State of Board of Health
Agenda
March 19, 2026– 9:00 a.m.
Perimeter Center, Boardroom 2

Call to Order and Welcome	Mike Desjadon, Chair
Introductions	Mr. Desjadon
Review of Agenda	Katelyn Briguglio, MPH Policy Administrator
Approval of December 12, 2025 Minutes	Mr. Desjadon
Commissioner's Report	B. Cameron Webb, MD, JD State Health Commissioner
Regulatory Action Update	John Kotyk Legislative and Regulatory Coordinator
Legislative and Budget Update – 2026 General Assembly	Mr. Kotyk Stephanie Gilliam Director, Office of Budget
Public Comment Period	
Break	
<u>Lunch Presentation:</u> State Health Services Plan (SHSP) Task Force Update	Karen L. Cameron Chair, SHSP Task Force
<u>Regulatory Action Items:</u> Proposed Amendments: Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501)	Lance Gregory Director, Office of Environmental Health Services
Final Regulations: Prescription Drug Price Transparency Regulation (12VAC5-219)	Arman Latif Chief Information Officer
<u>Non-Regulatory Action Item:</u> Board of Health Annual Report	Ms. Briguglio Kaitlyn Gentille, MPH Strategic Initiatives Coordinator Sr.
<u>Non-Regulatory Action Item:</u> Interim State EMS Plan Extension	Maria Beermann-Foat, PhD, NRP Director, Office of Emergency Medical Services

Presentation:

2026-2030 Plan for Well Being	Khalida Willoughby, MS Director, Center for Community Health Improvement Office of Family Health Services
Appointment of Nominating Committee	Mr. Desjadon
Other Business	
Adjourn	

DRAFT - NOT APPROVED

State Board of Health
December 12th, 2025- 9:00am
Perimeter Center, Boardroom 2

Members Present: Juanita Balenger; Charles Bott Ph.D., P.E., BCEE; James Cole; Douglas Daniels, DVM; Michael Desjadon, Chair; Kevin Dillard, MBA; Lee Jones, DMD; Thomas Lawton, MBA; Melissa Nelson, MD, Vice Chair; Ann B.R. Vaughters, MD; Walter Vest, MD; and Cynthia Warriner.

Kathy Gorman, MSN, RN, FAAN, and Amanda Gannon participated virtually from their homes.

Virginia Department of Health (VDH) Staff Present*:* Katelyn Briguglio, Policy Administrator; Michael Capps, Director of Policy and Planning; Stephanie Dunkel, Deputy Commissioner for Population Health and Preparedness; Charlotte Fajardo, Executive Assistant; Susan Fischer-Davis, MD, Chief Deputy Commissioner for Community Health Services; Breanne Forbes-Hubbard, Workforce Development and Engagement Director; Laurie Forlano, DO, MPH; Kaitlyn Gentile, Agency Management Analyst; Emily Hines, Agency Star; John Kotyk, Legislative and Regulatory Coordinator; Arman Latif, Acting Chief Information Officer; R. Christopher Lindsay, Chief Operating Officer; Maria Reppas, Director of Communications; John Ringer, Chief Financial Officer; Meredith Robinson, Agency Star; Karen Shelton, MD, State Health Commissioner; Tammie Smith, Public Relations Coordinator.

Other Staff Present: Robin Kurz, Senior Assistant Attorney General

Call to Order
Mr. Desjadon called the meeting to order at 9:00 am and led all present in the Pledge of Allegiance. Mr. Desjadon welcomed Mr. Dillard to his first meeting on the board.

Introduction
Mr. Desjadon welcomed those in attendance to the meeting. Mr. Desjadon then started the introductions of the Board members and VDH staff.

Review of Agenda
Ms. Briguglio reviewed the agenda and the items contained in the Board's binder.

Approval of October 2nd Meeting Minutes
The minutes from the October 2nd meeting were reviewed. Dr. Nelson motioned to approve the minutes, seconded by Ms. Warriner. Ms. Warriner then motioned to amend the minutes to reflect her comment that VDH had quickly corrected the challenges with pharmacies' reporting COVID-19 vaccine information into the VIIS system.

Dr. Nelson motioned to approve the October 2nd meeting minutes as amended,

and Mr. Jones seconded the motion, which was approved unanimously by voice vote.

Commissioner's Report

Dr. Shelton presented the Commissioner's Report to the Board. She updated the Board on key issues and projects VDH is engaged in including:

- Recognition of Agency Stars
- Key Personnel Changes
- Infectious Disease Update
- Maternal Health Website Update
- Nursing Home Oversight Update
- Performance Management Update
- Update on JLARC Progress
- Federal Grants Update
- Federal Shutdown Update
- Language and Disability Access Program
- Lead Poisoning Prevention
- Substance Use/Overdose Data Update
- Rural Health Transformation Update

Mr. Desjadon congratulated the agency on their efforts in navigating the recent federal government shutdown. Ms. Warriner highlighted the agency's efforts and quick response in ensuring COVID-19 vaccinations were available to the public despite confusion. Ms. Warriner also highlighted that the challenge of adapting to the VIIS system in pharmacies and reporting COVID-19 vaccine information was corrected quickly and thanked the agency for their role in correcting the issue promptly.

Regulatory Action Update

Mr. Kotyk reviewed the summary of all pending VDH regulatory actions. There are 56 pending actions under development:

- 14 NOIRAs
- 2 Emergency/NOIRAs
- 15 Proposed Actions
- 4 Final Actions
- 21 Fast Track Actions

Regulatory Actions Taken by the Commissioner on Behalf of the Board pursuant to § 32.1-20 of the Code of Virginia since the October 2nd, 2025, Board Meeting while the Board was not in Session:

- The Commissioner approved a Notice of Intended Regulatory Action (NOIRA) for the Rabies Regulations (12VAC5-105).
- The Commissioner approved a Notice of Intended Regulatory Action (NOIRA) for the Food Regulations (12VAC5-421).
- The Commissioner approved a Periodic Review of the Waterworks Regulations

(12VAC5-590).

Mr. Kotyk advised the Board that there are 5 periodic reviews in progress:

- 12 VAC 5-125 Regulations for Bedding and Upholstered Furniture Inspection Program
- 12 VAC 5-371 Regulations for the Licensure of Nursing Facilities
- 12 VAC 5-381 Home Care Organization Regulations
- 12 VAC 5-475 Regulations Implementing the Virginia Organ and Tissue Donor Registry
- 12 VAC 5-620 Regulations Governing Application Fees for Construction Permits for Onsite Sewage Disposal Systems and Private Wells

Public Comment Period

There were no people signed up for the public comment period.

Lunch Presentation: Pharmacy Benefit Managers

Harry L. Gewanter, MD, FAAP, MACR presented an overview of the role of Pharmacy Benefit Managers (PBMs). Additionally, information was presented on current actions and proposals affecting PBMs in other states and Congress.

There was discussion regarding the impact of spread pricing in pharmacy settings and the prohibition of spread pricing in Virginia. Additionally, there was discussion regarding the regulatory oversight of PBMs, that though insurance companies are regulated by the State Corporation Commission – Bureau of Insurance, PBMs are not subject to similar oversight. Additionally, that consumers may not be aware of their ability or the correct process to file complaints against their insurer.

Fast Track Regulations: Rules and Regulations Governing Health Data Reporting (12VAC5-215) and Methodology to Measure Efficiency and Productivity of Health Care Institutions (12VAC5-216)

Mr. Latif presented a Fast Track regulation regarding Rules and Regulations Governing Health Data Reporting (12VAC5-215) and Methodology to Measure Efficiency and Productivity of Health Care Institutions (12VAC5-216). This fast-track action combines two existing regulatory chapters (12VAC5-215 & 12VAC5-216) into a single chapter and reorganizes regulatory content that results in greater clarity of the requirements and practices related to the submission of financial and operational data used to evaluate the efficiency and productivity of the Commonwealth's medical care facilities. Outdated definitions have been removed, and new definitions have been added to make the provisions clearer and easier to understand.

Mr. Vest made a motion to approve the Fast Track Regulation, seconded by Dr. Nelson. The motion passed unanimously by voice vote. There was no discussion.

Other Business:

Ms. Warriner presented data from the December 10, 2025 Board of Pharmacy meeting regarding pharmacy closings in the state of Virginia. Ms. Warriner noted that the rate and number of closings is a serious issue that is affecting community access to pharmacies across the state.

Discussion included what, if any, action the board could and should take in declaring the position of the board regarding the growing challenge of pharmacy access. Ms. Warriner indicated that she would like the board to be aware of the severity of the problem.

Dr. Vest noted a study done approximately five years ago on the cost of prescriptions, which was recently re-done but had not been approved to be made public. He discussed the growing challenges associated with pharmacy deserts, which he termed "pharmacy wastelands" because they are created. Dr. Vest indicated an interest in the Board's declaring pharmacy deserts to be an emergency and ask the Governor to declare a state of emergency, which could allow the Board to promulgate emergency regulations. There was discussion on the desire for more information on the issue before such an action. Ms. Warriner mentioned the desire for the Board to be aware of the ongoing challenges and noted previous requests for a presentation from the Department of Medical Assistance Services (DMAS).

Dr. Vest motioned for the board to declare that there is a state of emergency and request the Governor to declare a state of emergency with regard to the increase of pharmacy closures and pharmacy deserts in Virginia. Ms. Warriner seconded the motion. There was further discussion about the hesitancy to take such an action without additional information. Dr. Vest then withdrew his motion.

Ms. Warriner motioned "for the Board of Health to request from DMAS information from:

- The single PBMs study report, and
- The cost of dispensing study report from December 2024; and

To request from the Joint Commission on Health Care (JCHC) information from:

- Their study on pharmacy deserts and closures."

Dr. Vest seconded the motion.

There was discussion on the ultimate objective from these actions. Ms. Warriner stated that she would like to get to the root causes of the issues, and that since the Board is responsible for population health, the Board should have more information to make decisions if it chooses to act.

Dr. Vaughters noted that the Board should consider what is under its purview, hear points from all relevant stakeholders and resist over-stepping with the request. Additionally, she noted a Freedom of Information Act (FOIA) request from the JCHC regarding the cost of dispensing study, and a desire not to circumvent a potential FOIA issue with the request. She subsequently motioned to amend Ms. Warriner's motion by removing the request for the cost of dispensing study from DMAS, which was seconded by Dr. Nelson. Discussion included a desire for full transparency of the taxpayer-funded studies, and questions about the closure data Ms. Warriner had presented. The motion failed by roll-call vote (9-N:

Balenger, Cole, Desjadon, Dillard, Gannon, Gorman, Lawton, Vest, Warriner; 4-Y: Daniels, Jones, Nelson, Vaughters; 1-A: Bott).

Ms. Warriner's original motion then passed by roll-call vote (12-Y, 1-N: Vaughters, 1-A: Bott).

Additionally, Mr. Cole shared with the board that the USDA approved a healthy foods waiver for the SNAP program in Virginia, which excludes food items high in sugar from the program.

Mr. Capps presented an update to the official 2026 meeting dates for the Board of Health which were approved at the October meeting, noting that the June 2026 travel meeting will occur on Thursday, June 11, 2026. Additionally, Ms. Briguglio provided housekeeping updates for board members including VDH's new reimbursement process and the upcoming required filing of the Financial Disclosure Statement pursuant to § 2.2-3114.

Mr. Desjadon once again welcomed Kevin Dillard to the board, and formally recognized Mr. Critzer's eight years of service to the Board of Health, including multiple years as chair. Mr. Desjadon recognized the work of the Office of Emergency Management Services (OEMS) over the past year and expressed that he was looking forward to continuing to work with VDH in the upcoming year.

Adjourn:

Upon a motion by Dr. Vest and second by Ms. Balenger, the meeting adjourned at 11:46 am.

A RESOLUTION OF THE VIRGINIA STATE BOARD OF HEALTH ADOPTED AT ITS MEETING ON DECEMBER 12, 2025

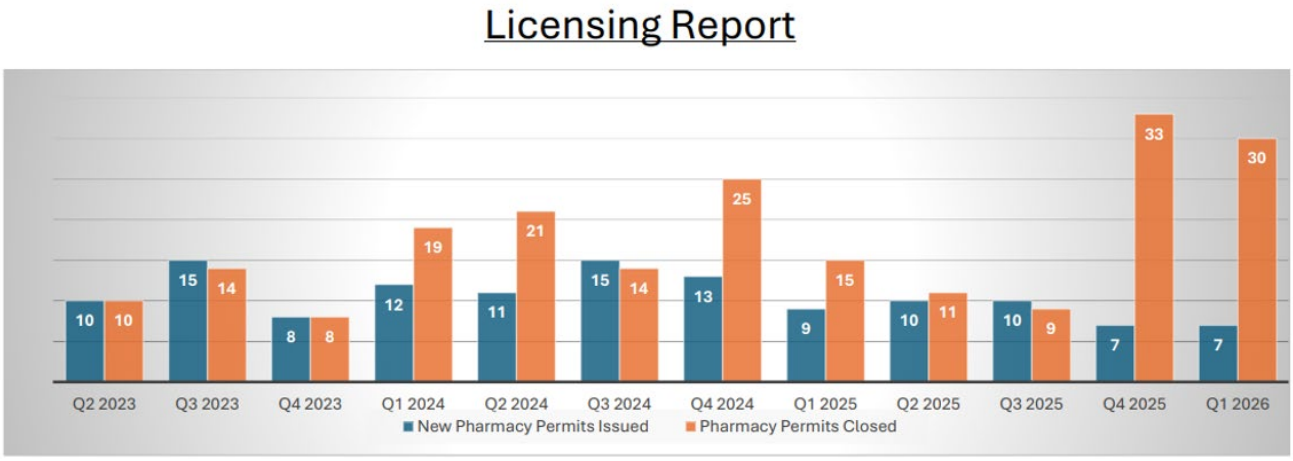
That the Board of Health request from the Department of Medical Assistance Services (DMAS) information from:

- The single PBMs study report, and
- The cost of dispensing study report from December 2024; and

Request from the Joint Commission on Health Care (JCHC) information from:

- Their study on pharmacy deserts and closures.

The following chart was provided by Cindy Warriner for the Board members to review.



COMMONWEALTH of VIRGINIA
Department of Health
B. Cameron Webb, MD, JD
State Health Commissioner
P O BOX 2448
RICHMOND, VA 23218
TTY 7-1-1 OR
1-800-828-1120

MEMORANDUM

DATE: February 20, 2026

TO: State Board of Health

FROM: Lance Gregory
Director, Office of Environmental Health Services

SUBJECT: Proposed Amendments – Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501)

Enclosed for your review are the proposed amendments to the Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501).

The current Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps contain basic requirements for compliance with federal standards, trash and garbage collection, water supplies, sewage and solid waste disposal, and storage of hazardous materials. This regulatory action is a comprehensive update of the Regulations, including the restructuring and updating of regulatory content for health and safety, clarity, style and formatting, and ease of understanding.

The comprehensive update includes the addition of sections related to migrant labor camp operations including general sanitation and maintenance requirements, provisions for heating and cooling, food handling, safety and health, and the reporting of communicable disease. Many of the changes refine and provide further clarity to existing regulations, including general administrative provisions (definitions, variances, and permitting), inspections and enforcement, and references to federal standards and exemptions, water supplies, sewage disposal, trash and garbage, storage of hazardous materials, and compliance with building and fire codes.

If the Board approves the proposed amendments, they will be submitted for Executive Branch Review and, upon approval by the Governor, published on the Virginia Regulatory Town Hall site, where they will be available for public comment for 60 days. The agency will then consider comments in the preparation of final amendments. The proposed amendments are necessary to update the Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps. As such, VDH recommends that the Board approve the proposed amendments to the summer camp regulations.

townhall.virginia.gov

Proposed Regulation
Agency Background Document

Agency name	Virginia Department of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC5-501
VAC Chapter title(s)	Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps
Action title	Amend Regulations as a Result of 2022 Periodic Review
Date this document prepared	12/1/2025

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The current Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501) contain basic requirements for compliance with federal standards, trash and garbage collection, water supplies, sewage and solid waste disposal, and storage of hazardous materials. This regulatory action is a comprehensive update of the Regulations, including the restructuring and updating of regulatory content for health and safety, clarity, style and formatting, and ease of understanding.

The comprehensive update and amendment includes the addition of sections related to migrant labor camp operations including general sanitation and maintenance requirements, provisions for heating and cooling, food handling, safety and health, and the reporting of communicable disease. Many of the changes refine and provide further clarity to existing regulations, including general administrative provisions (definitions, variances, and permitting), inspections and enforcement, and references to federal

standards and exemptions, water supplies, sewage disposal, trash and garbage, storage of hazardous materials, and compliance with building and fire codes.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

"CFR" means Code of Federal Regulations.

"DOLI" means the Virginia Department of Labor and Industry.

"H-2A" means the federal "Nonimmigrant Classification for a Temporary Worker" engaged in temporary or seasonal agricultural work.

"OSHA" means the Occupational Safety and Health Administration.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

This action derives from a 2022 periodic review of this chapter and a subsequent Notice of Intended Regulatory Action published on December 16, 2024.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The promulgating agency is the State Board of Health.

Section 32.1-12 of the Code of Virginia authorizes the Board to make, adopt, promulgate, and enforce the Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps. Chapter 6, Article 6 of Title 32.1 of the Code of Virginia enumerates the legal authority for VDH to regulate migrant labor camps.

Section 32.1-211 of the Code of Virginia outlines the Board of Health's authority to adopt regulations governing migrant labor camps, including the adoption of outlined safety standards necessary to protect the health of migrant workers that supplement the occupational safety and health regulations adopted by the Safety and Health Codes Board pursuant to §40.1-22.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

1) The purpose of this action is to amend the Regulations to update and clarify the requirements for migrant labor camp design, operation, maintenance, and safety. The proposed amendments provide the requirements necessary for migrant labor camp owners to protect the health, safety, and welfare of migrant workers by providing clear, consistent, and protective regulatory standards.

2) The Board of Health promulgated the Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-500) in or before 1950 and amended the Regulations effective November 1, 1980. Effective January 1, 2006, the Regulations (12VAC-500) were repealed and replaced by the Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501). Over the past 19 years, industry and migrant labor camp operations have evolved. Inconsistencies in migrant labor camp operations throughout the Commonwealth and variable interpretations of compliance with state and federal standards support the need for updated statewide regulations for health and safety at migrant labor camps.

   § 32.1-211 of the Code of Virginia outlines the minimal content of the regulations governing migrant labor camps. The Regulations as written do not meet all the Code requirements, including provisions that clearly define and outline the requirements to meet and maintain:

   a) the sites of camps,
   b) the provision of an adequate and convenient supply of pure water as defined in § 32.1-167,
   c) the disposal of sewage as defined in § 32.1-163,
   d) the storage and disposal of solid waste,
   e) the maintenance of the campgrounds, and
   f) the construction, maintenance, alteration or remodeling of buildings and structures for the housing of migrant workers and their families, including wash and bathrooms, central cooking facilities, central dining rooms, sleeping quarters, assembly rooms, lighting and ventilation.

3) The VDH Office of Environmental Health Services and a stakeholder workgroup of over 50 industry representatives collectively drafted, edited, and recommended the proposed amendments to the Regulations. As part of the agency's efforts to clarify and improve the readability and understanding of the Regulations, the amendments address the establishment and consistent use of defined terms and the style and formatting of regulatory content. The goal of the amendments is to collectively establish up-to-date basic health and safety standards for migrant labor camps and to address any vague or missing health and safety content outlined in federal standards adopted as part of the Regulation. In addition, the effort seeks to amend and clarify the vague regulatory language and content that contributes to inconsistencies in interpretation and the enforcement of the Regulation across the Commonwealth.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The proposed amendments reorganize the way information is provided; add new sections to clarify existing provisions or incorporate new provisions; delete sections in in whole to remove obsolete or duplicative information; revise references or citations; and correct sentence structure, grammar, spelling, and typographical errors. VDH reviewed and revised technical terms and word use to improve consistency throughout the Regulations. Substantive changes include:

1) adding definitions,
2) repealing or amending sections on enforcement requirements consistent with the Virginia Administrative Process Act and Title 32.1 of the Code of Virginia,
3) revising a section to clarify variance requirements,
4) revising sections to clarify plan review, permit, and inspection requirements,
5) revising sections to clarify federal standards and exemptions,
6) revising sections to clarify the requirements for solid waste, water supplies, sewage disposal, storage of hazardous materials, and compliance with building code,
7) adding a section on housing and sleeping facilities,
8) adding a section on general sanitation and maintenance,
9) adding a section on heating and cooling,
10) adding a section on storage, handling, and preparation of food,
11) adding a section on insects, rodents, and weed control,
12) adding a section on safety and first aid, and
13) adding a section on communicable disease.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

1) Primary advantages to the public, including private citizens and foreign agricultural workers hired by Virginia businesses, include improved health and safety protections for migrant workers. Improved protections will come from updated requirements for migrant labor camps that align with current industry and public health and safety standards. Private citizens and foreign agricultural workers who temporarily reside at migrant labor camps will be able to reference up-to-date health and safety regulations that are easy to read and understand. Businesses will also be able to increase health and safety protections through updated standards that are well defined, easy to read and understand, consistently implemented across the state, and in alignment with current industry standards and expectations.

   There are no primary disadvantages to the public, including private citizens and foreign agricultural workers. Potential primary disadvantages to businesses may include a minimal additional cost to update or maintain migrant labor camp operations to meet the amended standards.

2) Primary advantages to the agency include regulations that outline processes and expectations that will create statewide consistency in regulating VDH permitted establishments. The amendment of definitions will improve understanding and application of terms during inspections and enforcement. The administrative and operational amendments will provide regulations that

are easy to read and understand. The amendments remove vague and outdated standards and will align with up-to-date public health standards for water supply, sewage disposal, general sanitation and maintenance, food handling, and safety. The amendments will reduce inconsistencies in interpretation during inspection and enforcement of migrant labor camps and will facilitate improved communication and alignment with other state and federal agencies that oversee aspects of migrant labor operations.

There are no primary disadvantages to the agency.

Other pertinent matters of interest to the regulated community, government officials, and the public include the fact that the Regulations have not been revised or amended in 20 years. Failure to update state standards for the operations of migrant labor camps would indicate that the agency and the Commonwealth support the use of outdated regulations that do not meet the basic and minimal health and safety provisions that are consistent with current industry standards and the Code of Virginia.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

The VDH Office of Environmental Health Services and a stakeholder workgroup of over 50 industry representatives collectively drafted, edited, and recommended the proposed amendments to the Regulations, including content that may exceed federal requirements.

Sections 12VAC5-501-10 through 12VAC5-501-280 of the Regulations contain administrative procedures and are only applicable to state operations.

Sections 12VAC5-501-290 through 12VAC5-501-420 include “standards” for migrant labor camps and may be compared to federal standards.

- 12VAC5-501-290 *Primary source of standards* and 12VAC5-501-300 *Exception to occupational safety and health standards* explain the applicability of federal standards to the chapter.
- 12VAC5-501-310 *Solid waste* is not more restrictive than federal standards (29 CFR 1910.142(h); 20 CFR Part 654.414.). Rather, the section provides minimal storage and disposal requirements that align with federal standards or clarify requirements where federal standards do not specify an implied requirement. For example, where ETA standards require garbage containers to be “in good condition”, OSHA standards do not require containers to be “in good condition” but rather state that garbage containers be “approved by the appropriate health authority.”
- 12VAC5-501-320 *Requirements for water supplies* and 12VAC5-501-330 *Requirements of sewage disposal*, are not more restrictive than federal standards. Both ETA and OSHA standards defer to the local health authority for approval of the water supply and sewage disposal. The sections are not more restrictive than federal standards as federal standards require local approval for water (29 CFR 1910.142(c); 20 CFR Part 654.405) and sewage (29 CFR 1910.142(e); 20 CFR Part 654.406).
- 12VAC5-501-340 *Storage of hazardous materials* outlines storage and handling requirements for pesticides, toxic chemicals, and other hazardous materials. ETA standards (20 CFR Part 654.417(h) and (i)) require separation of agricultural pesticides, toxic chemicals, and flammable or volatile liquids or materials from housings areas and sleeping quarters. OSHA standards do not prescribe any hazardous material storage requirements. The amended section provides

health and safety provisions that protect workers where they sleep and eat, where federal standards are vague or non-existent.

- 12VAC5-501-350 *Compliance with Uniform Statewide Building Code, Statewide Fire Prevention Code and local requirements* states that newly constructed camps be constructed in accordance with the building code and be maintained in accordance with the fire code, if it is applicable to the structure. As the applicable building and fire codes are state specific, and as ETA and OSHA standards (29 CFR 1910.142(b)(11) and 29CFR 1910.142(i)(2); 20 CFR Part 654.413(c), 654.417(a) and (e)) refer to compliance with local code, this section is not more restrictive than federal standards.
- 12VAC5-501-360 *Housing and sleeping facilities* subsections A through E are not more restrictive than federal standards. Rather, the sections provide clarity of expectations where federal standards are vague or non-existent (29 CFR 1910.142(b); 20 CFR Part 654.407, 654.408, 654.416). For example, proposed subsection B requires that "a bed or cot in good repair shall be provided for each occupant," where ETA standards require beds be "comfortable and clean," and OSHA standards require beds be "provided." It is expected that federal standards of "comfortable, clean, and provided" means that, per the proposed section, "a bed or cot in good repair shall be provided for each occupant."
- 12VAC5-501-360 *Housing and sleeping facilities* subsection F may be considered more restrictive than federal standards. Subsection F proposes that "smoke detectors and fire extinguishers shall be provided in all migrant labor camp structures and shall be functional and serviced as appropriate." ETA standards require that "fire extinguishing equipment must be provided in a readily accessible place located not more than 100 feet from each housing unit." OSHA standards do not prescribe fire extinguisher requirements. The requirement to provide a functional fire extinguisher in all structures of the migrant labor camp supports the protection of life and safety of workers in the event of a fire.
- 12VAC5-501-370. *General sanitation and maintenance* is not more restrictive than federal standards. The proposed section clearly states that the migrant labor camp be kept clean, in good repair, and maintained to protect the health, safety, and well-being of workers using those facilities. If a federal standard does not explicitly require that a component of the migrant labor camp be kept clean or in good repair, it is considered an oversight of an assumed requirement; the proposed section clarifies the requirement where federal standards do not clearly iterate basic maintenance and cleanliness requirements.
- 12VAC5-501-380 *Heating and cooling* subsections A and D are not more restrictive than federal standards. Rather, where federal standards lack clear and consistent requirements for heating specifications (29 CFR 1910.142(b)(11), 1910.142(f)(4); 20 CFR Part 654.409(a), (b) and (d)), the subsections propose the requirement. Subsections B and C may be considered more restrictive than federal standards. Federal standards lack any cooling provisions for migrant labor camps, where the proposed section content proposes standards for cooling.
- 12VAC5-501-380 subsection A proposes that "all living quarters and service rooms or buildings shall be provided with operable heating equipment if during the period of occupancy the outdoor temperature falls below 68°F." ETA standards require heating be provided when temperatures are at 68°F or less, whereas OSHA standards state that heating is required if the camp is used in "cold weather"; OSHA does not describe or define "cold weather." ETA requires heating equipment that is capable of maintaining an indoor temperature of 68°F or more, whereas OSHA requires heating equipment capable of maintaining a temperature of at least 70°F in service buildings, specifically; it is expected that this heating temperature expectation (of 70°F) translates to indoor temperatures for "shelters" as well, as they are required to be heated if used during cold weather. Per OSHA, even if a camp was mobile or provided in tents or vehicles, a "service building" must be heated accordingly. Therefore, heating to at least 70°F in living and sleeping quarters is considered applicable. This subsection also proposes "cold weather" as 68°F or less but does not prescribe the minimum heating temperature required as ETA and OSHA address the requirement with specific yet differing temperatures.

- 12VAC5-501-380 subsection B proposes that "all living quarter and service room windows shall be provided with window shades or other methods of minimizing radiant heat such that the use of windows is not impeded, when during the period of occupancy, the outdoor temperature exceeds 80°F." Neither ETA nor OSHA standards prescribe a method to reduce radiant heat. Window shades or other provisions to reduce radiant heat may aid in keeping living and sleeping facilities cooler during hot weather.
- 12VAC5-501-380 subsection C proposes that "all rooms used for sleeping shall be provided with operable cooling equipment capable of maintaining a temperature of 85°F or less if during the period of occupancy, the outdoor heat index exceeds 90°F." Neither ETA nor OSHA standards prescribe a method to reduce heat within migrant labor housing. Several Virginia regulations require inside maximum temperatures between 80-85°F for occupants who cannot relocate or leave provided housing (Chapter 61. Standards and Regulations for Licensed Adult Day Centers (22VAC40-61-430), Chapter 73. Standards for Licensed Assisted Living Facilities (22VAC40-73-880), and Chapter 81. Standards for Planning, Design, Construction, and Reimbursement of Local Correctional Facilities (6VAC15-81-720)). Per the Virginia Department of Emergency Management, extreme heat often results in the highest number of annual deaths among all weather-related hazards. Extreme heat is defined as a period of high heat and humidity with temperatures above 90°F for at least two to three days. In extreme heat, evaporation is slowed, and the body must work extra hard to maintain a normal temperature (**https://www.vaemergency.gov/threats/extreme-heat**). Many migrant workers are exposed to high temperatures or extreme heat during the work-day. Most federal and state guidance on avoiding heat-related illness includes temporarily relocating to an area with air conditioning. As migrant workers may not have the ability to travel to air-conditioned areas, the provision of cooling equipment in sleeping areas during times of extreme heat will help support the health, safety, and well-being of migrant workers (https://www.ready.gov/heat; **https://www.cdc.gov/heat-health/about/index.html**).
- 12VAC5-501-380 subsection D proposes that "all heating and cooling units and equipment shall be installed and used in accordance with manufacturer specifications." While neither ETA nor OSHA standards state that equipment be installed or used in accordance with manufacturer specifications, it is expected that this requirement is assumed. The proposed section clarifies that the installation and use of equipment be in accordance with manufacturer specifications; this requirement will help ensure equipment is used safely and as intended.
- 12VAC5-501-390 *Storage, handling, and preparation of food* is not more restrictive than federal standards (29 CFR 1910.142(b)(10) and (11), 1910.142(i)(1), (2), and (3); 20 CFR Part 654.413(a), (b), (c) and (d)). The proposed section clarifies the requirement for food storage, handling, and preparation where federal standards do not clearly iterate basic cooking and eating area requirements.
- 12VAC5-501-390 subsection A proposes a VDH food permit be required in the event the camp owner prepares and serves food or contracts the preparation and service of food to workers. It may be noted that federal OSHA standards reference the "Food Service Sanitation Ordinance and Code," Part V of the "Food Service Sanitation Manual," U.S. Public Health Service Publication 934 (1965). This manual provides outdated food storage and handling provisions; Food handling science and safety has significantly evolved since 1965. Provisions in the manual may be harmful to human health.
- 12VAC5-501-390 subsection B outlines the basic requirements for cooking and eating areas, including refrigeration, a cooking surface such as a stove or hot plate, a sink with hot and cold running water, food storage and preparation areas, an eating area, and light. Most of the provisions proposed align with ETA standards as food storage and preparation standards are completely absent from OSHA standards. The absence of food storage and preparation requirements in OSHA standards creates confusion on what is acceptable for migrant labor camps subject to OSHA standards.

- 12VAC-501-390 subsection C proposes that surfaces within and near cooking and eating areas be cleanable and in good repair. Federal standards do not explicitly or consistently state that food storage and preparation areas shall be easily cleanable and in good repair.
- 12VAC5-501-390 subsection D proposes that cooking areas be ventilated in accordance with the applicable building code. Federal standards do not explicitly or consistently state that kitchens shall be ventilated. This subsection proposes that ventilation be considered as adequate ventilation aids in maintaining clean air and surfaces, and aids in fire prevention.
- 12VAC5-501-390 subsection E proposes that fire extinguishers be provided in cooking areas and be accessible. ETA standards require that “fire extinguishing equipment must be provided in a readily accessible place located not more than 100 feet from each housing unit.” OSHA standards do not prescribe any fire extinguisher requirements. The requirement to provide a functional fire extinguisher in cooking areas supports the protection of life and safety of workers in the event of a fire.
- 12VAC5-501-400 *Insects, rodents, and weed control* is not more stringent than federal standards (29 CFR 1910.142(j); 20 CFR Part 654.404(c) and 654.415). Where federal standards lack clear and consistent requirements for vegetation and pest controls, this section proposes the requirement. ETA identifies that housing and facilities be free from noxious plants and uncontrolled weeds or brush, whereas OSHA does not. ETA requires housing and facilities be free of insects, rodents and other vermin, whereas OSHA does not. However, as it may be impossible to ensure a facility is completely free of any insect, it may be expected that it is intended that a facility be "free from infestation;" OSHA requires effective measures be taken to prevent infestation of animals, insects, or pests, whereas ETA does not require such action. This section proposes consistent application to the prevention of uncontrolled vegetation and infestation of pests.
- 12VAC5-501-410 *Safety and first aid* subsection A is not more stringent than federal standards (29 CFR 1910.142(k); 20 CFR Part 654.417(g)) as such standards require first aid kits. Subsections B and C may be considered more stringent than federal standards as they require a migrant labor camp owner to develop an emergency response plan and to post emergency contact phone numbers in a central location accessible to workers. The development of an emergency response plan and posting emergency contacts is considered an essential first step to planning for an emergency and the safety of occupants of camps.
- 12VAC5-501-420 *Communicable disease* is not more stringent than federal standards (29 CFR 1910.142(l)). While the requirement to report communicable disease is not outlined in ETA standards, it is reported that in the absence of a standard in ETA, ETA facilities comply with the applicable OSHA standard. In Virginia, Chapter 90. Regulations for Disease Reporting and Control., requires persons in charge of a facility licensed by any agency of the Commonwealth to report the presence or suspected presence in his facility of persons who have common symptoms suggesting an outbreak situation. This section applies to owners and operators of permitted migrant labor camps.

Virginia Code sections § § 32.1-203 and 211 authorizes the State Board of Health to adopt regulations applicable to migrant labor camps. Virginia Code section § 32.1-211(A) requires the Safety and Health Codes Board to adopt regulations that are no more stringent than those actually enforced by the United States Department of Labor. Virginia Code section § 32.1-211(B) goes on to give the State Board of Health additional authority to issue regulations that are more restrictive than those enforced by the Department of Labor provided that those regulations are necessary to protect the health of migrant workers. The aforementioned regulations are more stringent than the applicable federal standards, but they are necessary to protect the health of migrant workers in the Commonwealth, thereby meeting the requirements of Virginia Code section § 32.1-211.

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as tribal governments, school boards, community services boards, and similar regional organizations. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

Other state agencies that will be particularly affected by the regulatory change include:

1) The Department of Workforce Development and Advancement (Virginia Works), and
2) The Virginia Department of Labor and Industry (DOLI).

The Virginia Works Agriculture and Foreign Labor Certification Program assists employers with finding the right workforce to fill their labor needs, often through the H-2A temporary agricultural program. The H-2A program allows agricultural employers to bring nonimmigrant foreign workers into the country to perform agricultural labor on a seasonal basis (Virginia Works 2025). The approval of foreign job orders by Virginia Works requires that a migrant labor camp be in compliance with applicable federal standards and be permitted by VDH in accordance with the Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501).

The DOLI administers the programs for Virginia Occupational Safety and Health and Labor and Employment Law (DOLI 2025). As the Regulations are intended to supplement the occupational, safety and health regulations of the Safety and Health Codes Board applicable to migrant labor camps, camp compliance with state Regulations may influence DOLI investigations and enforcement, if applicable.

Localities Particularly Affected

There are no localities particularly affected by the regulatory change.

Other Entities Particularly Affected

There are no other entities particularly affected by the regulatory change.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits) anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees, or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources.	There are no projected costs for the agency resulting from the regulatory change. There are no permit or plan review fees associated with migrant labor camps. The proposed changes provide clarity and consistency of application of the regulations and do not propose significant changes that would monetarily impact the agency.

For other state agencies: projected costs, savings, fees, or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	There are no projected costs, savings, fees, or revenues predicted for other state agencies related to or resulting from the regulatory change.
For all agencies: Benefits the regulatory change is designed to produce.	For all agencies, the regulatory change will produce a benefit of statewide consistency in regulating migrant labor camps through improved understanding and application of regulation. The updated regulations align with up-to-date public health and industry standards and improve public health and safety protections specific to migrant workers.

Impact on Localities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a or 2) on which it was reported. Information provided on that form need not be repeated here.

Projected costs, savings, fees, or revenues resulting from the regulatory change.	Local partners or associations such as the Virginia Agribusiness Council, Virginia Farm Bureau or similar entities may be affected by this action in regard to notification and support of their constituents. Local and tribal governments, school divisions, or other authorities are likely not affected by this action, unless they implement a local ordinance or other code specific to migrant labor camps, or if they operate a migrant labor camp. There are no monetizable direct or indirect costs or benefits to localities or local partners.
Benefits the regulatory change is designed to produce.	Potential indirect benefits to local partners associated with the proposed amendments may include improved public health and safety protections for migrant labor camps. The modernization of regulations could improve business and public perception of the agency and the Commonwealth's migrant labor camps through the provision of a consistently implemented regulation that increases public health protection for migrant workers.

Impact on Other Entities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a, 3, or 4) on which it was reported. Information provided on that form need not be repeated here.

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Entities affected by this change may include migrant labor camp owners and operators who operate a camp in Virginia. In addition, migrant workers and their families that reside in migrant labor camps may also be impacted by the proposed regulatory change.
Agency's best estimate of the number of such entities that will be affected. Include an estimate	The number of migrant labor camps permitted each year varies. In 2025, there were 372

of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated, and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	migrant labor camps permits issued in Virginia. Many migrant labor camps are owned and operated by small businesses. As VDH does not collect business data, it cannot be determined how many migrant labor camps are operated by small businesses.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	a) Projected costs related to reporting, record keeping, or other administrative costs required for compliance may include the cost of printing plans or specifications for the submittal of a plan review to the local health department (if plans or specifications are not submitted electronically), and/or the cost of printing a permit to post in the office or on the premises of a camp. The cost of printing plans and permits is considered negligible. b) Projected costs related to the development or management of real estate for operating a camp include the proposed requirement for a migrant labor camp to test for total coliforms and nitrate-nitrogen prior to permit issuance and at least annually thereafter. One sample per year per constituent will be required and will incur an estimated cost of approximately $52 for one coliform sample and approximately $56 for one nitrate-nitrogen sample, for an estimated total of $108 each year. c) There are no fees associated with a migrant labor camp permit application or plan review or other administrative requirement. d) Projected cost of purchases of equipment or services: • The proposed storage area marking requirement may incur a cost to print a sign in the primary and secondary language of the housing occupants. As a sign is already required in accordance with current regulation, one additional sign may be required. Such signs may be printed on a piece of paper or may be custom-made. The cost of providing written notification on a piece of paper is negligible, whereas a custom-made sign may incur an estimated average cost of approximately $16 per sign. • The proposed requirement to provide smoke detectors and fire extinguishers in all structures may incur a cost. The estimated cost of providing a smoke detector is approximately $17.31 per detector. The estimated cost of providing a fire extinguisher is approximately $34.14 per extinguisher.

	• The proposed requirement to provide cooling equipment, that may include fans, air conditioners, central air, geothermal systems, evaporative coolers, ventilation, or other methods of cooling may incur a cost. While cooling equipment options are at the discretion of the camp owner, it may be considered that fans or window air-conditioners may be the most familiar and likely cooling methods employed. The estimated cost of providing a window fan is approximately $55.32 per fan. The estimated cost of providing a window air-conditioner is approximately $196 per unit. • The requirement to provide fire extinguishers in kitchen areas may incur an estimated cost of approximately $34.14 per extinguisher. • The proposed requirement to provide first aid supplies within the camp may incur an estimated cost of approximately $54.04 per kit. e) There are no anticipated costs associated with the time required to comply with the requirements.
Benefits the regulatory change is designed to produce.	<u>Overall</u> Providing comprehensive, consistent, and up-to-date standards will provide the industry and the public with improved and comprehensive health and safety protections at migrant labor camps. <u>Definitions and Administrative.</u> Amended sections for definitions and administrative content will provide improved understanding and application of the regulations. Definitions for terms and acronyms will enhance reader understanding and provide consistency throughout the regulation. <u>Plan Review and Permits.</u> Amended sections for plan review and permitting will provide improved understanding of the plan review and permitting process. The plan review process will assist camp owners in designing and constructing a camp that aligns with both state and federal requirements. As federal standards may not align with the building code, not providing a regulatory structure to the plan review

	process may result in a migrant labor camp being built out of compliance with federal or state standards, thus resulting in delays in permitting and costly/timely retrofitting of structures to meet federal requirements. Inspection and Enforcement. Amended sections specific to inspection and enforcement provide an improved understanding and application of the regulation and clarity to the inspection and enforcement processes, as well as opportunities for appeal. Federal standards. The amended sections specific to federal standards provide an improved understanding of which standards apply to specific migrant labor camps. While the Regulations pursuant to § 32.1-211 are intended to supplement the Virginia Occupational Safety and Health (VOSH) Federal Identical General Industry Standards (16VAC25-90-1910), federal housing standards must be met for an owner or operator to operate a migrant labor camp. The section language makes it clear that compliance with the VOSH standards (OSHA or ETA) is required by the Regulations. Water supply. The proposed section improves understanding and application of the regulation and provides for improved protection of migrant workers in relation to camp water supply and distribution. Testing a water supply is the best way to ensure that drinking water is safe from harmful chemicals and bacteria. Testing for bacteria provides protection against acute gastrointestinal illness, while testing for nitrates can prevent health problems. In agricultural settings, testing for nitrates may act as an indicator for other contamination sources, such as improperly handled livestock manures, intensive livestock production facilities, excessive or inappropriate fertilizer applications, or failing septic systems. Sewage disposal. The proposed section improves understanding and application of the regulation and provides for protection of migrant workers and the environment in relation to camp sewage disposal. Hazardous materials storage.

	The proposed section provides a minimal requirement for chemical and hazardous material storage and handling that increases protection for migrant worker health and safety. General sanitation and facility maintenance. The proposed sections provide improved protection of and provisions for migrant labor camps and occupants in relation to solid waste handling, disposal, and management, facility buildings and grounds management and maintenance, and pest control. Housing facilities. The proposed section provides minimal requirements for migrant labor camp structures and sleeping quarters that increase protection for migrant worker health and safety. Heating and cooling. The proposed section provides indoor temperature requirements for migrant labor camp structures and sleeping quarters that provide occupants protection against the elements and reduced exposure to extreme temperatures. Maintaining safe indoor temperatures may help prevent heat-related illness and may improve worker well-being and productivity. Storage, handling, and preparation of food. The proposed section improves protection of migrant labor camp occupants in relation food storage and preparation and eating areas that can help ensure the provision of adequate facilities and may reduce the potential for foodborne illness. Safety and first aid. The sections provide a minimal standard that aims to protect migrant workers' health, safety, and welfare as it relates to access to first aid supplies while residing at a migrant labor camp. Providing a minimal requirement for emergency planning and response at a migrant labor camp increases protection for worker health and safety.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

The no-action alternative to revising the Regulations would allow migrant labor camp permitting, design, operation, maintenance, and health requirements to remain unclear and outdated. This no-action alternative would result in inconsistent interpretation and enforcement of migrant labor camp standards. In addition, there would be no adequate provisions for water supply, sewage disposal, general sanitation and maintenance, food handling, and safety. A no-action alternative would not align with the purpose and intent of the periodic review process required by Code of Virginia § 2.2-4017. Periodic review of regulations. Providing clear and up-to-date standards helps provide consistent oversight and management while reducing the risk of illness and injury at migrant labor camps throughout the Commonwealth. For the reasons previously stated, the agency is proposing to update and clarify all sections of the Regulations where needed, and to re-organize the overall content in a manner that is easy to follow, read, and understand.

During the development of the proposed amendments, stakeholders voiced the idea of repealing the Regulations and relying on Virginia Works to enforce the applicable federal housing standards for migrant labor camps. Such an action would reduce a duplicative inspection occurrence, where Virginia Works staff and VDH staff both inspect migrant labor camps to determine compliance with applicable state and federal housing standards. However, the Code of Virginia § 32.1-205 requires anyone operating a migrant labor camp to have a permit and § 32.1-207 further requires the Commissioner or their designee to inspect and issue a permit for the operation of the camp. While § 32.1-211 states that the Board [of Health] *may* adopt regulations governing migrant labor camps, it is considered that the repeal of the existing Regulation is not the intention of the Code of Virginia and would not remove the requirement that the Commissioner or their designee issue a permit to operate a migrant labor camp. The removal of regulation would confuse and complicate the required process of permit issuance. It is unclear how the agency would issue a permit to operate a migrant labor camp in the absence of regulation.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

The Board of Health is directed through the Code of Virginia § 32.1-205 to require a permit to operate a migrant labor camp and through § 32.1-207 to inspect and permit migrant labor camps. The Code of Virginia § 32.1-211 states that the Board may adopt regulations governing migrant labor camps which supplement the occupational safety and health regulations adopted by the Safety and Health Codes Board pursuant to Chapter 3 (§ 40.1-22 et seq.) of Title 40.1 and which are necessary to protect the health of migrant workers. Such regulations may include, but need not be limited to, standards governing:

1) The sites of camps.
2) The provision of an adequate and convenient supply of pure water as defined in § 32.1-167.
3) The disposal of sewage as defined in § 32.1-163.
4) The storage and disposal of solid waste.
5) The maintenance of the campgrounds.
6) The construction, maintenance, alteration or remodeling of buildings and structures for the housing of migrant workers and their families, including wash and bathrooms, central cooking facilities, central dining rooms, sleeping quarters, assembly rooms, lighting and ventilation.

If the Board considered establishing less stringent compliance requirements for migrant labor camps, the listed standard requirements would not be met. Current regulations do not meet acceptable standards of health specific to the majority of the requirements outlined in § 32.1-211, specifically the provision of an adequate and convenient supply of pure water, the maintenance of campgrounds, or the construction, maintenance, alteration or remodeling of buildings and structures for the housing of migrant workers and their families.

The agency worked with industry stakeholders to establish the proposed amendments that best align with Virginia's public health standards. In addition, any potential exemptions to the state regulation can be pursued by a migrant labor camp owner through the revised variance process provided in the proposed regulation.

As the Regulations have incorporated federal housing standards for temporary agricultural workers, the workgroup amended the Regulations to reduce or remove any duplicative content that already existed in federal standards. Where federal standards were vague or inconsistent, the Regulations provide consistent application and understanding of the regulatory requirements for migrant labor camps.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, indicate whether the regulatory change meets the criteria set out in EO 19 and the ORM procedures, e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable. In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, discuss the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation. Also, discuss why the agency's decision, consistent with applicable law, will minimize the economic impact of regulations on small businesses.

This proposed Regulation is not being used to announce a periodic review or a small business impact review.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency's response. Include all comments submitted: including those

received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

During the Notice of Intended Regulatory Action public comment period that ended January 15, 2025, the following public comments were received:

Commenter	Comment	Agency response
Anonymous (229068)	Dangerous mistake Americans are the most giving people in the world, but the way we are going about this is not right for the safety of our every Virginian American Citizen. Our nation and state must be united in keeping our homes, neighborhoods, towns, communities, and cities safe and secure. We have seen enough examples of Portland, Chicago, New York City, San Francisco, and other places where destruction of encampments for illegals are dangerous. Four years of economic decline, crime rates soaring, and poverty increases for American-Virginia citizens like me because of selfish interests. How about reaching out to citizens of Virginia who have been struggling for years ? Across the political aisles and working with everyone else? How about reporting the facts consistently even if it doesn't make you look good? Honest reporting How about talking responsibly for lockdowns, forced vaccinations, masks wearing, mandates, slow education progress? Family is the most important factor in the child's life, not big government. How about stop pushing solar power items and allow people to have choices? Please stop focusing on people based on race, gender, religion, education, location, etc? A person's character and hard work will always be valued! How about stop spying and censoring Americans, media outlets,?	The agency thanks the commentor for their comment.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

The Virginia Department of Health is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, (iii) the potential impacts of the regulation, and (iv) the agency's regulatory flexibility analysis stated in that section of this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Briana Bill, 109 Governor Street, 6th Floor, Richmond, VA 23219, briana.bill@vdh.virginia.gov, or fax (804) 864-7475. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of this stage, and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (https://townhall.virginia.gov) and on the Commonwealth Calendar website (https://commonwealthcalendar.virginia.gov/). Both oral and written comments may be submitted at that time.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between the existing VAC Chapter(s) and the proposed regulation. If the existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC5-501-10		**Definitions.** Defines words and terms used in the chapter.	**Change**: Deleted definitions not used in the chapter or that are otherwise described in section content: Approved water supply, Director, and Owner. Amended definitions to improve clarity and understanding and to meet style and formatting requirements: Commissioner, Department, Migrant labor camp, Migrant worker, and Variance.

			Added definitions to include words and terms used in amended chapter: Administrative Process Act, Applicable building code, Camp owner, Employment and Training Administration, Permit holder, Private well, Rainwater harvesting system, Tent, and Waterworks. **Intent**: Improve clarity and understanding of words and terms used in the amended chapter. **Rationale**: Definitions for words and terms will enhance reader understanding and provide consistent application throughout the regulation. **Impact**: Improved understanding and application of the regulation.
12VAC5-501-20		**Purpose of regulations.** Identifies that the purpose of the chapter is to ensure safe and healthy living conditions are provided for migrant workers; to establish standards to permit, deny, revoke or suspend a permit.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and is addressed by the Code of Virginia § 32.1 Article 2 and Article 3. **Impact**: None.
12VAC5-501-30		**Administration of regulations.** Outlines that the regulations are administered by the State Board of Health, the State Health Commissioner, the State Department of Health, and the district or local health director.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and is addressed by the Code of Virginia § 32.1 Article 2 and Article 3. **Impact**: None.
12VAC5-501-40		**Right of entry to inspect, etc.; warrants.** Provides the right of entry and the ability for inspection.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and is addressed by the Code of Virginia § 32.1-25. **Impact**: None.
12VAC5-501-50		**Continuing validity of existing permits.**	**Change**: Repealed.

		Provides that operational permits in effect prior to January 2006 shall remain valid until the expiration date.	**Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is no longer relevant. **Impact**: None.
12VAC5-501-60		**Application of the Administrative Process Act.** Provides that the Administrative Process Act shall govern the procedures for rendering all case decisions.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative. The content is provided in the Code of Virginia § 32.1-24. Applicability of Administrative Process Act. **Impact**: None.
12VAC5-501-70		**Emergency orders.** Allows the commissioner to issue emergency orders.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative. The content is provided in the Code of Virginia § 32.1-13. Emergency orders and regulations. **Impact**: None.
12VAC5-501-80		**Enforcement of regulations.** Outlines requirements for notices, orders, hearings, permit revocation, and legal action.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative. The Code of Virginia sections §§ 32.1-26, 32.1-27, 32.1-209, and 32.1-210 provide the referenced authority. Content relevant to notice and due process, is proposed amended section 12VAC5-501-220. Enforcement, notices, informal conferences. **Impact**: None.
12VAC5-501-90		**Penalties, injunctions, civil penalties, and charges for violations.** Outlines when a person may be guilty of a misdemeanor, compelled to comply with an	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative. The content is provided

		injunction, civil penalties, and to pay civil charges.	in Code of Virginia § 32.1-27. Penalties, injunctions, civil penalties and charges for violations. **Impact**: None.
12VAC5-501-100		**OSHA enforcement.** Provides that the chapter shall not bar the enforcement of the occupational safety and health standards.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary as the Code of Virginia § 40.1-22 provides this authority. **Impact**: None.
12VAC5-501-110		**Suspension of regulations during disasters.** Provides that in the case of a disaster, the commissioner may suspend regulations if they find that the regulations cannot be complied with and the public health is better served by not fully complying with the regulations.	**Change**: Amended. **Intent**: To clarify that the State Health Commissioner, and not their designee, may suspend certain regulations in the event of a disaster. **Rationale**: It should be clear that the authority to suspend regulations in the event of a disaster only resides with the State Health Commissioner, as the duly appointed representative of the Board of Health. **Impact**: Improved understanding of authority.
12VAC5-501-120		**Variances.** Provides the ability for variances issued by the Commissioner of Labor and Industry and the State Health Commissioner. Outlines the variance process.	**Change**: Amended. **Intent**: To streamline the variance content to align with other regulation variance processes and current practice. **Rationale**: The original section content does not meet current style and formatting requirements, some references to other code citations are incorrect or hard to understand, and the section content can be reduced and provided in a more succinct manner. Removed reference to variance approval by the Commissioner of Labor and Industry. Revised the section content that refers to the State Health Commissioner with reference to the commissioner.

			Impact: Improved understanding and application of the regulations. Provides migrant labor camp owners with a clear pathway to requesting a variance.
12VAC5-501-130		**Case decisions.** Provides that the commissioner or designee may make case decisions based on informal hearings.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative as the content is provided in the Code of Virginia § 2.2-4019 through § 2.2-4023.1. **Impact**: None.
12VAC5-501-140		**Request for hearing.** Outlines that a request for a hearing will be in writing and sent to the local health department and that requests must be received within 30 days of the decision.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative as the content is provided in the Code of Virginia § 2.2-4019 through § 2.2-4023.1. **Impact**: None.
12VAC5-501-150		**Hearing.** Provides any owner, camp operator, or named party, a right to a hearing.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative as the content is provided in the Code of Virginia § 2.2-4020. **Impact**: None.
12VAC5-501-160		**Appeals.** Provides that any appeal from a denial must be made in writing with 30 days of receipt of the denial and that an appeal may be made to circuit court.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: This section is unnecessary and duplicative as the content is provided in the Code of Virginia § 2.2-4023.1. **Impact**: None.
12VAC5-501-170		**Notice of intention to construct or remodel camp and submission of plans.**	**Change**: Amended.

		Provides that any person planning to construct, substantially remodel, or enlarge for occupancy or use a migrant labor camp or any portion of the facility thereof, or to convert a property for use as a migrant labor camp, to notify the local health department within 30 days of construction. The notice shall provide the property location, plans of proposed construction, and the name and mailing address of the person giving notice. The section then requires the local health department to provide the person with a copy of the Code of Virginia and the regulations.	**Intent**: Revise section title to: "Plan review." Amend content to better communicate the information provided by the applicant that the local health department requires to conduct a plan review; outline the plan review process, including approval or denial notification; and provide an expiration date for plan review approvals. **Rationale**: The plan review process is typical of VDH permitted establishment processes and the proposed section outlines the information required to conduct a review of the proposed camp to ensure likely compliance with state and federal standards. This section is intended to provide a consistent plan review process and response. As federal standards may not align with the building code, not providing a regulatory structure to the plan review process may result in a migrant labor camp being built out of compliance with federal standards, thus resulting in delays in permitting and costly/timely retrofitting of structures to meet federal requirements. **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners with a clear understanding of the plan review process.
12VAC5-501-180		**Permits.** Provides that no person shall own or operate a migrant labor camp without a permit. Outlines requirements to be met to allow for permit issuance; Prohibits permit transfer; Requires permits be posted and accessible.	**Change**: Amended. **Intent**: To streamline the permit content to align with other regulation permit processes and current practice. **Rationale**: The original section content does not meet current style and formatting requirements. The Code of Viriginia, § 32.1-206., requires an application for a permit to operate a migrant labor camp to be made to the Commissioner at least thirty days before such a camp is to be opened on a form prescribed by the Board. Stakeholders questioned the relevance of the application content outlined in subsection C. The requirement to describe the camp site and structures, the lodging provided, and a description of the water supply, sewage disposal

			system, and sanitary facilities is considered necessary to ensure compliance with state and federal standards. These descriptions may aid the local health department in reviewing the application for completeness and ensuring adequate services are in place for the number of occupants intended. A description of the agricultural activities may aid the local health department in determining if the housing is indeed agricultural or fishing related and therefore subject to permitting. **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners with a clear understanding of the permit process.
12VAC5-501-190		**Application for permit.** Provides that an application for a permit will be on a form prescribed by the board; that an application is required 30 days prior to opening the camp; that separate applications are required each year, and outlines department approval and denial notifications.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: The content related to an application for a permit is provided in amended section 12VAC5-501-180. **Impact**: None.
12VAC5-501-200		**Issuance of permit.** Provides that prior to issuance of a permit, the camp will be inspected. Provides that a permit shall expire December 31 each year and that changes in camp operator voids the permit and a new application is required.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: The content related to the issuance of a permit is provided in amended section 12VAC5-501-180. **Impact**: None.
12VAC5-501-210		**Denial of a permit.** Provides that when a permit is denied, within 10 days the department will send the applicant a written explanation.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: The content related to the denial of a permit is provided in amended section 12VAC5-501-180. **Impact**: None.
12VAC5-501-220		**Suspension of a permit.** Provides that the director may suspend a permit and provides the notification,	**Change**: Amended. **Intent**: Revise section title to: “Notice, enforcement, informal conferences.,” to

		compliance, and hearing request requirements.	convey requirements specific to notice, enforcement, and conferences, in that order. Amend content to better reflect the enforcement process by requiring notice of violation; reason and process for permit suspension; reason and process for permit revocation; informal fact-finding processes; and appeals. **Rationale**: The proposed section outlines the notice, enforcement, and informal conference processes that are typical of VDH enforcement processes. This section is intended to provide a consistent enforcement process and response. **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners with a clear understanding of the enforcement process.
12VAC5-501-230		**Revocation.** Provides that prior to revocation, the director shall notify the permit holder or camp operator. Provides the timeframe for revocation and informal hearings.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: The content related to the revocation of a permit is provided in amended section 12VAC5-501-220. **Impact**: None.
12VAC5-501-240		**Application after revocation.** Provides that anyone whose permit has been revoked may reapply.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: The content related to the re-application of a permit is provided in amended sections 12VAC5-501-180 and 12VAC5-501-220. **Impact**: None.
12VAC5-501-250		**Compliance with regulations.** Provides that the camp operator shall be responsible for ensuring the migrant labor camp is in compliance with regulation.	**Change**: Amended. **Intent**: To provide clarity of responsibility. **Rationale**: Clarifies that the permit holder is responsible for ensuring compliance with the regulations.

