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COST OF DISPENSING PRESCRIPTION DRUGS TO MEDICAID MEMBERS PHARMACY SURVEY REPORT

STATE OF WISCONSIN

JANUARY 30, 2017

MARSH & McLENNAN COMPANIES

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Executive Summary

The Wisconsin Department of Health Services (DHS) engaged Mercer Government Human Services Consulting (Mercer), a division of Mercer Health & Benefits LLC, to conduct a study on actual provider costs associated with dispensing covered outpatient prescription drugs to Wisconsin ForwardHealth members.

The objective of the study was to calculate the average cost of dispensing a prescription by providers serving Wisconsin Medicaid members. The survey was based on the most recent fiscal year (FY) completed by the providers, with the majority period of service being for Calendar Year 2015 (CY2015). A pharmacy's average professional dispensing fee was calculated by dividing the prescription department's operational, labor and allocated overhead costs by the number of prescriptions dispensed. All Wisconsin Medicaid-enrolled pharmacies and providers who dispensed outpatient drugs during CY2015 were required to participate in the Cost of Dispensing (COD) survey process.

Summary of Findings

Based on the analysis, Mercer recommends the State of Wisconsin (State) consider reimbursement of professional dispensing fees using a tiered rate structure based on total annual prescription volume. A tiered approach is becoming more common throughout the country because it best represents the average cost of dispensing a prescription drug by balancing efficiency with access. A tiered approach accurately and fairly represents the actual costs incurred by a dispensing provider. Mercer believes the winsorized mean (a more robust estimator that is less sensitive to outliers) weighted by provider response probability most closely represents the average cost of dispensing based on total prescription volume. Using tiers for the winsorized mean weighted by response probability best represents the average cost of dispensing a prescription drug within the State.

To reach the recommendation, Mercer separately analyzed multiple factors to determine which factors had a statistically significant impact on the average cost to dispense a prescription. The study found that the most significant pharmacy characteristics accounting for a significant proportion of the variation in the observed cost of dispensing include:

- Pharmacies with lower volume have significantly higher costs of dispensing.
- High percentage (20% or more) Medicaid prescriptions have higher costs of dispensing.
- Certain pharmacy types have significantly different costs of dispensing.

Of those factors that had a statistically significant impact, Mercer analyzed which factors most influenced dispensing costs and modeled the data using a winsorized weighted average

approach. The data showed that pharmacies with a lower volume of prescriptions consistently have significantly higher costs of dispensing and overall prescription volume most impacted provider dispensing costs. However, the range of average cost to dispense decreased as overall volume increased.

We looked at various calculation methods including weighted mean cost by total prescription volume, weighted mean cost by Medicaid prescription volume, and winsorized mean weighted by response probability. We found that while both the weighted mean cost by total prescription volume and the weighted mean cost by Medicaid prescription volume were viable options, the weighted mean cost of dispensing by prescription volume under-weights the costs related to pharmacies with low prescription volume and over-weights the costs related to pharmacies with high prescription volume. Weighting mean by total prescription volume or Medicaid prescription volume would likely cause underpayment to rural and low volume pharmacies which may reduce access in underserved areas.

However, by using the winsorized mean weighted by response probability, lower volume pharmacies in rural and underserved areas are more likely to be adequately compensated when using a tiered reimbursement structure, which will ensure continued access for ForwardHealth members. Conversely, using a lower reimbursement rate for providers with high prescription volumes effectively reimburses high volume provider expenses but efficiently uses the State's funds. Therefore, a tiered reimbursement structure based on the winsorized mean weighted by response probability results in the most equitable distribution and reimbursement, assuming that higher volume pharmacies continue to produce the largest volumes of pharmacy claims and the State's policy of paying no more than one dispensing fee per drug per member per month is in effect[1].

Table 1 shows the average dispensing fee for retail chain pharmacies (526), independent retail pharmacies (166), and long term care pharmacies (32) which are categorized collectively as "retail community" pharmacies and reflective of the scope of assessing professional dispensing fees specifically called out by the Center for Medicare & Medicaid Services (CMS) in the Covered Outpatient Drug final rule (CMS-2345-FC).

