

JOINT COMMISSION ON HEALTH CARE

ACCESS TO PHARMACY SERVICES IN VIRGINIA REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA



REPORT DOCUMENT #66

COMMONWEALTH OF VIRGINIA
RICHMOND
2026

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Access to Pharmacy Services in Virginia

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Access to Pharmacy Services in Virginia

POLICY OPTIONS IN BRIEF

Option: Submit a budget amendment to set a reimbursement fee floor, including drug ingredient costs and professional dispensing fees, for community pharmacies for all Medicaid members.
(Option 1, page 24)

Option: Introduce legislation and submit a budget amendment to establish an incentive program to provide funding for pharmacies operating in localities with low access to community pharmacies.
(Option 2, page 27)

Option: Submit a budget amendment to increase funding to the Virginia Association of Free and Charitable Clinics and the Virginia Community Healthcare Association to expand access to pharmacy services provided through free and charitable clinics and community health centers to localities with no operating community pharmacies.
(Option 3, page 28)

FINDINGS IN BRIEF

Community pharmacies are a critical access point for health care services

Community pharmacies dispense medications and provide clinical services that improve medication adherence and health outcomes for patients. Limited access to community pharmacies negatively impacts health outcomes.

Access to community pharmacies is changing in Virginia

The total number of community pharmacies operating in Virginia has declined steadily since 2019, leaving 22 localities in the Commonwealth with only one or no community pharmacy within its borders.

Imbalance between pharmacy expenses and revenue is the primary driver of pharmacy closures

Reimbursement rates for dispensing of medications are not sufficient to offset the expense of purchasing, stocking, and dispensing drug products. This loss results in financial pressures that drive pharmacy closures.

States can reduce financial challenges for pharmacies by addressing practices that limit pharmacy revenue

Virginia has placed limits on PBM practices that impact pharmacy revenue and could also establish minimum reimbursement fees for pharmacies when the state is the payer, including within the Commonwealth's Medicaid program.

States can provide incentives to maintain or re-establish pharmacies in low access communities

Pharmacies in rural communities face unique challenges to sustaining operations, including smaller populations, lower sales volumes, and high rates of Medicaid enrollment. Incentive programs provide direct financial support to select pharmacies or pharmacists meeting certain criteria in limited access areas. Additional funding for government-funded pharmacy services could expand access in areas with no pharmacies.

Access to Pharmacy Services in Virginia

Community pharmacies serve all members of the public by dispensing medications and providing critical health services, including testing for certain illnesses and administering vaccinations. They are an added benefit to communities because they are more accessible for more individuals, staffed with highly trained health care professionals, typically open longer hours than other health care offices, and provide face-to-face engagement with individuals to counsel on medications and provide other health-related education.

Beginning in 2019, the total number of community pharmacies operating in Virginia has declined each year, with a total decline of nearly 10 percent between 2019 and 2024.

During their October 2025 meeting, the Virginia State Board of Health adopted a resolution to recognize pharmacy deserts – areas of the state where communities have no or limited access to community pharmacies - as a threat to public health. Without access to community pharmacies, the resolution posits, individuals lose the ability to access needed medications, as well as other preventive health pharmacy services such as immunizations. This can be particularly harmful for individuals in medically underserved communities and individuals living with chronic conditions.

Recognizing the growing concern about changes in pharmacy access, in December of 2024, the Joint Commission on Health Care (JCHC) directed staff to study access to pharmacy services in Virginia, to better understand changes in access and the factors driving those changes (see APPENDIX 1 for the study resolution). While individuals can access pharmacy services through means other than community pharmacies, such as ordering medications through mail-order services and receiving vaccinations or testing and treatment for illness at primary health care offices, community pharmacies provide accessible, comprehensive services to all members of the public in one location. As such, this study focuses exclusively on access to pharmacy services provided through community pharmacies, including independent pharmacies, chain pharmacies, and government-funded or philanthropic pharmacies. The JCHC directed staff to:

- Describe how access to pharmacy services has changed in Virginia over time, and the impact of changes in access to pharmacy services on Virginians,
- Identify areas in Virginia that constitute pharmacy deserts, and describe populations in Virginia that are impacted by pharmacy deserts,
- Identify factors that impact access to pharmacy services in Virginia, including state and federal law,
- Describe strategies to ensure access to pharmacy services, including strategies implemented in other states, and

- Recommend policy options through which the state may ensure access to pharmacy services.

Community pharmacies are a critical access point for health care services

Retail community pharmacies, defined in § 38.2-3465 of the *Code of Virginia*, are open to the public, serve walk-in customers, and make available face-to-face consultations between licensed pharmacists and persons to whom medications are dispensed. For the purposes of this study, community pharmacies include independent pharmacies, chain pharmacies, and government-funded or philanthropic pharmacies. While dispensing of medications is their primary function, changes to Virginia law and regulations have formally expanded the scope of pharmacy practice in Virginia to include medication counseling and certain clinical services. Informally, pharmacists working in community pharmacies are trusted health professionals who often develop long-term relationships with the individuals they serve and are easily accessible for face-to-face advice on a myriad of health-related issues.

Federal and state rules govern the practice of pharmacy and the operation of pharmacies

Federal and state law and regulations establish boundaries for the practice of pharmacy, the services pharmacists and pharmacies may provide, and standards for the operation of pharmacy locations. Federal rules ensure that all medications are distributed safely and establish requirements for prescribing, dispensing, storing, and disposing of medications. State law and regulations establish additional requirements for pharmacies and pharmacists operating in Virginia. The Virginia Board of Pharmacy also sets regulations for licensing pharmacists and issuing permits to pharmacies. To be licensed by the Board of Pharmacy to practice in Virginia, pharmacists must earn a Doctor of Pharmacy (PharmD) degree from an accredited program, have at least 1,500 hours of clinical experience, and pass two assessments – one on knowledge and skills necessary to practice pharmacy safely and one on federal and state laws and regulations related to pharmacy practice. The Board of Pharmacy regulations allow pharmacies to employ pharmacy interns, pharmacy technicians, and pharmacy technician trainees who meet specified criteria to engage in the practice of pharmacy under the direct supervision of the licensed pharmacist.

Role of pharmacies has expanded from dispensing medications to the provision of clinical services

Prior to 1999, the definition of “practice of pharmacy” included in § 54.1-3300 of the *Code of Virginia* reflected a traditional, core focus on dispensing, describing the “practice of pharmacy” as:

The personal health service that is concerned with the art and science of selecting, procuring, recommending, administering, preparing, compounding, packaging, and dispensing of drugs, medicines and devices used in the diagnosis, treatment, or prevention of disease ...[including] the proper and safe storage and distribution of drugs, the maintenance of proper records, and the responsibility of providing information concerning drugs and medicines and their therapeutic values and use in the treatment and prevention of disease.

The *Code of Virginia* includes specific requirements for patient counseling, including conducting a prospective drug review for each new prescription and offering counseling to any person who presents a new prescription for filling. The requirement for patient counseling and education recognizes the role pharmacists can play in improving medication adherence, reducing medication problems, maximizing therapeutic outcomes, and improving patients' well-being.

Over the last three decades, the General Assembly has expanded the scope of pharmacy practice in Virginia, reflecting changing perspectives on the role of pharmacists and pharmacies in the health care system. In 1999, the General Assembly amended the *Code of Virginia* to allow pharmacists to enter into collaborative agreements with health care practitioners for the management of patient care. Prior to implementation of the collaborative model, pharmacists lacked authority to initiate drug therapy or modify drug therapy regimens prescribed by providers. Adoption of the collaborative practice model granted pharmacists the ability to exercise independent professional judgement within the bounds of the terms of a collaborative agreement to assess patients, order laboratory tests to monitor a patient's condition, select drugs and devices to manage or treat a patient's health condition, and initiate, monitor, continue, and adjust drug therapy regimens to improve patient outcomes in the absence of an order or other participation from a prescriber.

In the past five years, the General Assembly has enacted laws that granted authority to pharmacists to initiate treatment with and to dispense and administer certain vaccines, drugs, and devices to patients in the absence of a prescription issued by a prescriber (SIDEBAR). These subsequent changes to the *Code of Virginia* allow pharmacists to exercise independent clinical judgement, guided by appropriate clinical tools and consistent with protocols adopted by the Board of Pharmacy. The expansion of the scope of the practice of pharmacy reflects changing perceptions of the role of pharmacists in the delivery of health care services. No longer limited to dispensing drugs and devices pursuant to a practitioner's

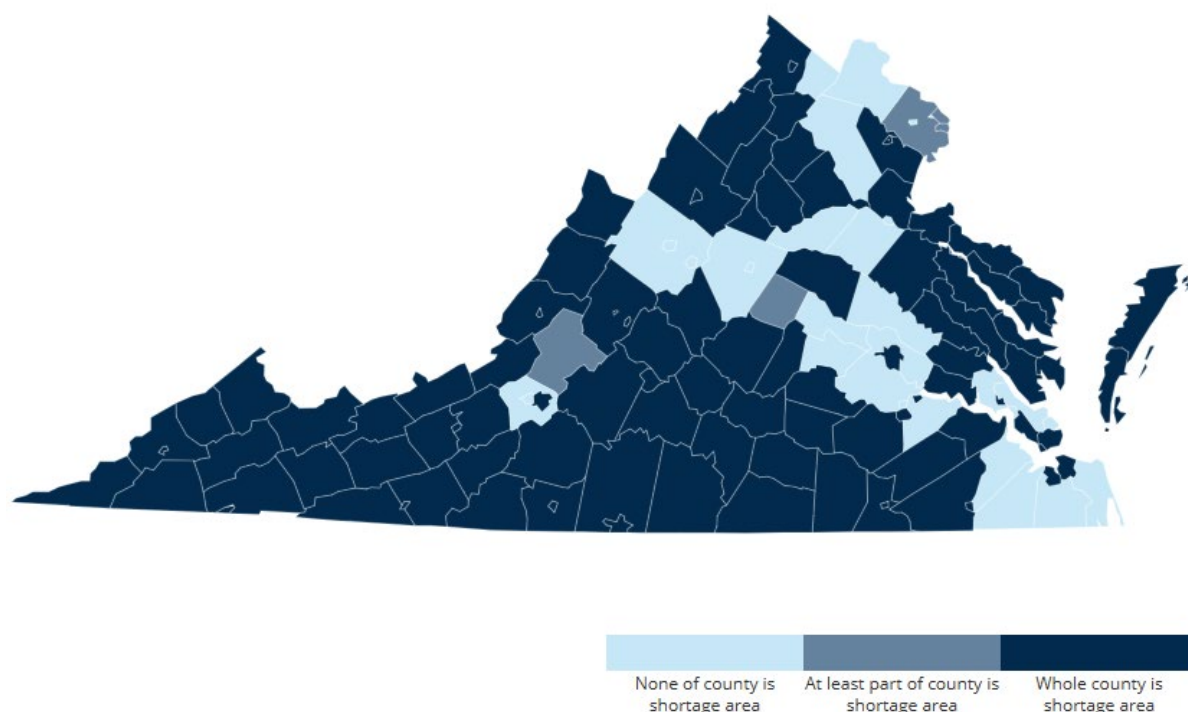
Pharmacist authority to administer drugs and vaccines. Pharmacists can dispense and administer certain drugs - such as naloxone, epinephrine and prenatal vitamins - and vaccines in the absence of a prescription. Pharmacies continue to be the primary source of COVID-19 vaccinations in the United States. By the end of the 2024-2025 vaccination season, retail community pharmacies administered 27.6 million doses of the vaccine, compared to 3.2 million doses in physician medical offices.

order, pharmacists now participate directly in the delivery of health care services, offering preventive and treatment services that improve both patient health outcomes and public health.