			Impact: Improved understanding and application of the regulations. Provides migrant labor camp permit holders with a clear understanding of the compliance requirement and responsibility.
12VAC5-501-260		**Inspections to be conducted.** Provides that inspections shall be conducted by the department and if the camp is found not in compliance, that the department may suspend or revoke the permit. Provides that the department shall inspect camps as often as necessary to ensure compliance.	**Change**: Amended. **Intent**: Revise section title to: "Inspections." Amend content to better reflect the inspection process by requiring inspections before permit issuance and as often as necessary to ensure compliance; requiring local health departments to notify the camp operator of the intent to inspect; requiring camp operators to accompany department staff during the inspection of sleeping areas and other areas where the worker's individual belongings are stored; and the requirement for the department to provide an inspection report. **Rationale**: The proposed section outlines the inspection process that is typical of VDH inspection processes, with amendments as requested by the stakeholder workgroup. This section is intended to provide a consistent inspection process. **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the inspection process.
12VAC5-501-270		**Inspection report.** Provides that the director or their designee shall provide the camp operator with a copy of the inspection report. Provides requirements of the report.	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: The inspection report requirement is provided in amended section 12VAC5-501-260. **Impact**: None.
12VAC5-501-280		**Correction.** Provides that an inspection report shall specify time for corrective action for violations. States that if a substantial and imminent health hazard is declared by the director, the operator	**Change**: Repealed. **Intent**: To remove unnecessary sections from the chapter. **Rationale**: Corrective actions are addressed in amended section 12VAC5-501-260. Imminent health hazards are

		shall cease operations immediately. Requires violations to be corrected within a reasonable amount of time.	addressed in amended section 12VAC5-501-220. **Impact**: None.
12VAC5-501-290		**Primary source of standards.** Provides that the occupational safety and health standards and any applicable exceptions shall apply to migrant labor camps.	**Change**: Amended. **Intent**: Amend content to better reflect the primary source of standards and how they apply to the chapter. **Rationale**: The chapter pursuant to § 32.1-211 is intended to supplement the Virginia Occupational Safety and Health (VOSH) standards titled, Federal Identical General Industry Standards (16VAC25-90-1910). The VOSH standards have adopted federal OSHA housing standards. Therefore, through the VOSH standards, federal standards are applicable to migrant labor camps, and the department shall inspect and enforce the federal standards as part of the chapter. **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of standards that apply to migrant labor camps.
12VAC5-501-300		**Exception to occupational safety and health standards.** Provides that migrant labor camps will be inspected in accordance with federal standards based on the date of construction.	**Change**: Amended. **Intent**: Amend content to better reflect the applicability of federal standards and how they apply to the chapter. **Rationale**: While the VOSH Federal Identical General Industry Standards (16VAC25-90-1910) have adopted the 29 CFR 1910.142 as federal OSHA standards for migrant labor camps, § 654.401 of the ETA provides that "employers whose housing was completed or under construction prior to April 3, 1980, or was under a signed contract for construction prior to March 4, 1980, may continue to follow the full set of the Department's ETA standards set forth in this subpart." Further, the ETA provides that "the Department will consider agricultural housing which complies with ETA transitional standards set forth in this subpart also to comply with the Occupational Safety and Health

			Administration (OSHA) temporary labor camp standards at 29 CFR 1910.142." Historically, it has been unclear how renovations or other minor construction impact the eligibility of a migrant labor camp to be subject to ETA standards. Subsection B identifies that cosmetic remodeling will not be considered new construction and should be treated as existing housing. **Impact**: Improved understanding and application of the application of federal standards. Provides migrant labor camp owners and the department with a clear understanding of which federal standards (ETA or OSHA) apply to migrant labor camps.
12VAC5-501-310		**Trash and garbage collections.** Provides that the camp operator shall provide for trash collection and disposal in accordance with the Solid Waste Management Regulations (9VAC20-80)	**Change**: Amended. **Intent**: Revise section title to: "Solid waste." Amend section content to clearly reflect the solid waste management requirements. Use the term "solid waste" to include the variety of waste that may be created at migrant labor camps, including trash, garbage, rubbish, or other types of waste. **Rationale**: The proposed solid waste provisions provided in the section address requirements that are not provided consistently in OSHA or ETA standards, including trash can durability and condition, lid function, size of containers, cleanliness, and general transportation of solid waste. In Virginia, solid waste shall be managed, transported and disposed of in accordance with the Solid Waste Management Regulations (9VAC20-81 et seq.) and applicable local ordinances. **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of solid waste management at migrant labor camps.
12VAC5-501-320		**Requirements for water supplies.**	**Change**: Amended. **Intent**: Amend section content to clearly reflect the water supply requirements

		Provides that all migrant labor camps shall have an approved water supply.	including a continuous supply of potable water provided by an approved source (private well, public water, rainwater harvesting system); a water distribution system installed in accordance with the applicable building code and maintained in a protective manner; water tested as directed by an approved laboratory and in compliance with total coliform and nitrate levels; provisions for discontinuation of water supply and reinstating a water supply; and emergency use of a water supply. **Rationale**: OSHA and ETA standards require an adequate and convenient water supply that meets standards of the health authority. In the absence of a state standard specific to water supply for migrant labor camps, the standards must be included within the chapter. The proposed provisions outlined in this section are similar to other state regulations that require a safe water supply be provided to a user of a permitted establishment (e.g. hotel, campground, food establishment). **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of water supply requirements at migrant labor camps.
12VAC5-501-330		**Requirements of sewage disposal.** Provides that all migrant labor camps shall comply with the sewage disposal regulations.	**Change**: Amended. **Intent**: Amend section content to clearly reflect the sewage disposal requirements, including an approved method and that it is unlawful to discharge sewage without treatment or process approved by the department. **Rationale**: OSHA standards only require that where public sewer is available that migrant labor camps connect to such systems. No other sewage disposal requirements are provided by OSHA. ETA requires sewage systems be connected to any available public system or otherwise compliance with the state authority. This proposed section outlines fundamental state requirements for safe sewage disposal.

			Impact: Improved understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of sewage disposal requirements at migrant labor camps.
12VAC5-501-340		**Storage of hazardous materials.** Provides requirements for hazardous material storage location, signage, security, and the provision of personal protective equipment for employees.	**Change**: Amended. **Intent**: Amend section content to clearly reflect the hazardous material storage requirements including the requirement that all chemicals be stored, used, and disposed of in accordance with the manufacturer instructions (the label). Proposes storage requirements such as separation from food and living quarters, set-back distances to private wells, and signage in the primary and secondary language of all housing occupants. **Rationale**: Federal OSHA standards have no requirement for hazardous material storage. Federal ETA standards acknowledge the safety concern through the provision of minimal standards. This proposed section is amended for clarity and basic chemical protection for housing occupants. **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of hazardous material storage requirements at migrant labor camps. Provides protection of the environment and housing occupants.
12VAC5-501-350		**Conformity with Uniform Statewide Building Code.** Provides that all newly constructed migrant labor camps shall comply with the Virginia Uniform Statewide Building Code (13VAC5-63).	**Change**: Amended. **Intent**: Revise section title to: "Compliance with the Uniform Statewide Building Code, Statewide Fire Prevention Code and local requirements." Amend section content to clearly reflect the requirement that newly constructed migrant labor camps be constructed in accordance with the building code. Requires buildings to be maintained in accordance with the fire code, if it applies to the building. **Rationale**: As both federal OSHA and ETA standards require compliance with the state and local ordinances, codes,

			and regulations, the proposed section provides reference to which code specifically applies in Virginia: the USBC (13VAC5-63) and the applicable Fire Prevention Code (13VAC5-52). **Impact**: Improved understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the requirement for migrant labor camps to be constructed and maintained in accordance with applicable building or fire code.
	12VAC5-501-360		**Change**: Proposed. **Intent**: Propose section title: “Housing and sleeping facilities.” Propose section content to clearly outline the requirements that lodging structures be cleanable and maintained in good repair, that beds with adequate and safe spacing are provided, and that fire prevention equipment is provided in all migrant labor camp structures. **Rationale**: Federal standards are inconsistent with the most basic housing standards. This section proposes consistent minimal requirements for housing and sleeping facilities that are considered to meet the minimal requirements for both OSHA and ETA standards. **Impact**: Understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the housing and sleeping facility requirements. Provides basic structural, cleanliness, and bedding requirements.
	12VAC5-501-370		**Change**: Proposed. **Intent**: Propose section title: “General sanitation and maintenance.” Propose section content to clearly outline the requirements that all structures used for the migrant labor camp be kept clean, in good repair, and maintained to protect the health, safety, and well-being of persons using those facilities

			Rationale: Where federal standards lack clear and consistent requirements for camp buildings, structures, equipment, etc. to be maintained clean and in good repair, this section proposes the requirement. **Impact**: Understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the general sanitation and maintenance requirements. Provides that camps be maintained in good repair and be kept clean.
	12VAC5-501-380		**Change**: Proposed. **Intent**: Propose section title: “Heating and cooling.” Propose section content to clearly outline the requirements to provide operable heating and cooling equipment, provide shades or other means to reduce radiant heat during hot weather, and that such equipment be installed and used in accordance with manufacturer specifications. **Rationale**: Where federal standards lack clear and consistent requirements for heating specifications, this section proposes the requirement. ETA requires heating be provided when temperatures are at 68°F or less, whereas OSHA states that heating is required if the camp is used in “cold weather”; OSHA does not describe or define what “cold weather” is. ETA requires heating equipment that is capable of maintaining an indoor temperature of 68°F or more, whereas OSHA requires heating equipment capable of maintaining a temperature of at least 70°F in service buildings, specifically; it is expected that this heating temperature expectation (of 70°F) translates to indoor temperatures for “shelters” as well, as they are required to be heated if used during cold weather. Per OSHA, even if a camp was mobile or provided in tents or vehicles, a “service building” must be heated accordingly. Therefore, heating to at least 70°F in living and sleeping quarters is considered applicable. This subsection also proposes “cold weather” as 68°F or less but does not prescribe

			the minimum heating temperature required as ETA and OSHA address the requirement with specific yet differing temperatures. Window shades or other provisions to reduce radiant heat may aid in keeping living/sleeping facilities cooler during hot weather. The proposed requirement to provide equipment capable of maintaining sleeping quarters with a temperature of 85°F or less when outside temperatures exceed a heat index of 90°F will provide workers with relief from extreme heat. Neither ETA nor OSHA standards prescribe a method to reduce heat within migrant labor housing. Several Virginia regulations prescribe maximum temperatures between 80-85°F for occupants who cannot relocate or leave provided housing (Chapter 61. Standards and Regulations for Licensed Adult Day Centers (22VAC40-61-430), Chapter 73. Standards for Licensed Assisted Living Facilities (22VAC40-73-880), and Chapter 81. Standards for Planning, Design, Construction, and Reimbursement of Local Correctional Facilities (6VAC15-81-720)). As migrant workers are often exposed to high or extreme heat during the work-day and most guidance on avoiding heat-related illness includes temporarily relocating to an area with air conditioning, the proposed provision of cooling equipment in the event of extreme heat may help protect the health and well-being of migrant workers (https://www.ready.gov/heat; https://www.cdc.gov/heat-health/about/index.html). The installation and use of equipment in accordance with manufacturer specifications will help ensure equipment is used safely and as intended. **Impact**: Understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the heating and cooling requirements. Provides that camps be maintained in a safe and comfortable temperature.

	12VAC5-501-390		**Change**: Proposed. **Intent**: Propose section title: “Storage, handling, and preparation of food.” Propose section content to clearly outline that if food is prepared or served by the camp owner or food preparation and service is contracted by the owner, that a food permit is required. Proposes that if food is prepared and served by the migrant workers that refrigeration, a stove, a sink, food storage, eating areas, and light be provided. Proposes that food storage and preparation areas be cleanable and in good repair, the ventilation be provided in accordance with building code, and that fire safety equipment be provided in cooking areas. **Rationale**: Where federal standards lack clear and current requirements for food storage and handling specifications, this section proposes the requirement. **Impact**: Understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the food handling and storage requirements.
	12VAC5-501-400		**Change**: Proposed. **Intent**: Propose section title: “Insects, rodents, and weed control.” Propose section content to clearly outline the requirements for reducing the potential for infestation of pests or overgrowth of noxious plants. **Rationale**: Where federal standards lack clear and consistent requirements for vegetation and vector controls, this section proposes the requirement. Federal ETA standards identify that housing and facilities be free from noxious plants and uncontrolled weeds/brush, whereas OSHA standards do not. ETA requires housing and facilities be free of insects, rodents and other vermin, whereas OSHA does not. However, as it may be impossible to ensure a facility is completely free of any insect, it may be expected that it is intended that a facility be "free from infestation;" OSHA requires effective measures be taken to prevent infestation

			of animals, insects, or pests, whereas ETA does not require such action. This section proposes consistent application to the prevention of uncontrolled vegetation and infestation of pests. **Impact**: Understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the vegetation and vector control requirements.
	12VAC5-501-410		**Change**: Proposed. **Intent**: Propose section title: “Safety and first aid.” Propose section content to clearly outline the requirements that a camp owner provide a first aid kit and develop and share with workers an emergency response plan. **Rationale**: Where federal standards require “first aid facilities,” it is expected that "first aid facilities" means that a method of administering first aid is provided. This section proposes a minimum requirement for a first aid kit and plans for emergency response. The development of an emergency response plan is considered an essential first step to planning for an emergency and the safety of occupants of camps. **Impact**: Understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding of the safety and first aid requirements.
	12VAC5-501-420		**Change**: Proposed. **Intent**: Propose section title: “Communicable disease.” Propose section content to clearly outline the requirement that the camp owner be in accordance with Regulations for Disease Reporting and Control (12VAC5-90), as applicable. **Rationale**: Chapter 90. Regulations for Disease Reporting and Control, 12VAC5-90-90.D requires persons in charge of a facility licensed by any agency of the Commonwealth to report the presence or suspected presence in his facility of persons who have common

			symptoms suggesting an outbreak situation. This section applies to owners and operators of permitted migrant labor camps and requires that they comply with the reporting requirements as part of the migrant labor camp permit requirements. **Impact**: Understanding and application of the regulations. Provides migrant labor camp owners and the department with a clear understanding that camp owners must comply with the Regulations for Disease Reporting and Control (12VAC5-90), as applicable.

Project 8552 - Proposed

Department of Health

Amend Regulations as a Result of Periodic Review

Chapter 501

Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps

Part I

Definitions and General Provisions

12VAC5-501-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Administrative Process Act" or "APA" means Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia.

"Applicable building code" means the local or statewide building code and referenced standards in effect at the time the building or portion thereof was constructed, altered, renovated, or underwent a change of occupancy.

~~"Approved water supply" means a waterworks that has a valid waterworks operation permit from the commissioner or a water supply that is evaluated, tested and, if found in compliance with the applicable standards, accepted and approved by the director or the director's designee.~~

"Board" means the State Board of Health.

"Camp operator" means a person who has charge, care, or control of a migrant labor camp.

"Camp owner" means a person who owns, leases, or proposes to own or lease a migrant labor camp.

"Commissioner" means the State Health Commissioner or his designee ~~who has been delegated powers in accordance with subdivision 2 of 12VAC5-501-30~~.

"Department" means the Virginia Department of Health ~~Department~~.

~~"Director" means the director of a city, county or district health department or his designated representative who is assigned responsibility for implementation of these regulations at the local level.~~

"Employment and Training Administration" or "ETA" means the administration of the United States Department of Labor that administers federal government job and worker programs, federal grants to states for public employment service programs, and unemployment benefits that are primarily serviced through state and local workforce development systems.

"Migrant labor camp" or "camp" means one or more structures, buildings, tents, barracks, trailers, vehicles, converted buildings, and unconventional enclosures of living space, constructed or manufactured for the purpose of lodging accommodations, reasonably contiguous, together with the land appertaining thereto, established, operated or used as living quarters for one or more persons, one or more of whom is a migrant worker engaged in agricultural or fishing activities, including related food processing. "Migrant labor camp" does not include (i) a summer camp, campground or hotel as defined in § 35.1-1 of the Code of Virginia,(ii) housing that, in the ordinary course of business, is regularly offered to the general public on a commercial basis and is provided to any migrant worker on the same or comparable terms and conditions as provided to the general public, or (iii) small businesses that are exempt under federal law as provided in

the Fair Labor Standards Act (29 USC § 201 et seq.) and the Migrant and Seasonal Worker Protection Act (29 USC § 1801 et seq.).

"Migrant worker" ~~means any individual from within or outside the Commonwealth who passes seasonally from one place to another for the purpose of employment (agricultural or fishing activities employment, including related food processing) , who is not a year-round employee, and who occupies living quarters other than his permanent home during the period of such work.~~ shall have the same meaning as defined in § 32.1-203 of the Code of Virginia.

~~"Owner" means a person who owns, leases or proposes to own or lease a migrant labor camp.~~

"Permit holder" means the camp owner or operator to whom the migrant labor camp permit is issued.

"Person" means an association, a corporation, individual, partnership, other legal entity, government, or governmental subdivision or agency.

"Private well" shall have the same meaning as defined in the Private Well Regulations (12VAC5-630).

"Rainwater harvesting system" shall have the same meaning as defined in the Rainwater Harvesting System Regulations (12VAC5-635).

“Tent” means a structure, enclosure, or shelter constructed of fabric or pliable material supported in any manner except by air or the contents it protects.

"Variance" means a conditional waiver of a specific regulation granted by the commissioner ~~or his designee~~ pursuant to 12VAC5-501-120, to a specific camp operator, relating to a specific situation or facility. Variances ~~and~~ may be granted for a specific period of time.

12VAC5-501-20. ~~Purpose of regulations.~~ (Repealed.)

~~This chapter has been promulgated by the State Board of Health to ensure that safe and healthy living conditions are provided for migrant workers and their families while they are employed and living in the Commonwealth of Virginia. This chapter establishes standards and procedures that the State Health Commissioner will follow in determining whether a permit to operate a migrant labor camp should be issued, denied, revoked, or suspended. In a similar way the chapter also delineates the procedures and requirements with which a camp must comply in order for the camp operator to obtain and retain a permit.~~

12VAC5-501-30. ~~Administration of regulations.~~ (Repealed.)

~~These regulations are administered by the following:~~

~~1. The State Board of Health, hereinafter referred to as the board, has responsibility to promulgate, amend and repeal regulations necessary to protect the public health.~~

~~2. The State Health Commissioner, hereinafter referred to as the commissioner, is the chief executive officer of the State Department of Health. The commissioner has the authority to act for the board when it is not in session (see § 32.1-20 of the Code of Virginia). The commissioner may delegate his powers under these regulations in writing to any subordinate.~~

~~3. The State Department of Health hereinafter referred to as "department" is designated as the primary agent of the commissioner for the purpose of administering these regulations.~~

~~4. The district or local health department is responsible for implementing and enforcing the regulatory activities required by these regulations.~~

12VAC5-501-40. ~~Right of entry to inspect, etc.; warrants.~~ (Repealed.)

~~Upon presentation of appropriate credentials and upon consent of the owner, camp operator or custodian, the commissioner or his designee shall have the right to enter at any reasonable~~

~~time onto any property to inspect, investigate, evaluate, conduct tests or take samples for testing as he reasonably deems necessary in order to determine compliance with the provisions of this chapter, any order of the board or commissioner, or any conditions in a permit, license or certificate issued by the board or commissioner. If the commissioner or his designee is denied entry, he may apply to an appropriate circuit court for an inspection warrant authorizing such investigation, evaluation, inspection, testing, or taking of samples for testing as provided in Chapter 24 (§ 19.2-393 et seq.) of Title 19.2 of the Code of Virginia.~~

Part II

Procedural Regulations

12VAC5-501-50. ~~Continuing validity of existing permits.~~ (Repealed.)

~~Operational permits in effect prior to January 1, 2006, unless otherwise revoked, shall remain valid until the expiration date of the permit.~~

12VAC5-501-60. ~~Application of the Administrative Process Act.~~ (Repealed.)

~~The provisions of Article 3 (§ 2.2-4018 et seq.) of the Virginia Administrative Process Act shall govern the procedures for rendering all case decisions.~~

12VAC5-501-70. ~~Emergency orders.~~ (Repealed.)

~~The commissioner may, pursuant to §§ 32.1-13 and 32.1-20 of the Code of Virginia, issue emergency orders as is necessary to preserve the public health, safety, welfare and environment. Emergency orders arising out of matters governed by these regulations shall state the reasons and factual basis upon which the emergency order is issued. The emergency order shall state the time period for which it is effective.~~

12VAC5-501-80. ~~Enforcement of regulations.~~ (Repealed.)

~~A. Notice. Whenever the commissioner or any district or local health department official has reason to believe that a violation of Title 32.1 or Title 35.1 of the Code of Virginia or of any provision of this chapter has occurred or is occurring, he shall so notify the alleged violator. Such notice shall be (i) in writing, with a request to the owner or camp operator to respond by providing any pertinent information on this issue they may wish; (ii) cite the statute, regulation or regulations that are allegedly being violated; and (iii) state the facts that form the basis for believing that the violation has occurred or is occurring. Such notification may be accompanied by a request that certain corrective action be taken.~~

~~B. Orders. Pursuant to the authority granted in §§ 32.1-26 and 35.1-6 of the Code of Virginia, the commissioner may issue orders to require any owner or camp operator, or other person, to comply with the provisions of these regulations. The order may require the following:~~

~~1. The immediate cessation and correction of the violation;~~

~~2. Appropriate remedial action to ensure that the violation does not continue or recur;~~

~~3. The submission of a plan to prevent future violations;~~

~~4. The submission of an application for a variance; and~~

~~5. Any other corrective action deemed necessary to comply with the regulations.~~

~~C. Hearing before the issuance of an order. Before the issuance of an order, pursuant to subsection B of this section, the commissioner must comply with the requirements of § 32.1-26 of the Code of Virginia.~~

~~D. Order—when effective. All orders issued pursuant to subsection B of this section shall become effective not less than 15 days after mailing a copy thereof by certified mail to the last known address of the owner, camp operator or person violating these regulations. Violation of an order is a Class 1 misdemeanor. See § 32.1-27 of the Code of Virginia.~~

~~E. Compliance. The commissioner may act as the agent of the board to enforce all effective orders and these regulations. Should any owner or camp operator fail to comply with any effective order or these regulations, the commissioner may:~~

~~1. Institute a proceeding to revoke the camp operator's permit in accordance with 12VAC5-501-230;~~

~~2. Request the attorney for the Commonwealth to bring a criminal action;~~

~~3. Request the Attorney General to bring an action for civil penalty, injunction, or other appropriate remedy; or~~

~~4. Do any combination of the above.~~

~~F. Not exclusive means of enforcement. Nothing contained in 12VAC5-501-70 or this section shall be interpreted to require the commissioner to issue an order prior to seeking enforcement of any regulation or statute through an injunction, mandamus or criminal prosecution.~~

12VAC5-501-90. ~~Penalties, injunctions, civil penalties, and charges for violations.~~ (Repealed.)

~~A. Any person willfully violating or refusing, failing, or neglecting to comply with any regulation or order of the board or commissioner or any provision of this chapter shall be guilty of a Class 1 misdemeanor unless a different penalty is specified.~~

~~B. Any person willfully violating or failing, neglecting or refusing to obey any lawful regulation or order of the board or commissioner or any provision of this chapter may be compelled in a proceeding instituted in an appropriate court by the board or commissioner to obey such regulations, order, or provision of this chapter and to comply therewith by injunction, mandamus, or other appropriate remedy.~~

~~C. Without limiting the remedies that may be obtained in subsection B of this section, any person violating or failing, neglecting or refusing to obey any injunction, mandamus or other remedy obtained pursuant to subsection B of this section shall be subject, in the discretion of the court, to a civil penalty not to exceed $25,000 for each violation. Each day of violation shall constitute a separate offense.~~

~~D. With the consent of any person who has violated or failed, neglected, or refused to obey any regulation or order of the board or commissioner or any provision of this chapter, the board may provide, in an order issued by the board against such person, for the payment of civil charges for past violations in specific sums not to exceed the limit specified in subsection C of this section. Such civil charges shall be instead of any appropriate civil penalty that could be imposed under subsection C of this section.~~

12VAC5-501-100. ~~OSHA enforcement.~~ (Repealed.)

~~Nothing contained herein shall be construed to bar the enforcement of occupational safety and health standards adopted by the Safety and Health Codes Board in the manner prescribed in Chapter 3 (§ 40.1-22 et seq.) of Title 40.1 of the Code of Virginia and regulations promulgated thereunder.~~

12VAC5-501-110. Suspension of regulations during disasters.

If, in the case of a manmade or natural disaster, the State Health ~~commissioner~~ Commissioner finds that certain regulations cannot be complied with and that the public health is better served by not fully complying with these regulations, ~~he~~ the State Health Commissioner may authorize the suspension of the application of the regulations for specifically affected localities and institute a provisional regulatory plan until the disaster is abated.

12VAC5-501-120. Variances.

A. In accordance with Chapter 1 (§ 40.1-6 ~~(9~~) of Title 40.1 of the Code of Virginia, a variance to ~~those~~ the occupational safety and health regulations set forth ~~at 29 CFR Part 1910~~ by the

Federal Identical General Industry Standards (16VAC25-90) may only be granted by the Commissioner of Labor and Industry. ~~Applications for such variances shall be directed to him.~~

B. The ~~State Health Commissioner or his designee~~ commissioner may grant a variance to ~~these regulations~~ this chapter by following the appropriate procedures set forth in this subsection. The commissioner may grant a variance, in whole or in part, to one or more of the requirements in this chapter, not including federal standards as referenced, if in the commissioner's discretion, (i) the hardship, which may be economic, imposed by the regulation outweighs the benefits that may be received by the public and (ii) granting the variance would not subject the public to unreasonable health risks or adversely impact the environment.

~~1. Requirements for a variance to these regulations. The commissioner may grant a variance if he finds that the hardship imposed, which may be economic, outweighs the benefits that may be received by the public and that granting such a variance does not subject the public to unreasonable health risks or environmental pollution.~~

~~2. Application for a variance to these regulations. Any camp operator who seeks a variance shall apply in writing within the time period specified in this subsection. The request should be sent to the local health department. Any request for a variance must be made in writing and received by the department prior to the denial of the migrant labor camp permit, or within 30 days after such denial. In the event a person applies for a variance within the 30-day period after the permit has been denied, the date for appealing the denial of the permit, pursuant to 12VAC5-501-160, shall commence from the date on which the department acts on the request for a variance. The application for a variance shall include:~~

~~a. A citation to the regulation from which a variance is requested;~~

~~b. The nature and duration of the variance requested;~~

~~c. Any relevant analytical results including results of relevant tests conducted pursuant to the requirements of these regulations;~~

~~d. Statements or evidence that establish that the public health, welfare and environment would not be adversely affected if the variance were granted;~~

~~e. Suggested conditions that might be imposed on the granting of a variance that would limit the detrimental impact on the public health and welfare;~~

~~f. Other information believed pertinent by the applicant; and~~

~~g. Such other information as the district or local health department or commissioner may require.~~

C. ~~Evaluation of an application for a variance to these regulations.~~ A permit holder or camp owner who seeks a variance shall submit a written request to the local health department in which the migrant labor camp is located. The request shall include:

~~1. The commissioner shall act on any request for a variance to these regulations submitted pursuant to this subsection within 60 days of receipt of the request.~~

~~2. In evaluating a variance application, the commissioner shall consider such factors as the following:~~

~~a. The effect that such a variance would have on the operation of the migrant labor camp;~~

~~b. The cost and other economic considerations imposed by this requirement;~~

~~c. The effect that such a variance would have on protection of the public health, safety, welfare and the environment; and~~

~~d. Such other factors as the commissioner may deem appropriate.~~

1. A citation to the regulation from which a variance is requested;

2. The nature and duration of the variance requested, including the specific hardship imposed by the regulation;

3. Evidence that establishes that granting the variance would not subject the public to unreasonable health risks or may adversely impact the environment;

4. Suggested conditions that might be imposed on the granting of the variance to limit the adverse impact on the public health and environment; and

5. Other information believed pertinent by the permit holder or camp owner.

D. ~~Disposition of a request for a variance to these regulations.~~ The permit holder or camp owner shall provide other information as the department or commissioner may require to evaluate the variance request.

~~1. If the commissioner proposes to deny the variance, he shall provide the camp operator an opportunity to an informal hearing as provided in § 2.2-4019 of the Code of Virginia. Following this opportunity for an informal hearing, the commissioner may reject any application for a variance by sending a rejection notice to the applicant. The rejection notice shall be in writing and shall state the reasons for the rejection. A rejection notice constitutes a case decision.~~

~~2. If the commissioner proposes to grant a variance request submitted pursuant to this chapter, the applicant shall be notified in writing of this decision. Such notice shall identify the variance and the migrant labor camp involved, and shall specify the period of time for which the variance will be effective. Such notice shall provide that the variance will be terminated when the migrant labor camp comes into compliance with the applicable regulation and may be terminated upon a finding by the commissioner that the migrant labor camp has failed to comply with any requirements or schedules issued in conjunction with the variance. The effective date of the variance shall be as noted in the variance letter.~~

~~3. All variances to these regulations granted to any migrant labor camp are not transferable unless otherwise stated. Each variance shall be attached to the permit to which it is granted. Each variance is revoked when the permit to which it is attached is revoked.~~

~~4. No camp operator may challenge the terms or conditions of a variance after 30 calendar days have elapsed from the receipt of the variance.~~

E. If the commissioner proposes to grant the variance, the commissioner shall notify the permit holder or camp owner in writing of this decision within 60 calendar days of receipt of the variance request to the local health department. If the commissioner proposes to deny the variance request, the commissioner shall notify the permit holder or camp owner of the proposed denial within 60 calendar days of the local health department's receipt of the variance request and provide an opportunity for an informal fact-finding conference as provided in § 2.2-4019 of the Code of Virginia.

F. The commissioner may revoke a variance if (i) circumstances relevant to the variance change, (ii) additional information becomes known that alters the basis for the original decision, (iii) the permit holder or camp owner fails to meet any conditions imposed by the variance, (iv) the variance subjects the public to unreasonable health risks or adversely impacts the environment, or (v) the permit is suspended or revoked.

G. A variance granted to a permit holder or camp owner may not be transferred.

H. If a variance is denied, expires, or is revoked, the camp owner, permit holder, or camp operator shall ensure the migrant labor camp complies with all provisions of this chapter.

12VAC5-501-130. ~~Case decisions.~~ (Repealed.)

~~The commissioner or the commissioner's designee may make case decisions based on informal hearings. An informal hearing is conducted by the department and held in conformance with § 2.2-4019 of the Code of Virginia. The district or local health department may record the hearing or create a written summary or record of the proceedings.~~

12VAC5-501-140. ~~Request for hearing.~~ (Repealed.)

~~A request for a hearing shall be made by sending the request in writing to the district or local health department in the locality where the migrant labor camp is located. Requests for hearings shall cite the reasons for the hearing request and shall cite the sections of these regulations involved and must be received within 30 calendar days of the decision by the department that led to the hearing request.~~

12VAC5-501-150. ~~Hearing.~~ (Repealed.)

~~Any owner, camp operator or named party whose rights, duties, or privileges have been, or may be affected by any case decision of the board or its subordinates in the administration of these regulations shall have a right to a hearing.~~

12VAC5-501-160. ~~Appeals.~~ (Repealed.)

~~A. Any appeal from a denial of a permit to operate a migrant labor camp must be made in writing and received by the local or state health department within 30 days of the date the denial letter was received.~~

~~B. Any request for hearing on the denial of an application for a variance pursuant to 12VAC5-501-120 D 1 must be made in writing and received within 30 days of receipt of the denial notice.~~

~~C. Pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), an aggrieved owner or camp operator may appeal a final decision of the commissioner to the appropriate circuit court.~~

12VAC5-501-170. ~~Notice of intention to construct or remodel camp and submission of plans~~ Plan review.

~~Any~~ A. A person planning to construct, substantially remodel, or enlarge for occupancy or use a migrant labor camp or any portion of the facility thereof, or to convert a property for use or occupancy as a camp shall ~~,~~ ~~give notice in writing to the local health director of his intent to do so~~ at least 30 days before the date of beginning such intended construction, remodeling, enlargement, or conversion ~~. The notice shall include the name of the city or county in which the property is located; the location of the property within that area; plans of the proposed construction, remodeling, enlargement or conversion; and the name, mailing address and telephone number of the person giving the notice. Upon receipt of such notice, the local health director shall forward to such person a copy of Article 6 (§ 32.1-203 et seq.) of Chapter 6 of Title 32.1 of the Code of Virginia relating to migrant labor camps and a copy of this chapter.~~ , submit complete and legible plans or documentation to the local health department in which the proposed project is located, in a form prescribed by the board. The plans or documentation shall include:

1. The name and address of the camp owner and a designation of whether that person is the intended camp operator of the migrant labor camp;

2. The location, boundaries, and dimensions of the proposed or existing migrant labor camp, including areas where livestock are kept if within 500 feet of camp lodging;

3. The proposed or existing method and location of sewage disposal and copies of permits or plans to construct, operate, or use any onsite sewage disposal system. If pump and haul of holding tanks or privies or other sewage disposal services are provided, the camp owner shall demonstrate that the disposal capacity can be met by the provider;

4. The proposed or existing sources and location of the potable water supply;

5. The number, location, and dimensions of all shelters, campsites, buildings, structures, recreation areas, and other features;

6. The number, description, and location of all proposed or existing toilets, sinks and showers; and

7. Other pertinent information as the department may deem necessary.

B. Cosmetic remodeling where a permit is not required by the authority having jurisdiction of the applicable building code shall not require plan review.

C. If the department determines that the proposed plans, if executed, will meet the requirements of this chapter and other applicable laws and regulations designed to protect public health, the department shall issue written approval to the camp owner.

D. If the department determines that the proposed plans, if executed, will not meet the requirements of this chapter and other applicable laws and regulations designed to protect public health, the department shall issue written denial of the plans, including the reasons for denial. The camp owner shall be notified of the opportunity for an informal fact-finding conference pursuant to § 2.2-4019 of the Code of Virginia.

E. No person may construct, substantially remodel, enlarge for occupancy, or convert a property for the use as a migrant labor camp until written approval has been granted by the department and a permit has been obtained in accordance with the Virginia Uniform Statewide Building Code (13VAC5-63), as applicable.

F. If construction, substantial remodel, enlargement, or conversion is not started within 18 months from the date of approval or completed within three years from the date of approval, the approval of the plans shall expire, and the camp owner must re-submit the plans for approval prior to continuing construction.

G. All construction, substantial remodeling, enlargements, or conversions shall be done in accordance with, and limited to work covered by, the plans and recorded changes that have been approved by the department.

12VAC5-501-180. Permits.

A. No person shall ~~own, establish, conduct, maintain, manage, or operate any migrant labor camp in this Commonwealth unless the migrant labor camp is permitted as provided in this section. All permits shall be in the name of the camp operator. Permits shall not be issued to newly constructed or extensively remodeled migrant labor camps until a certificate of occupancy has been issued by the building official. Only a person who complies with the requirements of these regulations shall be entitled to receive or retain such a permit~~ directly or indirectly, conduct, control, manage, operate, or maintain a migrant labor camp within the Commonwealth without a valid migrant labor camp permit from the department.

B. ~~Nontransference of migrant labor camp permits. Permits issued shall not be transferable from one person to another or from one location to another. A new camp operator shall be required to make a written application for a permit. The application forms are available from local health departments.~~ A separate permit is required for each migrant labor camp. No permit may be transferred from one person to another or from one location to another.

C. ~~Requirements for posting permits. The permit shall be posted in a location in the camp readily visible and accessible to the migrant workers.~~ An authorized representative of a migrant labor camp shall submit an application form, as prescribed by the department, for a permit to the local health department in which the migrant labor camp is to be located at least 30 calendar days before the camp is to be opened. The application shall include:

1. The migrant labor camp's physical address;

2. The name and contact information, including mailing address, for the camp owner;

3. If the camp operator is not the camp owner, the camp operator's name and contact information;

4. The anticipated dates of operation of the migrant labor camp;

5. The number of migrant workers expected to reside in the camp;

6. A description of the migrant labor camp site, including structures, lodging, and other areas used by migrant workers;

7. A description of the potable water supply, sewage disposal, and toilets, sinks, and showers;

8. A brief description of the agricultural or fishing activities performed by migrant workers to ensure the facility requires a migrant labor camp permit pursuant to § 32.1-203 and § 32.1-205 of the Code of Virginia;

9. A statement signed by the camp owner with the date of signature that attests to the accuracy of the information provided in the application and affirms that the camp owner will allow the department access to the establishment as specified under 12VAC5-501-260; and

10. Additional information as may be required by the department.

D. If the department finds that the migrant labor camp complies with this chapter, the department shall issue a permit to operate. The permit shall list the maximum number of occupants approved for each camp as determined by housing space or onsite sewage disposal capacity, whichever is less.

E. If the department finds that the migrant labor camp does not comply with this chapter and proposes to deny the application for permit, the department shall, within 10 business days, notify the camp owner in writing (i) citing the items that constitute the reasons for denial, (ii) providing the camp owner with the opportunity to reapply, and (iii) providing the camp owner with the opportunity for administrative process pursuant to the APA.

F. The camp operator shall post the permit conspicuously at a place in the camp readily visible and accessible to the migrant workers and the department.

12VAC5-501-190. ~~Application for permit.~~ (Repealed.)

~~A. Application for a permit to operate a migrant labor camp shall be made on a form prescribed by the board to the local health director of the county or city in which the migrant labor camp is located at least 30 days before such camp is to be opened. A separate application shall be submitted for each camp every year.~~

~~B. The local health director shall issue a permit after an inspection if the camp is found to be in compliance with this chapter.~~

~~C. If the camp is not found to be in compliance, the local health director may deny, revoke or suspend the permit or recommend denial of a variance.~~

~~D. Any expansion or modification of a permitted migrant labor camp shall require the obtaining of a new permit.~~

12VAC5-501-200. ~~Issuance of permit.~~ (Repealed.)

~~Prior to the issuance of a permit, the director or his designee shall inspect the migrant labor camp to determine compliance with the requirements of these regulations. The department shall issue a permit to the applicant if its inspection reveals that the proposed migrant labor camp complies with all requirements of these regulations. The permit shall expire annually on December 31. Also, changes in the camp operator void the permit and the new camp operator must apply for a new permit.~~

12VAC5-501-210. ~~Denial of a permit.~~ (Repealed.)

~~Whenever the department denies a permit to operate a migrant labor camp, it shall, within 10 days of the inspection, send the applicant a written explanation of the reasons why the permit was denied.~~

12VAC5-501-220. ~~Suspension of a permit~~ Notice, enforcement, informal conferences.

~~The director may suspend a permit to operate a migrant labor camp without an informal hearing if the director finds the continued operation constitutes a substantial and imminent threat to the public health. Upon receipt of such notice that a permit is suspended, the permit holder shall cease operation immediately and begin corrective action.~~

~~Whenever a permit is suspended, the holder of the permit or the camp operator shall be notified in writing by certified mail or by hand delivery. Upon service of notice that the permit is immediately suspended, the former permit holder shall be given an opportunity to request an informal hearing. If a permit holder wants to request an informal hearing, he must submit a request in writing to the director within 10 working days after he receives notice of the suspension. The written request shall be filed with the local health director by the former holder of the permit. If written request for an informal hearing is not filed within 10 working days, the suspension is sustained. Each holder of a suspended permit shall be afforded an opportunity for an informal hearing within three working days of receipt of a request for an informal hearing. The director may end the suspension at any time if the reasons for suspension no longer exist.~~

A. When the department has reason to believe that a violation of the Code of Virginia or any provision of this chapter has occurred or is occurring, the department shall notify the alleged violator. Such notice shall (i) be in writing, (ii) identify the specific statute or regulation allegedly violated, and (iii) state the facts which form the basis that the alleged violation has occurred or is occurring. This notification does not serve as an official finding, case decision, or adjudication, but the department may include a request for specific corrective actions.

B. The department may summarily suspend a permit to operate a migrant labor camp if continued operation constitutes a substantial and imminent threat to public health. An imminent public health threat may include a fire, flood, extended interruption of electrical or water service, sewage backup, misuse of poisonous or toxic materials, suspected outbreak, excessive dirt or filth that may contaminate people, water, or food, or other circumstances that may endanger public health.

1. Upon receipt of a notice that the permit is suspended, the permit holder shall cease migrant labor camp operations.

2. If a permit is suspended, the department shall provide written notification to the permit holder of the suspension and of the opportunity for an informal fact-finding conference pursuant to § 2.2-4019 of the Code of Virginia.

3. A request for an informal fact-finding conference shall be in writing and shall be filed with the local health department by the holder of a suspended permit. The department shall afford the holder of a suspended permit an opportunity for an informal conference within five business days of receipt of a request for the informal conference.

4. The department may end the suspension at any time if the reason for the suspension no longer exists.

C. The department may, after providing a notice of intent to revoke a permit, and after providing an opportunity for an informal conference in accordance with § 2.2-4019 of the Code of Virginia, revoke a permit for continuing violations of this chapter. Upon receipt of a notice that the permit is revoked, the permit holder shall cease migrant labor camp operations. The department shall revoke the permit if the permit holder fails to appear at or makes no effort to reschedule the informal fact-finding conference.

1. Upon revocation, the former permit holder shall be given an opportunity for an appeal of the revocation pursuant to the APA.

2. A person whose permit has been revoked may apply for a new permit by following the procedures outlined in 12VAC5-501-180.

D. A permit holder affected by a determination issued in connection with the enforcement of this chapter may challenge such determination pursuant to the APA.

12VAC5-501-230. ~~Revocation.~~ (Repealed.)

~~Prior to revocation, the director shall notify in writing the holder of the permit, or the camp operator, of the specific reason or reasons for which the permit is to be revoked. The permit shall be revoked at the end of the 30 days following service of such notice unless a written request for an informal conference is filed with the director within 10 days after the permit holder received the notice of revocation. If no request for an informal conference is filed within the 10-day period, the revocation of the permit shall be final.~~

12VAC5-501-240. ~~Application after revocation.~~ (Repealed.)

~~Any person whose permit has been revoked may apply for a new permit, after complying with these regulations, by following the procedures of these regulations.~~

12VAC5-501-250. Compliance with regulations.

The ~~camp operator~~ permit holder shall be responsible for ensuring that ~~the~~ a migrant labor camp ~~is in compliance~~ complies with ~~these and any applicable occupational safety and health regulations~~ this chapter throughout the permit period ~~for which the permit is valid~~.

12VAC5-501-260. Inspections~~to be conducted~~.

A. The ~~local health director or his designated representative~~ department shall ~~make inspections of camps occupied by migrants~~ inspect a migrant labor camp to determine compliance with this chapter ~~. If a camp is found not to be in compliance, the local health department may move to suspend or revoke the permit. Migrant labor camps shall be inspected~~ before permit issuance and as often as necessary ~~during their occupancy~~ to ensure compliance with ~~the regulations.~~ this chapter. The department may increase the frequency of inspections based upon its assessment of a camp operator's compliance history and the potential for illness or physical injury.

B. After the department presents official credentials and provides notice of the purpose and intent to conduct an inspection, the camp operator shall allow the department access to the camp for inspection during the camp's hours of operation and other reasonable times.

C. If the department conducts an inspection while migrant workers are actively housed within the camp, the camp operator shall accompany the department during the inspection.

D. Upon completion of an inspection, the department shall provide to the camp operator an inspection report that indicates whether the camp is in compliance with this chapter and that includes descriptions of observations and citations to alleged regulatory violations. The inspection report may establish time frames for compliance with this chapter and provide an opportunity for administrative process pursuant to the APA.

E. The camp operator shall correct the alleged regulatory violations included in the notice provided pursuant to subsection D of this section as soon as possible, and within the time frames established by the department.

12VAC5-501-270. ~~Inspection report.~~ (Repealed.)

~~The director or his designated representative who conducts an inspection of a camp shall provide the camp operator with a copy of a completed inspection report after an inspection has been conducted. The report shall indicate that the camp is either in compliance or shall specify which specific standards the director or his designated representative has reason to believe have~~

~~been or are being violated. The inspection report shall further specify needed corrective action or abatement procedures and a date by which this action is requested to be completed or the problem abated.~~

12VAC5-501-280. ~~Correction.~~ (Repealed.)

~~The completed inspection report shall specify a reasonable period of time for the correction of the suspected violations found. Where a period of time for the correction is specified, the correction shall be accomplished within the period specified and in accordance with the following provisions:~~

~~1. Should a substantial and imminent health hazard be declared by the director, including, but not limited to, substantial fire damage, sewage backing into the living or food preparation and service areas, lack of refrigeration or lack of water, the operator shall immediately cease operations. Operations shall not be resumed until authorized by the director. Authorization shall not be granted until such violations are corrected.~~

~~2. All suspected violations identified by the department are to be corrected within a reasonable period of time or as soon as possible, but in any event, within the period of time specified. A follow-up inspection shall be conducted by the director or his designee to confirm the corrections.~~

Part III

Standards

12VAC5-501-290. Primary source of standards.

The ~~occupational safety and health (OSHA) standards~~ Virginia Occupational Safety and Health (VOSH) Federal Identical General Industry Standards (16VAC25-90-1910) governing temporary labor camps pursuant to ~~(~~ 29 CFR 1910.142 ~~)~~ ~~promulgated by the Virginia Safety and Health Codes Board shall apply to migrant labor camps, subject to the exceptions and regulations~~ , and any applicable exemptions outlined in 12VAC5-501-300, shall apply to migrant labor camps and shall be enforced through this chapter.

12VAC5-501-300. Exception to occupational safety and health standards.

A. ~~Migrant housing facilities~~ In accordance with 20 CFR 654.401 of the federal Employment and Training Administration, or "ETA", if a migrant labor camp was constructed or under construction prior to April 3, 1980, or where a contract for construction was signed prior to March 4, 1980, ~~shall~~ the camp operator may elect to be governed by either ~~: (i) 20 CFR 654.401 et seq.; (ii) 12VAC5-501-250; or (iii) variances granted thereto. The choice of governing standards shall be left to the discretion of the individual camp operator.~~ VOSH standards (16VAC25-90-1910) pursuant to 29 CFR 1910.142 or ETA standards (§ 654.400 et seq.). However, no camp constructed after April 3, 1980, or where a contract for construction was signed after March 4, 1980, including all camp structures and additions to existing structures, may be governed by ETA standards. The camp ~~operator~~ owner shall specify in ~~his~~ the permit application the standard by which ~~he elects to~~ the camp shall be governed.

B. ~~Migrant housing facilities constructed or under construction on or after April 3, 1980, or where a contract for construction was signed on or after March 4, 1980, shall be governed by the requirements of 12VAC5-501-290 or variances granted thereto.~~ To qualify for ETA standards, all migrant labor camp structures on a single application must meet the construction date requirements. Cosmetic remodeling, such as roof or window replacement, bathroom repair, painting, floor refinishing or repair, and fixture upgrades of pre-1980 structures will not be considered new construction and should be treated as existing housing.

12VAC5-501-310. ~~Trash and garbage collections~~ Solid waste.

~~The camp operator shall provide either a bulk container into which family trash containers may be emptied by the migrant families or provide for a regular trash and garbage collection service. Refuse from the individual garbage cans and the bulk containers shall be disposed of by the camp operator in a manner authorized by the Solid Waste Management Regulations (9VAC20-80) of the Virginia Waste Management Board.~~

A. All solid waste shall be stored in durable containers with functional lids and maintained in good repair.

B. The camp operator shall provide an adequate number and size of containers for the collection and disposal of solid waste to prevent overflow or other unsanitary conditions.

C. Solid waste shall be managed, transported and disposed of in accordance with the Solid Waste Management Regulations (9VAC20-81) and applicable local ordinances.

12VAC5-501-320. Requirements for water supplies.

~~All migrant labor camps shall have an approved water supply.~~

A. The camp operator shall ensure that an adequate and continuous supply of safe, sanitary, potable water under pressure is provided. An approved water supply shall either be an approved private well in accordance with the Private Well Regulations (12VAC5-630), a permitted and approved Tier 4 rainwater harvesting system for potable water in accordance with the Rainwater Harvesting System Regulations (12VAC5-635), or a permitted waterworks in accordance with the Waterworks Regulations (12VAC5-590).

B. The approved water supply distribution system shall be designed and constructed in accordance with the applicable building code and maintained in good repair.

C. The source of a private well water supply, its storage, and distribution system shall be protected from surface drainage and other means of pollution.

D. The area surrounding a pump or hydrant used for a water supply shall be maintained in a properly drained and sanitary condition to prevent the accumulation of standing water or other unsanitary or nuisance conditions.

E. A migrant labor camp operator using a private well for potable water shall sample and test for total coliform in accordance with 12VAC5-630-431 and nitrate-nitrogen (NO3--N) within 12 months prior to permit issuance. Private well water shall be satisfactory for the total coliform standards identified in 12VAC5-630-431 and shall not have more than 10 mg/L nitrate-nitrogen (NO3-N). The camp operator shall make the water sample report available for review by the local health department before permit issuance and upon request.

F. A water sample shall be analyzed by a laboratory accredited by the Department of General Services Division of Consolidated Laboratory Services, or other laboratory approved by the department. All water samples shall be collected, preserved, and shipped per laboratory instruction.

G. The permit holder shall discontinue use of a public or private water supply if the water does not meet the requirements of this chapter.

1. When use of a water system is discontinued, the permit holder shall notify the department within 48 hours of when and why the water system is discontinued, the methods used to obtain and distribute potable water to occupants of the camp, and any other water system information requested by the department. If an alternate potable water supply cannot be provided to occupants of the camp, the permit holder shall close the camp until the water supply meets the provisions of this chapter.

2. Prior to restarting use of the water system, the permit holder shall provide documentation of a satisfactory water sample test to the department.

3. A water supply may be used for emergency use before receiving satisfactory testing results, even if public health and safety risks are unknown, as determined by the department. In these circumstances, a special water advisory shall be approved by the department and issued at the same time the water supply is used.

12VAC5-501-330. Requirements of sewage disposal.

~~All migrant labor camps shall comply with the board's regulations governing the disposal of sewage (12VAC5-610), promulgated pursuant to §§ 32.1-163 through 32.1-166 of the Code of Virginia. A copy of these regulations may be obtained from the local health department.~~

A. A migrant labor camp shall have and maintain an approved method of collecting, conveying, and disposing of sewage and liquid waste. All sewage and liquid waste shall be conveyed to the point of discharge through an approved sanitary sewage system, other system in accordance with the Sewage Handling and Disposal Regulations (12VAC5-610), or other applicable Virginia sewage regulations.

B. Pursuant to the Sewage Handling and Disposal Regulations (12VAC5-610), it shall be unlawful to discharge sewage, sink wastewater, shower wastewater, greywater, or other organic wastes in such a manner as to enter the ground surface, subsurface, or a body of water, except following a treatment device or process approved prior to construction by the commissioner or in accordance with an approved permit for the activity.

12VAC5-501-340. Storage of hazardous materials.

~~Agricultural pesticides or toxic chemicals shall be stored in secure, partitioned areas that are separate from food and living quarters. Pesticide storage areas shall be at least 100 feet from existing wells or surface water unless barriers or environmental safeguards are present that will prevent contamination of groundwater or surface water from a discharge. The entry to the pesticide storage area shall be clearly marked indicating that pesticides or hazardous materials are stored within. When not in use, the pesticide storage area shall be locked to minimize the unauthorized entry into the storage area. Water and personal protective equipment, as required on the labels of the stored pesticides, shall be available for employee protection in the event of a discharge or other emergency.~~

A. The camp operator shall ensure that pesticides are handled, stored, and disposed of in accordance with the product label, the Virginia Pesticide Control Act (§ 3.2-3900 et seq.), and all related regulations promulgated. Toxic chemicals and other hazardous substances shall be handled, stored, and disposed of in accordance with the product label and shall not create a hazard to human health or the environment.

B. Agricultural use pesticides, toxic chemicals, and other hazardous substances, including manure, fertilizer, and fuel, shall be stored in secure, partitioned areas separate from food and living quarters. Storage area setback distances to private wells shall be in accordance with the Private Well Regulations (12VAC5-630), as applicable. Residential use pesticides or toxic chemicals shall be stored so they do not contaminate food, equipment, utensils, linens, or single-service and single-use articles.

C. Pesticide, toxic chemical, and other hazardous substance storage areas shall be clearly marked in the primary and secondary language of all housing occupants, indicating that hazardous substances are stored within. Personal protective equipment shall be provided as indicated on applicable chemical safety data sheets. Personal protective equipment and chemical safety data sheets shall be readily available for use by migrant workers and for review upon request by the department.

12VAC5-501-350. ~~Conformity~~ Compliance with Uniform Statewide Building Code, Statewide Fire Prevention Code and local requirements.

~~All newly~~ A. A newly constructed migrant labor ~~camps~~ camp shall ~~comply~~ be constructed in accordance with the Virginia Uniform Statewide Building Code (13VAC5-63) and other local laws and applicable ordinances. A migrant labor camp consisting of vehicular trailers, tents, or other unconventional enclosures of living space as lodging may not be subject to the Virginia Uniform Statewide Building Code.

B. The camp operator shall maintain the buildings or structures used as part of the migrant labor camp in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-52), as applicable.

12VAC5-501-360. Housing and sleeping facilities.

A. The floors, walls and ceilings of all lodging units, hallways, bathrooms, storerooms, and all other spaces used or accessed by workers shall be easily cleanable and shall be kept clean and in good repair without holes. The requirements of this section shall not prevent the use of rugs or carpets so long as they are clean and in good repair.

B. A bed or cot in good repair shall be provided for each occupant. Beds may only be used for double occupancy for family accommodation.

C. Clean mattresses shall be provided and maintained in good repair.

D. Bed arrangements shall provide a minimum of 36 inches of clear space between each bed or cot. If double bunk beds are used, a minimum of 48 inches of clear space between bunks shall be provided. There shall be sufficient space between the floor and the underside of beds, cots, and bunks to facilitate cleaning.

E. When bunk beds are used, there shall not be less than 27 inches of separation between the top of the lower mattress and the bottom of the upper bed. The distance from the top of the upper mattress to the ceiling shall be a minimum of 36 inches. No triple-deck bunks may be used. Bunk beds shall provide a ladder or other method of ingress and egress to and from the top bunk. Bunk beds used by children shall be equipped with guardrails meeting the manufacturer's requirements attached to the upper bunks to prevent occupants from rolling out of bed.

F. Smoke detectors and fire extinguishers shall be provided in all migrant labor camp structures and shall be functional and serviced as appropriate.

12VAC5-501-370. General sanitation and maintenance.

The camp operator shall keep the buildings, facilities, rooms, equipment, fixtures, furnishings, emergency exits, and the grounds of a migrant labor camp clean, in good repair, and maintained to protect the health, safety, and well-being of persons using those facilities.

12VAC5-501-380. Heating and cooling.

A. The living quarters and service rooms or buildings shall be provided with operable heating equipment if during the period of occupancy the outdoor temperature falls below 68°F.

B. The living quarter and service room windows shall be provided with window shades or other methods of minimizing radiant heat such that the use of windows is not impeded, when during the period of occupancy, the outdoor temperature exceeds 80°F.

C. The rooms used for sleeping shall be provided with operable cooling equipment capable of maintaining a temperature of 85°F or less if during the period of occupancy, the outdoor heat index exceeds 90°F. The heat index may be determined referencing national resources, including the National Oceanic and Atmospheric Administration, the National Weather Service, and other national or local weather services.

D. The heating and cooling units and equipment shall be installed and used in accordance with manufacturer specifications.

12VAC5-501-390. Storage, handling, and preparation of food.

A. If a permit holder prepares and serves food or contracts for the preparation and service of food at central dining areas, food service operations shall comply with and be permitted through the Food Regulations (12VAC5-421) unless otherwise exempt pursuant to § 35.1-25 of the Code of Virginia.

B. If food for migrant workers is not provided in accordance with subsection A and migrant workers prepare food for themselves, cooking and eating facilities shall at a minimum, be provided with:

1. Refrigeration capable of maintaining 41°F or below. The camp operator or occupants shall have access to a device capable of measuring the temperature of each refrigeration unit;

2. An operable stove or hot plate with a minimum of two burners per 10 people;

3. A sink with hot and cold running water;

4. Food storage and preparation areas;

5. An eating area, including tables and chairs or equivalent seating for the intended use; and

6. Lighting of at least 30 foot candles (215 lux) at a distance of 30 inches above the floor in cooking and eating areas.

C. Floors, walls, kitchen sinks and appurtenances, and food storage and preparation surfaces within the cooking and eating area shall be easily cleanable and maintained in good repair.

D. Cooking areas shall be ventilated in accordance with the applicable building code.

E. Functional and serviced fire extinguishers shall be provided in cooking areas and shall be readily accessible.

12VAC5-501-400. Insects, rodents, and weed control.

A. Fly, mosquito, and rodent breeding shall be controlled by eliminating breeding places. An infestation of rodents or flies, ticks, mosquitos, or other insects of public health concern, including bed bugs, shall be evidence that sufficient vector control measures have not been implemented and shall be considered a violation of this chapter. Pesticidal measures shall be applied, if necessary, provided the pesticide and its use is in accordance with the rules promulgated by the Board of Agriculture and Consumer Services.

B. The growth of weeds, grass, poison ivy, or other noxious plants shall be controlled as a safety measure and as a means toward the reduction of ticks and chiggers.

12VAC5-501-410. Safety and first aid.

A. First aid supplies and equipment shall be located within the migrant labor camp in an area accessible by workers, including an OSHA-compliant first aid kit with or without medication.

B. The permit holder shall develop and maintain an emergency response plan. The emergency response plan shall be provided to camp occupants in the primary and secondary language of all housing occupants. The permit holder shall provide the emergency response plan to the department upon request. The plan shall include:

1. Identification of a point of contact during emergency incidents;

2. A written plan for communicating emergency response information to migrant workers; and

3. Provisions for worker safety, identification, and evacuation or relocation in the event of extended power outages, loss of potable water supply, failure of a sewage disposal system, natural disasters, fires, or other emergencies.

C. Contact telephone numbers for local police, fire response, and emergency medical services shall be posted in a central location accessible to migrant workers.

12VAC5-501-420. Communicable disease.

The migrant camp operator shall comply with the Regulations for Disease Reporting and Control (12VAC5-90), as applicable.

COMMONWEALTH of VIRGINIA

Department of Health

B. Cameron Webb, MD, JD
State Health Commissioner

P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

MEMORANDUM

DATE: February 25, 2026

TO: State Board of Health

FROM: Arman Latif
Director, Office of Information Management

SUBJECT: Final Stage – Promulgation of New Regulation to Implement Chapter 304 of the 2021 Acts of Assembly, Special Session 1

Enclosed for your review and approval is the Final stage of a standard regulatory action to promulgate new regulations implementing Chapter 304 of the 2021 Acts of Assembly, Special Session 1. The requirement to report prescription drug price information is new and there is no existing regulatory chapter. The Virginia Department of Health (VDH) has established and extended emergency regulations to 2029 while new regulations governing prescription drug price transparency in the Commonwealth are promulgated using the standard regulatory action process.

Minor substantive changes have been made since the Proposed stage. These changes are largely in response to stakeholder feedback and correct proposed language that incorrectly implies that the wholesale acquisition cost (WAC) of a prescription drug is negotiated between a wholesale distributor and manufacturer and clarify that the WAC is established by the manufacturer. Additional clarification is made to processes related to dispute resolution. Further technical amendments correct punctuation errors and conform the provisions to the *Form and Style Guidelines* published by the Virginia Registrar of Regulations by replacing proposed language with plain language words.

The State Board of Health is requested to approve the Final stage of this standard regulatory action. Should the Board approve this action, it will be submitted for Executive Branch Review. Following Executive Branch review and approval, the regulations will be published in the Virginia Register of Regulations and will undergo a 30-day public comment period, after which, the Final regulations will become effective.

townhall.virginia.gov

Final Regulation
Agency Background Document

Agency name	Virginia Department of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC5-219
VAC Chapter title(s)	Prescription Drug Price Transparency Regulation
Action title	Promulgation of New Regulation to Implement Chapter 304 of the 2021 Acts of Assembly, Special Session I
Date this document prepared	3/5/2026

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

Chapter 304 (2021 Acts of Assembly, Special Session I) requires the Virginia Department of Health (VDH) to promulgate regulations to govern the collection, reporting, and auditing of prescription price drug information provided by specific entities such as health carriers, pharmacy benefits managers, manufacturers, and wholesale distributors. The legislation also institutes a civil penalty on these entities for failure to report the required information that is based on the severity of the violation. As the requirement to report prescription drug price information is new, there is no existing regulatory chapter, and the VDH intends to promulgate a new regulatory chapter to best fit this mandate. Emergency regulations established in 2022 have expired and are extended until the enactment of the final regulations by Chapter 727 of the 2024 Acts of Assembly.

Substantive changes to subsections B and C of 12VAC5-219-100 remove language providing reporting entities the opportunity to request an informal fact-finding conference (IFFC) at the time the NDSO determines the reporting entity has not submitted information that can be validated. The change has been made to align the Final regulations with the existing IFFC process which requires the commissioner's case decision to be determined before an IFFC can be requested. Changes to 12VAC5-219-130 add a new requirement directing the commissioner to notify a reporting entity upon a determination that such entity's data submission or noncompliance is a failure to report. Updates specify the information to be included in the notice, permit the reporting entity to request an IFFC in accordance with § 2.2-4019 of the Code of Virginia, and clarify the timeframe during which the reporting entity has to request an IFFC. Amendments to subsection A of 12VAC5-219-140 revise the timeframe during which a reporting entity may request an IFFC to clarify that the request can be made within 15 calendar days of the date the commissioner's notice of civil penalty is issued.

Minor changes made between the proposed and final states of the regulatory action correct punctuation errors that were identified in the Proposed regulations. Further changes made between the Proposed and Final stages of this regulatory action update regulatory language in 12VAC5-219-80 to correctly reflect the process by which wholesale acquisition cost (WAC) is determined. The changes to 12VAC5-219-80 were made in response to public comment indicating that the proposed language incorrectly implies that the WAC is negotiated by wholesale distributors, and instead clarifies that the WAC is established by manufacturers. The term "informal fact-finding proceeding" has been amended throughout the Final regulations to "informal fact-finding conference" to promote consistency throughout the regulatory chapter.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

"Board" means the Board of Health.

"Data sharing agreement" or "DSA" means a formal and legally binding document that outlines the terms of sharing data between two or more parties, and which (i) defines the data to be shared; (ii) the purpose of sharing the data; (iii) responsibilities, rights, and usage limitations; and (iv) outlines associated costs for data sharing between parties.

"Final regulations" or "Regulations" means the regulations governing prescription drug price transparency in Virginia (12VAC5-219).

"IFFC" means an informal fact-finding conference as provided for in § 2.2-4019 of the Code of Virginia.

"Memorandum of Understanding" or "MOU" means a non-formal and non-legally binding agreement between two or more parties that outlines each party's intentions, roles, and objectives.

"NDSO" means Nonprofit data services organization.

"OAG" means Office of the Attorney General.

"VDH" means the Virginia Department of Health.

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) that the agency has "adopted final amendments" to the regulation; 3) the name of the agency taking the action; and 4) the title of the regulation. A suggested statement is, "On [insert date] the Board/Department of [insert name] adopted final amendments to the [title of regulation(s)]."

