accountability for rebate processes.

The interim Pharmacy Director provided insights into the current understanding of the successes of the single PBA model; however, noting that outcomes are not fully known given it is a somewhat recent implementation. The fiscal impact of transitioning to a single PBA has been partially quantified. DOM has observed administrative savings as it now costs less to oversee the CCOs. Although pharmacy claims are technically still funded by the CCOs through their reimbursement to the PBA, the claims payment process allows the State to capture the health care plan tax. Pharmacy spend tracking initiated by DOM with the single PBA implementation shows an increase in costs. However, quantifying overall pharmacy spend historically remains challenging and various analyses have reviewed the upward trend. The increasing national trend in pharmaceutical prices likely contributed to the increased pharmacy spend during this time as well. Additionally, DOM began covering GLP-1s for obesity treatment 12 months prior to the single PBA implementation, further impacting cost evaluations. Currently, there has been no observable monthly pharmacy drug cost savings since implementing the single PBA model, and an increase in claims payments has been noted.

Similar to other states, pharmacy access in Mississippi has been heavily impacted by closures, with the state experiencing some of the highest rates of pharmacy loss in the country.[63] Between 2010 and 2021, Mississippi was among the states with pharmacy closure rates greater than 35%, contributing to a net loss of pharmacies during this period.[64] More than half of Mississippi's counties reported losing pharmacies, with rural and suburban areas facing particularly steep declines compared to urban centers.[65] With about 380 independent pharmacies in the state, many communities, especially those without chain pharmacies, rely on local providers for access to medications and pharmacy services.[66]

Ohio

In 2009, Ohio submitted a SPA to remove the Medicaid pharmacy benefit from its managed care program and to administer it through the FFS delivery system.[67] However, after passage of the Affordable Care Act, the Ohio Department of Medicaid (ODM) reversed course opting to carve the benefit back into managed care program to be administered by its five MCOs.[68] Under this model, each MCO contracted separately with a PBM to manage the pharmacy benefit for their members. Though most of Ohio's Medicaid members are currently enrolled in an MCO, there is a small portion receiving services through FFS. Ohio continued to operate a FFS pharmacy benefit for these members. In the second year of the single PBM contract, ODM amended to add FFS operations.[69]

Total Medicaid Enrollment (SFY 2024):
2,832,501
Annual Drug Expenditure:
$4,415,034,773
Pharmacy Contracting Strategy:
Single Managed Care PBM, FFS PBM

For many years, various stakeholders, including ODM, raised concerns with the carve-in model.[70] Identified problems included reimbursement, rebates, clawbacks, fees, formulary, inaccessible data, contract steering, access to rural pharmacies, and dispensing fees.[71] As a response to stakeholder feedback, ODM engaged a third-party consultant to audit PBM performance in the state.[72] The third-party audit reviewed over 39 million Ohio Medicaid pharmacy claims between April 1, 2017, and March 31, 2018, and found an 8.8% spread between the amount PBMs billed to MCOs and the amount paid to pharmacies.[73] Following publication of this report, the Ohio General Assembly requested the Auditor of the State independently analyze the state pharmacy benefit. The State audit also reviewed more than 39 million claims paid between April 1, 2017, and March 31, 2018.[74] The State audit findings confirmed the third-party findings of approximately a 9% total spread.[75] Additionally, the State Auditor found that

[63] Guadamuz et al., *More US Pharmacies Closed than Opened in 2019-21*, Health Affairs (2024).
[64] Id.
[65] Id.
[66] Gwen Dilworth, *'Desperate Times': Independent pharmacies fear closure, due in part to pharmacy benefit managers* (Oct. 8, 2024).
[67] Ohio State Plan Amendment # 09-023 (2010).
[68] Menges Group, *Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States* (Apr. 2015); Royce et al., *Pharmacy benefit manager reform: lessons from Ohio* (2019).
[69] Ohio Department of Medicaid RFP# ODMR- 2021-0020
[70] Ohio Department of Medicaid, *About the SPBM and PPAC*
[71] Id,; Royce et al., *Pharmacy benefit manager reform: lessons from Ohio* (2019).
[72] Health Plan Data Solutions, *Executive Summary Report on MCP Pharmacy Benefit Manager Performance* (2018).
[73] Id.
[74] Ohio's Medicaid Managed Care Pharmacy Services Auditor of State Report (Aug. 2018).
[75] Id.

during this time, PBMs collected $208 million in fees on Medicaid generic drugs, which amounted to 31.4% of the $662.7 million in drug reimbursements paid by MCOs.[76]

To combat spread pricing, ODM moved to a "passthrough" payment model for all PBMs in 2019. Under this model, PBMs were prohibited from charging Medicaid more for a drug than what was reimbursed to the pharmacy. Later that year, the Ohio General Assembly passed HB 166, a two-year budget plan that included a provision requiring ODM to establish a single PBM to operate the Medicaid managed care pharmacy benefit.[77] In 2020, ODM conducted a competitive procurement and awarded the single PBM contract to Gainwell in 2021. ODM, and Gainwell had an 18-month implementation timeline with the ultimate go-live in 2022.

To ensure transparency, eliminate conflict of interest, and allow for maximum flexibility with rate setting, ODM established the single PBM as a PAHP through a 1915b waiver.[78] As a PAHP, Gainwell provides services to Medicaid members under contract with ODM on a non-risk basis meaning the State does not provide a capitation payment for pharmacy services, but rather pays the claims directly. Additionally, the State established a fixed and variable administrative fee structure for the single PBM. The fixed fee covers services, such as PA management and call centers, and the variable fee is based on the volume of claims processed.[79]

Under this model, the MCOs do not retain responsibility for the outpatient drug benefit other than certain clinical programs, such as MTM and care coordination.[80] Gainwell manages all prescriber, provider, and member services; utilization management; claims adjudication and payment; systems and technology; data warehouse, analytics and reporting; and coordinates with the MCOs on their clinical programs. ODM, alongside Gainwell, manages the pharmacy network. ODM works with an additional vendor (currently Optum) to set the unified PDL, manage the P&T Committee, and process federal and state supplemental rebates.[81]

As part of its oversight of the pharmacy program, ODM contracts with a pharmacy pricing and audit consultant (PPAC) for both the managed care single PBM and the FFS PBM. The consultant is responsible for determining reimbursement methodologies, conducting dispensing and ingredient cost assessments, and ensuring the single PBM and the FFS PBM comply with ODM's requirements.[82]

In addition to conducting research into publicly available sources, Myers and Stauffer interviewed ODM's Pharmacy Director to obtain additional information about ODM's implementation of the single PBM model. ODM's Pharmacy Director noted several challenges, successes, and recommendations and indicated that the biggest challenge during transition was the novelty of the program. Specifically, the Pharmacy Director noted that the FFS network could not be "copied and pasted" to create the MCO network, but rather, it had to be "contracted from scratch." Additionally, the biggest lesson learned was

[76] Id.
[77] HB 166 (2019).
[78] Ohio State Plan Amendment #22-0034 (2022); Ohio 1915(b) Waiver OH.0017.R00.00 (2022).
[79] From Myers and Stauffer's interview with Ohio state leader.
[80] Ohio Department of Medicaid, *About the SPBM and PPAC*
[81] Id.
[82] Lawless, *Ohio Medicaid selects Myers and Stauffer as Pharmacy Pricing and Audit Consultant* (Apr. 2021)

regarding PAs. Due to lack of complete PA files from the MCOs, ODM had to turn off all PA requirements for a period of time.

In addition to the above findings from research and literature review of publicly available sources, *Table 14* provides an overview of key comments and recommendations provided by ODM's Pharmacy Director.

Table 14: State Leader Input on Ohio's Single PBM Model Implementation

Issue Area	Key Considerations for a State Implementing this Model
State Goals for Implementing a single PBM Model	• Overarching goals for the program were transparency, accountability, and fairness. • Address the disconnect between pharmacy reimbursement and overall costs to the Medicaid program (spread pricing). • Address potential conflict of interest related to a retail pharmacy chain that is affiliated with one of the Medicaid PBMs and reported reductions in pharmacy reimbursements.
Successes Experienced by Ohio	• Increased accountability and transparency with PPAC. PPAC supports ODM's transparency goal by creating a rate methodology though the use of a survey. • Experienced positive impact on pharmacy network and now have more access for members than ever before. • Have seen a greater number of independent pharmacies opening throughout Ohio due to higher dispensing fees.
Challenges Experienced by Ohio	• The State experienced some minor setbacks after go-live, including difficulties with eligibility checks and with obtaining PA files from MCOs resulting in PA requirements being turned off temporarily.
Recommendations	• Adopt an AAC-based model and set AAC rates specifically for specialty drugs. • Construct a strong RFP and scrutinize RFP responses closely.

In September 2024, ODM engaged its state actuarial firm to conduct a cost effectiveness analysis of the single PBM program based on the first two years of operation.[83] The study found that the single PBM operated the largest, most-inclusive in-state network with over 99% of Ohio pharmacies contracted as in-network providers. Additionally, the study found a significant increase in dispensing fees paid directly to pharmacies with the average dispensing fee around $9 per prescription compared to approximately $0.73 under the previous model. Further, there was a notable reduction in administrative expenses resulting in an estimated $333 million in savings from the first two years. While the report did note that from the data reviewed, pharmacy expenditures under the single PBM were not materially different than under the carve-in model, ODM estimates that they will ultimately see net savings of $140 million in the first two years of the program.

[83] Milliman, *Ohio Single Pharmacy Benefit Manager Experience Analysis* (2024).

New York

Total Medicaid Enrollment (SFY 2024):
6,560,438
Annual Drug Expenditure:
$10,150,657,088
Pharmacy Contracting Strategy:
Carve-Out

Prior to 2023, New York State (NYS) managed care plans administered the pharmacy benefit through a carve-in arrangement, which created wide variability in formulary, PA criteria, and pharmacy networks. However, the FY 2021 Enacted State Budget included a statutory mandate for NYS Department of Health (DOH) to carve the pharmacy benefit out of managed care and into the FFS delivery system effective April 2021. In response to legislative concern over revenue losses due to the State absorbing rebates from health plans, community-based organizations, and 340B providers, the carve-out was delayed by two years. New York fully implemented a carve-out Medicaid pharmacy benefit model known as NYRx in 2023 and now maintains a single statewide formulary with uniform coverage criteria, a single PDL, centralized PA processing managed by the Medicaid FFS program and standardized, consistent rules and regulations.[84]

New York's decision to transition to the NYRx carve-out model was motivated by the following three key priorities:

- **Transparency and accountability.** Under the carve-in model, the use of multiple PBMs and varied contracting arrangements obscured pricing mechanisms and allowed anticompetitive behavior, such as spread pricing and deceptive marketing practices.[85]
- **Rebate maximization.** By administering pharmacy benefits through FFS and establishing rules, particularly around the use of 340B drugs, New York could maximize rebate revenue.
- **Access.** The new model would provide broader pharmacy access by removing narrow MCO networks and authorizing over 5,000 participating pharmacies statewide.[86]

NYS DOH led implementation of NYRx in collaboration with Prime, which administers PA, provider support and education, supplemental and preferred diabetic supply rebate negotiation, and federal and supplemental rebate administration. Pharmacy claims processing is performed through eMedNY, NYS's Medicaid Management Information System (MMIS). NYS DOH created the NYRx Transition Workgroup, which included patient advocates, providers, pharmacies, and plan representatives to support continuity of care and identify transition-related issues.[87] Planning and implementation for NYRx began in 2020 to target the initially planned implementation in 2021, and included activities such as the following:

- **Beginning July 2020:** NYS DOH began transition activities with stakeholders and vendors to address transition topics, including communication timelines, provider enrollment, and data sharing. General stakeholder meetings occurred monthly, and NYS DOH held planning meetings

[84] New York State Department of Health, Information about Medicaid's Prescription Drug Benefit and Changes Effective April 2023
[85] New York State Department of Financial Services, DFS Superintendent Adrienne A. Harris Announces Proposed Nation-Leading Regulations for Pharmacy Benefits Managers (Aug. 2023).
[86] Pharmacist Society of the State of New York, Governor Hochul Launches New Statewide Medicaid Pharmacy Benefit Program (Apr. 2023).
[87] New York State Department of Health, Transition of Pharmacy Benefit from Managed Care to NYRx All Stakeholders Implementation Meeting (May 2023).

with MCOs and led a 340B advisory group.[88] NYS DOH also conducted data analyses during 2020 to support continued medication access for members. New York published formal transition communications, hosted stakeholder webinars, and released the NYRx Provider Communications Toolkit.[89]

- **January 2023-March 2023:** New York initiated system testing and claims readiness validation. Pharmacy system upgrades and coordination with electronic health record vendors occurred.
- **April 2023-June 2023:** During this transition period, NYS DOH implemented a plan for coordination of existing prior authorizations to assure continuity for members and to avoid providers needing to request new authorizations. NYS DOH provided members a one-time temporary fill for up to a 30-day supply for prescriptions that typically required prior authorization. Prescribers were instructed to either seek PA during this transition period or to change to a preferred drug that did not require PA. PAs issued by MCOs prior to April 1, 2023 were also honored. Additionally, NYS DOH and its vendor worked with the MCOs to transfer all PA approvals to avoid providers needing to seek new ones. New York monitored all operations and processes to make adjustments to systems and resources where necessary.

In addition to the above findings from research and literature review of publicly available sources, Myers and Stauffer interviewed the NYS DOH Director of Pharmacy Services to obtain additional information about New York's implementation of the carve-out model. *Table 15* provides an overview of key comments and recommendations the state representatives provided.

Table 15: State Leader Input on New York's Carve-Out PBM Model

Issue Area	Key Considerations
State Goals for Implementing Carve-Out Model	• Consistency in how the benefit is administered throughout the state. • Reduced cost to New York. • Reduction in administrative burden for the state.
Successes Experienced by New York	• Because of the delay in implementation, the State was able to be very mindful throughout the transition, minimize disruption to members, and to be very thorough in member and provider communications. • The implementation of a 340B ceiling price created significant savings for the State. However, state leaders did indicate this took additional time to do correctly. • State leaders noted that collaboration and relationships between the State and pharmacies has improved under the carve-out model.
Challenges Experienced by New York	• Due to the increased volume of calls, the clinical call center contracts had to be adjusted. • Ensure policies and payments regarding the treatment of 340B claim rules and the impact on providers is considered.
Recommendations	• Be intentional about member and provider communications before and during the transition.

[88] New York State Department of Health, Medicaid Pharmacy Program Archives (January 2021)
[89] New York State Department of Health, Repository.

Issue Area	Key Considerations
	• Utilize contracted project managers to track and organize progress throughout the transition. • Consider carving the Medicaid pharmacy benefit out of managed care.

The NYRx model has widened access to pharmacy services for Medicaid members, particularly in rural and urban underserved areas, by allowing any pharmacy enrolled in Medicaid to dispense covered drugs. This removed previous MCO-specific network restrictions that often excluded independent or non-chain pharmacies. In total, this improves coverage for Medicaid recipients to a statewide network of more than 5,000 pharmacies.[90] Moreover, centralized PA reduced delays in medication initiation, particularly for complex chronic disease management. Patient advocates credit the NYRx structure with decreasing access barriers for transgender individuals, human immunodeficiency virus positive patients, and those requiring specialty medications.[91]

Additionally, NYS DOH estimated that transitioning to NYRx would yield over $400 million in annual savings, mostly stemming from enhanced rebate retention through better negotiation power.[92] However, these financial savings estimates have been largely offset by reimbursement commitments the State made to health care providers. To secure support for the carve-out, the State promised to reimburse 340B providers for lost revenue, of which totaled $519 million.[93] Additional time is required to understand the true fiscal impact of NYRx implementation.

The implementation of NYRx underscores the importance of strategic planning, stakeholder engagement, and communication in large-scale benefit transitions. While the program achieved its primary goals of transparency, rebate maximization, and standardization, it also illuminated the sensitivity of providers to financing and structural changes. Stakeholder trust was bolstered by the transparency of NYS DOH's planning process, and the establishment of a 340B reinvestment mechanism was seen as a model for other states exploring similar reforms.

West Virginia

The West Virginia Bureau for Medical Services (BMS) has operated its Medicaid pharmacy benefit as a full carve-out from managed care since 2017 when the State decided to centralize administration under its FFS delivery system.[94] This decision gave BMS full control of drug utilization, reimbursement, and rebate collection. As a result of this transition, all Medicaid members access prescriptions as an FFS benefit with a single PDL, managed by the State in consultation with the State's P&T Committee.[95]

Total Medicaid Enrollment (SFY 2024):
504,320
Annual Drug Expenditure:
$860,990,429
Pharmacy Contracting Strategy:
Carve-Out

[90] Pharmacist Society of the State of New York, Governor Hochul Launches New Statewide Medicaid Pharmacy Benefit Program (Apr. 2023).
[91] Id.
[92] New York State Department of Health, FY 2024 Enacted Budget Medicaid Scorecard.
[93] Hammond, Medicaid Drug 'Carve-Out' Led to Double Payments (Nov. 2023).
[94] Butler, *States Assert their Drug Purchasing Power to Capture Savings for Medicaid*, KFF (Nov. 2019).
[95] West Virginia Bureau for Medical Services. (2023). Chapter 518: Pharmacy services (West Virginia Medicaid Provider Manual).

Myers and Stauffer interviewed the BMS Director of Pharmacy Services who indicated there was provider dissatisfaction with the different PA processes across three MCOs and the length of time required to receive a response. BMS began receiving complaints about this process, concerns about fair reimbursement, and challenges in members receiving their medications. Therefore, in March 2017, BMS announced that beginning July 2017, all Medicaid pharmacy claims would be processed under the FFS program. Based on research and information provided by the BMS Pharmacy Director, key administrative responsibilities are provided internally by BMS and by various contractors as follows:

- Change Healthcare (part of Optum) provides support for PDL management and clinical support.
- The West Virginia University School of Pharmacy Rational Drug Therapy Program (RDTP) provides PA services. The school has 12 pharmacists to support access to a pharmacist regarding PA determinations.
- RDTP also manages the first two levels of appeals, and the third level is handled by the BMS Medical Director and an Appeals Pharmacist. BMS added this one position after implementing the carve-out to support the appeals process.
- Acentra (formerly Kepro) for PA services for specific medications, drugs, and agents that are only available in the "Buy and Bill" program.[96]
- Acentra, formerly Health Information Design, is BMS' retro DUR vendor and conducts initial reviews and referrals for the Retrospective DUR Committee.
- Gainwell provides pharmacy claims processing.
- BMS provides pharmacy data to the MCOs four times daily via an on-line portal. At the end of each day, the MCOs receive a report detailing all prescriptions filled for their members.

The State uses NADAC-based reimbursement for all drugs, combined with a PDF of $10.49 per prescription, which is designed to better align reimbursement with acquisition cost.[97]

The BMS Pharmacy Director indicated that transition to this new model was widely viewed as smoother than expected given the short four-month timeframe. BMS conducted early outreach to members and to providers and pharmacies and through multiple forums (e.g., faxed notices, collaboration with pharmacy associations and medical associations, etc.).

Table 16 provides an overview of additional key comments and recommendations provided by the BMS Pharmacy Director.

[96] West Virginia Bureau for Medical Services, Prior Authorization Criteria.
[97] Navigant Consulting, *Pharmacy savings report: Actuarial assessment of the SFY18 impact of carving out prescription drugs from managed care for West Virginia's Medicaid program* (2019).