Table 1: Winsorized Average Costs of Dispensing: Retail Community Pharmacy Types

	Prescription Volume	Response Probability	Total Prescription Volume	Medicaid Prescription Volume
Retail Community	0–34,999	$15.69	$15.00	$16.10
	35,000 or more	$10.51	$9.73	$9.62

Overall, the data collected through the COD survey supports Mercer's recommendation that the State should reimburse professional dispensing fees using a two-tiered dispensing fee based on

[1] ForwardHealth Pharmacy Provider Handbook; Topic #1349.

total prescription volume for the majority of the ForwardHealth pharmacy providers to ensure access in low volume pharmacies but share in the cost-saving efficiency of higher volume pharmacies. Also, moving to a two-tiered model will address the significance of both total prescription volume and high percentage of Medicaid prescription volume.

As part of the COD survey, Mercer also examined costs for dispensing of non-retail pharmacy provider types to understand if there are differences in professional dispensing fee costs in different settings. The scope of the federal outpatient drug rule is specific that COD surveys are required for setting professional dispensing fees in retail community pharmacies. However, the State felt it was important to understand if variation existed across provider types beyond the pharmacy setting.

Table 2: Winsorized Average Costs of Dispensing: Non-retail Pharmacy Types

	Response Probability	Total Prescription Volume	Medicaid Prescription Volume
Clinic/Outpatient	$16.31	$13.96	$17.05
Federally Qualified Health Centers (FQHC)	$24.92	$22.65	$26.65
Family Planning Clinics	$56.52	$37.56	$37.52
Specialty/Home Infusion	$292.90	$104.03	$54.07

Clinic/outpatient refers to pharmacies operating in health care clinics or outpatient hospital settings. Mercer's analysis shows that having clinic/outpatient entities use the retail community tiered dispensing fees above will be sufficient to meet the retail pharmacy dispensing related costs of these entities because the primary driver of costs for clinic/outpatient pharmacies is pharmacy department wages. Pharmacy department wages were reported 48% higher in clinic/outpatient hospital settings than in community retail settings, often due to activities billed through medical claims not eligible for a dispensing fee.

FQHCs (both community health centers and tribal health clinics) receive cost-based reimbursement for overall care. The purpose of including FQHCs in this study was not to use the data as a rate-setting tool, but to understand the differences in costs between provider types. DHS will not use the tiered dispensing fees described in Table 1 for FQHCs and will work with tribal clinics and community health centers to ensure that overall models of total reimbursement appropriately compensate safety net providers for their dispensing related costs.

DHS directed Family Planning providers in years past to use national drug code (NDC)-based billing for specific drugs. The purpose of this analysis was to understand if the NDC-based methodology adequately reimburses family planning providers for the services and costs to dispense. The $56.52 winsorized mean is an outlier from the recommended retail community tiered cost of dispensing results. The retail community tiered dispensing fee methodology would not appropriately reimburse family planning providers. Mercer recommends that DHS move away from an NDC-based billing model for this type of provider.

Specialty and Home Infusion clinics had very low usable survey response rates (50% and 23% respectively, as compared to 78% survey response rate for retail community pharmacies) and an extreme range of reported costs. Mercer recommends the State does not establish a separate dispensing fee for these provider types until the costs are further studied to determine the reasons for the strikingly higher costs due to the inconsistent and varied nature of the usable data received. Since the reimbursement requirements of the Covered Outpatient Drug final rule do not apply to drugs not typically dispensed through retail community pharmacies, Mercer recommends that the State reimburse these pharmacy providers utilizing the tiered professional dispensing fees outlined in Table 1 until additional studies are performed. The majority of these providers will fall into the low volume tier, which will provide a higher dispensing fee than the current dispensing fee rate.

Other concerns regarding Specialty and Home Infusion results are based on multiple factors including:

Reported data for Specialty and Home Infusion clinics was inconsistent and resulted in wide ranges with many outliers, whereas the range for retail community was smaller showing greater similarity. The twenty-fifth and seventy-fifth percentiles for specialty pharmacies were $52.21 and $341.77, respectively. Home Infusion ranges for the twenty-fifth and seventy-fifth percentile were $77.72 and $251.49, respectively, whereas the retail community twenty-fifth and seventy-fifth percentile was $8.48 and $13.27, respectively.