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

Promulgation of regulations that establish reporting requirements for prescription drug price transparency in Virginia is required by Chapter 304 (2021 Acts of Assembly, Special Session I). Emergency promulgation of this new regulatory chapter became effective on January 17, 2022, in accordance with § 2.2-4011 (B) of the Code of Virginia. The emergency regulations expired on July 16, 2023, and have been extended until December 31, 2029. The impetus for this regulatory action is to make the emergency regulation permanent.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Subsection D of § 32.1-23.4 of the Code of Virginia requires the VDH to adopt regulations to implement the provisions of § 32.1-23.4, which must include (i) provisions related to the specification of prescription drugs for the purpose of data collection and procedures for auditing information provided by health carriers, Pharmacy Benefit Managers, wholesale distributors, and manufacturers; and (ii) a schedule of civil penalties for failure to report information required pursuant to §§ 32.1-23.4, 38.2-3407.15:6, 38.2-3407.22, 54.1-3436.1, or 54.1-3442.02, which shall be based on the level of severity of the violation.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety, or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

Promulgation of regulations by the VDH that specify the standards for Virginia's prescription drug price transparency and reporting requirements is required by Chapter 304 (2021 Acts of Assembly, Special Session I). The regulations are essential to protect the health, safety, or welfare of citizens as they provide regulatory standards regarding prescription drug pricing, which is a driver of increased healthcare costs in the Commonwealth. The goal of the regulatory change is to encourage transparency of prescription drug price information, make prescription drug price information available to consumers for comparison, and to identify the factors related to prescription drugs that contribute to increased health care costs in the Commonwealth.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The regulation must contain the specification of prescription drugs for the purpose of data collection and procedures for auditing information provided by health carriers, pharmacy benefits managers, wholesale distributors, and manufacturers as well as a schedule of civil penalties for failure to report the information required that is based on the severity of the violation. The specification must include information required pursuant to §§ 32.1-23.4, 38.2-3407.15:6, 54.1-3436.1, and 54.1-3442.02 of the Code of Virginia.

The following changes have been made from the proposed stage to the final stage:

12VAC5-219-80. Wholesale distributor reporting requirements.
Amendments clarify that the WAC is established by the manufacturer and removes regulatory language that implies the WAC is negotiated between wholesale distributors and manufacturers, clarify data element definitions for "Current year minus one WAC" and "Current year WAC," and correct punctuation errors present in the proposed language.

12VAC5-219-100. Data validation; notification; response.
Changes remove the opportunity for reporting entities to request an IFFC when an NDSO notifies the entity that it cannot validate the data submitted as required under the regulatory chapter. Technical amendments update rectify incorrect references to regulatory provisions in subsection C, and specify in subsection D that the commissioner is permitted, but is not required, to determine a reporting entity's second failure to correct inaccurate or incorrect data submission as a failure to report.

12VAC5-219-110. Audit; corrective action plan.
Updates (i) to subsection D replaces "deficiencies" with "incomplete or inaccurate information;" (ii) to subsection E remove language allowing a reporting entity to request an IFFC to dispute the NDSO's determination that such entity has not provide complete or accurate information during an audit; and (iii) to subdivision 2 of subsection H are technical and replace mandated language with permissive language.

12VAC-219-120. Sanctions.
Updates conform regulatory language to the *Form and Style Guidelines* by utilizing negative construction when prohibiting reporting entities from violating the provisions of the regulatory chapter.

12VAC5-219-130. Civil Penalty.
Subsection A has been amended to require the commissioner to notify a reporting entity in writing of a determination of failure to report, outlines the information to be contained within the notification, and adjusts the timeframe during which an IFFC can be requested by a reporting entity. A new subsection has been added permitting the commissioner to reduce or waive a civil penalty imposed upon a reporting entity. Technical changes update remaining subsection headers and provisional references in subsections C and D.

12VAC5-219-140. Informal fact-finding proceeding.
Substantial changes adjust the timeframe during which a reporting entity may request an IFFC to clarify that the request can be made within 15 calendar days of the date the commissioner's notice of civil penalty is issued, and remove subsection B which outlines the responsibility of the reporting entity to identify the reasons for a failure to report information required under the regulatory chapter. Technical amendments update references to regulatory provisions that have been amended under the Final stage of the regulatory action.

Regulatory language referencing an “informal fact-finding proceeding” has been updated throughout the Final regulations to refer to an “informal fact-finding conference.” The changes have been made to enhance readability and to ensure consistency in the terms used in the regulatory chapter.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantage to the public in implementing the new provisions is increased transparency about prescription drug pricing. The primary disadvantage to the public in implementing the new provisions is that businesses subject to the reporting requirements may incur increased expenses for compliance; there is no primary disadvantage in implementing the new provisions to individual private citizens. The primary advantage to VDH or the Commonwealth in implementing the new provisions is increased transparency about prescription drug pricing and the availability of data for research. The primary disadvantage to VDH or the Commonwealth in implementing the new provisions is the fiscal impact of data collection and of adjudication in the event a reporting entity fails to comply.

Pertinent matters of interest to the regulated community, government officials, and the public are issues that were raised by stakeholders prior to the publication of the emergency regulation, during the public comment following the publication of the emergency regulation, and during the initial submission of reports on or before April 1, 2022. VDH discovered there were a number of reporting entities that met the definition of “manufacturer” that did not control the WAC for prescription drugs, so they had no data responsive to the legislative mandate but there was no statutory flexibility for VDH to exempt these entities from reporting. Other stakeholders raised concerns about the interplay between the mandates of Chapter 304 (2021 Acts of Assembly, Special Session I) and of Employee Retirement Income Security Act of 1974 (ERISA). Additionally, the nonprofit data services organization (NDSO) is in the process of analyzing the 2025 submissions from reporting entities and working with a subcontractor to validate the accuracy and completeness of submission; the results of that analysis will help inform additional potential revisions to the regulatory text.

Issues raised by stakeholders during the public comment period of the Proposed stage of this regulatory recommended that (i) the requirement in 12VAC5-219-20 directing reporting entities to register with the NDSO be removed as the information provided to the NDSO for registration is collected by the Commonwealth (Board of Pharmacy) during the licensing process for wholesale distributors; and (ii) 12VAC5-219-80 of the Proposed regulations be amended to reflect the correct process by which the WAC is established.

The recommended changes were not made to 12VAC5-219-20 in the Final regulations as removing the requirement impacts all reporting entities, not just wholesale distributors, and is not duplicative for other reporting entities that submit prescription drug price information. The information collected at the time a reporting entity is licensed varies between different licensing authorities, and the information collected by a licensing authority may not be the information needed by the NDSO for prescription drug price reporting registration. The NDSO is not a state agency of the Commonwealth and does not have the authority to access state agency systems and information unless specifically authorized by law, regulation, rule, contract, or other policy. This arrangement will require the NDSO to obtain the information needed for registration from various licensing authorities, which may or may not be authorized to collect and share the information needed by the NDSO for registration. Furthermore, it creates additional administrative burdens for the VDH and licensing authorities that provide the information to coordinate to establish DSAs

or MOUs, complete regulatory actions, or advocate for statutory changes related to the transmission of the information needed by the NDSO for reporting entity registration. Additionally, removing the requirement for all reporting entities restricts the NDSO's ability to maintain an accurate list of reporting entities that can be used to ensure that such entities adhere to statutory and regulatory mandates, and to ensure that consumers are provided with accurate and complete data to compare prescription drug price information.

Requirements More Restrictive than Federal

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

The regulations do not conflict with federal requirements.

President Donald Trump signed Executive Order 14273 on April 15, 2025, which requires federal agencies to identify and analyze approaches to reduce prescription drug costs for Americans and report findings to the President of the United States; including:

- Medicare price adjustments to address "pill penalties" and stabilize Part D premiums;
- Align US pricing and competition models with other nations;
- Increase prescription drug price transparency and efficiency initiatives;
- Reduce out-of-pocket costs paid by American consumers; and
- Reevaluate the role of PBMs in the pharmaceutical supply chain.

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

Other State Agencies Particularly Affected

There are no other state agencies particularly affected by the regulatory change.

Localities Particularly Affected

There are no localities particularly affected by the regulatory change.

Other Entities Particularly Affected

Other entities particularly affected by the regulatory change include reporting entities and consumers of prescription drugs.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency's response. Include all comments submitted: including those

received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Commenter	Comment	Agency response
Bryan Hannon, Health Care Distribution Alliance	On behalf of the Healthcare Distribution Alliance (HDA), the national trade association representing pharmaceutical wholesale distributors, thank you for the opportunity to provide comments on the proposed rules to implement Chapter 304 of the 2021 Acts of the Assembly, Special Session I. HDA was proud to work closely with lawmakers, including Delegate Sickles, to advance sensible price transparency legislation in 2021. As a full partner in the implementation of the law, HDA is committed to ensuring that the rulemaking process aligns with the legislative intent and supports the consistent and effective execution of the statute. First, we are concerned that 12VAC5-219-80 of the proposed rules incorrectly implies that wholesale distributors negotiate wholesale acquisition cost (WAC). Distributors are the logistics providers in the supply chain, safely and efficiently delivering medicines to more than 5,800 locations across Virginia. Distributors play no role in setting – or negotiating – a product's WAC. Instead, WAC is established solely by the manufacturer and communicated to distributors. We respectfully request that the draft rules be revised to accurately reflect this process and avoid mischaracterizing the role of wholesale distributors. Please see Appendix A for suggested edits. Additionally, 12 VAC 5-219-20 of the proposed rules require all reporting entities, including wholesale distributors, to register with the commonwealth's nonprofit data services organization (NDSO). This requirement is duplicative, as wholesale distributors are already licensed under § 54.1-3435, and the Board of Pharmacy's licensing	On behalf of the VDH, I would like to thank the Healthcare Distribution Alliance (HDA) for submitting its comments regarding the proposed rules to implement Chapter 304 of the 2021 Acts of Assembly, Special Session I. We acknowledge HDA's role in supporting the development of the original legislation and appreciate your continued partnership in ensuring the successful and accurate implementation of the statute. Your detailed feedback regarding the characterization of wholesale distributors' role in setting wholesale acquisition cost (WAC), as well as your concerns regarding duplicative registration requirements, has been received and will be taken under consideration as we move forward in the rulemaking process. Thank you again for your thoughtful input and continued engagement.

	process collects the same information that would be submitted to the NDSO. Since the Commonwealth already maintains this information, we respectfully recommend removing the redundant registration requirement for wholesale distributors in the final rules. Thank you for your consideration of these recommended changes. I am available for any questions or comments. Sincerely, Bryan D. Hannon Director, State Government Affairs Appendix A - HAD Recommended amendment to 12VAC5-219 Regulations 12VAC5-219-80 Wholesale distributor reporting requirements A. For the purposes of this section, "cost" means the expense incurred and the monetary value of the resources used or consumed in the provision of a prescription drug by a wholesale drug distributor. B. If the department determines that data received from carriers, PBMs, and manufacturers is insufficient, the department may request wholesale distributors to report the information specified in subsection C of this section. 1. The department shall publish a general notice in the Virginia Register of Regulations that contains the department's determination, the request for wholesale distributor reporting, and the deadline for wholesale distributors to report pursuant to subsection C of this section. 2. The NDSO shall notify every wholesale distributor of the department's determination and request by email at the wholesale distributor's email address of record.	

	C. If requested by the department pursuant to subsection B of this section and no more than 45 calendar days after the publication of the general notice pursuant to subdivision B 1 of this section, a wholesale distributor shall report for the 25 costliest prescription drugs dispensed in the Commonwealth, including each drug product of a reportable prescription drug: 1. The WAC ~~directly negotiated with~~ established by a manufacturer in the last calendar year; 2. The WAC ~~directly negotiated with~~ established by a manufacturer in the current calendar year; 3. Aggregate total discounts directly negotiated with a manufacturer in the last calendar year, for business in the Commonwealth; and 4. Aggregate total discounts, dispensing fees, and other fees negotiated in the last calendar year with pharmacies. D. In determining which prescription drugs are reportable under subsection C of this section, the wholesale distributor shall average the cost for all drug products of a dispensed prescription drug. E. A wholesale distributor shall report on all drug products of a prescription drug determined to be reportable pursuant to subsections C and D of this section. F. A wholesale distributor shall provide the information specified in subsection C of this section on a form prescribed by the department that includes the following data elements: Data Element Name / Data Element Description	

	Wholesale distributor tax identification number/ The nine-digit Taxpayer Identification Number used by the IRS. Wholesale distributor name/ The legal name of the reporting entity. Proprietary drug name/ The brand or trademark name of the prescription drug reported to the FDA. Nonproprietary drug name/ The generic name of the prescription drug assigned by the USAN Council. WAC Unit/ The lowest identifiable quantity of the prescription drug that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids. NDC/ The NDC assigned to each drug product of a prescription drug. Current year minus one WAC/ WAC in U.S. dollars, for each prescription drug ~~for which the wholesale distributor has negotiated with a manufacturer~~ in the last calendar year, related to prescriptions under a health benefit plan issued in the Commonwealth. Current year WAC/ WAC in U.S. dollars, for each prescription drug ~~for which the wholesale distributor has negotiated with a manufacturer~~ in the current calendar year, related to prescriptions under a health benefit plan issued in the Commonwealth. Total manufacturer discounts/ Total aggregate discounts for each prescription drug directly negotiated with a manufacturer in the last calendar year, for business in the Commonwealth. Total pharmacy discounts, dispensing fees, and other fees/	

	Total aggregate discounts, dispensing fees, and other fees for each prescription drug negotiated in the last calendar year with a pharmacy. Comments/ A text field for any additional information the wholesale distributor wishes to provide G. The commissioner, the department, and the NDSO may not disclose: 1. The identity of a specific wholesale distributor; 2. The price charged for a specific prescription drug or class of prescription drugs; or 3. The amount of any discount or fee provided for a specific prescription drug or class of prescription drugs.	
Meagan Altizer, VA Tech	Support Drug Pricing Transparency Reporting - This bill represents an important step toward increasing transparency and accountability in prescription drug pricing, which directly impacts the affordability of health care for Virginians. By requiring health carriers, pharmacy benefit managers, drug manufacturers, and wholesale distributors to report comprehensive cost data, the legislation ensures that policymakers, providers, and the public have access to accurate information about how drug prices are determined. Partnering with a nonprofit data services organization to compile and publish this information further strengthens public trust, providing an objective and accessible source of data. The inclusion of civil penalties for noncompliance emphasizes the seriousness of the reporting requirements and helps guarantee the integrity of the process. Ultimately, this bill	On behalf of the VDH, I would like to thank you for submitting comments regarding the proposed rules to implement Chapter 304 of the 2021 Acts of Assembly, Special Session I. Your support of the proposed changes as well as your feedback related to the impact of prescription drug pricing on health care affordability, the provision of accessible data to consumers, strengthening of public trust through publication of data, and implementation of civil penalties to guarantee process integrity have been received and will be taken under consideration as we move forward in the rulemaking process.

	empowers the state to identify cost drivers in the pharmaceutical supply chain and pursue meaningful reforms that protect patients from rising drug costs.	

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	New requirement from previous stage	Updated new requirement since previous stage	Change, intent, rationale, and likely impact of updated requirements
	12VAC5-219-80	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. **Corrected language to specify that the WAC is established by a manufacturer.** The changes below do not impose new requirements. **Technical amendment.**	None. Technical amendments only.	**Change:** Subdivisions 1, 2, and 3 of subsection C have been reworded to specify that the WAC is established by the manufacturer and is not negotiated between a manufacturer and wholesale distributor. Amendments to the Data Elements Definitions for "Current year minus one WAC" and "Current year WAC" strike language basing the definition on the WAC negotiated between a wholesale distributor and manufacturer and replace with language basing the definitions upon the WAC price for each prescription drug. A technical amendment adds a period after the word "provide" at the end of the Data Element Definition for the data element "Comments" in subsection F. **Intent:** To clarify the correct process by which

				the WAC is established and how WAC data elements are reported. The technical amendment ensures correct punctuation throughout the regulation. **Rationale:** The Final regulations should specify the conditions under which the WAC is determined and reported, in order to clarify the duties applicable to reporting entities. The Final regulations should also contain correct punctuation and should conform to the *Form and Style Guidelines* published by the Virginia Registrar of Regulations. **Likely Impact:** The requirements applicable to reporting entities, the Commissioner, and the NDSO will be easier to locate, read, and understand. The Final provisions will be easier to read and understand.
	12VAC5-219-100	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. This change does not impose a new requirement. **Technical amendments.**	The following substantive changes have been made between the Proposed and Final stages: **Subsections C & B – opportunity for reporting entity to request an IFFC has been removed.**	**Change:** Subsections B & C have been updated in response to feedback from the OAG to remove the opportunity for a reporting entity to request an IFFC when the NDSO has notified such entity that the data submitted cannot be validated. Technical changes to subdivisions 1, 2, and 3 of subsection C rectify an incorrect reference to subdivision A 1 and update the language to reference the correct provision as subdivision A 2. A technical amendment to subdivision 2 of subsection D replaces

				"shall" with "may" as the commissioner is authorized to deem a reporting entity's failure to correct incorrect or inaccurate data as a failure to report, but is permitted not to act on such determination. **Intent:** To ensure the Final regulations contain accurate references to regulatory provisions that support prescription drug price transparency requirements. The technical amendment has been made due to feedback from the OAG in February 2026. An IFFC may be requested after the commissioner has made a case decision. **Rationale:** Correcting the error will direct readers to applicable provisions that require the NDSO to notify a reporting entity when it cannot validate the data submitted in accordance with the regulatory chapter. The technical amendment has been made due to feedback from the OAG in February 2026, which clarified that the IFFC should occur after a case decision has been made by the commissioner. **Likely Impact:** The Final regulations will be easier to read and understand, and will align with current law related to the ability to request and conduct an IFFC.
	12VAC-219-110	This chapter does not currently exist in the VAC. Changes outlined below have	None. Technical amendments only.	**Change:** Updates to (i) subsection D replace "deficiencies" with "incomplete or inaccurate

		been made since the proposed stage. This change does not impose a new requirement. **Technical amendments.**		information;" and (ii) subsection E remove language allowing a reporting entity to request an IFFC to dispute the NDSO's determination that such entity has not provide complete or accurate information during an audit. Technical changes to subdivision 2 of subsection H replace mandated language with permissive language. **Intent:** Technical changes have been made due to feedback from the OAG in February 2026, clarified that the IFFC should occur after a case decision has been made by the commissioner. **Rationale:** Technical amendments have been made due to feedback from the OAG in February 2026, which determined (i) the word "deficiencies" implied that the there is a legal determination that regulations are not satisfied; and (ii) specified that the IFFC should occur after a case determination is made by the commissioner. **Likely Impact:** The Final regulations will align with the legal and regulatory insight provided by the Commonwealth's chief legal authority (OAG).
	12VAC5-219-120	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage.	None. Technical amendments only.	**Change:** A technical update to subsection A conforms regulatory language to the *Form and Style Guidelines* by utilizing negative form

				construction to express a prohibition on a reporting entity's ability to violate the provisions of the regulatory chapter. **Intent:** To conform the Final regulations to the *Form and Style Guidelines* published by the Virginia Registrar of Regulations. **Rationale:** The Final regulations should conform to the *Form and Style Guidelines* to ensure consistency throughout the Virginia Administrative Code. **Likely Impact:** The Final regulations will conform to *Form and Style Guidelines* and will be easier to read and follow.
	12VAC5-219-130	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. This change imposes a new requirement. **State Health Commissioner to notify reporting entities of failure to report.** This change does not impose a new requirement. **Technical amendments. Strike subsection D of proposed regulations.**	The following sections of the Proposed regulations have substantive changes: **Subsection A - State Health Commissioner to notify reporting entities of failure to report.** **Strike subsection D of proposed regulations.**	**Change:** Changes to subsection A require the commissioner to notify a reporting entity in writing of the commissioner's determination of a failure to report, and outlines the information to be contained within the notification sent to the reporting entity – (i) the dates during which the reporting entity has been deemed to have failed to report; (ii) the data elements alleged not to have been reported; (iii)any information in the commissioner's possession that may be relied upon for making an adverse determination; (iv) state the commissioner's intent to impose civil penalties or sanctions; (v) state the reporting entity's right to appeal by using an IFFC

				under the provisions of the Administrative Process Act (§2.2-400 et seq.); and (vi) state that the reporting entity shall either remit payment of a civil penalty or appeal by requesting an IFFC in accordance with § 2.2-4019 of the Code of Virginia. Subsection D has been stricken to align with correction action plan and notification timelines. These changes have been made in response to feedback provided by the OAG in February 2026. A new subsection (subsection B) has been added permitting the commissioner to waive or reduce a civil penalty imposed upon a reporting entity. Remaining subsection headers are updated to align with the changes to subsection B. Further technical changes update provisional references in subsections C and D to align with changes made between the Proposed and Final stages of the regulatory action. **Intent:** To ensure that (i) reporting entities are notified of the commissioner's determination of a failure to report, the imposition of sanctions and civil penalties, the reduction or waiver of civil penalties; (ii) the opportunity to request an informal fact-finding proceeding in accordance with the Administrative Process Act (Chapter 40 (§2.2-4000 et seq.) of Title 2.2

				of the Code of Virginia; (iii) the Final regulations align with the legal and regulatory insight provided by the Commonwealth's chief legal authority (OAG). **Rationale:** Including a procedural step by which reporting entities are notified of the commissioner's case decision and adverse action ensures that reporting entities are notified and aware of a failure to report, applicable penalties, and the opportunity to request an IFFC in accordance with § 2.2-4019 of the Code of Virginia. The regulations should align with feedback provided by the Commonwealth's chief legal authority (OAG). **Likely Impact:** The Final regulations will be easier to read, follow, and understand; and will also align with the legal and regulatory insight provided by the Commonwealth's chief legal authority (OAG).
	12VAC5-219-140	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. This change does not impose a new requirement. **Technical amendments.**	The following sections of the Proposed regulations have substantive changes: **Subsection A – adjusts the timeframe during which a reporting entity may request an IFFC.**	**Change:** Revisions to subdivision 2 of subsection A adjust the timeframe during which a reporting entity may request an IFFC by providing 15 calendar days from the date the commissioner's notice of civil penalty is issued rather than initiating the timeframe from the date the notice is received by the reporting entity. Subsection B has been removed and technical amendments update

				provisional references in subdivisions 1 and 2 of subsection C to align with the changes to subsection headers in 12VAC5-219-130 that have been made between the Proposed and Final stages of this regulatory action. **Intent:** To ensure timelines for requesting an IFFC are consistent throughout the Final regulations, and to ensure that references to other regulatory provisions are accurate and direct readers to the correct requirements. Changes to subsection A rectify inconsistency in subsections A and D which cite the number of days the reporting entity has to request an IFFC (14 vs 15 calendar days). **Rationale:** The Final regulations should provide a clear and consistent timeframe during which a reporting entity may request an IFFC. **Likely Impact:** Reporting entities will have a better understanding of when to request an IFFC as permitted in § 2.2-4019 of the Code of Virginia. The Final regulations will be easier to read, follow, and understand.

Detail of All Changes Proposed in this Regulatory Action

List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new

*requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
	12VAC5-219-80	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. **Corrected language to specify that the WAC is established by a manufacturer.** The changes below do not impose new requirements. **Technical amendment.**	**Change:** Subdivisions 1, 2, and 3 of subsection C have been updated to specify that the WAC is established by the manufacturer and is not negotiated between a manufacturer and wholesale distributor. Amendments to the Data Elements Definitions for "Current year minus one WAC" and "Current year WAC" strike language basing the definition on the WAC negotiated between a wholesale distributor and manufacturer and replace with language basing the definitions upon the WAC price for each prescription drug. A technical amendment adds a period after the word "provide" at the end of the Data Element Definition for the data element "Comments" in subsection F. **Intent:** To clarify the correct process by which the WAC is established and how WAC data elements are reported. The technical amendment ensures correct punctuation throughout the regulation. **Rationale:** The Final regulations should specify the conditions under which the WAC is determined and reported, in order to clarify the duties applicable to reporting entities. The Final regulations should also contain correct punctuation and should conform to the *Form and Style Guidelines* published by the Virginia Registrar of Regulations. **Likely Impact:** The requirements applicable to reporting entities, the Commissioner, and the NDSO will be easier to locate, read, and understand. The Final provisions will be easier to read and understand.
	12VAC5-219-100	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage.	**Change:** Subsections B & C have been updated in response to feedback from the OAG to remove the opportunity for a reporting entity to

		The following substantive changes have been made between the Proposed and Final stages: **Subsections C & B – opportunity for reporting entity to request an IFFC has been removed.** This change does not impose a new requirement. **Technical amendments.**	request an IFFC when the NDSO has notified such entity that the data submitted cannot be validated. Technical amendments to subdivisions 1, 2, and 3 of subsection C rectify an incorrect reference to subdivision A 1 and update the language to reference the correct provision as subdivision A 2. A technical amendment to subdivision 2 of subsection D replaces "shall" with "may" as the commissioner is authorized to deem a reporting entity's failure to correct incorrect or inaccurate data as a failure to report, but is not required to act on such determination. **Intent:** To ensure the Final regulations contain accurate references to regulatory provisions that support prescription drug price transparency requirements. The technical amendment has been made due to feedback from the OAG in February 2026. An IFFC may be requested after the commissioner has made a case decision. **Rationale:** Correcting the error will direct readers to applicable provisions that require the NDSO to notify a reporting entity when it cannot validate the data submitted in accordance with the regulatory chapter. The technical amendment has been made due to feedback from the OAG in February 2026, which clarified that the IFFC should occur after a case decision has been made by the commissioner. **Likely Impact:** The Final regulations will be easier to read and understand, and will align with current law related to the ability to request and conduct an IFFC.
	12VAC5-219-110	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. This change does not impose a new requirement. **Technical amendments.**	**Change:** Updates to (i) subsection D replace "deficiencies" with "incomplete or inaccurate information;" and (ii) subsection E remove language allowing a reporting entity to request an IFFC to dispute the NDSO's determination that such entity has not provide complete or accurate information during an audit. Technical

			changes to subdivision 2 of subsection H replace mandated language with permissive language. **Intent:** Technical changes have been made due to feedback from the OAG in February 2026, clarified that the IFFC should occur after a case decision has been made by the commissioner. **Rationale:** Technical amendments have been made due to feedback from the OAG in February 2026, which determined (i) the word "deficiencies" implied that the there is a legal determination that regulations are not satisfied; and (ii) specified that the IFFC should occur after a case determination is made by the commissioner. **Likely Impact:** The Final regulations will align with the legal and regulatory insight provided by the Commonwealth's chief legal authority (OAG).
	12VAC5-219-120	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. This change does not impose a new requirement. **Technical amendments.**	**Change:** A technical update to subsection A conforms regulatory language to the *Form and Style Guidelines* by utilizing negative form construction to express a prohibition on a reporting entity's ability to violate the provisions of the regulatory chapter. **Intent:** To conform the Final regulations to the *Form and Style Guidelines* published by the Virginia Registrar of Regulations. **Rationale:** The Final regulations should conform to the *Form and Style Guidelines* to ensure consistency throughout the Virginia Administrative Code. **Likely Impact:** The Final regulations will conform to *Form and Style Guidelines* and will be easier to read and follow.
	12VAC5-219-130	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage.	**Change:** Changes to subsection A require the commissioner to notify a reporting entity in writing of the commissioner's determination of a

		This change imposes a new requirement. **State Health Commissioner to notify reporting entities of failure to report. Information contained in notice.** This change does not impose a new requirement. **Technical amendments. Strike subsection D of proposed regulations.**	failure to report, and outlines the information to be contained within the notification sent to the reporting entity – (i) the dates during which the reporting entity has been deemed to have failed to report; (ii) the data elements alleged not to have been reported; (iii)any information in the commissioner's possession that may be relied upon for making an adverse determination; (iv) state the commissioner's intent to impose civil penalties or sanctions; (v) state the reporting entity's right to appeal by using an IFFC under the provisions of the Administrative Process Act (§2.2-400 et seq.); and (vi) state that the reporting entity shall either remit payment of a civil penalty or appeal by requesting an IFFC in accordance with § 2.2-4019 of the Code of Virginia. Subsection D has been stricken to align with correction action plan and notification timelines. These changes have been made in response to feedback provided by the OAG in February 2026. A new subsection (subsection B) has been added permitting the commissioner to waive or reduce a civil penalty imposed upon a reporting entity. Remaining subsection headers are updated to align with the changes to subsection B. Further technical changes update provisional references in subsections C and D to align with changes made between the Proposed and Final stages of the regulatory action. **Intent:** To ensure that (i) reporting entities are notified of the commissioner's determination of a failure to report, the imposition of sanctions and civil penalties, the reduction or waiver of civil penalties; (ii) the opportunity to request an informal fact-finding proceeding in accordance with the Administrative Process Act (Chapter 40 (§2.2-4000 et seq.) of Title 2.2 of the Code of Virginia; (iii) the Final regulations align with the legal and regulatory insight provided by the Commonwealth's chief legal authority (OAG).

			Rationale: Including a procedural step by which reporting entities are notified of the commissioner's case decision and adverse action ensures that reporting entities are notified and aware of a failure to report, applicable penalties, and the opportunity to request an IFFC in accordance with § 2.2-4019 of the Code of Virginia. The regulations should align with feedback provided by the Commonwealth's chief legal authority (OAG). **Likely Impact:** The Final regulations will be easier to read, follow, and understand; and will also align with the legal and regulatory insight provided by the Commonwealth's chief legal authority (OAG).
	12VAC5-219-140	This chapter does not currently exist in the VAC. Changes outlined below have been made since the proposed stage. The following sections of the Proposed regulations have substantive changes: **Subsection A – adjusts the timeframe during which a reporting entity may request an IFFC.** This change does not impose a new requirement. **Technical amendments.**	**Change:** Revisions to subdivision 2 of subsection A adjust the timeframe during which a reporting entity may request an IFFC by providing 15 calendar days from the date the commissioner's notice of civil penalty is issued rather than initiating the timeframe from the date the notice is received by the reporting entity. Subsection B has been removed and technical amendments update provisional references in subdivisions 1 and 2 of subsection C to align with the changes to subsection headers in 12VAC5-219-130 that have been made between the Proposed and Final stages of this regulatory action. **Intent:** To ensure timelines for requesting an IFFC are consistent throughout the Final regulations, and to ensure that references to other regulatory provisions are accurate and direct readers to the correct requirements. Changes to subsection A rectify inconsistency in subsections A and D which cite the number of days the reporting entity has to request an IFFC (14 vs 15 calendar days). **Rationale:** The Final regulations should provide a clear and consistent timeframe during which a reporting entity may request an IFFC.

			Likely Impact: Reporting entities will have a better understanding of when to request an IFFC as permitted in § 2.2-4019 of the Code of Virginia. The Final regulations will be easier to read, follow, and understand.

Project 6828 - Final

Department of Health

Promulgation of New Regulation to Implement Chapter 304 of the 2021 Acts of Assembly, Special Session I

Chapter 219

Prescription Drug Price Transparency Regulation

Part I

General Information and Requirements

12VAC5-219-10. Definitions.

The following words and terms when used in this chapter have the following meanings unless the context clearly indicates otherwise:

"30-day equivalent supply" means the total daily dosage units of a prescription drug recommended by its prescribing label as approved by the FDA for 30 days or fewer. If there is more than one such recommended daily dosage, the largest recommended daily dosage will be considered for purposes of determining a 30-day equivalent supply. "30-day equivalent supply" includes a 30-day supply and a single course of treatment under § 54.1-3442.02 B of the Code of Virginia.

"Biologic" means a therapeutic drug, made from a living organism such as human, animal, yeast, or microorganisms, that is licensed under a Biologic License Application by the FDA.

"Biosimilar" has the same meaning as ascribed to the term in § 54.1-3442.02 of the Code of Virginia.

"Brand-name drug" has the same meaning as ascribed to the term in §§ 54.1-3436.1 and 54.1-3442.02 of the Code of Virginia.

"Carrier" has the same meaning as ascribed to the term in § 38.2-3407.10 of the Code of Virginia.

"Commissioner" means the State Health Commissioner.

"Department" means the Virginia Department of Health.

"Discount" means any price concession, however characterized, offered or provided by a reporting entity for a prescription drug, including rebates and reductions in price, that has the effect of reducing the cost of a prescription drug for a consumer.

"Drug product" means a finished dosage form, such as a tablet or solution, that contains a prescription generally, but not necessarily, in association with inactive ingredients and that has been issued a National Drug Code by the FDA.

"Enrollee" has the same meaning as ascribed to the term in § 38.2-3407.10 of the Code of Virginia.

"FDA" means the U.S. Food and Drug Administration.

"Generic drug" has the same meaning as ascribed to the term in § 54.1-3436.1 of the Code of Virginia.

"Health benefit plan" has the same meaning as ascribed to the term in § 38.2-3438 of the Code of Virginia.

"IRS" means the U.S. Internal Revenue Service.

"Launched" means the month and year on which a manufacturer first marketed a prescription drug for sale in the Commonwealth.

"Manufacturer" has the same meaning as ascribed to the term in § 54.1-3401 of the Code of Virginia.

"National Drug Code" or "NDC" means a unique numeric code assigned by the FDA for each finished drug product or unfinished drug subject to the listing requirements of 21 CFR Part 207.

"New prescription drug" has the same meaning as ascribed to the term in § 54.1-3442.02 of the Code of Virginia.

"Nonprofit data services organization" or "NDSO" has the same meaning as ascribed to the term in § 32.1-23.4 of the Code of Virginia.

"Outpatient prescription drug" means a prescription drug that may be obtained only by prescription and dispensed by a pharmacy licensed to dispense prescription drugs in Virginia, including from a retail, outpatient, mail order, or other delivery setting. Outpatient prescription drug excludes prescription drugs provided as part of or incident to and in the same setting as inpatient and outpatient hospital services, hospice services, and dental services.

"Pharmacy benefits management" has the same meaning as ascribed to the term in § 38.2-3407.15:4 of the Code of Virginia.

"Pharmacy benefits manager" or "PBM" has the same meaning as ascribed to the term in § 38.2-3407.15:4 of the Code of Virginia.

"Premium" means the amount members pay to a carrier or health benefit plan for medical and prescription drug insurance.

"Prescription drug" has the same meaning as ascribed to the term in § 54.1-3401 of the Code of Virginia. "Prescription drug" includes biologics and biosimilars for which a prescription is needed.

"Rebate" has the same meaning as ascribed to the term in § 38.2-3407.22 of the Code of Virginia.

"Reporting entity" means carriers, PBMs, wholesale distributors, and manufacturers.

"Specialty drug" means a prescription drug that:

1. Has a price for a 30-day equivalent supply equal to or greater than the current minimum specialty tier eligibility threshold under Medicare Part D as determined by the U.S. Centers for Medicare and Medicaid Services; and

2. a. Is prescribed for a person with a chronic, complex, rare, or life-threatening medical condition;

b. Requires specialized supply chain features, product handling, or administration by the dispensing pharmacy; or

c. Requires specialized clinical care, including intensive clinical monitoring or expanded services for patients, such as intensive patient counseling, intensive patient education, or ongoing clinical support beyond traditional dispensing activities.

A prescription drug appearing on the Medicare Part D specialty tier is presumed to be a specialty drug.

"Spending" means the amount of money, expressed in U.S. dollars, expended after discounts.

"Therapeutically equivalent" means a generic drug that is:

1. Approved as safe and effective;

2. Adequately labeled;

3. Manufactured in compliance with 21 CFR Part 210, 21 CFR Part 211, and 21 CFR Part 212; and

4. Either:

a. A pharmaceutical equivalent to a brand-name drug in that it:

(1) Contains identical amounts of the identical active drug ingredient in the identical dosage form and route of administration; and

(2) Meets compendial or other applicable standards of strength, quality, purity, and identity; or

b. A bioequivalent to a brand-name drug in that:

(1) It does not present a known or potential bioequivalence problem, and the two drugs meet an acceptable in vitro standard; or

(2) If it does present such a known or potential problem, it is shown to meet an appropriate bioequivalence standard.

"USAN Council" means the United States Adopted Names Council.

"Utilization management" means strategies, including drug utilization review, prior authorization, step therapy, quantity or dose limits, and comparative effectiveness reviews, to reduce a patient's exposure to inappropriate drugs and lower the cost of treatment.

"Wholesale acquisition cost" or "WAC" has the same meaning as ascribed to the term in §§ 54.1-3436.1 and 54.1-3442.02 of the Code of Virginia.

"Wholesale distributor" has the same meaning as ascribed to the term in § 54.1-3401 of the Code of Virginia.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-20. Registration.

A. Each reporting entity shall furnish to and maintain with the NDSO:

1. The entity's legal name and any fictitious names under which the entity operates;

2. The entity's current mailing address of record; and

3. The entity's current email address of record.

B. The reporting entity shall notify the NDSO in writing of any change in the entity's legal name or addresses of record within 30 calendar days of such change.

C. Each reporting entity shall notify the NDSO of the entity's business closing; discontinuation of business as a carrier, PBM, manufacturer, or wholesale distributor; or acquisition at least 30 days prior to such closure, discontinuation, or acquisition.

1. A reporting entity shall file any report otherwise due on April 1 for the preceding calendar year pursuant to Part II (12VAC5-219-50 et seq.) of this chapter prior to its closure, discontinuation, or acquisition if the reporting entity plans or anticipates that between January 1 and April 1:

a. The entity's business will close;

b. The entity's business as a carrier, PBM, manufacturer, or wholesale distributor will be discontinued; or

c. The entity's acquisition will result in the discontinuation of its business as a carrier, PBM, manufacturer, or wholesale distributor.

2. The legal entity acquiring a reporting entity shall ensure that it complies with the provisions of this chapter.

3. The commissioner shall deem the failure to comply with subdivision C 1 of this section as a failure to report pursuant to Part II (12VAC5-219-50 et seq.) of this chapter.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-30. Notice.

A. The NDSO shall send to the reporting entity at the last known email address of record:

1. An annual notice on or before March 1 regarding the reporting entity's reporting obligations under Part II (12VAC5-219-50 et seq.) of this chapter. Failure to receive this notice does not relieve the reporting entity of the obligation to timely report;

2. Any notices pursuant to 12VAC5-219-90 C; and

3. Any notices pursuant to Article 1 (12VAC5-219-100 et seq.) of Part III of this chapter.

B. The department shall send notices pursuant to Part III (12VAC5-219-100 et seq.) of this chapter and case decisions to the last known email address of record and mailing address of record.

C. The NDSO shall provide any record requested by the commissioner or department related to the enforcement or administration of § 32.1-23.4 of the Code of Virginia or this chapter no more than 10 business days after the request, except as otherwise agreed to between the NDSO and the commissioner or the department.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-40. Allowable variances.

A. The commissioner may authorize a variance to Part II (12VAC5-219-50 et seq.) of this chapter.

B. A variance shall require advance written approval from the commissioner.

C. The department, the NDSO, or a reporting entity may request a variance at any time by filing the request in writing with the commissioner. The request for a variance shall include:

1. A citation to the specific standard or requirement from which a variance is requested;

2. The nature and duration of the variance requested;

3. A description of how compliance with the current standard or requirement is economically burdensome and constitutes an impractical hardship unique to the requester;

4. Statements or evidence why the purpose of the standard or requirement would not be frustrated if the variance were granted;

5. Proposed alternatives to meet the purpose of the standard or requirement; and

6. Other information, if any, believed by the requester to be pertinent to the request.

D. The requester shall provide additional information as may be requested or required by the commissioner to evaluate the variance request.

E. The requester may withdraw a request for a variance at any time.

F. The commissioner shall notify the requester in writing of the commissioner's decision on the variance request. If granted, the commissioner:

1. Shall identify:

a. The standard or requirement to which a variance has been granted;

b. To whom the variance applies; and

c. The effective date and expiration date of the variance; and

2. May attach conditions to a variance that, in the sole judgment of the commissioner, satisfies, supports, or furthers the purpose of the standard or requirement.

G. The requester shall comply with the standard or requirement to which a variance has been requested unless a variance has been granted.

H. The commissioner may rescind or modify a variance if:

1. The impractical hardship unique to the requester changes or no longer exists;

2. Additional information becomes known that alters the basis for the original decision, including if the requester elected to fail to comply with the standard or requirement prior to receiving a variance;

3. The requester fails to meet any conditions attached to the variance; or

4. Results of the variance fail to satisfy, support, or further the purpose of the standard or requirement.

I. If a variance is denied, expires, or is rescinded, the commissioner, the department, or the NDSO, as applicable, shall enforce the standard or requirement to which the variance was granted.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

Part II

Reporting Requirements

12VAC5-219-50. Carrier reporting requirements.

A. Every carrier offering a health benefit plan shall report annually by April 1 to the NDSO the information required in this subsection on total annual spending on prescription drugs, before enrollee cost-sharing, for each health benefit plan offered by the carrier in the Commonwealth:

1. For covered outpatient prescription drugs that were prescribed to enrollees during the immediately preceding calendar year:

a. The names of the 25 most frequently prescribed outpatient prescription drugs;

b. The names of the 25 outpatient prescription drugs covered at the greatest cost, calculated using the total annual spending by such health benefit plan for each outpatient prescription drug covered by the health benefit plan; and

c. The names of the 25 outpatient prescription drugs that experienced the greatest year-over-year increase in cost, calculated using the total annual spending by a health benefit plan for each outpatient prescription drug covered by the health benefit plan;

2. The percent increase in annual net spending for prescription drugs after accounting for aggregated discounts;

3. The percent increase in premiums that were attributable to each health care service, including prescription drugs;

4. The percentage of specialty drugs with utilization management requirements; and

5. The premium reductions that were attributable to specialty drug utilization management.

B. In determining which outpatient prescription drugs are reportable under subdivision A 1 of this section, the carrier shall:

1. Average the frequency of prescription for all drug products of an outpatient prescription drug for such health benefit plan to determine which outpatient prescription drugs are reportable under subdivision A 1 a of this section;

2. Average the cost, calculated using the total annual spending by such health benefit plan for all drug products of an outpatient prescription drug covered by the health benefit plan,

to determine which outpatient prescription drugs are reportable under subdivision A 1 b of this section; and

3. Average the year-over-year increase in cost, calculated using the total annual spending by a health benefit plan for all drug products of an outpatient prescription drug covered by the health benefit plan, to determine which outpatient prescription drugs are reportable under subdivision A 1 c of this section.

C. When submitting a report pursuant to this section, a carrier:

1. May not disclose the identity of a specific health benefit plan or the price charged for a specific prescription drug or class of prescription drugs;

2. Shall use a health benefit plan unique identifier as described in subsection E of this section in lieu of the health benefit plan's identity; and

3. Shall report on all drug products of an outpatient prescription drug determined to be reportable pursuant to subsections A and B of this section.

D. Every carrier offering a health benefit plan shall require each PBM with which it enters into a contract for pharmacy benefits management to comply with 12VAC5-219-60.

E. Every carrier shall provide the information specified in subsections A and B of this section on a form prescribed by the department that includes the following data elements:

Data Element Name	Data Element Definition
Carrier tax identification number	The nine-digit Taxpayer Identification Number used by the IRS.
Carrier name	The legal name of the reporting entity.
Health benefit plan category	The two-digit health plan category identifier. The first digit corresponds to the insurance line and valid values are D (Medicaid); R (Medicare); C (commercial); and O (other). The second digit corresponds to the insurance policy type and valid values include I (individual); F (fully insured group); S (self-insured group); and C (Commonwealth of Virginia employees).
Health benefit plan unique identifier	A unique five-digit incremental number assigned by a carrier to a health benefit plan within a given health benefit plan category for the purpose of anonymizing the health benefit plan's identity.
Proprietary drug name	The brand or trademark name of the prescription drug reported to the FDA.
Nonproprietary drug name	The generic name of the prescription drug assigned by the USAN Council.
WAC unit	The lowest identifiable quantity of the prescription drug that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids.
NDC	The NDC assigned to each drug product of an outpatient prescription drug.
Brand-name or generic	Whether the prescription drug is brand-name or generic.

Inclusion criteria	The criteria, as specified in subdivision A 1 of this section, that resulted in the outpatient prescription drug being determined to be reportable.
Net spending increase	The percent year-over-year increase in annual net spending for prescription drugs after accounting for aggregated discounts or other reductions in price.
Premium increase	The percent year-over-year increase in premiums that were attributable to each health care service, including prescription drugs.
Specialty drugs with utilization management	The percentage of specialty drugs with utilization management requirements.
Premium reductions	The percent year-over-year of premium reductions that were attributable to specialty drug utilization management.
Comments	A text field for any additional information the carrier wishes to provide.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-60. Pharmacy benefits manager reporting requirements.

A. Every PBM providing pharmacy benefits management under contract to a carrier shall report annually by April 1 to the NDSO the following information for each prescription drug upon which the carrier is reporting pursuant to 12VAC5-219-50:

1. The aggregate amount of rebates received by the PBM;

2. The aggregate amount of rebates distributed to the relevant health benefit plan; and

3. The aggregate amount of rebates passed on to enrollees of each health benefit plan at the point of sale that reduced an enrollee's applicable deductible, copayment, coinsurance, or other cost-sharing amount.

B. A PBM shall report on all drug products of a prescription drug determined to be reportable pursuant to subsection A of this section.

C. Every PBM shall provide the information specified in subsection A of this section on a form prescribed by the department that includes the following data elements:

Data Element Name	Data Element Definition
PBM tax identification number	The nine-digit Taxpayer Identification Number used by the IRS.
PBM name	The legal name of the reporting entity.
Proprietary drug name	The brand or trademark name of the prescription drug reported to the FDA.
Nonproprietary drug name	The generic name of the prescription drug assigned by the USAN Council.
NDC	The NDC assigned to each drug product of a prescription drug.

Brand-name or generic	Whether the prescription drug is brand-name or generic.
Carrier name	The legal name of the carrier to whom rebates were distributed or passed on.
Total rebates	Total aggregate rebates received or negotiated directly with the manufacturer in the last calendar year, for business in the Commonwealth.
Total rebates distributed	Total aggregate rebates distributed to the relevant health benefit plan in the last calendar year, for business in the Commonwealth.
Total rebates passed on	Total aggregate rebates passed on to all enrollees of a health benefit plan at the point of sale that reduced an enrollee's applicable deductible, copayment, coinsurance, or other cost-sharing amount in the last calendar year, for business in the Commonwealth.
Comments	A text field for any additional information the PBM wishes to provide.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-70. Manufacturer reporting requirements.

A. Except as provided in subsection D of this section, every manufacturer shall report annually by April 1 to the NDSO on each of its:

1. Brand-name prescription drugs and biologics, other than a biosimilar, with:

a. A WAC of $100 or more for a 30-day supply or a single course of treatment; and

b. Any increase of 15% or more in the WAC of the brand-name drug or biologic over the preceding calendar year;

2. Biosimilars with an initial WAC that is not at least 15% less than the WAC of the referenced brand biologic at the time the biosimilar is launched and that has not previously been reported to the NDSO; and

3. Generic drugs with a price increase that results in an increase in the WAC equal to 200% or more during the preceding 12-month period, when the WAC of such generic drug is equal to or greater than $100, annually adjusted by the Consumer Price Index for All Urban Consumers, for a 30-day supply.

For the purposes of this subdivision, a price increase is calculated as the difference between the WAC of the generic drug after increase in the WAC and the average WAC of such generic drug during the 12 months preceding the increase.

B. For each prescription drug identified in subsection A of this section, a manufacturer shall report:

1. The name of the prescription drug;

2. Whether the prescription drug is a brand-name or generic;

3. The effective date of the change in WAC;

4. Aggregate, company-level research and development costs for the most recent year for which final audit data is available;

5. The name of each of the manufacturer's new prescription drugs approved by the FDA within the previous three calendar years;

6. The name of each of the manufacturer's prescription drugs that, within the previous three calendar years, became subject to generic competition and for which there is a therapeutically equivalent generic version; and

7. A concise statement regarding the factors that caused the increase in WAC.

C. A manufacturer shall report on all drug products of a prescription drug determined to be reportable pursuant to subsection A of this section.

D. A manufacturer that does not own the NDC of a prescription drug or does not control the WAC of a prescription drug shall report annually by April 1 to the NDSO that it has no data responsive to the requirements of this section.

E. Except as provided in subsection D of this section, every manufacturer shall provide the information specified in subsections A and B of this section on a form prescribed by the department that includes the following data elements:

Data Element Name	Data Element Definition
Manufacturer tax identification number	The nine-digit Taxpayer Identification Number (TIN) used by the IRS.
Manufacturer name	The legal name of the reporting entity.
Proprietary drug name	The brand or trademark name of the prescription drug reported to the FDA.
Nonproprietary drug name	The generic name of the prescription drug assigned by the USAN Council.
NDC	The NDC assigned to each drug product of a prescription drug. If a segment contains fewer than the number of digits as defined in 12VAC5-219-10, a manufacturer shall add at least one "0" to the front of the segment such that the segment contains the specified number of digits.
Brand-name drug or generic drug	Whether the prescription drug is a brand-name drug or generic drug.
Date of market introduction	The year of market introduction of the prescription drug.
Effective date of change in WAC	If applicable, the month and year that the WAC changed.
Reasons for current-year WAC increase	If applicable, the reason that the manufacturer increased the WAC of the prescription drug compared with last year.
Inclusion criteria	The criteria, as specified in subsection A of this section, that resulted in the prescription drug being determined to be reportable.
Research and development costs	Aggregate, company-level research and development costs in U.S. dollars for the most recent year for which final audit data is available.
Year of research and development costs	The year in which final audit data is available.

Comments	A text field for any additional information the manufacturer wishes to provide.

F. A manufacturer's obligations pursuant to this section shall be fully satisfied by the submission to the NDSO of information and data that the manufacturer includes in the manufacturer's annual consolidation report on Securities and Exchange Commission Form 10-K or any other public disclosure.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-80. Wholesale distributor reporting requirements.

A. For the purposes of this section, "cost" means the expense incurred and the monetary value of the resources used or consumed in the provision of a prescription drug by a wholesale drug distributor.

B. If the department determines that data received from carriers, PBMs, and manufacturers is insufficient, the department may request wholesale distributors to report the information specified in subsection C of this section.

1. The department shall publish a general notice in the Virginia Register of Regulations that contains the department's determination, the request for wholesale distributor reporting, and the deadline for wholesale distributors to report pursuant to subsection C of this section.

2. The NDSO shall notify every wholesale distributor of the department's determination and request by email at the wholesale distributor's email address of record.

C. If requested by the department pursuant to subsection B of this section and no more than 45 calendar days after the publication of the general notice pursuant to subdivision B 1 of this section, a wholesale distributor shall report for the 25 costliest prescription drugs dispensed in the Commonwealth, including each drug product of a reportable prescription drug:

1. The WAC directly [~~negotiated with~~ established by] a manufacturer in the last calendar year;

2. The WAC directly [~~negotiated with~~ established by] a manufacturer in the current calendar year;

3. Aggregate total discounts directly negotiated with a manufacturer in the last calendar year, for business in the Commonwealth; and

4. Aggregate total discounts, dispensing fees, and other fees negotiated in the last calendar year with pharmacies.

D. In determining which prescription drugs are reportable under subsection C of this section, the wholesale distributor shall average the cost for all drug products of a dispensed prescription drug.

E. A wholesale distributor shall report on all drug products of a prescription drug determined to be reportable pursuant to subsections C and D of this section.

F. A wholesale distributor shall provide the information specified in subsection C of this section on a form prescribed by the department that includes the following data elements:

Data Element Name	Data Element Description
Wholesale distributor tax identification number	The nine-digit Taxpayer Identification Number used by the IRS.

Wholesale distributor name	The legal name of the reporting entity.
Proprietary drug name	The brand or trademark name of the prescription drug reported to the FDA.
Nonproprietary drug name	The generic name of the prescription drug assigned by the USAN Council.
WAC unit	The lowest identifiable quantity of the prescription drug that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids.
NDC	The NDC assigned to each drug product of a prescription drug.
Current year minus one WAC	WAC in U.S. dollars, for each prescription drug [~~for which the wholesale distributor has negotiated with a manufacturer~~] in the last calendar year, related to prescriptions under a health benefit plan issued in the Commonwealth.
Current year WAC	WAC in U.S. dollars, for each prescription drug [~~for which the wholesale distributor has negotiated with a manufacturer~~] in the current calendar year, related to prescriptions under a health benefit plan issued in the Commonwealth.
Total manufacturer discounts	Total aggregate discounts for each prescription drug directly negotiated with a manufacturer in the last calendar year, for business in the Commonwealth.
Total pharmacy discounts, dispensing fees, and other fees	Total aggregate discounts, dispensing fees, and other fees for each prescription drug negotiated in the last calendar year with a pharmacy.
Comments	A text field for any additional information the wholesale distributor wishes to provide [.]

G. The commissioner, the department, and the NDSO may not disclose:

1. The identity of a specific wholesale distributor;

2. The price charged for a specific prescription drug or class of prescription drugs; or

3. The amount of any discount or fee provided for a specific prescription drug or class of prescription drugs.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-90. Method of report submission.

A. A reporting entity shall submit any report required by this part to the NDSO through the NDSO's online collection tool.

B. A reporting entity shall submit any required report by uploading electronic spreadsheet files, or other methods as determined by the NDSO, that include all required information for each report and that comply with the NDSO's Prescription Drug Price Transparency Regulation (12VAC5-219) Submission Manual, Version 1.2.

C. The NDSO shall notify each reporting entity in writing at least 30 calendar days before any change in the report collection method.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

Part III

Enforcement

Article 1

Data Validation and Audits

12VAC5-219-100. Data validation; notification; response.

A. The NDSO shall:

1. Validate that the data received from each reporting entity pursuant to a report required under Part II (12VAC5-219-50 et seq.) of this chapter is complete no more than 90 calendar days after submission;

2. Notify a reporting entity if the NDSO cannot validate the data submitted pursuant to a report required under Part II (12VAC5-219-50 et seq.) of this chapter;

3. Send the notification specified in subdivision 2 of this subsection no more than three business days after completion of the data validation to the reporting entity's email address of record;

4. Identify in the notification specified in subdivision 2 of this subsection the specific report and the data elements within the report that are incomplete; and

5. Provide a copy of the notification specified in subdivision 2 of this subsection to the commissioner at the same time the notification is sent to the reporting entity.

B. Each reporting entity notified under subsection A of this section shall make changes necessary to correct the report [~~or request an informal fact-finding conference pursuant to § 2.2-4019 of the Code of Virginia~~] within 30 calendar days of the notification.

C. If a reporting entity fails to correct the report [~~or request an informal fact-finding conference~~] within 30 calendar days, the NDSO shall:

1. Notify a reporting entity that it has failed to correct the report;

2. Send the notification specified in subdivision A [~~1~~ 2] of this section no more than two business days after the reporting entity's failure to report to the reporting entity's email address of record;

3. Identify in the notification specified in subdivision A [~~1~~ 2] of this section the specific report and the data elements within the report that have not been corrected; and

4. Provide a copy of the notification specified in subdivision A [~~1~~ 2] of this section to the commissioner at the same time the notification is sent to the reporting entity.

D. If a reporting entity fails to correct the report within 15 calendar days of the second notice:

1. The NDSO shall provide to the commissioner within one business day of the second failure to correct:

a. The copy of the original report submitted by the reporting entity;

b. Any subsequent updated reports that the reporting entity may have filed; and

c. Any correspondence between the NDSO and the reporting entity after the notification sent pursuant to subsection A of this section; and

2. The commissioner [~~shall~~ may] deem the second failure to correct as a failure to report pursuant to Part II (12VAC5-219-50 et seq.) of this chapter.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-110. Audit; corrective action plan.

A. When submitting any notification or report to the NDSO, a reporting entity shall include:

1. A signed, written certification of the accuracy of any notification or report filed in a physical format; and

2. Electronic certification of the accuracy of any notification or report filed by email or through the NDSO's online collection tool.

B. The NDSO may verify the accuracy of finalized data reported by a reporting entity through an audit conducted by the NDSO, provided that the NDSO gives notice to the reporting entity at its email address of record no fewer than 30 calendar days prior to initiating the audit.

C. The NDSO shall send a copy of the audit findings to the reporting entity no more than five business days after the conclusion of the audit at the reporting entity's email address of record.

D. If [~~any deficiencies are~~ incomplete or inaccurate information is] found during the audit:

1. The NDSO shall:

a. Notify a reporting entity by providing a copy of the audit findings no more than five business days after completion of the audit to the reporting entity's email address of record; and

b. Provide a copy of the notification to the commissioner at the same time notification is sent to the reporting entity.

2. The reporting entity shall prepare a written corrective action plan addressing [~~each deficiency~~ the incomplete or inaccurate information] cited at the time of audit as specified in subsection E of this section.

E. The reporting entity shall submit to the NDSO and the commissioner a corrective action plan [~~or request an informal fact-finding conference pursuant to § 2.2-4019 of the Code of Virginia~~] no more than 10 business days after receipt of the audit findings. The corrective action plan shall include:

1. A description of the corrective action to be taken for [~~each deficiency~~ the incomplete or inaccurate information] and the position title of the employees to implement the corrective action;

2. The deadline for completion of all corrective action, not to exceed 45 business days from the receipt of the audit findings; and

3. A description of the measures implemented to prevent a recurrence of the [~~deficiency~~ the incomplete or inaccurate information] .

F. The reporting entity shall ensure that the person responsible for the implementation of the corrective action plan signs, dates, and indicates the person's title on the corrective action plan.

G. The NDSO shall:

1. Notify the reporting entity if the NDSO determines any item in the corrective action plan is unacceptable;

2. Grant the reporting entity two opportunities to revise and resubmit a corrective action plan that the NDSO initially determines to be unacceptable. If the reporting entity revises and resubmits the corrective action plan, the revision is due to the NDSO and the commissioner no more than 15 business days after the NDSO has notified the reporting entity pursuant to subdivision 1 of this subsection.

H. If a reporting entity fails to comply with the corrective action plan:

1. The NDSO shall provide to the commissioner any correspondence between the NDSO and the reporting entity after the notification sent pursuant to subsection D of this section; and

2. The commissioner may deem the failure to comply as a failure to report pursuant to Part II (12VAC5-219-50 et seq.) of this chapter.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

Article 2

Administrative Process

12VAC5-219-120. Sanctions.

A. [~~A~~ No] reporting entity may [~~not~~] violate the provisions of this chapter.

B. The commissioner may:

1. Petition an appropriate court for an injunction, mandamus, or other appropriate remedy or imposition of a civil penalty against the reporting entity pursuant to § 32.1-27 B or C of the Code of Virginia for each violation of this chapter; and

2. Levy a civil penalty upon the reporting entity as specified in 12VAC5-219-130 ~~B~~ C and pursuant to § 32.1-23.4 C of the Code of Virginia, in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) for each violation of Part II (12VAC5-219-50 et seq.) of this chapter.

C. Each day that a reporting entity fails to report in violation of this chapter is a sufficient cause for imposition of one or more sanctions. If a reporting entity knowingly submits false, inaccurate, or misleading data pursuant to the reporting requirements of this chapter, the commissioner shall deem that submission as a failure to report.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

12VAC5-219-130. Civil penalty.

A. [The commissioner shall notify a reporting entity in writing upon the commissioner's determination that the reporting entity has failed to report the information required by law. The notification shall:

1. State the factual basis for the commissioner's determination of a failure to report, including but not limited to:

a. The dates during which the reporting entity has been deemed to have failed to report;

b. The data elements alleged to not be reported; and

c. Any information in the commissioner's possession that may be relied upon for making an adverse determination;

2. State the commissioner's intent to impose civil penalties or sanctions;

3. State the reporting entity's right to request an informal fact finding conference under the provisions of the Administrative Process Act (Va. Code §2.2-4000 et seq); and

4. State that the reporting entity, pursuant to 12VAC5-219-140 D, shall either remit payment of a civil penalty or request an informal fact finding conference.]

B. The commissioner may reduce or waive the civil penalty imposed pursuant to this section if the commissioner, in the commissioner's sole discretion, determines that the violation was reasonable or resulting from good cause.

[~~B.~~ C.] Except as provided in subsection [~~A~~ B] of this section, the commissioner shall levy a civil penalty upon the reporting entity in an amount of:

1. For the first offense:

a. $500 for the first day in which the reporting entity fails to report;

b. $1,000 for the second day in which the reporting entity fails to report;

c. $1,500 for the third day in which the reporting entity fails to report;

d. $2,000 for the fourth day in which the reporting entity fails to report; and

e. $2,500 for the fifth day and each subsequent day in which the reporting entity fails to report; and

2. For the second offense:

a. $1,000 for the first day in which the reporting entity fails to report;

b. $1,750 for the second day in which the reporting entity fails to report; and

c. $2,500 for the third and each subsequent day in which the reporting entity fails to report; and

3. For the third and all subsequent offenses, $2,500 for each day in which the reporting entity fails to report.

The commissioner shall assess civil penalties in the aggregate on a per-day basis.

[~~C.~~ D.] The commissioner shall deem the first day in which the reporting entity fails to report as:

1. April 2 for a reporting entity that fails to submit any information or documentation pursuant to 12VAC5-219-50, 12VAC5-219-60, or 12VAC5-219-70 or for a reporting entity that knowingly submits false, inaccurate, or misleading data pursuant to 12VAC5-219-50, 12VAC5-219-60, or 12VAC5-219-70;

2. The 46th calendar day after the publication of the general notice pursuant to 12VAC5-219-80 [~~A~~ B] 1 for a wholesale distributor that fails to submit any information or documentation or that knowingly submits false, inaccurate, or misleading data;

3. The 16th calendar day after notification pursuant to 12VAC5-219-100 C 1 for a reporting entity that fails to correct its report submitted pursuant to Part II (12VAC5-219-50 et seq.) of this chapter; and

4. The calendar day immediately succeeding the deadline of a corrective action plan for a reporting entity that fails to comply with its corrective action plan approved pursuant to 12VAC5-219-110.