Table 16: State Leader Input on West Virginia's Pharmacy Carve-Out Model

Issue Area	Key Considerations for a State Implementing this Model
State Goals for Implementing Carve-Out Model	• Broader access to medications and ensuring continuity of care. • Increased efficiency and consistency in PA processes. • Cost savings for West Virginia.
Successes Experienced by West Virginia	• Reported improved rebate collection, centralized oversight, and reduced administrative duplication.[98] • Greater transparency in pricing and uniform access to medications regardless of MCO enrollment. • Successfully implemented in a four-month timeframe, expanding upon existing infrastructure for the FFS pharmacy benefit. However, additional time for hiring and training new PA staff would have been beneficial for their contractor.
Challenges Experienced by West Virginia	• BMS experienced challenges in cooperation and coordination with MCOs, such as difficulties with obtaining PA files and 24 months of historical claims from MCOs. BMS grandfathered PAs for 90 days to avoid disruptions in patient care. • MCOs raised concerns about care coordination and continuity of care. BMS worked to address these concerns through ensuring availability of data and a clinical portal for MCO case managers. • Due to increased claims volume, BMS' PA vendor had to hire additional pharmacists resulting in some delays due to getting staff up to speed. Additionally, state leaders noted an increased cost for the PA vendor due to increased claim volume.
Recommendations	• Ensure the inclusion of PDL dispensing rules in the system. • Ensure ample time is allowed for implementation of a new PBM vendor contract. • If creating new PDL, allow for a 180-day grandfather period prior to instituting any new PA requirements. Agreeing on file formats takes time, and persistence in getting the necessary files loaded is crucial. • Emphasize continuity of care.

Although West Virginia, like other states across the nation, has had challenges with pharmacy closures, there is indication that access for members improved. Before the carve-out, many pharmacies reported that inadequate reimbursement limited their ability to dispense certain drug classes to Medicaid members.[99] West Virginia's transition to a carve-out model yielded documented savings of over $54 million in the first year alone.[100] The BMS Director of Pharmacy Services attributed the savings primarily to reduced administrative charges and eliminating duplicative systems. Additionally, the State's reimbursement changes provided $122 million in dispensing fees to pharmacists.[101] West Virginia also indicated the potential for increased federal rebates due to improved accuracy when rebate files are generated from one source.[102]

[98] Navigant Consulting, *Pharmacy savings report: Actuarial assessment of the SFY18 impact of carving out prescription drugs from managed care for West Virginia's Medicaid program* (2019).
[99] Custom Rx Solutions, Medicaid Pharmacy Carve Out
[100] NCPA, West Virginia Medicaid saves $54.4 million with prescription drug carve-out (Mar. 2019).
[101] Id.
[102] Custom Rx Solutions, Medicaid Pharmacy Carve Out

Washington

Total Medicaid Enrollment (SFY 2024):
1,867,791
Annual Drug Expenditure:
$1,595,318,083
Pharmacy Contracting Strategy:
Carve-In

The Washington Health Care Authority (HCA) generally uses a carve-in pharmacy benefit model for its Medicaid managed care program where each of the five MCOs operating in the state contract directly with a PBM to manage the pharmacy benefit for their clients. Under this model, the MCOs maintain risk for the majority of drugs. However, HCA has opted to "partially carve-out" subsets of high-cost drugs including hemophilia and hepatitis C drugs.[103] In 2017, the state passed SB 5883 which required HCA implement a single PDL.[104] The goal of the single PDL was to maximize drug rebates while ensuring access to safe and effective drugs.[105] To avoid administrative burden and provider confusion, HCA chose to implement the single PDL in phases beginning in January 2018 with the final phase completed in 2020. Additionally, to ease the transition and maintain access for members, HCA engaged Magellan (now Prime Therapeutics) to provide evidence-based reviews on drugs' safety and efficacy for the state's DUR Board to assist in determining which drugs should be grandfathered and for what duration during the transition to the new single PDL.[106]

In addition to implementing a single PDL, Washington entered into a multi-agency purchasing initiative with AbbVie to purchase Mavyret for state-funded healthcare programs including Medicaid.[107] The contract consists of a value-based supplemental rebate agreement which provides a discount on a specific hepatitis C medication. As part of this modified subscription model, HCA negotiated an annual threshold purchase amount based on the approved state budget. Any additional drugs purchased above the threshold amount cost the state a nominal amount per pill for the remainder of that state fiscal year. Through this program, the cost to treat hepatitis C for Medicaid members is approximately 40% less than it was before the modified subscription model.[108]

In addition to the above findings from research and literature review of publicly available sources, Myers and Stauffer interviewed the HCA Assistant Chief Pharmacy Officer to obtain additional information about the HCA's implementation of its current pharmacy benefit model. Of particular note, the interviewed state leader emphasized the importance of network adequacy for Washington and listed several ways in which HCA works to avoid pharmacy deserts. Measures taken to ensure network adequacy include:

- **Coverage and Inclusion Requirements:** Washington State requires that health plans include critical access pharmacies in their networks. These are entities that are the sole pharmacy

[103] Gifford et. al., *How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020,* KFF (Apr. 2020).
[104] SB 5883 (2017).
[105] Washington State Healthcare Authority, *Apple Health Preferred Drug List: Implementing a Single, Standard Preferred Drug List for All Contracted Medicaid Fee-For-Service and Managed Care Health Systems: Final Report* (Nov. 2019).
[106] Id.
[107] Washington State Health Care Authority and Washington State Department of Health, *Hepatitis C Medications Comprehensive Purchasing Strategies* (Oct. 2019).
[108] Id.

available within a 25-mile radius, ensuring residents in remote areas have access to necessary pharmaceutical services.

- **Special Provisions for Island Pharmacies:** Pharmacies located on islands in Washington State have unique dispensing fees under the FFS program. This helps to maintain their financial viability and ensure continuous operation.
- **Network Adequacy Reviews:** When MCOs bid to provide services in different counties, Washington State conducts network adequacy reviews. This ensures the MCOs have sufficient network coverage, including pharmacy services, before they are approved to operate in those areas.
- **Contractual Obligations:** As part of the procurement process, MCOs must demonstrate their ability to maintain network adequacy, which includes having sufficient pharmacy coverage to meet the needs of the communities they serve, particularly in rural and underserved areas.

Table 17 provides an overview of key comments and recommendations the Assistant Chief provided.

Table 17: State Leader Input on Washington's Pharmacy Managed Care Carve-In Model

Issue Area	Key Considerations for a State Implementing this Model
State Rationale and Objectives for Using Carve-In Model	• Providing the pharmacy benefit to Medicaid members with risk assumed by the MCOs as compared to a carve-out model. • Improved consistency and continuity of care between pharmacy and medical benefits.
Successes Experienced by Washington	• Based on a report referenced by the interviewee, the uniform PDL reduced net expenditures and resulted in cost savings for Washington in 2018 and 2019, its first two years of implementation. • Monitoring of medications for potential carve-out to improve rate setting. • Continued evaluation and reporting the impact of policy changes to the pharmacy benefit model on reducing health care expenditures.
Challenges Experienced by Washington	• Complexity, staffing, and administrative burden of managing multiple different MCOs and PBMs. • New high-cost drugs needing to be carved out due to their high impact and unknown utilization, making rate setting difficult. • Fragmented data coordination between different MCOs and PBMs due to different entities using different data software and/or systems. • Potential lack of care continuity, resulting in barriers to consistent claims management between different MCOs and PBMs.
Recommendations	• Ensure appropriate resources and staffing for contract management, data analytics, timely communication, and PDL management. • Consider drug classes to carve-out when appropriate, such as high-cost drugs with inconsistent utilization that impacts setting rates with MCOs. • Explore the possibility of implementing more uniform standards for MCOs and PBMs, such as a single data system and/or structure.

Analysis of Findings

Comparison of Virginia Pharmacy Program with Study States

To provide a limited comparison of program costs on a PMPM basis across study states, Myers and Stauffer obtained enrollment data for SFY23 through SFY24 and half of SFY25 (ending December 2024) as indicated in *Table 18* and gross drug cost data for the same time period (see *Table 19*). The yearly expenditure for each program is in *Table 18*. This yearly cost was divided by the average enrollment to create an estimated PMPM cost for each program (see *Table 20*).

Table 18: Medicaid Enrollment

Medicaid Enrollment[109]			
State	**SFY23**	**SFY24**	**SFY25**
Virginia	1,935,225	1,892,387	1,740,170
Kentucky	1,484,934	1,384,304	1,261,685
Louisiana	1,712,987	1,564,849	1,383,349
Mississippi	696,828	617,874	524,056
New York	6,882,747	6,560,438	6,011,826
Ohio	3,114,374	2,832,501	2,628,601
Washington	2,085,425	1,867,791	1,784,115
West Virginia	606,775	504,320	472,640

Table 19: Medicaid Drug Expenditure

Medicaid Drug Expenditure[110]			
State	**SFY23**	**SFY24**	**SFY25**
Virginia	$2,563,679,057	$2,682,626,785	$1,456,451,845
Kentucky[111]	Not Available	Not Available	Not Available
Louisiana	$2,683,456,257	$2,552,949,064	$1,172,904,784
Mississippi	$724,741,786	$642,154,317	$278,841,080
New York	$7,803,075,059	$10,150,657,088	$5,378,425,363
Ohio	$4,757,550,117	$4,451,034,773	$2,109,660,779
Washington	$1,639,988,724	$1,595,318,083	$904,186,259
West Virginia	$902,637,765	$860,990,429	$457,741,410

[109] Data.Medicaid.Gov, *State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data* (Aug. 2025). SFY25 is the average enrollment for July 2024 through December 2024. Virginia enrollment data was provided by DMAS.
[110] Medicaid.gov, *State Drug Utilization Data* (Jan. 2025). SFY25 is Medicaid expenditures for July 2024 through December 2024. Virginia claims data was provided by DMAS. Kentucky expenditure data from Medicaid.gov is being reprocessed at the time of report.
[111] Kentucky expenditure data reported by CMS through its website, Medicaid.gov, is in the process of being updated as of the time of this report.

Table 20: Estimated PMPM

Estimated PMPM			
State	**SFY23**	**SFY24**	**SFY25[112]**
Virginia	$110.40	$118.13	$139.49
Kentucky	Not Available	Not Available	Not Available
Louisiana	$130.54	$135.95	$141.31
Mississippi	$86.67	$86.61	$88.68
New York	$94.48	$128.94	$149.11
Ohio	$127.3	$130.95	$133.76
Washington	$65.53	$71.18	$84.47
West Virginia	$123.97	$142.27	$161.41

FFS Program Comparison

One of the legislative requirements for this study was to review FFS pharmacy dispensing fees. For Virginia and the study states' FFS programs, each state utilizes a progressive ingredient cost structure based on a lowest of/lessor of various published price schedules to arrive at the cost basis for the ingredient cost. Kentucky, New York, Ohio, Washington, and West Virginia utilize a state maximum allowed cost (SMAC) in the lowest of/lessor ingredient cost. Virginia, Louisiana, and Mississippi do not have a SMAC. Some states apply specific pricing based on the drug type.

These state Medicaid programs also use PDFs assigned to drug claims based on a variety of criteria, such as pharmacy type, pharmacy annual prescription volume, medication type, etc. Ohio and Washington use annual pharmacy prescription volume to create tiers for dispensing fee payment. The remaining states have a PDF ranging from $10.18 to $11.29.

This information is detailed in *Table 21*. See *Appendix A. Definitions and Acronyms* for ingredient cost definitions and acronyms.

Table 21: FFS Ingredient Costs and Dispensing Fees[113]

FFS Ingredient Costs and Dispensing Fees		
Virginia		
Ingredient Cost	**Dispensing Fee**	**SMAC**
2022-2025 Prescription, non-prescription, specialty drugs, and long-term care (LTC) is the lower of: • NADAC. • Wholesale acquisition cost (WAC). • Federal upper limit (FUL). • U&C. Clotting factor will be the lesser of:	2022-2025 • $10.65	No

[112] SFY25 reflects the PMPM calculated utilizing data from July 2024 through December 2024. Kentucky expenditure data on Medicaid.gov is being reprocessed at time of report. Unable to calculate the PMPM for Kentucky.
[113] Medicaid.gov, *Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State* (Aug. 2025).

FFS Ingredient Costs and Dispensing Fees		
• NADAC. • WAC. • U&C.		
Kentucky		
Ingredient Cost	**Dispensing Fee**	**SMAC**
2022-2025 Legend, non-legend, specialty drugs, and LTC is the lower of: • NADAC. • WAC plus 0%. • FUL. • SMAC. • U&C. • Average sales price plus 6% is included in the lower of logic for clotting factor and physician-administered drugs (PADs).	2022-2025 • $10.64	Yes
Louisiana		
Ingredient Cost	**Dispensing Fee**	**SMAC**
2022-2024 Ingredient cost for brands is the lower of: • NADAC. • WAC • U&C. Ingredient cost for generics is the lower of: • NADAC. • WAC • FUL. • U&C. Beginning October 1, 2023 Clotting Factor: Louisiana clotting factor AAC.	2022-2023 • $10.99 Beginning October 1, 2023 • $11.81 • Clotting Factor: $.03500 per unit dispensed, up to a maximum amount of $1,676.22.	No
Mississippi		
Ingredient Cost	**Dispensing Fee**	**SMAC**
2022-2025 Ingredient cost is the lower of: • NADAC. • WAC plus 0%. • A rate set by DOM's rate setting vendor. • U&C.	2022-2025 • $11.29 • Specialty drugs not dispensed through retail pharmacy and dispensed primarily through mail - $61.14.	No

FFS Ingredient Costs and Dispensing Fees		
• PAD – Clinician Administered Drugs and Implantable Drug System Devices (CADD) reimbursed the lesser of the NADAC, the WAC + 0%, or the providers' U&C charges to the general public.		

New York		
Ingredient Cost	**Dispensing Fee**	**SMAC**
2022-2025 Ingredient cost is the lower of: • NADAC. • WAC less 3.3% (brand). • WAC less 17.5% (generic). • FUL. • SMAC. • U&C.	2022-2025 • $10.18	Yes

Ohio		
Ingredient Cost	**Dispensing Fee**	**SMAC**
2022-2025 Ingredient cost is lower of: • NADAC or U&C. If NADAC is not available, AAC is the lesser of: • WAC (WAC plus 0%). • SMAC. • Provider's U&C. Clotting factor will be the lesser of: • Payment limit shown in Medicare Part B pricing file, minus the furnishing fee. • Provider's U&C.	2022-2023 PDF is tiered: • Less than 49,999 prescriptions per year = $13.64. • Between 50,000 and 74,999 prescriptions per year = $10.80. • Between 50,000 and 74,999 prescriptions per year = $9.51. • 100,000 or more prescriptions per year = $8.30. 2024-2025 • Less than 49,999 prescriptions per year = $15.47. • Between 50,000 and 74,999 prescriptions per year = $11.40. • Between 50,000 and 74,999 prescriptions per year = $9.51. • 100,000 or more prescriptions per year = $8.30.	Yes

Washington		
Ingredient Cost	**Dispensing Fee**	**SMAC**
2022-2023 Ingredient cost is lower of: • NADAC.	2022-2023 PDF is tiered: • Less than 15,000 prescriptions per year =	Yes

FFS Ingredient Costs and Dispensing Fees		
• SMAC. • U&C. • WAC. • State AAC. <u>Beginning October 1, 2023</u> Ingredient cost does not exceed the lesser of AAC + PDF or U&C. AAC is the lesser of: • NADAC. • SMAC. • FUL. • U&C. • Submitted ingredient cost. Where NADAC does not exist, WAC is used as basis for reimbursement.	$5.25. • Between 15,001 and 35,000 prescriptions per year = $4.56. • 35,001 or more prescriptions per year = $4.24. • Unit dose systems: $5.25. <u>Beginning October 1, 2023</u> PDF is tiered: • Less than 30,000 prescriptions per year = $14.30. • Between 30,001 and 69,999 prescriptions per year = $11.91. • 70,000 or more prescriptions per year = $9.80. • Unit dose systems: $14.30.	
West Virginia		
Ingredient Cost	**Dispensing Fee**	**SMAC**
<u>2022-2025</u> Ingredient cost is lower of: • NADAC. • WAC. • FUL. • SMAC. • Submitted ingredient cost. • U&C. Clotting factor - WAC + 0%	<u>2022-2025</u> • $10.49	Yes

Administrative Costs

Estimating the administrative costs of PBMs involves a degree of interpretation and estimation due to several factors. First, we understand that each state's program is unique in multiple ways and that different PBMs administer the benefit for these states. PBMs cover a vast array of services, including formulary management, claims processing, PDL administration, retrospective DURs, PA request adjudication, pharmacy network contracting and auditing, and MTM. The complexity and variability of these services, as well as the populations included in managed care in each state, makes it challenging to provide a truly comparative estimation of administrative costs since different PBMs may offer different combinations of services and pricing models. The volume of prescriptions fluctuates over time, and reported volumes may vary based on the actual timeframe that is used for accruing them. Finally, the lack of publicly accessible contracts and contract amendments makes it difficult to verify price levels, as well as changes in service scope that may have been applied to the services and PBM administrative duties over time.

Table 22 provides a comparison of administrative cost per prescription for the Virginia Medicaid health plans and *Table 23* provides the types of services the respective states have selected to have their PBM(s) perform for them in the administration of the prescription benefit. The types of services offered and the associated administrative charges for providing those services directly influence the cost per prescription experienced by each state. *Table 22* includes the administrative fees for Virginia provided by DMAS, based on actual fees paid. Similar comparisons using actual costs for comparable states are not included due to the reliance on publicly available information.

Table 22: Administrative Cost per Prescription

Administrative Cost per Prescription – SFY23 and SFY24			
SFY23			
Health Plan	**Yearly Administrative Cost**	**Yearly Rx Count**	**Cost per Rx**
Aetna	$4,655,984	3,446,041	$1.35
Anthem	$13,574,372	6,156,889	$2.20
Molina	$1,601,188	1,384,843	$1.16
Sentara	$9,541,498	4,010,681	$2.38
United	$5,261,464	2,067,917	$2.54
Total	$34,634,506	17,066,371	$2.03
SFY24			
Health Plan	**Yearly Administrative Cost**	**Yearly Rx Count**	**Cost per Rx**
Aetna	$5,241,791	3,443,331	$1.52
Anthem	$9,944,464	6,153,622	$1.62
Molina	$1,518,028	1,397,399	$1.09
Sentara	$10,626,251	8,058,570	$1.32
United	$2,751,313	2,183,575	$1.26
Total	$30,081,847	21,236,497	$1.42

Table 23: PBM Administrative Services Provided

Services Provided	KY[114]	LA[115]	MS[116]	NY[117]	OH[118]	VA[119]	WA[120]	WV[121]
Claims processing/adjudication	✓	✓			✓	✓		
Clinical management services (e.g., prospective DUR, PDL, utilization management, etc.)	✓	✓			✓	✓		
MAC pricing and reimbursement oversight	✓							
Rebates								
340B claims handling	✓							
Quality management/assurance	✓				✓			
Web portal	✓				✓			

[114] Commonwealth of Kentucky Request for Proposals No. 758 2000000380 (2020).
[115] LDH, *Request for Proposals for Pharmacy Benefit Management Services for Louisiana Medicaid Managed Care Organizations RFP#: 3000018331* (Jan. 2022).
[116] Mississippi single PBM contract and request for proposal are not publicly available.
[117] New York has a carve out model. Services are handled directly by the State and its vendors.
[118] ODM, *Single Pharmacy Benefit Manager (SPBM) Request for Proposal, DXC Technology-Gainwell Proposal*.
[119] Prime, *DMAS New Pharmacy Benefit Administration Frequently Asked Questions (FAQs)* (2024).
[120] Washington health plans contract with multiple PBMs. Each PBM provides unique services for health plan.
[121] West Virginia has a carve out model. Services are handled directly by the state and its vendors.