While a mandatory survey, usable response rates for non-traditional providers were much lower than retail community and clinic/outpatient pharmacies. For example, the Home Infusion response rate was 23%, which does not provide adequate data to support a different dispensing fee reimbursement structure.

Overall, Mercer concluded that the COD survey instrument used was not designed to accommodate the accounting and billing systems of many of the FQHCs, Family Planning Clinics, Specialty, and Home Infusion provider types. This conclusion is based on the high rate of incomplete and rejected survey responses for these provider types. Mercer's survey uses a direct cost plus indirect allocation method that aligns with the accounting systems of most retail, for-profit pharmacies. However, non-retail pharmacy accounting systems may not capture data at the level of detail used in the survey, which creates additional effort in mapping costs to the appropriate expense category in a limited survey period. The survey design did not account for governmental or non-profit accounting methods used in most family planning clinics, narcotic treatment centers and some FQHCs, as it was designed for community retail pharmacies, which are typically for-profit organizations.

Survey results were revised in January 2017 to reflect corrected data received for 80 pharmacies. Stakeholders requested a review of the data presented in November 2016 because of the wide range between the proposed tiers ($21.03 to $9.50). Further data analysis identified

an underlying data issue with reported corporate overhead costs. Several respondents reported significantly higher overhead costs as a percentage of total cost. The providers were contacted to determine whether the survey response properly reflected overhead costs allocable to the professional dispensing fee. Some respondents incorrectly reported “corporate overhead” in the dispensing fee survey by providing corporate overhead costs for the entire store, but did not report total sales for the entire store; instead reporting only pharmacy sales. This inflated the amounts allocated to dispensing fee costs. Mercer requested a resubmission of corrected data from the providers and updated the survey results accordingly.

The updated data revealed a distinct break in costs to dispense for pharmacies with overall prescription volume less than 35,000 total prescriptions per year where previously there were several distinct breaks.

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Cost of Dispensing Survey

Introduction

On January 21, 2016, CMS published the federal Covered Outpatient Drugs final rule (CMS-2345-FC). The federal regulation addresses the rise in prescription drug costs by ensuring that Medicaid programs reform payment methodologies for prescription drugs. Under the final rule, states must reimburse covered outpatient drugs at actual acquisition cost plus a professional dispensing fee. These reimbursement requirements are for drugs dispensed in retail community pharmacies and 340B enrolled pharmacies that carve-in Medicaid. The regulation requires all states be in compliance with the reimbursement requirements of the Covered Outpatient Drugs final rule by April 1, 2017.

In order to comply with the professional dispensing fee requirement of the final rule, DHS and Hewlett Packard Enterprise (HPE) contracted with Mercer to conduct a professional COD survey. The survey obtained information on the costs associated with dispensing covered outpatient drugs to Wisconsin ForwardHealth members.

Several provider types were included in the survey population. Provider types other than pharmacies are allowed to bill for drugs and were surveyed, including family planning clinics, FQHCs, narcotic treatment centers, clinics and hospitals, but the term pharmacy is being used for simplicity.

Methodology

The study methodology included the following tasks:

- Held a project kick-off meeting with DHS and HPE to identify the population to be surveyed, review the survey objectives, tools and identified timelines to complete the survey and a final report.
- Requested a list of active providers who billed the state for prescription drugs from DHS and HPE, including available contact and address information and identified the universe of providers (study population) to be surveyed.
- Administered a demographic data survey to collect contact information and provider types for the survey population. DHS's letter was used to inform the respective providers of the pending dispensing fee survey and highlight the need to comply with the final rule.
- Held stakeholder meetings and gave providers an opportunity to provide input on the survey and survey process.
- Developed and updated the professional dispensing fee survey tool based on the project objectives and feedback from the kick-off meeting and stakeholder comments/input.

