

National Cost of Dispensing Study Q&A

Q1. What are the basic findings of the January 2020 Cost of Dispensing Study released by Abt Associates?

- A1. The national estimates of cost of dispensing in 2018 were as follows:
- The mean overall cost of dispensing per prescription was \$12.40. Payroll costs were the biggest drivers of the overall cost, accounting for roughly 58% of the overall cost of dispensing (\$7.22 out of the \$12.40).
 - The mean cost of dispensing for drugs covered by Medicaid FFS was \$12.45.
 - The mean specialty drug cost of dispensing was \$73.58 (interquartile range \$40.12 to \$86.48) for specialty pharmacies, defined as pharmacies with at least 10% of their prescription volume from specialty drugs.

Q2. How do the results of this study compare to current dispensing fees paid by state Medicaid fee-for-service programs?

- A2. Federal Medicaid rules require state Medicaid fee-for-service programs to pay pharmacies dispensing fees that cover pharmacies' costs of dispensing prescription medications and providing related services. Of the 47 states that currently pay pharmacies cost-based dispensing fees, only North Dakota pays dispensing fees that cover the average costs of dispensing of \$12.40. The report highlights the inadequacy of current Medicaid dispensing fees to cover costs incurred by pharmacies in their work providing prescriptions to this vulnerable population.

Q3. How do the results of this study compare to the 2014 Coalition for Community Pharmacy Action (CCPA) MPI Study?

- A3. The costs of dispensing estimated in this study are higher than the cost of dispensing from the 2014 CCPA MPI study. The mean cost of dispensing in 2018 estimated by this study was \$12.40, compared to the mean cost of dispensing in 2014 of \$10.55. Additionally, the 2014 study reported a mean Medicaid cost of dispensing of \$10.30, while this study reported mean Medicaid cost of dispensing of \$12.45. The 2014 CCPA MPI study did not estimate the cost of dispensing for specialty drugs.

Q4. In some instances there are individual states that do not have estimates. Why?

- A4. For a few states, the number of pharmacies participating in the study was too low to estimate a state COD with high confidence. In others, the responses were mainly from one company and we did not want to release any data that could potentially be identifiable. In the cases where it was possible, Abt pooled the data from several geographically adjacent states to get a regional estimate that is reported instead of a state estimate.

Q5. Are the study results a true reflection of the number of pharmacies (chain and independent) in any given state?

- A5. The data were adjusted to account for non-response bias. Individual store responses were eliminated from the sample for each state until the average volume for each state matched the average volume (calculated as total prescriptions written by prescribers in the state divided by the number of pharmacies in the state) for the year. Therefore, the adjusted database represents the

characteristics of the pharmacies in the state as closely as possible, including the characteristics of independent pharmacies. State-specific estimates were also adjusted to account for non-response bias. The adjustments are statistically valid.

Q6. How does the study reflect those instances where there was only one independent pharmacy response in any given state?

A6. There are no state results presented in the study that have only one “independent” respondent. Estimates were weighted for survey nonresponse and drug dispensing volume. For small states having less than two chains or 65 pharmacies, data was combined across states for reporting purposes to accurately reflect the cost of dispensing in that state. Additionally, the sample was adjusted to reflect the average volume by state to further address this issue.

Q7. When comparing this study to the 2014 CCPA MPI Study, what does this study reveal about how often a national study should be conducted?

A7. CMS encourages states to conduct cost of dispensing studies every two years to ensure that dispensing fees truly reflect the cost to dispense prescription drugs. The costs that were found in this study are higher than those from the 2014 study which demonstrates that there are factors that would warrant these types of studies being conducted periodically to accurately account for increases in labor cost and other components involved in the cost to dispense prescription drugs. As these changes continue to occur, it is important to conduct these studies, as the cost of dispensing will also be impacted.

Q8. How was the 2014 CCPA MPI Study used, and how were national and state numbers released?

A8. The 2014 CCPA MPI Study was released in its entirety to the public in 2015. For federal advocacy initiatives the national number (\$10.55) was used as a comparison to the national average dispensing fee at that time. At the state level, both the national average and the individual state numbers were used to argue the needed increase in dispensing fees, especially in states that were considering actual acquisition cost (AAC) reimbursement methodologies.

Q9. There are several states that are largely managed care and have carved prescription drugs into their managed care programs, how can this study be useful in those states?

A9. Because managed care plans have the ability to adopt similar reimbursement methodologies the study will play a critical role in advocating that managed care plans adopt a reimbursement rate floor and pay pharmacies reimbursement rates and dispensing fees that are adequate and reflect the true costs of dispensing.

Q10. Why was specialty considered and included in this study?

A10. Although most states have moved to cost-based reimbursement with increased dispensing fees, these reimbursement rates are still not enough to cover the cost to dispense a specialty drug. While states can use alternative benchmarks to resemble ingredient costs, the dispensing fees used for traditional prescription drugs are not sufficient to cover all associated tasks of dispensing a specialty drug.