Community pharmacies provide comprehensive services to all members of the public

Community pharmacies are open to all members of the public and pharmacists must be available during all times that pharmacy is offering services. As such, community pharmacies offer patients an accessible opportunity for in-person counseling, education, and communication, leading to improved medication adherence and better health outcomes for patients. Pharmacists' extended availability also means that patients may be able to access primary health care services that fall within the scope of the practice of pharmacy including vaccinations, point of care testing for and medications to treat influenza, strep, COVID-19, and urinary tract infections, and other medications that contribute to positive individual and public health outcome such as pre-exposure and post-exposure prophylaxis for human immunodeficiency virus, hormonal contraceptives, and prenatal vitamins. Access to community pharmacists who can provide these primary health care services is increasingly important as access to primary care professionals diminishes. As of July 2025, the Health Resources and Services Administration designated 104 localities in Virginia as either partially or wholly primary care shortage areas (FIGURE 1).

FIGURE 1. Localities designated as health professional shortage areas for primary care



SOURCE: Rural Health Information Hub (figure) and Health Resources and Services Administration (data), 2025.

In addition to the immediate benefits of dispensing and clinical primary care services pharmacists can provide, pharmacists interviewed for this study described numerous benefits to the long-term relationships they develop with the individuals they serve, which provide opportunities to educate and assist patients with a myriad of health care issues. Pharmacists reported helping their patients interpret documents from their insurance companies, registering patients for health care services, addressing patients' health-related social needs such as transportation or hunger, and even providing first aid while waiting on emergency transportation when individuals were unable to reach the emergency department on their own.

Limited access to community pharmacies negatively impacts health outcomes

When pharmacies close, patients served by those pharmacies may experience a variety of negative health outcomes. Studies show a connection between pharmacy closure and significant decreases in patients' medication adherence. Patients may be less willing or unable to travel further distances to the next closest pharmacy or complete the administrative burden of transferring prescriptions. Communities with limited pharmacy access also had lower rates of immunization against influenza and were less likely to have

access to the COVID-19 vaccine during the pandemic. In addition, pharmacy closures can strain remaining pharmacies that must take on additional patients. Overburdened pharmacy staff may have less time to counsel patients or offer other pharmacy services and are more likely to make prescription errors.

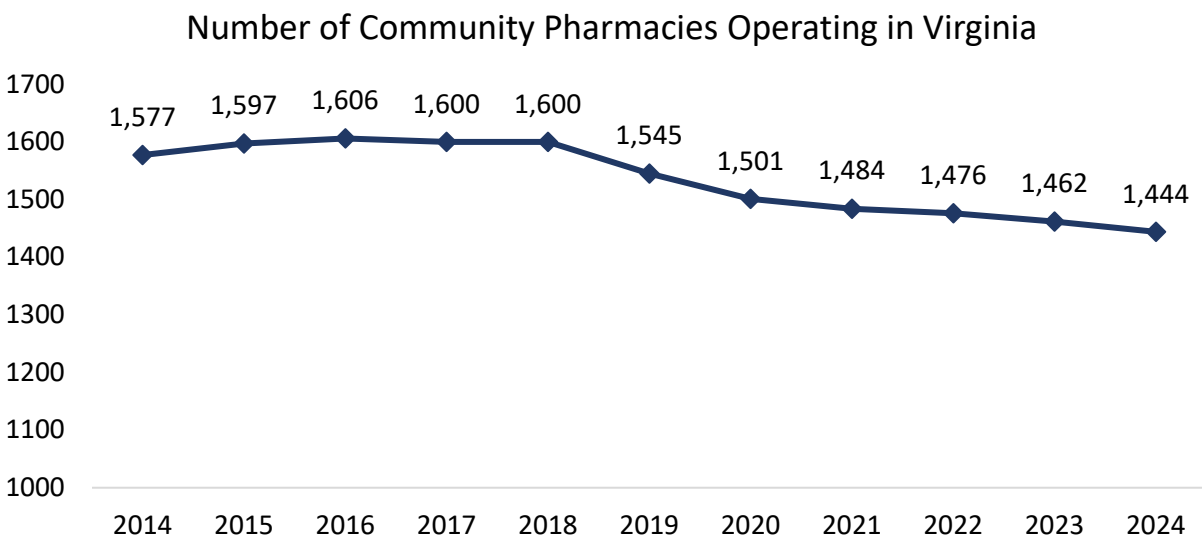
Access to community pharmacies is changing in Virginia

The total number of community pharmacies operating in Virginia, including independent, chain, and government-funded or philanthropic pharmacies, has declined steadily since 2019, leaving a growing number of localities in the Commonwealth with only one or no pharmacies operating within its borders. Trends in closures vary between independently owned and chain community pharmacies (see APPENDIX 2 for detailed methodology).

Community pharmacies operating in Virginia have declined by 8.4 percent

Between 2014 and 2024, the number of community pharmacies in Virginia decreased by 8.4 percent, from 1,577 pharmacies operating in 2014 to 1,444 pharmacies operating in 2024 (FIGURE 2). Partial year data from 2025 indicate that the trend in the number of operating community pharmacies continues to decline, with 1,402 operating pharmacies in Virginia as of September 2025. This continued decline prompted the State Board of Health to issue a resolution in October 2025 recognizing limited pharmacy access as a threat to public health.

FIGURE 2. Operating community pharmacies have declined by eight percent



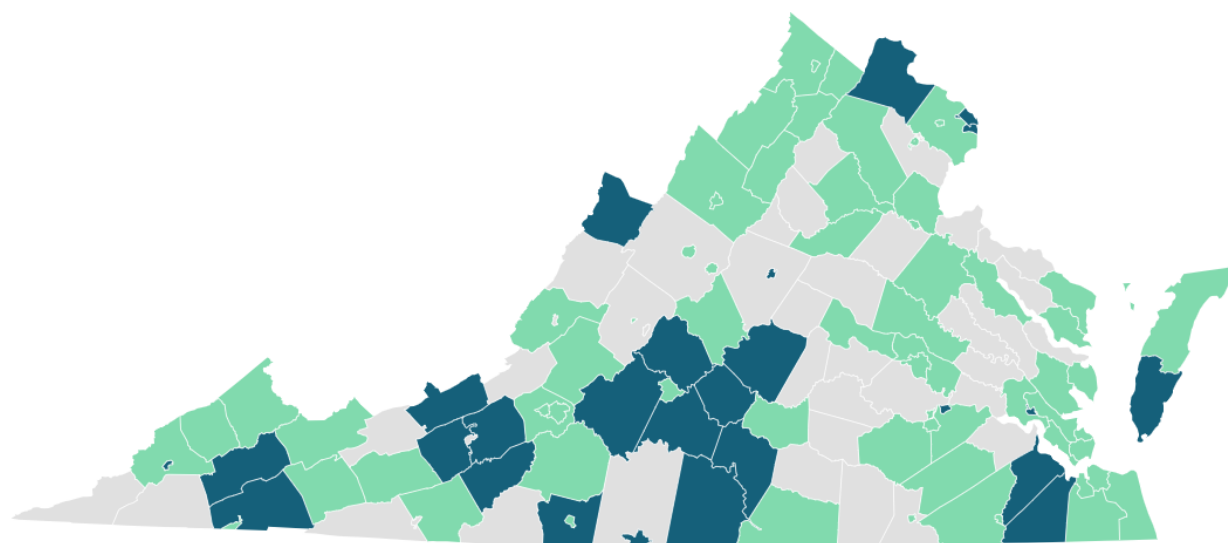
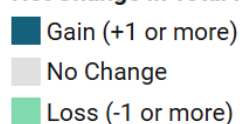
Source: JCHC analysis of Virginia Board of Pharmacy data, 2025.

About half of Virginia’s 135 cities and counties experienced a decline in the total number of operating community pharmacies in the last decade (FIGURE 3). Between 2014 and 2024, 67 localities (49.6 percent) experienced a net loss of at least one pharmacy, 40 localities (29.6 percent) experienced no change in the number of operating pharmacies, and 28 localities (20.7 percent) experienced a net gain of at least one pharmacy (see APPENDIX 3 for a count of pharmacies by locality).

FIGURE 3. Half of localities experienced a net loss of community pharmacies

Net Change in Community Pharmacies, 2014 to 2024

Net Change in Total Pharmacies



SOURCE: JCHC staff analysis of Virginia Board of Pharmacy data, 2025.

Net losses of community pharmacies were common across all locality types. Sixty-nine percent of urban localities, 65 percent of suburban localities, and 43 percent of rural localities experienced a net loss in community pharmacies between 2014 and 2024 (TABLE 1). For localities that experienced a net decline, 70 percent declined by two or fewer pharmacies. The loss of even a single pharmacy can be detrimental for communities. For example, in Southampton County and Prince George County, the single community pharmacy operating in those localities closed in 2015 and 2022, respectively. For those communities, the loss of a single pharmacy resulted in no access to community pharmacy services within the counties’ borders.

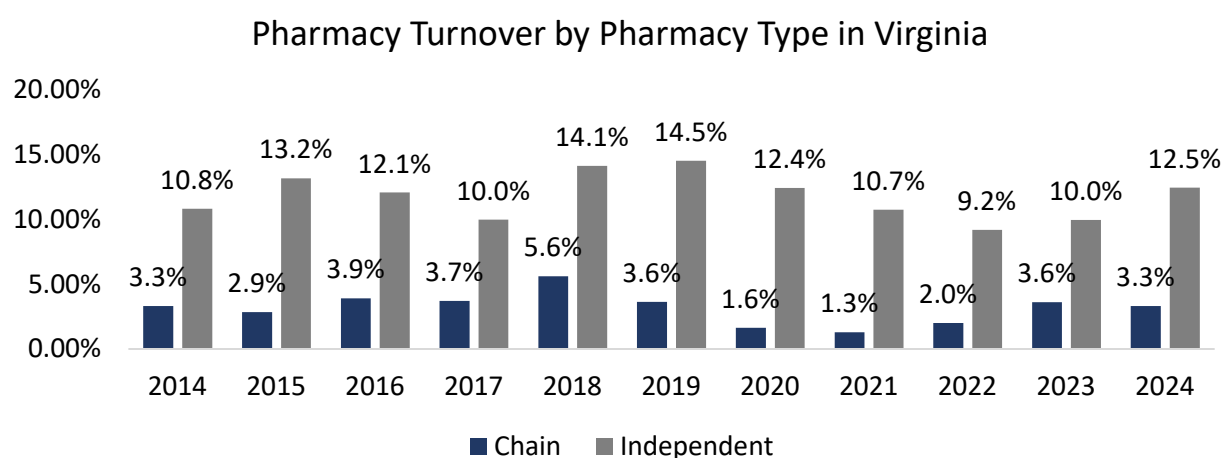
TABLE 1. Change in community pharmacies by locality type

Category	Rural (Percent Change)	Suburban (Percent Change)	Urban (Percent Change)
Net Gain	19 (19.2%)	4 (20.0%)	5 (31.3%)
No Change	37 (37.4%)	3 (15.0%)	0 (0.0%)
Net Loss	43 (43.4%)	13 (65.0%)	11 (68.8%)
Total	99	20	16

SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

Communities most impacted by changes in pharmacy access are served by independent pharmacies

Over a ten-year period, independent and chain pharmacies declined at a similar rate. Between 2014 and 2024, the total number of chain pharmacies operating in Virginia declined by 10.5 percent, while independent pharmacies declined by 8.6 percent. However, in any given year, pharmacy turnover - calculated as the number of pharmacy openings and closings divided by the total number of pharmacies operating each year - varies by pharmacy type (FIGURE 4). Independent pharmacies have significantly greater rates of pharmacy turnover than chain pharmacies, meaning the proportion of independent pharmacies opening and closing each year far exceeds that of chain pharmacies. Between 2014 and 2024, independent pharmacies opened and closed between three and six times the rate of chain pharmacies (see APPENDIX 4 for counts of openings and closing by pharmacy type).

