Final Briefing:

Access to Pharmacy Services in Virginia

Analysts: Jen Piver-Renna, Mayesha Alam, Khadeejat Lawal, Emily Atkinson, and Sarah Stanton

Study purpose

The JCHC directed staff to:

- Describe how access to pharmacy services has changed in Virginia over time and the impact of those changes
- Identify areas and populations in Virginia impacted by pharmacy deserts
- Identify factors that impact access to pharmacy services in Virginia
- Describe strategies to ensure access to pharmacy services
- Recommend policy options through which Virginia may ensure access to pharmacy services

Study approved by Commission for the 2025 workplan on December 17, 2024.

Community pharmacies are a critical access point for health care services

- Community pharmacies dispense medications and provide health services to all members of the public
- Since 2019, community pharmacies operating in Virginia have declined by nearly 10 percent
- Virginia State Board of Health adopted a resolution to recognize pharmacy deserts as a threat to public health

Findings in brief

- The practice of pharmacy has expanded over time to reflect the role of pharmacists in health care service delivery
- The number of community pharmacies operating in Virginia has declined since 2019, leaving communities with limited access to pharmacy services
- Primary driver of pharmacy closure is imbalance between pharmacy operating expenses and revenue
- States can address practices that limit pharmacy revenue and incentivize pharmacies in areas of limited access

Agenda

Practice of pharmacy and value of community pharmacies

Access to community pharmacies in Virginia

Pharmacy expenses and revenue sources

Strategies to reduce pharmacy financial challenges

Voting on policy options

Virginia has expanded the scope of the practice of pharmacy

- Federal and state law and regulations establish the boundaries of the practice of pharmacy
- Scope of pharmacy practice has expanded beyond dispensing:
  - Adoption of collaborative practice model
  - Authority to initiate treatment and administer vaccines

Community pharmacies provide comprehensive pharmacy services

- Access to community pharmacies improves medication adherence, individual health, and public health outcomes
- Closure of community pharmacies reduces medication adherence and vaccination rates, and strains remaining pharmacies that must serve additional patients