- Distributed the professional dispensing fee survey tool, instructions and a letter from the DHS to all respective providers that dispensed prescription drugs to ForwardHealth members during CY2015. DHS's letter was used to highlight the importance of the survey and provide methods for submission of the requested information needed for the dispensing fee analysis.
- Received completed surveys from pharmacies and sent follow-up reminder letters (email and direct mail) to pharmacies that had not submitted the survey by the due date.
- Initiated phone calls to remind non-responsive providers of the due date.
- Screened survey responses for completeness of the data and contacted pharmacies if needed.
- Compiled data into a Mercer database and performed initial cost analysis of the data.
- Selected a random sample of responses for validation against financial statements.
- Conducted statistical analyses of the cost data to determine an average cost and percentile distribution of cost of dispensing a prescription to ForwardHealth members within the State.
- Prepared the draft report.
- Reviewed the draft report with DHS and HPE.
- Finalized the proposed report. The final proposed report included:
  - Executive summary.
  - Dispensing cost study methodology.
  - Results and conclusion.
  - Exhibits.
- Held stakeholder meetings to share survey results and proposed report with providers.
- Received provider feedback on recommendations included in the proposed report.
- Completed further analysis based on stakeholder feedback and found underlying data issue with reported corporate overhead costs.
- Received updated data from respondents identified as outliers.
- Updated the proposed report and recommendations based on the new data.
- Finalized the report. The final report includes:
  - Executive summary.
  - Dispensing cost study methodology.
  - Results and conclusion.
  - Exhibits.

Survey Instrument Development

The 2016 Wisconsin Medicaid Professional Dispensing Fee Survey focused on collecting the actual costs incurred by providers that dispense prescription drugs to ForwardHealth members. The survey included independent and chain pharmacies, clinic outpatient pharmacies, family planning clinics, narcotic treatment centers, FQHCs, Home Infusion pharmacies, specialty pharmacies and long term care pharmacies. The survey tool was designed following review of dispensing fee surveys conducted at both the national and individual state levels and based on the needs identified by DHS and key stakeholders.

Development and receipt of the dispensing fee survey tools included:

- Developed survey tool and instructions for completion and submission alternatives.
- Created an online web-based survey.
- Created an Excel®-based spread sheet to accommodate retail pharmacy chains that submitted surveys for multiple locations.
- Established an email support mailbox.
- Established a toll-free number for technical assistance.

Survey Population

A list of 1388 active providers obtained from HPE served as the main data source to identify the study population. No providers were excluded. All providers were asked to self-select the appropriate pharmacy type based on the highest percentage of sales if a provider qualified for more than one provider type. Provider type classifications are not included in the ForwardHealth provider enrollment process.

The survey population list included 53 pharmacies that were non-responsive to the demographic survey and the professional dispensing fee survey, 70 providers classified as family planning clinics, three classified as narcotic treatment centers, 46 pharmacies classified as specialty or Home Infusion pharmacies, and 1,216 pharmacies classified as retail chain, independent retail, long term care (LTC), FQHC, or clinic/outpatient hospital pharmacies.

The survey population included 1,005 retail community pharmacies, of which 671 (66.8%) are chain, defined as having greater than four stores, 255 (25.4%) are independent and 79 (7.9%) are LTC pharmacies. The population also included 281 non-retail pharmacy providers, of which 70 (24.9%) are family planning clinics, 11 (3.9%) are FQHCs and 200 (71.2%) are associated with an outpatient hospital or clinic. The study population also included 24 specialty pharmacies, 22 Home Infusion pharmacies, and three narcotic treatment center providers.

Survey Distribution and Follow-up

Mercer mailed a survey packet, with secure links to the survey tool and survey instructions, on May 27, 2016, to 256 provider locations. An electronic file was sent to the providers representing 1,159 pharmacy site locations. A notice was included in the ForwardHealth Covered Outpatient Drug Pricing website on May 27, 2016 and a reminder email was sent to the non-responding pharmacies on June 24, 2016. Responding pharmacies were sent an email expressing gratitude for completing the survey on July 7, 2016.

Survey Response Rate and Non-Response Bias

Of 1,388 pharmacies in the study population, 1,202 pharmacies responded to the survey, representing a total response rate of 86.6%. Of the 1,202 pharmacies that responded, 965 pharmacies provided usable responses to the study, representing a usable response rate of 69.5%; 237 pharmacies provided non-usable responses.