FIGURE 4. Pharmacy turnover is higher among independent pharmacies

SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

Independent pharmacies are less likely to remain in operation after opening, compared to chain pharmacies (TABLE 2). On average, one hundred percent of chain pharmacies were still in operation three years after opening, compared to 79 percent of independent pharmacies. Within five years of opening, 84 percent of chain pharmacies were still in operation, compared to 65 percent of independent pharmacies.

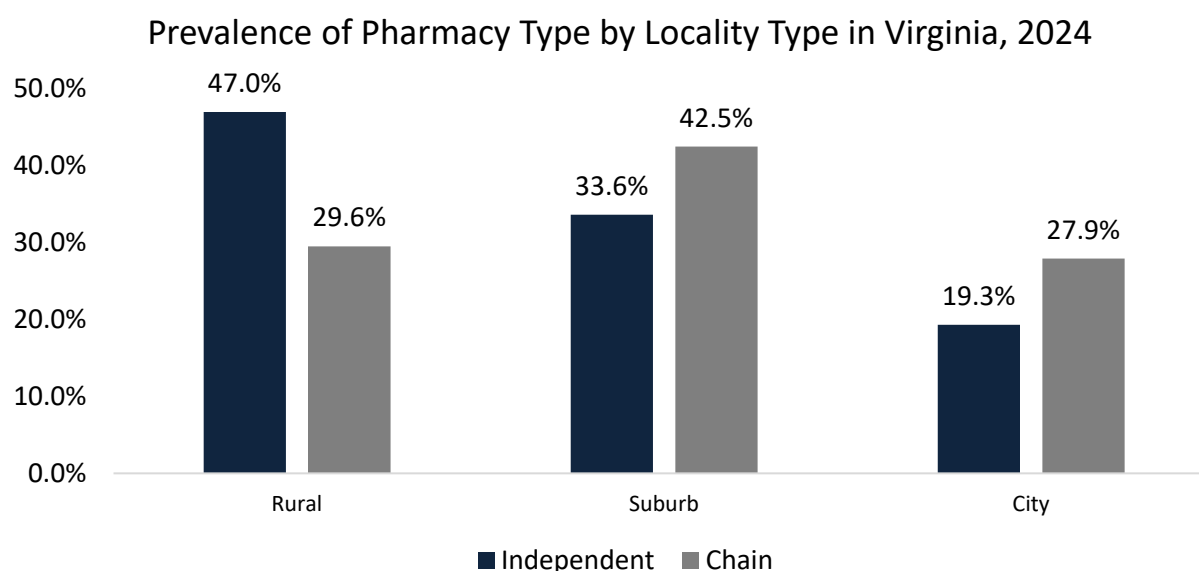
TABLE 2. Percent of pharmacies operating three, four, and five years after opening

Time period	Percent of chain pharmacies remaining in operation	Percent of independent pharmacies remaining in operation
Three years	100.0	79.4
Four years	99.5	74.0
Five years	84.1	65.4

SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

Turnover of independent pharmacies is more likely to impact rural communities, as community pharmacies operating in rural areas are more likely to be independent (FIGURE 5). Forty-seven percent of all independent pharmacies operating in Virginia in 2024 were located in rural communities, compared to 33.6 percent in suburban localities and 19.3 percent in cities. In contrast, most chain pharmacies operate in suburban areas (42.5 percent).

FIGURE 5. Independent pharmacies are more likely to operate in rural areas



SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

Increasingly, Virginians are living in communities with limited or no access to a community pharmacy

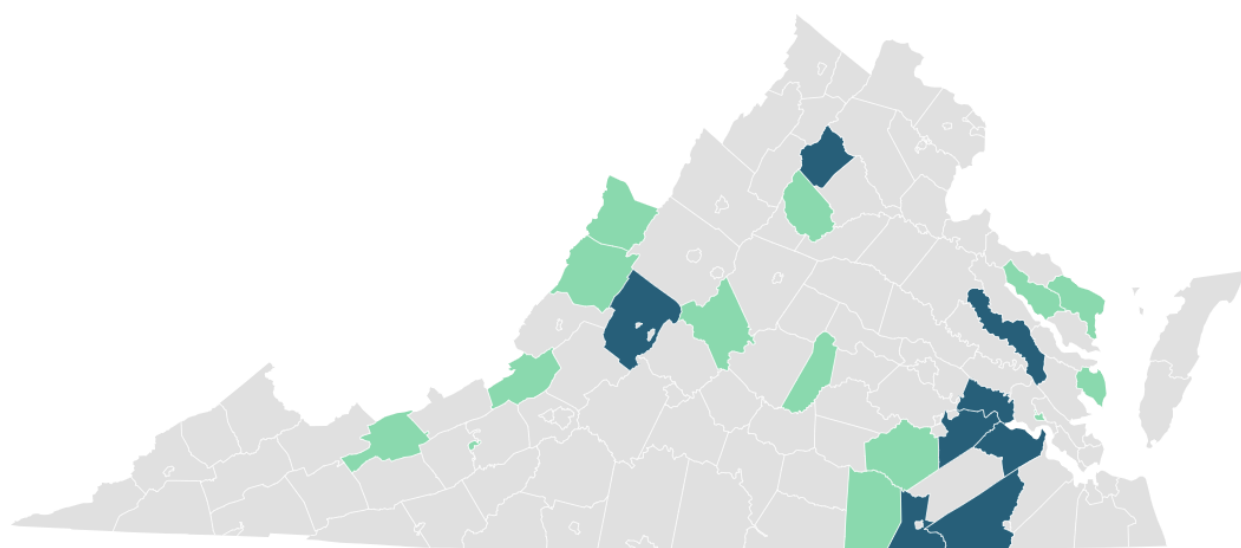
As the number of community pharmacies in Virginia has declined, more communities are experiencing limited pharmacy access. In calendar year 2024, 14 localities in Virginia had only one community pharmacy and eight localities had no community pharmacy located within its borders (FIGURE 6). In these pockets of limited access, individuals may need to travel long distances to receive medications or access other pharmacy services.

FIGURE 6. Some localities in Virginia have limited access to community pharmacies

Virginia Localities by Number of Pharmacies, 2024

Count of Community Pharmacies

- No Pharmacy
- One Pharmacy
- Two or More Pharmacies



SOURCE: JCHC staff analysis of Virginia Board of Pharmacy data, 2025.

All eight localities with no operating community pharmacies are all located in rural areas, where the closest pharmacy is between three and 21 miles away (TABLE 3). Six of these localities have not had an operating community pharmacy for at least ten years. Small populations and population decline in rural communities make sustaining any business difficult, pharmacies included. Six of the eight localities with no operating community pharmacy had a population of 10,000 or less in 2024.

TABLE 3. Localities with no community pharmacies in 2024

Locality	Miles to Nearest Pharmacy, Type	Pharmacies Operating in the Last Ten Years
Charles City	8 mi, 1 chain	None
Greensville	3 mi, 1 chain and 2 independents	None
King and Queen	18 mi, 1 independent	None
Prince George	10 mi, 1 chain	Independent, closed in 2014 Independent, closed in 2022
Rappahannock	20 mi, 1 chain and 2 independents	None
Rockbridge	4 mi, 1 chain and 2 independents	None
Southampton	12 mi, 1 independent and 2 chains	Independent, closed in 2015
Surry	21 mi, 2 chains and 2 independents	None

SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

Thirteen of the 14 localities with one operating community pharmacy are also located in rural areas (TABLE 4). Independent pharmacies are the single pharmacy in more than half of the localities (eight of 14 localities), chain pharmacies are the single pharmacy in four localities, and government-funded pharmacies serve two localities. In the last decade, nine of the 14 localities have had no other operating pharmacy; five of these localities had less than 10,000 population in 2024. By September of 2025, the one remaining community pharmacy in Brunswick County and Cumberland County closed. In addition, one of the two remaining pharmacies in Clarke County, Lunenburg County and Poquoson City closed in 2025, leaving those counties with only one community pharmacy still operating.

TABLE 4. Fourteen localities have a single pharmacy operating within its borders

Locality	Current Pharmacy (2024)	Pharmacies Operating in the Last Ten Years
Bath	Independent	No other pharmacies
Bland	Independent	1 independent, closed in 2021
Brunswick	Chain*	No other pharmacies
Craig	Independent	No other pharmacies
Cumberland	Independent*	No other pharmacies
Dinwiddie	Independent	1 independent, closed in 2014 1 independent, closed in 2018
Highland	Government (FQHC)	No other pharmacies
Madison	Independent	No other pharmacies
Mathews	Independent	1 independent, closed in 2019
Nelson	Government (FQHC)	1 independent, closed in 2019 1 chain, closed in 2023
Northumberland	Chain	1 independent, closed in 2020
Radford County	Chain	No other pharmacies
Richmond County	Chain	No other pharmacies
Williamsburg**	Independent	No other pharmacies

*Closed in 2025; **Suburban locality; FQHC = Federally Qualified Health Center

SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

There are 313 census tracts in Virginia – representing approximately 14 percent of Virginia’s population – that have limited access to a community pharmacy (TABLE 5). Limited access is defined as a tract that has at least 33 percent of its population living one mile or more from the pharmacy for urban tracts, more than five miles for suburban tracts, more than 10 miles for rural tracts, and more than 0.5 miles for tracts with less than 100 individuals owning a car. Individuals living in limited access census tracts are more likely to be in rural areas (35.4 percent compared to 24.3 percent in sufficient access census tracts) and slightly more likely to be uninsured (8.1 percent compared to 7.3 percent in sufficient access census tracts). Twenty-seven of the 313 census tracts with limited access overlap with Virginia localities that have either one or no pharmacies, indicating that limited access to pharmacies can occur at a county-wide or neighborhood-wide level.

TABLE 5. Fourteen percent of Virginia’s population has limited access to a community pharmacy

Characteristics	Sufficient access	Limited access
	N = 1857 census tracts	N = 313 census tracts
Percent of state population	85.7	14.3
Among census tracts:		
Percent classified as cities or suburbs	75.7	64.6
Percent classified as rural or towns	24.3	35.4
Percent of people living below 150% poverty level	17.7	17.5
Percent unemployed	4.6	4.9
Percent uninsured	7.3	8.1
Percent minority	39.0	40.9
Percent with no vehicle	6.5	5.2

SOURCE: JCHC analysis of data from Wittenauer et al., 2024 and the U.S. Census Bureau, 2025.