[~~D. Civil penalties are due 15 calendar days after the date of receipt of the notice of civil penalty imposition or 31 calendar days after the service of a case decision after an informal fact-finding proceeding, whichever is later.~~]

E. A reporting entity shall remit a check or money order for a civil penalty payable to the Treasurer of Virginia.

1. If a check, money draft, or similar instrument for payment of a civil penalty is not honored by the bank or financial institution named, the reporting entity shall remit funds sufficient to cover the original civil penalty amount, plus a $50 dishonored payment fee.

2. Unless otherwise provided, the commissioner may not refund civil penalties or fees.

F. A civil penalty imposed pursuant to subsection B of this section is a debt to the Commonwealth and may be sued for and recovered in the name of the Commonwealth.

1. On all past due civil penalties, the commissioner shall assess and charge:

a. Interest at the judgment rate as provided in § 6.2-302 of the Code of Virginia on the unpaid balance, unless a higher interest rate is authorized by contract with the debtor or provided otherwise by statute, which shall accrue on the 60th day after the date of the initial written demand for payment;

b. An additional amount that approximates the administrative costs arising under § 2.2-4806 of the Code of Virginia; and

c. Late penalty fees of 10% of the past due civil penalties.

2. The commissioner may refer a past due civil penalty for collection by the Division of Debt Collection of the Office of the Attorney General.

Statutory Authority

§§ 2.2-4805 and 32.1-23.4 of the Code of Virginia.

12VAC5-219-140. Civil penalty; informal fact-finding proceeding.

A. A reporting entity may dispute the imposition of a civil penalty pursuant to 12VAC5-219-120 B 2 by requesting an informal fact-finding proceeding pursuant to § 2.2-4019 of the Code of Virginia:

1. In writing to the commissioner; and

2. No more than 14 calendar days after the date [~~of receipt of~~] the notice of civil penalty imposition [is issued] .

[~~B. In requesting an informal fact-finding proceeding pursuant to subsection A of this section, a reporting entity:~~

~~1. Shall identify with specificity the reason or alleged good cause for its failure to report; and~~

~~2. May present factual data, argument, information, or proof in support of its reason or alleged good cause for its failure to report.~~]

[~~C.~~ B.] The request for an informal fact-finding proceeding:

1. May not toll the imposition of a civil penalty on a per-day basis, as specified in 12VAC5-219-130 ~~B~~ C; and

2. Shall toll all assessments and charges under 12VAC5-219-130 ~~F~~ G 1 until a case decision after an informal fact-finding proceeding has been served.

[~~D.~~ C.] If a reporting entity does not request an informal fact-finding proceeding pursuant to subsection A of this section, [~~the civil penalty imposed~~ the notice issued] pursuant to 12VAC5-219-120 B shall be [~~final~~ the final case decision] on the 15th calendar day after the date [~~of receipt of~~] the notice of civil penalty imposition [is issued] .

[~~E.~~ D.] If a reporting entity remains aggrieved by a case decision after an informal fact-finding proceeding, it may seek review of the case decision in accordance with Article 5 (§ 2.2-4025 et seq.) of Chapter 40 of Title 2.2. of the Code of Virginia.

Statutory Authority

§ 32.1-23.4 of the Code of Virginia.

Documents Incorporated by Reference (12VAC5-219)

Prescription Drug Price Transparency Data Submission Manual, Version 1.2, Virginia Health Information (rev. 8/2025)

COMMONWEALTH of VIRGINIA

Department of Health
B. Cameron Webb, MD, JD
State Health Commissioner

P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

[Date]

MEMORANDUM

TO: The Honorable Abigail D. Spanberger
Governor of Virginia

The Honorable Don Scott
Speaker of the House, Virginia House of Delegates

The Honorable L. Louise Lucas
President pro tempore, Senate of Virginia

FROM: Michael Desjadon
Chair, State Board of Health

SUBJECT: 2025 State Board of Health Annual Report

This report is submitted in compliance with the Code of Virginia § 32.1-14, which states:

> *The Board shall submit an annual report to the Governor and General Assembly. Such report shall contain information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia, including but not limited to, health status indicators, the effectiveness of delivery of health care, progress toward meeting standards and goals, the financial and geographic accessibility of health care, and the distribution of health care resources, with particular attention to health care access for those Virginia citizens in rural areas, inner cities, and with greatest economic need. Such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality.*

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

MD/KB
Enclosure

Pc: The Honorable Marvin B. Figueroa, Secretary of Health and Human Resources

2025

BOARD OF HEALTH ANNUAL REPORT

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

VIRGINIA DEPARTMENT OF HEALTH

PREFACE

The Code of Virginia § 32.1-14 tasks the Board of Health with submitting an annual report to the Governor and General Assembly containing information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia. The Code specifies that such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality. The report was drafted by the Virginia Department of Health on behalf of the Board of Health.

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EXECUTIVE SUMMARY

The Code of Virginia § 32.1-14 tasks the Board of Health with submitting an annual report to the Governor and General Assembly. This report must include comprehensive information on the Commonwealth's vital records and health statistics, along with a thorough analysis and summary of the health care issues affecting citizens of the Commonwealth. The content of the report shall encompass, but is not limited to, health status indicators, assessments of the effectiveness of health care delivery, evaluations of progress made toward established health standards and goals, and analyses of both the financial and geographic accessibility of care and the distribution of health care resources across the state. Particular focus must be given to health care access for citizens residing in rural communities, inner-city areas, and other regions where residents face the greatest economic need. Additionally, the report must include detailed statistics and analyses of the health status and conditions of minority populations in Virginia, disaggregated by age, gender, and locality.

The 2025 Board of Health Annual Report has been prepared by the Virginia Department of Health (VDH) in fulfillment of this statutory obligation and on behalf of the Board of Health. This document offers an updated assessment of the current state of public health in Virginia and ongoing public health initiatives. Reflecting VDH's overarching vision to make Virginia the healthiest state in the nation, the 2025 report reviews the Commonwealth's performance in key health indicators against national averages and those of peer states, thereby providing a broader context for evaluating health outcomes and progress across the Commonwealth.

INTRODUCTION

REPORT MANDATE

Pursuant to Virginia Code § 32.1-14, the Virginia Department of Health (VDH) is submitting the following Board of Health Annual Report summarizing information on the Commonwealth's vital records and health statistics, as well as a comprehensive analysis and summary of significant health care issues impacting the citizens of the Commonwealth of Virginia. In accordance with the provisions of this section, the report is further required to include disaggregated statistical data and interpretive analysis pertaining to the health status and conditions of Virginia's minority populations, stratified by age, gender, and geographic locality.

REPORT OUTLINE

This report provides a comprehensive overview of the health status of Virginians and evaluates statewide efforts to improve public health. The report begins with an introduction outlining the statutory mandate and the methodology used to assess health indicators. It includes an analysis of how Virginia compares with national health benchmarks, followed by detailed demographic data and vital health statistics. The report then explores the determinants of health, including education, access to care, economic conditions, and community context, laying the foundation for understanding health disparities. The report covers key public health concerns

such as maternal and child health, mental and behavioral health, and chronic and infectious diseases, with detailed breakdowns for specific conditions. Additional sections address the healthcare workforce and available incentives, and the document concludes with recommendations aimed at improving health equity and access across the Commonwealth. The appendix provides useful definitions and acronyms for reference.

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METHODOLOGY

For this report, VDH compiled and analyzed the most current data available pertaining to a range of healthcare issues affecting the residents of Virginia, as well as key indicators of overall health status. Comparative analyses were conducted to evaluate Virginia's performance relative to other states and national benchmarks.

The selection of topics included in this report was guided by a deliberate focus on priority areas in which VDH has concentrated resources and efforts over the past year. To ensure the comprehensiveness and accuracy of the information presented, VDH engaged subject matter experts (SMEs) from the relevant divisions and offices. These experts were requested to provide updated data specific to their domains, summarize critical findings, describe significant programs currently in place, and offer related recommendations for future improvements. This collaborative approach allowed for a nuanced understanding of the current health landscape in Virginia and facilitated the identification of actionable strategies to address ongoing challenges.

ANALYSIS OF HOW VIRGINIA COMPARES

VDH is firmly committed to advancing its vision of Virginia becoming the healthiest state in the nation. Population health rankings provide a valuable and standardized tool to objectively assess how Virginia compares to other states, offering measurable data that can highlight strengths and pinpoint areas requiring focused attention or improvement across various health indicators. These rankings support data-driven decision-making and help guide public health strategies aimed at improving overall health outcomes for Virginians. (Table 1). According to America's Health Rankings (produced by the United Health Foundation), Virginia's overall health ranking has shown steady improvement:

2022 Annual Report: Virginia rank 19th
2023 Annual Report: Virginia rank 18th
2024 Annual Report: Virginia rank 15th

As with most national health rankings of this scope, the underlying data are the latest finalized figures available at the time of publication (typically reflecting outcomes from the prior one to three years), ensuring the composite picture remains highly reliable and comparable across all 50 states. The remainder of this report utilizes data directly collected by or available to VDH.

Table 1. How Virginia Compares Nationally with Key Health Indicators from 2022-2024 Reports.

Health Indicator	2022 Rank	2023 Rank	2024 Rank
2024 Rankings in the Top Half of U.S. States			
Virginia's Overall Rank	***14***	***19***	***15***
Uninsured (% of Population)	21	21	23
Severe Housing Problems (% of occupied housing units)	23	22	25
Poverty	6	13	12
Unemployment	15	15	19

Economic Hardship Index	5	8	9
Food Insecurity	5	13	13
Childhood Immunizations (% by age 24 months)	30	28	24
Flu Vaccinations (% ages 18+)	16	20	9
Dedicated Health Care Provider (% ages 18+)	25	22	22
Firearm Deaths	18	17	23
Suicides	10	9	10
Drug Related Deaths	24	24	17
Asthma	24	16	24
Cancer	19	35	17
Diabetes	19	38	17
Depression	31	27	25
Obesity	27	30	15
2024 Rankings in the Bottom Half of U.S. States			
HPV Vaccination HPV Vaccination (% ages 13-17)	19	26	27
Amount of Mental Health Providers	37	36	36
Homicides	16	26	27
Arthritis	27	27	28
Cardiovascular Disease	27	26	33
Chronic Kidney Disease	20	24	35
Chronic Obstructive Pulmonary Disease	26	30	30
High Blood Pressure	32	32	30
High Cholesterol	46	46	36

Data Source: American Health Rankings, 2024 Annual Report

In the 2024 report, Virginia ranked among the top ten states for three indicators: the economic hardship index, adult flu vaccination rates, and suicide death. On the other hand, Virginia ranked in the bottom half of states in the 2024 report for HPV vaccination, amount of mental health providers, homicides, arthritis, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease (COPD), high cholesterol, and high blood pressure. In addition, Virginia ranked highly for other socioeconomic indicators such as poverty but faces ongoing challenges with uninsured rates and improving housing problems. Preventative health care in Virginia showed modest improvements, with higher childhood vaccination rankings and an increase in adult flu vaccination coverage; however, HPV vaccination rankings have declined since the 2022 report. Chronic disease trends are mixed, with improvements in rankings for cancer, diabetes, and obesity, but setbacks for asthma, cardiovascular disease, and kidney disease.

DEMOGRAPHICS

The Commonwealth of Virginia consists of 133 localities, grouped by VDH into 35 health districts and 5 health regions. In Virginia, the total population is 8,715,698.[1] Compared to over 7.5 million residents living within urban areas, approximately 1.0 million residents live in

[1] U.S. Census Bureau. (2024). *American Community Survey: 2019–2023 (5-year estimates)*. https://www.census.gov/programs-surveys/acs/

rural areas of Virginia. The Southwest region is primarily rural and the least populous of all health regions, while the Central and Northwest regions only have pockets of rural communities. The Northern region is primarily urban, densely populated, and relatively affluent, while the Eastern region has communities characterized by lower population density and high rates of economic challenges.

The population is almost evenly split by sex, with 4,409,697 million females (50.6%) and 4,306,001 million males (49.4%). In 2023, 59% of Virginians identified as non-Hispanic White, 18.4% identified as non-Hispanic Black, 10.7% identified as Hispanic (all races), 6.8% non-Hispanic Asian, 4.3% identifying as non-Hispanic with more than one race, 0.1% non-Hispanic American Indian or Alaska Native, and 0.1% Native Hawaiian and Pacific Islander. Virginia's demographic profile reveals an increasingly diverse and aging population, with a wide variation across regions in terms of density, economic opportunity, and access to essential services.

VITAL RECORDS AND HEALTH STATISTICS

In 2023, Virginia recorded 92,652 live births, reflecting a birth rate of 10.63 per 1,000 people. Virginia's birth rate has steadily declined over the past decade, dropping from over 12 births per 1,000 population in 2015 to just above 10.6 in 2023 (Figure 1). This trend mirrors broader demographic shifts seen nationwide, including delayed childbearing, smaller family sizes, and social and economic factors influencing fertility decisions.

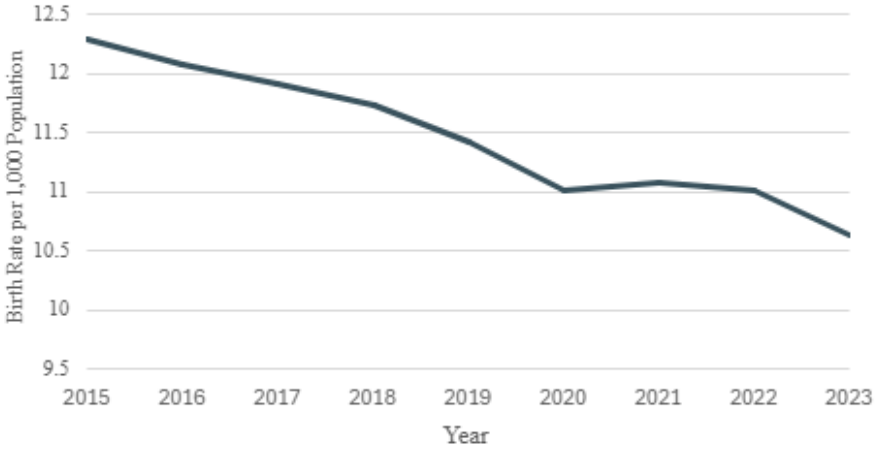


Figure 1: Birth Rate in Virginia (per 1,000 Population) from 2015 to 2023
Data Source: The Virginia Department of Health, Office of Information Management

In 2023, Virginia recorded 78,141 deaths. The total number of deaths highlights the scale of mortality in the Commonwealth, while life expectancy trends reveal how social determinants, access to care, and structural inequities continue to shape population health. Monitoring both measures is essential for identifying at-risk populations, guiding prevention strategies, and promoting health equity across Virginia.

Life expectancy in Virginia has fluctuated in recent years, with sharp declines observed in 2020 and 2021 during the COVID-19 pandemic, followed by partial recovery through 2023.

Despite these improvements, disparities remain evident across gender, race, and ethnicity. Asian and Pacific Islander residents consistently experience the highest life expectancy, averaging 87 years in 2024, while Black non-Hispanic residents face the lowest, with averages near 76 years in 2023. Females continue to outlive males, reflecting a persistent gender gap in longevity (Figure 2).

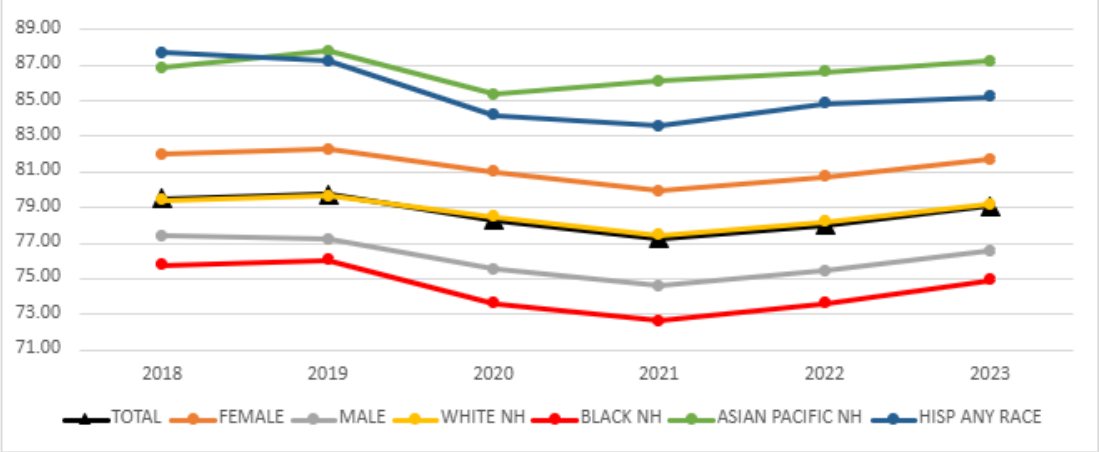


Figure 2: Life Expectancy by Gender, Race and Hispanic Origin from 2018 to 2024
Data Source: The Virginia Department of Health, Office of Information Management

Mortality in Virginia continues to be dominated by heart disease and cancer (Table 2). Together, these two conditions accounted for more than 31,000 deaths, with heart disease (16,449 deaths, 21.2%) narrowly surpassing cancer (15,287 deaths, 20.5%) as the top cause of mortality. These two causes alone represented more than two out of every five deaths in the state, underscoring the critical importance of chronic disease prevention and management strategies. More information is included in the Chronic Disease section of this report.

Table 2. Top 10 Leading Causes of Death in Virginia in 2023 (% of Total Deaths).

Leading Causes of Death	Number of Deaths	% of Total Deaths
Diseases of heart	16,449	21.23
Cancer	15,287	20.53
Accidents (unintentional injuries)	5,112	6.54
Cerebrovascular diseases	4,151	5.57
Chronic lower respiratory diseases	3,441	4.40
Diabetes mellitus	2,610	3.34
Alzheimer disease	2,289	2.93
Drug overdoses	2,151	2.89
Nephritis, nephrotic syndrome and nephrosis	1,561	2.00
COVID-19	1,368	1.75
Total Deaths in Virginia (2023)	78,141	

Data Source: The Virginia Department of Health, Office of Vital Records

Beyond these leading causes, several other health conditions contributed significantly to mortality. Accidents and unintentional injuries were the third leading cause, responsible for

5,112 deaths (6.5%), reflecting ongoing concerns about injury prevention, roadway safety, and accidents attributed to being under the influence of substances. Cerebrovascular diseases, such as stroke, led to 4,151deaths (5.6%), while chronic lower respiratory diseases accounted for 3,441 deaths (4.4%). These conditions emphasize the need for targeted interventions around cardiovascular health, smoking cessation, and environmental health factors. Other notable contributors included diabetes mellitus (2,610 deaths, 3.3%) and Alzheimer's disease (2,289 deaths, 2.9%), both of which reflect the intersection of aging populations and chronic health burdens. Drug overdoses claimed 2,151 lives (2.9%), making them one of the top ten causes of death in Virginia. This figure highlights the ongoing opioid crisis and reinforces the urgency of prevention, treatment, and harm reduction efforts across the state. Conditions such as kidney disease (1,561 deaths, 2.0%) and COVID-19 (1,368 deaths, 1.8%) also remain notable contributors to leading causes of death across the Commonwealth. While COVID-19 deaths have declined compared to prior years, the continued presence of the virus in the top ten causes of death demonstrates its lingering impact on public health.

Virginia registered 52,592 marriages and 23,191 divorces in FY2024; however, only 5,442 divorce certificates were requested and issued during the fiscal year.

CHRONIC DISEASES

Chronic diseases are the leading causes of illness, disability, and death in both Virginia and the United States. These conditions typically persist for one year or longer and require continuous medical care. Additionally, they can significantly restrict a person's ability to perform everyday activities. In 2023, there were 53,348 deaths among Virginians related to common chronic conditions. Heart disease and stroke are significant causes of death in Virginia, with hypertension and smoking, including electronic cigarette (e-cigarette) use, being considered as important risk factors that can contribute to poor health outcomes.

Chronic diseases affect a substantial portion of Virginia's population, with several conditions showing particularly high prevalence rates (Table 3). Nearly 40% of Virginians are affected by high cholesterol and over 35% of Virginians have been diagnosed with hypertension (high blood pressure). These cardiovascular risk factors highlight a significant public health concern, as heart disease has been the leading cause of death for Virginians (Table 2).

Other chronic conditions like arthritis (27.1%), diabetes (11.8%), current and lifetime asthma (10.2% and 15.9%, respectively), chronic obstructive pulmonary disease (COPD) (6.9%), and chronic kidney disease (4.2%) also contribute to the overall burden of chronic diseases, alongside cardiovascular conditions such as heart disease (4.3%) and stroke (3.7%).

By race, Black adult Virginians have the highest prevalence of asthma (current and lifetime), chronic kidney disease, chronic obstructive pulmonary disease, diabetes, hypertension, and stroke, while White adult Virginians have the highest prevalence of arthritis and high blood cholesterol. Additionally, females in Virginia exhibit the highest prevalence of arthritis, both current and lifetime asthma, COPD, and stroke, whereas males have highest prevalence of heart disease, high blood cholesterol, and hypertension. Prevalence rates for chronic kidney disease and diabetes were similar between females and males.

Overall, these figures emphasize the critical importance of targeted prevention, early detection, and effective management strategies for chronic diseases in Virginia to improve quality of life across the Commonwealth.

Table 3. Prevalence of Chronic Diseases in Virginia – Overall, By Race, and By Gender in 2023.

Chronic Disease	Total Prevalence (%)	Prevalence by Race (%)				Prevalence by Sex (%)	
		Black	Hispanic	White	Other	Female	Male
Arthritis	27.1	28.7	7.8	30.9	20.5	30.5	23.4
Asthma (Current)	10.2	12.5	6.6	9.6	12.4	13.1	7.1
Asthma (Lifetime)	15.9	17.4	12.3	15.0	20.0	18	13.6
COPD	6.9	8.0	N/A	7.5	5.3	7.4	6.5
Chronic Kidney Disease	4.2	6.3	N/A	4.1	N/A	4.3	4.2
Diabetes	11.8	16.5	6.2	11.9	8.7	11.8	11.9
Heart Disease	4.3	4.6	N/A	4.6	N/A	4.0	4.6
High Blood Cholesterol	39.3	36.2	28.6	42.1	38.8	37.5	41.3
Hypertension	35.6	45.0	17.5	37.4	25.3	33.7	37.6
Stroke	3.7	5.5	N/A	4.1	N/A	4.1	3.3

Data Source: The Virginia Department of Health, Office of Family Health Services

Chronic disease remains a significant public health problem in Virginia. Despite recent declines in mortality rates, both conditions continue to show stark disparities by race, sex, and age—especially among Black or African American residents and older adults. These findings underscore the importance of continued, targeted intervention through surveillance, prevention, and equity-focused cardiovascular programs. Addressing these chronic disease trends will require sustained investment, community engagement, and cross-sector collaboration.

HEART DISEASE

Heart disease was the leading cause of death in Virginia between 2019 and 2023. In 2023, 16,449 deaths were attributed to heart disease in Virginia. The age-adjusted mortality rate per 100,000 population for heart disease decreased from 165.5 deaths in 2021 to 152.5 deaths in 2023, which was a 9% decrease. While the state mortality rate from heart disease decreased in 2023, there continue to be groups in Virginia that are disproportionately affected:

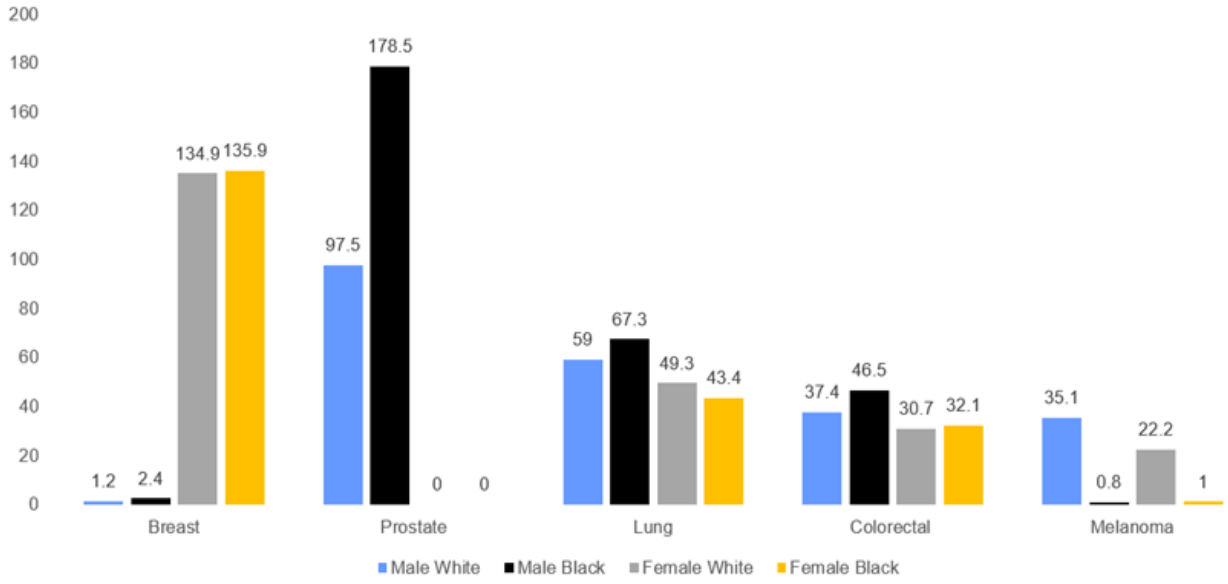
- The age-adjusted mortality rate among Black or African Americans was 185.2 deaths per 100,000 population, 21% higher than the overall state mortality rate.
- Males had an age-adjusted mortality rate of 184.5 per 100,000 population, 47% higher compared to 125.1 deaths per 100,000 for females.
- The highest age-adjusted mortality rate from heart disease was observed in Virginians 75 years and older, with 97.6 deaths per 100,000 population.

CANCER

In 2023, cancer was the second leading cause of death among Virginians and remains a major concern for chronic disease, with an all-sites incidence rate of 415 per 100,000 between 2019 and 2023. Prostate cancer has the highest incidence rate, particularly among Black males (178.5 per 100,000), followed by White males (97.5 per 100,000). Breast cancer is the most common cancer among women, with incidence rates nearly identical for White females (134.9 per 100,000) and Black females (135.9 per 100,000). Lung cancer incidence is highest among

Black males (67.3 per 100,000), while colorectal cancer affects both sexes and races more evenly, though rates are slightly higher in Black populations. Melanoma is most common among White males (22.2 per 100,000) and White females (35.1 per 100,000), with very low incidence among Black populations (Figure 3).

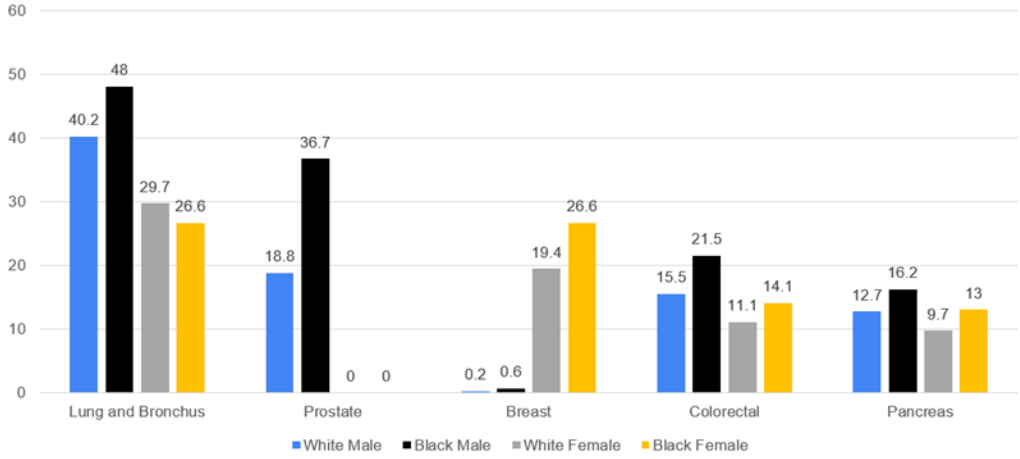
Figure 3. Incidence Rate for Virginia's Top Five Leading Cancers, 2018-2022



Source: Virginia Cancer Registry

Lung and bronchus cancer is the leading cause of cancer mortality, with Black males experiencing the highest mortality (48 per 100,000), followed by White males (40.2 per 100,000). Prostate cancer mortality is almost double among Black males (36.7 per 100,000) compared to White males (18.8 per 100,000). Despite approximately equal incidence, breast cancer deaths are highest among Black females (26.6 per 100,000), exceeding White females (19.4 per 100,000). Colorectal cancer mortality is elevated in Black males (21.5 per 100,000), while pancreatic cancer shows notable mortality burdens across all groups, with the highest among Black males (16.2 per 100,000) (Figure 4). Overall, this data reveals that while cancer incidence varies by sex and race, mortality disparities are especially pronounced, with Black male populations bearing the greatest burden of deaths from prostate, lung, breast, and colorectal cancers.

Figure 4. Mortality Rates for Virginia's Top Five Leading Cancers, 2019-2023



Source: Virginia Cancer Registry

VDH has established several programs designed to address cancer rates across the Commonwealth, including the Virginia Cancer Registry (VCR), Every Woman's Life (EWL), and the Virginia Comprehensive Cancer Control Program (VACCCP). The VCR plays a central role in documenting the cancer burden across the Commonwealth and serves as the statewide repository of data on all individuals diagnosed or treated for cancer in Virginia. Mandated by the Code of Virginia (§§ 32.1-70, 32.1-70.2, and 32.1-71), the VCR provides the foundation for cancer surveillance, research, and evidence-based public health action, ensuring that Virginia remains equipped to monitor cancer trends and respond effectively to this ongoing public health challenge**.**

The EWL program is Virginia's breast and cervical cancer screening program, designed to expand access to life-saving screening and diagnostic services for low-income, uninsured Virginians. Breast and cervical cancer screenings are among the most effective tools for reducing cancer mortality and health care costs. Biennial breast cancer screening for women aged 50–74 reduces breast cancer deaths by 26% compared to no screening. However, current resources fall far short of meeting need. According to 2022 Census data, 20,472 Virginia women aged 40–64 are eligible for EWL services, yet funding in FY25 allowed the program to serve only 6,471. This gap underscores the need for additional state investment to expand early detection resources for Virginia's high-risk populations. Since its inception in 1997, EWL has made significant strides: serving more than 76,000 Virginians, delivering over 221,000 breast and cervical screenings, and diagnosing 3,915 breast and cervical cancers (including pre-cancers). Expanding this program would further reduce preventable morbidity and mortality and associated costs, ensuring equitable access to care for vulnerable populations.

The VACCCP leads collaborative efforts to reduce the cancer burden statewide through implementation of the Virginia Cancer Plan (VCP). Working closely with the Cancer Action Coalition of Virginia (CACV), the VACCCP focuses on prevention, early detection, diagnosis and treatment, survivorship and palliative care, and the unique needs of pediatric, adolescent, and young adult cancer populations. Recent efforts include installing 738 sunscreen dispensers statewide with educational support, increasing HPV vaccination rates by 27% through partnerships and quality improvement initiatives, and expanding psychosocial support for 388 cancer survivors through community-based funding. These efforts illustrate VACCCP's

commitment to addressing cancer across the continuum of care while building healthier, more resilient communities.

Addressing cancer through surveillance, prevention, and control is a vital part of the state's public health strategy. Many cancer risk factors overlap with other chronic conditions, making a comprehensive approach impactful. While evidence-based screening exists for four of the top five cancers in Virginia (breast, colorectal, lung, and prostate), disparities in late-stage diagnoses and mortality persist across geography, race, and sex. Additionally, as of January 1, 2025, Virginia is home to an estimated 483,190 cancer survivors needing continued support. To effectively address cancer-related issues across the full continuum of care, increased funding is needed to support the VDH cancer program.

DETERMINANTS OF HEALTH

EDUCATION ACCESS AND QUALITY

Educational attainment and student stability highlight important aspects of well-being in Virginia. Among residents over the age of 25, 5.1% have some high school education without earning a diploma, while 23.9% hold a high school diploma or equivalent. Higher education is also well represented, with 23.3% of Virginians earning a bachelor's degree and 18.1% holding a graduate or professional degree. Despite these achievements, challenges remain for younger populations. During the 2024–2025 school year, 11,206 students in grades Pre-K through 12 were identified as lacking a fixed, regular, and adequate nighttime residence, with housing instability potentially inhibiting educational success.[2]

HEALTH CARE ACCESS AND QUALITY

In 2022, the state's supply of primary care providers (84.6 per 100,000 residents) closely mirrored the national average (83.8 per 100,000 residents).[3] In 2022, dental providers in Virginia (75 per 100,000 residents) slightly outpaced national figures (73.4 per 100,000 residents). Yet mental health care remained a weak spot, as of 2024, Virginia had 23,001 total mental health providers, (264 per 100,000 residents). While this is a significant number, it falls short of the national rate (332.6 per 100,000). This gap suggests that mental health services in Virginia may be less accessible compared to the national average, highlighting a potential area for resource expansion.

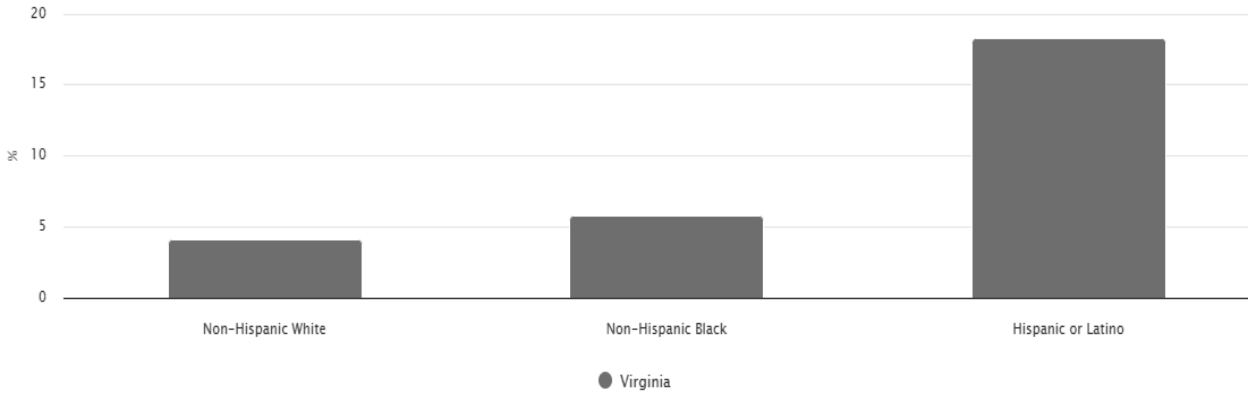
In 2023, Virginia had 87,873 uninsured children under the age of 19, accounting for 4.52% of the state's child population. This is somewhat better than the national average of 5.35%. However, disparities in uninsured rates are evident across racial and ethnic groups in Virginia. Non-Hispanic White children had an uninsured rate of 4.10%, Non-Hispanic Black children had an uninsured rate at 5.8%, and Hispanic or Latino children faced the highest

[2] Virginia Department of Education. (2025). *Enrollment & demographics*. Virginia Department of Education. Retrieved October 3, 2025, from https://www.doe.virginia.gov/data-policy-funding/data-reports/statistics-reports/enrollment-demographics

[3] American Medical Association. (2022). *AMA physician professional data and U.S. Census Bureau estimates of state population totals for 2022*. U.S. Census Bureau. https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html

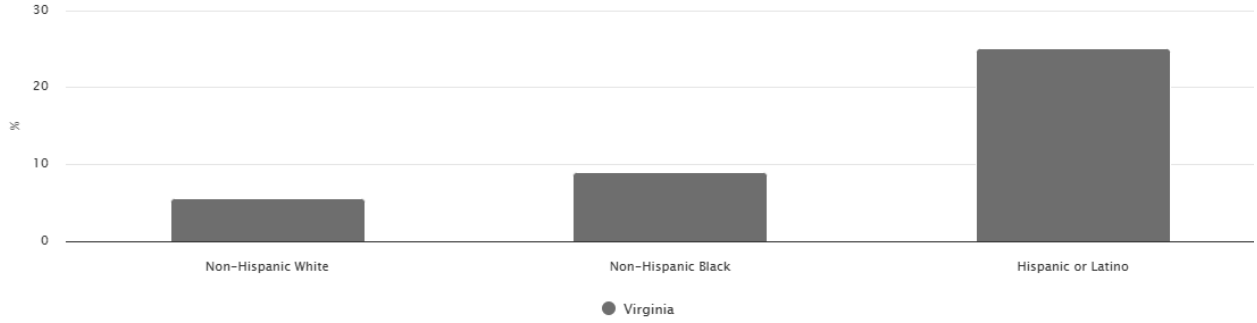
uninsured rate, 18.3% (Figure 5). Among adults aged 18-64 in Virginia, 8.60% (approximately 443,783 individuals) were uninsured, a rate below the national uninsured rate of 11.02%. Racial and ethnic disparities also persist in Virginia's adult uninsured rates. Non-Hispanic White adults had a 5.6% uninsured rate, Non-Hispanic Black adults had a higher rate at 8.9%, and Hispanic or Latino adults experienced a substantially higher uninsured rate of 25% (Figure 6). These figures indicate significant disparities in health insurance coverage, especially among Virginia's Hispanic or Latino children and adult populations, which stem in part from systemic barriers such as language access, immigration status, and employment in sectors less likely to offer health benefits.

Figure 5: Uninsured Population Under 19 in Virginia, by Race and Hispanic Ethnicity, Percent



Source: US Census Bureau, Small Area Health Insurance Estimates. 2023.

Figure 6: Uninsured Population Age 18- 64 in Virginia by Race and Hispanic Ethnicity, Percent



Source: US Census Bureau, Small Area Health Insurance Estimates. 2023.

Even among the insured, affordability remains a challenge. Over 634,000 Virginia adults (9.2% of the population) delayed medical care due to cost, underscoring that coverage alone doesn't guarantee access. For Virginia to move toward greater health equity, it must address not only provider shortages, insurance gaps, and cost of care, but also the racial and economic disparities that exist throughout those and other factors.

State Telehealth Plan

Virginia's Statewide Telehealth Plan, as outlined in § 32.1-122.03 (B) of the Code of Virginia, mandates the development and maintenance of a comprehensive telehealth strategy by

the State Board of Health. This plan aims to promote an integrated approach to the introduction and use of telehealth and telemedicine services across various sectors, including hospitals, primary care facilities, schools, and emergency medical services. The Board is required to consult with the Virginia Telehealth Network (VTN) or a similar Virginia-based nonprofit organization to provide direct consultation, track implementation, and facilitate updates to the plan as medical practices and technologies evolve to support telehealth efforts across the Commonwealth. The original (2021-2025) version of the Plan was adopted by the Board of Health in 2021. Starting in 2024, VDH and VTN worked with relevant stakeholders to review and revise the original version in the development of the 2026-2030 version of the Plan. The updated version was approved by the Board of Health in June of 2025.[4]

State Rural Health Plan

The Virginia State Office of Rural Health (VA-SORH) was established in 1991 with the purpose of creating, funding, and supporting a quality and sustainable rural healthcare infrastructure across the Commonwealth of Virginia. Operating within VDH's Office of Health Equity. The office's mission centers on partnering with rural communities to identify effective strategies and solutions that promote the health and prosperity of rural Virginians. To fulfill this mission, VA-SORH provides vital technical assistance (TA), regulatory updates, resources, and fosters opportunities for collaboration with communities statewide. In response to evolving rural health needs and those that developed amid the challenges of the COVID-19 pandemic, VA-SORH developed the 2022-2026 Virginia Rural Health Plan with input from key stakeholders. This plan emphasizes the strengths of Virginia's rural communities and focuses on seven priority areas: education, broadband access, nutrition and food security, healthy moms and babies, access to healthcare services, behavioral health including substance use disorder and recovery, and employment and workforce development. From the seven priority areas, the Virginia State Office of Rural Health has selected three to study and monitor longitudinally: nutrition and food security, healthy moms and babies, and employment and workforce development. These focus areas provide a comprehensive evaluation of the overall health and well-being of Virginia's rural communities and represent domains where the VDH holds the greatest influence. Looking ahead, a new plan is anticipated to be drafted in 2026 to continue addressing rural health priorities in Virginia.

HOUSING, TRANSPORTATION, AND ECONOMIC SECURITY

In 2023, an estimated 834,836 Virginians, about 10% of the state's population, lived below the federal poverty level (FPL). Approximately 1,964,400 people (23%) lived below 200% of the FPL. Economic hardship has profound implications for health, as lower income is often associated with reduced access to healthcare, nutritious food, safe housing, and preventive services, all of which contribute to health outcomes and life expectancy. The GINI Index measures income inequality, with scores ranging from 0 (perfect equality, where everyone has the same income) to 1 (perfect inequality, where one person has all the income). Using this index, Virginia scored 0.47, which reflects disparities in how resources are distributed across the state. High inequality can contribute to social stratification, stress, and unequal access to health-promoting opportunities, further perpetuating disparities in health outcomes.

[4] Virginia Department of Health. (2025). *Virginia State Telehealth Plan 2026–2030*. https://www.vdh.virginia.gov/content/uploads/sites/4/2026-2030-State-Telehealth-Plan.pdf

Virginia maintains one of the lower homelessness rates in the nation. At 8 per 10,000 people, the state's homelessness rate is significantly below the national average of 19.4 per 10,000, ranking Virginia 5th lowest among all 50 states. Despite this, an estimated 7,141 individuals experience homelessness in the Commonwealth, including 1,153 children less than 18 years old, 389 veterans, and 3,454 individuals identifying as Black/African American.

Housing affordability is another critical determinant of health. In 2023, more than 887,500 households in Virginia (27% of all households) were considered cost burdened, indicating that they spent more than 30% of their income on housing. High housing costs can force families to make difficult trade-offs between paying for shelter and covering other essentials such as healthcare, transportation, or food. Similarly, reliable transportation is essential for accessing medical care, employment, education, and grocery stores. In Virginia, 199,529 households (6%) did not have access to a motor vehicle in 2023.[5]

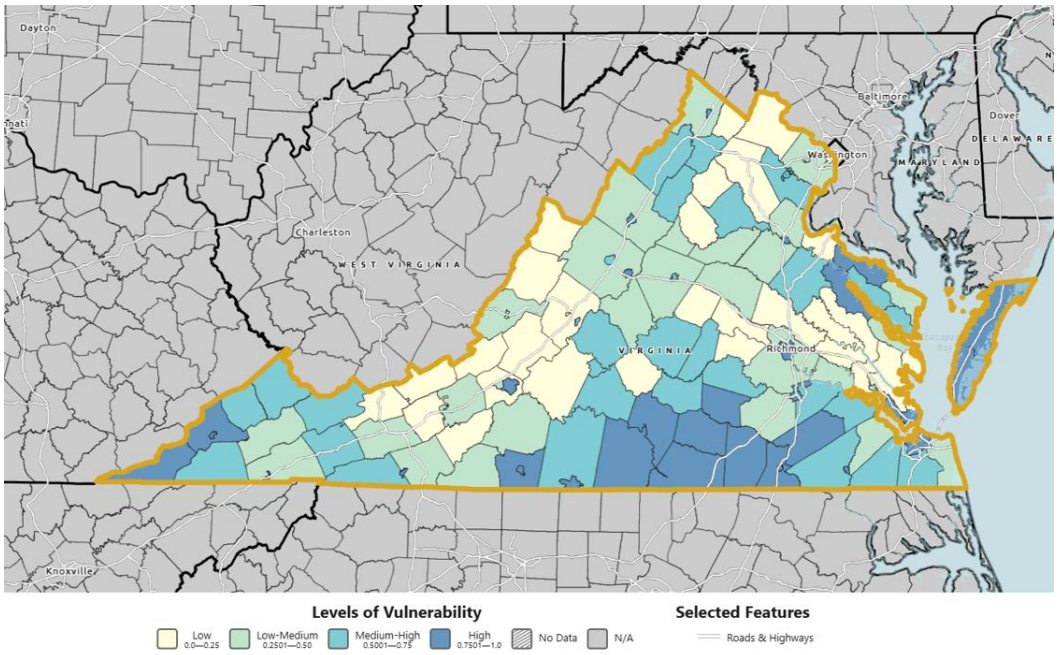
Food access and security are closely related to economic pressures, including housing and transportation. In Virginia, 44.9% of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits include children, while 18.1% of births in 2023 reported use of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Together, these data points illustrate the interconnected challenges of housing, homelessness, and food insecurity, all of which directly affect the well-being of Virginia families[5].

SOCIAL AND COMMUNITY CONTEXT

The Social Vulnerability Index (SVI) is used to identify communities that are considered to be more "at-risk," with a score of zero indicating low vulnerability and a scale of one indicating high vulnerability. Communities with higher vulnerability may be less able to prepare for, respond to, and recover from emergencies, whether they are natural disasters, environmental hazards, or public health crises. Virginia's SVI score of 0.39 in 2022 reflects moderate vulnerability when considering combined demographic and socioeconomic factors such as poverty, transportation access, and housing conditions (Figure 7). Addressing these interconnected housing, transportation, and economic challenges is vital for improving health equity and building resilient communities across the Commonwealth.

[5] U.S. Census Bureau. (2024). *American Community Survey: 2019–2023 (5-year estimates)*. https://www.census.gov/programs-surveys/acs/

Figure 7: Social Vulnerability Index (SVI) in Virginia



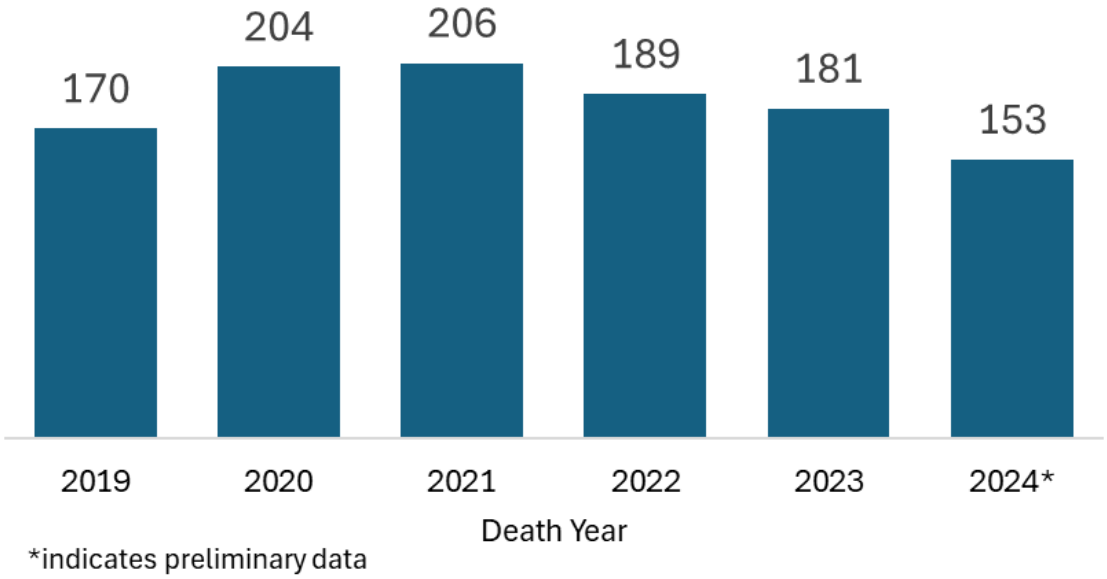
MENTAL HEALTH

Mental health is defined by emotional, psychological, and social well-being, which can be influenced by what an individual does to impact their well-being. It can also be attributed to how a person handles stress and makes healthy choices. Mental health is essential in every stage of life, from childhood and adolescence through adulthood, with both mental and physical health impacting overall health and can increase the risk for developing many types of chronic conditions.

YOUTH SUICIDE PREVENTION

In Virginia, youth suicide prevention is a coordinated, multi-agency effort led by the VDH under the authority of Code of Virginia § 32.1-73.7. According to the Virginia Youth Survey, 33.4% of public high school students reported feeling sad or hopeless almost every day for two or more weeks in 2023, a significant increase from 25.7% in 2013. Feelings of sadness or hopelessness peaked among public high school students in 2021, at 38.2%. Almost one in five (18.4%) of Virginia public middle school students who responded to the Virginia Youth Survey also reported their mental health as not good most of the time or always. From 2019 to 2023, suicide deaths among Virginia residents aged 10-24 years peaked in 2021 at 206 deaths (Figure 8); on average, there were 190 suicide deaths among Virginia youth each year. Most suicide deaths among youth were male (82%), White (61%), older youth aged 20-24 years (60%), and by firearm (58%) from 2019 to 2023. Preliminary data from 2024 show there were 153 suicide deaths among Virginia residents aged 10-24 years, a 15% decrease from 2023.

Figure 8: Suicide Deaths Among Virginia Residents Aged 10-24 years, 2019-2024



Source: Virginia Department of Health, Division of Health Statistics

The VDH Suicide Systems Project (SSP)

In Virginia, youth suicide prevention is a coordinated, multi-agency effort led by the VDH under the authority of Code of Virginia § 32.1-73.7. The Suicide Systems Project (SSP) is an upstream prevention program which acts as a federal passthrough, TA hub, and leader in the coordination of suicide prevention efforts across the Commonwealth. Since 2001, the VDH SSP has received funding through a variety of cooperative agreements from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), Office of Women's Health, and Health Resources and Services Administration Maternal Child Health Division (HRSA MCH) to address gaps in the suicide prevention continuum of care. This program does not receive any dedicated state funding for the prevention of youth suicide.

The VDH SSP, housed within the Office of Family Health Services' Division of Prevention and Health Promotion, takes a systems approach to addressing suicide, recognizing that no single linear strategy can fully resolve the issue. Instead, the SSP employs a multipronged, dynamic framework that emphasizes shaping the environments in which Virginians live and interact to reduce the likelihood of suicide attempts before they occur. This proactive, prevention-oriented approach is well-suited to the public health workforce, which has long relied on data collection, identifying drivers of poor health outcomes, and navigating complex systems to improve health. Through its TA hub model, the SSP supports suicide prevention efforts across diverse environments by providing training, capacity building, gap identification, policy development, best-practice guidance, and partner convening to strengthen comprehensive strategies for suicide prevention across the Commonwealth.

Virginia Mental Health Access Program (VMAP)

The Virginia Mental Health Access Program (VMAP) is a statewide initiative partially funded by the VDH designed to bolster mental, behavioral, and emotional health support across Virginia. VMAP focuses on supporting infants, children, adolescents, young adults, as well as

pregnant and postpartum individuals by equipping medical providers with the tools, training, and consultation services needed to improve mental health outcomes.

VMAP addresses critical barriers to access, with 100% of the state's localities being designated as mental health professional shortage areas. Additionally, about 65% of pediatricians report that they lack sufficient training in pediatric mental health. In response, VMAP has trained over 1,100 primary care providers to screen, diagnose, and manage pediatric mental health concerns and offers a VMAP Line that provides same-day mental health consults and care navigation support for providers.

As of 2024, 2,313 primary care providers (PCPs) were registered with VMAP. A 26% increase from the previous year. VMAP enabled 8,236 calls through its consult line, resulting in 5,476 mental health consultations and 9,859 care navigation requests, directly supporting 6,691 pediatric patients.

MATERNAL AND CHILD HEALTH

INFANT MORTALITY

Infant mortality rate (IMR) is defined as the death of a baby before reaching one year of age, per 1,000 live births. Between 2021 and 2024, Virginia's IMR remained stable from 5.9 deaths per 1,000 live births (566 infant deaths) to a preliminary estimate of 6.0 deaths per 1,000 live births in 2024 (561 infant deaths). In 2021, Black or African American infants had the highest rate at 10.0 deaths per 1,000 live births—more than double the rates for White infants (4.6) and Asian or Pacific Islander infants (3.9). Hispanic infants experienced a higher rate at 6.5, reflecting broader inequities in maternal and child health. By 2024, preliminary data show mixed progress across groups. Infant mortality decreased slightly among Asian or Pacific Islander infants (from 3.9 to 3.7) and White infants (from 4.6 to 4.3), while the rate among Hispanic infants fell from 6.5 to 5.4. In contrast, the rate for Black or African American infants increased to 12.2, further widening an already significant disparity. These patterns highlight the ongoing need for targeted, equity-focused interventions to improve outcomes for disproportionately affected communities.

Strategies such as supporting the development of health practices like transportation safety, safe sleep habits, and supporting mom and baby with information, resources, and referrals are needed to reduce the IMR in Virginia.

MATERNAL MORTALITY

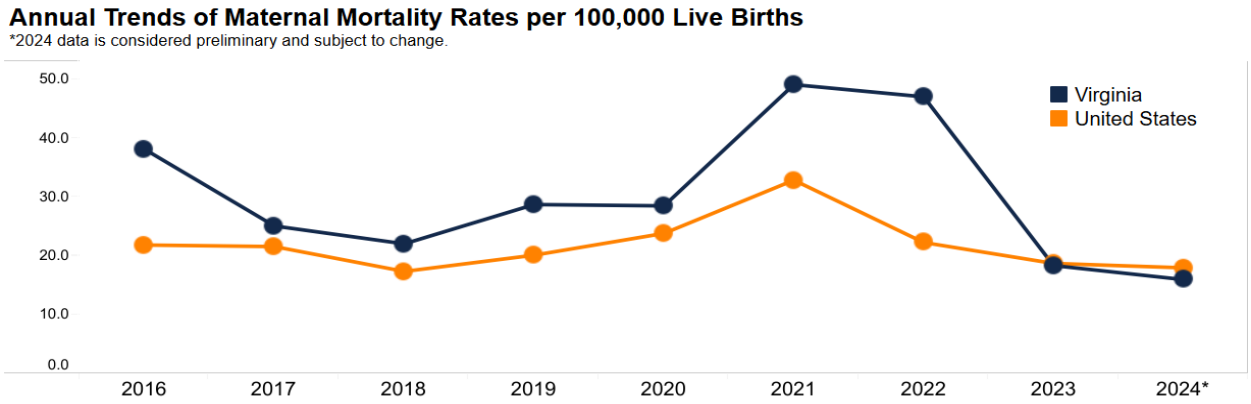
Maternal mortality rate (MMR), as defined by the World Health Organization (WHO), refers to the death of an individual during pregnancy or within 42 days following the end from causes related to or aggravated by the pregnancy or its management. However, this definition may not fully capture the broader scope of mortality experienced by pregnant and postpartum individuals, particularly in cases where complications arise beyond the 42-day window or where social determinants contribute to adverse outcomes. Maternal deaths do not only represent profound personal loss but also serve as a critical indicator of the effectiveness and responsiveness of a healthcare system.

In 2021, Virginia's MMR fell from 47.1 deaths per 100,000 live births (47 maternal deaths) to a preliminary estimate of 16.0 deaths per 100,000 live births in 2024 (15 maternal

deaths), with improvements across all racial and ethnic groups (Figure 9). Despite this, Black or African American mothers consistently faced the highest MMR: 101.6 in 2021, which was more than double the state average, declining to 52.4 in 2024 according to preliminary data, which is still over three times higher than the statewide rate.

Other racial and ethnic groups also saw substantial improvements. The MMR for Hispanic mothers dropped from 26.6 in 2021 to 5.9 in 2024, while the rate for White mothers declined from 41.9 to 8.3 over the same period. The rate for Asian or Pacific Islander mothers remained relatively stable, decreasing slightly from 13.6 in 2021 to 13.3 in 2024. These trends show overall improvement but highlight persistent disparities that require targeted action to improve maternal health outcomes.

Figure 9: Annual Trends of Maternal Mortality Rate in Virginia and United States from 2016-2024



Source: Virginia Department of Health, Division of Health Statistics

Maternal Mortality Review Team (MMRT)

VDH has established programs designed to address maternal mortality, including the Maternal Mortality Review Team (MMRT), which plays a critical role in safeguarding the health and lives of women in Virginia by identifying, reviewing, and analyzing all pregnancy-associated deaths in the Commonwealth. Established in 2002 as a partnership between the Office of Family Health Services and the Office of the Chief Medical Examiner, the MMRT was codified in 2019 under § 32.1-283.8 of the Code of Virginia. The MMRT reflects a broad spectrum of expertise, including physicians, midwives, nurses, social workers, dietitians, public health officials, hospital administrators, and representatives from professional associations and advocacy organizations. This diversity ensures a comprehensive evaluation of each case and supports the development of well-rounded, evidence-based recommendations.

The MMRT's work is guided by the Pregnancy-Associated Mortality Surveillance System (PAMSS), which uses multiple data sources, including death certificates, birth and fetal death records, the Virginia Violent Death Reporting System, and medical and autopsy records to identify women who were pregnant within 365 days of their death. Each case undergoes a thorough review process to confirm eligibility, determine the circumstances surrounding the death, and assess contributing factors at the community, patient, healthcare facility, and provider levels. Using consensus decision-making, the MMRT evaluates whether each death was pregnancy-related, whether it was preventable, and what specific changes in care could have improved outcomes.

Through this review process, the MMRT generates actionable recommendations to improve clinical practices, strengthen healthcare systems, address community-level barriers, and inform public health policy. The MMRT's work has direct implications for reducing preventable maternal deaths, improving maternal health outcomes, and advancing health equity for women across Virginia. By bridging the gap between data and intervention, the MMRT serves as both a watchdog and a catalyst for change in maternal health care statewide.

Virginia Mental Health Access Program (VMAP) for Moms+

VDH has also established the Virginia Mental Health Access Program (VMAP) for Moms +, an expansion of the VMAP program possible due to additional funding in 2023 and 2024. Perinatal mental health issues are the leading cause of maternal mortality in America and, when ignored, can lead to adverse health outcomes, including preterm delivery and difficulty bonding with the child. VMAP Moms + focuses on pregnant and postpartum individuals by equipping medical providers with the tools, training, and consultation services needed to improve mental health outcomes. VMAP for Moms+ launched to provide additional support to providers caring for pregnant and postpartum patients and their families. VMAP for Moms+ also initiated Perinatal Education for Advanced Clinical Expertise (PEACE), a training that assist practitioners aid mental health conditions in pregnant and postpartum individuals. The first PEACE training was successfully piloted in November 2024.

Community Doulas

Community doulas help lower maternal mortality rates by improving access to care through system coordination and navigation. Virginia was the 4th state in the nation to offer community doula services as a benefit for Medicaid members. Leaders from both VDH and the Department for Medical Assistance Services (DMAS) collectively provided input and direction into both the state certification and reimbursement processes. Both initiatives went into full effect in early 2022. To date, there are 217 state-certified doulas, and the majority of these doulas serve Medicaid members and other underrepresented communities across the Commonwealth, which addresses disparities in maternal mortality.

Maternal and Child Health Dashboard

In 2025, VDH released two new dashboards to track maternal mortality and pregnancy-associated deaths, as well as an upgraded Maternal and Child Health (MCH) Dashboard that breaks down preterm birth, infant mortality, low birthweight and prenatal care data by region, race, and ethnicity. These dashboards serve as a next key step to raise awareness and push for systemic changes to improve maternal outcomes for Black women.

Women, Infant, And Children (WIC)

The special supplemental nutrition program for women, infants, and children (WIC) is designed to improve health outcomes for pregnant women, infants, and children under the age of five by promoting nutrition and access to health services. WIC provides nutrition education, breastfeeding promotion and support, supplemental nutritious foods, counseling at WIC clinics, and screening and referrals to other health, welfare, and social services. To be eligible for the WIC program, applicants must meet categorical, residential, income, and nutrition risk requirements.

Maternal, Infant, And Early Childhood Home Visiting (MIECHV)

The Maternal, Infant, And Early Childhood Home Visiting (MIECHV) Program supports pregnant women, families, and at-risk parents of children from birth to age five by connecting them with resources and helping them build the skills needed to raise healthy, school-ready children. The program enhances maternal and child health, prevents child abuse and neglect, promotes positive parenting, and supports early childhood development and school readiness. Administered by VDH and overseen by the Virginia home visiting consortium, MIECHV provides funding to expand evidence-based home visiting services and strengthen early childhood systems at both the state and local levels. Between September 30, 2024, and September 29, 2025, the MIECHV program served 1,451 adults and 1,253 children across 1,378 households. Postpartum care improved year over year: in FY24, 53.9% of mothers received a postpartum visit with a healthcare provider within eight weeks of delivery, compared to 66.2% in FY25.