Services Provided	KY[114]	LA[115]	MS[116]	NY[117]	OH[118]	VA[119]	WA[120]	WV[121]
Customer service/call center management	✓	✓			✓	✓		
PA processing	✓	✓			✓	✓		
Pharmacy network oversight	✓	✓			✓	✓		
Appeals and grievances	✓				✓			
Pharmacy lock-in					✓			
Fraud, waste, and abuse	✓				✓			

Rebate Analysis

Myers and Stauffer reviewed the percent of rebates collected for both managed care and FFS compared to gross drug expenditures for FFYs 2023 and 2024 for the Medicaid programs of Virginia and the comparison states. We compiled rebate data from the CMS-64 Financial Management Reports and included both federal statutory rebates and state supplemental rebates.[122] With the exception of Virginia, gross expenditure data were compiled from the Medicaid State Drug Utilization Data (SDUD) that was publicly available from CMS.[123] Due to timing differences between the inclusion of claims within the SDUD data set and the invoicing and subsequent collection of rebates, the amounts associated with each time period reviewed do not align directly. Various factors can create variances in the reporting of rebates. For example, a change in benefit design, transition of delivery system, or delays in rebate invoicing processes can act to disjoin the timing and amounts between claims processing and eventual rebate collection. Due to such issues, data was consolidated across both FFY 2023 and 2024 in an attempt to mitigate the impact of some of the year-to-year variances.

Based on this analysis, the median percentage of rebates collected as compared to gross expenditures for Virginia and the other comparison states included in the study is 62% of gross pharmacy expenditures. Virginia was slightly below this median value at 56%. Some state-to-state variability in the percentage of rebates collected should be expected. For example, differences in PDLs maintained by the State or formularies used by specific managed care plans all impact this measurement. *Table 24* shows the average rebate percent of gross expenditures for Virginia and the study states.

Table 24: Average Rebate Percent of Gross Expenditures

FFY 2023 and 2024 Combined			
State	**Gross Expenditure**	**Rebate**	**Average Rebate as Percent of Gross Expenditure**
Virginia	$5,351,697,674	$2,990,645,860	56%
Kentucky[124]	Not Available	Not Available	Not Available
Louisiana	$5,195,780,043	$3,031,558,763	58%
Mississippi	$1,319,779,649	$949,247,792	72%
New York	$18,882,467,865	$12,314,637,576	65%
Ohio	$9,222,687,656	$5,669,534,845	61%
Washington	$3,282,508,746	$2,428,076,539	74%
West Virginia	$1,764,936,626	$1,102,513,723	62%

[122] CMS- 64 Financial Management Report.
[123] Medicaid.gov state drug utilization.
[124] Kentucky expenditure data reported by CMS through its website, Medicaid.gov, is in the process of being updated as of the time of this report.

Transparency and Access Comparison

Chain and independent pharmacy closures have become increasingly common across the United States, which has resulted in the emergence of "pharmacy deserts"— communities that are both low income and lack adequate access to pharmacies. According to a 2024 study, more than 15 million people nationwide live in pharmacy deserts spanning urban, suburban, and rural areas.[125] This pattern of limited access highlights a growing public health concern that extends to Virginia where pharmacy access challenges have also been documented.[126]

Virginia Pharmacy Deserts and Access

The 2025 study published by the Journal of the American Pharmacist Association, analyzed the distribution of pharmacies across the Commonwealth of Virginia and sought to identify strategies to improve equity in access.[127] The study found that pharmacy deserts in Virginia are not confined to rural communities but also exist in urban neighborhoods, often where populations are low income, uninsured, or rely heavily on public health coverage, such as Medicare or Medicaid. In fact, the authors classified 51 of the 2,198 census tracts in Virginia as pharmacy deserts, and 69 tracts as meeting the low access criterion. They noted that in the Commonwealth, pharmacy deserts were most prevalent in urban census tracts (5.5%), followed by rural areas (2.9%), and suburban communities (0.1%).

Importantly, the study revealed that Virginians in pharmacy deserts are more likely to face socioeconomic vulnerabilities, including higher poverty rates, lower median household incomes, and a higher proportion of residents without private insurance. These factors compound the access problem by limiting individuals' ability to seek alternatives, such as traveling farther to obtain prescriptions. The researchers concluded that targeted interventions, such as incentivizing pharmacies to remain in or relocate to underserved areas and ensuring independent pharmacies are included in preferred pharmacy networks, could help mitigate these inequities.

To further support this PBM study, Myers and Stauffer conducted a separate analysis of access to community retail pharmacies that are open to the general public in Virginia. To identify the number of pharmacies suitable for analysis, Myers and Stauffer used the most recent monthly data from NCPDP DataQ, which identified 1,764 active pharmacy National Provider Identifier (NPI) records.[128] We excluded 453 pharmacies that we determined did not meet the criteria of community retail pharmacies open to the general public leaving 1,311 pharmacies suitable for analysis. Using this total, we quantified each zip code to count the number of pharmacy NPI records per zip code. We found that a total of 351 zip codes include one or more pharmacies. *Table 25* provides additional information for the zip codes reviewed.

[125] Rachel Wittenauer, et al., *Locations and characteristics of pharmacy deserts in the United States: a geospatial study, Health Affairs Scholar* (Jan. 2024).
[126] Joseph Boyle, et al., *Characterizing pharmacy deserts and designing a model to minimize inequities in pharmacy distribution in Virginia*, JAPhA (Apr. 2025).
[127] Id.
[128] NCPDP, *DataQ*.

Table 25: Pharmacy Zip Code Comparison

Category	Number of Zip Codes
With Residents	903
With Pharmacies	351
Without Pharmacies	552

Review of the 2020 Census data revealed that Virginia has a population of 8,631,637, with 903 zip codes having residents.[129] Our analysis found that 14.4%, or 1,243,875 residents, live in zip codes without a pharmacy; however, not all these zip codes would be considered a pharmacy desert. Due to very low population density, many of these zip codes would not be expected to be able to support a pharmacy. Between the calculated average and median figures for Virginia, pharmacy deserts were defined as the expectation of approximately 6,000 residents per pharmacy, resulting in 14.9% or 135 of 903 zip codes being classified as such for all Virginians. These were further categorized into urban, suburban/exurban, and rural zip codes utilizing the existing 2020 Rural-Urban Commuting Area codes.[130] *Table 26* through *Table 28* below provide a comparison of Virginia's total population and Medicaid population, as well as tables of pharmacy desert classification and statistics for the entire Commonwealth.

Table 26: Comparison of Virginia Total Population and Medicaid Population

Category	Total Population	Medicaid Population
Total Members	8,631,637*	1,837,805** (21.3% of Virginia residents)
Total Pharmacies	1,311	1,311
Average Population/Members per Pharmacy	6,584	1,402
Median Population/Members per Pharmacy	5,307	1,058
Members in Zip Codes without Pharmacies	1,243,875 (14.4%)	261,624 (14.2%)

***Total Virginia population reported by the 2020 Census.*

***Total Medicaid population derived from Virginia DMAS 2025 data.*

Table 27: Pharmacy Desert Classification in Virginia

Category	Number of Zip Codes
No Pharmacy, Zip Code Population > 6,000	40
Zip Code Population More than 12,000 Residents Per Pharmacy	36
Rural* Zip Code, No Pharmacy, Zip Code Population > 2,000	59
Total	**135**

**Acknowledgement that historically low-density Rural areas were able to support a lower dispensing volume pharmacy.*

Table 28: Pharmacy Desert Statistics for Virginia*

Category	Number of Zip Codes	Percentage
Urban	57	42.2%
Suburban/Exurban	14	10.4%
Rural	64	47.4%
Total	**135**	**100.0%**

***Total Pharmacy Deserts: 135 Zip Codes (14.9%)*

[129] U.S. Census Bureau, *Decennial Census* (2020).
[130] USDA Economic Research Service, *2020 Rural-Urban Commuting Area (RUCA) Codes* (2020).

Data from DMAS shows that the Medicaid population consists of 1,837,805 members, which accounts for 21.3% of Virginia's total population.[131] Our analysis found that 14.2% or 261,624 Medicaid members live in zip codes without a pharmacy. However, not all these zip codes would be considered a pharmacy desert due to very low population density, indicating that many of these zip codes would not be expected to be able to support a pharmacy.

Virginia Pharmacy Deserts

An estimated 160 of 903 Virginia zip codes (17.7%) are classified as pharmacy deserts for Medicaid members.

For purposes of this study, we have defined a Virginia Medicaid pharmacy desert to exist when one of the criteria in *Table 29* is met. *Table 29* and *Table* 30 provide pharmacy desert classification and statistics for Medicaid members, revealing 160 of 903 zip codes (17.7%) being classified as such for Medicaid members.

Table 29: Medicaid Pharmacy Desert Classification

Category	Number of Zip Codes
No pharmacy in a zip code with more than 1,200 Medicaid members.	41
Zip code population with more than 2,400 Medicaid members per pharmacy.	46
Rural* zip code with no pharmacy and 400-1,200 Medicaid members.	73
Total	**160**

**Acknowledgement that historically low-density rural areas were able to support a lower dispensing volume pharmacy.*

*Table 30: Medicaid Pharmacy Desert Statistics**

Category	Number of ZIP Codes	Percentage
Urban	56	35.0%
Suburban/Exurban	16	10.0%
Rural	88	55.0%
Total	**160**	**100.0%**

**Total Medicaid Pharmacy Deserts: 160 Zip Codes (17.7%)*

Figure 1 through *Figure 4* are maps of pharmacy deserts for Virginia as a whole, two urban areas, and one rural area.

[131] *Virginia DMAS 2025 data.*

Figure 1: Virginia Pharmacy Desert Types

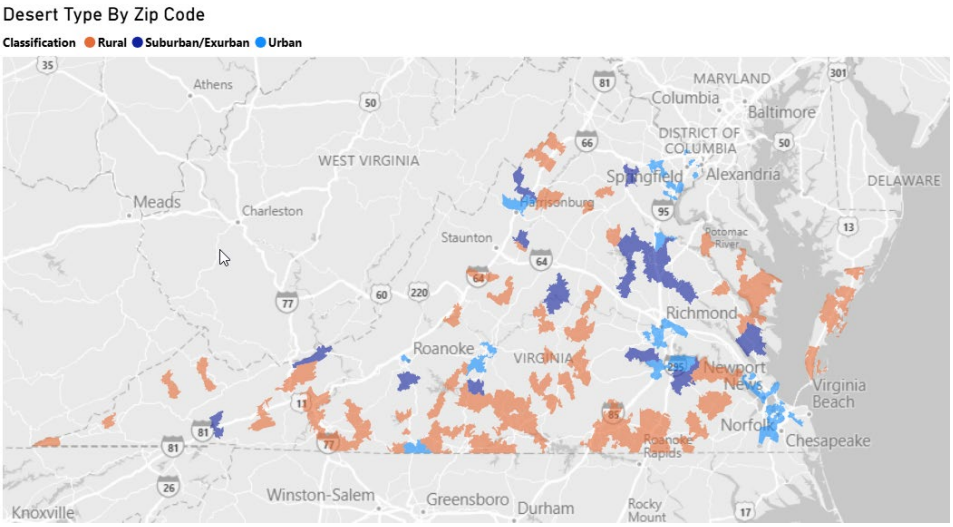


Figure 2: Richmond Pharmacy Desert Types (Urban)

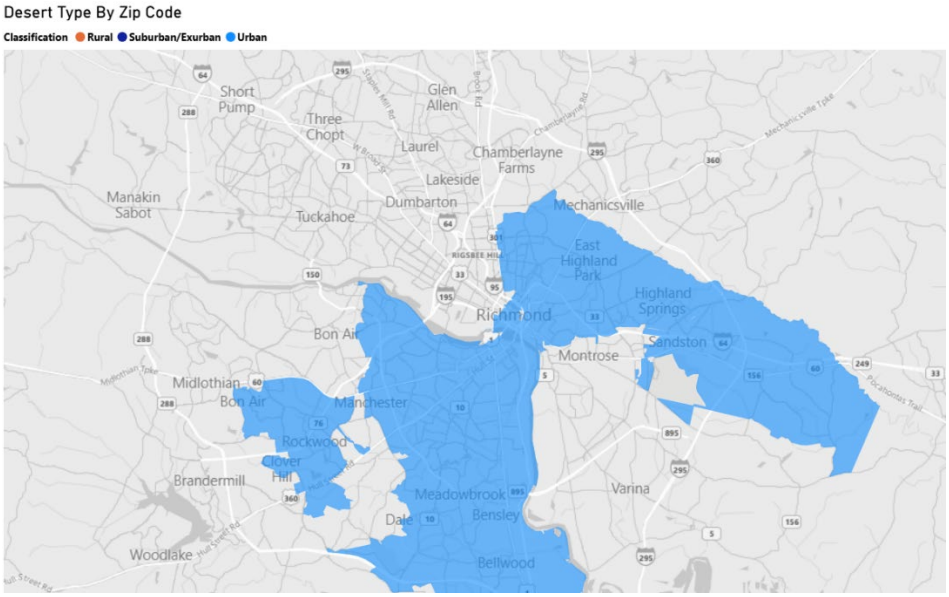


Figure 3: Norfolk Pharmacy Desert Types (Urban)

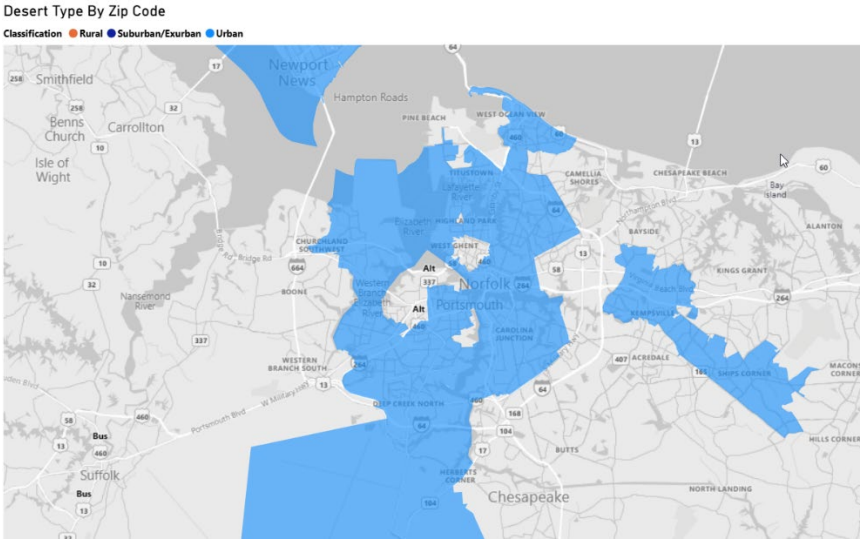
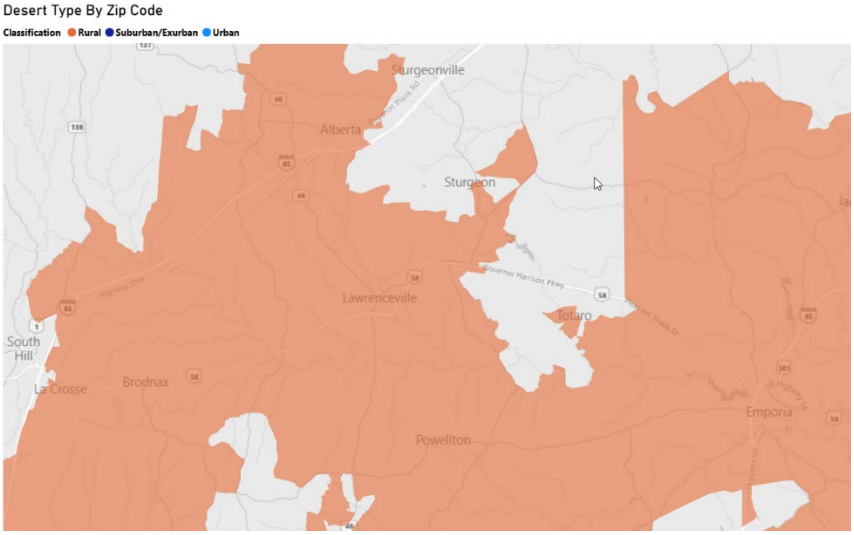


Figure 4: Lawrenceville Pharmacy Desert Types (Rural)



Both the total population and the Medicaid population in Virginia experience similar geographic disparities in access to pharmacies. The percentage of residents living in zip codes without pharmacies is nearly identical for both groups, highlighting a systemic issue that affects all demographics. This notable disparity in pharmacy access — particularly impacting many zip codes — underscores the urgent need to address these gaps. It is important to ensure all residents, especially vulnerable groups, have adequate access to pharmacy services.

Pharmacy Access

Pharmacy access appears to be a systemic issue in Virginia as the percentage of residents living in zip codes without pharmacies is nearly identical for both Medicaid and non-Medicaid populations.

Single PBM Contracting: Options Analysis and Fiscal Considerations

In this section of our report, Myers and Stauffer provides various Medicaid pharmacy program contracting models and programmatic components for DMAS' consideration as it designs and plans for implementation of a contract with a single third-party administrator to serve as its PBM for all Medicaid pharmacy benefits. Based on interviews, research, and application of our industry experience, Myers and Stauffer has identified the following four distinct contracting and payment models in use among Medicaid state agencies for contracting with a single PBM:

- Single PBM: MCO At-Risk.
- Single PBM: MCO Non-Risk.
- Carve-Out PAHP.
- Managed Care Carve-Out.

Each state, however, implements its pharmacy program and PBM contracting requirements differently in areas like risk-bearing parties, contracting, and payment arrangements. Additionally, it is important for DMAS to consider the varying options for programmatic components for its single PBM contract design, such as responsibilities for network development and management, management of the P&T Committee and PDL, and utilization management among others. DMAS must consider options for its program design that are most appropriate to meet the Commonwealth's needs and goals for the Medicaid pharmacy benefit.

Single PBM Contracting Options

Table 31 provides the basic structure for the four PBM contracting options detailed in this section. In each, DMAS procures the PBM contract and requires claims for managed care members to be processed through the State-selected PBM administering the Medicaid outpatient pharmacy benefit. The overarching differences between the options are the contracting mechanisms and funding flow. Also, while we have focused our discussion of each option on the managed care pharmacy benefit, DMAS is anticipated to require the PBM to manage the FFS pharmacy benefit as well for each option.

Table 31: High-Level Overview of Single PBM Contracting Options

Single PBM Contracting and Payment Option	Party that Procures the Single PBM Contract	Source of Funds for Single PBM Remuneration	Who Compensates the Single PBM?	MCO Agreement with Single PBM?*
MCO At-Risk	State (zero-dollar contract)	Capitation rate	MCO	Yes
MCO Non-Risk	State	State (provides MCOs with administrative fee funds)	MCO (passes through funds received from State)	Yes

Single PBM Contracting and Payment Option	Party that Procures the Single PBM Contract	Source of Funds for Single PBM Remuneration	Who Compensates the Single PBM?	MCO Agreement with Single PBM?*
Carve-Out PAHP	State	State (capitation rate or non-risk based payment)	State	Yes
Pharmacy Carve-Out	State	State	State	No contract

**In addition to traditional contracts, written agreements with MCOs may include non-contractual agreements, such as service agreements, memorandums of understanding, letters of intent, or letters of agreement to outline intentions, objectives, roles, expectations, and any other requirements that will align the participating parties on their purpose and desired outcomes.*

Below we provide additional information about the four options. Each option has related benefits and risks, many of which are similar across options but are more dependent on how the option is implemented and operationalized. For example, for any of these four models and as stakeholders raised during our interviews, there is a potential negative impact to the MCOs' ability to provide care coordination and care management for members if service authorizations or sharing of data is untimely. Thorough collaboration among DMAS, the PBM, MCOs, and other vendors to review data integration needs before implementation and providing MCOs with real-time or near real-time view into pharmacy claims activity are two examples of implementation and operational strategies that can help to alleviate this risk.