Imbalance between pharmacy expenses and revenue is the primary driver of pharmacy closures

Just like any other business, the financial stability of a pharmacy is primarily determined by the balance between the costs of operation and the amount of income. Unlike other businesses, however, community pharmacies face unique challenges in maintaining this balance because different parties external to the pharmacy set the price of medications the pharmacy must purchase and the amount of income the pharmacy can earn for dispensing them.

Costs of operating a pharmacy are increasing

Operating a pharmacy can include expenses related to the building itself - like a lease or mortgage, utilities, and maintenance; supplies needed to package and dispense medications; technology and the maintenance of technology to support dispensing and sales; and required regulatory fees for licensing, permitting, and registration. Expenses that most impact pharmacists’ balance sheets, however, are the cost of purchasing medications and the cost of labor.

Purchasing medications is the primary expense for pharmacies

Purchasing drugs to maintain an appropriate inventory is the main expense for pharmacies, totaling between 60 to 75 percent of pharmacy expenses. Pharmacies purchase drugs from

wholesalers at negotiated prices, but drug prices can fluctuate and may change at any time. Over the period from January 2022 to January 2023, prices increased for more than 4,200 drug products; 46 percent of which increased at a rate that was greater than the rate of inflation during that period. The average drug price increase over the course of that period was 15.2 percent, which translates to an average price increase of \$590 per drug product.

Determining which drugs to maintain in a pharmacy's inventory depends on patient needs, prescribing frequency, and available cash flow to purchase drug stock. Pharmacists interviewed for this study stated that when available financial resources are limited, they must make tough decisions about their inventory. Pharmacists may choose not to purchase and stock rarely prescribed medications, or those for which the cost exceeds available resources. Pharmacists also reported considering their expected reimbursement for dispensing drug products when making decisions about which drug products to stock, declining to purchase or stock drug products that cost more to acquire than the pharmacist can expect to earn from reimbursement for dispensing. Pharmacists' decisions to not stock certain drug products can impact patients' access to medications, leaving some patients to find alternative sources for needed medications.

Costs of labor are also a significant expense for pharmacies

Labor costs are the second largest expense in pharmacies, totaling 15 to 25 percent of pharmacy expenses. Labor costs include the salaries of the pharmacist-in-charge (PIC), who must be on site when the pharmacy is providing services, any other pharmacists employed by the pharmacy, and any pharmacy technicians, pharmacy technician trainees, and pharmacy interns employed by the pharmacy. To remain sufficiently staffed, pharmacies must offer competitive salaries and, in the past ten years, average compensation for pharmacy employees has increased significantly. The median salary for pharmacy technicians increased by 60 percent in Virginia, from \$25,000 to \$40,000.

In the face of increasing labor costs, pharmacies must make difficult business decisions about the type and number of staff to employ, particularly when pharmacy revenues are not sufficient to cover expenses. Pharmacists interviewed for this study report that while pharmacy technicians can help pharmacies serve more patients and provide additional pharmacy services, potentially increasing revenue, hours for these positions or the positions themselves are often the first to be cut when the pharmacy is not able to make ends meet. While reducing staff may alleviate short-term financial stress, it may also result in overworked staff or shorter pharmacy operating hours, reducing access to pharmacy services for patients and increasing the risk of dispensing errors.

Revenue generated by pharmacies is not keeping pace with the costs of operation

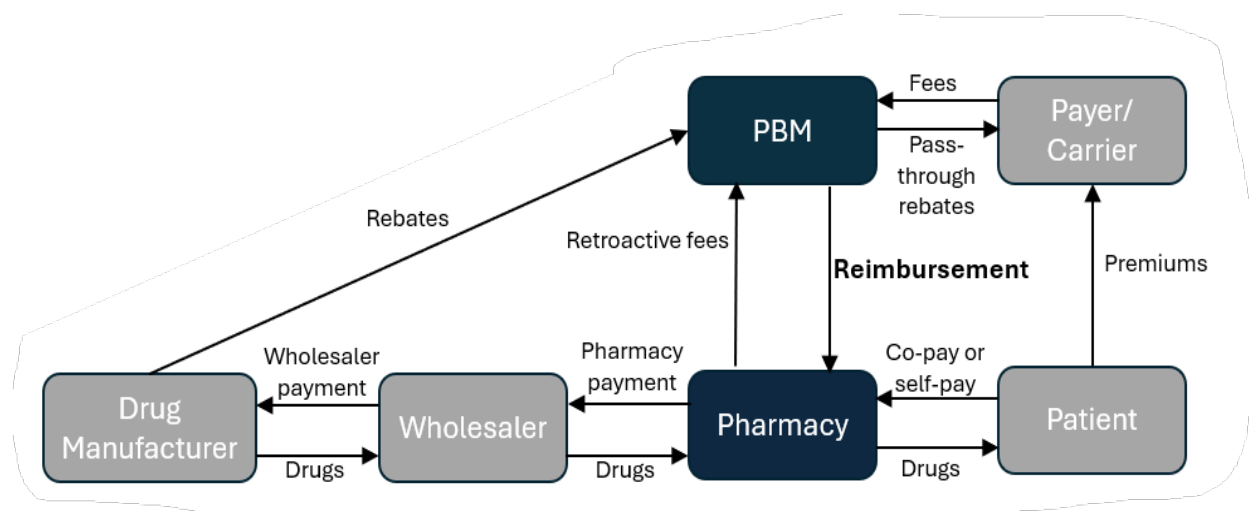
The primary source of revenue for community pharmacies is reimbursement fees for dispensing of medications, though community pharmacies can also earn revenue from

reimbursement for other pharmacy services. Evidence indicates that reimbursement rates for dispensing and revenue generated from other pharmacy services, if offered, are not sufficient to offset the expense of purchasing, stocking, and dispensing drug products.

Reimbursement rates for dispensing often fail to cover the full operational costs for many pharmacies

Contracts between the pharmacy and a pharmacy benefit manager (PBM), a third party hired by a payer to manage the payer's prescription drug program, establish reimbursement fees. For example, an employer who offers an employer-sponsored health plan may contract with a PBM to manage and administer the prescription drug aspect of a health plan (FIGURE 7). Similarly, a commercial health plan may contract with a PBM to manage prescription drug benefits for plan enrollees. PBMs that contract with payers also contract with pharmaciesⁱ to set the amount the pharmacy will be paid for dispensing drugs to health plan participants.

FIGURE 7. PBMs contract with multiple entities



SOURCE: Adapted from Powell, M. & Huss, T. (2025). Pharmacy Benefit Managers (PBMs): Pharmacy Drug Pricing and Potential Fiduciary Issues [Legal Document]. Thomson Reuters Practical Law.

The amount of reimbursement fees paid to pharmacies by PBMs varies by payer and drug type but usually includes the drug ingredient costs plus a professional dispensing fee. The **ingredient costs** portion of a reimbursement fee should cover the cost to the pharmacy of purchasing the drug product from a wholesaler. Several benchmarks are available to

ⁱ Most independent pharmacies work with a Pharmacy Services Administrative Organization (PSAO) that provides administrative support to the pharmacy, including negotiating contracts with PBMs, for a set fee.

determine ingredient costs, including a Centers for Medicare and Medicaid Services (CMS)-administered voluntary monthly survey of pharmacies that produces the National Average Drug Acquisition Cost (NADAC); the Average Wholesale Price (AWP), defined as the average price at which wholesalers sell drugs to pharmacies; or the Wholesale Acquisition Cost (WAC), defined as the manufacturer's price for a drug before any discounts, rebates, or other reductions are applied. The **professional dispensing fee** portion of a reimbursement fee should compensate pharmacies for operational costs associated with filling prescriptions, including labor, supplies, and administrative overhead. Contracts between pharmacies and PBMs set out the methodology for calculating the ingredient costs and the amount a pharmacy will receive as the professional dispensing fee.

The terms of agreements between PBMs and payers and PBMs and pharmacists are confidential, limiting transparency. Independent community pharmacies report that, with limited bargaining power, they cannot successfully negotiate favorable PBM contracts and must frequently accept “take-it-or-leave-it” contract terms that result in reimbursement rates that fall below the pharmacies’ acquisition cost for drugs and do not cover the labor, operational, or supply costs needed for filling the prescription. Chain community pharmacies, in contrast, can leverage economies of scale to negotiate more favorable contract terms and can absorb lower reimbursement levels due to diverse revenue streams. PBM practices, such as post-payment audits and contract terms that impose performance-based or retroactive fees, called clawbacks, exacerbate the fiscal impact of low reimbursement rates by reducing the amount of reimbursement pharmacies can retain after a sale.

Studies show that independent pharmacies often lose money on prescriptions once acquisition costs, dispensing costs, and post-adjudication fees are accounted for. Professional surveys indicate that the loss resulting from low reimbursement fees results in financial pressures that drive pharmacy closures. This problem is more pronounced in communities with low population, where the volume of dispensing is not sufficient to bring in enough revenue to cover costs, or in communities with larger numbers of patients covered by plans that offer lower reimbursement fees.

The power of PBMs has increased because the PBM industry has consolidated in recent years. As of 2022, three PBM companies control 80 percent of the market in the United States. Citing concerns about consolidation, transparency, and conflicts of interest, the Federal Trade Commission opened an inquiry in 2022 into PBM business practices and has since filed a lawsuit for engaging in anticompetitive and unfair rebating practices that have artificially inflated the list price of insulin drugs.

Pharmacies can earn income from other pharmacy services, though reimbursement for services is not sufficient to prevent closure

Since 2020, pharmacists have had the authority to deliver and may receive reimbursement for clinical services beyond dispensing, such as vaccinations and test-and-treat protocols,

depending on the payer. For Medicaid specifically, Senate Bill 1538 (Pillion), passed during the 2023 General Assembly session, required the Department of Medical Assistance Services (DMAS) to reimburse services covered by the Medicaid state plan provided by a pharmacist, pharmacy technician, or pharmacy intern. While these services can provide additional revenue streams for pharmacies, revenue earned through reimbursement for clinical services delivered in a pharmacy setting is not sufficient to offset the staff time to provide such services. Delivering clinical services requires a significant amount of a pharmacist's time and reduces the time pharmacists can devote to dispensing, thereby limiting the financial benefit of providing clinical services. While pharmacists can delegate dispensing activities to pharmacy technicians, pharmacy technician trainees, and pharmacy interns, not all pharmacies are able to employ sufficient staff to take on these responsibilities. Without robust staff support, a pharmacy offering clinical services may further undercut its ability to earn revenue from dispensing, its primary source of income.

States can reduce financial challenges for pharmacies by addressing practices that limit pharmacy revenue

Federal and state regulation of PBMs has rapidly increased in the last decade. Like other states, Virginia has taken steps to improve PBM transparency and strengthen PBM oversight. However, key opportunities remain for Virginia to further address PBM practices, including the amount of reimbursement fees paid to pharmacies, that contribute to the financial challenges community pharmacies face.