Healthy Start Program

The Virginia Healthy Start Initiative, known as Loving Steps, is part of a national effort to improve the health and well-being of pregnant and postpartum women, infants, and families. This program focuses on communities experiencing persistently high infant mortality rates (IMR) and significant perinatal health disparities. Loving Steps operates in Norfolk, Petersburg, Portsmouth, Hopewell, and Westmoreland County, locations chosen because of persistently high infant mortality rates and significant perinatal health inequities

Loving Steps is grounded in the Five Healthy Start Approaches, which guide its interventions and community partnerships. The program focuses on improving women's health before, during, and after pregnancy; promoting high-quality, standardized maternal and infant health services; and strengthening family resilience by engaging both parents and addressing the underlying stressors that contribute to poor birth outcomes. Loving Steps also works to achieve collective impact by serving as a community hub that coordinates partners and drives systemwide improvements. Accountability is strengthened through continuous quality improvement, performance monitoring, and evaluation.

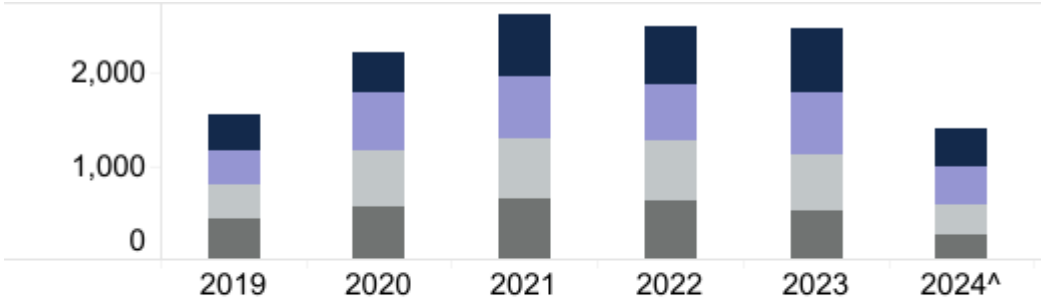
Through these coordinated strategies, Loving Steps supports case management, care coordination, education, screening, and referrals that directly benefit participating families. Recent progress demonstrates the program's impact: between April 1, 2024, and March 31, 2025, 80.4% of enrolled clients completed a postpartum visit, an important measure for preventing complications and supporting long-term maternal well-being. Ultimately, Loving Steps plays a crucial role in reducing preventable infant deaths, improving maternal health, and expanding opportunities for healthier pregnancies and births in communities across Virginia.

SUBSTANCE USE AND OVERDOSE

From 2019 to 2023, Virginia experienced 11,389 drug overdose deaths from all substances, with a crude death rate of 26.4 per 100,000 population in 2023. In that year alone, there were 2,463 drug overdose deaths, marking a 1% decrease from 2022, though still below the 2021 peak of 2,622 deaths (Figure 10). Nearly 79% of these 2023 deaths involved fentanyl,

fentanyl analogs, or tramadol, highlighting the ongoing impact of synthetic opioids. Preliminary 2024 data (as of June 2025) indicate 1,403 drug overdose deaths among Virginia residents, representing a 43% decrease from 2023.

Figure 10: All-Drug Death Count Among Virginia Residents by Quarter (2019-2024)



	2019	2020	2021	2022	2023	2024^
Q1	382	437	675	624	680	403
Q2	371	616	663	605	665	424
Q3	358	598	645	641	597	326
Q4	435	565	639	620	521	250
Total	**1,546**	**2,216**	**2,622**	**2,490**	**2,463**	**1,403**

Data Sources: Virginia Department of Health, Office of Family Health Services

The burden of substance use is also reflected in healthcare utilization. In 2020, Virginia recorded 7,725 hospitalizations related to drug overdoses (89.92 per 100,000 population) and 6,447 hospitalizations for substance use disorder (SUD) (75.05 per 100,000). In 2023, there were 21,881 drug overdose emergency department visits, a 2% decrease from 2022, and 31,360 substance use-related incidents requiring emergency medical services (EMS) to respond. Injection drug use remains a major risk factor for infectious disease transmission, contributing to 30% of acute hepatitis C cases and 55 new HIV diagnoses in 2023 (6% of all new HIV cases).

This data underscores the complex and interconnected health impacts of substance use in Virginia, emphasizing the need for sustained prevention, treatment, harm reduction, and recovery strategies across the Commonwealth.

Naloxone Distribution Program

In FY 2025, VDH's Naloxone Distribution Program provided 158,700 naloxone kits and 355,390 harm reduction test strips, an increase of 10% and 15%, respectively, compared to FY 2024. Notably, VDH expanded program offerings this fiscal year, including offering an additional type of test strip (nitazene test strips; offered in addition to fentanyl, benzodiazepine, and xylazine test strips) and offering select partners access to an additional strength/formulation of naloxone (nasal naloxone 8 mg; VDH also offers nasal naloxone 4 mg and intramuscular naloxone).

In FY 2025, all of VDH's naloxone partners began using a new application and ordering portal, custom built by the Office of Information Management. This portal has significantly streamlined application and order review, improved communication with partners, and increased

data quality for the program. This has allowed VDH to cope with the increased interest in naloxone; VDH maintained agreements with 837 partners in FY 2025, a 30% increase from FY 2024.

VDH continues to share programmatic data with partners, particularly local health departments through a quarterly newsletter. VDH also circulates a quarterly report for local health districts with more detailed data relevant to the health planning region. VDH also maintains a data dashboard for local health districts to view up-to-date information about naloxone and test strip distribution. VDH employs robust communication with partners, including attending conferences, hosting webinars, and holding small group and one on one discussions to hear concerns and raise awareness of naloxone access in Virginia.

Comprehensive Harm Reduction (CHR)

Comprehensive Harm Reduction (CHR) is a core component of Virginia's public health response to the opioid crisis and associated infectious diseases. CHR provides services to people who use drugs and are not yet ready or able to stop using. Services include syringe access, HIV/HCV/STI testing, overdose prevention, linkage to treatment, and other supportive services. As of 2025, Virginia has 15 authorized CHR sites, including four local health districts, two Veterans Administration hospitals, and nine community-based organizations.

Over the past year, CHR services expanded with the authorization of new sites, including Community Access Network (Lynchburg), Nationz Foundation (Henrico, Richmond, and Petersburg), and Strength in Peers (Augusta County, Waynesboro, and Staunton). In FY 2025, 5,987 unique participants made 31,505 visits to CHR sites. These sites distributed over 1.5 million sterile syringes, 11,659 naloxone kits, 12,621 fentanyl test strips, and 129,040 condoms. Participants reported 2,536 overdose reversals, a slight increase from the previous year. Linkages to care included 4,605 connections to mental health or substance use disorder services, 228 to hepatitis C treatment (a 53% increase from the prior year), and five to HIV treatment.

Nonfatal and fatal drug overdoses remain a significant public health issue in Virginia. VDH continues to coordinate an agencywide drug overdose prevention response, including active monitoring and surveillance, primary prevention and rescue initiatives, and CHR efforts. Virginia continues to build upon its substance use disorder work, expertise, and lessons learned from its Centers for Disease Control and Prevention (CDC) previous and current cooperative agreement funding, while simultaneously aligning with shifts in the overdose epidemic. Chapter 487 of the 2025 Acts of Assembly also directed VDH to report certain information to the Department of Health Profession's Prescription Monitoring Program (PMP) when a patient has experienced a nonfatal opioid overdose. Once finalized, this expansion to PMP data will allow prescribers and other providers to make more informed clinical decisions regarding narcotics and other substances with the potential for addiction or misuse.

Opioid Impact Registry

The Code of Virginia § 54.1-3408 directs VDH to develop a Commonwealth opioid impact reduction registry. This registry includes a list of nonprofit organizations that work to reduce the effects of opioid use in the Commonwealth. As part of this effort, VDH has established a process for determining which organizations should be included, defines the criteria

and metrics for inclusion, and assesses the administrative burdens local governments face when procuring services from these organizations in a timely manner.

In alignment with the recommendations provided by the Opioid Impact Registry Report to the General Assembly, 211 Virginia is expanding to serve as the registry. Coordinated through the Virginia Department of Social Services, 211 Virginia is a free, confidential service that connects individuals with information about available community services throughout the Commonwealth, including assistance with substance use. 211 Virginia has launched a landing page specifically for substance abuse resources and is currently working to expand substance use referral blocks. Between June and July of 2025, 211 Virginia piloted a prompt asking platform users if they needed support with substance use, which, if selected, would activate a second prompt providing an option for additional information. As a result, 211 Virginia completed almost 1,500 referrals to 350 resources within a 2-month period.

SMOKING AND E-CIGARETTE USE PREVALENCE

Smoking remains the single largest preventable cause of death and disease, increasing the risk of heart disease, stroke, lung disease, and many types of cancer. Current smoking prevalence among adults 18 years and older in Virginia declined from 14.0% in 2019 to 10.9% in 2023; however, regional disparities remain. In 2023, three out of five regions of Virginia had a smoking prevalence higher than the state (10.9%). Southwestern region of Virginia had the highest smoking prevalence (15.5%), followed by Central region (14.6%) and Eastern region (11.0%) (Table 4).

Table 4. Prevalence of Adults Smokers in Virginia by Region, 2019-2023.

'Current Smoker' Prevalence Among Adults in Virginia					
Region	**2019**	**2020**	**2021**	**2022**	**2023**
Virginia	**14.0%**	**13.6%**	**12.4%**	**12.1%**	**10.9%**
Central	14.9%	13.7%	14.8%	13.6%	14.6%
Eastern	16.2%	15.6%	14.4%	13.7%	11.0%
Northern	8.6%	6.8%	5.5%	6.3%	6.5%
Northwestern	14.1%	15.3%	13.0%	12.5%	9.8%
Southwestern	19.8%	21.3%	19.3%	18.4%	15.5%

Virginia Department of Health, Behavioral Risk Factor Surveillance Survey.

E-cigarette use among adults 18 years and older in Virginia peaked at 7.7% in 2022 and declined slightly to 7.0% in 2023. Two regions of Virginia had a prevalence of e-cigarette use higher than the state prevalence in 2023, including Southwestern Virginia (8.7%) closely followed by Central Virginia (8.6%) (Table 5).

Table 5. Prevalence of Adult E-Cigarette Users in Virginia by Region, 2019-2023.

'Current E-Cigarette' Prevalence Among Adults in Virginia					
Region	**2019**	**2020**	**2021**	**2022**	**2023**
Virginia	**6.4%**	**5.2%**	**6.8%**	**7.7%**	**7.0%**
Central	5.3%	3.2%	7.5%	9.5%	8.6%
Eastern	7.9%	7.5%	8.3%	8.7%	7.0%
Northern	4.1%	4.3%	5.0%	4.9%	5.7%
Northwestern	6.9%	4.9%	8.0%	8.4%	6.1%
Southwestern	9.1%	6.0%	5.8%	8.5%	8.7%

Virginia Department of Health, Behavioral Risk Factor Surveillance Survey.

VDH currently has several programs actively supporting prevention efforts, including the Cardiovascular Health and Stroke Programs, Virginia Stroke Care Quality Improvement Initiative, and the Tobacco Control Program and Cessation Services. Building statewide capacity for population-based chronic disease prevention by funding chronic disease staff at VDH would assist the agency in implementing chronic disease prevention activities, convene clinical-community partnerships to address health disparities, and strengthen data surveillance and monitoring of chronic disease trends and interventions

INFECTIOUS DISEASES

RESPIRATORY ILLNESSES

The 2024-2025 respiratory disease season (including influenza, COVID-19, and RSV) highlighted the persistent and unpredictable burden of respiratory illness on public health and healthcare systems. In Virginia, respiratory illness activity peaked later than in the previous two seasons, during the week ending February 8, 2025. COVID-19 activity remained lower than in prior winters, while influenza activity surged sharply after a delayed onset. Virginia reported six influenza-associated pediatric deaths for the 2024-25 respiratory season, the highest since the 2019-2020 season.

Unusual respiratory illnesses and clinical presentations emerged during the season, including a significant rise in pediatric pneumonia and severe influenza-associated medical complications. In September 2024, Virginia surveillance systems detected a significant rise in emergency department and urgent care visits for pediatric pneumonia. In response, VDH partnered with the Division of Consolidated Laboratory Services (DCLS) to conduct enhanced surveillance and laboratory testing, which identified a range of pathogens, primarily rhinoviruses/enteroviruses and *Mycoplasma pneumoniae*. In February 2025, CDC issued an alert regarding an increase in influenza-associated encephalopathy (IAE), including acute necrotizing encephalopathy (ANE). VDH identified five cases of IAE in Virginia following a national call for cases. Additionally, VDH observed a notable increase in influenza-associated myositis (difficulty walking) and sialadenitis (inflammation of the salivary gland), particularly among children. These situations prompted rapid public health responses, including enhanced surveillance and targeted communication with healthcare providers and the public.

VDH's Respiratory Illness Dashboard, launched in September 2020, integrates multiple data streams to a comprehensive view of respiratory disease trends across Virginia. Public health messaging is amplified through immunization events, paid media campaigns, clinician letters, news releases, and social media outreach. In February 2025, VDH implemented a regulatory variance to Virginia's COVID-19 disease reporting and control regulations. This removed the requirement to report individual COVID-19 cases. This decision aligned with the current epidemiological context and supported a reduced reporting burden for clinicians in Virginia.

In March 2024, a multistate outbreak of influenza A(H5N1) virus in dairy cows raised concerns about public health and U.S. food system integrity. In response, VDH developed emergency response plans, and activated an Incident Command Structure during two H5 detections in birds in Virginia. VDH monitored over 200 individuals exposed to avian influenza and enhanced influenza surveillance systems to improve detection potential. VDH also provided timely recommendations and education to both the public and healthcare providers. While no human or cattle cases have been reported in Virginia to date, the situation underscores the importance of interagency coordination, early detection, and rapid response capabilities.

The 2024-2025 respiratory season demonstrated the unpredictable nature of respiratory pathogens and the critical need for sustained investment in surveillance systems, workforce capacity, immunization infrastructure, and public communication. The season highlighted vulnerabilities in public health infrastructure when rescinded federal funding led to an 83% reduction (10 staff members) of the VDH respiratory disease team in March 2025. Support for the workforce and these programs is essential to protect Virginians and ensure a resilient public health response to both seasonal and emerging threats.

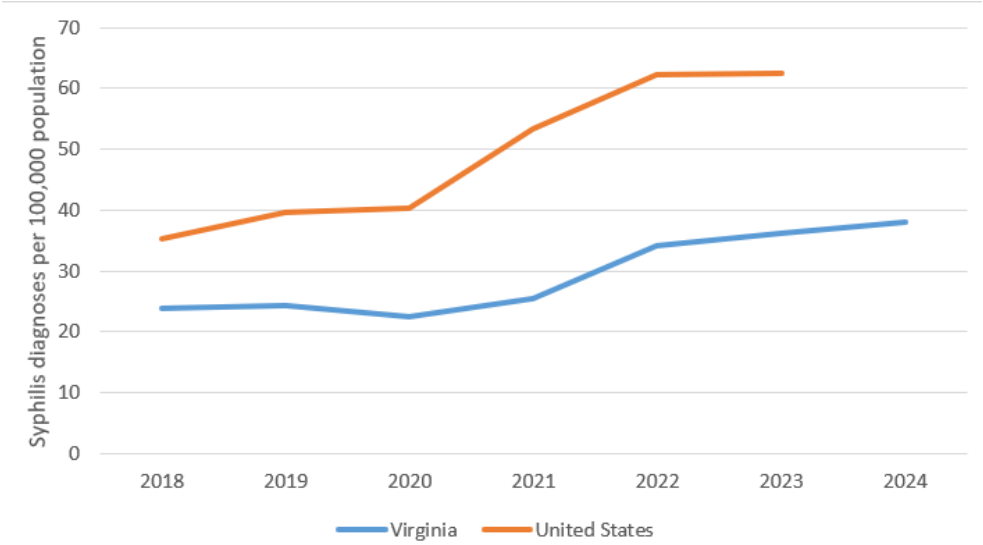
Ahead of the 2025-2026 season, VDH launched "The Little Things" campaign, which brings small but powerful health habits to life by personifying them as unique, helpful characters — each representing an action including: washing hands, covering coughs, or getting immunized. These playful figures work together to promote simple, everyday behaviors that help prevent the spread of respiratory illnesses. By making health habits fun, memorable, and approachable, the campaign encourages people of all ages to adopt small actions that can make a big difference. The campaign materials are available in English and Spanish. The campaign will be shown as a Public Service Announcement campaign and in 45 movie theaters across Virginia.

SYPHILIS

Since 2010, acquired (adult) syphilis rates have been rising in Virginia and across the United States (Centers for Disease Control and Prevention, 2023). Data on nationwide syphilis rates for 2024 were not available when this report was published; however, Virginia 2024 data was included. The increase has been particularly steep since 2020, with syphilis diagnoses surging significantly (Figure 11). In Virginia, the rate of new syphilis diagnoses increased 60.2% from 2020-2024 compared to a nationwide increase of 54.7% between 2020-2023. In 2024, the rate of syphilis was 38.1 cases per 100,000 population in Virginia. Nationwide, there were 62.5 cases per 100,000 population in 2023. Between 2018 and 2023, syphilis rates rose by 77.6% nationwide and 51.5% in Virginia. The rate increased by another 5.1% from 2023 to 2024 in Virginia, leading to a total increase of 59.2% from 2018 to 2024. VDH has also observed concerning changes in self-reported use of opioids and other drugs. As the number of cases of early syphilis in Southwest Virginia increased 51% from 2022 to 2024, the percentage of cases involving self-reported injection drug use also increased, from 6.9% to 9.6%. Between 2022 and

2024, the percentage of cases of early syphilis involving self-reported cocaine use in the prior 12 months doubled in every health planning region except eastern Virginia, which saw a tripling of cases involving self-reported opioid use.

Figure 11. Acquired Syphilis Rates per 100,000 Residents in Virginia and U.S, 2018-2024



Data Sources: Virginia Department of Health, Centers for Disease Control and Prevention

Alongside worsening rates of syphilis, losses of federal funding and pharmaceutical rebates that supported the STI workforce in prior years have negatively impacted VDH's ability to adequately staff its public health response. Between January 2023 and July 2025, the total number of STI surveillance staff available to receive and process new reports of syphilis morbidity shrunk by 30%, and the number of disease intervention specialists available to reach out to individuals diagnosed with syphilis to ensure they and their partners receive timely and appropriate testing and treatment shrunk by 19%.

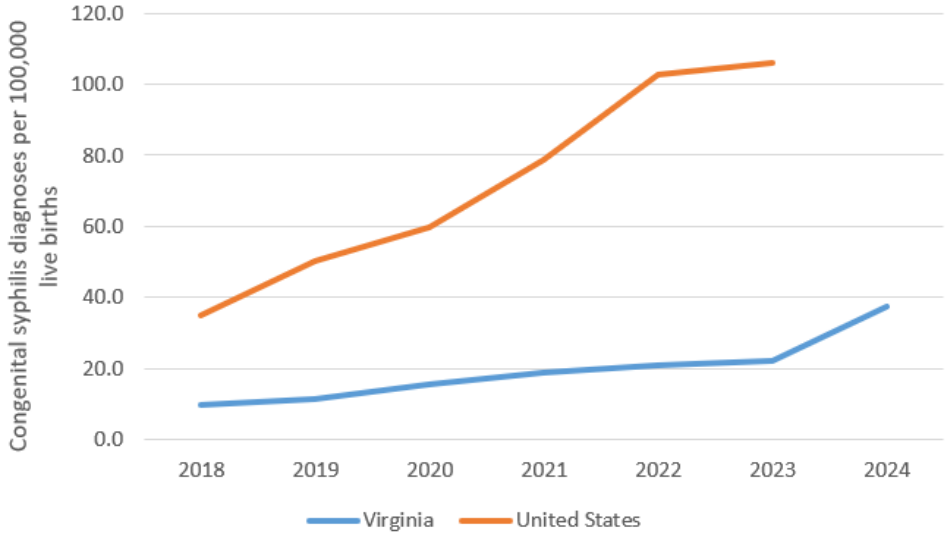
VDH's Syphilis Incident Management Team (IMT), formed in December 2023, has played a key role in responding to increases in morbidity. The regional syphilis response task force in eastern Virginia worked with the Sentara and Riverside health systems to integrate electronic prompts to order syphilis testing in their electronic health record system, resulting in a significant increase in tests ordered. VDH's Division of Pharmacy Services, working closely with the Division of Disease Prevention, succeeded in maintaining an adequate supply of injectable syphilis treatment for all patients referred to public health throughout a multi-year national shortage. The IMT staged rapid syphilis testing pilots for women of reproductive age at community-based harm reduction sites and worked with the manufacturer of the nation's first FDA-approved syphilis self-test to stage statewide pilots using donated test kits.

CONGENITAL SYPHILIS

Congenital syphilis (CS) cases in the United States in 2023 reached the highest level seen since 1992.[6] At the national level, cases increased each year of the last decade. Virginia has seen

a similar upward trend in CS diagnoses, though its rates remain lower than the national rates (Figure 12). In 2023, Virginia's CS rate was 22.0 cases per 100,000 live births, compared to the national rate of 105.8, with a more gradual increase in Virginia. Between 2018 and 2023, Virginia's CS rates rose by 120%, while the national rate increased 203%. From 2023 to 2024, CS rates in Virginia saw a concerning 71% increase. This indicates that in Virginia, congenital syphilis rates increased 276% between 2018-2024, exceeding the national rate of increase. Data for the national CS rate in 2024 was not available at the time this report was published.

Figure 12: Congenital Syphilis Rates per 100,000 Livebirths in Virginia and Nationwide



Data Source: Virginia Department of Health, Centers for Disease Control and Prevention

In response to increases in CS rates, VDH's Division of Disease Prevention (DDP) established the Perinatal Surveillance Coordinator (PSC) position in 2019. The PSC reviews all open syphilis investigations involving pregnant women to ensure prompt and adequate treatment and partner services. The PSC also follows up with providers on all positive syphilis test results in newborns to ensure they get proper evaluation and care.

In 2021, DDP established the Congenital Syphilis and Perinatal HIV Case Review Board (CRB), which consists of a diverse group of public and private health professionals. The CRB meets annually to review CS and perinatal HIV cases with the purpose of identifying barriers, missed opportunities, and gaps in care to develop recommendations to address systemic issues and prevent future CS cases. VDH has also issued several letters to healthcare providers to alert them of the rising rates of CS and provide guidance on CDC screening and treatment recommendations.

MEASLES

Between March and September 2025, VDH responded to a series of measles cases linked to international travel. In March, two Maryland residents were diagnosed with measles following overseas travel, prompting VDH to manage public exposures at Dulles International Airport and other locations in Northern Virginia. Fortunately, no secondary cases were identified. On April

[6] Centers for Disease Control and Prevention. (2024). Sexually Transmitted Infections Surveillance, 2023. Retrieved from CDC: Centers for Disease Control and Prevention: https://www.cdc.gov/syphilis/about/index.html?CDC_AAref_Val=https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.ht

19, VDH confirmed a measles case in a preschool-aged child from Northwest Virginia who had also traveled internationally. The investigation identified over 100 contacts across several healthcare settings. VDH coordinated post-exposure prophylaxis and implemented quarantine recommendations for non-immune individuals, successfully preventing any secondary transmission.

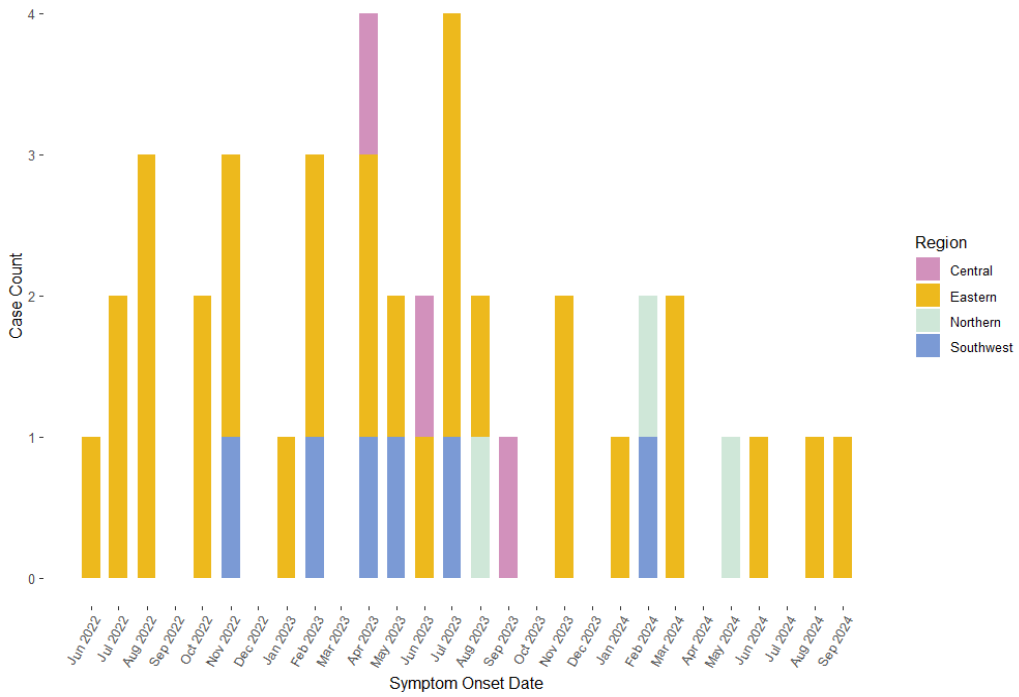
In May, a second measles case in Northwest Virginia involved a teenager with recent international travel, prompting a large-scale response that identified over 350 contacts across public spaces and two healthcare facilities. Working closely with UVA Hospital, VDH provided post-exposure prophylaxis and issued quarantine guidance to contain the spread. A single secondary case was later reported on June 5 in a young child in the same region. In late August, VDH confirmed the state's fourth measles case of the year in a school-age child from the Eastern Region, also with recent international travel. For both outbreaks, VDH issued regional news releases to inform the public about possible exposure locations.

MENINGOCOCCAL DISEASE

Meningococcal disease, caused by the bacterium *Neisseria meningitidis*, is a serious illness that manifests primarily as meningitis or meningococcemia (a bloodstream infection). Of the six *N. meningitidis* serogroups — A, B, C, W, X, and Y — responsible for most meningococcal disease worldwide, four serogroups (B, C, W, and Y) circulate in the United States. In recent years, multiple factors have contributed to shifting trends in meningococcal disease epidemiology, including changes in antimicrobial resistance patterns and the emergence of new strains in populations not previously associated with meningococcal infection.

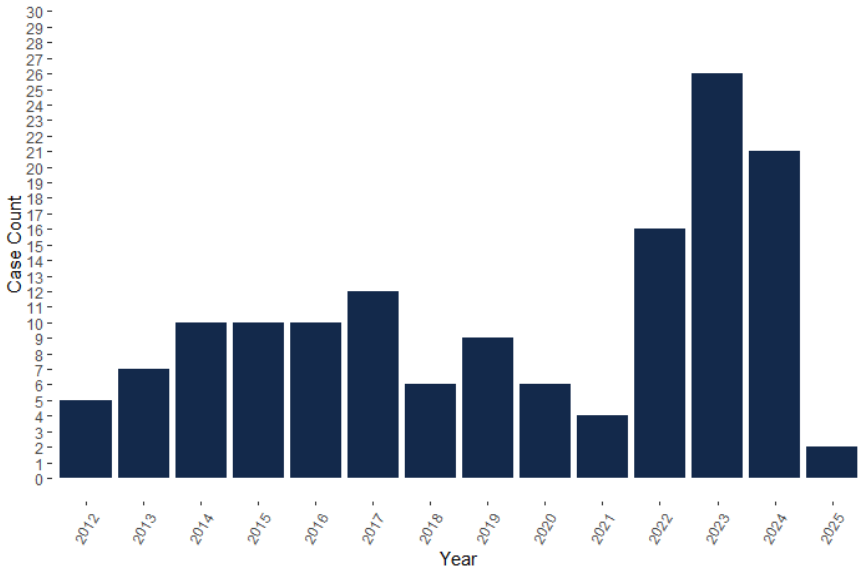
Since 2022, Virginia has reported an increase in cases of meningococcal disease primarily attributed to a statewide outbreak of *N. meningitidis* serogroup Y sequence type 1466 (NmY ST1466) that was first identified in Eastern Virginia in June of that year. From June 2022 – September 2024, 41 outbreak cases were reported across Eastern (29), Southwest (6), Central (3) and Northern Virginia (3), including eight fatalities (Figure 13). During the preceding 10 years, Virginia averaged only eight meningococcal disease cases per year (Figure 14). Meningococcal disease trends returned to pre-outbreak levels in January 2025, though the strain associated with this outbreak continues to circulate in Virginia and nationally.

Figure 13: Meningococcal Disease Outbreak Cases June 2022- September 2024



Data Source: The Virginia Department of Health, Office of Epidemiology

Figure 14: State Meningococcal Disease Outbreak Cases 2012-2025



Data Source: The Virginia Department of Health, Office of Epidemiology

Most outbreak cases occurred in people ages 30–60 years (64%), Black or African American people (76%), and people with HIV (12%). Thirty-nine patients (95%) were unvaccinated against *N. meningitidis* serogroup Y. This outbreak demonstrated the potential for *N. meningitidis* to spread in populations not previously considered at high risk for meningococcal infection, such as adults 30-60 years. An undefined at risk population made vaccination efforts challenging. While post-exposure prophylaxis (PEP) antibiotics helps prevent

secondary cases, CDC does not routinely recommend vaccinating close contacts. In this outbreak, the MenACWY vaccination of close contacts was recommended for contacts 11 years of age and older in addition to PEP to prevent additional cases among a population presumed to be at risk.

In 2023, Virginia's public health lab began whole genome sequencing (*N. meningitidis*), to support outbreak detection and response. The recent outbreak underscored the need for better meningococcal vaccine coverage in high-risk groups, especially people with HIV, consistent with national trends for *NmY ST1466*. VDH targeted HIV providers to promote MenACWY vaccination and advised local health departments to follow ACIP guidelines for vaccines and PEP. This investigation was published in CDC's *Morbidity and Mortality Weekly Report (MMWR)* in October 2024. Since 2020, antibiotic-resistant *N. meningitidis* strains have risen in Virginia, now causing over half of cases in Northern Virginia.

VDH shared this recommendation with the provider community via clinician letter in April 2024. Additional cases have been identified in Southwest and Eastern Virginia since 2024, including an outbreak of a penicillin-resistant strain in Roanoke City in March 2025. Two cases were identified, including 1 fatality, among employees of a food processing facility. Following a swift public health investigation, over 150 contacts received PEP, and 101 contacts received meningococcal vaccine. VDH continues to monitor penicillin-resistant *N. meningitidis* and partners with CDC and neighboring jurisdictions to update PEP guidance.

HEALTH CARE WORKFORCE INCENTIVES

The VDH Health Workforce Unit, housed within the Office of Health Equity, plays a vital role in supporting healthcare professionals across the Commonwealth. The unit administers 15 distinct workforce incentive programs designed to recruit, retain, and support healthcare providers, particularly in underserved communities. These programs collectively manage $18.3 million in state general funds and $822,000 in federal funds, with all state funds eligible for rollover into the next fiscal year.

During FY 2024, the General Assembly directed VDH to establish Virginia's Earn to Learn (ETL) Nursing Education Acceleration Program. The ETL program provides funding to educational institutions in the Commonwealth that offer Virginia Board of Nursing-approved nursing education programs for pre-licensure Registered Nurses (RN) and Licensed Practical Nurses (LPN) to foster collaborative clinical training arrangements between grant recipients, hospitals, and health providers. Through these partnerships, RN and LPN students participate in a paid clinical apprenticeship that enables them to earn a wage comparable to their current level of practice while training to obtain a higher certification level.

The first cohort of Earn to Learn grantees were comprised of 13 academic institutions. Originally funded from September 2024 through December 2025. Ten of the grantees have requested to extend their contracts through June 30, 2026, to implement Earn to Learn. Applications for the second cohort were open through May 30, 2025, and reviewed in June. Both J. Sargent Reynolds and Piedmont Virginia Community Colleges were selected to join Cohort 2. VDH currently has a plan in place to obligate the remaining $7.59M from FY25 and FY26 before the 2026 General Assembly Session concludes. The vast majority of these funds will be eligible for Cohorts 1 & 2 to expand and continue their ETL efforts in state FY27.

Additionally, annual funding for VDH's Nursing Preceptor Incentive Program, designed to reduce the shortage of registered nurse clinical education opportunities and establish new preceptor rotations for nursing students was increased from $500,000 in FY2022 to $3.6 million in FY2025, and anesthesiology was added as a priority "high demand" field. In 2023, the per-slot incentive amount was increased from $1,000 to $5,000.

EMERGENCY MEDICAL SERVICES

The VDH Office of Emergency Medical Services (OEMS) is responsible for planning and coordinating an effective and efficient statewide EMS system. OEMS is responsible for the licensing of EMS agencies and vehicles, the certification and training of all levels of EMS personnel (EMTs, Paramedics), and coordination with the State EMS Advisory Board on the development of the State Board of Health's EMS regulations. Further, OEMS manages critical specialized systems, including the designation of hospital Trauma Centers, and provides essential funding, technical support, and guidance to regional EMS councils and local rescue agencies, thereby guaranteeing quality emergency medical response across Virginia.

LOCAL HEALTH DISTRICT CLINICAL SERVICE DELIVERY

VDH is a centralized health department and operates through a network of 35 Local Health Districts (LHDs), each responsible for delivering public health services tailored to their community's needs. LHDs serve a wide range of functions, including providing immunizations, public health surveillance, communicable disease investigations, sexually transmitted infection management, and environmental health inspections to improve public health across Virginia. To further demonstrate the impact of clinical services provided by the LHDs across the state, the tables below present data on clinical encounters for core public health programs provided by the districts.

LHDs across Virginia continue to play a critical role in preventive healthcare by providing a wide range of clinical and public health services. In FY25, LHDs administered a total of 137,025 immunizations, underscoring their commitment to disease prevention (Table 6). The most frequently administered vaccines were Tdap vaccinations (26,535 doses) and meningococcal (21,585 doses) vaccinations. In addition to immunization services, LHDs conducted 91,312 sexually transmitted infection (STI) tests and treatments (Table 7). Among these STI services, chlamydia and gonorrhea tests were the most common (24,681), followed by HIV (20,598) and syphilis (20,168) testing encounters. These efforts support the early detection, treatment, and prevention of STIs within local communities. LHDs also provided 40,218 family planning encounters during FY25, with the most frequent services being Depo-Provera administration (11,556) and pregnancy testing (10,370) (Table 8). Additionally, a total of 254,533 tuberculosis (TB)-related encounters were reported, with the most frequent being office visits (78,376), which include medication pick up or a consultation with a client (Table 9). TB education sessions (63,390) were the second most common type of encounter. These services highlight ongoing efforts to prevent and manage TB across the Commonwealth.

Table 6. Number of Immunizations Provided By LHDs in FY25.

Immunization Type	Number of Vaccines Provided

COVID-19	7,071
Influenza	1,745
Hepatitis A	11,963
Hepatitis A & B	300
Hepatitis B	10,662
Haemophilus influenza type B (Hib)	1,936
Human Papillomavirus 9	16,133
Meningococcal	21,585
Measles, Mumps, Rubella, and Varicella	10,196
Pneumococcal	3,797
Polio	11,741
Rabies	1,487
Rotavirus	965
Respiratory Syncytial Virus	205
Smallpox & Mpox	464
Tetanus, Diphtheria, and Pertussis (Tdap)	26,535
Varicella	9,831
Zoster	409
Yearly Totals	**137,025**

Data Source: Virginia Department of Health, Office of Community Health Services.

Table 7. Number of STI Testing and Treatments Provided By LHDs in FY25.

Activity Type	Number of STI Testing or Treatment Services Provided
Azithromycin Treatment	412
Bicillin Treatment	3,744
Ceftriaxone Treatment	1,639
Chlamydia and Gonorrhea Testing	24,681
Contact Investigation	2,141
Doxycycline Treatment	3,396
Contact Referral due to Exposure	4,223
Expedited Partner Treatment	70
Hepatitis Testing	9,027
Herpes Testing	370
HIV Testing	20,598
HSV Testing	843
Syphilis Testing	20,168
Yearly Totals	**91,312**

Data Source: Virginia Department of Health, Office of Community Health Services.

Table 8. Number of Family Planning Encounters at LHDs in FY25.

Activity Type	Number of Family Planning Encounters
Depo-Provera	11,556
Gyn Pap Test	3,899
Long-Acting Reversible Contraceptive (LARC) Removal, Insertion, or Removal with Insertion	4,667
Patches and rings	385
Pills	5,552
Pregnancy test	10,370
Vaginal Smear	3,789
Yearly Totals	**40,218**

Data Source: Virginia Department of Health, Office of Community Health Services.

Table 9. Number of Latent Tuberculosis (TB) Infections and Active TB Client Encounters at LHDs in FY25.

Activity Type	Number of Latent TB Infection and Active TB Client Encounters
Case Management	15,170
File Status	79
Home Visit	5,506
Laboratory	39,913
Observed Therapy	14,585
Office Visit	78,376
Radiology	465
TB Assessment	10,482
TB Education	63,390
TB Medication	8,799
TB Screening	17,758
Telehealth Visit	10
Yearly Totals	**254,533**

Data Source: Virginia Department of Health, Office of Community Health Services.

RECOMMENDATIONS

The 2025 Board of Health Annual Report highlights the overall health status of the Commonwealth, guided by the VDH's vision of making Virginia the healthiest state in the nation. Achieving this vision requires ongoing monitoring of core health indicators, alongside consistent tracking of specific diseases and conditions each year. The annual report remains a vital tool for communicating progress on health measures throughout Virginia and could benefit from broader dissemination. This report also identifies key opportunities for the state to advance solutions addressing several urgent health challenges facing the Commonwealth. These recommendations focus on leveraging resources effectively, integrating social determinants of health, and prioritizing vulnerable populations to achieve equitable health outcomes statewide.

Implementation of these recommendations will require the State Board of Health and VDH to work effectively with a wide range of public health stakeholders. Recommendations are as follows:

Social Determinants of Health:

- Improve access to care by reducing transportation, geographic, and digital barriers through community-based services, such as establishing public transit partnerships or utilizing ride-sharing services, and expanding connectivity through supporting mobile clinics, telehealth, and investing in broadband access to reduce digital divides.
- Advance equitable care delivery by promoting culturally responsive practices, language access, and routine screening for social needs with clear referral pathways.
- Support education and workforce development by strengthening health literacy and creating health career pipeline programs.
- Address housing instability by increasing support for permanent supportive housing.
- Promote food security initiatives by integrating nutrition education into healthcare and other community programs, screening for food insecurity, and expanding WIC and nutrition program participation, with targeted outreach to underserved populations.

Maternal and Child Health:

- Enhance support for pregnant and postpartum individuals with substance use challenges by integrating peer recovery and perinatal into care settings.
- Strengthen workforce capacity through training for support professionals (e.g. doulas, community health workers, peer support specialists) working with this population.

Youth Suicide Prevention :

- Expand prevention efforts for youth by addressing the unique needs of young people following high school, including those entering the workforce, military, or higher education.
- Ensure VDH undergoes strategic planning by convening a taskforce to update the Virginia Suicide Prevention Plan every three years, focusing on preventing suicide through youth-specific strategies.
- Improve access to mental health care by strengthening the mental health workforce in Virginia and increasing the accessibility of mental health resources.

Substance Use and Overdoses

- Support high-demand harm reduction services by ensuring adequate staffing and resources to maintain quality and accessibility of high-volume CHR sites.
- Continue efforts to partner with local community partners to enhance availability of needed resources (i.e., providing naloxone and distributing test strips)

Chronic Diseases:

- Strengthen statewide chronic disease prevention by enhancing public health capacity, fostering clinical-community partnerships, and improving data surveillance to address disparities.

- Facilitate timely data sharing of cancer registry data to researchers and academic centers who use the data to advance cancer research.

Infectious Diseases:

- Sustain comprehensive surveillance for respiratory and other infectious diseases using advanced tools and monitoring systems.
- Maintain robust outbreak detection through active and passive disease surveillance.
- Promote and facilitate increased vaccination uptake for key vaccine preventable diseases to reach herd immunity thresholds.
- Focus immunization efforts on vulnerable and high-risk populations to reduce health disparities

APPENDIX A: CODE OF VIRGINIA § 32.1-14

§ 32.1-14. Annual report

The Board shall submit an annual report to the Governor and General Assembly. Such report shall contain information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia, including but not limited to, health status indicators, the effectiveness of delivery of health care, progress toward meeting standards and goals, the financial and geographic accessibility of health care, and the distribution of health care resources, with particular attention to health care access for those Virginia citizens in rural areas, inner cities, and with greatest economic need. Such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality.

APPENDIX B: ACRONYMS AND ABBREVIATIONS

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

ACS – American Community Survey

ANE – Acute Necrotizing Encephalopathy

CAMS - Collaborative Assessment and Management of Suicidality

CAVC – Cancer Action Coalition of Virginia

CDC – Centers for Disease Control and Prevention

CHR – Comprehensive Harm Reduction

CRB – Congenital Syphilis and Perinatal HIV Case Review Board

CS – Congenital Syphilis

COPD – Chronic Obstructive Pulmonary Disease

DCLS – Division of Consolidated Laboratory Services

DDP – Division of Disease Prevention

DIS – Disease Intervention Specialists

EMS – Emergency Medical Services

PEACE – Perinatal Education for Advanced Clinical Expertise

PMP –Virginia Prescription Monitoring Program

PSC – Perinatal Surveillance Coordinator

SAMHSA – Substance Abuse and Mental Health Services Administration

SME – Subject Matter Expert

SNAP – Supplemental Nutrition Assistance Program

SSP – Suicide Systems Project

SUD – Substance Use Disorder

SVI – Social Vulnerability Index

TA – Technical Assistance

EWL - Every Woman's Life

FPL – Federal Poverty Level

FY – Fiscal Year

HRSA MCH – Office of Women's Health, and Health Resources and Services Administration Maternal Child Health Division

IAE – Influenza-associated Encephalopathy

IMR – Infant Mortality Rate

IMT – Incident Management Team

MIECHV – The Maternal, Infant, and Early Childhood Home Visiting Program

MMR – Maternal Mortality Rate

MMRT – Maternal Mortality Review Team

PAMSS– Pregnancy-Associated Mortality Surveillance System

PEP – Post-exposure Prophylaxis

PCP – Primary Care Providers

VACCCP –Virginia Comprehensive Cancer Control Program

VA-SORH – Virginia State Office of Rural Health

VCP – Virginia Cancer Plan

VCR – Virginia Cancer Registry

VDH – Virginia Department of Health

VMAP – Virginia Mental Health Access Program

VTN – Virginia Telehealth Network

WGS – Whole Genome Sequencing

WHO – World Health Organization

WIC – Women, Infants, and Children

APPENDIX C: ADDITIONAL DETAILS

America's Health Rankings

America's Health Rankings is an annual report that provides a comprehensive assessment of the nation's health on a state-by-state basis. It is prepared by the United Health Foundation, a private, non-profit foundation dedicated to improving health and health care. Drawing on data from national and state-level sources, such as the CDC and U.S. Census Bureau, the report evaluates a wide range of health indicates to highlight public health strengths and challenges across the U.S.

The Social Vulnerability Index (SVI)

The Social Vulnerability Index (SVI), a tool developed by the CDC, is used to help identify communities that may need more support before, during, or after disasters such as hurricanes, disease outbreaks, or other public health emergencies. The SVI uses U.S. Census data from the American Community Survey to rank census tracts on 15 social factors, such as poverty, disability status, minority status, and crowded housing. The social factors are then grouped into four themes: socioeconomic status, household composition and disability, minority status and language, and housing type and transportation. The index ranges from 0 to 1, where 1 represents a community that is highly vulnerable and most at-risk and 0 represents a community that is not vulnerable and is the least at-risk. Communities with higher vulnerability may be less able to prepare for, respond to, and recover from emergencies, whether they are natural disasters, environmental hazards, or public health crises. These rankings help public health officials allocate resources more effectively and prioritize communities that are most at risk.

Virginia Youth Survey (VYS)

Through a five-year grant provided by the CDC and in collaboration with the Virginia Foundation for Healthy Youth, the Virginia Youth Survey (VYS) is a statewide survey administered by VDH every odd year in randomly selected Virginia public schools. The VYS has been developed to monitor priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults within the Commonwealth. VYS is a part of broader efforts to monitor and promote adolescent health at the state and local levels that are designed to improve the well-being of young people across the state.

Board of Health Annual Report

Katelyn Briguglio, MPH
Policy Administrator
Kaitlyn Gentille, MPH
Strategic Initiatives Coordinator, Sr.

March 19, 2026

Annual Report Mandate

The 2025 Virginia Department of Health Annual Report is mandated by § 32.1-14 of the Code of Virginia.

The Board shall submit an annual report to the Governor and General Assembly. The report shall contain information on the Commonwealth's:

- vital records and health statistics
- an analysis and summary of health care issues affecting the citizens of Virginia, including
  - health status indicators,
  - effectiveness of delivery of health care
  - progress toward meeting standards and goals
  - financial and geographic accessibility of health care
  - distribution of health care resources, with particular attention to health care access for those Virginia citizens in rural areas, inner cities, and with greatest economic need
- statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality

Methodology

- VDH compiled and analyzed the most current data on a wide range of healthcare issues impacting Virginia residents.
  - Referenced the most up to date data for a wide range of healthcare issues
- Topic selection focused on priority areas where VDH concentrated resources and efforts over the past year.
- Subject matter experts (SMEs) from relevant divisions and offices contributed to ensure accuracy and comprehensiveness of the information.

How Virginia Compares

- **Virginia improved from 19th in the nation in 2023 to 15th in 2024.**
- **Virginia performed well on several socioeconomic indicators (e.g., poverty) but continues to face challenges with uninsured rates and housing-related problems.**

Health Indicator	2022 Rank	2023 Rank	2024 Rank
2024 Rankings in the Top Half of U.S. States			
Virginia's Overall Rank	***14***	***19***	***15***
Uninsured (% of Population)	21	21	23
Severe Housing Problems (% of occupied housing units)	23	22	25
Poverty	6	13	12
Unemployment	15	15	19
Economic Hardship Index	5	8	9
Food Insecurity	5	13	13
Childhood Immunizations (% by age 24 months)	30	28	24
Flu Vaccinations (% ages 18+)	16	20	9
Dedicated Health Care Provider (% ages 18+)	25	22	22
Firearm Deaths	18	17	23
Suicides	10	9	10
Drug Related Deaths	24	24	17
Asthma	24	16	24
Cancer	19	35	17
Diabetes	19	38	17
Depression	31	27	25
Obesity	27	30	15
2024 Rankings in the Bottom Half of U.S. States			
HPV Vaccination HPV Vaccination (% ages 13-17)	19	26	27
Amount of Mental Health Providers	37	36	36
Homicides	16	26	27
Arthritis	27	27	28
Cardiovascular Disease	27	26	33
Chronic Kidney Disease	20	24	35
Chronic Obstructive Pulmonary Disease	26	30	30
High Blood Pressure	32	32	30
High Cholesterol	46	46	36

Data Source: American Health Rankings, 2024 Annual Report

Source: American Health Rankings, 2024 Annual Report

Demographics

Virginia Demographics

- Total population: 8,715,698.
- Urban vs. Rural Distribution:
  - 7.5 million residents live in urban areas
  - ~1 million residents live in rural areas

Sex distribution:

- 50.6% female (4,409,697)
- 49.4% male (4,306,001)

Source: U.S. Census Bureau. 2024. *American Community Survey: 2019-2023*

Race and Ethnicity of Virginians:

- 59% identified as non-Hispanic White
- 18.4% identified as non-Hispanic Black
- 10.7% identified as Hispanic (all races)
- 6.8% non-Hispanic Asian
- 4.3% identifying as non-Hispanic with more than one race
- 0.1% non-Hispanic American Indian or Alaska Native
- 0.1% Native Hawaiian and Pacific Islander

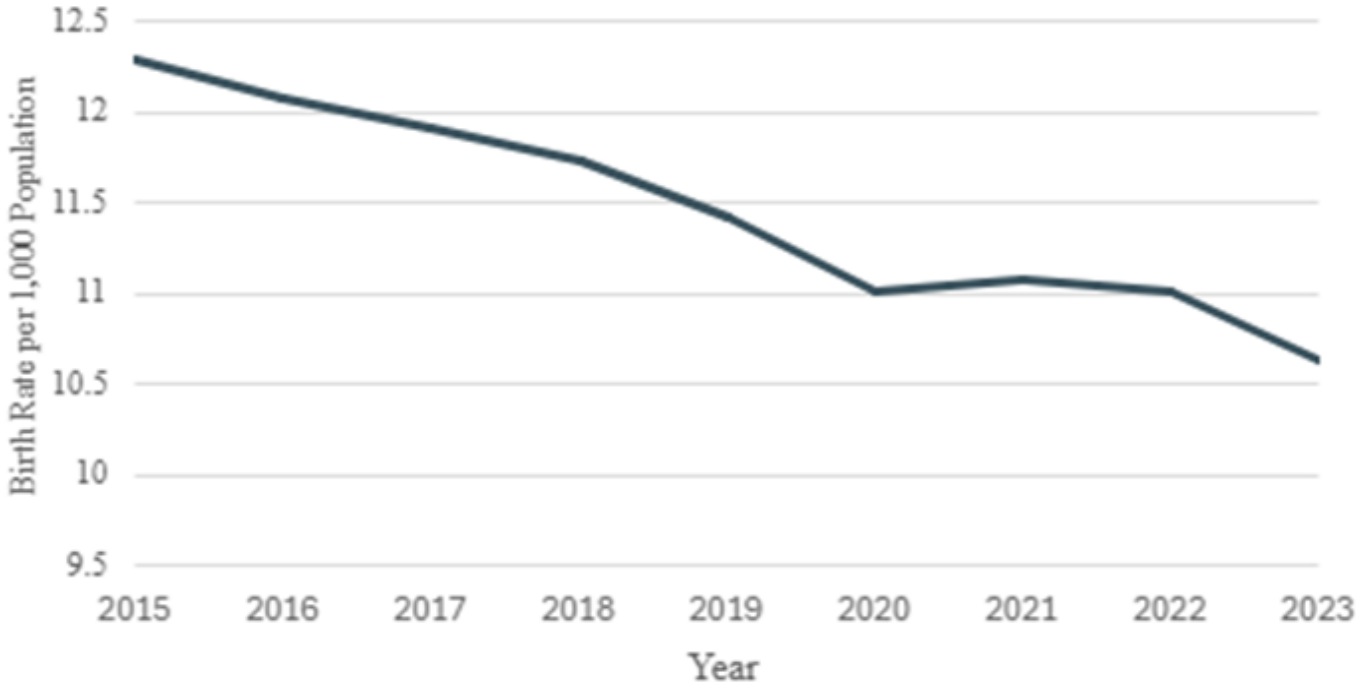
Source: Virginia Department of Health, Office of Family Health Services

Vital Records and Health Statistics

Births

- **92,652 live births recorded in 2023.**

Birth Rate in Virginia (per 1,000 Population) from 2015 to 2023



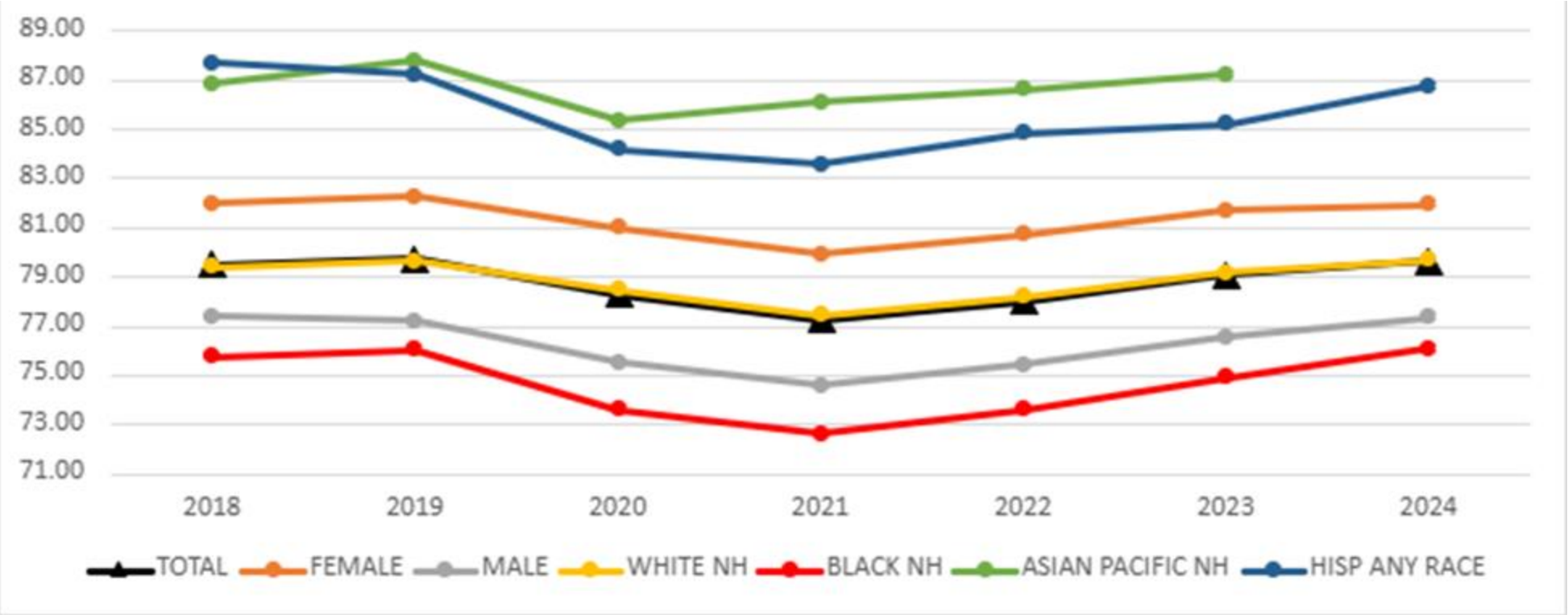
The Virginia Department of Health, Office of Information Management

Vital Records and Health Statistics

Deaths & Life Expectancy

- **78,141 deaths recorded in 2024.**

Life Expectancy by Gender, Race and Hispanic Origin from 2018 to 2024



The Virginia Department of Health, Office of Information Management

Chronic Diseases

Chronic Disease	Total Prevalence (%)	Prevalence by Race (%)				Prevalence by Sex (%)	
		Black	Hispanic	White	Other	Female	Male
Arthritis	27.1	28.7	7.8	30.9	20.5	30.5	23.4
Asthma (Current)	10.2	12.5	6.6	9.6	12.4	13.1	7.1
Asthma (Lifetime)	15.9	17.4	12.3	15.0	20.0	18	13.6
COPD	6.9	8.0	N/A	7.5	5.3	7.4	6.5
Chronic Kidney Disease	4.2	6.3	N/A	4.1	N/A	4.3	4.2
Diabetes	11.8	16.5	6.2	11.9	8.7	11.8	11.9
Heart Disease	4.3	4.6	N/A	4.6	N/A	4.0	4.6
High Blood Cholesterol	39.3	36.2	28.6	42.1	38.8	37.5	41.3
Hypertension	35.6	45.0	17.5	37.4	25.3	33.7	37.6
Stroke	3.7	5.5	N/A	4.1	N/A	4.1	3.3

Source: Virginia Department of Health, Office of Family Health Services

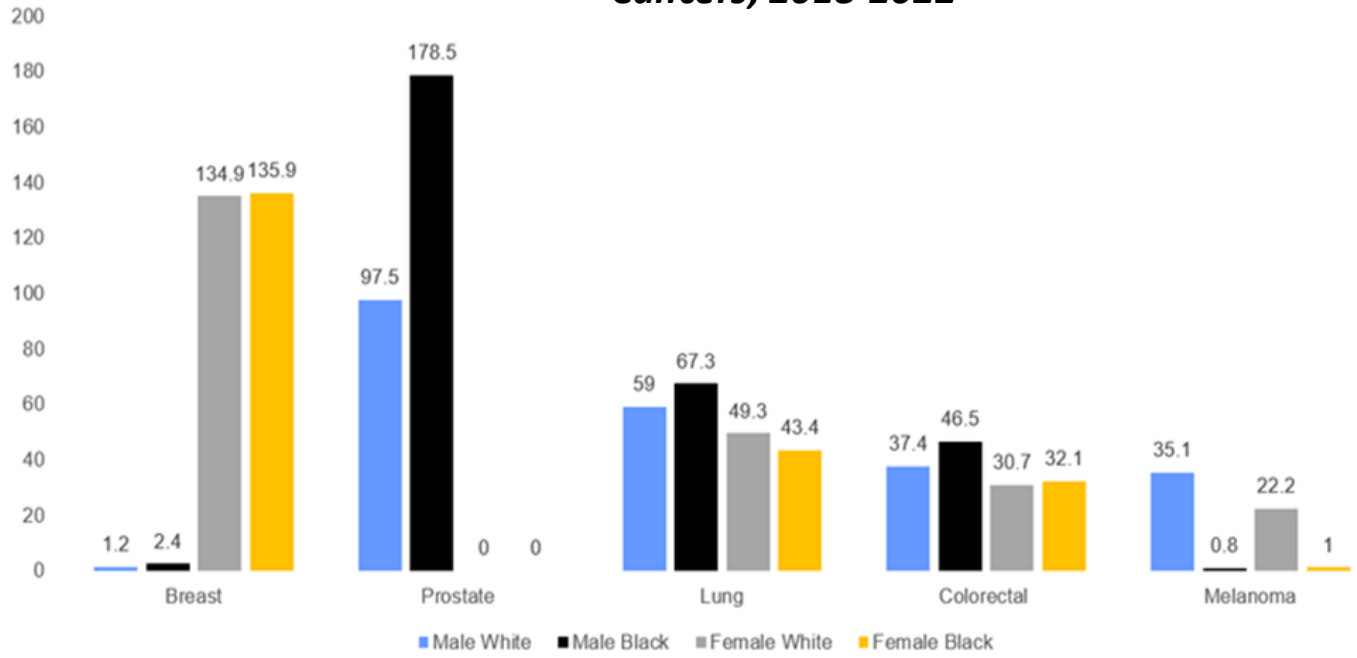
Heart Disease

- Heart disease was the leading cause of death in Virginia between **2019** and **2023**.
- The age-adjusted mortality rate per 100,000 population for heart disease decreased from 165.5 deaths in 2021 to 152.5 deaths in 2023, which was a **9% decrease**
- Despite the decrease, there continue to be groups in Virginia that are disproportionately affected:
  - The age-adjusted mortality rate among Black or African Americans was 185.2 deaths per 100,000 population, **21% higher than the overall state mortality rate**.
  - Males had an age-adjusted mortality rate of 184.5 per 100,000 population, **47% higher** compared to 125.1 deaths per 100,000 for females.
  - The highest age-adjusted mortality rate from heart disease was observed in Virginians 75 years and older, with 97.6 deaths per 100,000 population.