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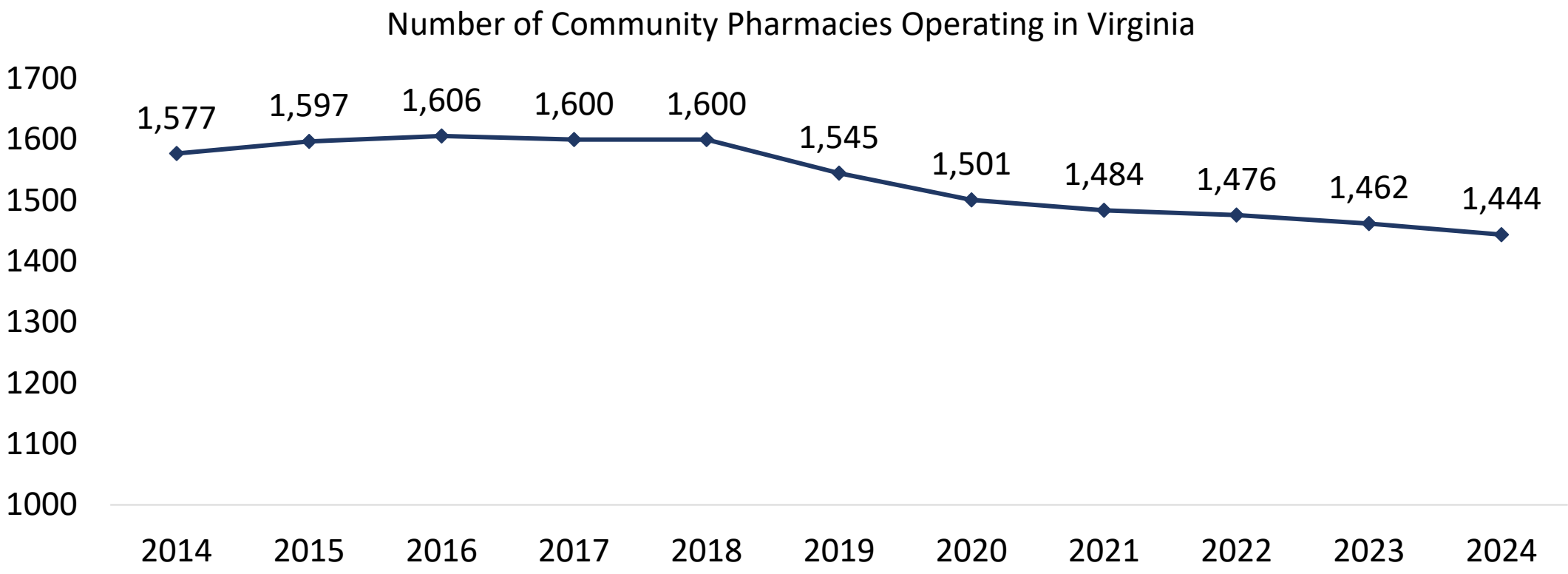
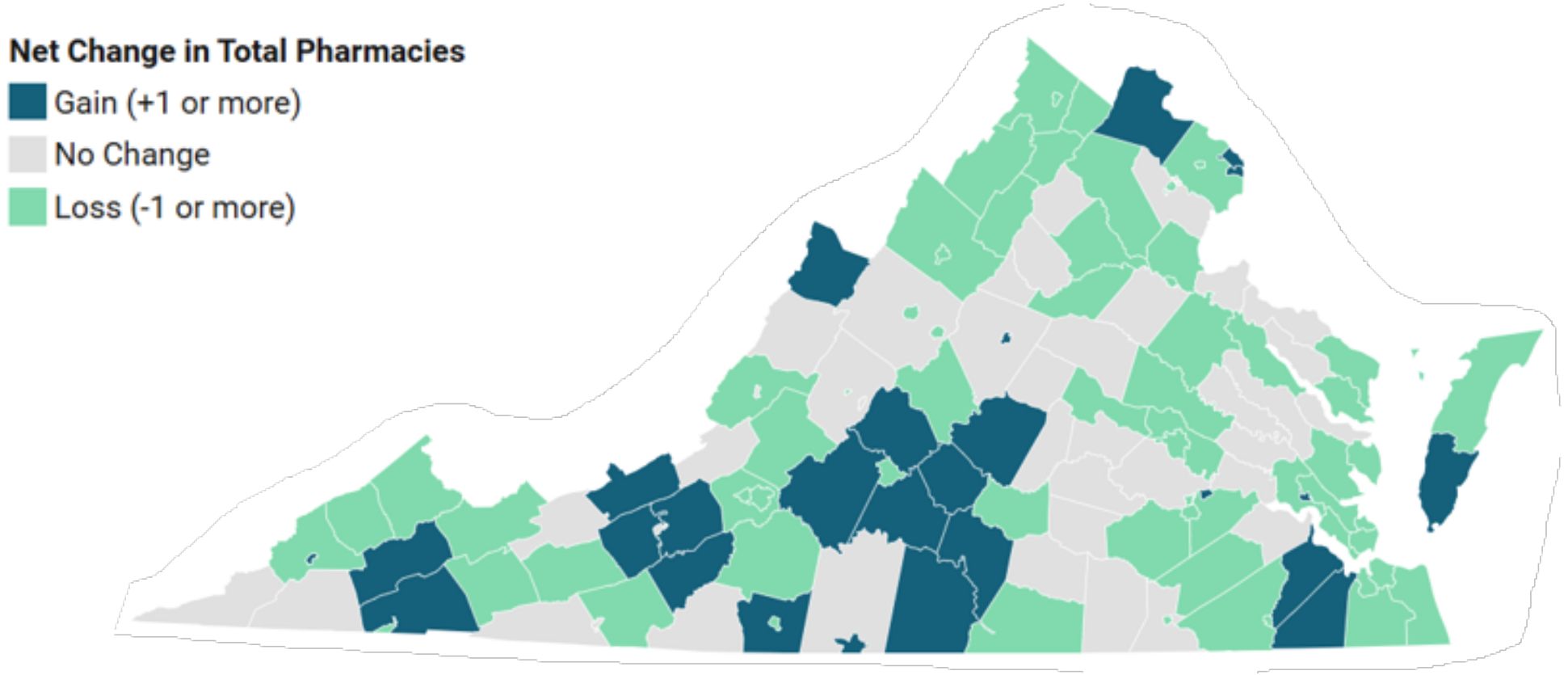
Community pharmacies are declining in Virginia