States can place limits on PBM practices that impact pharmacy revenue in specific circumstances

PBMs operate within a framework of federal and state law and regulations. The federal Employee Retirement Income Security Act of 1974 (ERISA) establishes uniform rules for employer-sponsored health plans, including self-insured plans. Provisions of ERISA preempt state laws "relating to" any ERISA-covered benefit plan, preventing states from regulating the administration or design of employer-sponsored health plans. In 2020, the Supreme Court made clear that the protections of ERISA extend to agreements between covered health plans and PBMs, ruling in *Rutledge v. PCMA* that states may not impose rules mandating specific benefit plans or "binding" plan administrators. States may, however, regulate PBMs directly, so long as state laws and regulations do not require changes to plan benefit designs. Laws targeting PBM reimbursement methods are allowed. Since 2017, 48 states have enacted laws regulating PBM practices across multiple broad categories ranging from licensing and registration requirements to spread pricing bans and standardized contracting (TABLE 6).

TABLE 6. Categories of state-level PBM regulation enacted since 2017

Reform Type	Description
Rebate and Fee Disclosure	PBMs are increasingly required to disclose rebates, discounts, and fees to regulators or plan sponsors to improve visibility into pharmaceutical spending. Some proposals also seek to delink rebates from list prices, allowing PBMs to receive only bona fide service fees reflecting the value of their services.
Spread Pricing Prohibitions	States have banned spread pricing in Medicaid and state employee health plans, ensuring PBMs do not retain the difference between what they charge payers and reimburse pharmacies. Some proposals also require timely updates to generic drug reimbursement schedules.
Audit and Oversight	Reforms focus on how PBMs conduct post-payment audits. States now limit recoupments to material billing errors that affect payment accuracy or clinical validity, excluding minor documentation issues. Laws commonly require advance notice, defined procedures, reasonable timelines, and appeal rights to curb punitive auditing. States also mandate aggregate audit reporting to help regulators assess whether audits serve fraud-control functions or generate revenue.
Standardized Contracting	Reforms call for predictable, standardized pharmacy contract terms and comprehensive disclosure of reimbursement methodologies to create a more level playing field.
Network Strengthening	Rules require PBMs to contract with pharmacies that accept reasonable terms, improving access in underserved areas and providing enforcement tools for violations.
High-Value Formulary and Physician Support	PBMs and plans are encouraged to support prescribers in choosing cost-effective drugs and to design formularies that prioritize comparative clinical benefits and overall patient care costs.

SOURCE: National Conference of State Legislatures, 2025.

Virginia has enacted many of the reforms implemented by other states. Provisions of Article 9 (§ 38.2-3465 et seq.) of Chapter 34 of Title 38.2 of the *Code of Virginia* require any entity performing pharmacy benefit management services to obtain a license from the State Corporation Commission (SCC) before acting as a PBM in the Commonwealth, prohibit certain conduct by health plans - also known as “carriers”- and PBMs, and establish reporting requirements for carriers and PBMs, including requirements related to:

- **Disclosure of Ownership and Control:** PBMs must provide the SCC with information about officers, beneficial owners, and management structures in the license application.
- **Annual Renewal and Certification:** PBMs must obtain a license from the SCC prior to operating in Virginia, renew licenses annually, and certify ongoing compliance with applicable statutes and regulations.
- **Prohibited Conduct:** PBMs and carriers may not engage in certain conduct such as requiring that a pharmacy receive reimbursement no less than that paid to a PBM affiliate for the same service or restricting a patient's choice of pharmacy.
- **Audit and Reporting Obligations:** Carriers contracting with PBMs must provide the SCC with rights to audit PBM books and records relevant to pharmacy benefit activities.
- **Rebate, Retained Rebate, and Fee Reporting:** Carriers or their contracted PBMs are required to report aggregate data for each health benefit plan, including total rebates received, rebates distributed to the plan, rebates passed to enrollees, and retained rebates to the SCC.
- **Prohibition of Spread Pricing in the Commonwealth:** Carriers and their contracted PBMs may not conduct spread pricing, defined as when a PBM charges a health plan a price for a drug that differs from what the PBM pays the pharmacy.
- **Complaint Process and Enforcement:** The insurance commissioner and SCC retain authority to promulgate regulations, enforce violations, audit PBMs, and adjudicate noncompliance claims under the PBM statutes. The SCC's Bureau of Insurance accepts complaints about PBM practices for commercial health plans and may investigate alleged violations of the PBM statutes.

States can establish minimum reimbursement fees when the state is the payer

While federal law limits the authority of states to impose requirements related to the administration or design of health plans covered by ERISA, states may establish requirements for health plans that are exempt from ERISA. Specifically, states may adopt rules relating to program administration or design for plans for which the state is the payer, including requirements for minimum reimbursement fees for dispensing of prescription drugs. Because the Commonwealth is the payer in the case of the state employee health plan and the Commonwealth's Medicaid program, Virginia can impose minimum reimbursement fees for drugs dispensed to covered individuals.

The Department of Human Resource Management establishes reimbursement fees for the Commonwealth's self-insured state employee health plans

Virginia's state employee health plans cover approximately 95,000 employees and their family members across the Commonwealth. Most employees participate in self-insured plans administered by Anthem or Aetna, with smaller percentages of employees choosing fully insured plans administered by Kaiser Permanente (Northern Virginia) or Sentara (Hampton Roads) where those plans are available. As the payer, the Commonwealth enters into agreements with Anthem, Aetna, Kaiser Permanente, and Sentara for administration of health care benefits for covered individuals. PBMs manage pharmacy benefits for covered individuals. The Department of Human Resource Management (DHRM), the state agency charged with administering Virginia's state employee health plans, selects the PBM for self-insured plans offered through Anthem and Aetna while Kaiser Permanente and Sentara select the PBMs that administer pharmacy benefits for the fully insured plans they offer for state employees without input from the state.

DHRM currently contracts with CarelonRx to provide PBM services for the self-insured state employee health plans. CarelonRx negotiates drug costs and dispensing fees on behalf of the fully insured state employee health plans through their contracting process. Drug ingredient costs and dispensing fees that make up the reimbursement fee paid for dispensing medications to covered state employees can vary by each individual pharmacy contract; however, CarelonRx guarantees minimum drug ingredient cost and dispensing fee amounts for all participating pharmacies, which are set annually. Stakeholders interviewed for this report did not express any concerns about the amount or adequacy of the reimbursement fee paid to pharmacies for dispensing prescription drugs to individuals covered under the state employee health plan.

The General Assembly may establish minimum reimbursement fees for the Medicaid program

Virginia's Medicaid program is a significant payer of health care costs in the Commonwealth, providing health care coverage for approximately 1.8 million individuals in 2025, including 226,245 enrolled in the Fee-For-Service (FFS) program and 1,641,088 enrolled in the managed care program.ⁱⁱ DMAS administers the FFS program directly and enters into contracts with managed care organizations (MCOs) to provide health coverage for enrolled members. PBMs manage pharmacy benefits for all Medicaid members, either pursuant to a contract between DMAS and the PBM, in the case of the FFS program, or pursuant to contracts between an MCO and a PBM, in the case of the managed care program. Because the Commonwealth is the payer for health care services provided to Medicaid members enrolled in both the FFS and managed care programs, the General

ⁱⁱ Data as of November 1, 2025

Assembly has the authority to establish reimbursement fees for prescriptions dispensed to covered individuals.

Reimbursement fees for dispensing of prescription drugs to individuals enrolled in the FFS program are set in the contract between DMAS and the PBM selected to administer pharmacy benefits for the program. Beginning in 2017, CMS required states to ensure that reimbursement fees included payment for the cost of the drug ingredient and a professional dispensing fee, defined as a fee that pays for costs in excess of the ingredient cost of a covered outpatient drug and includes pharmacy costs associated with dispensing the drug to a Medicaid beneficiary. DMAS regulations set forth in *12VAC30-80-40* set the amount of the professional dispensing fee for covered drugs dispensed by a retail community pharmacy at \$10.65 and the amount of the drug ingredient cost as an amount equal to the lowest of the NADAC, the federal upper limit (FUL), or the providers' usual and customary (U&C) charge to the public as identified by the claim charge.

The amount of the professional dispensing fee paid to pharmacies for dispensing covered drugs to Medicaid FFS members is determined by a cost of dispensing survey. DMAS is required by subsection I of *12VAC30-80-40* to administer the survey at least every five years. The survey collects information about the actual costs pharmacies incur when dispensing prescriptions for Medicaid FFS members to determine the weighted average cost of dispensing prescriptions to Virginia Medicaid members. The current professional dispensing fee of \$10.65 outlined in *12VAC30-80-40* was set following completion of a 2019 cost of dispensing survey and included in a final rule published in September of that year. The amount reflected a substantial increase from the previous professional dispensing fee of \$3.75 set in 2014. DMAS administered the quinquennial cost of dispensing survey in 2024; however, as of November 1, 2025, DMAS has not proposed an updated professional dispensing fee amount, nor has DMAS released the results of the 2024 survey. DMAS also denied JCHC staff requests for a copy of the final report on the 2024 cost of dispensing survey. As a result, no information about potential adjustments to the professional dispensing fee established in 2019 is available at this time. Inflation-adjusted estimates suggest a dispensing fee between \$13 and \$14 would be comparable.

DMAS enters into contracts with each MCO offering coverage to Medicaid members in Virginia which include provisions related to covered individuals, covered services, payment amounts and methodologies, reporting and other requirements. MCOs then contract with PBMs for administration of pharmacy benefits for enrolled Medicaid members. MCOs, together with the PBMs, establish reimbursement fees for prescriptions dispensed to Medicaid members enrolled in managed care plans. The terms of contracts between MCOs and PBMs are not publicly available, so the process by which reimbursement rates, including drug ingredient costs and professional dispensing fees, are set and the amount of reimbursement fees provided are unknown. Based on interviews with pharmacists in Virginia, dispensing fees for Medicaid members within MCOs are between "pennies" to \$2.00, depending on type of drug dispensed.

While MCOs and PBMs negotiate the terms of agreements between them, the General Assembly has authority to establish minimum reimbursement fee amounts for prescriptions dispensed to Medicaid members enrolled in managed care plans. With General Assembly authority, DMAS may require MCOs to include requirements for minimum reimbursement fees for dispensing of prescription drugs to covered individuals in contracts between the MCO and any PBM with which the MCO contracts to manage pharmacy benefits for plan members.

States have successfully set reimbursement floors for their Medicaid programs

An increasing number of states are addressing insufficient reimbursement rates by setting a reimbursement floor. A reimbursement floor is a mandated minimum payment or payment methodology for pharmacy claims that an MCO and its PBM subcontractors must meet. It prevents payments from falling below a sustainable threshold regardless of other rebate or contractual manipulations. The floor may include both ingredient costs and professional dispensing fees. States adopting this strategy typically use NADAC plus a fixed dispensing fee as the reimbursement floor:

West Virginia. In 2021, West Virginia passed House Bill 2263 that significantly changed the regulation of PBMs operating in the state, including the PBM contracted by the state to administer prescription drug benefits for West Virginia's Medicaid managed care enrollees. The legislation set a minimum reimbursement rate for pharmacies by PBMs at NADAC plus a professional dispensing fee of \$10.49. The bill also prohibited PBMs from using spread pricing, excluding pharmacies from its network, imposing retroactive fees, or holding onto rebates.

