

Agency	<u>FY2025</u>	<u>FY2026</u>	<u>FY2027</u>	<u>FY2028</u>	<u>FY2029</u>	<u>FY2030</u>
DMAS (Administration)	-	\$250,000	\$20,515,608	\$14,780,237	\$14,780,237	\$14,780,237
DMAS (Medical)	-	-	Indeterminate	Indeterminate	Indeterminate	Indeterminate

Department of Planning and Budget
2025 General Assembly Session
State Fiscal Impact Statement

Position Impact:

<u>Agency</u>	<u>FY2025</u>	<u>FY2026</u>	<u>FY2027</u>	<u>FY2028</u>	<u>FY2029</u>	<u>FY2030</u>
DMAS	-	-	5.0	5.0	5.0	5.0

Fiscal Analysis: Currently, DMAS only contracts with a PBM to administer the fee-for-service (FFS) pharmacy benefit. Each managed care organization (MCO) that administers pharmacy benefits for Virginia Medicaid recipients individually contracts with a PBM. The bill would require DMAS to contract with a third-party administrator to serve as the state PBM for pharmacy benefits provided through both FFS and managed care. In addition, the bill requires that the state PBM use pass-through pricing as well as the common formulary, reimbursement methodologies, and dispensing fees as negotiated by DMAS. The provision to prohibit spread pricing is moved from Code § 32.1-325.

DMAS utilized Mercer, the agency-contracted actuarial firm, to develop medical assistance cost estimates for the introduced version of this bill. These estimates were based on pharmacy spending observed during calendar year 2023, pharmacy trend assumptions, and membership projections provided by DMAS. The initial Mercer analysis indicated that the program design could increase pharmacy costs to the Medicaid program by \$36.9 to \$51.1 million (all funds) each year. These cost projections were based on the adoption of a uniform preferred drug list and utilization of the current FFS dispensing fee (\$10.49). The amended bill requires DMAS to negotiate dispensing fees. While it is assumed that a negotiated fee would be less than the current FFS rate and likely higher than those paid by managed care organizations, DMAS does not have sufficient data to develop a revised cost estimate. In addition to pharmacy costs, an administrative savings from converting to a single PBM may occur. Because this single PBM would contract with each MCO, each MCO would no longer have a need for administrative costs to support their own PBM contract; thus, the capitation rates would be adjusted down. To estimate this savings, DMAS used a 2019 Mercer study of single PBM options. For this model, Mercer estimated a potential \$10 million (all funds) savings beginning in the year of implementation. Note: This savings amount has been revised from the initial statement to reflect a better understanding of information provided in the study.

DMAS maintains that the bill would require administrative effort for which the agency is not currently budgeted. While the bill is not effective until July 1, 2026, DMAS indicates that the assistance of an outside vendor in FY 2026 would be necessary to expedite the process of contracting with a PBM. Based on historical experience, the agency maintains that a minimum of \$500,000 (\$250,000 general fund) is needed. In addition to PBM selection costs, DMAS assumes that funding would be needed for five positions along with PBM contract and systems costs. The preliminary agency estimate is \$22.7 million (\$2.2 million general fund) in the first year of implementation and \$18.3 million (\$3.5 million general fund) each year thereafter. DMAS maintains that these positions would be needed to support the development and functions of the PBM. More specifically, the department expects that these positions would be dedicated to oversight, reporting, troubleshooting, rebate management, compliance, and escalations. DMAS reports that this effort is consistent with the level of staffing seen in other states for the pass-through model.

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The bill stipulates that the evaluation would not affect the implementation date of July 1, 2026. However, there is no evaluation required by this legislation. Therefore, no associated costs are assumed.

Other: This bill is a companion to HB 2610.