Option 1: Single PBM: MCO At-Risk

Table 32 provides the high-level design features and the potential risks and benefits of this PBM contracting strategy.

Table 32: Single PBM: MCO At-Risk

Option 1: Implement a Single PBM Contract with MCOs Maintaining Risk*	
High-Level Design Features • **DMAS:** Procures a zero-dollar contract with the single PBM. DMAS provides oversight of the single PBM, including responsibility for contract implementation oversight, defining performance metrics and required single PBM reporting, and assessment of penalties. • **MCOs:** Contract directly with DMAS-selected single PBM but continue managing PAD benefit. Pharmacy benefit remains in the capitated rate, and the MCO pays the single PBM for their services. • **Single PBM:** Zero-dollar contract with DMAS includes the single PBM's responsibilities, reporting requirements, and penalties. The single PBM contracts with the MCOs using a DMAS approved agreement.	
Potential Benefits	*Potential Risks*
• MCOs maintain risk for pharmacy benefits. • Preserves budget predictability for DMAS. • Decreases ability of MCOs to steer members toward MCO or PBM-owned pharmacies, including specialty pharmacies.	• Single PBM's ability to provide payment to network pharmacies may be at risk if MCOs do not remunerate the single PBM timely. • *Additional staffing may be necessary for oversight of contractual compliance of the single PBM and coordinated operations.*

Option 1: Implement a Single PBM Contract with MCOs Maintaining Risk*	
• *Reduces DMAS administrative burden and expenses (i.e., oversight of one vendor versus multiple MCOs).* • *Enhances DMAS' ability to oversee drug pricing and pricing transparency.* • *Reduces administrative burden on prescribers, pharmacies, and members.* • *Options for pharmacy network to be managed by DMAS or the single PBM, both of which promote member access and choice of pharmacy provider by forming one statewide pharmacy network.* • *DMAS can reduce or eliminate conflicts of interest that may exist in carve-in model between MCO PBMs and their vertically aligned MCOs/insurers, pharmacies, and providers.* • *Provides greater DMAS oversight to monitor for spread pricing and to address directly with the PBM through use of DMAS contract language.*	• *Conflicts of interest may continue to exist if the single PBM procured by DMAS also owns Medicaid network pharmacies or is owned by an MCO. Risk of steerage to single PBM-owned pharmacies or specialty pharmacies unless addressed in the PBM contract.* • *Issues with timely SAs or untimely sharing of pharmacy data with the MCOs may have a negative impact on outcomes, care coordination, and care management.*

**Italicized benefits and risks are listed in all contracting and payment model options*

Option 2: Single PBM: MCO Non-Risk

Table 33 provides the high-level design features and the potential risks and benefits of this PBM contracting strategy.

Table 33: Single PBM: MCO Non-Risk

Option 2: Implement a Single PBM Contract with State Maintaining Risk and Single PBM Paid by MCO *(passthrough)**	
High-Level Design Features • **DMAS:** Contracts with single PBM and provides oversight, including responsibility for contract implementation, defining performance metrics and required single PBM reporting, and assessment of penalties. Removes the outpatient pharmacy drug payments from MCO capitated rate and pays the pharmacy benefit using a passthrough payment approach. • **MCOs:** Contract directly with DMAS-selected single PBM but continue managing PAD benefit. MCOs transfer funds received from DMAS to the single PBM to pay pharmacy claims. • **Single PBM:** Contracts with MCOs. Receives pharmacy reimbursement funds from MCOs and pays pharmacies.	
Potential Benefits	*Potential Risks*
• *Reduces DMAS administrative burden and expenses (i.e., oversight of one vendor versus multiple MCOs).*	• DMAS at risk for pharmacy benefit. • DMAS at risk if financial payment transactions between the MCOs and the single PBM are not tracked to ensure transparency.

Option 2: Implement a Single PBM Contract with State Maintaining Risk and Single PBM Paid by MCO *(passthrough)**	
• *Enhances DMAS' ability to oversee drug pricing and pricing transparency.* • *Reduces administrative burden on prescribers, pharmacies, and members.* • *Options for pharmacy network to be managed by DMAS or the single PBM, both of which promote member access and choice of pharmacy provider by forming one statewide pharmacy network.* • *DMAS can reduce or eliminate conflicts of interest that may exist in carve-in model between MCO PBMs and their vertically aligned MCOs/insurers, pharmacies, and providers.* • *Decreases ability of MCOs to steer members toward MCO or PBM-owned pharmacies, including specialty pharmacies.* • *Provides greater DMAS oversight to monitor for spread pricing and to address directly with the PBM through use of DMAS contract language.*	• Single PBM's ability to provide payments to network pharmacies may be at risk if MCOs do not remunerate the single PBM timely. • Removing pharmacy benefit from MCO management may limit incentives for MCOs to initiate measures to promote cost-effective prescribing. • *Additional staffing may be necessary for oversight of contractual compliance of the single PBM and coordinated operations.* • *Conflicts of interest may continue to exist if a single PBM also owns Medicaid network pharmacies or is owned by an MCO. Risk of steerage to single PBM-owned pharmacies or specialty pharmacies unless addressed in the PBM contract.* • *Issues with timely SAs or untimely sharing of pharmacy data may have a negative impact on outcomes, care coordination, and care management.*

**Italicized benefits and risks are listed in all contracting and payment model options.*

Option 3: Carve-Out PAHP

Table 34 provides the high-level design features and the potential risks and benefits of this PBM contracting strategy.

Table 34: Carve-Out PAHP

Option 3: Implement a Single PBM Contract with PBM Operating as a PAHP*
High-Level Design Features • **DMAS:** DMAS contracts with the single PBM and pays the single PBM directly based on either a capitated rate or on an administrative fee. DMAS is required to submit a 1915b waiver application to CMS for the single PBM to operate as a PAHP. DMAS also enters into written agreements with the MCOs and single PBM that outline respective responsibilities and how DMAS, the MCOs, and single PBM will collaborate. • **MCOs:** MCO contracts with DMAS. MCO is also required to enter into written agreements with DMAS and the single PBM that outline respective responsibilities and how DMAS, MCOs, and the single PBM will collaborate. MCOs are not responsible for remuneration to the single PBM. • **Single PBM:** Single PBM contracts directly with DMAS. The single PBM is required to establish formal, non-contractual written agreements with MCOs that outline respective responsibilities and how the MCOs and single PBM will collaborate.

Option 3: Implement a Single PBM Contract with PBM Operating as a PAHP*	
Potential Benefits	*Potential Risks*
• Allows DMAS for a choice of at-risk or non-risk payments to the single PBM. • Transparency in rebates and operations of administering the pharmacy benefit because of DMAS' direct contract with and payment for services to the single PBM. • *Reduces DMAS administrative burden and expenses (i.e., oversight of one vendor versus multiple MCOs).* • *Enhances DMAS' ability to oversee drug pricing and pricing transparency.* • *Reduces administrative burden on prescribers, pharmacies, and members.* • *Options for pharmacy network to be managed by DMAS or the single PBM, both of which promote member access and choice of pharmacy provider by forming one statewide pharmacy network.* • *DMAS can reduce or eliminate conflicts of interest that may exist in the carve-in model between MCO PBMs and their vertically aligned MCOs/insurers, pharmacies, and providers.* • *Decreases ability of MCOs to steer members toward MCO or PBM-owned pharmacies, including specialty pharmacies.* • *Provides greater DMAS oversight to monitor for spread pricing and to address directly with the PBM through use of DMAS contract language.*	• Use of a 1915b waiver requires additional administrative responsibilities of DMAS (e.g., reporting to CMS, independent assessment, etc.). • Removing pharmacy benefit from MCO management may limit incentives for MCOs to initiate measures to promote cost-effective prescribing. • *Additional staffing may be necessary for oversight of contractual compliance of the single PBM and coordinated operations.* • *Conflicts of interest may continue to exist if the single PBM also owns Medicaid network pharmacies or is owned by an MCO. Risk of steerage to single PBM-owned pharmacies or specialty pharmacies unless addressed in the PBM contract.* • *Issues with timely SAs or untimely sharing of pharmacy data may have a negative impact on outcomes, care coordination, and care management.*

**Italicized benefits and risks are listed in all contracting and payment model options.*

Option 4: Managed Care Carve-Out

Table 35 provides the high-level design features and the potential risks and benefits of this PBM contracting strategy.

Table 35: Managed Care Carve-Out

Option 4: Implement a Managed Care Carve-Out*
High-Level Design Features
• **DMAS:** Contract with a PBM to manage the pharmacy benefit for Medicaid members in FFS and managed care. DMAS sets the pharmacy reimbursement and dispensing fees and remunerates the PBM. • **MCOs:** MCOs continue to be responsible for PADs. • **Single PBM:** Single PBM contracts directly with DMAS.

Option 4: Implement a Managed Care Carve-Out*	
Potential Benefits	*Potential Risks*
• Transparency in rebates and operations of administering the pharmacy benefit because of DMAS' direct contract with and payment for services to the PBM. • *Reduces DMAS administrative burden and expenses (i.e., oversight of one vendor versus multiple MCOs).* • *Enhances DMAS' ability to oversee drug pricing and pricing transparency.* • *Reduces administrative burden on prescribers, pharmacies, and members.* • *Options for pharmacy network to be managed by DMAS or the single PBM, both of which promote member access and choice of pharmacy provider by forming one statewide pharmacy network.* • *DMAS can reduce or eliminate conflicts of interest that may exist in the carve-in model between MCO PBMs and their vertically aligned MCOs/insurers, pharmacies, and providers.* • *Decreases ability of MCOs to steer members toward MCO or PBM-owned pharmacies, including specialty pharmacies.* • *Provides greater DMAS oversight to monitor for spread pricing and to address directly with the PBM through use of DMAS contract language.*	• Removing pharmacy benefit from MCO management may limit incentives for MCOs to initiate measures to promote cost-effective prescribing. • *Additional staffing may be necessary for oversight of contractual compliance of the single PBM and coordinated operations.* • *Conflicts of interest may continue to exist if single PBM also owns Medicaid network pharmacies or is owned by an MCO. Risk of steerage to single PBM-owned pharmacies or specialty pharmacies unless addressed in the PBM contract.* • *Issues with timely SAs or untimely sharing of pharmacy data may have a negative impact on outcomes, care coordination, and care management.*

**Italicized benefits and risks are listed in all contracting and payment model options.*

Single PBM Contract Design Considerations

After selecting the PBM contracting strategy, there are many design components that DMAS will need to make decisions for when building out the program design and contracting requirements. One key decision that will impact many of DMAS' design considerations is if DMAS will continue its current contract for pharmacy SAs, as well as its contract for claims adjudication, rebate administration, and formulary management services, or if those services will be included in the single PBM contract. Each design consideration will also have multiple subsequent decision points. Additionally, each design decision also stands to affect the fiscal impact of the single PBM contracting strategy. The following are examples of design components and decision points DMAS will need to consider when finalizing its program design and contracting requirements. These are only meant to be examples and are not all-inclusive. Many more considerations may be identified throughout planning specific to Virginia's Medicaid program and particularly as decisions are made for contracting and payment structures and for programmatic areas that impact each other.

Table 36: Single PBM Design and Contracting Considerations and Decision Points

Design and Contracting Considerations	Sample Decision Points
Network Development and Management	• Will the single PBM use the FFS Virginia Medicaid Pharmacy Network, the MCOs' current networks, or contract its own network? • What specific geographic pharmacy shortages and challenges must be considered? Will DMS include specific contract requirements for MCOs and/or the PBM to help address geographic pharmacy shortages or to offer alternate options? For example, what will the role of mail order be? • Are there any special considerations for specialty pharmacy enrollment? • Who will be responsible for network management activities, such as provider outreach and education? Provider recruitment? Provider complaints? Provider audits and other oversight?
P&T Committee and PDL	• Will DMAS use its current vendor to support the P&T Committee, or will that function be moved to the single PBM vendor? If the current vendor, will the single PBM have a voice in benefit design? • Will MCOs have a voice in benefit design for the therapeutic classes not closed under the CCF? • Will there be a change in MCO involvement with the P&T Committee and CCF placement decisions? • Will there be any distinction between the FFS and the MCO PDLs? • How will the different over-the-counter benefits that are offered as value-added services by the MCOs today be impacted? • What prescriber and member education is necessary, and which party will be responsible for communications?
Utilization Management	• Will MCOs have a voice in SA criteria? • Will relaxation of utilization management and SA edits be implemented during the transition to the single PBM? If so, how long? • Especially for the MCO at-risk model, what level of visibility and input will the MCOs have in assessing single PBM fidelity to SA criteria and other utilization management edits? • What responsibilities will MCOs continue to have (e.g., pharmacy lock-in, retro DUR)?
Rebate Invoicing and Collection	• What opportunities exist to maximize rebates and potentially grow supplemental rebates? • Will the rebate administrative functions stay with the current vendor or will rebate responsibilities be included in the single PBM contract?
Oversight and Compliance	• What DMAS department will be responsible for the oversight and compliance monitoring of the single PBM? • Are there additional staffing or other resource needs to perform these duties effectively? • What role, if any, will the MCOs have in assessing the single PBM's performance? • What reporting mechanisms may DMAS require of the single PBM to demonstrate transparency to DMAS and potentially to external stakeholders?

Design and Contracting Considerations	Sample Decision Points
Reimbursement	• Will DMAS adjust pharmacy reimbursement rates for MCO member claims to more closely align with the current FFS reimbursement rates and dispensing fees? • Will an enhanced reimbursement methodology be used for rural pharmacies or independent pharmacies? • Will there be changes to how 340B pharmacies are reimbursed?

Financial Considerations for Implementing a Single PBM Contract

Fiscal Impact

Single PBM design decisions will significantly affect the fiscal impact on DMAS.

As presented throughout this report, there are many decisions to be made by DMAS regarding the single PBM program design and contract. These decisions as well as how the model is operationalized will significantly affect the fiscal impact the single PBM will have for the Virginia Medicaid program. The single PBM model will require significant DMAS operational involvement and oversight to ensure proper, efficient, and cost-effective administration of the pharmacy benefit. Further, our research shows that each state that has transitioned to a single PBM contract has done so from various unique starting points, and reports of projected savings have varied across and sometimes within these transitions.

Additionally, comprehensive studies of actual savings after implementation are also limited. Therefore, the fiscal impact on the Commonwealth will need to be continually analyzed and updated as DMAS makes design decisions, and consideration should be given to the Virginia-specific environment and starting point.

Based on our analysis, the estimated fiscal impact of transitioning to a single PBM results in initial implementation costs over an 18-month period consisting of a 6-month procurement period and 12-month contract implementation period. Potential savings would begin in Year 1 during the first six months of the contract being operational followed by full savings potential beginning in subsequent contract years. The estimate of savings are reflected in *Table 37*.

Table 37: Fiscal Impact Summary by Period

Period	Description	Potential Estimated Fiscal Impact*
Year 0	6-month procurement and 6 months of implementation activities	An initial cost of $6.2 million to $9.6 million.
Year 1	Additional 6 months of implementation activities and 6 months of single PBM contract operations	Potential cost of $6.1 million to savings of $1.6 million during continued implementation and transition to operations.
Years 2+	Full 12-month periods of single PBM operations	Potential savings of $10.2 million-$22.1 million annually.

**Total funds*

The range in these estimates largely represents the unknowns related to the decisions DMAS will need to make during the design of the single PBM model and the results of the procurement process. In the following, we discuss this analysis in more detail including the fiscal considerations and potential costs and savings. We also include our assumptions regarding key DMAS decisions.

The inputs into this analysis are based on the best available information supplied by DMAS, cost and volume metrics we derived from the data sources received, publicly available data and experiences from other states, our industry knowledge, and our application of that information to DMAS' current pharmacy environment and program. We have neither independently verified the accuracy nor completeness of data or inputs received, nor do we represent this review as an actuarial analysis.

Potential Costs and Assumptions

The following costs and assumptions were made when assessing the potential fiscal impact of the DMAS single PBM contract.

- **Single PBM Administrative Fee.** The single PBM will adjudicate claims and perform PBM functions for both the MCO as well as FFS outpatient pharmacy program. These costs will be incurred starting after the program go-live (i.e., month 19). Based on other single PBM awards, our understanding of current market rates, and the size of the Virginia Medicaid program we have projected that the administrative fees for the single PBM could range between $16.4 million and $20.5 million per year.

- **PBM Implementation Fees.** PBMs may assess implementation fees that are designed to capture the cost of design, development, and implementation (DDI) of the PBM system and services. These activities vary but include costs, such as discovering and understanding a state's claims adjudication rules, benefit design and conditions for coverage, eligibility categories and how benefits are assigned to eligibility groups, pharmacy reimbursement methodologies and provider payment rules, reporting, and many other factors. During this DDI phase, the PBM translates business requirements into system requirements, designs the system, and tests their alignment with the state's program rules and requirements.

  For our calculations, we have assumed an implementation fee of $1.5 million to $2.5 million over the 18-month implementation period.

- **Staffing.** Each comparative state had varying experiences regarding staffing changes when transitioning to a single PBM contract. Further, several states interviewed questioned whether the staffing levels experienced were appropriate or sufficient for the implementation or ongoing monitoring and oversight of the single PBM model. Based on the pharmacy leadership from the states interviewed, we made the following staffing observations:

Single PBM Staffing

DMAS is anticipated to need an additional 7-8 FTEs for the single PBM implementation and ongoing operations and oversight.

- **Kentucky:** Prior to and at the start of contract implementation, Kentucky assigned two pharmacists, one policy analyst, and two business analysts to support the transition to its single MCO PBM contract. However, one pharmacist resigned during contract implementation. DMS subsequently expanded its staff in 2021 with the addition of two pharmacists. Per discussion with state leaders, their transition would have benefited from staffing that included 3-4 pharmacists, even if temporarily contracted, a few highly experienced technicians to review test claims, and a strong project manager.
- **Louisiana:** Though state leaders noted during the interview that it would have been extremely beneficial to have additional staff, none were added to support implementation of the single PBM contract.
- **Mississippi:** Mississippi did not have staffing changes to support its transition to a single PBA contract.
- **New York:** While New York did not add staff to support its transition to a pharmacy carve-in model, eight additional staff have been hired since implementation. Additionally, staff for data and finance functions were also onboarded. These hires were made in lieu of contracting a vendor's support. However, the state leaders interviewed noted that it would have been beneficial to have additional staff during the transition.
- **Ohio:** To support implementation of its single PBM contract, Ohio hired six pharmacists, a data analyst, and a program integrity specialist. The additional pharmacists have remained on staff to support ongoing program operations, bringing the ODM pharmacy team from three to nine total pharmacists.

We encourage DMAS to assess the staffing and organizational structure within its current pharmacy unit to better identify and quantify staffing needs and costs. Based on feedback from DMAS, the experience of other states, and Virginia stakeholder feedback regarding opportunities for DMAS to further enhance vendor oversight, DMAS is anticipated to need additional staff for both the short-term implementation and the long-term operations, oversight, and monitoring of the single PBM.