While overall costs of dispensing were calculated according to the time to dispense all drugs, specialty drug costs of dispensing were calculated according to the time required to dispense specialty prescriptions. There are several additional tasks that are involved with dispensing a specialty drug and while these tasks are like those for traditional drugs, there is more time

required to adequately dispense a specialty drug to a patient. For example, specialty drugs often require more time for benefits investigation (e.g., prior authorization), education (e.g., dosing, side effect management, and appropriate drug administration and storage), and often have requirements from the manufacturer (e.g., documentation, lab tests). Given this added time and the extra tasks, there was a need to show that the dispensing fees used for non-specialty are not accurate and higher dispensing fees are needed to fully cover the cost of dispensing a specialty drug.

Q11. Did the Study look at all specialty drugs or a predetermined list and how was this list defined?

A11. The study was based on a predetermined list of specialty products that were identified as being on two or more specialty lists of PBMs or insurance companies as of August 1, 2018 and was provided to all survey respondents. The cost of dispensing for specialty products across all pharmacies was estimated for those pharmacies that provided the necessary information. As the study results show, among those pharmacies, the average specialty drug cost of dispensing is quite variable which further highlights the challenge of using a single standardized approach for reimbursing pharmacies for dispensing specialty drugs.

Q12. The study references clinical and care coordination activities as a part of the dispensing fee? Does this include all clinical services that pharmacists provide?

A12. Dispensing fees established as a part of this study are those fees that are truly reflective of the cost to acquire and dispense prescription drugs to the Medicaid population. The current reimbursement to pharmacies for dispensing prescription medications is based on the cost of the drug plus a payment to dispense the drug. This reimbursement structure does not include payment for other professional services. Only those counseling, monitoring, and other services required to dispense were considered and factored into the cost of dispensing calculation. Any supplemental clinical care provided to improve patient outcomes/experience (such as immunizations, medication care plan/medication therapy management services, chronic care management, medication optimization, and other valuable services) were not factored into the calculation of the dispensing fee, as those are separate and distinct professional services.

Q13. Does the study capture specialty drugs dispensed by both specialty pharmacies and traditional community retail pharmacies?

A13. It is important to note that there is no universal, industry-wide accepted definition of specialty drugs or specialty pharmacy. Due to this lack of industry-wide definition, the study calculated the mean cost of dispensing specialty drugs for pharmacies with high specialty dispensing volume, defined as pharmacies with at least 10% of their total prescription volume from specialty drugs. Additionally, although this study was based on a predetermined list of specialty drugs, this list was only a subset based on PBM covered specialty drugs at that time and may not be truly reflective of all the drugs dispensed and managed by specialty pharmacies. Lastly, to account for other pharmacies that may also dispense specialty drugs, the study also calculated the cost of dispensing specialty drugs for all pharmacies responding to the surveys.

Q14. Why does the study results show a mean cost of dispensing and a range for specialty drugs? Is there a flat fee like the overall national number that can be used for the cost of dispensing of specialty drugs?

A14. The study notes that there were several limitations to estimating the specialty cost of dispensing reported in this study. The study revealed that there is a level of variability in specialty drug costs of dispensing which indicates that more information is needed and should be collected in order to reimburse accurately for dispensing specialty drugs. While this study did find a mean specialty drug cost of dispensing of \$73.58 (interquartile range \$40.12 to \$86.48), this may not fully capture other contributing factors (i.e. specialty pharmacies accreditation status, operating model, type of drugs dispensed, and disease states being managed) that impact the cost to dispense specialty drugs.

Q15. How will the specialty findings in this study be used?

A15. Because this is the first national study to look at the cost of dispensing for specialty drugs, this study will serve as a foundation to encourage more analysis of and focus more attention on reimbursement rates for specialty drugs. Between 2014 and 2018 there has been an increased need to further study the cost to dispense specialty drugs and this study can be used to provide new information that is critical in updating the true cost of dispense. While there is a need to control spending for high costs drugs, there is an equal need to ensure that pharmacies are reimbursed properly when these drugs are dispensed to ensure maximal therapeutic outcomes are achieved. Similar to the use of other studies, the specialty pharmacy findings will also be used in federal and state lobbying initiatives to argue for needed increases in dispensing fees for specialty drugs. These findings will also be useful in advocating for state studies and research on reimbursement rates for specialty drugs.

Q16. How will the results of the study be disseminated/communicated and to what audience?

A16. The study results will be released in its entirety to the public. NACDS, NASP and NCPA will collaborate on a communication strategy and time for dissemination to the public for its intended use at the state and federal levels. The study is intended to be used as a resource for establishing pharmacy dispensing fees and will be used for all advocacy initiatives to promote increased dispensing fees that are aligned with the national numbers.