Ohio Medicaid Pharmacy Cost of Dispensing Survey

Survey forms by Myers and Stauffer LC under contract with the Ohio Department of Medicaid

M&S Use Only		Return Comp	leted Forms to:
		Myers and Sta	auffer LC
		700 W. 47th 9	Street, Suite 1100
		Kansas City, N	Missouri 64112
ROUND ALL AMOUNTS TO NEAREST DOLLAR OR WHOLE NUM	ИBER		
Complete and return by August 29, 2024			
Call toll free (800) 374-6858 or email disp_survey@mslc.com	n if you have any que	estions.	
An electronic version of the Ohio Medicaid Pharmacy Cost of The electronic version aids the user by calculating totals and of the data. Please send an email to disp_survey@mslc.com returned via email to disp_survey@mslc.com.	d transferring inform	nation to the reconciliati	ion to help ensure the accuracy
Name of Pharmacy		IPI (one location per sur	rvey):
Street Address		Telephone No. (
City County		State	Zip Code
DECLARATIO	ON BY OWNER AND P	REPARER	
belief, it is true, correct, complete, and in agreement with the explained in the reconciliation. Declaration of preparer (othe knowledge. Signature of Owner Printed Name	r than owner) is base		
Preparer's Signature (if other than owner) Printed Name	Title/P	osition	Date
Preparer's Street Address	City and State		Zip
Phone Number	Email Address		
DECLA All Ohio Medicaid pharmacies must complete all pages of this survey	RATION OF EXEMPTI		
□ New pharmacies that were in business less than six months du		_	4
	ring the most recently t	ompleted reporting period	
Enter date the pharmacy opened:			
$2. \; \square \;$ Pharmacies with a change in ownership that resulted in less that	an six months in busine	ss during the reporting per	riod.
Enter the date pharmacy changed ownership:			
If your pharmacy meets either of the above criteria, check the box next to the considered "exempt" will need to complete the first three pages (sections IA Myers and Stauffer at (800)374-6858 or email disp_survey@mslc.com for ass	and IB) of the survey. If yo		

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.,

Decembe	r 31, 2023, or December 31	, 2022, if 2023 records a	are not yet com	plete). (Include mo	onth/day/year).	, , , ,
All Phar	macies should comple	te lines (a) through	(n).			
	List the total number of	all prescriptions dispen	sed during you	r most recently cor	npleted fiscal ye	ear as follows:
					4	
(a)	1. New	2. R	Refill		3. Total	
	"Prescriptions Dispensed." Rep kept on a daily or monthly log of Single Pharmacy Benefit Manag	or on your computer. Addition	nally, please note th	e total prescription volu	ime attestation is also	st survey. This information may be o used to assist in setting the
(b)	Sales and Floor Space			•		
		Pharmacy Departme	ent Only		e (Retail and Department)	
Sales (Excl	uding Sales Tax)				parament,	
Cost of Go						
Floor Spac	e (see instructions below)		Sq. Ft.		Sq. Ft.	
tax ret	cales excluding sales tax. Total urn (if the tax return only incluould not include non-prescription of Goods Sold. If pharmacy departs	des the store being survey ion over the counter drugs	red). "Pharmacy D s, durable medica	Department" sales sho I equipment or other	ould only include so nonprescription it	ales of prescription drugs
area). S For > The be pharm	Space. Provide square footage Since floor space will be used in simplicity, when measuring the Patient waiting area > Countifore mentioned areas should be acy department to account for ring the total store square foot	n allocating certain expense e pharmacy department ex seling area > Pharmacy o de included in total store ar waiting area, counseling a	es, accuracy is im sclude all of the fo department office rea, but not phar area, pharmacy de	portant. bllowing: e space > Pharmacy macy department squ epartment office spac	department stora lare footage. A fac e and pharmacy d	age tor will be added to the epartment storage. When
(c)	Amount of State Sales Ta	ex collected during fiscal	year used for s	Survey (round to neare	st whole dollar)	\$
	What is the approximate	percentage of prescrip	tions dispensed	for the following o	classifications?	
(d)	1. Medicaid (fee for serv	ice)%	2. Medicaid N	/Janaged Care/Gain	well SPBM	%
	3. Other Third Party	%	4. Cash			%
	What is the approximate	percentage of paymen	ts received fror	n the following clas	sifications?	
(e)	1. Medicaid (fee for serv	ice) %	2. Medicaid N	Managed Care/Gain	well SPBM	%
	3. Other Third Party	%	4. Cash		•	%
(f)	Ownership Affiliation 1. Independent (1 to 3 are institutional (service)	3 units)	2. □ Cł	nain (4 or more unit		70
(g)	Type of Ownership					
(6)	1. ☐ Individual	2. Corporation	3. □ P	artnership	4. □ Other	(specify)
(h)	Location of Pharmacy (pl 1. □ Medical Office Build 3. □ Stand Alone Buildin 5. □ Outpatient Hospital	ding g	4. □ Gi	nopping Center rocery Store / Mass ther (specify)	Merchant	
	Does your pharmacy pur 1. □ Yes	chase drugs through the	e 340B Drug Pri 2. □ No			
(i)	If yes, are prescriptions of 1. □ Yes	lispensed to Ohio Medio	caid members p 2. 🗆 No		inventory?	
	If you are a provider that 1. □ Covered Entity	participates in the 340	, ,	ram, indicate if you	ı are a:	