Myers and Stauffer's fiscal impact model assumes that Virginia will hire seven to eight additional staff. These staff would include two data analysts, one rebate manager, an appeals coordinator, and three to four clinical pharmacists to support the single PBM implementation, operations, and ongoing monitoring and oversight.

- **Temporary DMAS Staffing.** In addition to permanent staff and contracted external resources, DMAS will likely require temporary staffing support to manage the high intensity period surrounding procurement, readiness, and implementation of the single PBM contract. These temporary positions typically provide capacity for administrative coordination, testing support, data validation, and other internal processes during system build and transition. To ensure alignment between the PBM's adjudication platform and DMAS' enterprise systems, temporary staffing should include dedicated internal systems integration resources who can coordinate with the MMIS vendor and ensure technical interfaces are properly configured, tested, and

deployed. In parallel, a financial process resource is expected to be needed to oversee fiscal reconciliation processes, claims payment readiness, and adjustments to existing accounting workflows impacted by the new PBM structure. These resources will be critical given the single PBM implementation will occur proximal to the implementation of DMAS' new Fiscal Agent Services (FAS) contract.

For purposes of this analysis, we have assumed DMAS will require five to six temporary FTEs to assist with these functions. These staff are expected to be required during the pre-implementation and implementation periods which cover a 24-month period.

- **External Implementation Support.** Some states have utilized consultant services to support the implementation of the single PBM contract. This support has included designing the single PBM model, drafting a single PBM RFP, supporting the procurement, offering SLA requirements, and providing project management and subject matter expertise to support readiness reviews, implementation, and post-implementation stabilization. Additionally, states have also used external consultant services to support the ongoing oversight of the single PBM vendor and pharmacy operations longer term. As mentioned, DMAS will need to assess its current internal staffing and their availability, as well as the need for external support during the implementation and oversight of the single PBM. This consultant may also serve as staff augmentation while DMAS recruits and onboards additional staff required to support the implementation and operations of the single PBM.

  Our fiscal impact analysis assumes DMAS will utilize external support during the design, procurement planning, implementation period, and ongoing operations of the single PBM for a total of 24 months of support. Depending on the scope of services requested of this consultant, we have assumed $1.8 to $2.1 million per year.

- **Medicaid Management Information System Vendor and Related Vendor Costs.** Transitioning to a single PBM model will necessitate targeted system changes and integration work within the Commonwealth's MMIS and other DMAS vendor systems. Integration activities may include establishing new interfaces between the selected PBM and MMIS, updating data exchange protocols, modifying reporting functions, and other activities. These complex enhancements are resource-intensive components of PBM implementation efforts and will include additional configuration and testing to align the PBM adjudication platform with Virginia's claims payment and data warehouse infrastructure.

  We have assumed DMAS will incur system integration costs which may include MMIS vendor enhancements, interface development, and testing, as well as coordination and changes with other related vendors' systems. In addition to system integration costs, there may be other related operational costs. For example, new member identification cards will need to be printed and issued to all Medicaid members to reflect the carrier information for the selected single PBM. For our fiscal analysis, we have estimated total system integration and related vendor costs to range between $3.4 million and $5.9 million which will be incurred over an 18-month period.

- **MCO Supplemental Rebates.** DMAS' MCOs are allowed to negotiate supplemental rebates for open classes on the CCF which are not subject to the Commonwealth's supplemental rebate program. The MCOs leverage their national book of business to negotiate and retain these rebates. According to the DMAS actuary, the MCO capitation rates consider the MCO supplemental rebates, across all five plans, to equal $21.8 million in the current rates. These rebates reflect a cost offset to DMAS today; however, the MCOs will no longer collect supplemental rebates under the single PBM model. Additionally, DMAS does not have the negotiating power of a large national payer. While there is a corresponding offset in our analysis for the portion of those rebates DMAS would be able to negotiate and collect, the $21.8 million is treated as an additional cost starting with the full implementation of the single PBM.
- **Pharmacy Reimbursement.** Pharmacy reimbursement changes were not funded by the legislature and savings from transitioning to a single PBM model are not guaranteed. Therefore, no changes to the pharmacy reimbursement methodology have been included. We assume pharmacy reimbursement for MCO claims, in the aggregate, would not change from the current total MCO expenditures.

Potential Savings and Assumptions

Myers and Stauffer made the following offsets to costs, and assumptions were made when assessing the potential fiscal impact of the DMAS single PBM contract.

- **MCO PBM Administrative Fees.** Under the current Cardinal Care pharmacy carve-in model, each MCO contracts with its own PBM and incurs an administrative fee for PBM services. This administrative fee is incorporated into each of the five MCOs' monthly capitation payment. Based on data provided by the state's actuary, we have included MCO PBM administrative fees of $31.1 million which will no longer be paid upon implementation of the single PBM.
- **FFS PBM Administrative Fees.** Since DMAS will contract with a single PBM for all Medicaid pharmacy claims, it will no longer incur the separate FFS PBM administrative fees. Based on information provided, DMAS currently pays approximately $6.1 million per year to the FFS PBM vendor. Under the consolidated single PBM model, these costs would be eliminated and are reflected as annual savings in this analysis.
- **Rebates.** Transitioning to a single PBM contract and implementing a single PDL offered the opportunity for savings for DMAS. First, transition to a single PDL offers the opportunity to drive market share and enhance supplemental rebates. While some states have experienced large savings by implementing the single PDL, DMAS has proactively implemented the CCF which addresses the drugs and drug classes that have the largest opportunity to drive increased rebates. Therefore, DMAS may experience a small percentage increase in its supplemental rebates.

  Additional incremental savings may be achieved through the inclusion of the open CCF classes in the DMAS supplemental rebate program. However, these classes are not included today because of their low probability to result in significant supplemental rebates. Finally, and as discussed later in this analysis, the single PBM brings the opportunity to ensure consistent

application of service authorization requests which could further enhance additional rebate revenue.

Given DMAS' existing work to drive supplemental rebates through the CCF, our analysis conservatively assumes an increase in rebate revenue that equates to 15% to 20% of the lost MCO supplemental rebates.

- **Utilization Management and Other Efficiencies.** Again, DMAS has established a strong CCF and utilization management approach — both of which are further supported by a supplemental rebate program. Additionally, DMAS actuaries have applied a pharmacy utilization efficiency factor in recent years to the capitation rate setting process to account for opportunities to drive MCO efficiencies in the administration of the pharmacy benefit. However, Myer and Stauffer assumes implementation of the single PBM will further improve the consistent application of utilization management requirements and edits as well as result in other efficiencies.

  We have assumed the savings through streamlined utilization management and other efficiencies to equate to 0.50% to 0.75% of the MCO pharmacy expenditures as a result of this transition.

- **Spread Pricing Elimination.** No savings are included in the fiscal impact as spread pricing is not permitted in the current DMAS pharmacy program. Spread pricing in the program was prohibited as a result of the passage of HB 1291 from the 2020 legislative session.

- **Other Impacts to MCO Capitation Rates.** Additional potential impacts to the MCO capitation rates will need to be determined through an actuarial review. For purposes of this review, those impacts are assumed to be minimal.

Table 38 provides a summary of the cost items, assumptions, the estimated fiscal impact, and timing of each.

Table 38: Summary of Costs and Assumptions

Cost	Description	Assumptions and Caveats	Estimated Cost
Single PBM Administrative Fee	Fees for PBM services for both FFS and MCO populations.	• Based on pricing from other states' PBM procurements and adjustments for the DMAS program and implementation timeframe. • Final cost dependent upon service scope, reporting requirements, and integration with existing vendors.	**$16.4 to $20.5 million annual cost after single PBM implemented.**
FFS PBM Administrative Fees	Total estimated administrative fees paid by DMAS for FFS PBM services	• Based on invoice totals provided by DMAS.	**$6.1 million annual cost until full single PBM implemented.**

Cost	Description	Assumptions and Caveats	Estimated Cost
Single PBM Implementation Fee	One-time DDI cost for system configuration, business rule translation, benefit design alignment, and testing.	• Based on PBM DDI fees similar to those experienced in other states.	**$1.5 million to $2.5 million one-time cost.**
DMAS FTEs	Permanent staff expansion to oversee PBM operations and maintain performance monitoring.	• Assumes 3 to 4 pharmacists, 2 data analysts, 1 appeals coordinator, and 1 rebate manager. • Reflects expanded vendor oversight and appeals management functions. • Staffing levels may be adjusted based on DMAS' internal resource availability.	**$925,000 to $1.1 million annual cost.**
Temporary DMAS Implementation Resources	Time-limited internal resources to assist transition activities, testing, data validation, and integration of the PBM platform with the MMIS and other MES modules. Includes a financial process resource to align accounting workflows.	• Assumes 5 to 6 temporary FTEs for 24 months. • Roles may include internal system integration consultant, financial consultant, and business analysts.	**$1.8 million to $2.5 million per year for the first two years.**
External Implementation Support	Consultant services to assist DMAS with project management, RFP and contract development, readiness reviews, stakeholder engagement, and post-implementation stabilization.	• Assumes 24 months of engagement covering procurement through post-implementation stabilization. • Provides subject matter expertise and staff augmentation while DMAS onboards new internal staff.	**$1.8 million to $2.1 million per year cost for the first two years.**
System Integration and Related Vendors	Enhancements and change orders to the MMIS and related vendors to implement the single PBM interfaces, testing, reporting functions, and other operational costs (e.g., reprinting of member ID cards).	• Assumes required changes will result in a change order and additional costs to DMAS.	**$3.4 million to $5.9 million one-time cost over a two-year period.**
MCO Supplemental Rebates Removal from Capitation Rates	Reflects the loss of MCO-retained rebates currently built into MCO capitation payments.	• Assumes DMAS may not recover equivalent supplemental rebate value under a single PBM model as MCOs.	**$21.8 million annual cost.**

Table 39 provides a summary of the savings, assumptions, the estimated fiscal impact, and timing of each.

Table 39: Summary of Savings and Assumptions

Savings	Description	Assumptions and Caveats	Estimated Savings
MCO PBM Administrative Fees	Total estimated administrative fees paid by the MCOs for PBM services.	• Based on information from DMAS' actuary.	**$31.1 million annual savings after single PBM implemented.**
FFS PBM Administrative Fees	Total estimated administrative fees paid by DMAS for FFS PBM services.	• Based on invoice totals provided by DMAS.	**$6.1 million annual savings after single PBM implemented.**
Rebates Savings	Increased supplemental rebate revenue generated through single PDL.	• Accounts for 6-month collection lag on rebate payments. • Assumes recovery of 15%-20% of lost MCO supplemental rebates achievable.	**$3.3 million-$4.4 million annual savings starting in Year 2.**
Utilization Management Cost Offset and Other Efficiencies	Administrative savings generated from consistent application of utilization management criteria, reduced duplicative MCO pharmacy operations, and additional utilization management efforts.	• Reflects long-term savings from unified utilization management efforts and other program efficiencies. • Assumes savings equivalent to 0.5%-0.75% of total MCO pharmacy expenditures.	**$6.6 million to 9.9M savings during Year 1.** **$13.2 million-$19.7 million annual savings after single PBM implemented.**

Table 40 provides the estimated net fiscal impact to DMAS as a range by year.

Table 40: Fiscal Impact by Year

Fiscal Impact by Year						
Estimated New Costs						
	YR 0		YR 1		YR 2+	
Potential Costs	**Low**	**High**	**Low**	**High**	**Low**	**High**
PBM Administrative Fees						
Single PBM	$ -	$ -	$8,217,667	$10,272,084	$16,435,334	$20,544,168
FFS PBM	$ -	$ -	$ -	$ -	$ -	$ -
PBM Implementation Fee	$1,000,000	$1,666,667	$500,000	$833,333	$ -	$ -
Staffing						
DMAS Permanent Staff	$925,000	$1,100,000	$925,000	$1,100,000	$925,000	$1,100,000
DMAS Temporary Staff	$1,820,000	$2,496,000	$1,820,000	$2,496,000	$ -	$ -
Implementation Consultant	$1,800,000	$2,100,000	$1,800,000	$2,100,000	$ -	$ -
MMIS and Related Vendor Costs	$666,667	$2,333,333	$2,733,333	$3,566,667	$ -	$ -
MCO Rebate Loss	$ -	$ -	$10,905,001	$10,905,001	$21,810,001	$21,810,001

Fiscal Impact by Year						
Total Funds	**$6,211,667**	**$9,696,000**	**$26,901,001**	**$31,273,085**	**$39,170,335**	**$43,454,169**
State Funds	$1,652,500	$2,174,667	$9,936,506	$11,156,348	$17,130,511	$18,680,029
Federal Funds	$4,559,167	$7,521,333	$16,964,495	$20,116,737	$22,039,824	$24,774,140
Estimated Savings						
	YR 0		**YR 1**		**YR 2+**	
Potential Saving	**Low**	**High**	**Low**	**High**	**Low**	**High**
MCO PBM Administrative Fees	$ -	$ -	$(15,560,416)	$(15,560,416)	$(31,120,831)	$(31,120,831)
FFS PBM Administrative Fees	$ -	$ -	$(3,033,540)	$(3,033,540)	$(6,067,079)	$(6,067,079)
Rebates	$ -	$ -	$ -	$ -	$(3,271,500)	$(4,362,000)
Utilization Management & Efficiencies	$ -	$ -	$(6,581,710)	$(9,872,565)	$(13,163,420)	$(19,745,129)
Total Funds	$ -	$ -	**$(25,175,665)**	**$(28,466,520)**	**$(53,622,830)**	**$(61,295,040)**
State Funds	$ -	$ -	$(11,743,093)	$(13,375,686)	$(25,109,178)	$(28,915,361)
Federal Funds	$ -	$ -	$(13,432,572)	$(15,090,833)	$(28,513,652)	$(32,379,679)
Estimated Net Fiscal Impact						
	YR 0		**YR 1**		**YR 2+**	
	Low	**High**	**Low**	**High**	**Low**	**High**
Potential Net Cost	**$6,211,667**	**$9,696,000**	**$6,097,420**	**$(1,565,519)**	**$(10,168,661)**	**$(22,124,704)**
State Net Impact	$1,652,500	$2,174,667	$(586,745)	$(3,439,181)	$(6,429,149)	$(11,784,850)
Federal Net Impact	$4,559,167	$7,521,333	$6,684,165	$1,873,662	$(3,739,512)	$(10,339,855)

Negative numbers represent a savings to DMAS.

Note: In years 1 forward, the "low" estimate of the net fiscal impact is calculated using the lowest saving compared to the highest cost. Likewise, the "high" estimate of the net fiscal impact is calculated using the highest savings compared to the lowest cost.

Dispensing Fee Analysis

Throughout the stakeholder interviews, there were recommendations for an increase in dispensing fees, especially for independent and rural pharmacies. However, the legislative action did not include a corresponding budget to fund such a reimbursement increase.

Should subsequent saving be realized or legislative funding be allotted to fund an increase in dispensing fees, the following below present the fiscal impact when increasing the average dispensing fee per claim in one dollar increments to approach the $10.65 PDF for FFS claims for the three prior fiscal years. *Table 41* through *Table 43* show the fiscal impact by only increasing MCO dispensing fee for in-state rural pharmacies and *Table 42* shows the fiscal impact for increasing MCO dispensing fee for independent pharmacies. These analyses illustrate the sensitivity of total dispensing expenditures to fee adjustments and underscore the importance of aligning future rate actions with verified savings outcomes.

Table 41: Fiscal Impact on MCO Dispensing Fee – All MCO Claims

All MCO Claims					
SFY23		SFY24		SFY25	
Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid	Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid	Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid
$1.00	$21.76 million	$1.00	$21.24 million	$1.00	$20.78 million
$2.00	$43.52 million	$2.00	$42.47 million	$2.00	$41.56 million
$3.00	$65.29 million	$3.00	$63.71 million	$3.00	$62.34 million
$4.00	$87.05 million	$4.00	$84.94 million	$4.00	$83.12 million
$5.00	$108.81 million	$5.00	$106.18 million	$5.00	$103.91 million
$6.00	$130.57 million	$6.00	$127.42 million	$6.00	$124.69 million
$7.00	$152.33 million	$7.00	$148.65 million	$7.00	$145.47 million
$8.00	$174.10 million	$8.00	$169.89 million	$8.00	$166.25 million
$9.00	$195.86 million	$9.00	$191.12 million	$9.00	$187.03 million
$10.00	$217.62 million	$10.00	$212.36 million	$10.00	$207.81 million
$11.00	$239.38 million	$11.00	$233.60 million	$11.00	$228.59 million

Table 42: Fiscal Impact on MCO Dispensing Fee – MCO In-State Rural Claims

MCO In-State Rural Claims					
SFY23		SFY24		SFY25	
Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid	Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid	Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid
$1.00	$5.38 million	$1.00	$5.17 million	$1.00	$4.95 million
$2.00	$10.75 million	$2.00	$10.34 million	$2.00	$9.90 million
$3.00	$16.13 million	$3.00	$15.51 million	$3.00	$14.85 million
$4.00	$21.51 million	$4.00	$20.68 million	$4.00	$19.80 million
$5.00	$26.89 million	$5.00	$25.86 million	$5.00	$24.76 million
$6.00	$32.26 million	$6.00	$31.03 million	$6.00	$29.71 million
$7.00	$37.64 million	$7.00	$36.20 million	$7.00	$34.66 million
$8.00	$43.02 million	$8.00	$41.37 million	$8.00	$39.61 million
$9.00	$48.39 million	$9.00	$46.54 million	$9.00	$44.56 million
$10.00	$53.77 million	$10.00	$51.71 million	$10.00	$49.51 million
$11.00	$59.15 million	$11.00	$56.88 million	$11.00	$54.46 million

Table 43: Fiscal Impact on MCO Dispensing Fee – MCO Independent Pharmacy Claims

MCO Independent Pharmacy Claims					
SFY23		SFY24		SFY25	
Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid	Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid	Increase in Average Dispensing Fee	Estimated Fiscal Impact on Total Dispensing Fees Paid
$1.00	$4.96 million	$1.00	$4.80 million	$1.00	$4.63 million
$2.00	$9.92 million	$2.00	$9.61 million	$2.00	$9.25 million
$3.00	$14.88 million	$3.00	$14.41 million	$3.00	$13.88 million
$4.00	$19.84 million	$4.00	$19.21 million	$4.00	$18.50 million
$5.00	$24.80 million	$5.00	$24.02 million	$5.00	$23.13 million
$6.00	$29.75 million	$6.00	$28.82 million	$6.00	$27.76 million
$7.00	$34.71 million	$7.00	$33.62 million	$7.00	$32.38 million
$8.00	$39.67 million	$8.00	$38.42 million	$8.00	$37.01 million
$9.00	$44.63 million	$9.00	$43.23 million	$9.00	$41.63 million
$10.00	$49.59 million	$10.00	$48.03 million	$10.00	$46.26 million
$11.00	$54.55 million	$11.00	$52.83 million	$11.00	$50.89 million

Ingredient Cost Reimbursement

In addition to requesting increases to dispensing fees, many stakeholders also voiced a desire for DMAS to reimburse MCO pharmacy claims more consistent with the FFS ingredient cost reimbursement methodology. This was offered by stakeholders as a potential solution to address Virginia's pharmacy closure rate and to promote improved access to pharmacies, especially in rural areas.

Ingredient Cost Reimbursement Review

Should DMAS receive funding for pharmacy dispensing fee increases, DMAS should concurrently review ingredient cost reimbursement as the FFS ingredient cost reimbursement may be less than that of managed care.