Source: Virginia Department of Health, Office of Family Health Services

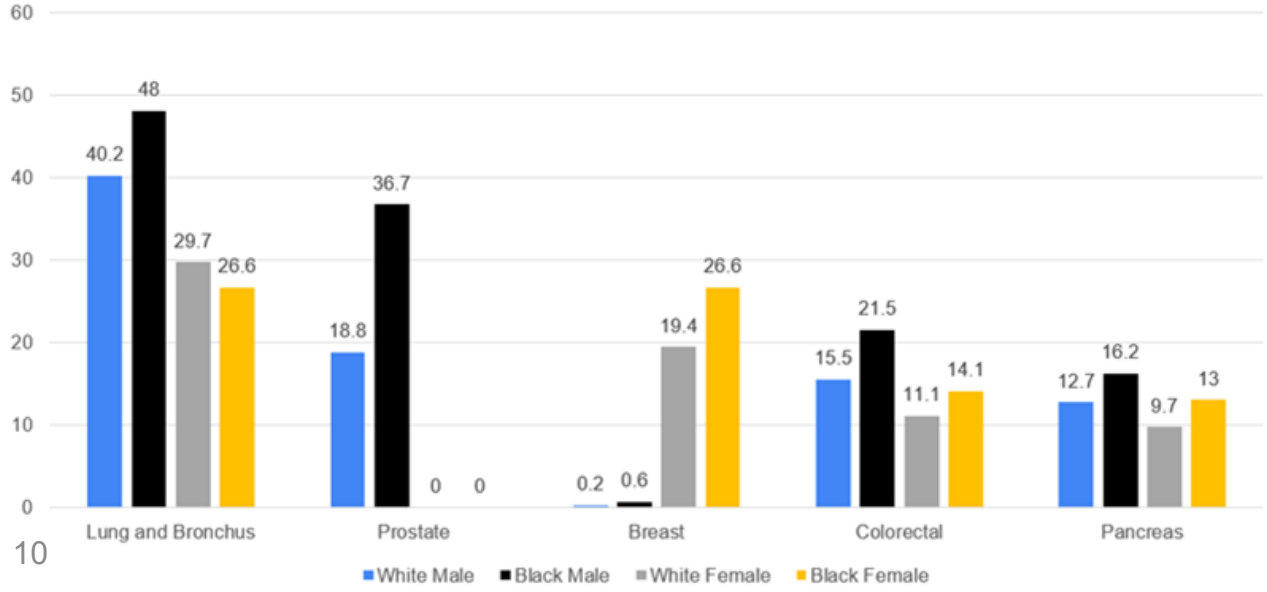
Cancer

Incidence Rate for Virginia's Top Five Leading Cancers, 2018-2022



Source: Virginia Cancer Registry

Mortality Rates for Virginia's Top Five Leading Cancers, 2019-2023



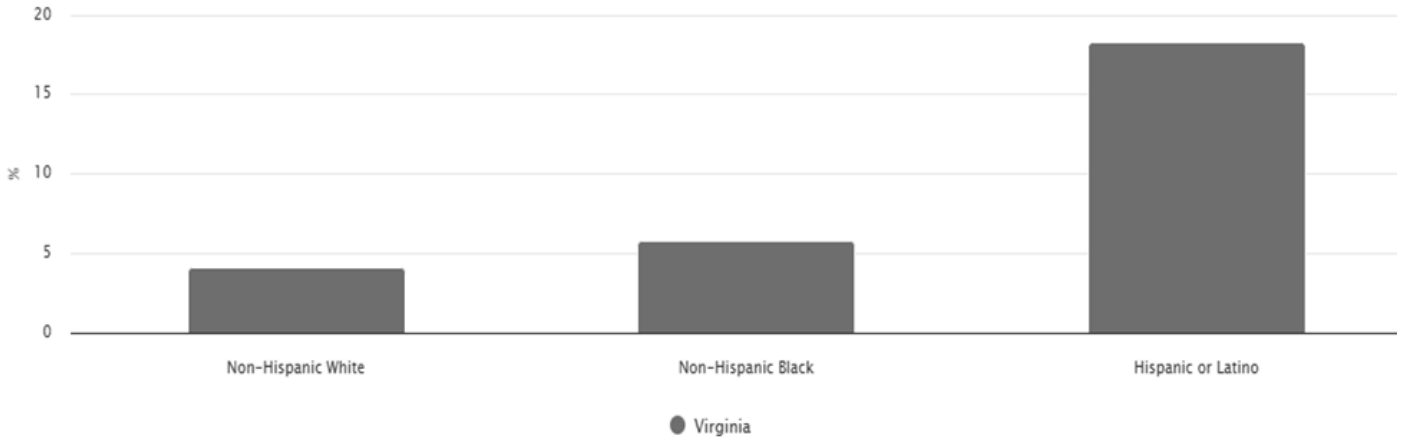
Healthcare Access and Quality

- **Among children under 19 in Virginia, 87,873 uninsured children, accounting for 4.52% of the state's child population.**
- **This is somewhat better than the national average of 5.35%.**
  - **Non-Hispanic White children had an uninsured rate of 4.10%,**
  - **Non-Hispanic Black children had an uninsured rate at 5.8%,**
  - **and Hispanic or Latino children faced the highest uninsured rate, 18.3%**

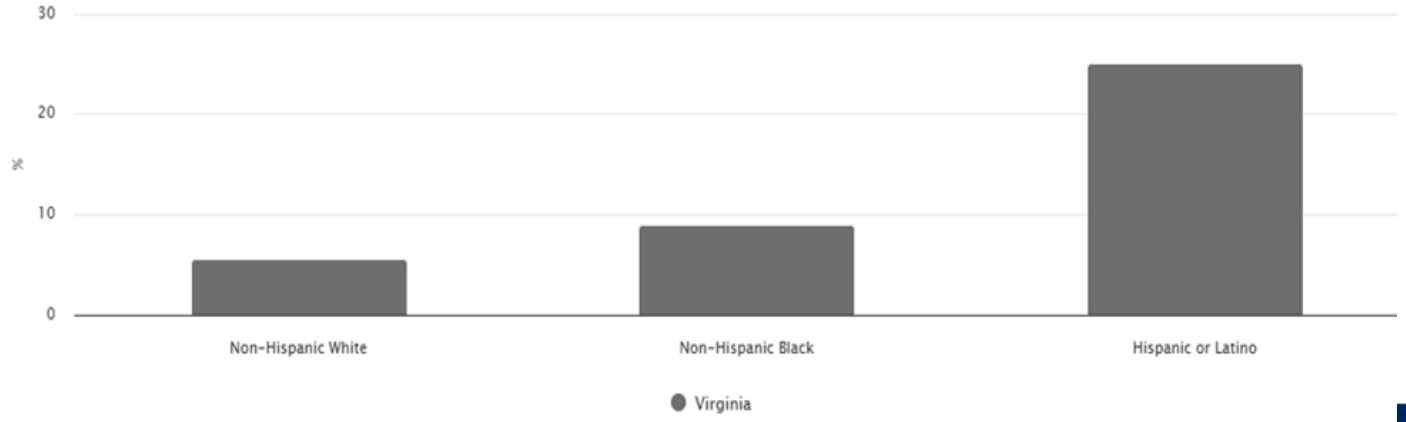
Among adults aged 18-64 in Virginia, 8.60% (approximately 443,783 individuals) were uninsured, a rate below the national uninsured rate of 11.02%.

- **Non-Hispanic White adults had a 5.6% uninsured rate,**
- **Non-Hispanic Black adults had a higher rate at 8.9%,**
- **and Hispanic or Latino adults experienced a substantially higher uninsured rate of 25%**

Uninsured Population Under 19 in Virginia, by Race and Hispanic Ethnicity, Percent



Uninsured Population Age 18- 64 in Virginia by Race and Hispanic Ethnicity, Percent



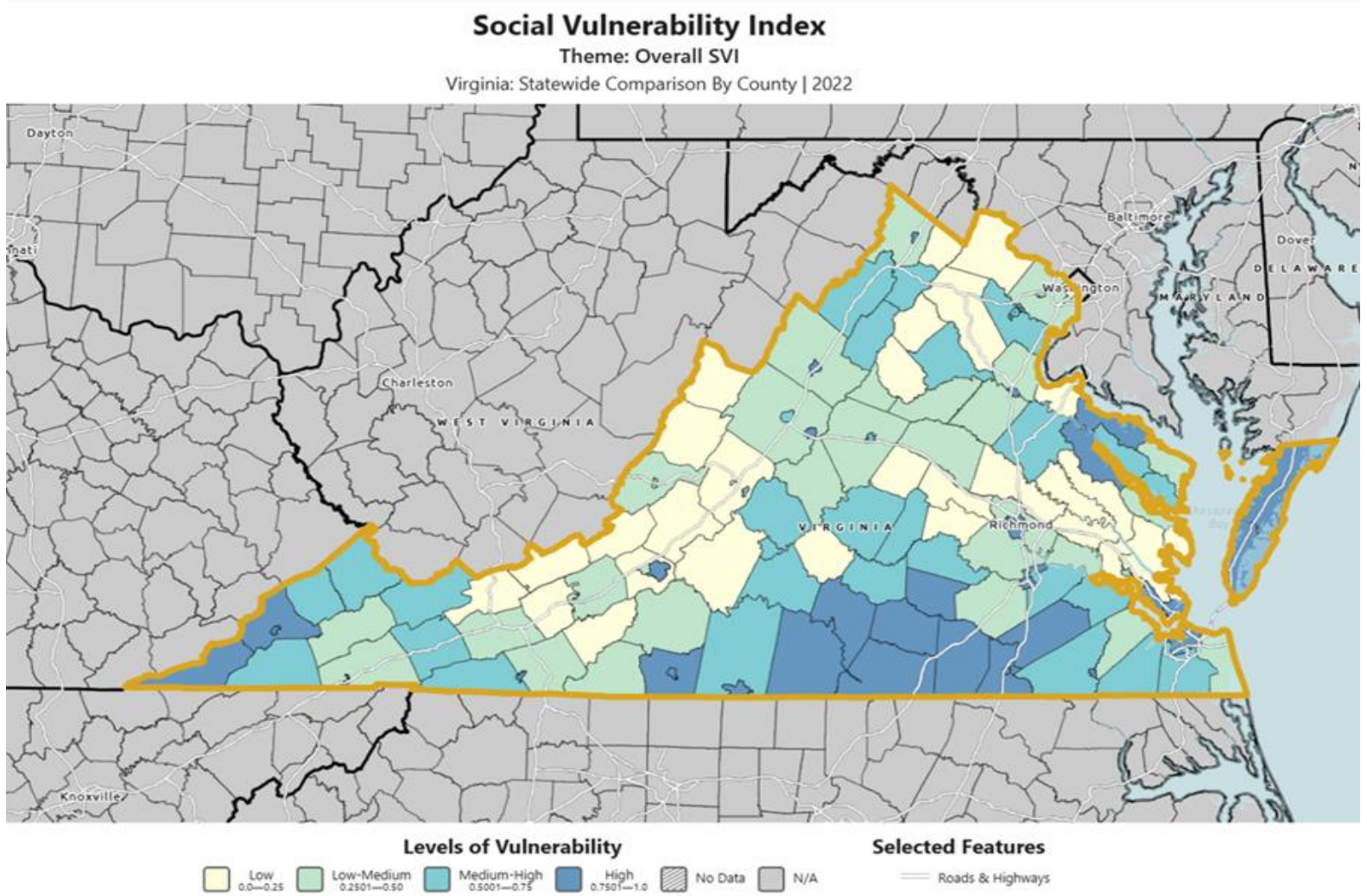
US Census Bureau, Small Area Health Insurance Estimates. 2023.

Housing, Transportation, and Economic Security

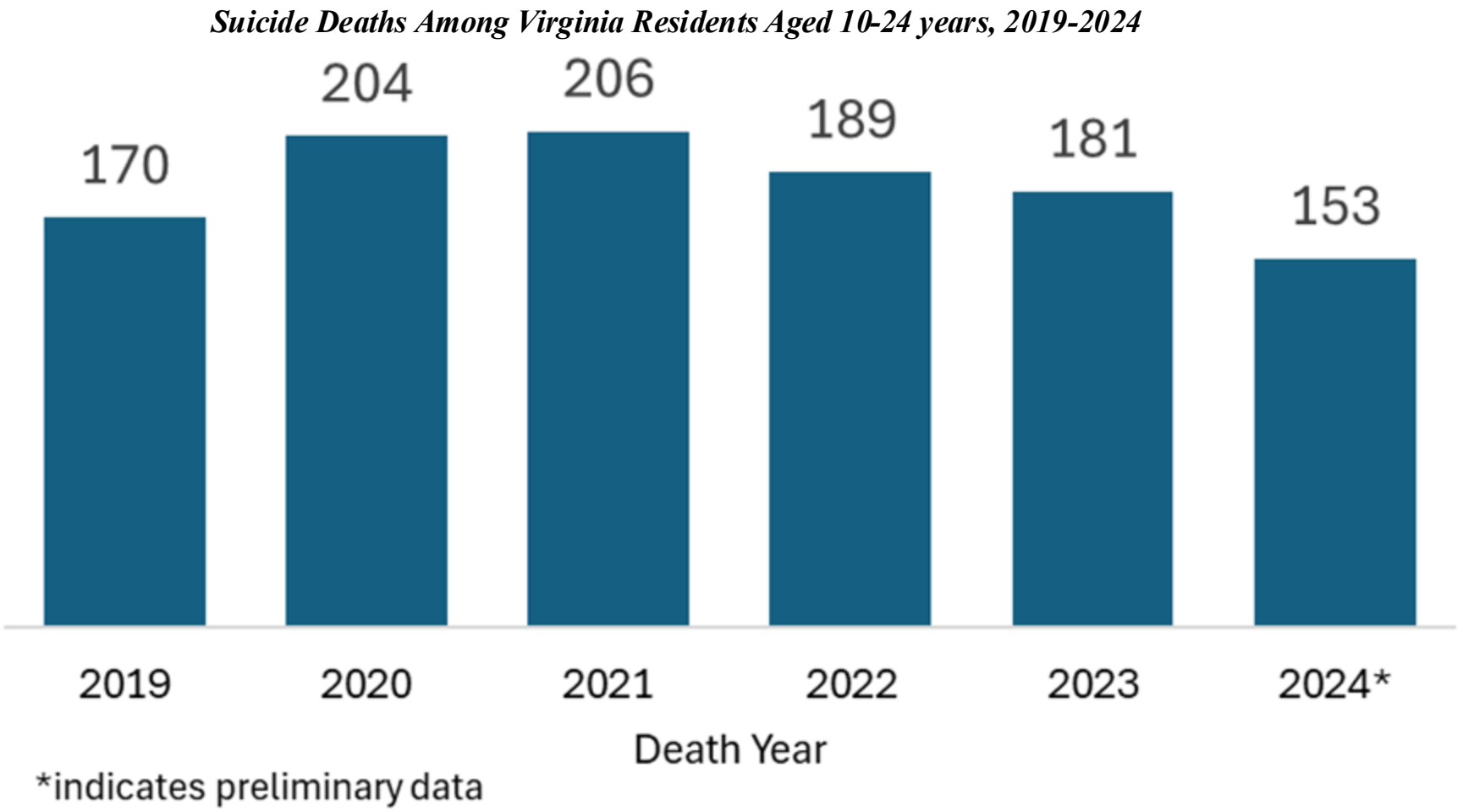
- **In 2023:**
  - An estimated 834,836 Virginians, about 10% of the state's population, lived below the federal poverty level (FPL). Approximately 1,964,400 people (23%) lived below 200% of the FPL.
  - More than 887,500 households in Virginia (27% of all households) were considered cost burdened, indicating that they spent more than 30% of their income on housing
  - 199,529 households (6%) did not have access to a motor vehicle
- **Virginia maintains one of the lower homelessness rates in the nation. At 8 per 10,000 people, the state's homelessness rate is significantly below the national average of 19.4 per 10,000**

Social and Community Context

- **Virginia's SVI score was 0.39 in 2022**



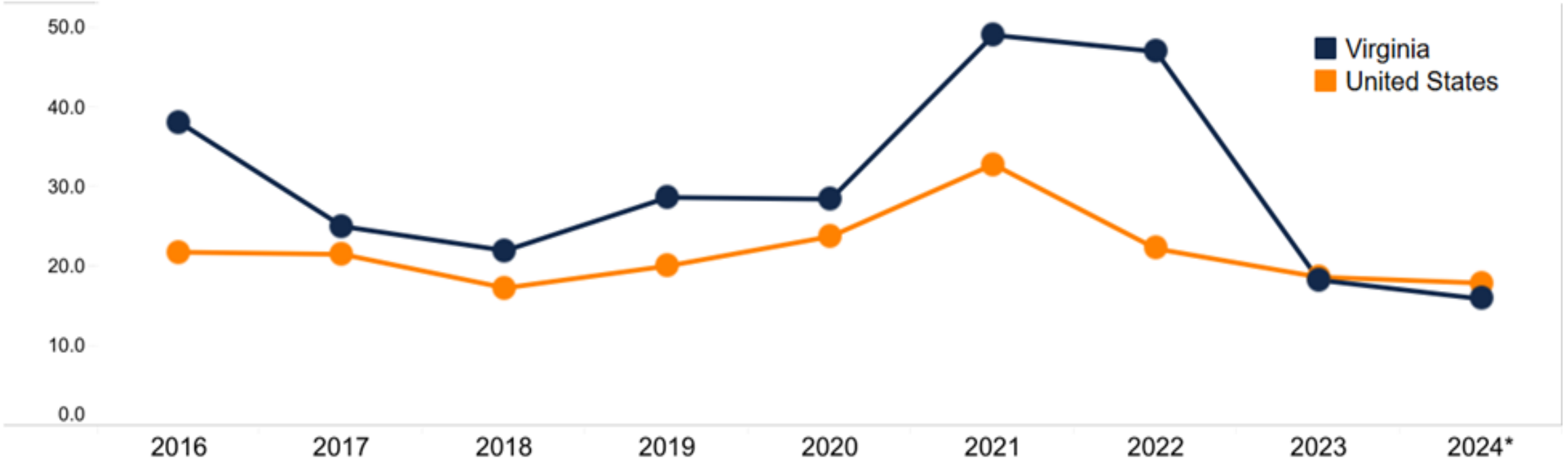
Youth Suicide Prevention



Maternal and Child Health

Annual Trends of Maternal Mortality Rates per 100,000 Live Births

*2024 data is considered preliminary and subject to change.



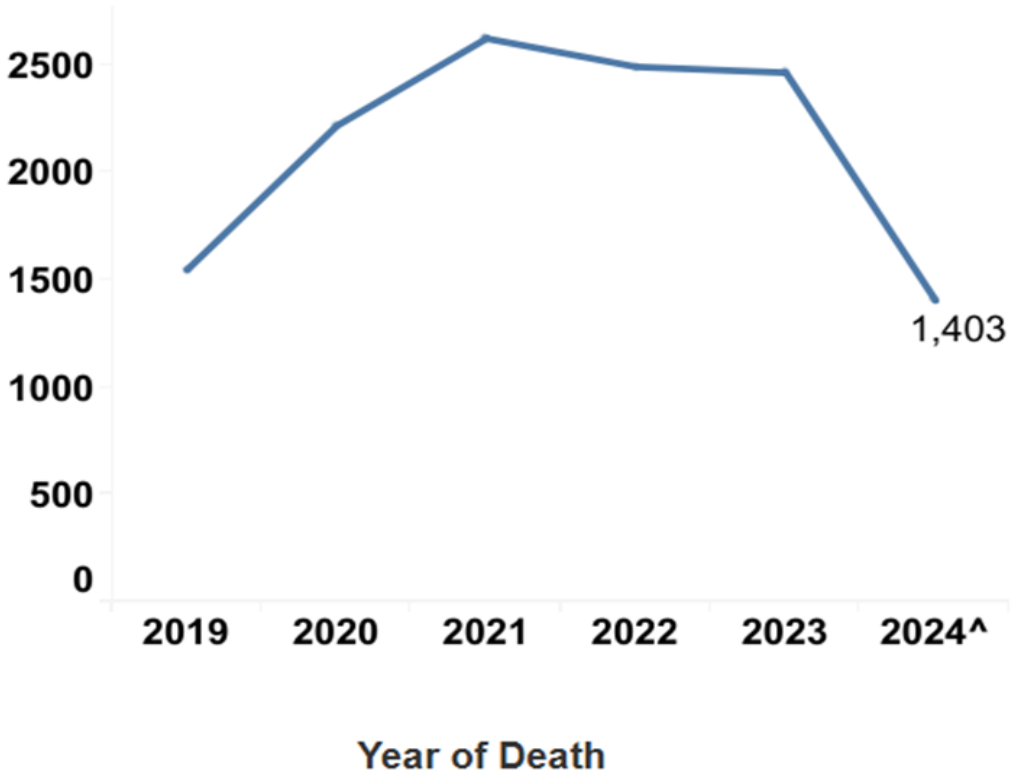
Programing Specific to Maternal Health

- **Maternal Mortality Review Team**
  - Reviews pregnancy-associated deaths and recommend improvements
- **Virginia Mental Health Access Program (VMAP) for Moms+**
  - Address perinatal mental health conditions through enhanced screening and early intervention
- **Community Doulas**
  - Provide navigation, advocacy, and continuous perinatal care
- **Maternal and Child Health Dashboard**
  - Collects and monitors data for a variety of maternal health indicators
- **Women Infant and Children (WIC)**
  - Provide families with nutrition support and education, referrals, and more
- **Maternal, Infant, and Early Childhood Home Visiting (MIECHV)**
  - Provide families with parenting support, care coordination, and more

Substance Use and Overdose

- **11,389 drug overdose deaths in Virginia from 2019–2023**
  - 2023 crude death rate: 26.4 per 100,000 population
  - 1% decrease from 2022
  - Remains below the 2021 peak of 2,622 deaths
- **79% of 2023 deaths involved fentanyl, fentanyl analogs, or tramadol**
- **Preliminary 2024 data: 1,403 overdose deaths**
  - 43% decrease from 2023
- **2023 emergency response:**
  - 21,881 ED visits for drug overdoses (2% decrease from 2022)
  - 31,360 EMS responses for substance use incident

All-Drug Death Count Among Virginia Residents, 2019-2024



Data Sources: Virginia Department of Health, Office of Family Health Services

Programing Specific to Substance Use and Overdoses

- **Naloxone Distribution Program**
  - Distributed 158,000 naloxone kits and 355,390 harm reduction test strips
  - Launched an online portal that supported 837 partner organizations
- **Comprehensive Harm Reduction (CHR)**
  - Provide access to syringes, testing, naloxone, and care referrals
  - In FY25, 5,987 participants made 31,505 visits
- **Opioid Impact Registry**
  - 211 Virginia is expanding to provide an opioid impact reduction registry
  - During a 2025 pilot, 1,500 referrals were made to 350 resources

Smoking and E-Cigarette Use

- **Smoking**
  - Current smoking prevalence in Virginia declined from 14.0% in 2019 to 10.9% in 2023
  - In 2023, three out of five regions of Virginia had a smoking prevalence higher than the state (10.9%). Southwestern region of Virginia had the highest smoking prevalence (15.5%), followed by Central region (14.6%) and Eastern region (11.0%)

- **E-Cigarettes**
  - E-cigarette use in Virginia peaked at 7.7% in 2022 and declined slightly to 7.0% in 2023.
  - Two regions of Virginia had a prevalence of e-cigarette use higher than the state prevalence in 2023, including Southwestern Virginia (8.7%) closely followed by Central Virginia (8.6%)

'Current Smoker' Prevalence Among Adults in Virginia

Region	2019	2020	2021	2022	2023
Virginia	**14.0%**	**13.6%**	**12.4%**	**12.1%**	**10.9%**
Central	14.9%	13.7%	14.8%	13.6%	14.6%
Eastern	16.2%	15.6%	14.4%	13.7%	11.0%
Northern	8.6%	6.8%	5.5%	6.3%	6.5%
Northwestern	14.1%	15.3%	13.0%	12.5%	9.8%
Southwestern	19.8%	21.3%	19.3%	18.4%	15.5%

'Current E-Cigarette' Prevalence Among Adults in Virginia

Region	2019	2020	2021	2022	2023
Virginia	**6.4%**	**5.2%**	**6.8%**	**7.7%**	**7.0%**
Central	5.3%	3.2%	7.5%	9.5%	8.6%
Eastern	7.9%	7.5%	8.3%	8.7%	7.0%
Northern	4.1%	4.3%	5.0%	4.9%	5.7%
Northwestern	6.9%	4.9%	8.0%	8.4%	6.1%
Southwestern	9.1%	6.0%	5.8%	8.5%	8.7%

Virginia Department of Health, Behavioral Risk Factor Surveillance Survey.

Respiratory Illnesses

- **Season included influenza, COVID-19, and RSV**
- **Respiratory illness peaked week ending Feb 8, 2025**
- **<u>H5N1 Preparedness & Response (2024–2025)</u>**
  - Multistate outbreak in dairy cattle prompted preparedness actions
  - VDH activated Incident Command Structure during two H5 bird detections
  - 200+ individuals monitored for avian influenza exposure
- **83% reduction in VDH respiratory disease team in March 2025 due to loss of federal funding**
  - Loss of 10 staff members
- **<u>“The Little Things” Campaign</u>**
  - New statewide campaign promoting small, everyday protective behaviors
  - Characters personify actions: handwashing, covering coughs, getting immunized, etc.
  - Materials available in English and Spanish

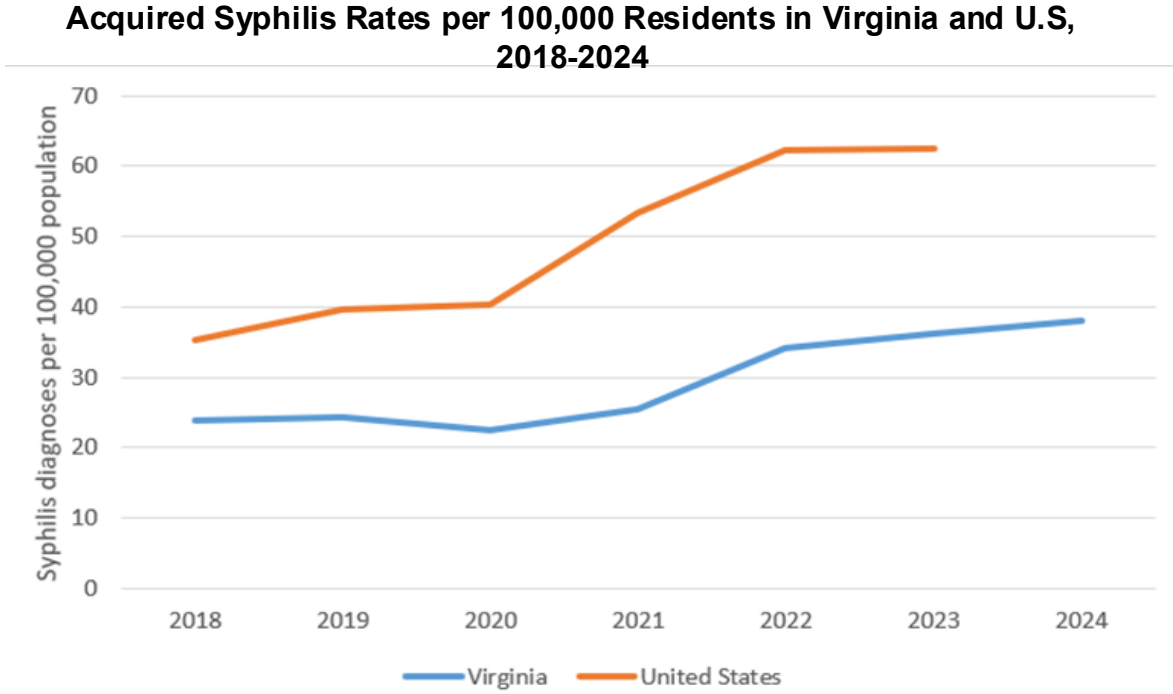
Syphilis and Congenital Syphilis

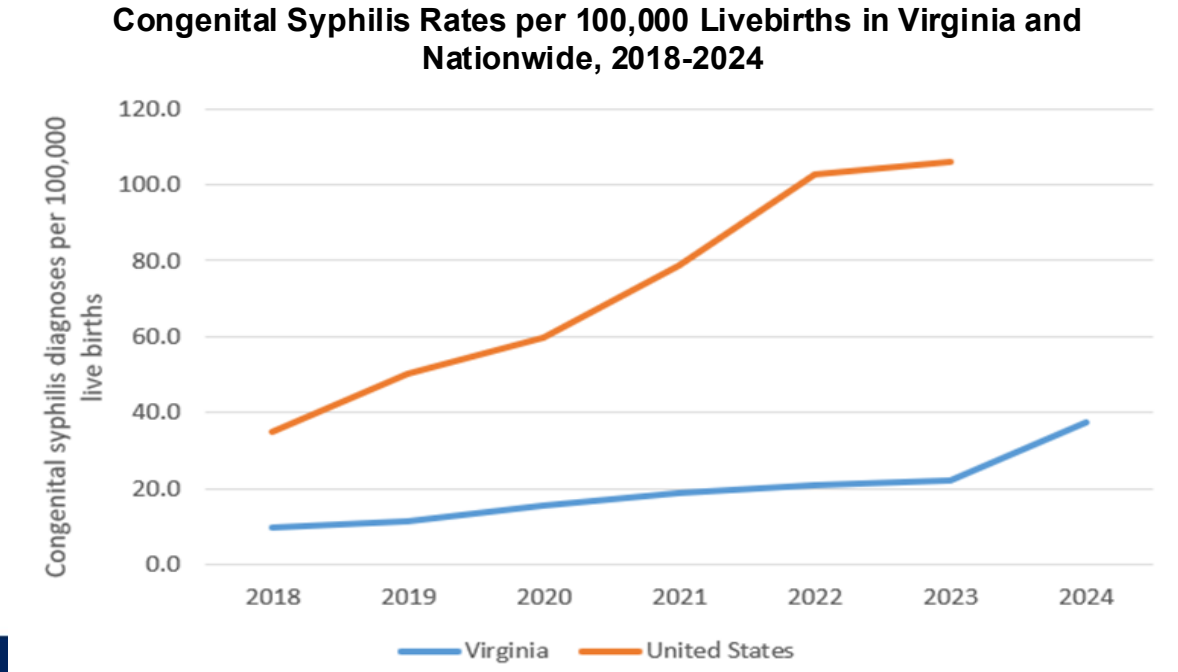
Syphilis

- Virginia's syphilis rate increased 60.2% (2020–2024)
- National increase of 54.7% (2020–2023)
- 2024 Virginia rate: 38.1 cases per 100,000

Congenital Syphilis (CS)

- CS cases in the United States in 2023 reached the highest level seen since 1992
- 2023 Virginia CS rate: 22.0 per 100,000 live births
- 2023 U.S. CS rate: 105.8 per 100,000 live births
- 2023–2024 Virginia CS rate increased 71%





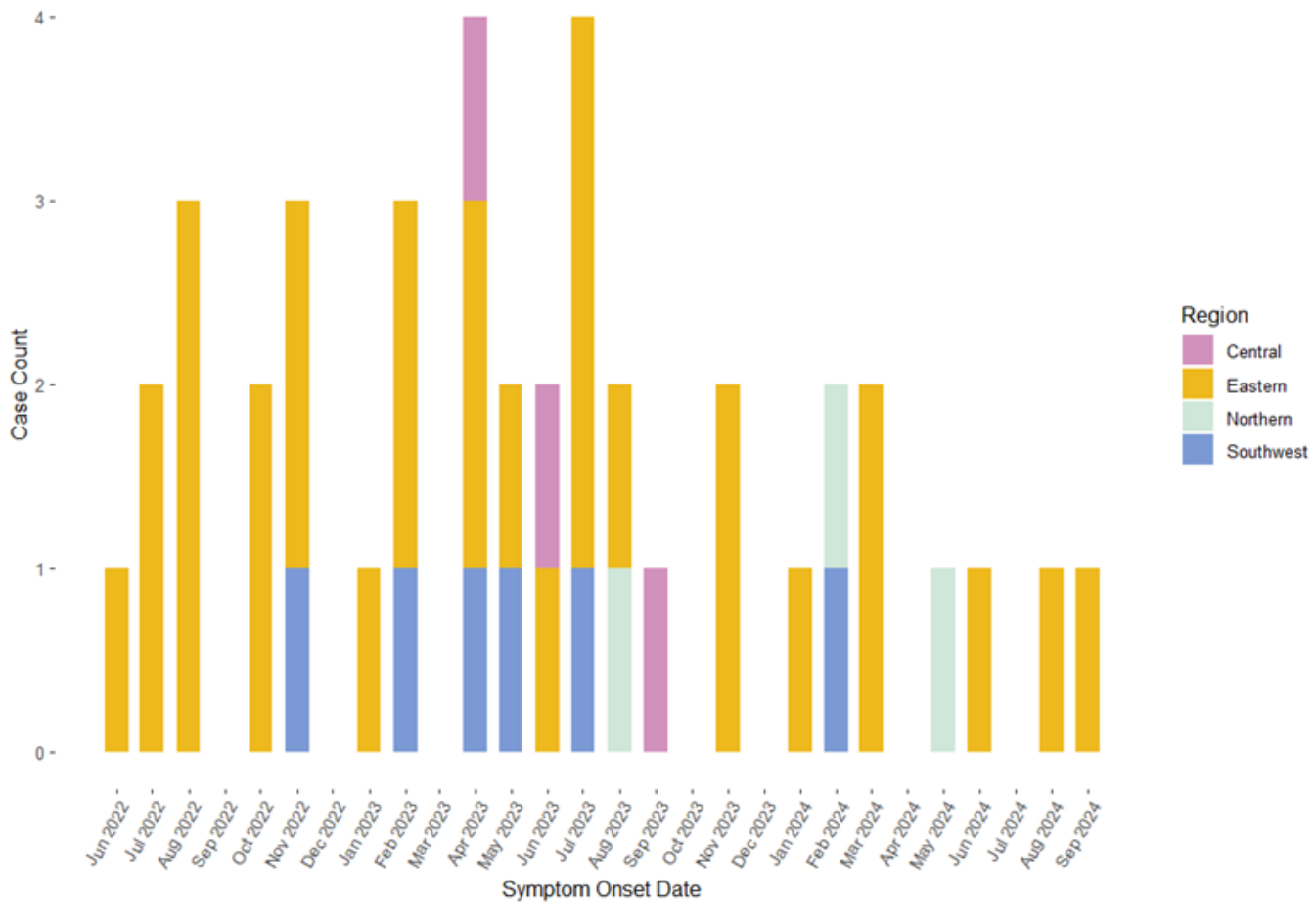
Measles

- **Initial March 2025 Cases**
  - Two Maryland residents diagnosed after international travel
  - VDH managed public exposures at Dulles International Airport and locations in Northern Virginia
- **April 19 Case – Northwest Virginia**
  - Preschool-aged child with recent international travel
  - VDH coordinated:
    - Post-exposure prophylaxis (PEP)
    - Quarantine recommendations for non-immune contacts
- **May Case – Northwest Virginia**
  - Teenager with international travel exposure
  - Joint response with UVA Hospital:
    - Provided PEP
    - Issued quarantine guidance
- **August Case – Eastern Region**
  - School-age child with international travel
  - VDH issued regional news releases to notify public of exposure locations

Meningococcal Disease

- **Since 2022, Virginia has reported an increase in cases of meningococcal disease primarily attributed to a statewide outbreak of *N. meningitidis* serogroup Y sequence type 1466 (NmY ST1466)**
  - From June 2022 – September 2024, 41 outbreak cases were reported across Eastern (29), Southwest (6), Central (3) and Northern Virginia (3), including eight fatalities
- **Outbreak cases disproportionately occurred in people ages 30–60 years (64%), Black or African American people (76%), and people with HIV (12%). Thirty-nine patients (95%) were unvaccinated against N. meningitidis serogroup Y.**

Meningococcal Disease Outbreak Cases June 2022- September 2024



Healthcare Workforce Incentives

The VDH Health Workforce Unit administers 15 distinct workforce incentive programs designed to recruit, retain, and support healthcare providers, particularly in underserved communities.

- These programs collectively manage $18.3 million in state general funds and $822,000 in federal funds
- To date, the unit has issued nearly 350 incentive payments totaling $2.45 million.

Earn to Learn Nursing Education Acceleration Program

- Provides funding to educational institutions in the Commonwealth that offer Virginia Board of Nursing-approved nursing education programs for pre-licensure Registered Nurses (RN) and Licensed Practical Nurses (LPN) to foster collaborative clinical training arrangements between grant recipients, hospitals, and health providers.
- **First cohort:**
  - Comprised of 13 academic institutions
  - 10 grantees requested to extend their contracts
  - VDH plans to obligate the $7.59M from FY25 and FY26

Local Health District Clinical Service Delivery

Core services:

- **Public health surveillance**
- **Communicable disease investigations**
- **STI management**
- **Environmental health inspections**

FY25 Clinical Encounter Highlights:

- 137,025 immunizations administered
- Top vaccines: Tdap (26,535), Meningococcal (21,585)
- 91,312 STI tests/treatments
- Top tests: Chlamydia & Gonorrhea (24,681), HIV (20,598), Syphilis (20,168)
- 40,218 family planning encounters
- Frequent services: Depo-Provera (11,556), Pregnancy testing (10,370)
- 254,533 TB-related encounters
- Most common: Office visits (78,376), TB education (63,390)

RECOMMENDATIONS

Recommendations: Social Determinants

- Improve access to care by reducing transportation, geographic, and digital barriers through community-based services, such as establishing public transit partnerships or utilizing ride-sharing services, and expanding connectivity through supporting mobile clinics, telehealth, and investing in broadband access to reduce digital divides.
- Advance equitable care delivery by promoting culturally responsive practices, language access, and routine screening for social needs with clear referral pathways.
- Support education and workforce development by strengthening health literacy and creating health career pipeline programs.
- Address housing instability by increasing support for permanent supportive housing.
- Promote food security initiatives by integrating nutrition education into healthcare and other community programs, screening for food insecurity, and expanding WIC and nutrition program participation, with targeted outreach to underserved populations.

Recommendations: Maternal & Child Health

- Enhance support for pregnant and postpartum individuals with substance use challenges by integrating peer recovery and perinatal into care settings.

- Strengthen workforce capacity through training for support professionals (e.g. doulas, community health workers, peer support specialists) working with this population.

Recommendations: Youth Suicide Prevention

- Expand prevention efforts for youth by addressing the unique needs of young people following high school, including those entering the workforce, military, or higher education.

- Ensure VDH undergoes strategic planning by convening a taskforce to update the Virginia Suicide Prevention Plan every three years, focusing on preventing suicide through youth-specific strategies.

- Improve access to mental health care by strengthening the mental health workforce in Virginia and increasing the accessibility of mental health resources.

Recommendations: Substance Use & Overdose

- Support high-demand harm reduction services by ensuring adequate staffing and resources to maintain quality and accessibility of high-volume CHR sites.

- Continue efforts to partner with local community partners to enhance availability of needed resources (i.e., providing naloxone and distributing test strips)

Recommendations: Chronic Disease

- Strengthen statewide chronic disease prevention by enhancing public health capacity, fostering clinical-community partnerships, and improving data surveillance to address disparities.

- Facilitate timely data sharing of cancer registry data to researchers and academic centers who use the data to advance cancer research.

Recommendations: Infectious Disease

- Sustain comprehensive surveillance for respiratory and other infectious diseases using advanced tools and monitoring systems.
- Maintain robust outbreak detection through active and passive disease surveillance.
- Promote and facilitate increased vaccination uptake for key vaccine preventable diseases to reach herd immunity thresholds.
- Focus immunization efforts on vulnerable and high-risk populations to reduce health disparities

QUESTIONS

Virginia Department of Health, Office of Emergency Medical Services (OEMS)
OEMS Strategic Plan
Interim Statewide EMS Strategic

Mission

Support the essential functions of public health through a coordinated, people centered Emergency Medical Care system for the Commonwealth of Virginia.

Vision

Support a comprehensive, efficient, and resilient Emergency Medical Care System within the Commonwealth of Virginia that is focused on the core public health mission.

Goals

1. Ensure the Office of EMS is properly positioned to support the essential public health functions of Virginia's emergency care system.
    a. The Office of EMS will focus on essential functions such as EMS training, Certification and Regulation, and Trauma System administration, to ensure that the needs of Agencies, Providers, Councils, and other stakeholders are met
    b. Administer Return to Locality, Rescue Squad Assistance Fund, Trauma Fund, and other Code mandated programs in an efficient, timely, and accountable fashion
    c. Create an actionable plan to ensure that the Office of EMS can meet its mission into the future in a fiscally responsible way.
2. Create a new strategic and operational plan based on engagement with multiple sectors and community partners to support the mission of the Office of EMS.
    a. Work with members of the EMS Advisory board, EMS Agencies, EMS Council leaders, and other EMS stakeholders and community partners to create a Strategic and Operational plan for FY2025 and beyond that is built on the core public health mission of the Office of EMS.
    b. Keep accountability to the EMS community front of mind as we institute the proper financial controls and processes to ensure programs and Code required functions are properly aligned with available resources
3. Maintain and build a competent, engaged, and valued workforce.
    a. Focus on activities and processes that promote increased retention and engagement with OEMS staff
    b. Realign leadership structure of OEMS to create better focus on functions, increased communication, and higher levels of accountability from leadership and staff.
    c. Provide for transparency in decision-making as appropriate to staff of OEMS and stakeholders in the EMS community

COMMONWEALTH of VIRGINIA
Department of Health

B. Cameron Webb, MD, JD
State Health Commissioner

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RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

02/26/2026

DECISION MEMORANDUM

TO: State Board of Health

FROM: B. Cameron Webb, MD, JD,
State Health Commissioner

SUBJECT: Extension of the OEMS Interim Strategic Plan and Authorization of a Statewide EMS System and Community Needs Assessment Aligned with EMS Agenda 2050

I. PURPOSE

Approval to extend the current Office of Emergency Medical Services (OEMS) Interim Statewide Emergency Medical Services (EMS) plan to maintain operational stability while a new statewide EMS strategic framework is developed; and

Authorization to conduct an 18-month Statewide EMS System and Community Needs Assessment, aligned with the national *EMS Agenda for the Future 2050*, during the extension period in order to develop the Commonwealth's next multi-year EMS strategic and operational plan.

II. BACKGROUND

Code of Virginia § 32.1-111.3 requires the Board of Health to develop a Statewide Emergency Medical Services (EMS) Plan. The Office of Emergency Medical Services is currently operating under an Interim Statewide EMS Plan designed to stabilize operations, strengthen fiscal accountability, reinforce essential public health functions, and prepare for development of a longer-term strategy.

The Interim State EMS Plan focuses on:

1. Supporting essential EMS public health functions, including certification, regulation, and trauma system administration.

2. Administering Code-mandated programs such as Return to Locality, Rescue Squad Assistance Fund, and the Trauma Fund.
3. Ensuring financial controls and responsible resource alignment.
4. Strengthening workforce retention, leadership structure, and transparency.
5. Developing a future strategic and operational plan grounded in stakeholder engagement.

While the Interim State EMS Plan has successfully supported stabilization and accountability, the Commonwealth has an opportunity to strengthen the evidentiary foundation for its next State EMS Plan through a comprehensive statewide assessment integrating clinical performance data, hospital interface metrics, workforce sustainability indicators, and broader community determinants of health.

The proposed statewide assessment will provide that foundation and directly inform development of the Commonwealth's next multi-year EMS strategic and operational plan.

III. JUSTIFICATION

A. Extension of the Interim State EMS Plan

The Interim State EMS Plan was intentionally designed as a transitional framework. During a period of transition, the intent of the Interim State EMS Plan was to:

- Maintain continuity of essential services and Code-mandated responsibilities.
- Avoid adoption of a long-term strategic plan without validated statewide data.
- Ensure that future priorities reflect current operational realities, equity considerations, workforce dynamics, and hospital interface challenges.
- Provide stakeholders clarity that the next strategic plan will be informed by a transparent, data-driven process.

Extension of the Interim State EMS Plan will preserve operational stability while the Commonwealth undertakes a structured and comprehensive statewide evaluation of the EMS system.

B. Authorization of the Statewide EMS System and Community Needs Assessment

The Statewide assessment is necessary to:

1. Establish a comprehensive baseline of EMS system performance using National EMS Information System (NEMSIS) data and National EMS Quality Alliance (NEMSQA) measures.
2. Evaluate hospital interface dynamics, including emergency department offload intervals and system flow.
3. Incorporate community-level context through County Health Rankings and Roadmaps and the Centers for Disease Control and Prevention and Agency for Toxic

Substances and Disease Registry Social Vulnerability Index to advance equity-focused analysis.
4. Engage EMS agencies, hospitals, Community Services Boards, Local Health Districts, local governments, and patients to capture lived experience and system barriers.
5. Align Virginia's EMS system modernization efforts with the six guiding principles of *EMS Agenda for the Future 2050*: safety and effectiveness, integration, equity, reliability and preparedness, sustainability and efficiency, and adaptability and innovation.

The assessment will be conducted over 18 months using the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework and will culminate in a Statewide EMS Needs and Opportunities Report that will serve as the evidentiary foundation for the Commonwealth's next multi-year EMS strategic and operational plan.

No new programmatic funding is requested during the assessment phase, and the work will be conducted using existing staff capacity and data infrastructure. Any future resource recommendations will be presented following completion of the assessment.

Extension of the Interim State EMS Plan and authorization of the statewide assessment are complementary actions designed to ensure operational stability while establishing a validated, data-driven foundation for the Commonwealth's next EMS strategic plan.

IV. RECOMMENDATION

It is respectfully recommended that:

1. Approve extension of the current Office of Emergency Medical Services (OEMS) Interim State EMS Plan through completion of the statewide assessment and subsequent adoption of a new multi-year EMS strategic and operational plan; and

2. Authorize the Virginia Department of Health, Office of Emergency Medical Services, in coordination with the State EMS Advisory Board, to initiate and complete the 18-month Statewide EMS System and Community Needs Assessment aligned with *EMS Agenda for the Future 2050*. This plan will be effective July 1, 2027.

Upon completion of the assessment, the Office of Emergency Medical Services will submit:

- The Statewide EMS Needs and Opportunities Report;
- A new multi-year EMS strategic and operational plan grounded in validated findings and aligned with the regional EMS council planning cycle; and
- Any recommended policy, regulatory, or funding actions for consideration.

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.

Joint Commission on Health Care

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Vice Chair

The Honorable Senator Ghazala F. Hashmi

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Access to Pharmacy Services in Virginia

Contents

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)

November 2025

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.

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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

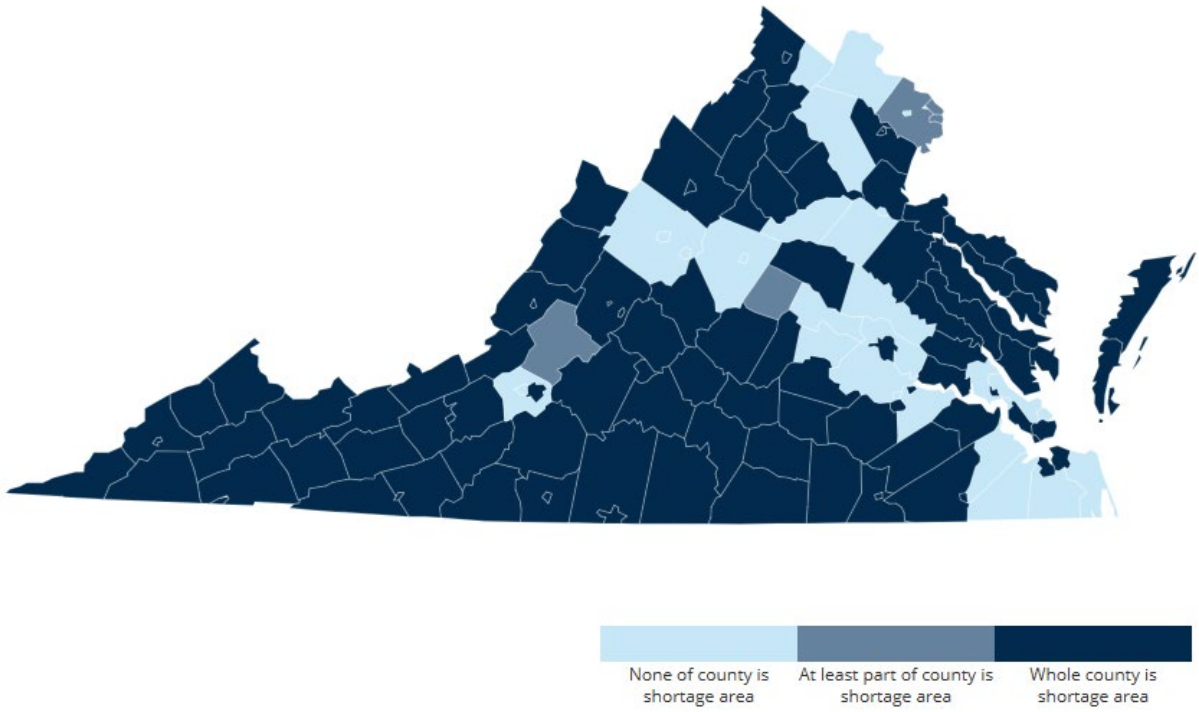
Pharmacist authority to administer drugs and vaccines. Pharmacists can dispense and administer certain drugs - such as naloxone, epinephrine and prenatal vitamins - and vaccines in the absence of a prescription. Pharmacies continue to be the primary source of COVID-19 vaccinations in the United States. 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.

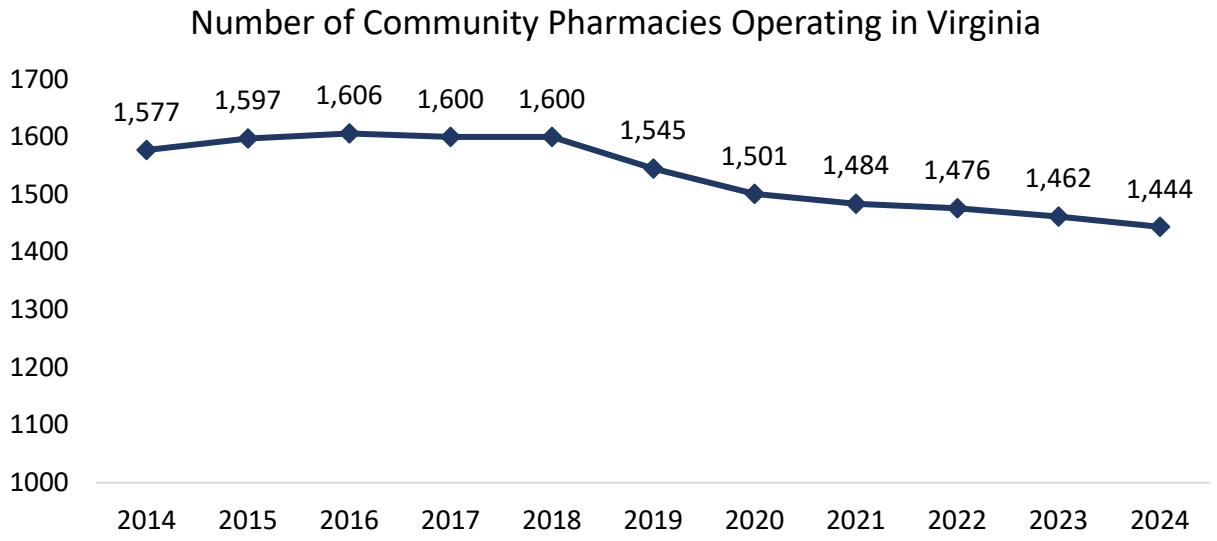
Access to community pharmacies is changing in Virginia

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.

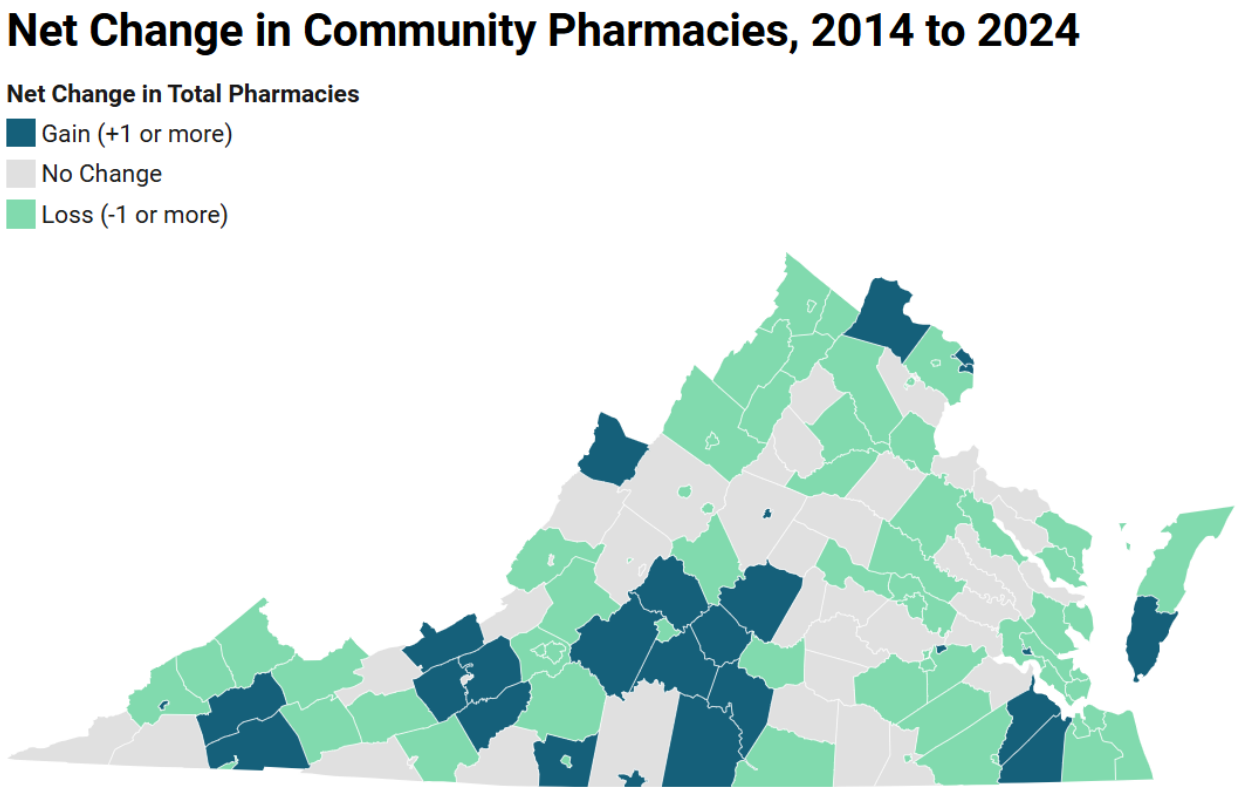
FIGURE 2. Operating community pharmacies have declined by eight percent



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



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

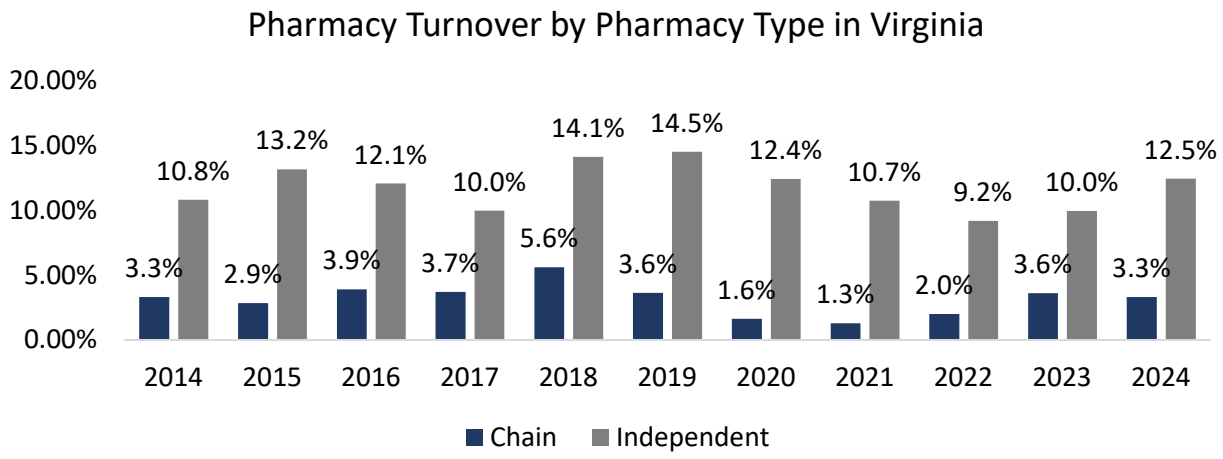
Category	Rural (Percent Change)	Suburban (Percent Change)	Urban (Percent Change)
Net Gain	19 (19.2%)	4 (20.0%)	5 (31.3%)
No Change	37 (37.4%)	3 (15.0%)	0 (0.0%)
Net Loss	43 (43.4%)	13 (65.0%)	11 (68.8%)
Total	99	20	16

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.

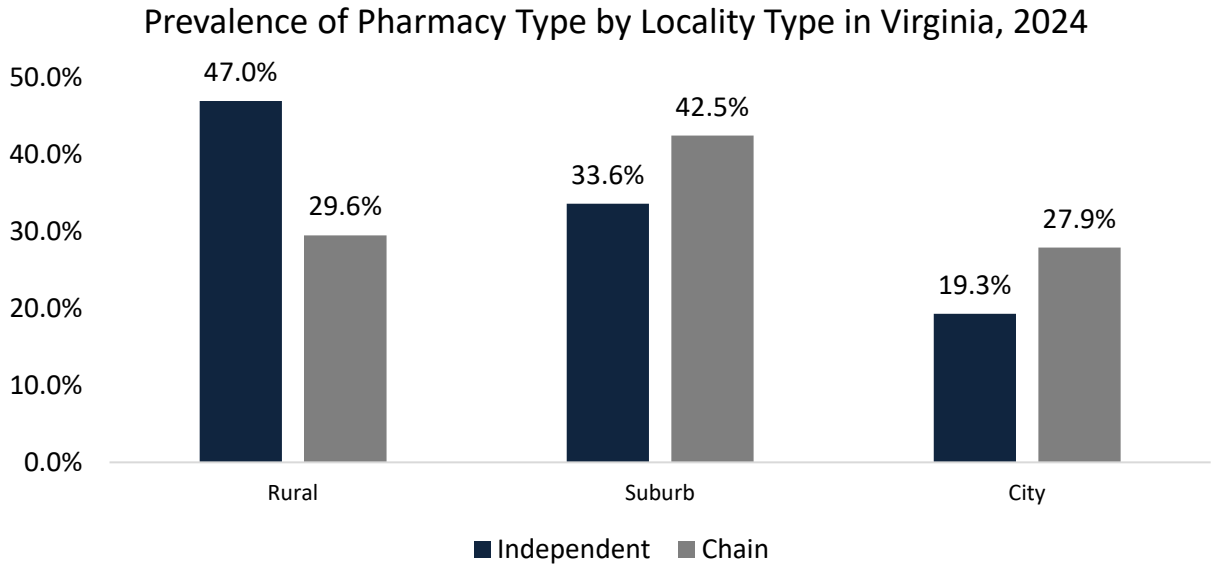
TABLE 2. Percent of pharmacies operating three, four, and five years after opening

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

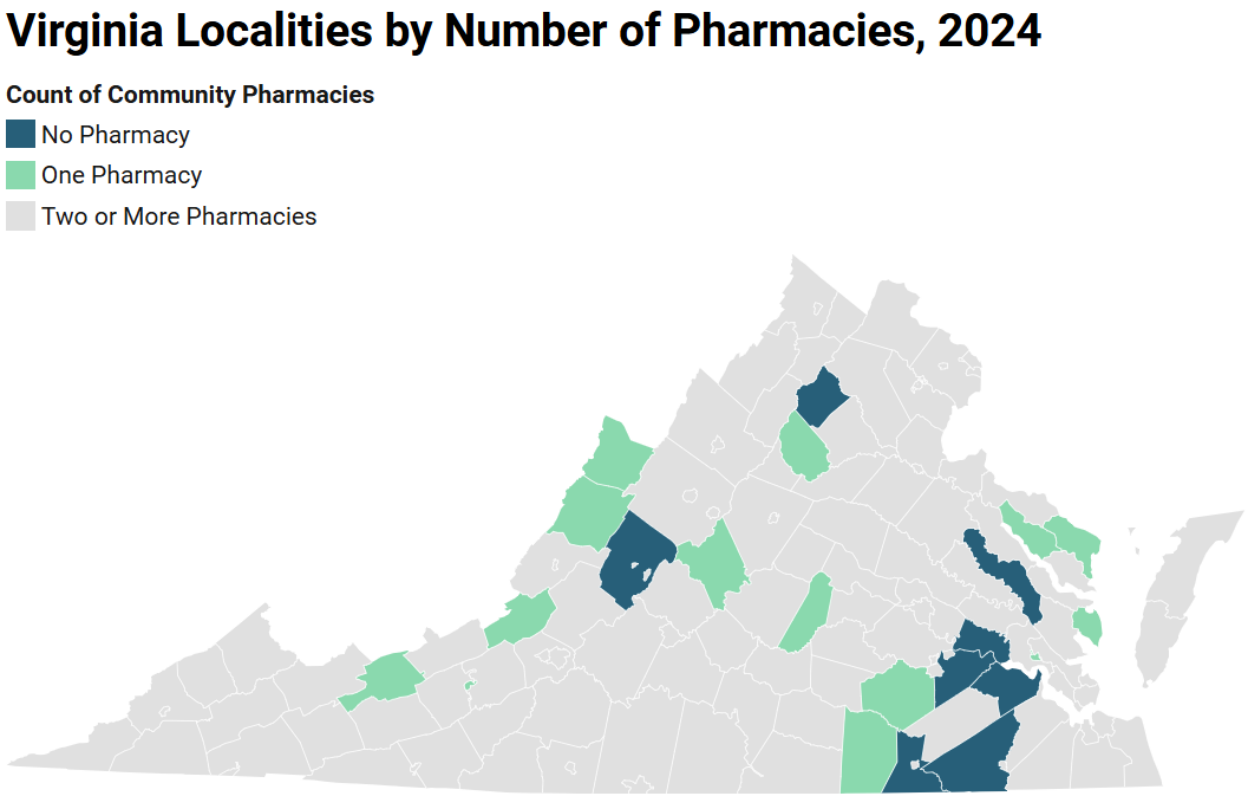


SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

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



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 N = 1857 census tracts	Limited access 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

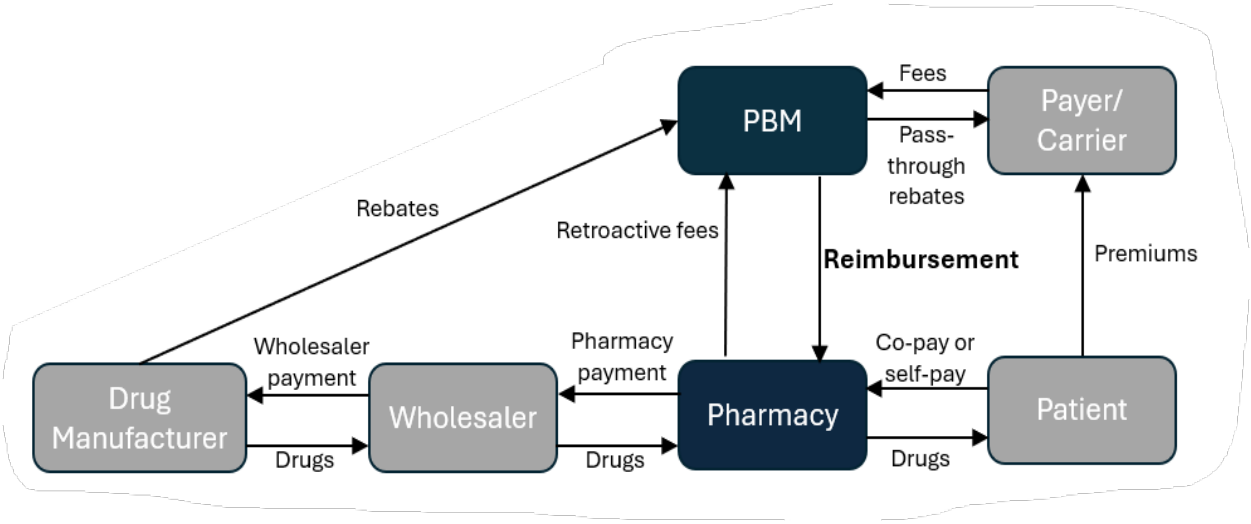
The primary source of revenue for community pharmacies is reimbursement fees for dispensing of medications, though community pharmacies can also earn revenue from

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 pharmacies[i] 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 Mangers (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 Formularies 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 Permante (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 Appropriate 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 Appropriate 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). Viginia'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 study[i] 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

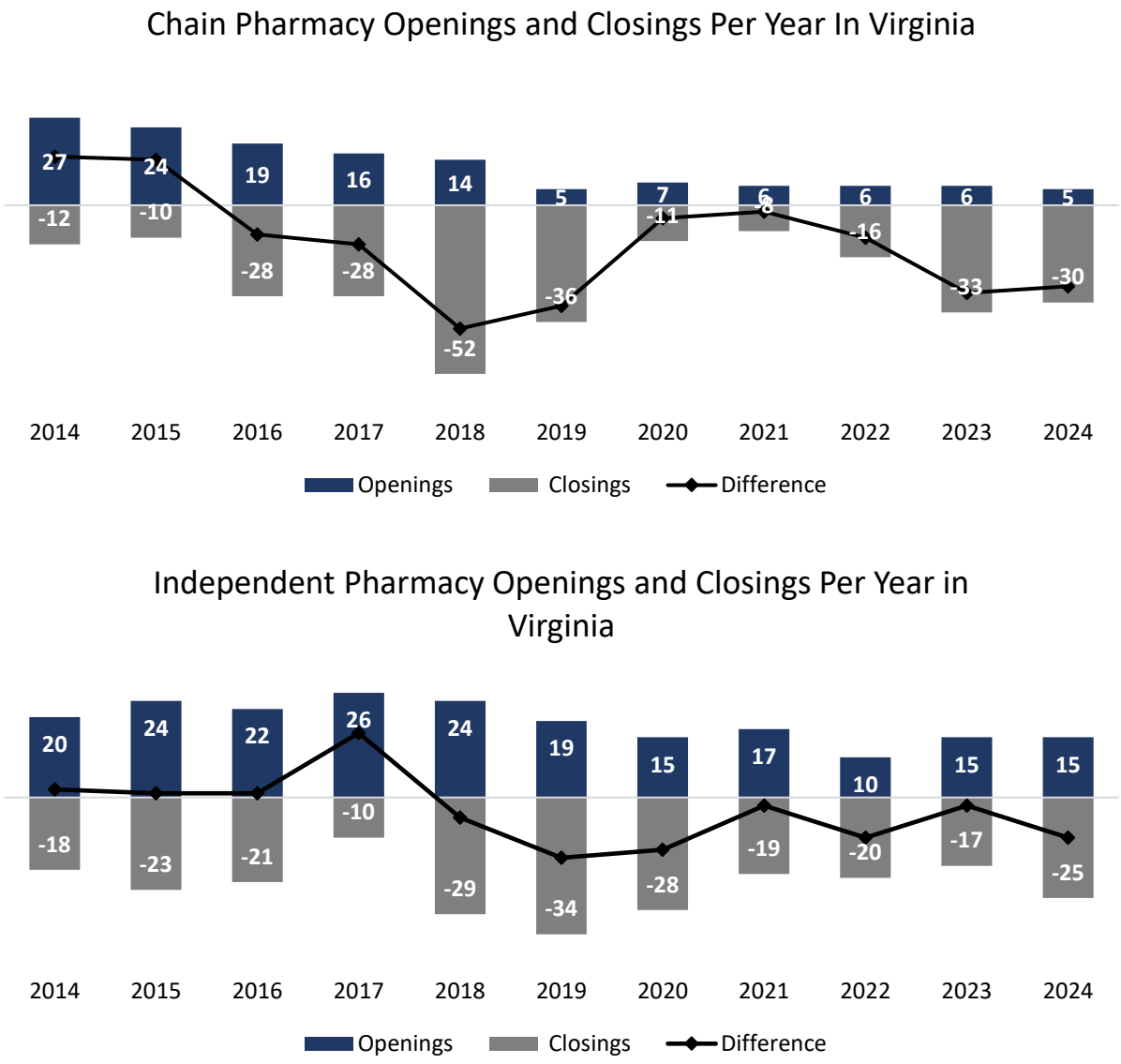
Locality	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Cumberland	1	1	1	1	1	1	1	1	1	1	1
Danville	18	18	19	18	18	18	17	18	18	18	19
Dickenson	7	7	7	7	7	7	7	7	7	6	6
Dinwiddie	3	2	2	2	2	1	1	1	1	1	1
Emporia	3	3	4	3	3	3	2	2	2	2	2
Essex	3	3	3	3	3	3	3	3	3	3	2
Fairfax County	180	185	183	186	193	181	171	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.