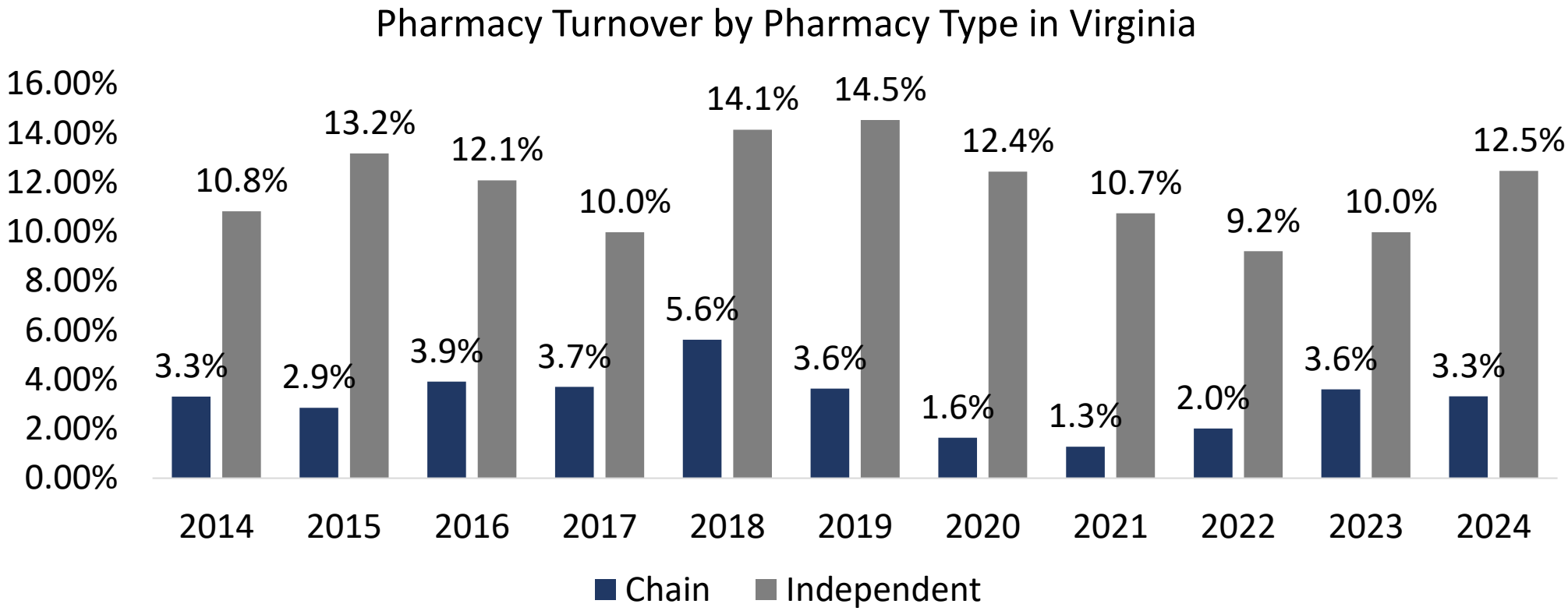
SOURCE: JCHC analysis of Virginia Board of Pharmacy data, 2025.