Again, no legislative funding was made available to support an ingredient cost reimbursement increase, and repricing of the MCO paid claims was beyond the scope of this review. However, with FFS using the NADAC, the FFS ingredient cost reimbursement may be less than that of managed care. Should legislative funding for outpatient reimbursement changes be made available, DMAS should concurrently review both ingredient cost reimbursement and dispensing fees in its analysis.

Recommendations and Considerations

Best Practices in PBM Contracting

We understand that DMAS will have a relatively short timeline for procuring a single PBM contract to have in place by July 1, 2026. We recommend DMAS consider the following first steps in procurement planning:

- **Determine Procurement Strategy.** Confirm if DMAS will conduct a competitive procurement through use of an RFP or if it will consider a noncompetitive, sole-sourced approach by expanding the scope of work of the existing FFS vendor(s). The non-competitive process may provide for decreased procurement and implementation costs and a timelier implementation process. Mississippi, for example, added the single PBA scope of work to an existing contract. In contrast, a competitive procurement may promote competition, thereby driving down the costs of the selected single PBM's services. DMAS would need to coordinate with its contracting office to determine regulatory requirements and to understand what procurement options are allowable should this be an outstanding decision point.

- **Develop a Detailed Implementation Plan.** Most states interviewed felt a lesson learned from their transitions to a single PBM model is that they would have preferred longer timelines for a comprehensive implementation to ensure sufficient time for procurement, review of PBM readiness, and systems testing. Recommendations ranged from 12 to 18 months. Given the recommendations from state leaders and the considerations below, Myers and Stauffer recommends an 18-month implementation.

  DMAS should develop an implementation plan that provides sufficient time for single PBM model design, implementation, systems testing, and go-live readiness review. The systems coordination and integration activities will be significant, and DMAS will want to collaborate with its MCOs and IT vendors to determine required timeframes. Additionally, the plan should consider competing priorities for DMAS, MCO and Fiscal Agent Services (FAS) staff due to other initiatives and implementations that are in process or planned during the same timeframes. Of particular consideration are implementation of the Fiscal Agent Services (FAS) core module of DMAS's Medicaid Enterprise System (MES), implementation of requirements resulting from H.R.1 (also known as the One Big Beautiful Bill Act), and ongoing implementation of new Medicaid Managed Care Rule requirements. Also, DMAS may not have sufficient time for posting, hiring, and training new pharmacy positions prior to a July 1, 2026 contract award date. Therefore, DMAS may be onboarding new pharmacy team members as implementation activities progress.

Implementation Timeline

Myers and Stauffer recommends the following general timelines for issuing an RFP for a single PBM contract:

- **Issue RFP:** Early January 2026.
- **Proposals Due:** Early March 2026.
- **Proposal Evaluations and Award:** March-April 2026.
- **Contract Award and Protest Period:** May-June 2026.
- **Contract Implementation:** July 2026-June 2027.

Additionally, there are many unknowns that are out of DMAS control but may impact timelines for implementation and go-live. CMS guidance for requirements of H.R.1 are forthcoming, and states are uncertain as to timelines and programmatic changes that must be planned and implemented. Additionally, should bid protests or lawsuits be filed resulting from the single PBM procurement, implementation dates may be impacted.

Should DMAS decide to implement a PAHP, we recommend beginning discussions with CMS for submission timing for a 1915b waiver application. CMS must issue a decision on approval within 90 days after the State's submission of a complete application.

- **Establish a Planning Workgroup.** This workgroup will be charged with reviewing all key programmatic decisions that need to be made, such as those we describe in the earlier *Options Analysis and Recommendations* section (e.g., responsibilities for network development and management, PDL management, etc.). These decisions will be required whether procuring via an RFP or amendment of a current PBM contract. We recommend including internal SMEs for the pharmacy and managed care programs, particularly individuals who will be responsible for drafting the required single PBM contract and MCO contract amendments. As planning progresses, decisions must be documented and finalized for leadership review and approval. Additionally, the workgroup will want to determine what federal authority will be required based on the finalized design.

Should DMAS elect to move forward with an RFP for a single PBM that is responsible for both the Medicaid and FFS pharmacy benefit, below are best practices for PBM contracting that we recommend DMAS consider in addition to the programmatic components outlined in our *Options Analysis and Recommendations*.

- **Establish Clear Lines of Accountability.** Given implementation of a single PBM will include, at a minimum, the PBM, five MCOs, and DMAS, it will be important for DMAS to incorporate detailed information in the RFP background or other resource materials outlining which entity holds specific responsibilities. Additionally, establishing early and often communications across all parties during implementation will help in identifying potential challenges early and prior to go-live.
- **Comprehensive Transition Plan.** Each party should collaborate to identify transition needs and responsibilities. DMAS will provide oversight of transitions and ensure all vendors are providing the support and information necessary within required timeframes. This will be especially important if any vendors are exiting so responsibilities are complete at contract term date or no later than the timeframe they are required to provide support beyond the term date.
- **Identify Data Needs for the Procurement.** Identify data that can be provided to proposers as part of the procurement process. States have specifically faced challenges from several perspectives with transition of PAs to the single PBM. DMAS will want to work to provide accurate estimates of the number of PAs processed on a monthly and annual basis. This information will help inform DMAS of the estimated number of staff they should expect vendors to propose and will also help vendors to develop those estimates and related costs.

- **Identify Data Needs for Transition.** Similarly, actual PA information will need to be transitioned from the FFS PBM and MCOs to the single PBM. Discussions for other data needs and responsibilities for areas, such as third-party liability will be important. Additionally, early identification of systems connectivity needs is essential.
- **Include Detailed Contract Requirements.** Ensure the single PBM contract includes detailed requirements to allow for clarity on its responsibilities and to allow for DMAS to hold the PBM accountable when out of compliance. Detailed requirements will also decrease ambiguity about which party is responsible for specific tasks. For example, if DMAS holds the network that the PBM uses for services for MCO members, it will be important to clearly define which entity is responsible for specific provider outreach and education. Additionally, clarity about responsibilities for member services and communications is also essential for avoiding contractor staff and member confusion.
- **Ensure the Following Requirements are Addressed:**
    - **Staffing.** Consider how specific to be in staffing and required qualifications. At a minimum, DMAS will want to require key leadership positions. Also, we recommend that DMAS indicate if they must be full-time, live in the Commonwealth, and required hours of availability. Additionally, DMAS should indicate notification requirements for key staff departures and right of approval of replacement hires.
    - **Service Agreement.** If DMAS requires the MCOs to sign service agreements with the PBM, determine if the PBM will establish one agreement template that will be used with all MCOs, if the MCOs are allowed to request additional terms or services, and if there are specific requirements that DMAS will require to be included. These decisions should be documented in the PBM contract with DMAS.
    - **Pricing Transparency.** Include requirements that address that spread pricing is not allowed. Additionally, consider language to prevent common strategies used by PBMs that do not benefit the Commonwealth, such as clawbacks, fees, chargebacks, grants, other payments, steerage, and conflicts of interest.
    - **Payment Processes and Timelines.** Establish requirements for how the PBM will be paid, timeframes for receipt of those payments, and timelines in which the PBM must provide payment to providers.
    - **Provider and Member Appeals Processes.** Clearly define the PBM's role in supporting appeals and fair hearing processes related to PAs.
    - **Comprehensive Structure for Performance Standards, SLAs, Corrective Action, and Assessment of Penalties.** Ensure performance standards, SLAs, and penalties that tie to specific requirements and are not ambiguous. This will avoid vendor pushback if and when DMAS must assess penalties.
    - **Value-Based Payment (VBP) Enabling Language.** Inclusion of VBP enabling language will provide single PBM responders to the RFP with an opportunity to offer solutions for VBP implementation should DMAS undertake such an effort in the future. Inclusion will also

ensure contractual language is in place to define this commitment and the vendor's role.

- **Auditing Provisions.** Incorporate requirements to allow DMAS to select and hire an independent evaluator to audit PBM contract compliance.
- **Provider Audits.** Include the required number of audits per year and required coordination with MCOs and Program Integrity to avoid duplicative audits and to identify potential for fraud, waste, and abuse.
- **Interoperability.** The single PBM will be required to integrate with existing DMAS systems and architecture. DMAS should involve its technology office to ensure all system requirements and expectations regarding interoperability and other requirements, such as security, are clearly defined.
- **Reporting.** Establish required PBM reporting to the MCOs and DMAS, including assistance to DMAS with any federal reporting requirements. DMAS could include higher level reporting requirements in the contract and work with the PBM to establish required reporting and frequency of each report. Reporting examples include:
  - Aggregate and claims-level data.
  - Call center metrics.
  - Rebate invoicing and collection metrics/analyses.
  - Pharmacy network metrics (metrics dependent on PBM responsibilities).
  - Payment metrics (correct dispensing fee, applying the correct pricing model).
  - Administrative fee metrics/data.
  - Pharmacy complaints.
  - Pharmacy audit reports.
- **Annual Market Checks.** To ensure competitive PBM terms over the life of the contract. Annual market checks serve as a mechanism to verify that the PBM continues to deliver contracted services at the lowest possible cost. This process involves benchmarking against industry standards and evaluating competitor offerings to ensure the PBM remains competitive and continues to provide value to DMAS and its members.
- **Early Termination Clauses.** While most State general terms include termination clauses, review those to determine for clarity of when the PBM or DMAS could terminate the contract early.

- **Ensure DMAS Maintains Oversight Responsibility.** Louisiana representatives attributed some of the State's challenges with the single PBM model to the oversight structure that was established. MCOs maintained oversight responsibility of the PBM, and LDH was not able to implement penalties. Alternatively, Kentucky maintained responsibility for PBM oversight and penalty assessment within DMS. DMS has a robust and collaborative monitoring process, which

has been successful for DMS in understanding what is working well and where corrective actions are required.

Statutory and Regulatory Recommendations

Myers and Stauffer offers the following considerations for statutory and regulatory changes that DMAS may want to present to the Virginia Legislature for the Medicaid program:

- **Single PBM Model Definition.** HB 2610 indicates that DMAS must contract with a "single third-party administrator to serve as the state pharmacy benefits manager to administer all pharmacy benefits for Medicaid recipients, including those enrolled in a managed care organization." This specificity does not allow for DMAS to implement alternate models (e.g., separate PBM contracts for FFS and managed care). While DMAS may ultimately determine that one PBM contract to serve all Medicaid members is the preferred option, having this specificity in legislation limits pharmacy benefit administration options should DMAS' experience with the single PBM model necessitate future changes. DMAS should consider requesting changes that allow for more flexibility.

- **Single PBM Model Implementation Date.** As previously discussed in this study, State pharmacy leaders recommend allowing sufficient time for implementation of the single PBM model due to issues, such as necessary transition of benefits and systems connectivity and testing. Additionally, circumstances happen that are out of Medicaid agencies' control that can impact the amount of time allowed for implementation by a specified date. For example, if the RFP process results in bid protests or lawsuits, there is an impact to planned implementation dates. Changes at the federal level could also have impacts. Based on these types of issues, DMAS may want to consider requesting that the current implementation date of July 1, 2026, be modified to as soon as reasonable for DMAS to complete all required procurement and implementation functions for a successful contract go-live.

  Further, the enabling legislation includes reference that this report "shall not affect the implementation date of July 1, 2026" while also stating that "[b]y July 1, 2026, the Department shall select and contract with a single third-party administrator." DMAS may wish to gain clarification that the requirement is to contract with the single PBM by July 1, 2026, and implementation activities would commence at that point. Full implementation of the single PBM contract would fall after that date, July 1, 2027, according to our recommendations.

- **Pharmacy Reimbursement.** HB 2610 did not provide funding to support increases in pharmacy reimbursement. The Governor proposed a targeted dispensing fee increase for critical access pharmacies as part of the final 2025 budget, but this change was not adopted by the General Assembly. While a change in pharmacy reimbursement is an independent consideration separate from implementation of a single PBM, Virginia may want to consider future allocation of additional funding for the Medicaid pharmacy benefit to help address access issues. For example, other states have reinvested savings from their implementation of a single PBM model in provider reimbursement (e.g., increased dispensing fees, more appropriate ingredient cost methodology). This may be a longer-term decision based on future assessment of single PBM model investment impacts.

Final Considerations

As DMAS plans for transition to a new Medicaid pharmacy contracting strategy as mandated by HB 2610, Myers and Stauffer offers the below summary of key observations from our PBM study and industry experience. DMAS has an opportunity through this transition to achieve various program improvements, but to do so will require thoughtful planning, detailed implementation activities, and comprehensive ongoing oversight and compliance monitoring.

Potential program improvements when transitioning to a single PBM model include the following:

- Decreased administrative burden for pharmacy providers.
- Administrative savings from efficiencies and economies of scale with PBM administrative fees being paid to one PBM versus each MCO's PBM.
- Greater transparency and oversight of the Medicaid related PBM activities and ensuring compliance with state and contractual requirements.
- Greater control over utilization management and consistent application of utilization management initiatives and requirements.
- Potential for greater supplemental rebates, including expanding supplemental rebate program to include some "open" classes on the CCF.

To realize the above potential improvements when implementing a single PBM model, Myers and Stauffer has observed the following are necessary:

- Ample time dedicated for single PBM model design, implementation, systems testing, and go-live readiness review. Hiring of additional staff and resources who will be dedicated to monitoring and oversight of PBM contract implementation and ongoing operations.
- Diligence is required to establish a comprehensive procurement vehicle, as well as contracting requirements and service agreements, to clearly identify roles and responsibilities across DMAS, single PBM, and MCOs and ensure accountability. This includes review and amendment of Cardinal Care MCO contracts.
- Defined process and timelines for payment to the single PBM to assure timely claims payment.
- Safeguards to protect members' access and continuity of services during the transition period (e.g., grandfather PAs, if needed).
- Data exchange mechanisms to ensure each MCO has real-time or near real-time access to pharmacy claims and drug utilization data for its assigned members.
- Consideration of the impact of single PBM contract implementation on other vendors from both an operational perspective and any additional costs that DMAS may incur from these vendors.
- Communication strategy that encompasses all affected stakeholders and keep them informed and solicits feedback throughout the process.

- Monitoring of actual savings and strategic use of savings, if realized, to maintain or improve access.
- Ongoing actuarial analysis and monitoring of the impact on the single PBM on the MCO capitation rates as this is a significant source of savings.

Finally, this study is comprehensive in nature, providing insights from Virginia stakeholders and other states' pharmacy leaders, data and financial considerations, and options and recommendations for single PBM contracting in Medicaid programs. However, as acknowledged throughout this report, there are countless issues that DMAS must consider in determining the single PBM program design and contracting strategy that will be of most benefit to the Commonwealth. This study should serve as a basis for DMAS' use as it moves forward in planning with the recognition that decisions are intricately related and will have overarching impacts on the best approach to moving forward as well as to cost and savings estimates presented in this report.

Appendices

Appendix A. Definitions and Acronyms

Table 44 provides a glossary of definitions of terms and acronyms used throughout this report.

Table 44: Glossary of Definitions and Acronyms

Glossary of Definitions and Acronyms		
Terminology	**Acronym**	**Definition**
Actual Acquisition Cost	AAC	AAC is the state Medicaid agency's determination of pharmacy providers' actual prices paid to acquire drug products marketed or sold by a specific manufacturer. AAC is the current Medicaid benchmark to set payment for drug ingredients.
American Rescue Plan Act	ARPA	The American Rescue Plan Act of 2021 was a $1.9 trillion economic stimulus bill designed to enable all Americans to respond to and recover from COVID-19 impacts.[132]
Average Actual Acquisition Cost	AAAC	Average of AAC. See AAC definition.
Average Manufacturer Price	AMP	AMP is the average price paid to the manufacturer by wholesalers and retail community pharmacies that purchase drugs directly from the manufacturer. AMP is used to calculate drug rebates under the Medicaid Drug Rebate Program.
Average Sales Price (single source drugs)	ASP	The ASP is the volume-weighted average of the manufacturers' average sales prices for all NDCs assigned to the drug or biological product.
Average Sales Price (multiple source drugs)	ASP	The ASP for all drug products included within the same multiple source drug billing and payment code is the volume-weighted average of the manufacturers' average sales prices for those drug products.
Average Wholesale Price	AWP	AWP is the published list price for a drug sold by wholesalers to retail pharmacies and nonretail providers. It is akin to a sticker price and used as a starting point for negotiation for payments to retail pharmacies.
Centers for Medicare and Medicaid Services	CMS	Federal agency within the U.S. Department of Health and Human Services responsible for administering Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[133]
Clawback	-	A pharmacy clawback refers to a controversial practice in which the PBM retroactively reduces or denies pharmacy claim reimbursements or changes the reimbursement amount to be paid after the adjudication of a claim.[134]
CMS Covered Outpatient Drugs	COD	Of those drugs which are treated as a prescribed drug for the purposes of section 1905(a)(12) of the Social Security Act (SSA), a drug which may be dispensed only upon a prescription (exceptions

[132] U.S. Economic Development Administration, *American Rescue Plan Partnering with America's Communities to Build Back Better*.
[133] CMS, *About Us*.
[134] Pharmaceutical Care Management Association

Glossary of Definitions and Acronyms		
Terminology	**Acronym**	**Definition**
		noted in the CFR language).[135]
Common Core Formulary	CCF	Virginia's established formulary that applies to both FFS and Cardinal Care members and includes designated preferred drugs in therapeutic drug classes that are on the PDL.[136] MCOs' PDLs must include all drugs on the CCF, and they cannot place additional restrictions on drugs that are in these designated classes.
Coordinated Care Organization	CCO	Health plan contracted with Mississippi DOM to manage and provide healthcare services to beneficiaries in MississippiCAN and CHIP.[137]
Consumer Price Index for All Urban Consumers	CPI-U	The Consumer Price Index for All Urban Consumers (CPI-U) is a monthly measure of the average change over time in the prices paid by consumers for a market basket of consumer goods and services. The CPI-U is based on the spending patterns of urban consumers. [138]
Drug Utilization Review	DUR	State Medicaid programs are required to implement DUR programs pursuant to federal regulations.[139] DUR is intended to interpret patterns of drug use in Medicaid programs and can be leveraged to reduce costs associated with inappropriate prescribing and use of drugs. CMS requires any MCO that includes covered outpatient drugs to operate a DUR program that is as comprehensive as the state's FFS program. Most states maintain conflict of interest polices for DUR Board membership.[140]
Electronic Prior Authorization	ePA	An alternative option where providers can submit their prior authorization through an electronic channel, often a web-based portal.[141]
Federal Supply Schedule	FSS	The collection of multiple award contracts used by federal agencies, U.S. territories, Indian tribes, and other specified entities to purchase supplies and services from outside vendors. FSS prices for the pharmaceutical schedule are negotiated by the Department of Veterans Affairs and are based on the prices that manufacturers charge their "most-favored" non-federal customers under comparable terms and conditions. Because terms and conditions can vary by drug and vendor, the most-favored customer price may not be the lowest price in the market. FSS prices are publicly available.
Federal Upper Limit	FUL	The FUL sets a reimbursement limit for some generic drugs; calculated as 175% of the AMP.
Fee for Service	FFS	A method of payment for health services, where the state Medicaid agency is able to pay providers directly for specific individual services.[142]

[135] 42 CFR § 447.500.
[136] Medical Society of Virginia, *Medicaid Common core Formulary "Quick List" for Physicians* (2019).
[137] Mississippi Division of Medicaid, *MississippiCAN Health Plans*.
[138] Bureau of Labor Statistics, *CPI-All Urban Consumers (Current Series) Help and Information* (2018).
[139] Social Security Act § 1927(g).
[140] 42 C.F.R. § 438.3(s)(4) and (5); KFF, *Conflict of Interest Policies in Medicaid Pharmacy Review* (Jul. 2019).
[141] CVS Caremark, *Electronic Prior Authorization Information* (2025).
[142] Minnesota Department of Human Services, *Fee-For-Service Definition* (Sept. 2021).