Page 2

SECTION IA	Page 3 A 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
(1)	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 pl	narmacy 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
If your plas applic	harmacy provides delivery, mail order, specialty or compounding services, complete lines (r) through (w)
(r)	How many <u>total</u> prescriptions filled are delivered?
(s)	How many Ohio Medicaid prescriptions filled are delivered?
	Does your pharmacy deliver prescriptions by mail (U.S. Postal Service, FedEx, UPS, etc.)? 1. □ Yes 2. □ No
(t)	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.
	How many total prescriptions dispensed were compounded?
(v)	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:
(w)	Does your pharmacy dispense prescriptions in lockable vials? 1. □ Yes 2. □ No If yes, please answer the following: What are the total number of prescriptions dispensed in lockable vials for the reporting period? What was the total cost associated with the purchase of lockable vials for the reporting period?
	Please describe and provide the amounts for any expenses for special equipment, initial set-up as well as any other ongoing expenses required to be able to dispense lockable vials. (attach additional pages if needed).
	IB OTHER INFORMATION ditional information you feel contributes significantly to your cost of filling a prescription. Attach additional pages if needed.

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

Product Category	Number of Prescriptions	Dollar Amount of Sales	Line No.
nfusion Products			
ompounded infusion products			(1a)
otal Parenteral Nutrition (TPN) products			(1b)
Clotting factors or derivatives			(1c)
nfusion supplies (e.g., tubing, needles, catheter lushes, IV site dressings, etc.)			(1d)
Total for Infusion Products			(1e)
<u>Specialty</u>			
Prefilled or ready to inject products			(2a)
Orals			(2b)
Total for Specialty			(2c)
Non-specialty			
Orals			(3a)
Topicals			(3b)
njectables			(3c)
Compounded (non-infusion)			(3d)
Enteral nutrition			(3e)
All Other (including opthalmic, otic, etc.)			(3f)
Total for Non-specialty			
Total (Chauld approximate approximate			
Total (Should reconcile to prescriptions and Pharmacy Department sales reported in Section IA)			(4)
			(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.

Page 5

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.

				Pero	ent of Time Spent		
		Table Calada (Carlodian)	Birmani	Other Dis	MTM, Vaccine	Non Rx	
		Total Salaries (including bonuses	Dispensing	Other RX	Administration,	Related	7
Employee Classification	Estimate of FTEs ¹	and draws for owners) ²	Activities ³	Related Duties ⁴	Clincial Services ⁵	Duties ⁶	Total ⁷
Owner: Registered Pharmacist (if							
applicable)							
Owner: Non-Pharmacist (if							
applicable)							
Pharmacist							
^r echnician							
Delivery							
/							
Loren							
Nurses			$\overline{}$				
Customer service representatives							
Billing							
-							
Dille and discharge							
Other Admin							
Contract Labor (Pharmacist)							
Contract Labor (other)							
			7				
Staff not related to RX dispensing			0.0%	0.0%	0.0%	100.0%	100.0%
starr not related to tix dispensing			0.0%	0.0%	0.0%	100.0%	100.0%
	Total Salaries		(13)				
Per	sion and Profit Sharing		(14)				
	Other Employee Benefits	3	(15)				
	ouler Employee Benefits		(15)				
	Total Labor Expense:		(16)				

Please review footnotes and additional instructions for reporting personnel costs on the next page.