Ohio. Effective October 1, 2022, Ohio completed a "carve-out" of its Medicaid pharmacy benefit, transitioning from a managed care model to a single PBM operating pursuant to a contract with the state Medicaid agency for all managed care members. Under the new system, pharmacies receive reimbursement based on a set formula for both ingredient costs and dispensing fees. Ohio also mandated a significant increase in dispensing fees paid to pharmacies, from an average of \$0.73 per prescription under the previous system to \$9.00 under the new one. As a result of this transition, the Medicaid agency was able enroll most pharmacies in Ohio into its network, thus maximizing accessibility of pharmacy services for members.

Tennessee. Effective November 1, 2023, Tennessee received approval of a state plan amendment to update its professional dispensing fees for licensed retail pharmacies that serve Medicaid members. Tennessee's new tiered dispensing fee structure includes a \$13.16 dispensing fee for pharmacies with a prescription volume of less than 65,000 claims per year and \$9.02 for pharmacies with a prescription volume of 65,000 or more claims per year.

New Mexico. In 2024, New Mexico passed House Bill 165, requiring Medicaid MCOs to reimburse community pharmacies for the full cost of prescription drugs based on

NADAC plus a \$10.30 professional dispensing fee, an approximate five percent increase over the previous professional dispensing fee. Fiscal analysis suggests that this five percent increase in reimbursement to New Mexico's 78 community pharmacies would cost the state between \$65,000 and \$195,000.

Illinois. Effective January 1, 2026, Illinois will update its Critical Access Pharmacy Program to permit pharmacies meeting certain criteria to receive an enhanced professional dispensing fee of \$21.05 for each medication dispensed to a Medicaid MCO member. To qualify, pharmacies must have owners with control interest in ten or fewer pharmacies, be open to the public, not owned by a hospital and be physically located in a county with a population under 50,000 that is also designated as a medically underserved area.

Virginia could set a minimum reimbursement fee for the Medicaid program

The General Assembly has previously considered efforts to set minimum reimbursement fees within the Medicaid program. In 2019, Senator Dunnavant introduced a budget amendment (Item 303 #23s) requiring that all prescriptions within the Medicaid program, including prescriptions dispensed to members enrolled in the FFS program and the managed care program, be reimbursed in an amount no lower than NADAC for the drug ingredient costs plus a professional dispensing fee of \$10.65, and that no other payment or fee arrangements should reduce or offset this dispensing fee. The final Appropriation Act did not include this amendment.

More recently, during the 2024 General Assembly Session, Delegate Hodges introduced two budget amendments (Items 288 #49h and #58h) that, taken together, required DMAS to select and contract with a single PBM to administer pharmacy benefits for all Medicaid members, including members enrolled in a managed care organization with whom DMAS contracts for the delivery of Medicaid services, and to amend contracts with MCOs to require MCOs to provide pharmacy reimbursement fees to match the existing fee for FFS program reimbursement fee of NADAC for the drug ingredient cost plus a professional dispensing fee of \$10.65. A report, completed by Mercer for DMAS and published in October of 2019, indicated that setting a minimum reimbursement fee of \$10.65 would increase state costs by \$20 million while efficiencies from implementing a single PBM, as described in Delegate Hodges' 2024 budget amendment, would save the state at least \$32 million, potentially offsetting the cost of the increased reimbursement fee for dispensing of prescriptions to Medicaid members. Like the amendment introduced in 2019, the final Appropriation Act did not include either of the 2024 amendments.

In 2025, Governor Youngkin proposed an amendment to House Bill 1600 that would have required DMAS to include in its contracts with MCOs a minimum professional dispensing

fee of \$4 per prescription for critical access pharmacies. The amendment would have cost \$7.2 million, including \$1.7 million from the state general fund, but was not included in the final appropriation act. In that same year, the General Assembly did reconsider the question of a single PBM for the Medicaid program, enacting the *Save the Local Pharmacies Act*, which directed DMAS to select and contract with a third-party administrator to serve as the state's single PBM to administer all pharmacy benefits for Medicaid recipients, including those enrolled in MCO plans, and to require that the MCO contract utilize the single state PBM for the purpose of administering all pharmacy benefits for Medicaid members enrolled with the MCO. The Act also directed DMAS to include in its contract with the single PBM a provision requiring the PBM to use the common formulary, reimbursement methodologies, and dispensing fees negotiated by the Department. Estimates provided by DMAS during the 2025 Session indicate anticipated savings to the Commonwealth resulting from implementation of the Act of approximately \$10 million. At the same time, DMAS estimated that the cost of increasing the reimbursement fee for dispensing of prescriptions for Medicaid members enrolled in managed care to \$10.65, consistent with the FFS reimbursement fee, would cost the Commonwealth between \$36.9 and \$51.1 million in combined general and nongeneral funds each year. Estimates of the fiscal impact of a reimbursement fee set at an amount other than the amount currently required for the FFS program were not available.

While the provisions of the Act establish a mechanism by which DMAS may implement increased reimbursement fees for dispensing, the Act does not specifically require DMAS to adopt higher reimbursement fees or establish a minimum reimbursement fee, meaning implementation of the single PBM may not result in any meaningful change to reimbursements paid to pharmacies dispensing prescription medications to Medicaid members. The General Assembly could establish a reimbursement floor for fees for dispensing prescriptions to Medicaid members. To be enforceable, DMAS must build a reimbursement floor into the actuarial assumptions and state-directed payment frameworks so that MCOs are able to factor the amount into their capitation rates or receive risk adjustment. Contracts between DMAS and MCOs would have to specify the amount of the reimbursement floor and require MCOs to include the amount in contracts entered into with PBMs.

- ➔ **Option 1:** The JCHC could submit a budget amendment to set a reimbursement fee floor for drug ingredient costs and professional dispensing fees paid to community pharmacies for all medications dispensed to Medicaid members, including those enrolled in FFS and managed care arrangements.

If the General Assembly wished to constrain costs associated with implementation of a reimbursement floor to remain within the anticipated savings resulting from the transition to a single state PBM, the reimbursement floor could be designed to apply to a subset of

pharmacy claims rather than all Medicaid claims for dispensing at all pharmacies. For example, the reimbursement floor could be designed to include a tiered rate based on volume, drug type, or other criteria, similar to the program implemented in Tennessee, or to target specific types of pharmacies, such as those serving areas with limited access to pharmacy services, similar to the model adopted by Illinois.

Current information about reimbursement fees paid by MCOs and the potential savings that may accrue to the Commonwealth due to the transition to a single state PBM is not available. As such, JCHC staff cannot determine the reimbursement floor that would result in cost savings or cost neutrality to the state alongside the implementation of a single PBM. Item 292.MM of the 2025 Appropriation Act directed DMAS to complete a comprehensive evaluation of potential benefits, cost savings, and implementation concerns associated with utilizing a single state PBM, and directed DMAS to engage an independent consultant to assess best practices and provide guidance on structuring a model that maximize cost savings and operational effectiveness. The Appropriation Act further directed DMAS to include, as part of the evaluation, a review of FFS and managed care pharmacy dispensing fees and recommendations for adjustments necessary to maintain adequate pharmacy participation and patient access. DMAS's report to the General Assembly is due December 1, 2025. Although completed prior to the preparation of this report, DMAS did not make available the analysis provided by the independent consultant to JCHC staff, despite staff requests.

States can provide incentives to maintain or re-establish pharmacies in low-access communities

Maintaining or re-establishing community pharmacies in areas of the state with historically low access to pharmacy services can be particularly challenging given the high costs of operation, low reimbursement rates, and low patient volume. States have attempted to encourage pharmacies to remain or establish in areas of low access through targeted incentive programs.

Pharmacies in rural communities face unique challenges to maintaining operations

As the total number of pharmacies in Virginia declines, urban, suburban, and rural communities all experience the loss of community pharmacies. However, rural communities may feel more of an impact from pharmacy closures, where the number of operating pharmacies is low and a single closure can mean loss of access to a pharmacy altogether. As of September of 2025, 15 localities in Virginia were served by a single community pharmacy. Another ten localities lacked a single operating pharmacy; of those ten, three saw their only remaining pharmacy close within the last three years. Two additional localities do not have any community pharmacies operating within their borders but do

have access to service through pharmacies operated by Federally Qualified Health Centers. Twenty-three of these localities are rural.

In rural communities, smaller populations often mean lower sales volumes for retail establishments, reducing the opportunity for income. In rural communities with high rates of Medicaid enrollment, low reimbursement rates combine with low sales volume to create significant financial challenges for pharmacies. Independent pharmacies serve most localities with a single operating pharmacy and may be unable to offset low revenues with financial support from other locations or sources. The realities of operating in rural communities with larger numbers of Medicaid members create unique challenges for these pharmacies. For localities with no operating pharmacies, these realities may prevent new community pharmacies from opening.

Incentive programs could support community pharmacies in low access communities

While increasing reimbursement for dispensing could reduce the risk of closure for all existing pharmacies, pharmacies serving rural communities may require additional support to remain open. Two states have implemented incentive programs that provide direct financial support to select pharmacies or pharmacists meeting certain criteria.

Maryland. From state fiscal year (SFY) 2021 to SFY23, Maryland operated the Small Rural Pharmacy Grants Program, a state funded initiative that awarded up to \$1 million annually in state general funds to small, rural pharmacies that participate in Maryland's Medicaid program. Eligible pharmacies must have three or fewer stores under the same ownership, be in a rural zip code, and have 30,000 or fewer total paid Medicaid prescription claims in the previous year. The purpose of the grant is to prevent closures of small, rural pharmacies by providing an additional \$5 per Medicaid managed care prescription dispensed, paid in one annual allotment. Pharmacies can use funds to offset the costs of dispensing or for packaging supplies, developing or expanding prescription delivery services, and maintaining or upgrading pharmacy point-of-service computer systems. The program sunset in SFY2024.

Oregon. In 2025, Oregon legislators considered House Bill 2549 that would expand Oregon's rural health care income tax credit program to include pharmacists working at least 20 hours per week in rural areas. Although the bill did not pass, Oregon has implemented a successful tax credit program for other health professionals since 1989. In its current form, physicians, physician assistants, nurse practitioners, and dentists, among others, are eligible for a tax credit between \$3,000 and \$5,000, depending on the degree of rurality of the providers' practice location, for a maximum of 10 years. Evaluation results by an external contractor indicate that the program incentive positively impacts long-term retention of providers in rural areas and costs the state between \$18,000 and \$20,000 per participant over the average course of an individual's participation.

Incentive programs like those adopted in Maryland and Oregon may sustain pharmacies in challenging financial situations or encourage pharmacists or other operators to establish pharmacies in areas of limited access. Targeting programs to pharmacies in certain types of communities or that serve certain types of patients can benefit pharmacies serving those at greatest risk of losing access while containing program costs to the state. Tax credits for pharmacists, like the program implemented in Oregon, can incentivize providers to provide services in rural and underserved areas. Direct financial assistance programs like the program implemented in Maryland can offset low revenues resulting from low sales volume or low reimbursement amounts, supporting pharmacy operations.

During the 2025 General Assembly Session, Delegate Anthony introduced House Bill 2023 to establish the Independent Pharmacy Support Program, administered by the Virginia Department of Health, to provide state-funded grants to 20 qualifying independent pharmacies to ensure the continued provision of essential health services in medically underserved areas. The bill defined independent pharmacies as privately owned and operated, not part of a chain with more than ten locations, and publicly traded. To be eligible for a grant, an independent pharmacy would be required to be licensed by the Board of Pharmacy, operate in a rural or medically underserved area of the Commonwealth, demonstrate financial need, provide a detailed plan for use of grant funds to sustain operations, and demonstrate the anticipated impact of continued operations on community public health outcomes. Independent pharmacies eligible for the program would be permitted to use funds to pay the cost of employee salaries, rent, insurance, technology upgrades, inventory, and supplies.