Glossary of Definitions and Acronyms		
Terminology	**Acronym**	**Definition**
Healthcare Provider Shortage Areas	HPSA	Service areas or population groups that are designated as having few primary medical care, dental, or mental health providers to meet the needs of the population.[143]
Inflation Reduction Act	IRA	Legislation included several drug pricing reforms, particularly for Medicare-inflation related rebates.
Kentucky Department for Medicaid Services	DMS	State agency responsible for administering the state Medicaid program in Kentucky.
Long-Term Care	LTC	Medical and non-medical care to address an ongoing need.[144]
Louisiana Department of Health	LDH	State agency responsible for administering the state Medicaid program in Louisiana.
Managed Care Organization	MCO	Health plan that utilizes a managed care model to keep a high standard of care while limiting costs.[145]
Maximum Allowable Cost	MAC	MAC is a reimbursement limit set by states in addition to the FUL.
Medicaid Drug Rebate Program	MDRP	Program that includes CMS, state Medicaid agencies, and participating drug manufacturers to help offset the Federal and state costs of some outpatient prescription drugs for Medicaid members.[146]
Medicaid Services Investment and Accountability Act of 2019	MSIAA	Law that influenced changes to Medicaid, which included creating a MDRP (see definition). It provided the Secretary with additional authorities to ensure drug manufacturers follow MDRP, and drugs are classified appropriately for rebate calculation.[147]
Medical Loss Ratio	MLR	The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards.[148]
Medically Underserved Areas	MUA	Shortage of primary health care services for residents within a specific geographic area.[149]
Mississippi Division of Medicaid	DOM	State agency responsible for administering the state Medicaid program in Mississippi.
National Average Drug Acquisition Cost	NADAC	NADAC is intended to be a national average of the prices at which pharmacies purchase a prescription drug from manufacturers or wholesalers, including some rebates. NADAC can be used to calculate AAC.
National Council for Prescription Drug Programs	NCPDP	Multi-stakeholder, non-profit organization that develops and encourages industry standards for the pharmaceutical industry.[150]

[143] Utah Department of Health & Human Services, *Shortage Designations*.
[144] MedicaidLongTermCare.org, *Medicaid Long Term Care: Definition, Programs & Locations* (Jul. 2025).
[145] Definitive Healthcare, *Managed Care Organization (MCO)* (2025).
[146] Medicaid.gov, *Medicaid Drug Rebate Program (MDRP)* (Aug. 2025).
[147] MACPAC, *Advising Congress on Medicaid and CHIP Policy* (Jul. 2023).
[148] CMS, *Medical Loss Ratio* (2024).
[149] MSU, *MUA and MUP Fact Sheet*.
[150] NCPDP, *Our Vision*.

Glossary of Definitions and Acronyms		
Terminology	**Acronym**	**Definition**
National Drug Codes	NDC	Unique number that serves as a universal product identifier for human drugs in the United States.[151]
National Provider Identifier	NPI	A 10-digit identification number mandated by the Health Insurance Portability and Accountability Act (HIPAA) to identify health care providers.[152]
New York State	NYS	Refers to the state of New York.
New York State Department of Health	NYSDOH	State agency responsible for administering the state Medicaid program in New York.
New York State Medicaid Pharmacy Program	NYRx	Program designed to cover medically necessary FDA approved prescription and non-prescription drugs for Medicaid members.[153]
Ohio Department of Medicaid	ODM	State agency responsible for administering the state Medicaid program in Ohio.
Per Member Per Month	PMPM	The average monthly cost of medical services for each individual member of a population.
Pharmacy Benefit Administrator	PBA	See Pharmacy Benefit Manager definition.
Pharmacy Benefit Manager	PBM	Entity that manages prescription drug plan benefits by working with health insurers, large employers, and other payers.[154]
Pharmacy Deserts	-	Geographic areas, either rural or urban, where residents lack access to a local pharmacy, often require travel greater than one to ten miles depending on demographics and vehicle access.
Physician Administered Drug	PAD	A physician-administered drug is an outpatient drug other than a vaccine that is typically administered by a health care provider in a physician's office or other outpatient clinical setting.[155]
Preferred Drug List	PDL	The PDL is a listing of drugs that represent a major component of the covered outpatient drugs available to Medicaid members. It was developed to better manage utilization and expenditure. PDL drugs are often generic or lower cost drugs, or they are drugs for which manufacturers provide a supplemental rebate.[156]
Prepaid Ambulatory Health Plan	PAHP	A non-comprehensive prepaid health plan that provides certain outpatient services and does not cover any inpatient services.[157]
Prior Authorization	PA	PA requires the prescriber to receive pre-approval for prescribing a particular drug for that medication to qualify for coverage under the terms of the pharmacy benefit plan.[158] DMAS uses the term "service authorization."

[151] U.S. FDA, *National Drug Code Database Background Information.*
[152] CMS.gov, *National Provider Identifier Standard (NPI)* (Sept. 2024).
[153] New York State Dep't of Health, *Welcome to NYRx, the Medicaid Pharmacy Program* (Jan. 2024).
[154] The Commonwealth Fund, *What Pharmacy Benefit Managers Do, and How They Contribute to Drug Spending* (Mar. 2025).
[155] MACPAC, Physician Administered Drugs.
[156] KFF, *State Medicaid Preferred Drug Lists* (Jul. 2019).
[157] KFF, *Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts* (Jun. 2015).
[158] Academy of Managed Care Pharmacy, *What is Prior Authorization and Why is it an Essential Managed Care Tool* (Jul. 2019).

Glossary of Definitions and Acronyms		
Terminology	**Acronym**	**Definition**
Professional Dispensing Fee	PDF	The PDF represents the charge for the professional services provided by the pharmacist when dispensing a FFS prescription (including overhead expenses and profit). Medicaid and most direct pay insured prescription programs use dispensing fees to establish pharmacy payment for prescriptions. PDFs do not include any payment for the drugs being dispensed.
Rebates	-	The return of part of the purchase price from the seller to the buyer.[159]
Related Party	-	An entity having direct or indirect ties and financial interest. For example, a pharmacy owned by a pharmacy benefit manager; a pharmacy benefit manager owned by a managed care organization; etc.
Request for Proposals	RFP	Formal document issued by an organization that outlines specific requirements for a project.
Service Authorization	SA	A managed care member's request, or a Provider's request, on behalf of a member, for the provision of services. SA is interchangeable with PA.
Sovereign States Drug Consortium	SSDC	A multi-state pool of Medicaid programs that collaborate to negotiate and secure supplemental rebates from drug manufacturers.[160]
Spread Pricing	-	A PBM practice of charging payers like Medicaid more than the PBM pays the pharmacy for the same medication. The PBM keeps the difference as profit.[161]
State Drug Use Review (DUR) Board	-	DUR Boards are responsible for reviewing information on drug effectiveness and issuing evidence-based recommendations on coverage criteria, such as placement of drugs on the PDL and utilization controls. In addition to effectiveness and safety, the committee may also factor in cost considerations to their decisions.[162]
State Drug Utilization Data	SDUD	Drug utilization data reported by states for covered outpatient drugs paid for by state Medicaid agencies since the start of the Medicaid Drug Rebate Program. The data includes state, drug name, National Drug Code, number of prescriptions, and dollars reimbursed.[163]
State Maximum Allowable Cost	SMAC	Each state's MAC. See MAC definition.
State Plan Amendments	SPA	Formal request made from a state to CMS to make changes to its Medicaid State Plan.
Supplemental Rebates[164]	-	States negotiate with manufacturers to obtain supplemental rebates within selected therapeutic classes. Manufacturers will

[159] AMCP, *Pharmaceutical Manufacturer Rebates* (Oct. 2023).
[160] Sovereign States Drug Consortium, *Sovereign States Drug Consortium*.
[161] Deborah Yetter, *Relief from drug industry middlemen stalled in Kentucky as independent pharmacies struggle*, Kentucky Lantern (Jul. 2025).
[162] 42 U.S.C. §1396r-8 (d) (4).
[163] Data.Medicaid.gov, State Drug Utilization Data (2023). https://data.medicaid.gov/dataset/d890d3a9-6b00-43fd-8b31-fcba4c8e2909.
[164] The Medicaid and CHIP Payment and Access Commission, *Medicaid Payment for Outpatient Prescription Drugs* (May 2018).

Glossary of Definitions and Acronyms		
Terminology	**Acronym**	**Definition**
		offer these supplemental rebates through a bidding process as an incentive to be selected for a state's PDL preferred status. Supplemental rebates are not subject to the best price floor, and states often use placement on a PDL as leverage in negotiation.
Washington Health Care Authority	HCA	State agency responsible for administering the state Medicaid program in Washington state.
West Virginia Bureau for Medical Services	BMS	State agency responsible for administering the state Medicaid program in West Virginia.
West Virginia University School of Pharmacy Rational Drug Therapy Program	RDTP	Program designed to support rational drug use by providing PA for medications on the states' PDLs.[165]
Wholesale Acquisition Cost	WAC	WAC is the manufacturer's list price to wholesalers. The WAC represents manufacturers' published catalog, or list, price for sales of a drug (brand name or generic) to wholesalers. However, in practice, the WAC is not what wholesalers pay for drugs.
Uniform PDL	-	When a state uses a uniform PDL, the state is responsible for designing and setting the PDL for all the Medicaid health plans, as well as the FFS program. Often, a variety of names are used to describe this practice including single PDL, statewide PDL, unified PDL, etc.[166]
Usual & Customary	U&C	The U&C charge to the general public.
Virginia Department of Medical Assistance Services	DMAS	Agency that runs the Virginia Medicaid program.[167]

[165] https://pharmacy.hsc.wvu.edu/rdtp/what-is-rdtp/
[166] Open Minds, *State Medicaid Adoption of Preferred Drug Lists* (Oct. 2019).
[167] VA Dep't of Medical Assistance Serv., *Definitions and Abbreviations*.

Appendix B. Stakeholder Engagement

Myers and Stauffer conducted extensive stakeholder engagement to inform this PBM study. Below is a listing of interview participants and survey respondents.

Table 45: Interview Participants and Survey Respondents

Stakeholder Engagement: Listing of Interview Participants – Organizations and Individuals	
Stakeholder Group	**Participants**
State Agencies	• Department of Health Professions, Board of Pharmacy. • Board of Health. • Virginia Commonwealth University (VCU), Center for Pharmacy Practice Innovation.
Provider Organizations	• Virginia Association of Health Systems Pharmacists. • Virginia Community Pharmacists Association. • Virginia Pharmacy Association/Virginia Academy of Independent Pharmacists. • Virginia Association of Chain Drugstores.
Legislators	• Senator Creigh Deeds. • Delegate Mark Sickles. • Delegate Otto Wachsmann. • Susan Massart (House Appropriations Committee). • Michael Tweedy (Senate Finance and Appropriations Committee).
Vendors	• Mercer. • Change Healthcare, now United/OptumRx. • Prime Therapeutics State Government Solutions.
MCOs	• Virginia Association of Health Plans. • Aetna: CVS Caremark. • Anthem: CarelonRx. • Humana: Humana Pharmacy Solutions. • UnitedHealthcare: OptumRx. • Sentara: Express Scripts.
DMAS	• Executive Team. • Deputies. • Pharmacy Operations Manager. • Managed Care Contracts and Operations Team Members.
Clinics/Hospitals and Health Systems Operating Pharmacies	• Chesapeake Regional Healthcare. • Central Virginia Health Services, Inc. • VCU Health Systems. • Virginia Hospital & Healthcare Association. • Central Virginia Health Services.
Medical Associations	• No responses received.

Appendix C. Data Analysis Exhibits

Non-Specialty Brand Reimbursement by SFY

As shown in *Table 46*, the number of non-specialty brand drug claims decreased over the three SFY periods; however total expenditures continued to rise. The average ingredient cost paid as a percentage of AWP held steady at approximately 79%. The average dispensing fee paid for the period increased from $2.00 to $2.32 over the three-year period. Non-specialty brand drugs make up 9.27% of MCO pharmacy claims and 35.98% of MCO pharmacy expenditures for SFY23 through SFY25.

Table 46: Non-Specialty Brand Reimbursement by SFY

Non-Specialty Brand Reimbursement by SFY						
SFY	**Total Number of Paid Claims**	**Percent Change in Number of Paid Claims**	**Total Amount Paid**	**Percent Change in Total Amount Paid**	**Average Ingredient Paid as Percent of AWP**	**Average Dispensing Fee**
2023	2,070,517		$959,222,573		78.69%	$2.00
2024	1,931,142	-6.7%	$950,846,686	-0.9%	78.94%	$2.32
2025	1,912,956	-0.9%	$980,612,472	3.1%	78.74%	$2.32
Totals	**5,914,615**		**$2,890,681,731**			

Non-Specialty Generic Reimbursement by SFY

As shown in *Table 47*, the number of non-specialty generic drug claims decreased over the three SFY periods, as well as total expenditures. The average ingredient cost paid as a percentage of AWP decreased from 14.43% to 12.75%, indicating a decrease in ingredient cost reimbursement relative to the AWP. The average dispensing fee paid for the period increased from $0.82 to $1.08 over the three-year period. Non-specialty generic drugs make up 89.27% of MCO pharmacy claims and 13.73% of MCO pharmacy expenditures for SFY23 through SFY25.

Table 47: Non-Specialty Generic Reimbursement by SFY

Non-Specialty Generic Reimbursement by SFY						
SFY	**Total Number of Paid Claims**	**Percent Change in Number of Paid Claims**	**Total Amount Paid**	**Percent Change in Total Amount Paid**	**Average Ingredient Paid as Percent of AWP**	**Average Dispensing Fee**
2023	19,406,808		$385,112,633		14.43%	$0.82
2024	18,996,179	-2.1%	$365,649,561	-5.1%	13.20%	$1.04
2025	18,535,426	-2.4%	$352,514,487	-3.6%	12.75%	$1.08
Totals	**56,938,413**		**$1,103,276,681**			

Specialty Brand Reimbursement by SFY

As shown in *Table 48*, the number of specialty brand drug claims and total expenditures increased over the three SFY periods. The average ingredient paid as a percentage of AWP decreased from 78.77% to 77.60%, indicating a slight reduction in ingredient cost reimbursement relative to the AWP. The average dispensing fee paid for the period increased from $1.91 to $3.34 over the three-year period. Specialty brand drugs make up 1.10% of MCO pharmacy claims and 47.49% of MCO pharmacy expenditures for SFY23 through SFY25.

Table 48: Specialty Brand Reimbursement by SFY

Specialty Brand Reimbursement by SFY						
SFY	**Total Number of Paid Claims**	**Percent Change in Number of Paid Claims**	**Total Amount Paid**	**Percent Change in Total Amount Paid**	**Average Ingredient Paid as Percent of AWP**	**Average Dispensing Fee**
2023	211,011		$1,132,078,073		78.77%	$1.91
2024	233,731	10.8%	$1,260,159,047	11.3%	77.53%	$3.17
2025	255,819	9.5%	$1,423,070,412	12.9%	77.60%	$3.34
Totals	**700,561**		**$3,815,307,531**			

Specialty Generic Reimbursement by SFY

As shown in *Table 49*, the number of specialty generic drug claims and total expenditures increased over the three SFY periods. The average ingredient paid as a percentage of AWP increased from 59.22% to 61.53%, indicating an increase in ingredient cost reimbursement relative to the AWP. The average dispensing fee paid for the period increased from $2.02 to $2.57 over the three-year period. Specialty generic drugs make up 0.35% of MCO pharmacy claims and 2.79% of MCO pharmacy expenditures for SFY23 through SFY25.

Table 49: Specialty Generic Reimbursement by SFY

Specialty Generic Reimbursement by SFY						
SFY	**Total Number of Paid Claims**	**Percent Change in Number of Paid Claims**	**Total Amount Paid**	**Percent Change in Total Amount Paid**	**Average Ingredient Paid as Percent of AWP**	**Average Dispensing Fee**
2023	74,150		$68,296,975		59.22%	$2.02
2024	75,445	1.7%	$74,793,626	9.5%	60.23%	$2.71
2025	76,821	1.8%	$81,037,793	8.3%	61.53%	$2.57
Totals	**226,416**		**$224,128,393**			

Appendix D. Chain and Independent

Chain versus Independent Non-Specialty Brand Pharmacy Reimbursement

The difference for non-specialty brand name drug claims' average ingredient amount paid as a percentage of AWP between chain and independent was nominal. The dispensing fees for independent pharmacies were greater than chain pharmacies across fiscal years for non-specialty brand name drugs.

Table 50: Chain versus Independent Non-Specialty Brand Pharmacy Reimbursement

Chain versus Independent Non-Specialty Brand Pharmacy Reimbursement				
SFY	**Average Ingredient Paid as Percent of AWP: Chain**	**Average Ingredient Paid as Percent of AWP: Independent**	**Average Dispensing Fee: Chain**	**Average Dispensing Fee: Independent**
2023	78.71%	78.60%	$1.93	$2.23
2024	79.01%	78.68%	$2.17	$2.85
2025	78.77%	78.60%	$2.19	$2.86

Chain versus Independent Non-Specialty Generic Pharmacy Reimbursement

The difference for non-specialty generic drug claims' average ingredient amount paid as a percentage of AWP between chain and independent was nominal. The dispensing fees for independent pharmacies were greater than chain pharmacies across fiscal years for non-specialty generic drugs.

Table 51: Chain versus Independent Non-Specialty Generic Pharmacy Reimbursement

Chain versus Independent Non-Specialty Generic Pharmacy Reimbursement				
SFY	**Average Ingredient Paid as Percent of AWP: Chain**	**Average Ingredient Paid as Percent of AWP: Independent**	**Average Dispensing Fee: Chain**	**Average Dispensing Fee: Independent**
2023	14.73%	13.34%	$0.78	$0.94

Chain versus Independent Non-Specialty Generic Pharmacy Reimbursement				
SFY	Average Ingredient Paid as Percent of AWP: Chain	Average Ingredient Paid as Percent of AWP: Independent	Average Dispensing Fee: Chain	Average Dispensing Fee: Independent
2024	13.15%	13.40%	$1.00	$1.16
2025	12.92%	12.04%	$1.03	$1.27

Chain versus Independent Specialty Brand Pharmacy Reimbursement

Due to the high cost of specialty brand drugs, differences in reimbursement percentages can have a significant impact for specialty products. As noted above, specialty brand claims account for only 1.10% of MCO pharmacy claims, but 47.49% of all MCO pharmacy expenditures. For brand specialty drugs, the average ingredient amount paid as a percentage of AWP was greater for the chain pharmacies than the independent pharmacies. Chain pharmacies were also paid a higher average dispensing fee.

