Single State-Directed Pharmacy Benefit Administrators: Ohio and Other States

Briefing for the Colorado Commission on Medicaid · November 2026

Why the Commission asked

On November 10th, the Commission adopted line 115, which calls for an independent evaluation of moving Medicaid pharmacy administration to a single state-directed pharmacy benefit administrator, drawing on other states' experience, including Ohio's. As written, the evaluation would cover implementation cost, net General Fund savings, effects on pharmacies and members, and changes to managed care financing. The line relates to line 24.

This briefing gives members a starting picture of what other states have done and what they found, so that the questions the evaluation asks fit Colorado's situation. It is not a recommendation for or against the model.

Bottom line

- **Colorado is already most of the way to a single state-directed model.** Most Health First Colorado pharmacy is paid fee-for-service through one state-contracted pharmacy benefit management (PBM) system, with HCPF setting the drug list, rates, and rebate strategy. The open question is the pharmacy benefit run by the two capitated managed care plans, Denver Health Medicaid Choice and Rocky Mountain Health Plans PRIME.
- **The single-PBM states started somewhere very different.** Kentucky, Ohio, Louisiana, and Mississippi each had five to seven managed care plans, each with its own PBM, covering most members. Their savings came from consolidating that. Colorado's savings, if any, would come from a much smaller slice of spending.
- **Reported savings are real but contested.** Kentucky reports about $282.7 million less spending over two years. Ohio reports about $140 million over two years, but its own actuary's middle scenario shows about $19 million, and its range runs from $139.5 million in savings to a $99.4 million cost. The actuary called the result "not materially different" from managed care.
- **Money moves rather than disappears.** Administrative costs and spread pricing fall, and state rebates rise. Pharmacy dispensing fees rise sharply (Ohio's average went from 73 cents to more than $9 a prescription), which helps pharmacy access, especially independent and rural pharmacies.
- **Implementation and durability are real risks.** Ohio paused and rebuilt prior authorization in its first months. Louisiana ended its single PBM on October 1, 2025, two years after launch, and returned pharmacy to each plan's own PBM.
- **For Colorado, the evaluation question is narrower than Ohio's:** whether to move the two plans' pharmacy into the existing state system, and what that would do to plan capitation, Denver Health's 340B savings, care coordination, and members' access.

Where Colorado starts

- **One state system for most members.** Health First Colorado runs the outpatient pharmacy benefit for fee-for-service members through its Pharmacy Benefit Management System (PBMS), one of the core modules of the state's Medicaid enterprise system. MedImpact became the fee-for-service claims processor on April 1, 2026.
- **The state keeps the levers.** HCPF, not the vendor, sets the preferred drug list, pharmacy reimbursement, and supplemental rebate decisions.
- **Scale.** In FY 2024-25 the fee-for-service benefit served 685,939 members, paid 8.12 million claims, and spent about $1.636 billion before rebates.
- **Two plans run their own pharmacy benefit.** Denver Health Medicaid Choice and Rocky Mountain Health Plans PRIME are capitated for physical health, including pharmacy, and each keeps its own drug list and PBM. Together they cover a small share of members compared with the fee-for-service population.
- **Pricing rules already reach the plans.** Colorado law requires pass-through pricing in Medicaid pharmacy contracts entered into from January 1, 2025, including PBMs affiliated with a managed care organization.

Colorado could make a chance to be more similar to Ohio, which would be a carve-out of the two plans' pharmacy into the state PBMS, or a requirement that they use a state-selected PBM. Either would be far smaller than what Ohio, Kentucky, or Louisiana did.

State by state

Two models are in use. In the **single-PBM model** (Kentucky, Ohio, Louisiana, Mississippi, Virginia), managed care plans keep paying for pharmacy, but every plan must use one PBM the state selects, under state-set rates and one drug list. In the **full carve-out model** (California, New York, and others), pharmacy leaves managed care entirely and the state pays it fee-for-service through an administrative vendor. Colorado's fee-for-service benefit already works like the second model.

State	Model and start	Vendor	What was reported	Status and cautions
Kentucky	Single PBM for all plans, July 2021 (SB 50, 2020); single drug list from January 2021	MedImpact (fee-for-service also moved to MedImpact in January 2024)	State told legislators managed care would have cost $282.7 million more over two years without SB 50	Still in place. Followed an audit finding spread pricing cost $123.5 million in one year. Medicaid officials called the transition smooth.
Ohio	Single PBM, October 2022 (HB 166, 2019); plans still capitated for other services; fee-for-service added July 2023	Gainwell	ODM: about $140 million net over two years and $333 million in administrative savings. Milliman: middle scenario about $19 million; range $139.5 million saved to $99.4 million cost. Supplemental rebates rose from about $246 million to about $424 million a year.	Prior authorization paused, then phased back in by May 2023; vendor fined $200,000 in 2024. Average dispensing fee rose from 73 cents to more than $9. Over 99% of pharmacies in network. Critics dispute the baseline.