House Bill 2023 failed to report from the House Committee on Health and Human Services during the 2025 Session and was referred to the JCHC for further study. Pharmacists interviewed for this study expressed support for any incentive that could help to sustain pharmacy services, but also emphasized that absent changes in reimbursement fees, such programs may not be sufficient to address the financial deficit pharmacies are currently facing. The JCHC could consider creating an incentive program to provide financial support to at-risk pharmacies or pharmacies that choose to establish in low access areas, like the program described in House Bill 2023.

- ➔ **Option 2:** The JCHC could introduce legislation and submit a budget amendment to establish an incentive program to provide funding for pharmacies operating in localities with low access to community pharmacies.

House Bill 2023 did not specify a grant amount for pharmacies, and no accompanying budget amendment was introduced to designate a total amount of funding available for distribution through the program. The cost of a new incentive program for pharmacies serving low- or no-access communities would depend on program eligibility criteria and the amount of each grant provided. The JCHC could narrowly tailor eligibility criteria to direct assistance to pharmacies in localities with no or limited access to community pharmacies, or pharmacies with certain patient population mixes, such as a high

proportion of Medicaid members. The JCHC could also select fixed grant amounts or could link grant amounts to criteria such as dispensing volume, including volume of prescriptions dispensed to Medicaid managed care members. In Maryland, for example, eligible pharmacies may receive an additional \$5 per prescription dispensed to a Medicaid managed care member for up to 30,000 claims per year, capping the maximum award per pharmacy at \$150,000. With total program funding at \$1 million, Maryland can serve six to seven pharmacies with 30,000 Medicaid claims per year, or more if pharmacies claim incentives at lower volumes.

Additional funding for government-funded pharmacy services could expand access in areas with no pharmacies

Health safety net providers offer an opportunity to meet the need for pharmacy services in localities with no operating pharmacies. Health safety net practices provide health care to individuals who may not otherwise be able to access services, including individuals in underserved areas of the Commonwealth and those who are not insured or underinsured or who otherwise cannot afford health services. Currently, two localities – Highland and Nelson Counties – rely on health safety net practices as their only source of pharmacy services in the community.

In Virginia, the health safety net includes 70 free and charitable clinics and 31 nonprofit organizations that provide health services through 228 community health centers (including Federally Qualified Health Centers, FQHCs). Virginia's community health centers offer access to comprehensive, integrated primary and preventive health care services, including pharmacy services, to all members of the community, regardless of insurance status or ability to pay. Free and charitable clinics operated by nonprofit organizations may also offer pharmacy services; each organization establishes its own eligibility criteria, so the scope of access to pharmacy services offered by these types of clinics may vary.

Free and charitable clinics and community health centers receive most of their funding from sources other than the state. However, Virginia does provide funding for free and charitable clinics and community health centers, including funding dedicated specifically to the delivery of pharmacy services to eligible individuals. In Fiscal Year (FY) 2026, the General Assembly appropriated \$1.3 million to the Virginia Association of Free and Charitable Clinics (VAFCC), and \$434,750 to the Virginia Community Healthcare Association (VCHA) from the general fund to provide medically necessary pharmacy supplies and pharmacy services to low-income, uninsured patients. The General Assembly could provide additional funding to VAFCC and VCHA to support expansion of pharmacy services to Virginia localities in which no community pharmacy is operating.

- ➔ **Option 3:** The JCHC could submit a budget amendment to increase funding to the Virginia Association of Free and Charitable Clinics and the Virginia Community Healthcare Association to expand access to pharmacy services provided by existing clinics and community health centers to localities with no operating community pharmacies.

VAFCC and VCHA could use funds to establish permanent pharmacy locations in unserved localities or to support alternative approaches to delivery of pharmacy services, such as delivery options. For example, the Northern Neck Middlesex Free Health Clinic pharmacy ships prescription medications dispensed from the Clinic's Kilmarnock pharmacy to patients at six other clinics that participate in Rx Partnership's Access to Medication Program (AMP). The AMP provides critically needed generic and brand name medications to vulnerable, low-income, and uninsured residents at healthcare facilities that do not have an on-site pharmacy. Providing additional funds would allow charitable pharmacies like the Northern Neck Middlesex Free Health Clinic pharmacy to support more patients at more clinics in pharmacy deserts. Allowing free and charitable clinics and community health centers flexibility to determine how to spend any funds appropriated would allow funding recipients to tailor approaches to best meet community needs.

Appendix 1: Study resolution



Study Resolution

Access to Pharmacy Services in Virginia

Authorized by the Joint Commission on Health Care on December 17, 2024

WHEREAS, pharmacy services include dispensing of medication, patient education, vaccinations, and testing services; and

WHEREAS, pharmacies can be an important community asset, providing access to essential health services for members of the surrounding community, particularly in areas with limited access to primary care providers; and

WHEREAS, pharmacy deserts, geographical areas characterized by limited access to pharmacy services, are associated with lower medication adherence and poor health outcomes for members of the surrounding community, and research suggests medically underserved populations are more likely to live in pharmacy deserts; and

WHEREAS, nationally, one in eight pharmacies, a majority of which were independent pharmacies, ceased operation between 2009 and 2015 and, more recently, large retail pharmacy chains announced over 2,000 additional pharmacy closures nationally, including many locations in Virginia over the next three years; and

WHEREAS, many factors contribute to pharmacy closures and loss of access to pharmacy services in Virginia, including reduced sales, low reimbursement rates, and low dispensing fees under Medicaid; and

WHEREAS, implementing strategies to ensure access to pharmacy services could improve the health and well-being of Virginians; now, therefore be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to study access to pharmacy services in Virginia.

The study shall (i) describe how access to pharmacy services has changed in Virginia over time, and the impact of changes in access to pharmacy services on Virginians, (ii) identify areas in Virginia that constitute pharmacy deserts, and describe populations in Virginia that are impacted by pharmacy deserts, (iii) identify factors that impact access to pharmacy services in Virginia, including state and federal law, (iv) describe strategies to ensure access to pharmacy services, including strategies implemented in other states, and (v) recommend policy options through which the state may ensure access to pharmacy services.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the *Code of Virginia*, all agencies of the Commonwealth, including the Department of Medical Assistance Services, the Department of Social Services, the Department of Behavioral Health and Developmental Services, the Department of Health Professions, and the Department of Health shall provide assistance, information, and data to the Joint Commission on Health Care for this study upon request.

Appendix 2: Methods and data sources

JCHC staff used Virginia Board of Pharmacy data to analyze state- and city/county-level trends in pharmacy openings and closings as well as pharmacy distribution at the city/county-level as of the end of calendar year 2024. The Virginia Board of Pharmacy provided a dataset to JCHC staff of pharmacies licensed to operate in Virginia from 2014 to 2024 containing pharmacy name, address, license issue data, closure data (if applicable), and pharmacy type for pharmacies operating during 2024 or later. JCHC staff reviewed publicly available information to classify pharmacy type for pharmacies that closed prior to 2024. For this study, analysis was restricted to “open-door” pharmacies that serve the public, including Board of Pharmacy-defined chain community pharmacies (5 or more pharmacies with the same owner), independent community pharmacies (less than 5 pharmacies with the same owner), and pharmacies associated with community health centers, health departments, free clinics, or Community Services Boards (referred to as government-funded or philanthropic pharmacies for the study). The final dataset contained information on 1,926 pharmacies (TABLE 7).

TABLE 7. Number of pharmacies by type in study sample

Type	Number	Percent of Total
Chain Pharmacies	1,296	67.3
Independent Pharmacies	549	28.5
Government-run or philanthropic pharmacies	81	4.2
Total	1,926	100.0

JCHC staff also analyzed census tract-level data to understand the characteristics of communities that are more likely to be impacted by limited services from community pharmacies. Data for this analysis was sourced from Wittenauer et al.’s 2024 studyⁱ of pharmacy deserts, the first study to develop a comprehensive, systematically defined map of pharmacy desert locations in the United States based on data from the National Council

ⁱ Wittenauer, R., Shah, P. D., Bacci, J. L., & Stergachis, A. (2024). Locations and characteristics of pharmacy deserts in the United States: a geospatial study. *Health affairs scholar*, 2(4), qxae035. <https://academic.oup.com/healthaffairsscholar/article/2/4/qxae035/7630415>

of Prescription Drug Programs. Census tracts were identified as either low access or pharmacy desert based on the following criteria:

1. Low access: Tract has at least 33% of its population living 1 mile or more from the pharmacy for urban tracts, more than 5 miles for suburban tracts, more than 10 miles for rural tracts, and more than 0.5 miles for tracts with less than 100 individuals owning a car.
2. Pharmacy desert: A census tract meeting the low access indicator that also has either (1) 20% or more of its population living below the Federal Poverty Level or (2) a median household income that was less than 80% of the median income of the nearest metropolitan area.

Wittenauer et al. identified 192 census tracts in Virginia as low access and 122 census tracts as pharmacy deserts. JCHC staff used socioeconomic data obtained from the US Census Bureau American Community Survey to further describe census tracts for this study.

Appendix 3: Operating community pharmacies by locality

	Number of Pharmacies Operating Per Year by Locality										
Locality	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Accomack	6	6	6	6	5	5	5	5	5	5	5
Albemarle	15	16	16	17	16	16	16	16	16	16	15
Alexandria	27	27	27	28	30	31	32	32	33	32	33
Alleghany	3	3	3	2	2	2	2	2	2	2	2
Amelia	2	2	2	2	2	2	2	2	2	2	2
Amherst	3	3	3	4	4	4	4	4	4	5	5
Appomattox	4	4	5	5	5	5	5	5	5	5	5
Arlington	43	45	44	44	43	41	43	43	43	44	44
Augusta	5	5	5	4	4	4	4	3	5	5	5
Bath	1	1	1	1	1	1	1	1	1	1	1
Bedford County	6	7	7	7	7	8	8	9	9	8	8
Bedford City	4	4	4	4	4	4	4	3	3	3	3
Bland	1	1	1	1	1	1	1	2	1	1	1
Botetourt	6	5	5	3	3	3	3	2	2	2	2
Bristol	7	7	8	8	8	8	9	8	7	7	6
Brunswick	1	1	1	1	1	1	1	1	1	1	1
Buchanan	11	10	11	11	11	11	11	11	11	10	10
Buckingham	3	3	3	3	3	3	3	3	4	5	4
Buena Vista	2	2	2	2	2	2	2	2	2	2	2
Campbell	5	5	5	5	5	5	5	5	6	6	6
Caroline	3	4	3	3	3	3	3	3	3	2	2
Carroll	5	4	3	3	3	3	3	3	3	3	3
Charles City	0	0	0	0	0	0	0	0	0	0	0
Charlotte	2	2	2	2	2	2	2	2	2	2	3
Charlottesville	9	9	10	12	11	10	10	10	10	10	10
Chesapeake	45	45	50	49	47	43	43	44	44	43	40
Chesterfield	58	61	62	61	60	59	56	56	57	58	58
Clarke	3	3	3	3	3	3	3	3	2	2	2
Colonial Heights	11	10	9	10	10	10	10	10	10	10	10
Covington	3	3	3	2	3	3	3	3	3	3	3
Craig	1	1	1	1	1	1	1	1	1	1	1
Culpeper	9	9	9	9	9	9	8	8	8	8	8