Usable responses were defined as responses that contain sufficient data to permit calculation of the following variables:

- Measurable reporting period.
- Measurable financial reporting period.
- Prescription area square footage.
- Total square footage.
- Total number of prescriptions.
- Prescription sales (if not an “Other” owner type) [not including over-the-counter (OTC) sales].
- Total sales (if not an “Other” owner type).
- Prescription department payroll.
- Total prescription department costs.
- Total sales less than total costs of dispensing (if not “Other” owner type).

Four steps were taken to conserve the numbers of pharmacies in the sample. Responses from pharmacies with ownership type “Other” (126 responses, 90 in the final sample) sometimes lacked sales or indicated sales less than dispensing costs. Since many of these providers appeared to be non-profit organizations, it seemed reasonable that they may have charged nothing or heavily discounted prices for their prescriptions. Therefore Mercer did not remove them from the sample. In the case that sales were missing altogether for these pharmacies, overhead expenses were allocated by floor space rather than by sales.

A substantial number of retail chain and clinic/outpatient pharmacies reported no facility or overhead costs (23 and 102, respectively). For these pharmacies the total facility costs and total overhead costs were imputed by calculating the mean total facility costs per square foot and mean total overhead costs per dollar of sales for the other retail chain and clinic/outpatient pharmacies in the sample. These means were then multiplied by total square footage and total sales to estimate the total facility costs and total overhead costs, respectively, for the retail chain and clinic/outpatient pharmacies that did not report facility or overhead costs.

Responses that were missing critical information required to calculate cost of dispensing were unusable and excluded from the analysis. In addition, responses which reported total costs of dispensing (which do not include the cost of drug inventory) greater than total sales were deemed unusable. Table 3 reports the numbers and reasons for responses excluded from the sample.

Table 3: Accounting of unusable responses

Reason	Number Dropped from Sample*
Missing number of months open	7
Missing financial period beginning or end	27
Missing pharmacy department area square footage	37
Missing total square footage	35
Missing total number of prescriptions	40
Missing prescription sales (not including OTC sales)	32
Missing total sales	31
Missing prescription department payroll	46
Missing prescription department expenses	42
Missing facility costs	49
Missing overhead costs	74
Negative facility costs	1
Costs of dispensing greater than total sales	52
Open less than a year	34
Revised survey data submissions	70
Outliers (greater or less than 3 standard deviations from the mean)	33

* Greater than 237 because some pharmacies had multiple missing essential data elements.

The sample was examined for outliers. An initial cost of dispensing was calculated for each pharmacy. Costs of dispensing over $3,000.00 were flagged as outliers (nine pharmacies). Then the sample was divided into retail community pharmacies (retail chain, independent retail and long term care [LTC]), non-retail providers (FQHC, family planning or clinic/outpatient pharmacies) and specialty/Home Infusion pharmacies. For each, the mean and standard deviation of the normal log of the cost of dispensing was estimated. Responses greater or less than three standard deviations from the normal log of the mean were flagged as outliers (24 additional pharmacies). This eliminated retail community pharmacies with costs of dispensing less than $0.52 or greater than $189.15, non-retail providers with costs of dispensing less than $3.87 or greater than $509.37 and specialty/Home Infusion pharmacies with costs of dispensing less than $3.23 or greater than $9,537.43. The cost of dispensing for the remaining retail community pharmacies ranged from $4.40 to $170.34, the cost of dispensing for the remaining non-retail providers ranged from $4.35 to $172.31 and the costs of dispensing for the remaining specialty/Home Infusion pharmacies ranged from $11.73 to $2,147.29, and the costs of dispensing for remaining clinic/outpatient pharmacies ranged from $5.86 to $113.61.

Of 965 pharmacies providing usable responses to the survey, 526 (54.5%) and 166 (17.2%) were classified as chain (four or more stores) and independent pharmacies, respectively.

Additionally, of the 965 usable responses, 167 (17.3%) were received from clinic/outpatient hospital pharmacies, 51 (5.3%) were received from family planning clinics, six (0.6%) were received from FQHC pharmacies, five (0.5%) were received from Home Infusion providers, 32 (3.3%) were received from LTC pharmacies and 12 (1.2%) were received from specialty pharmacies. No usable responses were received from narcotic treatment centers.