JOINT COMMISSION ON HEALTH CARE

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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
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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

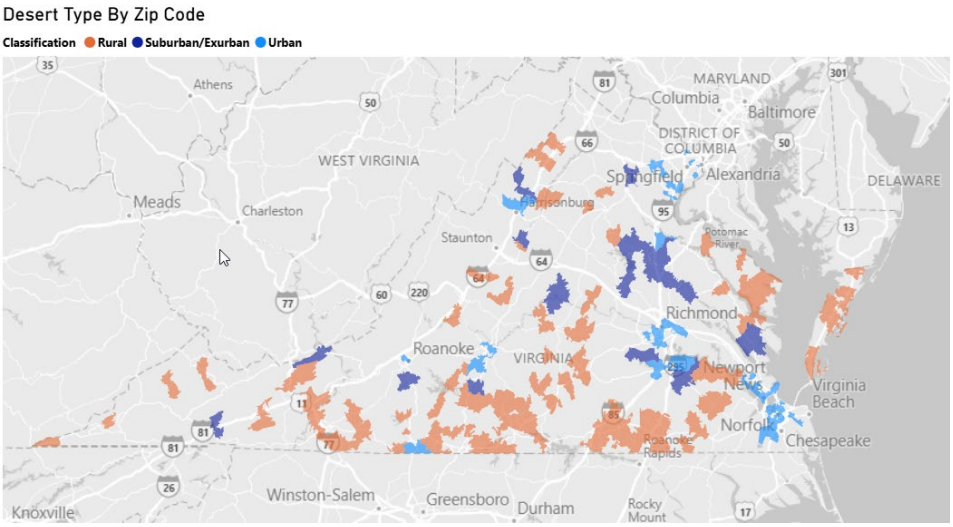


Figure 2: Richmond Pharmacy Desert Types (Urban)

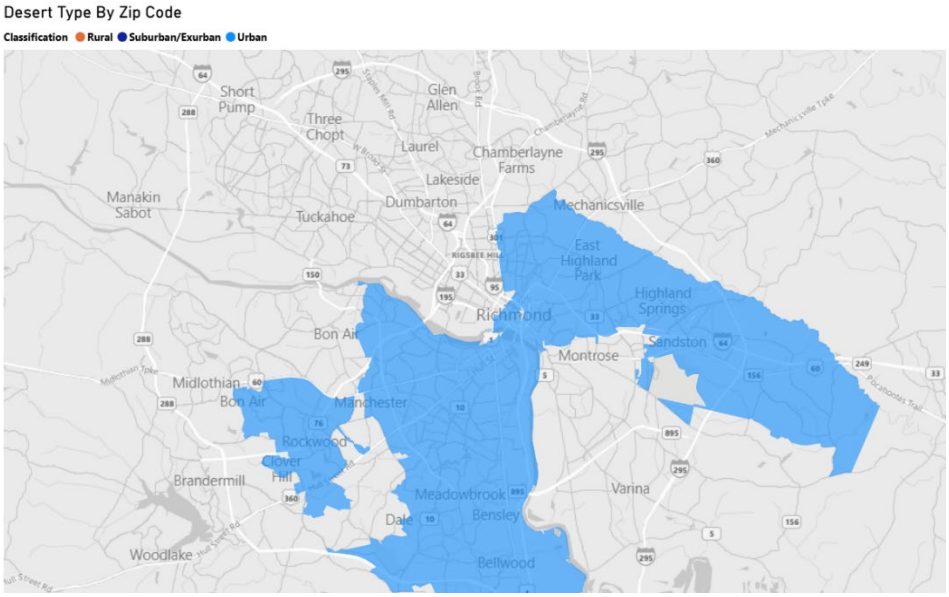


Figure 3: Norfolk Pharmacy Desert Types (Urban)

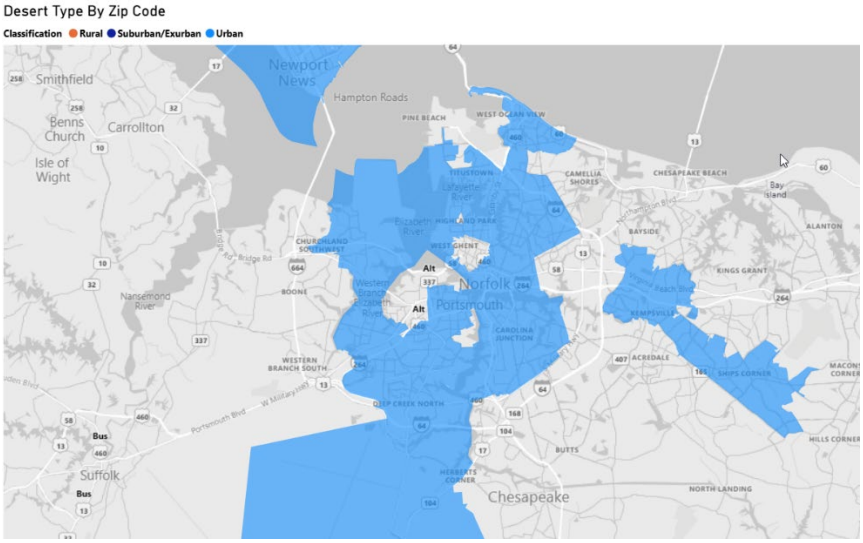
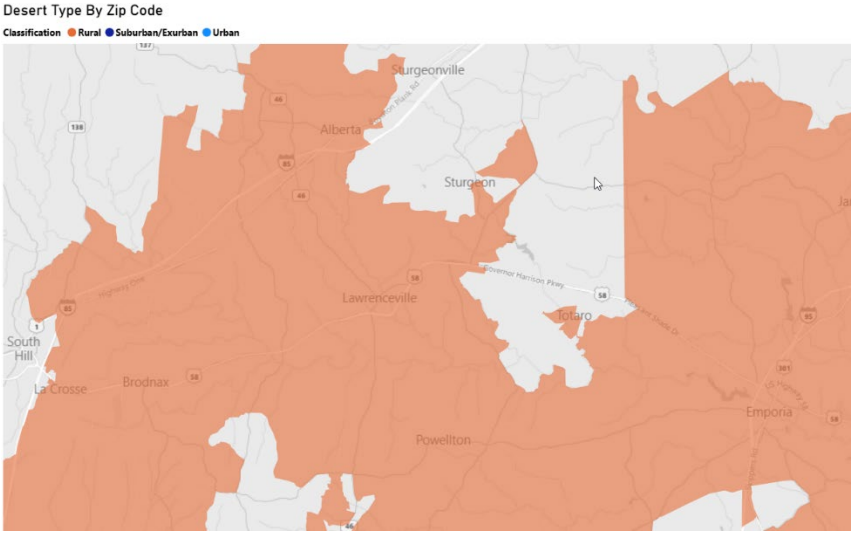


Figure 4: Lawrenceville Pharmacy Desert Types (Rural)



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).

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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*.

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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

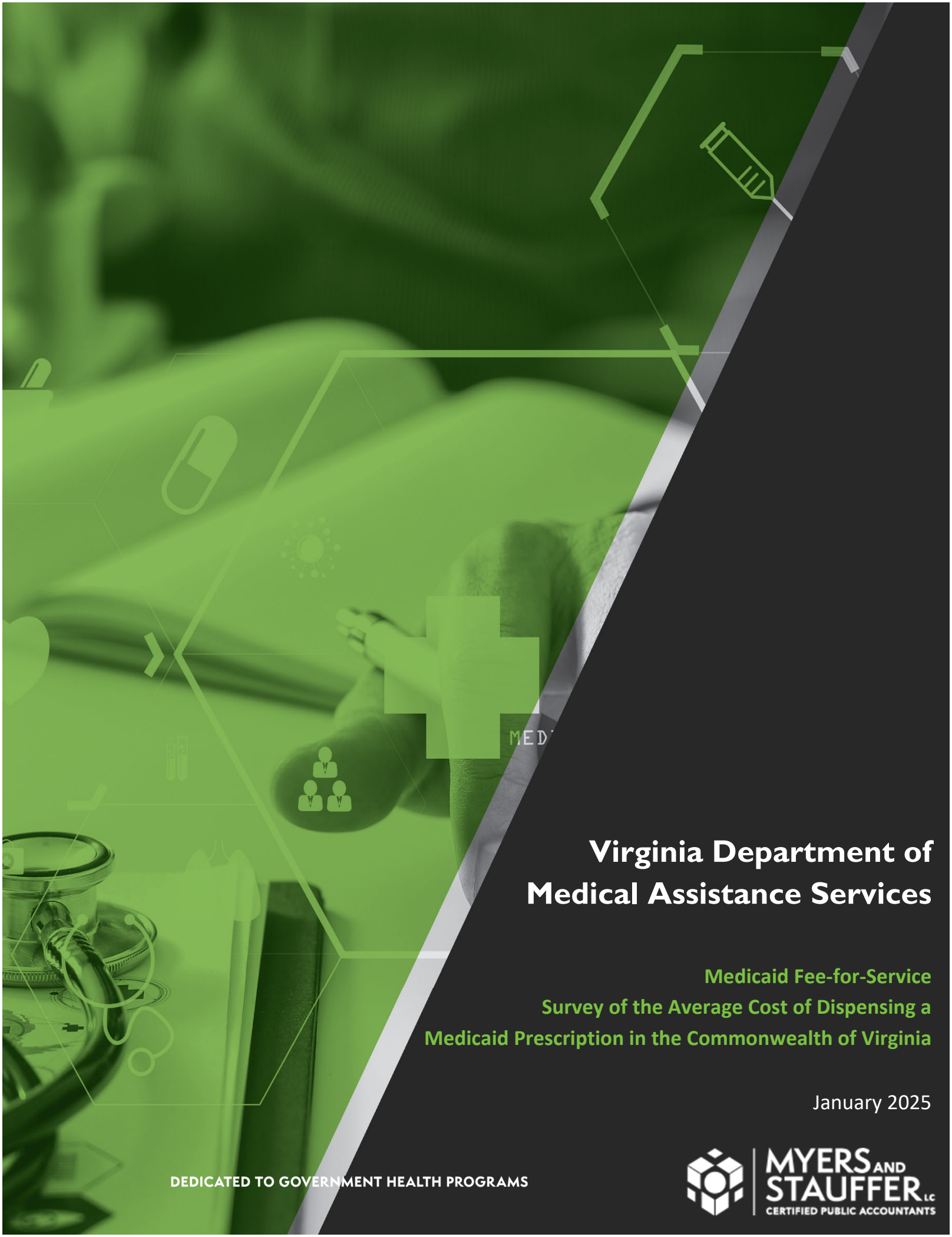
Rural versus Urban Specialty Generic Pharmacy Reimbursement				
SFY	Average Ingredient Paid as Percent of AWP: Urban	Average Ingredient Paid as Percent of AWP: Rural	Average Dispensing Fee: Urban	Average Dispensing Fee: Rural
2023	32.21%	37.53%	$1.95	$0.61
2024	32.65%	32.64%	$2.40	$0.83
2025	31.69%	31.38%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



Virginia Department of Medical Assistance Services

Medicaid Fee-for-Service Survey of the Average Cost of Dispensing a Medicaid Prescription in the Commonwealth of Virginia

January 2025

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

EXHIBITS

Chapter 1: Executive Summary

Introduction

Under contract to the Virginia Department of Medical Assistance Services (DMAS), Myers and Stauffer LC performed a study of pharmacy dispensing cost. The cost of dispensing study followed the methodology and used a survey instrument similar to those used by Myers and Stauffer in a previous survey for DMAS and in surveys for Medicaid pharmacy engagements in several other states. The methodology was consistent with guidelines from the Centers for Medicare and Medicaid Services (CMS) regarding the components of pharmacy cost that are appropriately reimbursed by the pharmacy dispensing fee of a state Medicaid fee-for-service (FFS) program.

DMAS provides prescription services to Medicaid members in the Commonwealth of Virginia through both a FFS program and through five contracted managed care organizations. On an annual basis, there are approximately 43,000 members utilizing the FFS pharmacy program filing approximately 280,000 prescriptions. Total dispensing fees paid for FFS prescriptions are approximately $2.4 million per year. In comparison, the managed care program accounts for approximately 20 million prescriptions dispensed per year with dispensing fees determined by the individual managed care organization and their contracted pharmacy benefit manager (PBM).

The cost of dispensing survey followed the methodology and used a survey instrument similar to those used by Myers and Stauffer in previous surveys for DMAS and Medicaid pharmacy engagements in several other states. The methodology was consistent with guidelines from the Centers for Medicare and Medicaid Services (CMS) in its finalized rule for Medicaid FFS pharmacy reimbursement regarding the components of pharmacy cost that are appropriately reimbursed by the pharmacy dispensing fee of a state Medicaid program (CMS-2345-FC) and furthermore consistent with recent clarifications relating to adequate support for changes to Medicaid professional dispensing fees as described in CMS-2434-F (e.g., “adequate cost-based data, such as a State or national survey of retail pharmacy providers”).

Myers and Stauffer obtained from DMAS a list of pharmacy providers currently enrolled in the Virginia Medicaid pharmacy program. According to the provider list, there were 1,781 pharmacy providers that were enrolled in the Virginia Medicaid pharmacy program. Although the pharmacy provider list was compared to a listing of pharmacies obtained from the Virginia Board of Pharmacy, Myers and Stauffer relied on the DMAS list of pharmacies as the basis for the cost of dispensing survey and all 1,781 pharmacies enrolled in Virginia Medicaid were requested to submit survey information for this study.

Myers and Stauffer performed desk review procedures to test completeness and accuracy of all dispensing cost surveys submitted. There were 434 pharmacies that filed cost surveys that could be included in this analysis. Data from these surveys, in conjunction with pharmacy-specific cost-finding algorithms, was used to calculate the average cost of dispensing at each pharmacy and results from these pharmacies were subjected to statistical analysis.

Summary of Findings

Per the survey of pharmacy dispensing cost for pharmacies participating in the Virginia Medicaid program, the mean cost of dispensing, weighted by Medicaid volume, was $13.70 per

prescription for all pharmacies including specialty pharmacies.[1] For non-specialty pharmacies only, the mean cost of dispensing, weighted by Medicaid volume, was $12.72 per prescription. Table 1.1 includes additional measures of the average cost of dispensing.

Table 1.1 Dispensing Cost for Virginia Medicaid Pharmacies

	All Pharmacies Inclusive of Specialty	Non-specialty Pharmacies Only
Pharmacies Included in Analysis	434	355
Unweighted Mean (Average) [A]	$31.52	$14.51
Weighted Mean (Average) [A,B]	$13.70	$12.72
Unweighted Median [A]	$12.73	$11.82
Weighted Median [A, B]	$11.69	$11.39

[A] Inflated to common point of June 30, 2024 (midpoint of year ending December 31, 2024).
[B] Weighted by Medicaid volume.

There are several statistical measurements that may be used to express the central tendency, or "average", of a distribution, the most common of which are the mean and the median. Weighted means and medians are often preferable to their unweighted counterparts. The weighted mean is the average cost for all prescriptions, rather than the average for all pharmacies as in the unweighted mean. This implies that low volume pharmacies have a smaller impact on the weighted average than high volume pharmacies. The weighting factor can be either total prescription volume or Medicaid prescription volume. The weighted median is determined by finding the pharmacy observation that encompasses the middle value prescription. The implication is that half of the prescriptions were dispensed at a cost of the weighted median or less, and half were dispensed at the cost of the weighted median or more. As with the weighted mean, the weighting factor can be either total prescription volume or Medicaid prescription volume.

For both weighted means and weighted medians, the use of Medicaid prescription volume as the weighting factor is particularly meaningful for consideration in determining appropriate reimbursement since it emphasizes the cost of dispensing from those pharmacies that dispense more significant volumes of Medicaid prescriptions.

Conclusions

Cost of Dispensing Trends

Myers and Stauffer has performed multiple cost of dispensing studies for Virginia and other states during the decade between 2010 and 2020. In most of these surveys we have observed a pattern of little to no cost increase over time. While some input costs, including labor, increased over this time period, other factors, including increased efficiencies associated with dispensing

[1] For purposes of this report, "specialty" pharmacies are those pharmacies that self-reported sales for intravenous, home infusion, blood factor and/or other specialty products of 30 percent or more of total prescription sales.

prescriptions, restrained the increase in the cost of dispensing, *on a per prescription basis*. This phenomenon has been observed by other researchers as well.

An increase in the average cost of dispensing on the order of 20 percent to 30 percent has been observed in the most recent cost of dispensing survey depending on the specific measurements of cost being compared. Broad economic factors, including inflationary pressures, appear to have had an impact on pharmacy costs and increases were observed within both the overhead and labor components of the cost of dispensing.

Professional Dispensing Fee Options

Federal regulations at 42 CFR § 447.518(d) require that when states propose changes in the Medicaid FFS pharmacy program to either the ingredient portion of pharmacy reimbursement or the professional dispensing fee, states must consider both to ensure that total reimbursement to the pharmacy provider is in accordance with requirements of section 1902(a)(30)(A) of the Social Security Act. Furthermore, states must provide adequate data, such as an in-state or other survey of retail pharmacy providers, to support any proposed changes to either the professional dispensing fee or ingredient component of the pharmacy reimbursement methodology. Professional dispensing fees must also be supported by adequate cost-based data such as the findings of the survey methodology described within this report.

There are several options which DMAS can consider for the professional dispensing fee portion of reimbursement for the FFS pharmacy program. The use of a single professional dispensing fee for all pharmacies represents the simplest reimbursement option and is the most widely used methodology for pharmacy dispensing fees among state Medicaid FFS programs.

Based on the results of the survey of pharmacy dispensing cost, a single dispensing fee of $13.70 would reimburse the weighted average cost of dispensing prescriptions to Virginia Medicaid FFS members inclusive of both specialty and non-specialty pharmacies. A single dispensing fee of $12.72 would reimburse the weighted average cost of dispensing prescriptions to Virginia Medicaid FFS members for non-specialty pharmacies but would not account for the cost of dispensing prescriptions by specialty pharmacies.

As an alternative to a reimbursement methodology based on a single dispensing fee, several states have adopted professional dispensing fee methodologies that either recognize differences in cost among categories of pharmacies or are designed to incentivize a desired behavior. The total volume of prescriptions dispensed and the cost of dispensing at an individual pharmacy typically have been inversely correlated. A tiered approach to professional dispensing fees has the advantage of setting dispensing fees that are better matched, on average, to an individual pharmacy's cost of dispensing. However, the use of any tiered dispensing fee methodology creates additional complexity and results in increased administrative burdens for a Medicaid program. This report includes average cost of dispensing measurements for tiers based on pharmacy total prescription volume which can be considered in the process of evaluating potential professional dispensing fees for the Virginia Medicaid FFS program.

Despite indications that the cost of dispensing in specialty pharmacies varies from the cost of dispensing in non-specialty pharmacies, the use of a differential dispensing fee for specialty pharmacies is relatively infrequent among state Medicaid FFS programs. Several states have set dispensing fees based on the cost of dispensing observed at non-specialty pharmacies. This report includes average cost of dispensing measurements for several categories of specialty pharmacies which can be considered in the process of evaluating professional dispensing fees for the Virginia Medicaid FFS program.

Additional Recommendation

Myers and Stauffer has noted in numerous engagements for other state Medicaid programs that having regulatory language or a provision in the Medicaid provider agreement requiring pharmacies to participate in the cost of dispensing survey will increase the response rate. Several chain organizations will only participate in a cost of dispensing survey if there is a requirement. The Virginia legislature and/or DMAS should update cost of dispensing survey participation requirements before the next cost of dispensing survey is due to be conducted in 2029.

Chapter 2: Dispensing Cost Survey and Analysis

The Virginia Department of Human Services (DMAS) engaged Myers and Stauffer LC to perform a study of costs incurred by pharmacies participating in the Virginia Medicaid pharmacy program to dispense prescription medications. There are two primary components related to the provision of prescription medications: dispensing cost and drug ingredient cost. Dispensing cost consists of the overhead and labor costs incurred by a pharmacy to fill prescription medications.

Within its definition of the term "professional dispensing fee", the Centers for Medicare and Medicaid Services (CMS) has provided some guidelines for appropriate costs to be reimbursed via a Medicaid pharmacy dispensing fee. The definition states:

> *"Professional dispensing fee means the fee which—*
>
> *(1) Is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed;*
>
> *(2) Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid recipient. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and*
>
> *(3) Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including systems costs for interfacing with pharmacies."* [2]

In its recently published final rule, CMS-2434-F, CMS clarified that proposed changes to professional dispensing fees should be based on "adequate cost-based data, such as a State or national survey of retail pharmacy providers or other reliable cost-based data other than a survey." Specifically, CMS indicated that "…submission by the State of data that are not based on pharmacy costs, such as market-based research (for example, third party payments accepted by pharmacies), to support the professional dispensing fee would not qualify as supporting data."[3]

[2] See 42 CFR § 447.502 and "Medicaid Program; Covered Outpatient Drugs." (CMS-2345-FC) Federal Register, 81: 20 (1 February 2016) p 5349.

[3] See 42 CFR § 447.518 and "Medicaid Program; Misclassification of Drugs, Program Administration and Program Integrity Updates Under the Medicaid Drug Rebate Program." (CMS-2434-F) Federal Register, 89: 187 (26 September 2024) p 79020.

Since CMS published CMS-2345-FC in February 2016, states have transitioned their fee-for-service (FFS) Medicaid programs to professional dispensing fees based on its requirements. There are 32 states that apply a single state-wide professional dispensing fee to all prescription claims. These single state-wide dispensing fees range from $8.96 (Rhode Island) to $12.46 (North Dakota). There are eight states which have adopted tiered professional dispensing fees which are based on annual pharmacy total prescription volume. In states with volume-based tiers for professional dispensing fees, there are between two and four dispensing fee tiers. Seven states have adopted differential professional dispensing fees that are based on other criteria. For example, in Alaska professional dispensing fees vary based on whether a pharmacy is located on or off of the state's road system.

In contrast to Medicaid FFS programs, Medicaid managed care plans are frequently more aligned with the reimbursement methodologies of commercial health plans and Medicare Part D plans who usually contract with a PBM to administer pharmacy benefits. For pharmacies within their networks, these PBMs do not typically use ingredient reimbursement methodologies that are based on average acquisition cost (AAC), as are used in Medicaid FFS programs, but rather use other industry standard benchmarks such as the Average Wholesale Price (AWP) to which various discounts are applied. Proprietary Maximum Allowable Cost (MAC) lists for pricing of generic products are also frequently utilized. Dispensing fees paid are established within contracts with network pharmacies as determined by PBMs and /or individual managed care organizations. These dispensing fees are often less than $1.00 and are markedly less than the average cost of dispensing, on a per prescription basis, incurred by most pharmacies.

In recent years, several states have implemented requirements within their managed care programs to increase transparency of pharmacy reimbursement and provide increased oversight of the administration of the pharmacy benefit. States have adopted several models to provide this additional level of oversight. Most states with Medicaid managed care continue to use the traditional PBM model but some have increased requirements associated with the provision of the pharmacy benefit within managed care. These increased requirements have included the elimination of spread pricing, restrictions on retrospective reimbursement adjustments, elimination of transaction fees and implementation of additional reporting requirements on PBMs and health plans. In some cases, states have mandated minimum levels of pharmacy reimbursement which may include some elements of the reimbursement methodology of a state's FFS Medicaid program such as professional dispensing fees and/or levels of ingredient reimbursement. In some cases, the extension of the elements of the FFS reimbursement methodology may be limited to certain pharmacy types (e.g., setting the reimbursement methodology for in-state independent pharmacies but excluding chain pharmacies and/or pharmacies that are related parties to a PBM).

Other states have adopted the single PBM (SPBM) model in which the state Medicaid agency selects one PBM to serve all health plans. States which have either implemented the SPBM model or are in an implementation stage include Kentucky, Louisiana, Mississippi, and Ohio. Recently enacted legislation in the state of Texas suggests that it may also adopt an SPBM model in the near future. Other states have signaled interest in potential explorations of the SPBM model. Two models of SPBM contracting have been utilized within states that have implemented this approach. Under the most commonly used model, the state Medicaid agency

procures the SPBM and requires each health plan to contract individually with the SPBM. In this model, the state agency sets overall policies which the SPBM must follow for all claims processed but health plans remain at risk for the provision of the pharmacy benefit. In contrast, under another model, the SPBM is solely contracted with the state Medicaid agency and operates as a prepaid ambulatory health plan, which exclusively provides the pharmacy benefit to all members enrolled in a managed care plan; under this alternative model health plans are not at risk for the pharmacy benefit.

A small number of states have operated a Medicaid managed care program, but have opted to carve out the pharmacy benefit, retaining it within the Medicaid FFS program. Examples of states which have operated within a carve-out model of pharmacy benefit management for a number of years include Missouri, Tennessee, West Virginia, and Wisconsin. Notably, two large states, California and New York, carved out the pharmacy benefit from their managed care programs in the past four years and now operate the pharmacy benefit exclusively within their FFS program. Such a transition has significant impacts on the federal regulatory framework controlling the reimbursement methodologies that must be used (i.e., the Covered Outpatient Drugs Final Rule at CMS-2345-FC) and may have other significant impacts in terms of state financing of the Medicaid program. Although the carve-out model has the potential for states agencies to exert greater control over pharmacy benefit management practices, the transition is often complex and requires significant agency resources to implement.

Methodology of the Dispensing Cost Survey

In order to determine costs incurred to dispense pharmaceuticals to members of the Virginia Medicaid pharmacy program, Myers and Stauffer utilized a survey method consistent with federal regulations for the expenses to include within a pharmacy dispensing fee (42 CFR § 447.502) and the methodology of previous surveys conducted by Myers and Stauffer in several other states. Myers and Stauffer collaborated with DMAS to refine the survey tool to meet their objectives.

Survey Distribution

Myers and Stauffer obtained from DMAS a list of pharmacy providers currently enrolled in the Virginia Medicaid pharmacy program. According to the provider list, there were 1,781 pharmacy providers enrolled in the Virginia Medicaid pharmacy program. Myers and Stauffer relied on the DMAS list of pharmacies as the basis for the cost of dispensing survey and all 1,781 pharmacies enrolled in Virginia Medicaid were requested to submit survey information for this study.

Surveys were mailed to all 1,781 pharmacy providers included on the DMAS pharmacy list on September 12, 2024. Each surveyed pharmacy received a copy of the cost survey (Exhibit 1), a letter of introduction from DMAS (Exhibit 2), an instructional letter from Myers and Stauffer (Exhibits 3a and 3b), and an invitation to participate in webinars hosted by Myers and Stauffer (Exhibit 4).

Concerted efforts to encourage participation were made to enhance the survey response rate. A survey help desk was provided by Myers and Stauffer. A toll-free telephone number and email address were listed on the survey form and pharmacists were instructed to call or email to resolve

any questions they had concerning completion of the survey form. The instructional letter offered pharmacy owners the option of having Myers and Stauffer complete certain sections of the survey for those that were willing to submit copies of financial statements and/or tax returns. For convenience in completing the cost of dispensing survey, the survey forms were made available in both a printed format and in an electronic format (Microsoft Excel).

Myers and Stauffer hosted informational presentations on September 24, 2024 and September 26, 2024. Providers were given an overview of the cost of dispensing survey process and the survey tool. Providers were given the opportunity to ask questions during the presentation and encouraged to reach out to the survey help desk if they had further questions or needed assistance completing the survey.

Reminder postcards were sent on September 26, 2024 to non-respondent pharmacies (Exhibit 5). An additional postcard was sent on October 17, 2024 with a further reminder and an extension of the original due date of October 17, 2024 to October 24, 2024 (Exhibit 6).

To further encourage survey participation, a reminder email was sent to all non-respondent providers on September 26, 2024. Additional reminder emails were sent to providers on October 15, 2024 and October 21, 2024.

In addition to the survey reminders sent by Myers and Stauffer, DMAS also leveraged selected individuals representing the Virginia pharmacist community to act as “champions” to advocate for survey participation to fellow pharmacists within their regions.

Providers were given instructions to report themselves as ineligible for the survey if they met certain criteria. Pharmacies were to be deemed exempt or ineligible if they had closed their pharmacy, had a change of ownership, or had less than six months of cost data available (e.g., due to a pharmacy that recently opened, or changed ownership). Of the 1,781 surveyed pharmacies, 17 pharmacies were determined to be exempt or ineligible to participate (based on the returned surveys).

Surveys were accepted through November 6, 2024. As indicated in Table 2.1, 434 surveyed pharmacies submitted a usable cost survey for this study resulting in a response rate of 24.6 percent.

Some of the submitted cost surveys contained errors or did not include complete information necessary for full evaluation. For cost surveys with such errors or omissions, the pharmacy was contacted for clarification. There were limited instances in which issues on the cost survey were not resolved in time for inclusion in the final analysis. [4]

The following table, 2.1, summarizes the dispensing cost survey response rate.

[4] There were 10 incomplete surveys received on or November 6, 2024 that were eventually determined to be unusable because they were substantially incomplete or missing essential information. These issues could not be resolved in a timely manner with the submitting pharmacy. These incomplete surveys were not included in the count of 434 usable surveys received.

Table 2.1 Dispensing Cost Survey Response Rate

Pharmacy Category	Medicaid Enrolled Pharmacies	Pharmacies Exempt or Ineligible from Filing	Eligible Pharmacies	Usable Cost Surveys Received	Response Rate
Chain[5]	1,257	2	1,255	316	25.2%
Non-chain	524	15	509	118	23.2%
TOTAL	**1,781**	**17**	**1,764**	**434**	**24.6%**
In-State Urban[6]	1,257	8	1,249	280	22.4%
In-State Rural	257	2	255	64	25.1%
Out-of-State	267	7	260	90	34.6%
TOTAL	**1,781**	**17**	**1,764**	**434**	**24.6%**

Table 2.2 Pharmacies in Virginia

	Count
Virginia Pharmacies Licensed by Virginia Board of Pharmacy	1,720
Virginia Pharmacies Enrolled by DMAS	1,514
Virginia Pharmacies NOT Enrolled in DMAS [A]	206

[A] *Pharmacies not enrolled in DMAS includes free clinics, hospital based, infusion, and other non-retail pharmacies.*

Tests for Reporting Bias

For the pharmacy traits of affiliation (i.e., chain or non-chain) and location (i.e., urban or rural), the response rates of the submitted surveys were tested to determine if they were representative of the population of Medicaid provider pharmacies. Since the overall response rate of the surveyed pharmacies was less than 100 percent, the possibility of bias in the response rate should be considered. To measure the likelihood of this possible bias, chi-square (χ^2) tests were performed. A χ^2 test evaluates differences between proportions for two or more groups in a data set.

Of the 434 usable cost surveys, 316 were from chain pharmacies and 118 were from non-chain pharmacies. There was a response rate of 25.2 percent for chain pharmacies compared to a

[5] For purposes of this survey, a chain was defined as an organization having four or more pharmacies under common ownership or control on a national level.

[6] For measurements that refer to the urban or rural location of a pharmacy, Myers and Stauffer used the pharmacies zip code and the "Zip Code to Carrier Locality File" from the Centers for Medicare & Medicaid Services to determine if the pharmacy was located in an urban or rural area.

response rate of 23.2 percent for non-chain pharmacies. The results of the χ^2 test indicated that the difference in response rate between chain and non-chain pharmacies was not statistically significant at the 5 percent confidence level.

A χ^2 test was also performed with respect to the urban versus rural location for responding pharmacies that were located in the Commonwealth of Virginia. Of the 1,514 non-exempt pharmacies located in the Commonwealth of Virginia, 1,257 pharmacies (or 83 percent) were located in an urban area. The remaining 257 pharmacies (or 17 percent) were located in a rural area. The number of pharmacies that returned a completed survey from an urban location was 280 (a response rate of 22.4 percent) and the number of pharmacies that returned a completed survey from a rural location was 64 (a response rate of 25.1 percent). The results of the χ^2 test indicated that the difference in response rate between urban and rural pharmacy locations (within the state) was not statistically significant at the 5 percent confidence level.

Desk Review Procedures

A desk review was performed for 100 percent of surveys received. This review identified incomplete cost surveys; pharmacies submitting these incomplete cost surveys were contacted by telephone and/or email to obtain information necessary for completion. The desk review process also incorporated a number of tests to determine the reasonableness of the reported data. In many instances, pharmacies were contacted to correct or provide confirmation of reported survey data that was flagged for review as a result of these tests for reasonableness.

Cost Finding Procedures

For all pharmacies, the basic formula used to determine the average dispensing cost per prescription was to calculate the total dispensing-related cost and divide it by the total number of prescriptions dispensed:

$$\text{Average Dispensing Cost} = \frac{\text{Total (Allowable) Dispensing Related Cost}}{\text{Total Number of Prescriptions Dispensed}}$$

Although the denominator of the cost of dispensing formula (i.e., the “total number of prescriptions dispensed”) is relatively straight-forward, the calculation of the numerator of the formula (i.e., “total allowable cost related to dispensing prescriptions”) can be complex. “Cost finding” principles must be applied since not all reported pharmacy expenses were strictly related to the prescription dispensing function of the pharmacy. Most pharmacies are also engaged in lines of business other than the dispensing of prescription drugs. For example, many pharmacies have a retail business with sales of groceries, durable medical equipment, medical supplies, over-the-counter (OTC) drugs, non-medical items and other goods The existence of these other lines of business necessitates that procedures be applied to estimate the portion of expenses that are associated with the prescription dispensing function of the pharmacy.

"Cost finding" is the process of recasting cost data using rules or formulas in order to accomplish an objective. In this study, the objective is to estimate the cost of dispensing prescriptions to Medicaid members. To accomplish this objective, some pharmacy expenses must be allocated between the prescription dispensing function and other business activities. This process identified the reasonable and allowable costs necessary for dispensing prescriptions to Medicaid members.

For purposes of the study, the cost of dispensing was considered as two primary components: overhead and labor. The cost finding rules employed to determine the cost of dispensing associated with the overhead and labor components are described in the following sections.

Overhead Costs

Overhead cost per prescription was calculated by summing the allocated overhead of each pharmacy and dividing this sum by the number of prescriptions dispensed. Overhead expenses that were reported for the entire pharmacy were allocated to the prescription department based on one of several methods as described on the following pages:

- **All, or 100 percent**

  For overhead expenses that were considered to be entirely related to prescription functions, 100 percent of the expenses were allocated.

  Overhead expenses that were considered entirely prescription-related include:

  - Prescription department licenses.
  - Prescription delivery expense.
  - Prescription computer expense.
  - Prescription containers and labels. (For many pharmacies the costs associated with prescription containers and labels are captured in their cost of goods sold. Subsequently, it was often the case that a pharmacy was unable to report expenses for prescription containers and labels. In order to maintain consistency, a minimum allowance for prescription containers and labels was determined to use for pharmacies that did not report an expense amount for containers and labels. The allowance was set at the 95th percentile of prescription containers and labels expense per prescription for pharmacies that did report prescription containers and labels expense: $0.87 per prescription).
  - Certain other expenses that were separately identified on Lines (32a) to (32t) of Page 7 of the cost survey (Exhibit 1).[7]

[7] "Other" expenses were individually analyzed to determine the appropriate basis for allocation of each expense: sales ratio, area ratio, 100 percent related to cost of dispensing or 0 percent (i.e., not allocated).

- **None, or 0 percent**

  For overhead expenses that are not considered to be related to prescription functions, none of the expenses were allocated.

  Overhead expenses that were not allocated as a prescription expense include:

  - Income taxes [8]
  - Bad debts [9]
  - Advertising [10]
  - Charitable Contributions [11]
  - Credit Card Processing Fees [12]
  - Certain expenses reported on Lines (32a) through (32t) of Page 7 of the cost survey (Exhibit 1) were excluded if the expense was not related to the dispensing of prescription drugs.

Most expenses were assumed to be related to both prescription and nonprescription functions of the pharmacy and were allocated using either an area ratio or a sales ratio as described below:

---

[8] Income taxes are not considered an operational cost because they are based upon the profit of the pharmacy operation.

[9] Bad debt expense is not referenced in CMS guidelines for professional dispensing fees at 42 CFR § 447.502. Furthermore, the exclusion of bad debts from the calculation of the cost of dispensing is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub.15-1, Section 304:

> *"The allowance of unrecovered costs attributable to such bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that the costs of services covered by the Program will not be borne by individuals not covered, and the costs of services not covered by the Program will not be borne by the Program."*

It is recognized that some bad debts may be the result of Medicaid co-payments that were not collected. However, it was not possible to isolate the amount of bad debts attributable to uncollected Medicaid co-payments from the survey data. Additionally, there may be programmatic policy reasons to exclude uncollected Medicaid co-payments from the calculation of the cost of dispensing. Inclusion of cost for uncollected co-payments in the dispensing fee might serve to remove incentives for pharmacies to collect Medicaid co-payments when applicable. Given that co-payments were established to bring about some measure of cost containment, it may not be in the best interest of a Medicaid pharmacy program to allow uncollected co-payments to essentially be recaptured in a pharmacy professional dispensing fee.

[10] Advertising expense is not referenced in CMS guidelines for professional dispensing fees at 42 CFR § 447.502. Furthermore, the exclusion of most types of advertising expense is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub. 15.1, Section 2136.2:

> *"Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable."*

[11] Charitable contributions are not referenced in CMS guidelines for professional dispensing fees at 42 CFR § 447.502. Individual proprietors and partners are not allowed to deduct charitable contributions as a business expense for federal income tax purposes. Any contributions made by their business are deducted along with personal contributions as itemized deductions. However, corporations are allowed to deduct contributions as a business expense for federal income tax purposes. Thus, while Line 13 on the cost report recorded the business contributions of a corporation, none of these costs were allocated as a prescription expense. This provides equal treatment for each type of ownership.

[12] Credit card processing fees were not allowed on the basis that prescriptions for Medicaid members are not predominantly paid through credit or debit card payments.

- **Area ratio**

  In order to allocate expenses that were considered to be reasonably related to building space an area ratio was calculated. The process to calculate the area ratio included multiple steps. First, a ratio was calculated as prescription department floor space (in square feet) divided by total floor space. This initial ratio was then increased by a factor of 2.0 from the square footage values reported on the cost survey. The use of this factor creates an allowance for waiting and counseling areas for patients, a prescription department office area and common store area needed to access the prescription department. Finally, the resulting ratio was adjusted downward, when applicable, to not exceed the sales ratio (in order to avoid allocating 100 percent of these costs in the instance where the prescription department occupies the majority of the area of the store). This final calculation was considered to be the area ratio to use for cost allocation purposes.

  Overhead expenses allocated on the area ratio include: [13]

  - Depreciation
  - Real estate taxes
  - Rent [14]
  - Repairs
  - Utilities

- **Sales ratio**

  Remaining expenses that were shared by both the prescription and non-prescription functions of the pharmacy were allocated using a sales ration which was calculated as prescription sales divided by total sales.

  Overhead expenses allocated using the sales ratio include:

  - Personal property taxes
  - Other taxes
  - Insurance
  - Interest
  - Accounting and legal fees
  - Telephone and supplies
  - Dues and publications

[13] Allocation of certain expenses using a ratio based on square footage is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub. 15-2, Section 3617.

[14] The survey instrument included special instructions for reporting rent and requested that pharmacies report "ownership expenses of interest, taxes, insurance and maintenance if building is leased from a related party". This treatment of related-party expenses is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub. 15-2, Section 3614:

> *"Cost applicable to home office costs, services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost-conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere."*

Labor Cost

Labor cost was calculated by allocating total salaries, payroll taxes, and benefits based on the percent of time spent in the prescription department. The allocations for each labor category were summed and then divided by the number of prescriptions dispensed to calculate labor cost of dispensing per prescription. There are various classifications of salaries and wages requested on the survey (Lines (1) to (12) of Page 5 of the survey – Exhibit 1) due to the different treatment given to each labor classification.

Although some employee pharmacists spent a portion of their time performing nonprescription duties, it was assumed in this study that their economic productivity when performing nonprescription functions was less than their productivity when performing prescription duties. The total salaries, payroll taxes, and benefits of employee pharmacists were multiplied by a factor based upon the percent of prescription time. Therefore, a higher percentage of salaries, payroll taxes, and benefits was allocated to the labor cost of dispensing than would have been allocated if a simple percent of time allocation were utilized. Specifically, the percent of prescription time indicated was adjusted by the following formula: [15]

$$\frac{(2)(\%Rx\ Time)}{(1+(\%Rx\ Time))}$$

The allocation of salaries, payroll taxes, and benefits for all other prescription employees (Line (2) and Lines (4) to (12) of Page 5 of the survey – Exhibit 1) was based directly upon the percentage of time spent in the prescription department as indicated on the survey. For example, if the reported percentage of prescription time was 75 percent and total salaries were $10,000, then the allocated cost associated with dispensing prescriptions would be $7,500.

Owner Compensation Issues

Since compensation reported for owners are not expenses that have arisen from arm's length negotiations, they are not similar to other expenses. Accordingly, limitations were placed upon the allocated salaries, payroll taxes, and benefits of owners. A pharmacy owner may have a different approach toward other expenses than toward his/her own salary. Owners may pay themselves above the market cost of securing the services of an employee. In this case, paying themselves above market cost effectively represents a withdrawal of business profits, not a cost of dispensing. In contrast, owners who pay themselves below market cost for business reasons also misrepresent the true cost of dispensing.

To estimate the expense that would have been incurred had an employee been hired to perform the prescription-related functions actually performed by the owner, upper and lower limits were imposed on owner salaries and benefits. For purposes of setting limits on owner compensation,

[15] Example: An employee pharmacist spends 90 percent of his/her time in the prescription department. The 90 percent factor would be modified to 95 percent: **(2)(0.9) / (1+0.9) = 0.95** Thus, 95 percent of the reported salaries, payroll taxes, and benefits would be allocated to the prescription department. It should be noted that most employee pharmacists spent 100 percent of their time in the prescription department.

separate limits were applied to owners who are pharmacists and owners who are not pharmacists. Constraints for owners were set using upper and lower thresholds for hourly compensation that represented approximately the 95th and 40th percentiles of salaries and benefits for employee pharmacists and employee non-pharmacists (adjusted by an estimate of full-time equivalent (FTE) staff count to estimate hourly wages). The upper and lower constraints that were developed are shown in Table 2.3. Adjustments to owner salaries and benefits were only applied if the reported amounts were below the lower limit or in excess of the upper limit in which case the reported amounts were adjusted up or down to the respective limits.

Table 2.3 Hourly Wage Limits for Owners

Owner Type	Lower Limit (Hourly)	Upper Limit (Hourly)
Pharmacist	$60.94	$88.29
Non-Pharmacist	$18.87	$57.69

A sensitivity analysis of the owner labor limits was performed in order to determine the impact of the limits on the overall analysis of pharmacy cost of dispensing. Of the 434 pharmacies in the cost analysis, owner limits impacted 47 pharmacies, or 10.8 percent. Of these, 20 pharmacies had costs *reduced* as a result of application of these limits (on the basis that a portion of owner salary "cost" appeared to represent a withdrawal of profits from the business), and 27 pharmacies had costs *increased* as a result of the limits (on the basis that owner salaries appeared to be below their market value). In total, the final estimate of average pharmacy cost of dispensing per prescription was decreased by approximately $0.01 as a result of the owner salary limits.

Overall Labor Cost Constraints

An overall constraint was placed on the proportion of total reported labor that could be allocated as prescription labor. The constraint assumes that a functional relationship exists between the proportion of allocated prescription labor to total labor and the proportion of prescription sales to total sales. It is also assumed that a higher input of labor costs is necessary to generate prescription sales than nonprescription sales, within limits.

The parameters of the applied labor constraint are based upon an examination of data submitted by all pharmacies. These parameters are set in such a way that any resulting adjustment affects only those pharmacies with a percentage of prescription labor deemed unreasonable. For example, the constraint would come into play for an operation that reported 75 percent pharmacy sales but 100 percent pharmacy labor since, some labor must be devoted to generating the 25 percent nonprescription sales.

To determine the maximum percentage of total labor allowed, the following calculation was made:

$$\frac{0.3(Sales\ Ratio)}{0.1+(0.2)(Sales\ Ratio)}$$

A sensitivity analysis of the labor cost constraint was performed in order to determine the impact of the limit on the overall analysis of pharmacy cost. The analysis indicates that of the 434 pharmacies included in the cost of dispensing analysis, this limit was applied to 18 pharmacies. In total, the final estimate of average pharmacy cost of dispensing per prescription was decreased by approximately $0.34 as a result of the labor cost restraint.

Inflation Factors

All allocated costs for overhead and labor were totaled and multiplied by an inflation factor. Inflation factors are intended to reflect cost changes from the middle of the reporting period of a particular pharmacy to a common fiscal period ending December 31, 2024 (specifically from the midpoint of the pharmacy's fiscal year to June 30, 2024 which is the midpoint of the fiscal period ending December 31, 2024). The midpoint and terminal month indices used were taken from the Employment Cost Index (ECI), (all civilian, all workers; seasonally adjusted) published by the Bureau of Labor Statistics (BLS) (Exhibit 7). The use of inflation factors is preferred in order for pharmacy cost data from various fiscal years to be compared uniformly. The majority of submitted cost surveys were based on a fiscal year which ended on or within four months of December 31, 2023.

Cost of Dispensing Analysis and Findings

The dispensing costs for surveyed pharmacies are summarized in the following tables and paragraphs. Findings for pharmacies are presented collectively, and additionally are presented for subsets of the surveyed population based on pharmacy characteristics.

There are several statistical measurements that may be used to express the central tendency of a distribution, the most common of which are the mean and the median. Findings are presented in the forms of means and medians, both weighted and unweighted.

The measures of central tendency used in this report include the following:

Unweighted mean: the arithmetic average cost of dispensing for all pharmacies.

Weighted mean: the average cost of dispensing for all prescriptions dispensed by surveyed pharmacies, weighted by prescription volume. The resulting number is the average cost for all prescriptions, rather than the average for all pharmacies as in the unweighted mean. This implies that low volume pharmacies have a smaller impact on the weighted average than high volume pharmacies. This approach, in effect, sums all costs from surveyed pharmacies and divides that total cost by the total number of prescriptions from the surveyed pharmacies. The weighting factor can be either total prescription volume or Medicaid prescription volume.

Median: the value that divides a set of observations (such as cost of dispensing) in half. In the case of this survey, the median is the value such that one half of the pharmacies in the set have a cost of dispensing that is less than or equal to the median and the other

half of the pharmacies have a cost of dispensing that is greater than or equal to the median.

Weighted Median: this is determined by finding the pharmacy observation that encompasses the middle value prescription. The implication is that one half of the prescriptions were dispensed at a cost equal to or less than the weighted median, and one half of the prescriptions were dispensed at a cost equal to or more than the weighted median. In a hypothetical example, if there were 1,000,000 Medicaid prescriptions dispensed by the surveyed pharmacies and the pharmacies were arrayed in order of their cost of dispensing, the median weighted by Medicaid volume is the cost of dispensing of the pharmacy that dispensed the middle, or 500,000th prescription.

Statistical "outliers" are a common occurrence in pharmacy cost of dispensing surveys. This occurs when a small number of pharmacies have a cost of dispensing that is atypical as compared to the majority of pharmacies. The unweighted mean is particularly susceptible to the impact of these outlier values. In situations in which the magnitude of outlier values results in a measure of the unweighted mean that does not represent what might be typically thought of as an accurate measure of central tendency, weighted means or medians are often considered to be preferable.

For all pharmacies, the cost of dispensing findings are presented in Table 2.4.

Table 2.4 Dispensing Cost per Prescription – All Pharmacies

	Dispensing Cost
Unweighted Mean	$31.52
Mean Weighted by Medicaid Volume	$13.70
Unweighted Median	$12.73
Median Weighted by Medicaid Volume	$11.69

n=434 pharmacies
Dispensing costs have been inflated to the common point of June 30, 2024 (midpoint of year ending December 31, 2024).

See Exhibit 8 for a histogram of the dispensing cost for all pharmacies. There was a large range between the highest and the lowest dispensing cost observed. However, the majority of pharmacies (approximately 70 percent) had average dispensing costs between $6 and $17.

Exhibit 9 includes a statistical summary with a wide variety of measures of pharmacy dispensing cost with breakdowns for many pharmacy attributes potentially of interest. For measurements that refer to the urban or rural location of a pharmacy, Myers and Stauffer used the pharmacies' zip code and the "Zip Code to Carrier Locality File" from the Centers for Medicare & Medicaid Services to determine if the pharmacy was located in an urban or rural area.

Specialty Pharmacies

Several pharmacies included in the cost analysis were identified as specialty pharmacies. There is not a statutory, regulatory, or universal industry accepted definition of "specialty pharmacies". The terms "specialty products" or "specialty drugs" typically refer to high-cost prescription drugs

used to treat complex, chronic conditions. These drugs often require special handling and administration, along with continuous monitoring by a health care professional. Although some state Medicaid programs have established lists of “specialty drugs” for specific purposes, these lists are not uniform across all Medicaid programs. For purposes of this report, “specialty pharmacies" are pharmacies that self-reported sales for intravenous, home infusion, clotting factor and/or other specialty products of 30 percent or more of total prescription sales. The analysis revealed significantly higher cost of dispensing associated with pharmacies with these criteria.

In most pharmacy cost of dispensing studies in which information on clotting factor, intravenous solution, home infusion and other specialty dispensing activity has been collected by Myers and Stauffer, such activity has been found to be associated with higher cost of dispensing. Discussions with pharmacists providing these services indicate that the activities and costs involved for these types of prescriptions are significantly different from the costs incurred by other pharmacies. The reasons for this difference include:

- Costs of special equipment for mixing and storage of clotting factor, intravenous, infusion and other specialty products.
- Costs of additional services relating to patient education, compliance programs, monitoring, reporting and other support for specialty products.
- Higher direct labor costs due to more intensive activities to prepare certain specialty prescriptions in the pharmacy.

The difference in dispensing costs that were observed for providers of specialty products compared to those pharmacies that did not offer these specialty products is summarized in Table 2.5. Of the 79 pharmacies classified as “specialty” for purposes of Table 2.5, there were 48 of these pharmacies that were located outside of Virginia; the remaining 31 pharmacies were located inside Virginia.

Table 2.5 Dispensing Cost per Prescription - Specialty versus Other Pharmacies

Type of Pharmacy	Number of Pharmacies	Average Total Annual Prescription Volume (mean and median)	Average Medicaid Prescription Volume (mean and median)	Unweighted Mean	Mean Weighted by Medicaid Volume
Specialty Pharmacies	79	Mean: 132,921 Median: 34,988	Mean: 4,411 Median: 291	$107.95	$23.23
Other Pharmacies	355	Mean: 124,514 Median: 75,010	Mean: 9,557 Median: 6,065	$14.51	$12.72

n= 434 pharmacies
Dispensing costs have been inflated to the common point of June 30, 2024 (midpoint of year ending December 31, 2024).

Non-specialty Pharmacies

The analyses summarized in Tables 2.7 through 2.11 below exclude the specialty pharmacy providers. In making this exclusion, no representation is made that the cost structure of those pharmacies is not important to understand. However, it is reasonable to address issues relevant to those pharmacies separately from the cost structure of the vast majority of pharmacy providers that provide "traditional" pharmacy services. Table 2.7 restates the measurements noted in Table 2.4 excluding pharmacies that dispensed significant volumes of specialty prescriptions.

Table 2.7 Dispensing Cost per Prescription – Excluding Specialty Pharmacies

	Dispensing Cost
Unweighted Mean	$14.51
Mean Weighted by Medicaid Volume	$12.72
Unweighted Median	$11.82
Median Weighted by Medicaid Volume	$11.39

n= 355 pharmacies

Dispensing costs have been inflated to the common point of June 30, 2024 (midpoint of year ending December 31, 2024).

Relationship of Dispensing Cost with Prescription Volume

There is a significant correlation between a pharmacy's total prescription volume and the dispensing cost per prescription. This result is not surprising because many of the costs associated with a business operation, including the dispensing of prescriptions, have a fixed component that does not vary significantly with increased volume. For stores with a higher total prescription volume, these fixed costs are spread over a greater number of prescriptions resulting in lower costs per prescription. A number of relatively low volume pharmacies in the survey skew the distribution of dispensing cost and increase the measurement of the unweighted average (mean) cost of dispensing. Means and medians weighted by either Medicaid volume or total prescription volume may provide a more realistic measurement of typical dispensing cost.

Pharmacies were classified into meaningful groups based upon their differences in total prescription volume. Dispensing costs were then analyzed based upon these volume classifications. Table 2.8 displays the calculated cost of dispensing for non-specialty pharmacies arrayed into tiers based on total annual prescription volume. Table 2.9 provides statistics for pharmacy annual prescription volume.

Table 2.8 Dispensing Cost by Pharmacy Total Annual Prescription Volume

Statistic	Value [A]
Mean	124,514
Standard Deviation	328,771
10th Percentile	31,164
25th Percentile	54,286
Median	75,010
75th Percentile	102,321
90th Percentile	132,344

n= 355 pharmacies

[A] Excludes specialty pharmacies, which for purposes of this report are those pharmacies that self-reported sales for intravenous, home infusion, clotting factor and/or other specialty products of 30 percent or more of total prescription sales.

Dispensing costs have been inflated to the common point of June 30, 2024 (midpoint of year ending December 31, 2024).

Table 2.9 Statistics for Pharmacy Total Annual Prescription Volume

Total Annual Prescription Volume of Pharmacy	Number of Pharmacies [A]	Unweighted Mean	Mean Weighted by Medicaid Volume
0 to 54,999	92	$22.04	$17.87
55,000 to 88,999	137	$12.51	$11.96
89,000 and Higher	126	$11.17	$11.79

n= 355 pharmacies

[A] Excludes specialty pharmacies, which for purposes of this report are those pharmacies that self-reported sales for intravenous, home infusion, clotting factor and/or other specialty products of 30 percent or more of total prescription sales.

Dispensing costs have been inflated to the common point of June 30, 2024 (midpoint of year ending December 31, 2024).

A histogram of pharmacy total annual prescription volume and a scatterplot of the relationship between dispensing cost per prescription and total prescription volume are included in Exhibit 10.

Other Observations Associated with Dispensing Cost and Pharmacy Attributes

The dispensing cost of the surveyed pharmacies was broken down into the various components of overhead and labor related costs. Table 2.10 displays the means of the various cost components for surveyed pharmacies. Labor-related expenses accounted for approximately 67 percent of overall prescription dispensing costs.

Expenses in Table 2.10 are classified as follows:

- Owner professional labor – owner's labor costs were subject to constraints in recognition of its special circumstances as previously noted.

- Employee professional labor consists of employee pharmacists. Other labor includes the cost of delivery persons, interns, technicians, clerks and any other employee with time spent performing the prescription dispensing function of the pharmacy.
- Building and equipment expense includes depreciation, rent, building ownership costs, repairs, utilities and any other expenses related to building and equipment.
- Prescription-specific expense includes pharmacist-related dues and subscriptions, prescription containers and labels, prescription-specific computer expenses, prescription-specific delivery expenses (other than direct labor costs) and any other expenses that are specific to the prescription dispensing function of the pharmacy.
- Other overhead expenses consist of all other expenses that were allocated to the prescription dispensing function of the pharmacy including interest, insurance, telephone, and legal and professional fees.