Half of Virginia localities experienced a net loss of community pharmacies



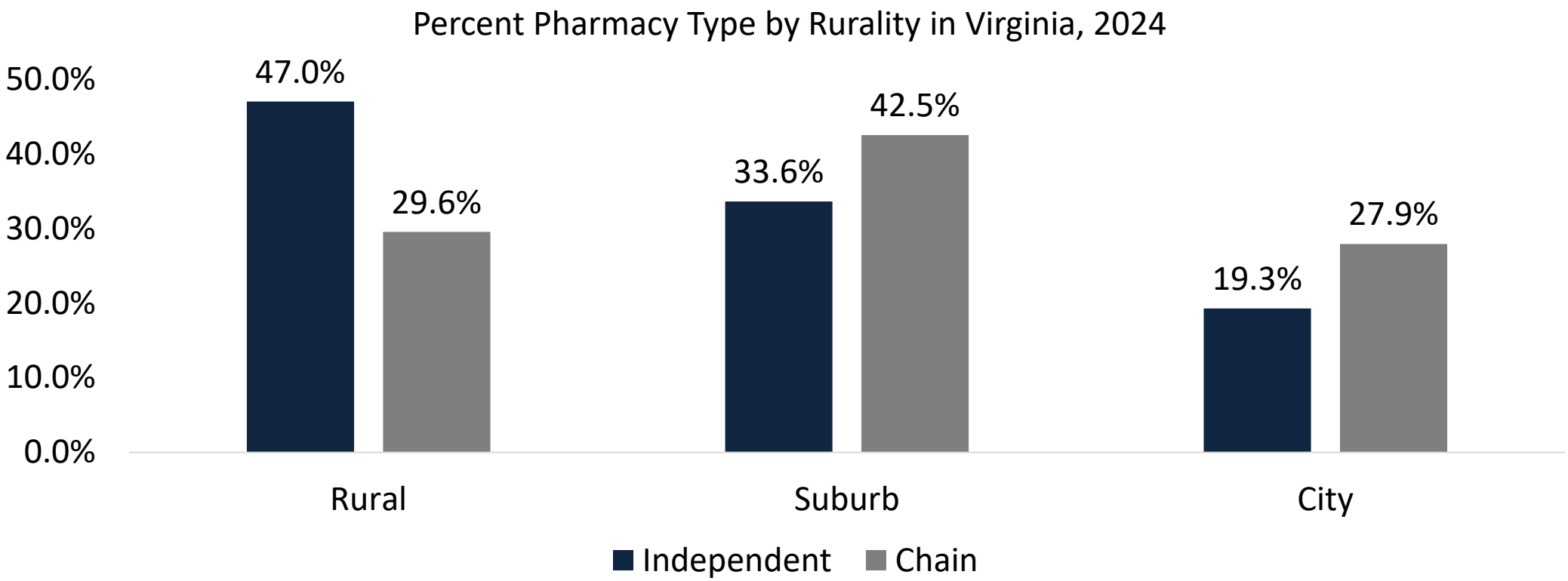
SOURCE: JCHC staff analysis of Virginia Board of Pharmacy data, 2025.