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

3

4

- 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.
 - 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.
 - 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.
 - Report the percent of time for Medication Therapy Management (MTM), Vaccine Administration, or clinical services. 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. Clinical Services include any professional services performed by the pharmacist under a consult agreement that are separately billed and not reimbursed by the prescription professional dispensing fee.
- 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%.
- Other Employee Benefits includes employee medical insurance, disability insurance, education assistance, etc.

Complete this section using your internal financial statement or tax return for the <u>fiscal year ending listed on Page 2</u>. 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.

202	3 Тах	Form	1	1		_
1040 Schedule C	1065	1120	11208	R	Round all amounts to nearest dollar or whole number. Expense Amount Reported Myers an Stauffer Use Only	Line
13	16a	20	14	Depreciat	tion (this fiscal year only - not accumulated)	(1)
23	14	17	12	S	(a) Personal Property Taxes Paid	(2)
23	14	17	12	Тахе	(b) Real Estate Taxes	(3)
23	14	17	12	Та	(c) Payroll Taxes	(4)
				·	Any other taxes should be itemized separately on page 8.	
20b	13	16	11		uilding (if building is leased from a related party then report ownership sof interest, taxes, insurance and maintenance)	(5)
20a	13	16			uipment and Other	— (6)
21	11	14			& maintenance	(7)
15	21*	26*			e (other than employee medical)	
16a&b	15	18		Interest		— (9)
17	21*	26*	20*	Legal and	d Professional Fees	(10)
27a*	21*	26*			blications, and Subscriptions	(11)
27a*	12	15	10	Bad Debt	ts (this fiscal year only - not accumulated)	(12)
n/a	n/a	19	n/a	Charitabl	e 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	g and Office Supplies (exclude prescription containers and labels)	(16)
8	21*	22	16	Advertisii	ng/Marketing	
27a*	21*	26*	20*	Compute	er Expenses (systems, software, maintenance, etc.)	(18)
9,27a*	21*	26*	20*	Prescription	on Delivery Expenses (wages to a driver should only be reported on pg. 5)	(19)
27a*	21*	26*	20*	Prescripti	ion Containers and Labels	(20)
24a&b	21*	26*	20*	Travel, M	leals and Entertainment	(21)
27a*	21*	26*	20*	Switching	g / E-Prescribing Fees	(22)
27a*	21*	26*	20*	Security /	Alarm	(23)
27a*	21*	26*	20*	Bank Cha	arges	(24)
27a*	21*	26*	20*	Credit Ca	ard Processing Fees	(25)
27a*	21*	26*	20*	Interior N	Maintenance (housekeeping, janitorial, etc.)	(26)
27a*	21*	26*	20*	Exterior N	Maintenance (lawn care, snow removal etc.)	(27)
27a*	21*	26*	20*	Pharmacy	y Licenses / Permits	(28)
27a*	21*	26*	20*	Employee	e Training and Certification	(29)
27a*	21*	26*	20*	Continuir	ng Education	(30)
					Total Page 7 overhead expenses (lines 1 to 30)	(31)

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 in Section IIB (a) (page 7), accreditation and/or certification fees, restocking fees, postage, administrative expenses, amortization, mandated language access services, 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.

	Amount Sta	yers and ouffer Use
	Reported	Only Line No.
		(32a)
		(32b)
		(32c)
		(32d)
		(32e)
		(32f)
		(32g)
		(32h)
		(32i)
		(32j)
		(32k)
		(321)
		(32m)
		(32n)
		(320)
		(32p)
		(32q)
		(32r)
		(32s)
		(32t)
Total page 8 overhead expenses (lines 32a to 32t)		(33)

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.

			Financial Statement or
1		Cost Survey Amounts	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