State	Model and start	Vendor	What was reported	Status and cautions
Louisiana	Single PBM for six plans (about 1.7 million members), October 2023; fee-for-service not included	Magellan, then Prime Therapeutics	Limited public savings data	Phased out October 1, 2025; each plan returned to its own PBM. The state bulletin gives no reason.
Mississippi	Single PBM for plans, FY 2024	State-selected PBM	Limited public data so far	Too early to judge.
Virginia	Single PBM for all Medicaid populations enacted 2025 (HB 2610 / SB 875)	To be procured	DMAS study (House Document 8, Myers and Stauffer) modeled options and implementation cost; a 2019 study estimated $10.1 million to $22 million in savings	Start delayed to January 2027. The Governor first sent the bill back as a study before signing.
California	Full carve-out (Medi-Cal Rx), January 2022, about 13 million people	Magellan, now Prime Therapeutics	LAO found net state savings likely but net cost possible; savings partly come from capturing 340B margins that had gone to providers	Early access and call center problems; plans lost the ability to coordinate pharmacy with other care.
New York	Full carve-out (NYRx), April 2023	State fee-for-service with vendors already in place	State estimated $166 million in first-year savings, shared federal and state	Fought for years by 340B clinics and hospitals, who estimated about $240 million a year in lost revenue; state added supplemental clinic payments. New York had moved pharmacy into managed care about a decade earlier.

Lessons and cautions for Colorado

1. **The starting point sets the size of the prize.** The large savings figures come from states where five to seven plan PBMs were consolidated. Colorado would be folding two plans into a state system that already covers most members, so expect a much smaller number, and test it rather than borrow Ohio's or Kentucky's.
2. **Savings depend on the comparison.** Ohio's figure ranges from savings to cost depending on what managed care is assumed to have cost. The evaluation should report a range and say what each scenario assumes.
3. **Follow where the money goes.** Administrative fees, spread pricing, and plan margins fall, and the state collects more rebates. Dispensing fees and pharmacy payments rise. That shift is good for pharmacy access, especially independent and rural pharmacies, but it offsets part of the savings.
4. **Managed care financing changes.** Moving pharmacy out changes plan capitation and the plans' incentive and ability to coordinate drugs with the rest of care. The evaluation should look at what Denver Health Medicaid Choice and Rocky Mountain Health Plans PRIME would lose and how their rates would be reset.
5. **340B is the biggest Colorado-specific question.** In California and New York, part of the state's savings came from 340B margins that hospitals and clinics had kept. Denver Health is a large 340B

provider, so the evaluation should estimate that effect directly and say whether any of it would need to be replaced.

6. **Plan the transition carefully.** Ohio's early problems came from incomplete prior authorization data and call volume. Contract standards (calls answered, decisions within 24 hours), carried-over authorizations, and transition fills matter.
7. **These changes are not always permanent.** Louisiana reversed course after two years, and New York moved pharmacy into managed care and later back out. It would be worthwhile to explore those reversions more closely and understand the lessons learned.

Questions the line 115 evaluation could answer: How much does pharmacy cost in the two plans today, net of rebates, compared with fee-for-service? What would carving it out save in administrative cost and rebates, and what would it add in dispensing fees and state staffing? How would plan rates change? What would happen to Denver Health's 340B savings? What would members and pharmacies experience during the switch?

Sources

- HCPF, Pharmacy Benefit Management System fact sheet (FY 2024-25 figures) and Pharmacy Resources
- HCPF, Colorado Medicaid Enterprise Solutions
- HCPF, Provider News, January 20, 2026 (fee-for-service PBM change)
- HCPF, MCO Payment Reform Report FY 2022-23
- Ohio Department of Medicaid, SPBM findings memo and Milliman analysis, April 2025
- Summary of the Ohio Joint Medicaid Oversight Committee hearing, June 26, 2025 (AI-generated summary; check against the hearing record)
- NCPA, Kentucky saves big with single PBM and Medicaid reform resources (pharmacy trade group)
- Kentucky Lantern, Reprieve for Kentucky's independent pharmacies
- Responsive Government, Cutting out the middleman
- Louisiana Department of Health, Informational Bulletin 25-25 and single PBM notice
- Virginia DMAS, House Document 8 (2025), Medicaid PBM study; NCPA, Virginia single PBM; Cardinal News on the January 2027 delay and 2019 savings estimate
- California LAO, Analysis of the carve out of Medi-Cal pharmacy services; Managed Healthcare Executive, California carving out pharmacy benefits
- New York DOH, NYRx transition FAQ; City & State, 340B clinics and the carve-out and safety-net providers
- Minnesota Senate Health Committee handout on Kentucky, Ohio, Louisiana, and Mississippi (advocacy handout)

Note: several sources are pharmacy or plan trade groups with a stake in the outcome; the state and actuarial figures are the firmer ground.