Independent pharmacies turnover more frequently than chains



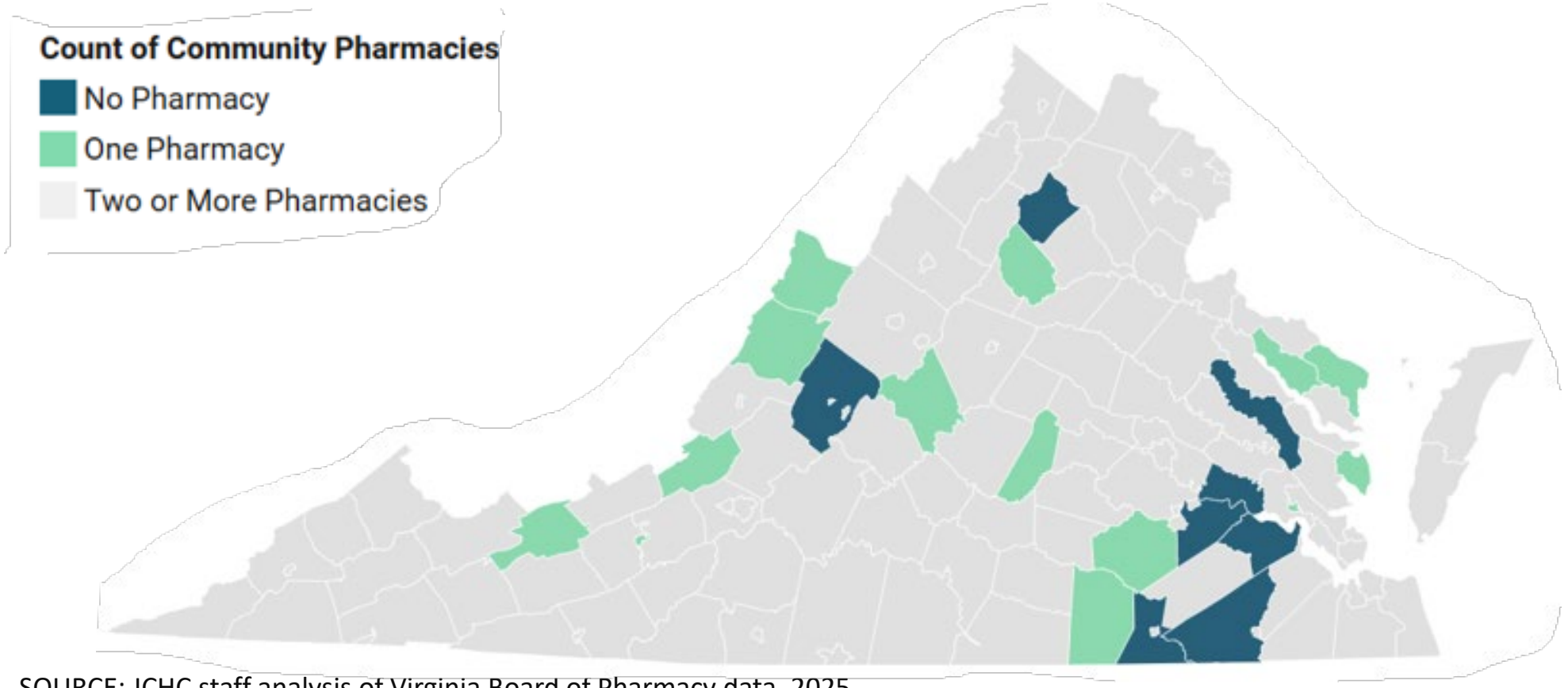
SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

Independent pharmacies are more likely to operate in rural communities



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

22 localities in Virginia have limited or no access to a community pharmacy



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

Individuals travel long distances to receive medications

- Among 8 localities with no community pharmacy:
  - Nearest pharmacy is between 3 and 21 miles away
  - 6 localities have not had any operating pharmacy in the last decade
- Among 14 localities with a single pharmacy:
  - 8 localities are served by an independent pharmacy, 2 by a government-funded pharmacy, and 4 by a chain pharmacy
  - 9 localities have not had any other operating pharmacy in the last decade