Table 2.10 Components of Prescription Dispensing Cost

Type of Expense	Mean Weighted by Medicaid Volume [A]
Owner Professional Labor	$0.496
Employee Professional and Other Labor	$7.975
Building and Equipment	$1.097
Prescription Specific Expenses (including delivery)	$1.515
Other Overhead Expenses	$1.642
Total	**$12.725**

n= 355 pharmacies

[A] *Excludes specialty pharmacies, which for purposes of this report are those pharmacies that self-reported sales for intravenous, home infusion, clotting factor and/or other specialty products of 30 percent or more of total prescription sales.*

Dispensing costs have been inflated to the common point of June 30, 2024 (midpoint of year ending December 31, 2024).

A chart of the components of prescription dispensing cost is provided in Exhibit 11.

In addition to pharmacy dispensing cost data, several pharmacy attributes were collected on the cost survey. A summary of those attributes is provided at Exhibit 12.

Expenses Not Allocated to the Cost of Dispensing

In the following Table 2.11, measurements are provided for certain expenses that were not included in the cost of dispensing. Reasons for not including these costs were discussed previously in the report. For all of the expenses below, average cost per prescription was calculated using a sales ratio as the basis for allocation.

Table 2.11 Non-Allocated Expenses per Prescription

Expense Category	Mean Weighted by Medicaid Volume [A]
Bad Debts	$0.024
Charitable Contributions	$0.008
Advertising	$0.156

n= 355 pharmacies

[A] Excludes specialty pharmacies, which for purposes of this report are those pharmacies that self-reported sales for intravenous, home infusion, clotting factor and/or other specialty products of 30 percent or more of total prescription sales.

Dispensing costs have been inflated to the common point of June 30, 2024 (midpoint of year ending December 31, 2024).

Additional Cost of Dispensing Analysis

During the survey tool development phase of the project, based on discussions with stakeholders and consultation with DMAS, various questions were included on the cost of dispensing survey form to address specific areas of concern. Stakeholders expressed a concern that open and unfilled pharmacist and technician positions were having an impact on their pharmacy business, and that those impacts were not necessarily reflected in the collection of pharmacy overhead and labor cost. This led to additional questions being incorporated into the personnel cost page of the survey tool (see Exhibit 1, page 5).

Pharmacies were requested to identify if they had any unfilled pharmacist positions, and if so, the number of those open pharmacist positions. An affirmative response regarding open pharmacist positions was received from 16 pharmacies (i.e., 3.7 percent of all respondent pharmacies). For these 16 pharmacies, they reported an average of approximately one open pharmacist position.

Pharmacies were similarly requested to identify if they had any unfilled pharmacy technician positions, and if so, the number of those open pharmacy technician positions. An affirmative response regarding open pharmacy technician positions was received from 52 pharmacies (i.e., 12 percent of all respondent pharmacies). For these 52 pharmacies, they reported an average of approximately two open pharmacy technician positions.

Exhibit 1
Virginia Medicaid Pharmacy Cost of Dispensing Survey - Survey Form

Virginia Medicaid Pharmacy Cost of Dispensing Survey

Survey forms by Myers and Stauffer LC under contract with the Virginia Department of Medical Assistance Services

M&S Use Only

Return Completed Forms to:
Myers and Stauffer LC
700 W. 47th Street, Suite 1100
Kansas City, Missouri 64112

ROUND ALL AMOUNTS TO NEAREST DOLLAR OR WHOLE NUMBER

Complete and return by **October 17, 2024**

Call toll free (800) 374-6858 or email disp_survey@mslc.com if you have any questions.

An electronic version of the Virginia Medicaid Pharmacy Cost of Dispensing Survey is available. The electronic version is in Excel format. The electronic version aids the user by calculating totals and transferring information to the reconciliation to help ensure the accuracy of the data. Please send an email to disp_survey@mslc.com to request the electronic version of the survey. Completed surveys can be returned via email to disp_survey@mslc.com.

Name of Pharmacy _____ Prov. No. (NPI) _____

Street Address _____ Telephone No. (____) _____

City _____ County _____ State _____ Zip Code _____

DECLARATION BY OWNER AND PREPARER

I declare that I have examined this cost survey including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the related financial statements or federal income tax return, except as explained in the reconciliation. Declaration of preparer (other than owner) is based on all information of which preparer has any knowledge.

_____	_____	_____	_____
Signature of Owner	Printed Name	Title/Position	Date
_____	_____	_____	_____
Preparer's Signature (if other than owner)	Printed Name	Title/Position	Date

_____	_____	_____
Preparer's Street Address	City and State	Zip
(_____)_____	_____	
Phone Number	Email Address	

DECLARATION OF EXEMPTION

All Virginia Medicaid pharmacies are requested to complete all pages of this survey unless you meet the following criteria:

1. □ New pharmacies that were in business less than **six months** during the most recently completed reporting period.

   Enter date the pharmacy opened: _____

2. □ Pharmacies with a change in ownership that resulted in less than **six months** in business during the reporting period.

   Enter the date pharmacy changed ownership: _____

If your pharmacy meets either of the above criteria, check the box next to the explanation describing your situation and report the relevant date. Pharmacies which are considered "exempt" do not need to complete the remaining portions of the survey. If you have any questions as to the status of your pharmacy please call Myers and Stauffer at (800)374-6858 or email disp_survey@mslc.com for assistance.

Virginia Medicaid Pharmacy Cost of Dispensing Survey

SECTION IA -- PHARMACY ATTRIBUTES

The following information is from fiscal / tax year ending _____

Complete these forms using your most recently completed fiscal year for which financial records are available and complete (e.g., December 31, 2023, or December 31, 2022, if 2023 records are not yet complete). **(Include month/day/year).**

All Pharmacies should complete lines (a) through (n).

(a) **List the total number of all prescriptions dispensed during your most recently completed fiscal year as follows:**

1. New _____ **2. Refill** _____ **3. Total** _____

"Prescriptions Dispensed." Report the total number of all prescriptions filled during the fiscal year being reported on this cost survey. This information may be kept on a daily or monthly log or on your computer.

(b) **Sales and Floor Space**

	Pharmacy Department Only	Total Store (Retail and Pharmacy Department)
Sales (Excluding Sales Tax)		
Cost of Goods Sold		
Floor Space (see instructions below)	Sq. Ft.	Sq. Ft.

Store sales excluding sales tax. Total store sales and cost of goods sold can usually be obtained from a financial statement or a federal income tax return (if the tax return only includes the store being surveyed). "Pharmacy Department" sales should only include sales of prescription drugs and should not include non-prescription over the counter drugs, durable medical equipment or other nonprescription items.

Cost of Goods Sold. If pharmacy department cost of goods sold is not readily available, leave that line blank.

Floor Space. Provide square footage for pharmacy department dispensing area and total store square footage (pharmacy department + retail area). Since floor space will be used in allocating certain expenses, accuracy is important.

For simplicity, when measuring the pharmacy department exclude all of the following:

> Patient waiting area > Counseling area > Pharmacy department office space > Pharmacy department storage

The before mentioned areas should be included in total store area, but not pharmacy department square footage. A factor will be added to the pharmacy department to account for waiting area, counseling area, pharmacy department office space and pharmacy department storage. When measuring the total store square footage exclude any storage area (e.g., basement, attic, off-the-premises areas or freight in-out areas).

(c) Amount of State Sales Tax collected during fiscal year used for survey (round to nearest whole dollar) **$** _____

(d) What is the approximate percentage of **prescriptions dispensed** for the following classifications?

1. Medicaid (fee for service) _____ % 2. Medicaid Managed Care _____ %

3. Other Third Party _____ % 4. Cash _____ %

(e) What is the approximate percentage of **payments received** from the following classifications?

1. Medicaid (fee for service) _____ % 2. Medicaid Managed Care _____ %

3. Other Third Party _____ % 4. Cash _____ %

(f) Ownership Affiliation

1. □ Independent (1 to 3 units) 2. □ Chain (4 or more units)
3. □ Institutional (service to LTC facilities only) 4. □ Other (specify) _____

(g) Type of Ownership

1. ☐ Individual 2. ☐ Corporation 3. ☐ Partnership 4. ☐ Other (specify) _____

(h) Location of Pharmacy (please check one)

1. □ Medical Office Building 2. □ Shopping Center
3. □ Stand Alone Building 4. □ Grocery Store / Mass Merchant
5. □ Outpatient Hospital 6. □ Other (specify) _____

(i) Does your pharmacy purchase drugs through the 340B Drug Pricing Program?

1. □ Yes 2. □ No

If yes, are prescriptions dispensed to Virginia Medicaid members provided from 340B inventory?

1. □ Yes 2. □ No

If you are a provider that participates in the 340B discount program, indicate if you are a:

1. □ Covered Entity 2. □ Contract Pharmacy

Myers and Stauffer will keep financial information strictly confidential.

Virginia Medicaid Pharmacy Cost of Dispensing Survey

SECTION IA -- PHARMACY ATTRIBUTES, CONTINUED

(j)	Do you own your building or lease from a related party (i.e., yourself, family member, or related corporation)? If so, mark yes, on page 7 you should only report expenses related to building ownership, i.e. interest, taxes, insurance, maintenance, etc. 1. □ Yes 2. □ No
(k)	How many hours per week is your pharmacy open? _____ Hours
(l)	How many years has a pharmacy operated at this location? _____ Years
(m)	Do you provide 24-hour emergency services for pharmaceuticals? 1. □ Yes 2. □ No
(n)	What percentage of prescriptions dispensed were generic products? _____%

If your pharmacy dispenses prescriptions to long-term care facilities, complete lines (o) through (q).

(o)	How many total prescriptions were dispensed to long-term care facilities or assisted living homes?_____
(p)	Do you dispense in unit dose packaging to long-term care facilities (e.g., medisets, blister packs, etc.)? 1. □ Yes 2. □ No If yes, how many total prescriptions were dispensed in unit dose packaging? _____
(q)	If you provide unit dose packaging, what percent of unit dose packaging is: 1. Purchased from manufacturers _____% 2. Prepared in the pharmacy _____%

If your pharmacy provides delivery, mail order, specialty or compounding services, complete lines (r) through (v) as applicable.

(r)	How many total prescriptions filled are delivered? _____
(s)	How many Virginia Medicaid prescriptions filled are delivered? _____
(t)	Does your pharmacy deliver prescriptions by mail (U.S. Postal Service, FedEx, UPS, etc.)? 1. □ Yes 2. □ No If yes, what is the total number of prescriptions that are delivered by mail? _____
(u)	Are you presently providing specialty products or services (e.g., intravenous, infusion, enteral nutrition, clotting factors or derivatives, other pre-filled injectable or oral specialty products)? 1. □ Yes 2. □ No **If yes, you must complete the product breakdown in section IC on page 4.**
(v)	How many total prescriptions dispensed were compounded? _____ How many total prescriptions were compounded in a sterile environment? _____ For prescriptions that are compounded, what is the average number of minutes spent preparing a prescription by pharmacists and technicians? Pharmacist: _____ Technician: _____

SECTION IB -- OTHER INFORMATION

List any additional information you feel contributes significantly to your cost of filling a prescription. Attach additional pages if needed.

Myers and Stauffer will keep financial information strictly confidential.

Virginia Medicaid Pharmacy Cost of Dispensing Survey

SECTION IC -- PHARMACEUTICAL PRODUCT BREAKDOWN FOR PHARMACIES DISPENSING SPECIALTY PRODUCTS

If you answered yes to question (u) in Section IA, provide a breakdown of the specialty and non-specialty products dispensed in your pharmacy using the categories described below. Please report the number of prescriptions and dollar amount of sales in one category only, for example some clotting factors can be prefilled, however place it in "clotting factors or derivatives" only and not in "prefilled or ready to inject products". Number of prescriptions dispensed and sales should match your fiscal reporting period for the cost survey and reconcile to prescriptions and sales reported on Page 2 lines (a) and (b) in Section IA. You should also respond to the questions below the product breakdown regarding services provided in association with the dispensing of specialty products.

Product Category	Number of Prescriptions	Dollar Amount of Sales	Line No.
Infusion Products			
Compounded infusion products			(1a)
Total Parenteral Nutrition (TPN) products			(1b)
Clotting factors or derivatives			(1c)
Infusion supplies (e.g., tubing, needles, catheter flushes, IV site dressings, etc.)			(1d)
Total for Infusion Products			(1e)
Specialty			
Prefilled or ready to inject products			(2a)
Orals and all other specialty products not include in other categories above			(2b)
Total for Specialty			(2c)
Non-specialty			
Orals			(3a)
Topicals			(3b)
Injectables			(3c)
Compounded (non-infusion)			(3d)
Enteral nutrition			(3e)
All Other (including opthalmic, otic, etc.)			(3f)
Total for Non-specialty			
Total (Should reconcile to prescriptions and Pharmacy Department sales reported in Section IA)			(4)

Additional Pharmacy Attribute Questions for Pharmacies Dispensing Specialty Products

(a) What percentage of prescriptions dispensed were for products with REMS (Risk Evaluation and Mitigation Strategy) reporting requirements?	
(b) What percentage of prescriptions dispensed were for products that had patient monitoring and compliance activities in place?	
(c) What percentage of prescriptions dispensed were for products that had special storage requirements (e.g., refrigeration, etc.)?	

SECTION ID -- OTHER INFORMATION

Use the section below to provide additional narrative description of the specialty products and services that are provided by your pharmacy. Use this section to describe any patient monitoring programs, patient compliance programs, case management services or disease management services provided by your pharmacy. Describe any specialized equipment used in your pharmacy. Attach additional pages if needed.

Myers and Stauffer will keep financial information strictly confidential.

Virginia Medicaid Pharmacy Cost of Dispensing Survey

SECTION IIA -- PERSONNEL COSTS

Complete each employee classification line in aggregate. If there are no employees in a specific category, please leave blank. Provide your best estimate of the percentage of time spent working in each category, the rows must equal 100%. Complete these forms using the **same fiscal year as listed on page 2** and used for reporting overhead expenses. See page 6 for additional instructions.

			Percent of Time Spent					
Employee Classification	Estimate of FTEs[1]	Total Salaries (including bonuses and draws for owners)[2]	Dispensing Activities[3]	Other RX Related Duties[4]	MTM and Vaccine Administration[5]	Non Rx Related Duties[6]	Total[7]	Line No.
Owner: **Registered Pharmacist** (if applicable)								(1)
Owner: **Non-Pharmacist** (if applicable)								(2)
Pharmacist								(3)
Technician								(4)
Delivery								(5)
Nurses								(6)
Customer service representatives								(7)
Billing								(8)
Other Admin								(9)
Contract Labor (Pharmacist)								(10)
Contract Labor (other)								(11)
Staff not related to RX dispensing			0.0%	0.0%	0.0%	100.0%	100.0%	(12)

Total Salaries		(13)
Pension and Profit Sharing		(14)
Other Employee Benefits[8]		(15)
Total Labor Expenses		(16)

(17) Do you currently have unfilled pharmacist positions at this pharmacy? 1. □ Yes 2. □ No

(18) If you answered yes to question 17, how many open pharmacist positions do you have at this pharmacy? _____

(19) Do you currently have unfilled pharmacy technician positions at this pharmacy? 1. □ Yes 2. □ No

(20) If you answered yes to question 19, how many open pharmacy technician positions do you have at this pharmacy? _____

(21) Please describe any additional pharmacist professional services provided to patients that affect the cost of dispensing at this pharmacy, in the box below. Attach additional pages if needed.

Please review footnotes and additional instructions for reporting personnel costs on the next page.

SECTION IIA -- PERSONNEL COSTS

General	Provide your best estimate of the percentage of time each employee or group of employees spent working for each category. While it is understood that there may not be a specific report that can be generated to complete this section of the survey, use the job description of each employee and the general workflow of your pharmacy to estimate the percent of time for employee(s) in each category for which you report salaries and FTEs. Each row must equal 100%.

Footnote

1	FTE: Full-time Equivalent. Divide the total number of weekly hours worked for each job category by 40 hours to determine the estimated number of full time equivalent positions. This value can be a decimal but should be rounded to the nearest tenth. Example: 3 pharmacists; pharmacist 1 works 38 hours per week, Pharmacist 2 works 22 hours per week, Pharmacist 3 works 16 hours per week. Calculation = (38 + 22 + 16) ÷ 40 = 1.9 FTEs.
2	Total Salaries should include any bonuses and/or draws for owners.
3	Report the percent of time for any direct Dispensing Activities. Direct prescription dispensing activities as defined in 42 CFR § 447.502 include the pharmacist time associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. This includes, but is not limited to, a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, and special packaging.
4	Report the percent of time for Other RX Related Duties. Other Rx Related Duties include, but are not limited to, time spent maintaining the facility and equipment necessary to operate the pharmacy, third party reimbursement claims management, ordering and stocking prescription ingredients, taking inventory and maintaining prescription files.
5	Report the percent of time for Medication Therapy Management (MTM) and Vaccine Administration. MTM is a service typically provided by a licensed pharmacist intended to improve outcomes by assisting beneficiaries with understanding their conditions and the medications used to treat them (note that counseling services provided to patients at dispensation should be reported as Direct Dispensing Activities). Vaccine Administration includes patient registration, administration of the vaccine, and patient monitoring for COVID-19, flu, or other vaccines administered by the pharmacy.
6	Non Rx Related Duties should include any duties that are not related to the prescription department.
7	Totals for the Percent of Time Spent Breakdown. All columns must total 100%.
8	Other Employee Benefits includes employee medical insurance, disability insurance, education assistance, etc.

Virginia Medicaid Pharmacy Cost of Dispensing Survey

SECTION IIB -- OVERHEAD EXPENSES

Complete this section using your internal financial statement or tax return for the **same fiscal year as listed on Page 2**. You should only use a tax return if the only store reported on the return is the store being surveyed. If you are using a tax return, the line numbers in the left columns correspond to federal income tax return lines. Use your most recently completed fiscal year for which financial records are available and completed (e.g., December 31, 2023, or December 31, 2022, if 2023 records are not yet complete). **If you prefer, you may submit a copy of your financial statement and/or tax return (including all applicable schedules) and Myers and Stauffer can complete Sections IIB and III (pages 7, 8, and 9).**

*** Notes about tax return line references**

Form 1040, Sched C, line 27a is for "other expenses" and a detailed breakdown of this category is typically reported on page 2, Part V of the form. Form 1065 (line 20), Form 1120 (line 26) and Form 1120S (line 19) are for "other deductions" and there are typically detailed breakdowns of the expenses in this category in the "Statements" attached to the returns.

2023 Tax Form				Round all amounts to nearest dollar or whole number.	Expense Amount Reported	Myers and Stauffer Use Only	Line No.
1040 Schedule C	1065	1120	1120S				
13	16a	20	14	Depreciation (this fiscal year only - not accumulated)			(1)
23	14	17	12	Taxes (a) Personal Property Taxes Paid			(2)
23	14	17	12	(b) Real Estate Taxes			(3)
23	14	17	12	(c) Payroll Taxes			(4)
				Any other taxes should be itemized separately on page 7.			
20b	13	16	11	Rent - Building (if building is leased from a related party then report ownership expenses of interest, taxes, insurance and maintenance)			(5)
20a	13	16	11	Rent - Equipment and Other			(6)
21	11	14	9	Repairs & maintenance			(7)
15	21*	26*	20*	Insurance (other than employee medical)			(8)
16a&b	15	18	13	Interest			(9)
17	21*	26*	20*	Legal and Professional Fees			(10)
27a*	21*	26*	20*	Dues, Publications, and Subscriptions			(11)
27a*	12	15	10	Bad Debts (this fiscal year only - not accumulated)			(12)
n/a	n/a	19	n/a	Charitable Contributions			(13)
25	21*	26*	20*	Utilities (a) Telephone			(14)
25	21*	26*	20*	(b) Heat, Water, Lights, Sewer, Trash and other Utilities			(15)
18&22	21*	26*	20*	Operating and Office Supplies (exclude prescription containers and labels)			(16)
8	21*	22	16	Advertising/Marketing			(17)
27a*	21*	26*	20*	Computer Expenses (systems, software, maintenance, etc.)			(18)
9,27a*	21*	26*	20*	Prescription Delivery Expenses (wages to a driver should only be reported on pg. 5)			(19)
27a*	21*	26*	20*	Prescription Containers and Labels			(20)
24a&b	21*	26*	20*	Travel, Meals and Entertainment			(21)
27a*	21*	26*	20*	Switching / E-Prescribing Fees			(22)
27a*	21*	26*	20*	Security / Alarm			(23)
27a*	21*	26*	20*	Bank Charges			(24)
27a*	21*	26*	20*	Credit Card Processing Fees			(25)
27a*	21*	26*	20*	Interior Maintenance (housekeeping, janitorial, etc.)			(26)
27a*	21*	26*	20*	Exterior Maintenance (lawn care, snow removal etc.)			(27)
27a*	21*	26*	20*	Pharmacy Licenses / Permits			(28)
27a*	21*	26*	20*	Employee Training and Certification			(29)
27a*	21*	26*	20*	Continuing Education			(30)
				Total Page 7 overhead expenses (lines 1 to 30)			(31)

Myers and Stauffer will keep financial information strictly confidential.

SECTION IIB -- OVERHEAD EXPENSES, CONTINUED

(Round all amounts to nearest dollar or whole number.)

Other non-labor expenses not included on lines (1) through (30)

Examples: Franchise fees, other taxes not reported on page 7, accreditation and/or certification fees, restocking fees, postage, administrative expenses, amortization, etc. Specify each item and the corresponding amount. **Note that labor expenses are reported in Section IIA (page 5).** For corporate overhead expenses allocated to the individual store, please attach documentation to establish the expenses included in the allocation and describe the allocation basis.

	Expense Amount Reported	Myers and Stauffer Use Only	Line No.
			(32a)
			(32b)
			(32c)
			(32d)
			(32e)
			(32f)
			(32g)
			(32h)
			(32i)
			(32j)
			(32k)
			(32l)
			(32m)
			(32n)
			(32o)
			(32p)
			(32q)
			(32r)
			(32s)
			(32t)
Total page 8 overhead expenses (lines 32a to 32t)			(33)

Myers and Stauffer will keep financial information strictly confidential.

Virginia Medicaid Pharmacy Cost of Dispensing Survey

SECTION III -- RECONCILIATION WITH FINANCIAL STATEMENT OR TAX RETURN

The purpose of this reconciliation is to ensure that all expenses have been included and that none have been duplicated. Complete these forms using the same fiscal year which was used to report overhead and labor expenses.

		Cost Survey Amounts	Financial Statement or Tax Return Amounts
(1)	Total Expenses per Financial Statement or Tax Return[1]		
(2)	Total Labor Expenses (total from page 5, line 16)		
(3)	Overhead Expenses (total from page 7, line 31)		
(4)	Overhead Expenses, Continued (total from page 8, line 33)		
(5)	Total Expenses per Cost Survey [add Lines (2), (3), and (4)]		
	Specify Items with Amounts that are on Cost Survey but not on Financial Statement or Tax Return		
(6a)			
(6b)			
(6c)			
(6d)			
(6e)			
	Specify Items with Amounts that are on Financial Statement or Tax Return but not on this Cost Survey		
(7a)			
(7b)			
(7c)			
(7d)			
(7e)			
(8)	Total [add Lines (1) to (7e)] Column Totals Must be Equal		

[1] If you used a tax form to complete the cost of dispensing survey, the total expenses per tax return will be found on the following lines for 2023 tax forms:

1040C - Line 28
1065 - line 22
1120 - line 27
1120S - line 21

Myers and Stauffer will keep financial information strictly confidential.

Exhibit 2
Informational Letter from the Virginia Department of Medical Assistance Services Regarding Pharmacy Cost of Dispensing Survey (Independent and Chain Pharmacies)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL J. ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219

September 12, 2024

To: Pharmacy Providers Enrolled with the Department of Medical Assistance Services

Subject: 2024 Pharmacy Cost of Dispensing Survey

The Virginia Department of Medical Assistance Services (DMAS) is conducting a pharmacy cost of dispensing survey as required by Virginia Administrative Code 12VAC30-80. DMAS requests all pharmacy providers enrolled with DMAS to participate in the survey and provide all necessary documentation to the designated vendor.

Background

DMAS has contracted with the firm of Myers and Stauffer, LC, Certified Public Accountants, a reputable firm with extensive experience in developing and conducting pharmacy cost of dispensing surveys, to conduct a comprehensive study to determine the cost of dispensing prescriptions to Virginia Medicaid fee-for-service members.

Survey

To accomplish the amount of work which must be performed and to ensure an accurate and valid measurement of dispensing costs, all forms must be completed as quickly and accurately as possible. Both DMAS and Myers and Stauffer guarantee confidentiality of your survey responses.

Please return the completed survey directly to Myers and Stauffer, no later than **October 17, 2024**. If you would prefer to complete the survey electronically, please contact Myers and Stauffer to request an Excel spreadsheet.

Contacts

The enclosed instructions include a toll-free number to assist you in completing the survey. If you have questions or concerns that Myers and Stauffer is unable to answer, call, Kiara Jasper, Pharmacy Systems Administrator at (804)762-3112 or email Kiara.jasper@dmas.virginia.gov.

Thank you for your cooperation and continued support of the Virginia Medicaid Pharmacy Program.

Sincerely,

Cheryl J. Roberts, JD
Director

Exhibit 3a
Letter from Myers and Stauffer LC Regarding Pharmacy Cost of Dispensing Survey (Independent Pharmacies)

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

September 12, 2024

Re: Virginia Department of Medical Assistance Services- Pharmacy Cost of Dispensing Survey

Dear Pharmacy Owner/Manager:

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Myers and Stauffer LC, a national Certified Public Accounting firm, to conduct a pharmacy cost of dispensing survey as part of the process to evaluate the costs associated with dispensing medications in the Commonwealth of Virginia. All pharmacies enrolled in the Virginia Medicaid Pharmacy Program are requested to participate in the survey according to the following instructions:

1. Complete the enclosed "Virginia Medicaid Pharmacy Cost of Dispensing Survey".
2. For your convenience, Myers and Stauffer will complete Section IIB "Overhead Expenses" and Section III "Reconciliation with Financial Statement or Tax Return" for you if you submit a copy of your store financial statements or your business federal income tax return (Forms 1065, 1120, 1120S or Schedule C of Form 1040 and accompanying schedules). The financial statements or federal income tax form must include information for only a single store/location. You will still need to complete the other sections of the survey.
3. If your financial statements or tax return have not been completed for your most recent fiscal year, complete the survey using your prior year's financial statements (or tax return) and the corresponding prescription data for that year. Myers and Stauffer will apply an appropriate inflation factor.
4. Retain a copy of the completed survey forms for your records.

Responding in an electronic format is preferred:

We strongly encourage pharmacies to respond in an electronic format. You may obtain an Excel spreadsheet version of the survey by contacting Myers and Stauffer at (800) 374-6858 or by email at disp_survey@mslc.com. The electronic version of the survey collects the same information as the paper version and will automatically complete certain calculations. Surveys that are completed electronically may be returned via email to the

same email address with the Excel survey file and other supporting documentation attached.

If you prefer to respond in a paper format:

Please send completed forms to:

Myers and Stauffer LC
Certified Public Accountants
Attn: Virginia Medicaid Pharmacy Cost of Dispensing Survey
700 W. 47th Street, Suite 1100
Kansas City, MO 64112

You may return the survey using the enclosed Business Reply Envelope. Postage will be paid by Myers and Stauffer.

Pharmacies are encouraged to return the requested information as soon as possible, **but forms must be returned no later than October 17, 2024.**

Whether you complete the survey in paper or electronic format, we recommend that you retain a copy of the completed survey forms for your records.

It is very important that pharmacies respond with accurate information. All submitted surveys will be reviewed and validated by staff at Myers and Stauffer. If the review yields the need for additional inquiries, Myers and Stauffer staff will contact you.

Cost of dispensing surveys and supporting documentation submitted to Myers and Stauffer for this project will remain strictly confidential.

Myers and Stauffer will be conducting informational meetings via telephonic/internet-based webinars to further explain the survey. At these meetings, Myers and Stauffer will present more details about the survey process, discuss what information is being requested and answer any questions regarding the survey form. Please refer to the enclosed information meeting flyer for further information on the dates and times of these webinar meetings and instructions for registration.

If you have any questions, please call toll free at 1-800-374-6858 or send an email to disp_survey@mslc.com.

Your cooperation in providing the information for this survey is greatly appreciated.

Sincerely,

Matt Hill, CPA, CPhT
Senior Manager
Myers and Stauffer, LC
Email: mhill@mslc.com

Enclosures: Letter from the Virginia Department of Medical Assistance Services
Virginia Medicaid Pharmacy Cost of Dispensing Survey Form
Myers and Stauffer LC Business Reply Envelope
Informational Meeting Invitation

Exhibit 3b
Letter from Myers and Stauffer LC Regarding Pharmacy Cost of Dispensing Survey (Chain Pharmacies)

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

September 12, 2024

Re: Virginia Department of Medical Assistance Services – Pharmacy Cost of Dispensing Survey

Dear Pharmacy Owner/Manager:

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Myers and Stauffer LC, a national Certified Public Accounting firm, to conduct a pharmacy cost of dispensing survey as part of the process to evaluate the costs associated with dispensing medications in the Commonwealth of Virginia. All pharmacies enrolled in the Virginia Medicaid Pharmacy Program are requested to participate in the survey.

Enclosed is the "Virginia Medicaid Pharmacy Cost of Dispensing Survey" form. You may respond to the survey using either a paper or electronic format. You will need to submit survey information for each pharmacy that participates in the Virginia Medicaid program. In past surveys performed by Myers and Stauffer LC, most pharmacy chains have preferred to respond to the survey in electronic format.

We have also enclosed a list of your pharmacies which participate in the Virginia Medicaid program. Pharmacy information is presented as shown in records from DMAS. If this list is inaccurate, please notify Myers and Stauffer LC.

It is very important that all pharmacies cooperate fully by filing an accurate cost survey. Pharmacies are encouraged to return the required information as soon as possible, **but forms must be returned no later than October 17, 2024.**

Respond in an electronic format is preferred:

We strongly encourage pharmacies to respond in an electronic format. You will need to submit survey data for each store on the attached list and any additional stores/locations that participate in the Virginia Medicaid program using an Excel spreadsheet template provided by Myers and Stauffer LC. To obtain the Excel spreadsheet, send a request by email to disp_survey@mslc.com or contact Myers and Stauffer LC staff directly (contact information below). Surveys that are completed electronically may be submitted via email or contact Myers and Stauffer for access to our Secure File Transfer Protocol portal.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
700 W 47th Street, Suite 1100 | Kansas City, MO 64112
PH 816.945.5300 | PH 800.374.6858 | FX 816.945.5301
www.mslc.com

If you prefer to respond in a paper format:

You will still need to submit a completed survey for each store on the attached list and **any additional stores/locations** that participate in the Virginia Medicaid program. You may make copies of the enclosed survey form as needed or contact Myers and Stauffer LC and request additional copies of the survey form. Please send completed forms to:

Myers and Stauffer LC
Certified Public Accountants
Virginia Medicaid Pharmacy Cost of Dispensing Survey
700 W. 47th Street, Suite 1100
Kansas City, MO 64112

You may return the surveys using the enclosed Business Reply Envelope. Postage will be paid by Myers and Stauffer LC.

Whether you complete the survey in paper or electronic format, we recommend that you retain a copy of the completed survey forms for your records. Also, please describe any cost allocations used in preparing the income statement such as administrative expense, etc. Warehousing and distribution costs should be shown in cost of goods sold or listed separately.

It is very important that pharmacies respond with accurate information. All submitted surveys will be reviewed and validated by staff at Myers and Stauffer LC. If the review yields the need for additional inquiries, Myers and Stauffer LC staff will contact you.

Cost of dispensing surveys and supporting documentation submitted to Myers and Stauffer LC for this project will remain strictly confidential.

Myers and Stauffer LC will be conducting informational meetings via telephonic/ internet-based webinars to further explain the survey. At these meetings, Myers and Stauffer LC will present more details about the survey process, discuss what information is being requested and answer any questions about regarding the survey form. Please refer to the enclosed information meeting flyer for further information on the dates and times of these webinar meetings and instructions for registration.

If you have any questions, please call toll free at 1-800-374-6858 or send an email to disp_survey@mslc.com. Your cooperation in providing the information for this survey is greatly appreciated.

Sincerely,

Matt Hill, CPA, CPhT
Senior Manager
mhill@mslc.com

Enclosures: Letter from the Virginia Department of Medical Assistance Services
Virginia Medicaid Pharmacy Cost of Dispensing Survey
List of Pharmacies that participate in the Virginia Medicaid program
Myers and Stauffer LC Business Reply Envelope
Informational Meeting Invitation

Exhibit 4
Informational Meeting Flyer
(Independent and Chain Pharmacies)

Informational Meetings
Virginia Department of Medical Assistance Services
Pharmacy Cost of Dispensing Survey

The Virginia Department of Medical Assistance Services (DMAS) is conducting a pharmacy cost of dispensing survey. The survey results will be used to evaluate the costs associated with dispensing medications in the Commonwealth of Virginia.

DMAS has engaged Myers and Stauffer LC to perform the pharmacy cost of dispensing study. To help prepare pharmacy owners and managers to participate in the survey, Myers and Stauffer LC, will be conducting informational meetings via telephonic/internet-based webinars. At these meetings, Myers and Stauffer LC will present more details about the survey process, discuss what information is being requested and answer questions regarding the survey form.

Pharmacies are invited to attend one of the informational meetings. **Attendance at one of the webinar sessions requires a reservation.** Please call or email Myers and Stauffer LC for a reservation and further meeting details.

If you are unable to attend a webinar or have questions about the survey, Myers and Stauffer LC offers a help desk to answer survey questions.

To reach Myers and Stauffer LC:

1-800-374-6858

-or-

disp_survey@mslc.com

Schedule of Informational Meetings (via telephone and Internet)

Date	Time (Eastern)
Tuesday, September 24, 2024	3:00 PM
Thursday, September 26, 2024	8:30 AM

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Exhibit 5
First Survey Reminder Postcard
(Independent and Chain Pharmacies)

REMINDER

Survey Due October 17, 2024

Virginia Department of Medical Assistance Services

Pharmacy Cost of Dispensing Survey

MYERS AND STAUFFER LC

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Myers and Stauffer LC to conduct a pharmacy cost of dispensing survey. All pharmacy providers that participate in the Virginia Medicaid pharmacy program are requested to participate in the survey.

You should have received a letter from DMAS, Myers and Stauffer LC, and a copy of the pharmacy cost of dispensing survey form. Your participation in the cost of dispensing survey is important. This survey is being used by DMAS to evaluate future fee-for-service pharmacy reimbursement rates.

If you have not received a survey form or have misplaced your survey form, you can contact Myers and Stauffer LC. If you have any questions regarding the survey or need the Excel version of the survey, please contact Myers and Stauffer LC toll free at (800) 374-6858 or via email to disp_ survey@mslc.com.

Surveys are due no later than
October 17, 2024

MYERS AND STAUFFER LC

Exhibit 6
Second Survey Reminder / Extension Postcard (Independent and Chain Pharmacies)

FINAL REMINDER

Due Date Extended to October 24, 2024

Virginia Department of Medical Assistance Services

Pharmacy Cost of Dispensing Survey

MYERS AND STAUFFER LC

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Myers and Stauffer LC to conduct a pharmacy cost of dispensing survey. All pharmacy providers that participate in the DMAS Medicaid pharmacy program are requested to participate in the survey.

Several weeks ago you should have received a letter from DMAS, Myers and Stauffer LC, and a copy of the pharmacy cost of dispensing survey form. Your participation in the cost of dispensing survey is important. This survey is being used by DMAS to evaluate future fee-for-service pharmacy reimbursement rates. All Virginia Medicaid pharmacy providers should participate in the survey.

If you have not received a survey form or have misplaced your survey form, you can contact Myers and Stauffer LC. If you have any questions regarding the survey or need the Excel version of the survey, please contact Myers and Stauffer LC toll free at (800)374-6858 or via email to disp_survey@mslc.com.

Surveys are due no later than
October 24, 2024

MYERS AND STAUFFER LC

Exhibit 7
Table of Inflation Factors for Cost of Dispensing Survey

Table of Inflation Factors for Dispensing Cost Survey

Virginia Department of Medical Assistance Services

Fiscal Year End Date	Midpoint Date	Midpoint Index [1]	Terminal Month Index (6/30/2024) [1]	Inflation Factor	Number of Stores with Year End Date
5/31/2022	11/30/2021	147.6	165.5	1.121	1
6/30/2022	12/31/2021	148.1	165.5	1.117	0
7/31/2022	1/31/2022	148.8	165.5	1.112	0
8/31/2022	2/28/2022	149.4	165.5	1.108	0
9/30/2022	3/31/2022	150.1	165.5	1.103	0
10/31/2022	4/30/2022	150.8	165.5	1.097	0
11/30/2022	5/31/2022	151.4	165.5	1.093	0
12/31/2022	6/30/2022	152.1	165.5	1.088	9
1/31/2023	7/31/2022	152.7	165.5	1.084	0
2/28/2023	8/31/2022	153.3	165.5	1.08	0
3/31/2023	9/30/2022	153.9	165.5	1.075	0
4/30/2023	10/31/2022	154.5	165.5	1.071	0
5/31/2023	11/30/2022	155.0	165.5	1.068	0
6/30/2023	12/31/2022	155.6	165.5	1.064	0
7/31/2023	1/31/2023	156.2	165.5	1.06	0
8/31/2023	2/28/2023	156.8	165.5	1.055	208
9/30/2023	3/31/2023	157.4	165.5	1.051	2
10/31/2023	4/30/2023	157.9	165.5	1.048	0
11/30/2023	5/31/2023	158.5	165.5	1.044	0
12/31/2023	6/30/2023	159.0	165.5	1.041	142
1/31/2024	7/31/2023	159.5	165.5	1.038	2
2/29/2024	8/31/2023	160.1	165.5	1.034	32
3/31/2024	9/30/2023	160.6	165.5	1.031	2
4/30/2024	10/31/2023	161.1	165.5	1.027	0
5/31/2024	11/30/2023	161.6	165.5	1.024	1
6/30/2024	12/31/2023	162.1	165.5	1.021	18
7/31/2024	1/31/2024	162.7	165.5	1.017	0
8/31/2024	2/29/2024	163.4	165.5	1.013	17

Total Number of Stores	**434**

[1] Midpoint and terminal month indices were obtained from the Employment Cost Index, (all civilian; seasonally adjusted) as published by the Bureau of Labor Statistics (BLS). Quarterly indices published by BLS were applied to last month in each quarter; indices for other months are estimated by linear interpolation.

Inflation factors are intended to reflect cost changes from the middle of the reporting period of a particular pharmacy to a common fiscal period ending December 31, 2024 (specifically from the midpoint of the pharmacy's fiscal year to June 30, 2024 which is the midpoint of the fiscal period ending December 31, 2024).

Exhibit 8
Histogram of Pharmacy Dispensing Cost

Histogram of Pharmacy Dispensing Cost

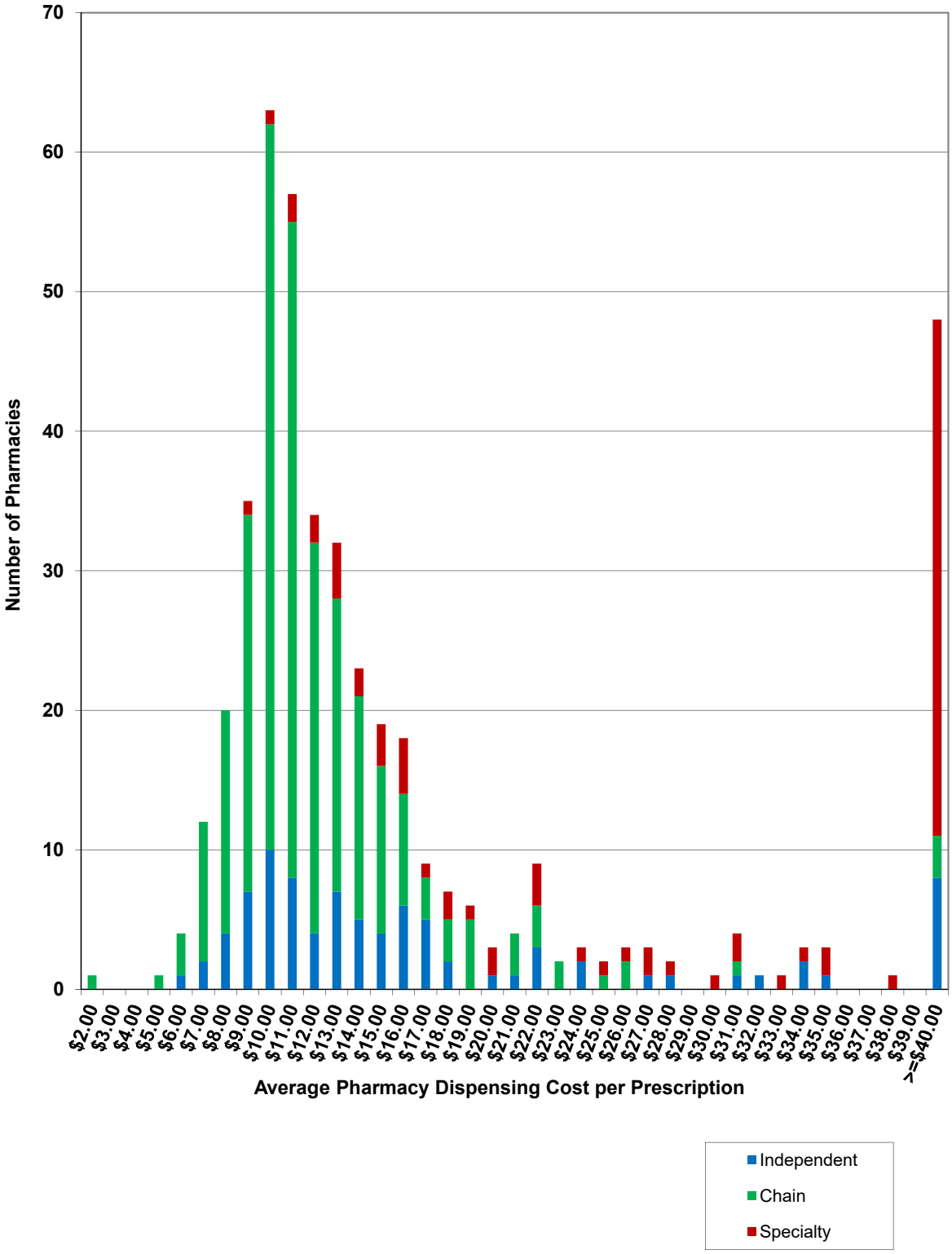


Exhibit 9
Pharmacy Cost of Dispensing Survey Data - Statistical Summary

Pharmacy Cost of Dispensing Survey
Statistical Summary
Virginia Department of Medical Assistance Services

Characteristic	n: Number of Pharmacies	Average Total Prescription Volume	Average Medicaid Prescription Volume	Pharmacy Dispensing Cost per Prescription [1] — Measurements of Central Tendency — Means — Mean	Means — Weighted by Total Rx Volume	Means — Weighted by Medicaid Rx Volume	Medians — Median	Medians — Weighted by Total Rx Volume	Medians — Weighted by Medicaid Rx Volume	Other Statistics — Standard Deviation	95% Confidence Interval for Mean (based on Student t) — Lower Bound	Upper Bound	*t* Value (with n-1 degrees of freedom)
All Pharmacies in Sample	434	126,044	8,620	$31.52	$30.00	$13.70	$12.73	$13.24	$11.69	$97.63	$22.30	$40.73	1.97
Non Specialty Pharmacies [2]	355	124,514	9,557	$14.51	$13.09	$12.72	$11.82	$11.57	$11.39	$10.43	$13.42	$15.60	1.97
Specialty Pharmacies [2]	79	132,921	4,411	$107.95	$101.19	$23.23	$35.04	$116.82	$13.55	$212.56	$60.34	$155.56	1.99
Non Specialty Pharmacies Only													
Affiliation:													
Chain	268	81,326	7,813	$12.66	$11.38	$11.64	$11.50	$10.93	$10.93	$4.95	$12.07	$13.26	1.97
Independent	87	257,552	14,929	$20.18	$14.76	$14.48	$14.01	$14.01	$14.01	$18.13	$16.32	$24.05	1.99
Location (Urban vs. Rural): [3]													
In State Urban	254	83,155	8,856	$14.23	$12.09	$12.61	$11.86	$11.16	$11.23	$9.97	$13.00	$15.47	1.97
In State Rural	59	75,206	14,169	$12.47	$11.42	$11.81	$11.47	$10.96	$10.96	$4.83	$11.22	$13.73	2.00
Out of State	42	443,900	7,316	$19.00	$14.63	$16.09	$13.74	$14.01	$15.59	$16.32	$13.92	$24.09	2.02
Annual Rx Volume:													
0 to 54,999	92	34,951	5,409	$22.04	$18.09	$17.87	$16.77	$15.33	$15.38	$16.88	$18.55	$25.54	1.99
55,000 to 88,999	137	71,022	6,533	$12.51	$12.37	$11.96	$11.90	$11.84	$11.50	$5.17	$11.64	$13.39	1.98
89,000 and Higher	126	248,070	15,874	$11.17	$12.80	$11.79	$10.48	$11.12	$10.93	$3.80	$10.50	$11.84	1.98
Annual Medicaid Rx Volume: [4]													
0 to 2,299	99	127,549	675	$18.76	$14.30	$16.69	$13.61	$11.62	$12.98	$15.31	$15.71	$21.81	1.98
2,300 to 9,499	132	89,937	5,510	$13.69	$11.46	$13.71	$11.52	$10.71	$11.41	$9.27	$12.09	$15.29	1.98
9,500 and Higher	124	158,897	20,956	$11.98	$13.30	$12.35	$11.07	$14.01	$11.34	$3.66	$11.33	$12.63	1.98
Medicaid Utilization Ratio: [4]													
0.0% to 3.49%	105	212,164	2,314	$16.79	$14.23	$14.71	$12.98	$13.24	$14.01	$13.77	$14.12	$19.45	1.98
3.50% to 13.19%	132	100,492	7,789	$12.52	$11.66	$11.68	$11.16	$11.12	$11.12	$6.79	$11.35	$13.69	1.98
13.20% and Higher	118	73,391	17,980	$14.70	$12.36	$13.00	$11.80	$11.07	$11.39	$10.00	$12.87	$16.52	1.98

Pharmacy Cost of Dispensing Survey
Statistical Summary
Virginia Department of Medical Assistance Services

Characteristic	n: Number of Pharmacies	Average Total Prescription Volume	Average Medicaid Prescription Volume	Pharmacy Dispensing Cost per Prescription [1] — Measurements of Central Tendency — Means — Mean	Means — Weighted by Total Rx Volume	Means — Weighted by Medicaid Rx Volume	Medians — Median	Medians — Weighted by Total Rx Volume	Medians — Weighted by Medicaid Rx Volume	Other Statistics — Standard Deviation	95% Confidence Interval for Mean (based on Student t) — Lower Bound	Upper Bound	*t* Value (with n-1 degrees of freedom)
Non Specialty Pharmacies Only													
Institutional:													
LTC Institutional Pharmacies [5]	9	370,410	22,972	$17.86	$16.13	$14.29	$14.07	$14.07	$14.07	$9.39	$10.65	$25.08	2.31
Non-LTC Institutional Pharmacies [5]	346	118,117	9,208	$14.42	$12.85	$12.62	$11.79	$11.39	$11.19	$10.46	$13.31	$15.52	1.97
Unit Dose:													
Does dispense unit dose	9	407,141	18,843	$18.19	$15.71	$14.28	$13.71	$13.24	$16.24	$9.10	$11.20	$25.19	2.31
Does not dispense unit dose	346	117,162	9,315	$14.41	$12.86	$12.64	$11.77	$11.35	$11.34	$10.46	$13.30	$15.52	1.97
Provision of Compounding Services													
Provides compounding (>=10% of Rxs)	5	106,633	3,307	$53.99	$36.64	$47.96	$65.28	$32.55	$65.28	$32.78	$13.29	$94.69	2.78
Compounding <10% of Rxs	350	124,769	9,646	$13.94	$12.81	$12.55	$11.79	$11.50	$11.39	$8.69	$13.03	$14.86	1.97

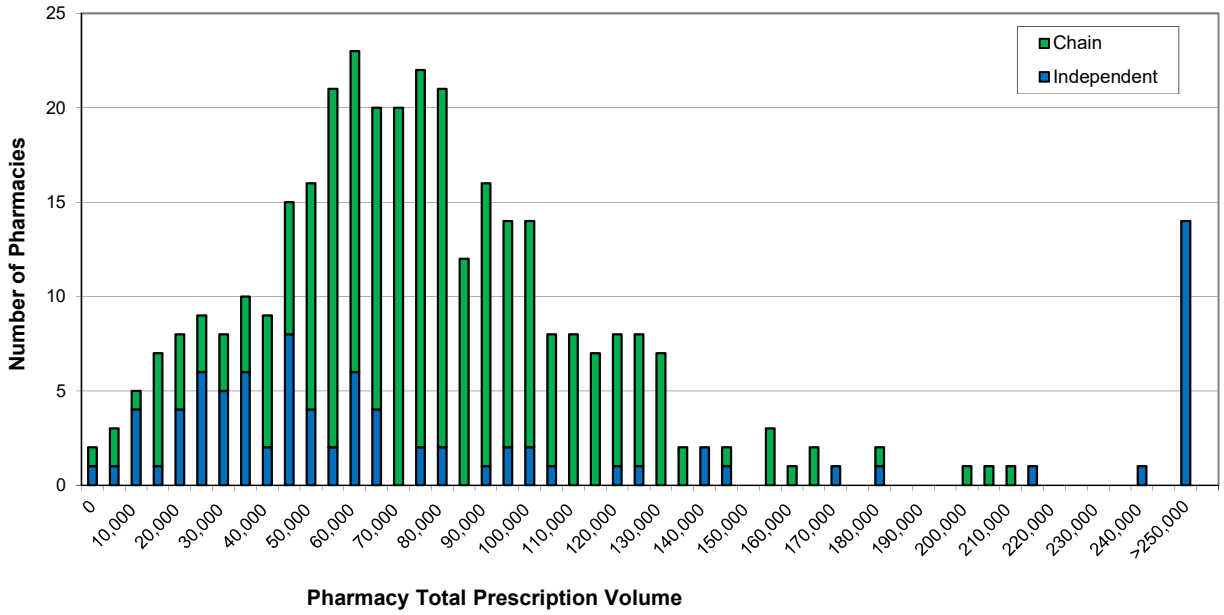
Notes:
1) All pharmacy dispensing costs are inflated to the common point of 6/30/2024 (i.e., midpoint of a fiscal year ending 12/31/2024).
2) For purposes of this report a "specialty pharmacy" is one that reported sales for intravenous, home infusion, clotting factor and/or other specialty services of 30% or more of total prescription sales.
3) Myers and Stauffer used the pharmacies' zip code and the Zip Code to Carrier Locality File from the Centers for Medicare & Medicaid Services to determine if the pharmacy was located in an urban or rural area.
4) Medicaid volume is based on Virginia fee-for-service Medicaid volume for the time period of July 1, 2023 to June 30, 2024.
5) For purposes of this report an "LTC Institutional Pharmacy" is one that reported dispensing 25% or more of prescriptions to long-term care facilities.

Exhibit 10
Charts Relating to Pharmacy Total Prescription Volume:

A: Histogram of Pharmacy Total Prescription Volume

B: Scatter-Plot of Relationship between Dispensing Cost per Prescription and Total Prescription Volume

Histogram of Pharmacy Total Prescription Volume



Scatter Plot of Relationship Between Dispensing Cost per Prescription and Total Prescription Volume

(Non-Specialty Pharmacies, Total Prescription Volume < 250,000)

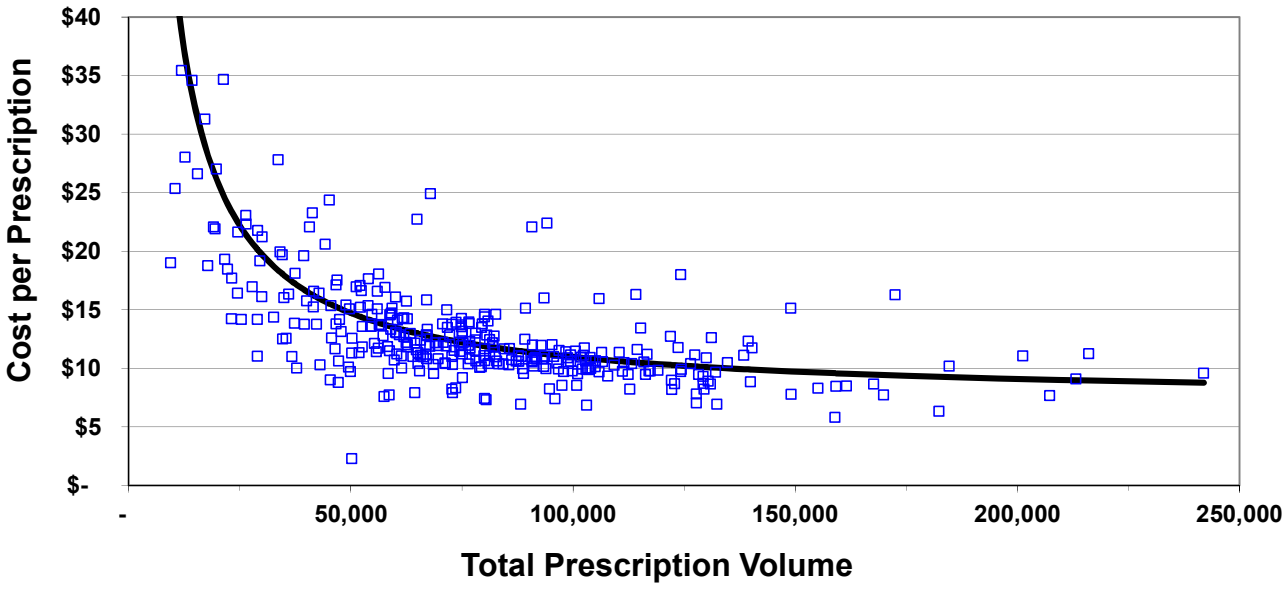


Exhibit 11
Chart of Components of Cost of Dispensing per Prescription

Chart of Components of Dispensing Cost per Prescription

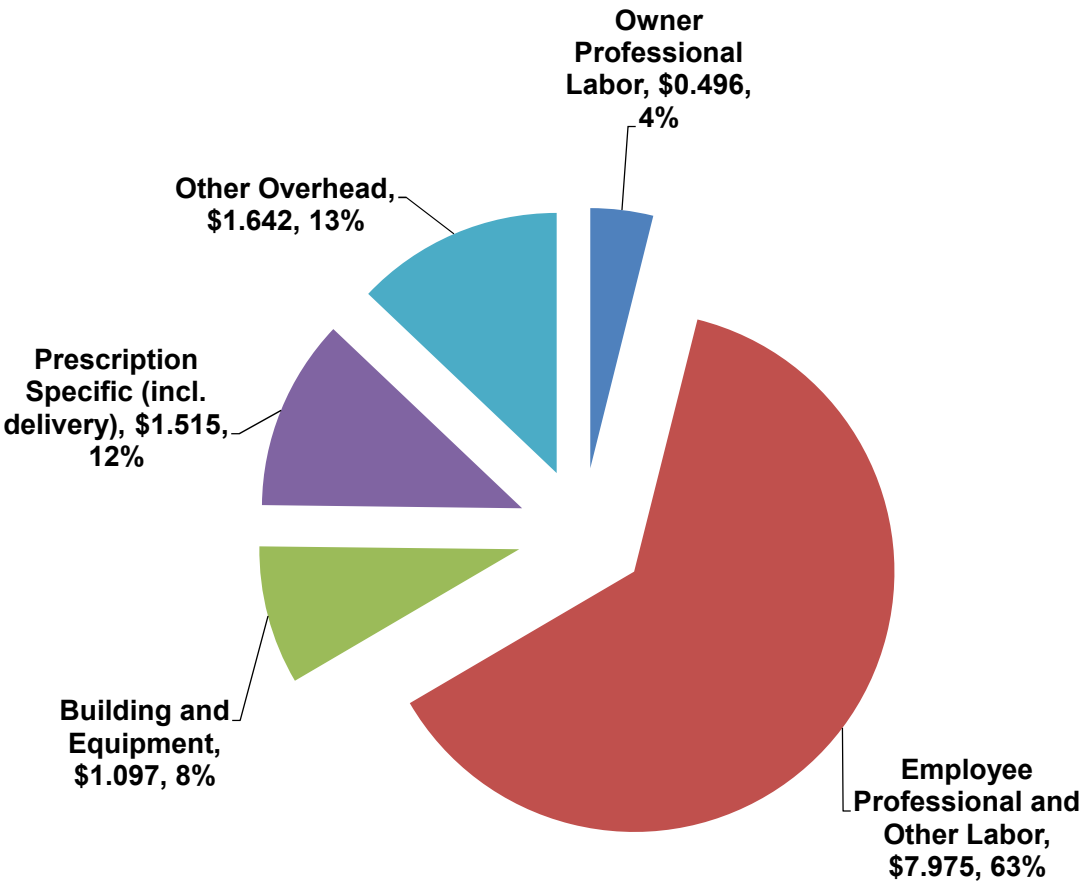


Exhibit 12
Summary of Pharmacy Attributes

Summary of Pharmacy Attributes
Virginia Department of Medical Assistance Services

Attribute	Number of Pharmacies Responding	Statistics for Responding Pharmacies		
		Response	Count	Percent
Payer Type: percent of prescriptions (averages)	434	Medicaid fee for service	N/A	2.7%
		Medicaid managed care	N/A	12.3%
		Other third party	N/A	77.5%
		Cash	N/A	7.5%
		Total	N/A	*100.0%*
Payer Type: percent of payments (averages)	434	Medicaid fee for service	N/A	2.6%
		Medicaid managed care	N/A	11.4%
		Other third party	N/A	80.9%
		Cash	N/A	5.1%
		Total	N/A	*100.0%*
Type of ownership	434	Individual	7	1.6%
		Corporation	412	94.9%
		Partnership	5	1.2%
		Other	10	2.3%
		Total	*434*	*100.0%*
Location	434	Medical office building	55	12.7%
		Shopping center	22	5.1%
		Stand alone building	248	57.1%
		Grocery store / mass merchant	58	13.4%
		Outpatient Hospital	5	1.2%
		Other	46	10.6%
		Total	*434*	*100.0%*
Building ownership (or rented from related party)	434	Yes, (own building or rent from related party)	16	3.7%
		No	418	96.3%
		Total	*434*	*100.0%*
Hours open per week	426	59.0 hours	N/A	N/A
Years pharmacy has operated at current location	432	15.8 years	N/A	N/A
Provision of 24 hour emergency services	434	Yes	96	22.1%
		No	338	77.9%
		Total	*434*	*100.0%*
Percent of prescriptions to generic products	425	Percent of prescriptions dispensed that were generic products	425	78.5%
Percent of prescriptions to long-term care facilities	434	2.9% for all pharmacies; (34.1% for 37 pharmacies reporting > 0%)	N/A	N/A
Provision of unit dose services	434	Yes (average of 24.0% of prescriptions for pharmacies indicating provision of unit dose prescriptions. Approximately 92.6% of unit dose prescriptions were reported as prepared in the pharmacy with 7.4% reported as purchased already prepared from a manufacturer)	45	10.4%
		No	389	89.6%
		Total	*434*	*100.0%*
Percent of total prescriptions delivered	434	16.0% for all pharmacies; (28.3% for 246 pharmacies reporting > 0%)	N/A	N/A
Percent of Medicaid prescriptions delivered	434	2.9% for all pharmacies; (19.8% for 64 pharmacies reporting > 0%)	N/A	N/A
Percent of prescriptions dispensed by mail	434	10.6% for all pharmacies; (36.4% for 126 pharmacies reporting >0% percent of prescriptions dispensed by mail)	N/A	N/A

Summary of Pharmacy Attributes
Virginia Department of Medical Assistance Services

Attribute	Number of Pharmacies Responding	Statistics for Responding Pharmacies		
		Response	Count	Percent
Percent of Total prescriptions compounded.	434	1.9% for all pharmacies; (2.9% for 285 pharmacies reporting >0 compounded Rxs)	N/A	N/A
Percent of Virginia Medicaid prescriptions compounded.	434	0.6% for all pharmacies; (13.8% for 19 pharmacies reporting >0 compounded Rxs)	N/A	N/A
Pharmacy has current unfilled pharmacists positions.	434	Yes (average of 1.1 open positions for pharmacies reporting yes).	16	3.7%
		No	170	39.2%
		Nonresponsive	248	57.1%
		Total	*434*	100.0%
Pharmacy has current unfilled pharmacy technician positions.	434	Yes (average of 1.9 open positions for pharmacies reporting yes).	52	12.0%
		No	134	30.9%
		Nonresponsive	248	57.1%
		Total	*434*	*100.0%*