Table 52: Chain versus Independent Specialty Brand Pharmacy Reimbursement

Chain versus Independent Specialty Brand Pharmacy Reimbursement				
SFY	Average Ingredient Paid as Percent of AWP: Chain	Average Ingredient Paid as Percent of AWP: Independent	Average Dispensing Fee: Chain	Average Dispensing Fee: Independent
2023	80.94%	75.32%	$2.71	$0.69
2024	80.34%	73.69%	$4.67	$1.03
2025	80.21%	74.71%	$5.16	$1.22

For SFY23, two health plans were drivers of the lower reimbursement to independent pharmacies for brand specialty drug claims. For SFY24 and SFY25, one health plan reimbursed brand specialty drug claims 9% lower for independent pharmacies than chain pharmacies. For SFY23, three health plans were drivers for average dispensing fees being higher for chain pharmacies than for independents. They had an average dispensing fee per claim more than $1.50 higher for chain pharmacies than for independents. One of those plans had an average dispensing fee that was $6.25 higher for chains than independents. For SFY24 and SFY25, there were two health plans that had average dispensing fees that were more

than $2.50 higher for chain pharmacies than independents. One health plan had approximately a $10 higher average dispensing fee for chains than independents.

Table 53: Chain versus Independent Specialty Brand Pharmacy Reimbursement by Plan

Chain and Independent Specialty Brand Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Chain	Average Ingredient Paid as Percent of AWP: Independent	Average Dispensing Fee: Chain	Average Dispensing Fee: Independent	Average Ingredient Paid as Percent of AWP: Chain	Average Ingredient Paid as Percent of AWP: Independent	Average Dispensing Fee: Chain	Average Dispensing Fee: Independent	Average Ingredient Paid as Percent of AWP: Chain	Average Ingredient Paid as Percent of AWP: Independent	Average Dispensing Fee: Chain	Average Dispensing Fee: Independent
AETNA	CVS	80.78%	79.93%	$0.71	$0.33	80.53%	79.88%	$0.90	$0.30	80.50%	79.80%	$1.14	$0.54
ANTHEM	CARELONRX	81.20%	80.76%	$0.29	$0.18	80.04%	80.19%	$0.44	$0.21	79.73%	80.38%	$0.76	$0.31
MOLINA	CVS	79.35%	79.49%	$0.77	$0.60	78.90%	78.69%	$1.08	$0.36	79.13%	79.21%	$1.23	$0.68
SENTARA	EXPRESS SCRIPTS	80.38%	71.51%	$1.63	$0.13	79.98%	70.62%	$2.77	$0.13	79.86%	70.45%	$3.19	$0.19
UNITED	OPTUMRX	82.45%	81.24%	$13.42	$7.17	82.23%	82.20%	$25.29	$14.62	81.94%	82.48%	$24.44	$15.60
VIRGINIA	ELIXIR	80.14%	75.57%	$3.00	$0.55								

Chain versus Independent Specialty Generic Pharmacy Reimbursement

Independent pharmacies were paid an average ingredient amount as a percentage of AWP that was 4.68% less than chain pharmacies for specialty generic drug claims in SFY23. However, by SFY25 the difference became negligible. Independent pharmacies were paid higher dispensing fees across all three fiscal years.

Table 54: Chain versus Independent Specialty Generic Pharmacy Reimbursement

Chain versus Independent Specialty Generic Pharmacy Reimbursement				
SFY	**Average Ingredient Paid as Percent of AWP: Chain**	**Average Ingredient Paid as Percent of AWP: Independent**	**Average Dispensing Fee: Chain**	**Average Dispensing Fee: Independent**
2023	42.30%	37.62%	$1.37	$3.34
2024	40.27%	38.82%	$2.14	$3.87
2025	38.35%	38.66%	$2.35	$3.00

Appendix E. Related Versus Non-Related Party

Related versus Non-Related Non-Specialty Brand Pharmacy Reimbursement

The difference between non-specialty brand drug claims average ingredient amount paid as a percentage of AWP between related and non-related party pharmacies was nominal. The average dispensing fee for non-related party pharmacies was greater than related party pharmacies across all three state fiscal years.

Table 55: Related and Non-Related Non-Specialty

Related and Non-Related Non-Specialty Brand Pharmacy Reimbursement				
SFY	Average Brand Ingredient – Related Party	Average Brand Ingredient – Non-Related Party	Average Dispensing Fee for Brand Drugs-Related Party	Average Dispensing Fee for Brand Drugs – Non-Related Party
2023	79.13%	78.57%	$1.19	$2.23
2024	78.34%	79.11%	$1.88	$2.44
2025	77.99%	78.95%	$1.82	$2.47

Related versus Non-Related Non-Specialty Generic Pharmacy Reimbursement

In the aggregate over the three SFYs, the difference in average ingredient amount paid as a percentage of AWP for related-party pharmacies compared to non-related pharmacies was nominal for non-specialty brand drugs. However, the ingredient amount paid as a percentage of AWP varied greatly between health plans as shown in *Table 56*. Related-party pharmacies had a lower average dispensing fee than urban pharmacies ranging from $0.76 to $1.05 over the three fiscal years.

Table 56: Related and Non-Related Non-Specialty Generic Pharmacy Reimbursement

Related and Non-Related Non-Specialty Generic Pharmacy Reimbursement				
SFY	Average Generic Ingredient – Related Party	Average Generic Ingredient – Non-Related Party	Average Dispensing Fee for Generic Drugs – Related Party	Average Dispensing Fee for Generic Drugs – Non-Related Party
2023	15.44%	14.16%	$0.22	$0.98

Related and Non-Related Non-Specialty Generic Pharmacy Reimbursement				
SFY	Average Generic Ingredient – Related Party	Average Generic Ingredient – Non-Related Party	Average Dispensing Fee for Generic Drugs – Related Party	Average Dispensing Fee for Generic Drugs – Non-Related Party
2024	14.50%	12.85%	$0.25	$1.26
2025	12.59%	12.79%	$0.27	$1.32

Table 57: Related and Non-Related Non-Specialty Generic Pharmacy Reimbursement by Plan

Related and Non-Related Non-Specialty Generic Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party
AETNA	CVS	17.04%	14.92%	$0.11	$0.28	14.80%	12.43%	$0.06	$0.25	13.85%	11.82%	$0.05	$0.24
ANTHEM	CARELONRX	14.93%	13.73%	$0.12	$0.32	14.53%	13.67%	$0.04	$0.25	11.96%	14.76%	$0.04	$0.22
MOLINA	CVS	14.96%	10.03%	$0.13	$0.31	14.38%	12.55%	$0.07	$0.21	13.05%	11.61%	$0.07	$0.22
SENTARA	EXPRESS SCRIPTS	14.13%	14.62%	$0.56	$0.49	18.50%	13.41%	$0.01	$0.57	17.75%	13.19%	$0.00	$0.62
UNITED	OPTUMRX	9.36%	13.67%	$8.06	$4.01	6.63%	9.63%	$14.65	$6.99	5.75%	9.51%	$14.62	$6.91
VIRGINIA	ELIXIR		14.90%		$1.01								

Related versus Non-Related Specialty Brand Pharmacy Reimbursement

Due to the high cost of specialty brand drugs, differences in reimbursement percentages can have a significant impact for specialty products. As noted above, specialty brand claims account for only 1.10% of MCO pharmacy claims, but 47.49% of all MCO pharmacy expenditures. For brand specialty drugs the average ingredient amount paid as a percentage of AWP was nominally greater for related-party pharmacies than non-

related party pharmacies for SFY23. For SFY24 and SFY25 the average ingredient amount paid as a percentage of AWP was more than 4% higher for non-related party pharmacies than for related-party pharmacies. For SFY24 and SFY25 one health plan reimbursed brand specialty drug claims 9% lower for related-party pharmacies than non-related party pharmacies. Related-party pharmacies were paid a higher average dispensing fee for all three state fiscal years.

Table 58: Related and Non-Related Specialty Brand Pharmacy Reimbursement

Related and Non-Related Specialty Brand Pharmacy Reimbursement				
SFY	**Average Brand Ingredient – Related Party**	**Average Brand Ingredient – Non-Related Party**	**Average Dispensing Fee for Brand Drugs – Related Party**	**Average Dispensing Fee for Brand Drugs – Non-Related Party**
2023	79.18%	78.44%	$2.61	$1.45
2024	75.88%	80.08%	$3.62	$2.70
2025	75.47%	80.19%	$3.97	$2.81

For SFY24 and SFY25 one health plan reimbursed brand specialty drug claims 9% lower for related-party pharmacies than non-related party pharmacies. For SFY23, one health plan was the primary driver for average dispensing fees being higher for related-party pharmacies than for independents. This health plan had an average dispensing fee per claim that was $9.81 higher for related-party pharmacies than for non-related party pharmacies. For SFY24 and SFY25, all but one plan paid higher average dispensing fees to non-related party pharmacies than related-party pharmacies. One health plan had dispensing fees for related-party pharmacies that ranged between approximately $16 to $18 higher average than dispensing fees for non-related party pharmacies.

Table 59: Related and Non-Related Specialty Brand Pharmacy Reimbursement by Plan

Related and Non-Related Specialty Brand Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party
AETNA	CVS	80.90%	80.31%	$0.60	$0.62	80.78%	80.06%	$0.56	$0.84	80.94%	79.91%	$0.53	$1.17
ANTHEM	CARELONRX	81.06%	81.33%	$0.25	$0.30	79.85%	80.51%	$0.02	$0.91	79.33%	80.56%	$0.01	$1.01
MOLINA	CVS	78.44%	79.95%	$0.71	$0.71	78.24%	79.18%	$0.59	$0.96	78.60%	79.57%	$0.50	$1.32
SENTARA	EXPRESS SCRIPTS	71.20%	74.54%	$0.40	$0.44	69.85%	79.32%	$0.04	$1.96	69.62%	79.42%	$0.02	$2.35
UNITED	OPTUMRX	82.17%	82.39%	$17.04	$7.23	82.18%	82.28%	$31.90	$13.77	82.15%	81.90%	$30.17	$14.02
VIRGINIA	ELIXIR		77.57%		$1.73								

Related versus Non-Related Specialty Generic Pharmacy Reimbursement

For specialty generic drugs the average ingredient amount paid as a percentage of AWP was nominally greater for related-party pharmacies than for non-related-party pharmacies during SFY23. For SFY24 and SFY25 the average ingredient amount paid as a percentage of AWP was at least 11.50% higher for non-related party pharmacies than for related-party pharmacies. Non-related-party pharmacies were paid higher dispensing fees across all three fiscal years.

Table 60: Related and Non-Related Specialty Generic Pharmacy Reimbursement

Related and Non-Related Specialty Generic Pharmacy Reimbursement				
State Fiscal Year	Average Generic Ingredient-Related-Party	Average Generic Ingredient- Non-Related-Party	Average Dispensing Fees for Generic Drugs-Related-Party	Average Dispensing Fees for Generic Drugs-Non-Related Party
2023	40.96%	40.66%	$0.96	$2.45

Related and Non-Related Specialty Generic Pharmacy Reimbursement				
State Fiscal Year	Average Generic Ingredient-Related-Party	Average Generic Ingredient- Non-Related-Party	Average Dispensing Fees for Generic Drugs-Related-Party	Average Dispensing Fees for Generic Drugs-Non-Related Party
2024	34.32%	46.01%	$1.74	$3.24
2025	32.56%	44.53%	$1.88	$2.93

The difference in average ingredient amount paid as a percentage of AWP varied significantly between plans across all three state fiscal years. All plans except for one paid higher average dispensing fees to non-related-party pharmacies than related-party pharmacies. One health plan that paid higher dispensing fees to related-party pharmacies had fees ranging from $11.52 to $22.20 across the three SFYs.

Table 61: Related and Non-Related Specialty Generic Pharmacy Reimbursement by Plan

Related and Non-Related Specialty Generic Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party	Average Ingredient Paid as Percent of AWP: Related Party	Average Ingredient Paid as Percent of AWP: Non-Related Party	Average Dispensing Fee: Related Party	Average Dispensing Fee: Non-Related Party
AETNA	CVS	64.39%	60.08%	$0.06	$1.12	62.39%	60.68%	$0.00	$1.07	56.30%	61.73%	$0.00	$1.02
ANTHEM	CARELONRX	39.52%	38.02%	$0.09	$2.85	29.56%	42.88%	$0.01	$2.10	22.95%	38.31%	$0.00	$1.50
MOLINA	CVS	42.56%	44.89%	$0.06	$2.02	47.48%	53.36%	$0.00	$1.37	46.29%	52.84%	$0.00	$1.48
SENTARA	EXPRESS SCRIPTS	26.32%	36.09%	$0.00	$1.79	27.01%	41.73%	$0.00	$3.10	26.85%	42.74%	$0.00	$2.79
UNITED	OPTUMRX	37.49%	32.56%	$16.74	$5.22	36.86%	32.42%	$31.75	$9.56	36.60%	30.04%	$29.53	$9.33
VIRGINIA	ELIXIR		37.54%		$2.12								

Appendix F. In-State Urban Versus Rural

Rural versus Urban Non-Specialty Brand Pharmacy Reimbursement

The difference between non-specialty brand drug claims average ingredient amount paid as a percentage of AWP between urban and rural was nominal. The average dispensing fee for urban pharmacies was greater than rural pharmacies in SFY23 by $0.13 and was nominal as of SFY25.

Table 62: Rural versus Urban Non-Specialty Brand Pharmacy Reimbursement

Rural versus Urban Non-Specialty Brand Pharmacy Reimbursement				
SFY	**Average Ingredient Paid as Percent of AWP: Urban**	**Average Ingredient Paid as Percent of AWP: Rural**	**Average Dispensing Fee: Urban**	**Average Dispensing Fee: Rural**
2023	78.53%	79.27%	$2.02	$1.89
2024	78.86%	79.21%	$2.28	$2.34
2025	78.66%	78.99%	$2.29	$2.30

Rural versus Urban Non-Specialty Generic Pharmacy Reimbursement

Rural pharmacies were paid an average ingredient amount as a percentage of AWP 1% lower than urban pharmacies and the average dispensing fee was approximately $0.20 lower than for urban pharmacies during all fiscal years. *Table 63* details the pharmacy reimbursement for each health plan for all three SFYs for non-specialty generic drug claims.

Table 63: Rural versus Urban Non-Specialty Generic Pharmacy Reimbursement

Rural versus Urban Non-Specialty Generic Pharmacy Reimbursement				
SFY	**Average Ingredient Paid as Percent of AWP: Urban**	**Average Ingredient Paid as Percent of AWP: Rural**	**Average Dispensing Fee: Urban**	**Average Dispensing Fee: Rural**
2023	14.80%	13.68%	$0.83	$0.65
2024	13.40%	12.44%	$1.05	$0.85
2025	12.98%	11.81%	$1.10	$0.88

Table 64: Rural versus Urban Non-Specialty Generic Pharmacy Reimbursement by Plan

Rural and Urban Non-Specialty Generic Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural
AETNA	CVS	16.34%	14.38%	$0.19	$0.21	13.95%	12.02%	$0.14	$0.18	13.21%	11.39%	$0.14	$0.19
ANTHEM	CARELONRX	14.56%	12.87%	$0.22	$0.18	14.24%	12.79%	$0.13	$0.15	13.75%	12.16%	$0.12	$0.14
MOLINA	CVS	13.21%	12.28%	$0.24	$0.22	13.56%	12.28%	$0.15	$0.18	12.59%	11.08%	$0.15	$0.17
SENTARA	EXPRESS SCRIPTS	14.71%	13.75%	$0.50	$0.44	13.43%	13.17%	$0.68	$0.27	13.33%	12.61%	$0.74	$0.30
UNITED	OPTUMRX	13.94%	12.09%	$4.08	$3.88	9.62%	8.95%	$7.09	$6.72	9.46%	8.91%	$7.01	$6.56
VIRGINIA	ELIXIR	15.06%	14.59%	$1.26	$0.47								

Rural versus Urban Specialty Brand Pharmacy Reimbursement

Rural pharmacies received ingredient amount payments that were approximately 5% higher as a percentage of AWP than urban pharmacies. Rural pharmacies also received higher average dispensing fee for specialty brand claims with a difference in average dispensing fees of $0.52 in SFY23 and $1.68 in SFY25.

Table 65: Rural versus Urban Specialty Brand Pharmacy Reimbursement

Rural versus Urban Specialty Brand Pharmacy Reimbursement				
SFY	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural
2023	74.95%	80.28%	$1.31	$1.83
2024	74.06%	79.63%	$1.83	$2.83
2025	74.12%	79.44%	$2.06	$3.75

One plan paid an ingredient amount as a percent of AWP that was approximately 8.5% lower for urban pharmacies than for rural pharmacies. All health plans had higher average dispensing fees for rural pharmacies than for urban pharmacies across all three fiscal years.

Table 66: Rural versus Urban Specialty Brand Pharmacy Reimbursement by Plan

Rural and Urban Specialty Brand Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural
AETNA	CVS	79.65%	79.84%	$0.47	$0.64	79.33%	79.40%	$0.67	$0.85	79.07%	79.24%	$0.87	$1.85
ANTHEM	CARELONRX	79.49%	79.53%	$0.25	$0.42	78.80%	78.84%	$0.78	$1.14	79.10%	79.04%	$1.13	$2.11
MOLINA	CVS	79.02%	79.26%	$0.46	$0.97	78.18%	78.70%	$0.72	$1.69	78.56%	78.90%	$1.07	$1.56
SENTARA	EXPRESS SCRIPTS	71.38%	80.01%	$0.29	$1.22	70.84%	79.68%	$0.86	$1.33	70.44%	78.91%	$0.93	$1.88
UNITED	OPTUMRX	81.25%	81.48%	$7.11	$7.47	81.33%	81.64%	$13.27	$13.80	81.38%	81.78%	$13.65	$15.69
VIRGINIA	ELIXIR	72.62%	81.04%	$2.31	$1.43								

Rural versus Urban Specialty Generic Pharmacy Reimbursement

Rural pharmacies were paid an average ingredient amount as a percentage of AWP that was 5.32% more than urban pharmacies for specialty generic drug claims in SFY23. However, by SFY25 the difference became negligible. Rural pharmacies had a lower average dispensing fee than urban pharmacies ranging from $1.34 to $1.57 over the three fiscal years.

Table 67: Rural versus Urban Specialty Generic Pharmacy Reimbursement

Rural versus Urban Specialty Generic Pharmacy Reimbursement				
SFY	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural
2023	32.21%	37.53%	$1.95	$0.61
2024	32.65%	32.64%	$2.40	$0.83
2025	31.69%	31.38%	$2.18	$0.82

The ingredient amount paid as a percentage of AWP varied greatly between health plans. All health plans had lower average dispensing fees for rural pharmacies than for urban pharmacies across all three fiscal years.

Table 68: Rural versus Urban Specialty Generic Pharmacy Reimbursement by Plan

Rural and Urban Specialty Generic Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural
AETNA	CVS	55.92%	41.57%	$0.87	$0.11	55.11%	41.77%	$0.96	$0.06	53.71%	41.52%	$0.89	$0.06
ANTHEM	CARELONRX	25.56%	32.46%	$1.68	$0.12	24.89%	25.51%	$1.36	$0.05	19.77%	14.68%	$1.04	$0.04
MOLINA	CVS	40.17%	41.87%	$1.80	$0.08	47.71%	38.29%	$1.29	$0.01	48.18%	34.72%	$1.38	$0.01

Rural and Urban Specialty Generic Pharmacy Reimbursement													
		SFY23				SFY24				SFY25			
Plan	PBM	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural
SENTARA	EXPRESS SCRIPTS	29.16%	44.73%	$1.36	$0.45	28.07%	38.03%	$2.34	$0.18	28.23%	37.18%	$2.13	$0.24
UNITED	OPTUMRX	26.60%	25.81%	$4.97	$3.72	27.95%	11.11%	$8.64	$7.29	28.16%	25.19%	$8.14	$7.22
VIRGINIA	ELIXIR	27.07%	38.14%	$2.48	$0.48								