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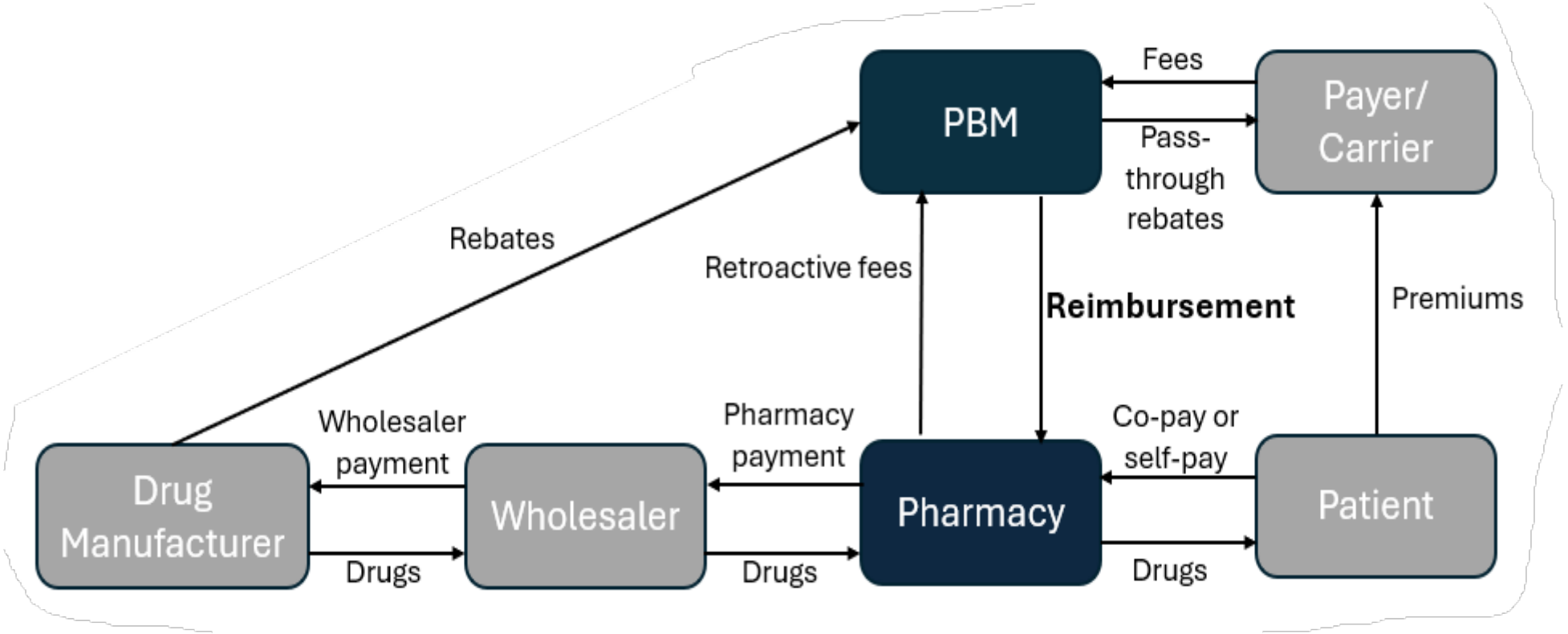
Pharmacy operating expenses are increasing

- Cost of medications purchased from wholesalers is increasing at a greater rate than inflation
- Median salaries for pharmacy technicians have increased by 60 percent in Virginia
- Other primary expenses are related to the physical building, supplies, technology, and regulatory fees

Reimbursement fees for dispensing are the primary source of revenue



PBM = pharmacy benefit manager
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.

Reimbursement fees include ingredient costs and a professional dispensing fee

- Drug ingredient costs cover the cost to the pharmacy of purchasing the drug from the wholesaler
- Professional dispensing fees compensate the pharmacy for the operational costs associated with dispensing medications

Revenue is not keeping pace with the costs of pharmacy operation

- Reimbursement rates for dispensing fall below drug acquisition costs and costs of dispensing
- Pharmacists must make tough decisions about their drug stock, workforce, operating hours, and business viability, particularly in:
  - Independent pharmacies
  - Communities with low population and low dispensing volume
  - Communities with larger numbers of patients covered by plans with lower reimbursement fees

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States can place limits on PBM practices impacting pharmacy revenue

- ERISA establishes uniform rules for employer-sponsored health plan, preempting states from passing laws regulating the administration or design of covered plans
- States may regulate PBMs directly so long as the state does not require any changes to benefit design
  - 48 states have enacted laws regulating PBM practices
  - Laws targeting PBM reimbursement methods are permitted

ERISA = Employee Retirement Income Security Act; PBM = Pharmacy Benefit Manager

Virginia has enacted robust PBM reform

The *Code of Virginia* requires:

- Disclosure of ownership and control
- Annual renewal and certification
- Prohibited conduct
- Audit and reporting obligations
- Rebate, retained rebate, and fee reporting
- Prohibition of spread pricing
- Complaint process and enforcement

States can establish reimbursement fees when the state is the payer

- DHRM contracts directly with CarelonRx to provide PBM services for self-insured state employee health plans
  - Contract terms specify minimum ingredient cost and dispensing fee
  - Stakeholders had no concerns about adequacy of reimbursement
- The General Assembly has the authority to establish reimbursement fees for Fee-For-Service (FFS) and managed care programs