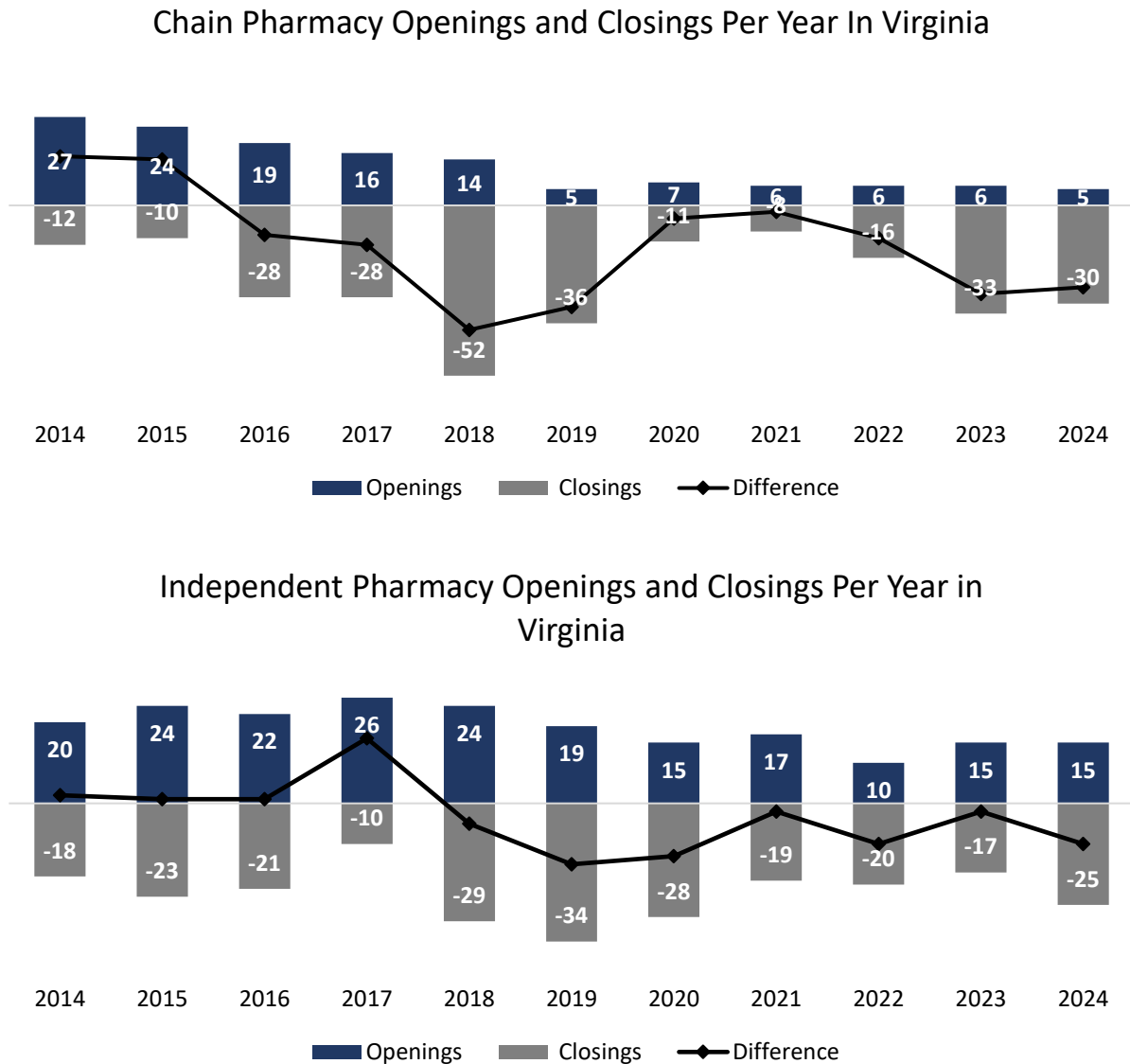
Locality	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Cumberland	1	1	1	1	1	1	1	1	1	1	1
Danville	18	18	19	18	18	18	17	18	18	18	19
Dickenson	7	7	7	7	7	7	7	7	7	6	6
Dinwiddie	3	2	2	2	2	1	1	1	1	1	1
Emporia	3	3	4	3	3	3	2	2	2	2	2
Essex	3	3	3	3	3	3	3	3	3	3	2
Fairfax County	180	185	183	186	193	181	171	167	164	164	163
Fairfax City	14	13	13	13	12	10	10	10	10	10	9
Falls Church City	7	7	7	7	8	8	7	6	6	6	8
Fauquier	13	12	12	12	12	11	11	12	12	11	11
Floyd	1	1	1	1	2	2	2	2	2	2	2
Fluvanna	3	3	3	3	3	3	3	3	3	3	3
Franklin County	10	10	9	9	9	8	8	7	7	7	7
Franklin City	4	4	4	4	5	4	4	4	4	4	3
Frederick	14	14	14	14	14	13	13	13	13	13	13
Fredericksburg	12	12	12	13	12	11	11	11	11	10	11
Galax	5	5	5	5	5	5	5	5	5	5	5
Giles	4	4	4	4	4	4	4	4	5	5	5
Gloucester	7	7	7	7	7	7	7	7	6	6	6
Goochland	4	3	3	2	2	2	2	2	2	2	2
Grayson	2	2	2	2	2	2	1	1	1	1	2
Greene	3	3	3	3	3	3	3	3	3	3	3
Greensville	0	0	0	0	0	0	0	0	0	0	0
Halifax	5	5	5	5	5	5	5	5	6	6	6
Hampton	25	26	25	24	24	21	20	19	18	17	16
Hanover	24	26	27	26	27	24	23	23	23	24	23
Harrisonburg	18	17	18	17	17	17	17	16	16	16	15
Henrico	68	70	72	76	74	73	70	70	71	71	66
Henry	6	6	6	7	6	6	6	6	6	6	7
Highland	0	1	1	1	1	1	1	1	1	1	1
Hopewell	4	4	4	4	5	5	5	5	5	5	5
Isle Of Wight	4	4	5	5	5	5	5	5	5	5	6
James City	23	23	24	23	22	23	22	21	21	19	18
King and Queen	0	0	0	0	0	0	0	0	0	0	0
King George	2	2	2	2	2	2	2	2	2	2	2
King William	3	3	3	3	3	3	3	2	2	2	3
Lancaster	7	7	7	7	7	6	6	6	5	5	5

Locality	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Lee	7	7	7	7	7	7	7	7	7	7	7
Lexington	6	6	6	6	5	5	5	5	5	5	5
Loudoun	59	62	64	62	64	67	67	66	65	68	69
Louisa	4	4	4	4	4	4	3	3	3	3	4
Lunenburg	2	2	2	2	2	2	2	2	2	2	2
Lynchburg	21	21	22	23	23	22	21	21	21	20	19
Madison	1	1	1	1	1	1	1	1	1	1	1
Manassas City	14	13	14	14	15	13	11	11	11	11	11
Manassas Park City	2	2	2	2	2	2	2	2	2	2	2
Martinsville	10	9	9	8	8	8	8	8	7	7	6
Mathews	2	2	2	2	2	2	1	1	1	1	1
Mecklenburg	9	10	9	9	9	9	9	8	8	8	8
Middlesex	2	2	2	2	2	2	2	2	2	2	2
Montgomery	16	17	17	15	16	16	16	17	17	17	18
Nelson	3	3	3	3	3	3	2	2	2	2	1
New Kent	3	3	3	3	3	3	3	3	3	3	3
Newport News	33	31	32	32	31	30	30	30	30	27	26
Norfolk	40	43	43	45	44	39	38	37	36	36	32
Northampton	4	4	4	4	4	4	5	5	5	5	5
Northumberland	2	2	2	2	2	2	2	1	1	1	1
Norton City	3	3	3	3	3	3	3	3	4	4	4
Nottoway	3	3	3	3	3	3	3	3	3	3	3
Orange	8	8	8	8	8	7	7	7	7	7	7
Page	4	3	3	3	2	2	2	2	2	2	2
Patrick	4	4	4	4	4	4	4	4	4	4	4
Petersburg	13	13	13	10	10	10	8	8	8	8	7
Pittsylvania	4	4	4	4	4	3	4	4	4	4	4
Poquoson	3	3	3	3	3	2	1	2	2	2	2
Portsmouth	20	20	17	16	16	14	14	14	15	15	16
Powhatan	3	3	3	4	4	3	3	3	3	3	3
Prince Edward	6	6	6	5	5	6	5	5	5	5	5
Prince George	1	0	0	0	1	1	1	1	1	0	0
Prince William	57	59	60	59	61	60	57	56	57	57	57
Pulaski	8	8	8	9	8	8	9	9	9	9	9
Radford County	1	1	1	1	1	1	1	1	1	1	1
Radford City	3	3	3	3	3	3	4	5	5	5	5
Rappahannock	0	0	0	0	0	0	0	0	0	0	0

Locality	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Richmond County	1	1	1	1	1	1	1	1	1	1	1
Richmond City	31	33	33	33	31	31	32	31	30	29	30
Roanoke County	15	16	16	16	17	17	16	16	16	13	13
Roanoke City	28	30	29	27	25	24	24	24	26	24	23
Rockbridge	0	0	0	0	0	0	0	0	0	0	0
Rockingham	9	9	9	9	9	9	9	8	6	7	7
Russell	8	8	8	8	8	8	9	9	9	9	9
Salem	12	12	12	11	11	12	11	10	10	9	9
Scott	6	7	7	7	7	7	6	6	6	6	6
Shenandoah	9	9	7	7	7	7	6	6	6	6	6
Smyth	12	12	12	12	12	11	11	11	11	11	10
Southampton	1	1	0	0	0	0	0	0	0	0	0
Spotsylvania	18	18	18	19	21	19	19	19	18	18	18
Stafford	20	20	20	21	21	21	20	20	19	18	18
Staunton City	10	10	10	9	9	9	7	7	8	8	8
Suffolk	14	16	17	18	18	17	15	15	15	16	16
Surry	0	0	0	0	0	0	0	0	0	0	0
Sussex	3	3	3	3	3	3	2	2	2	2	2
Tazewell	18	18	18	18	18	17	17	17	17	17	17
Virginia Beach	84	86	85	85	81	77	74	71	69	69	65
Warren	8	7	7	7	7	7	7	5	5	5	5
Washington	16	16	17	17	16	16	16	17	17	17	17
Waynesboro	9	9	10	10	10	9	9	8	8	8	8
Westmoreland	3	3	3	3	3	3	3	3	3	3	3
Williamsburg	1	1	1	1	1	1	1	1	1	1	1
Winchester	15	12	12	12	12	12	12	12	12	12	11
Wise	16	15	14	15	16	16	15	16	14	13	15
Wythe	9	9	10	9	9	9	8	9	7	8	8
York	10	11	10	10	11	11	10	10	10	10	9

Appendix 4: Count of openings and closings by pharmacy type

FIGURE 8. Pharmacy Openings and Closings Per Year by Pharmacy Type



SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.



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