DHRM = Virginia Department of Human Resource Management

Reimbursement fees for Medicaid FFS established by regulation

- *12VAC30-80-40* sets the reimbursement fee for dispensing to Medicaid FFS members:
  - Professional dispensing fee of $10.65
  - 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
- Current dispensing fee based on 2019 cost of dispensing survey; DMAS has not released results of the 2024 survey

NADAC = National Average Drug Acquisition Cost; DMAS = Department of Medical Assistance Services

MCOs and PBMs set reimbursement fees for Medicaid managed care

- In managed care, DMAS contracts with Managed Care Organizations (MCOs) who then contract with PBMs to administer the prescription drug benefit
- Contract terms are not publicly available, but stakeholders report reimbursement fees between “pennies” and $2.00

States address insufficient fees by setting a reimbursement floor

- West Virginia - NADAC plus $10.49 dispensing fee for all PBMs
- Ohio – $9.00 dispensing fee for Medicaid managed care
- Tennessee - $13.16 dispensing fee for pharmacies with less than 65,000 Medicaid managed care claims; $9.02 for 65,000 or more
- New Mexico – NADAC plus $10.30 professional dispensing fee for Medicaid managed care
- Illinois - $21.05 dispensing fee for Medicaid managed care claims from critical access pharmacies

Virginia could set a reimbursement floor for the Medicaid program

- General Assembly has previous considered minimum reimbursement fees in the 2019, 2024, and 2025 state budgets
- *Save the Local Pharmacies Act* directs DMAS to select a single PBM to administer pharmacy benefits
  - Does not specifically require increased reimbursement fees
  - Enforceable minimum reimbursement fees must be built into MCO contracts

Policy 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.

Implementation Considerations

- Anticipated costs associated with a reimbursement floor could apply to a subset of pharmacies rather than all Medicaid claims for dispensing
- Information about current reimbursement fees or potential savings that may accrue due to the transition to a single PBM was not available to JCHC staff

Incentives can maintain or re-establish pharmacies in low access communities

- Pharmacies require greater support to survive in low access communities
  - Typically rural, with smaller population and lower sales volume
  - High rates of Medicaid enrollment with low reimbursement
- States have implemented incentive programs targeting pharmacies in rural areas
  - Maryland's small rural pharmacy grants program
  - Oregon's rural health care income tax credit program

Virginia has considered an incentive program for independent pharmacies

- House Bill 2023 (Anthony) proposed a program that would provide grants to qualifying pharmacies in medically underserved areas
  - Tabled during the 2025 session and referred to JCHC for study
  - Stakeholders expressed support for the program but emphasized that it may not be sufficient to address pharmacies' financial deficit

Policy 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.

Implementation Considerations

Costs of an incentive program are dependent upon eligibility criteria and the amount of each grant

- Could be narrowly tailored to pharmacies within limited access communities or certain payer mixes
- Could include fixed grant amounts for all eligible pharmacies or variable grant awards linked to dispensing volume

Government-funded pharmacy services could support areas with no access

- Health safety net providers provide health care and pharmacy services to underserved communities and individuals who cannot afford health services
  - 70 free and charitable clinics
  - 228 community health centers
- VAFCC and VCHA receive state funding to provide pharmacy services to low-income, uninsured patients

VAFCC = Virginia Association of Free and Charitable Clinics; VCHA = Virginia Community Healthcare Association

Policy 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.

Implementation Considerations

- Policy option permits flexibility to determine how funding could best meet community needs
- Funds could establish permanent pharmacy locations or capacity for alternative approaches

Opportunity for public comment

- Submit written public comments by close of business on Friday, December 19th

  Email: jchcpubliccomments@jchc.virginia.gov

  Mail: 411 E. Franklin Street, Suite 505

  Richmond, VA 23219

NOTE: All public comments are subject to FOIA and must be released upon request.

Member Discussion and Voting

Policy options

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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.
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.
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.