To determine whether the distributions of the responding sample by type and geographic characteristics differ from those observed in the study population, Chi-square analysis was performed. The results were most statistically significant ($p < 0.05$) for pharmacy type and for overall prescription volume.

Given the disproportionately high response rates by provider type for retail chain and clinic/outpatient pharmacies (78.4% and 83.5%) relative to independent retail pharmacies, family planning clinics, FQHCs, Home Infusion providers, LTC and specialty pharmacies (65.1%, 72.9%, 54.5%, 22.7%, 40.5% and 50.0%, respectively) we adjusted the results for non-response by applying survey weights in the calculation of the dispensing cost. This adjustment allows the survey results to be generalized to the study population. Specifically, a stratification approach was used to calculate response probability as a function of type of pharmacy.

The predicted response probability was used to form adjustment cells. Within each adjustment cell, the response weight was calculated as one divided by the probability of response. Survey weights applied to observations summed to the number of pharmacies in the study population for which pharmacy type was known and for which at least one of that pharmacy type was received (1,332).

This approach adjusted for the under-representation of pharmacy types mentioned above and allowed the survey results to be generalized to the population of 1,335 pharmacies for which pharmacy type was known. The approach yielded a higher survey weight for the responses received from independent retail pharmacies, family planning clinics, FQHCs, Home Infusion providers, LTC and specialty pharmacies to create a mix in the sample that is representative of the mix of pharmacy types observed in the population.

Table 4 shows the characteristics of the survey population, respondents, respondents weighted by number of pharmacies represented and response probability.

Table 4: Characteristics of the pharmacy respondents and pharmacy population with known pharmacy type

Pharmacy Type	Population	Sample (Usable Responses)	Response Rate	Weighting	Sum of Weights of Responses
Clinic/Outpatient	200	167	83.5%	1.198	200
Family Planning Clinic	70	51	72.9%	1.373	70

Pharmacy Type	Population	Sample (Usable Responses)	Response Rate	Weighting	Sum of Weights of Responses
FQHC	11	6	54.5%	1.833	11
Home Infusion	22	5	22.7%	4.400	22
Independent Retail	255	166	65.1%	1.536	255
LTC	79	32	40.5%	2.469	79
Narcotic Treatment Center	3	0	0.0%	NA	0
Retail Chain	671	526	78.4%	1.276	671
Specialty	24	12	50.0%	2.000	24
Total*	**1,335**	**965**			**1,332**

* Total population and total sum of weights differ slightly because no narcotic treatment center responses were usable.

Costs and Expenses Elements

Costs included in the calculation include those defined in 42 CFR 447.502, which states "Professional dispensing fee means the fee which:

1. Is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed.
2. Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. Pharmacy costs include, but are not limited to, reasonable costs associated with 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, special packaging, overhead associated with maintaining the facility and equipment necessary to operate the pharmacy."

The expenses included in the cost of dispensing calculation are classified as: pharmacy or prescription department payroll expenses, pharmacy or prescription department expenses, facility expenses and other administrative expenses. The expenses related to filling a prescription need to be identified and allocated to the prescription department relative to the rest of the pharmacy areas. The allocation can be made based on area ratio, sales ratio or 100%. Area ratio is calculated by dividing the prescription department square footage by total square footage. Sales ratio is calculated by dividing prescription sales (not including OTC sales) by total sales for the reporting period.

Salary expenses included in the cost of dispensing calculation are those related to prescription department payroll, including compensation, benefits and payroll taxes. These payroll expenses are allocated at 100% to the prescription department, except where Medication Therapy Management (MTM) was reimbursed separately for comprehensive medication reviews. Pharmacist salaries were reduced by the percentage of MTM comprehensive medication review

revenue, compared to total prescription department revenue, plus MTM revenue. This reduction was necessary since the provider already received reimbursement for time through MTM billing. Intervention-based MTM revenue did not reduce pharmacist salaries as reimbursement for MTM intervention-based compensation will be included in the professional dispensing fee.

- Prescription department expenses, allocated at 100%, included:
- Prescription containers, label and other pharmacy supplies.
- Professional liability insurance for pharmacists.
- Prescription department licenses, permits and fees.
- Dues, subscriptions and continuing education for the prescription department.
- Delivery expenses (prescription-related only).
- Computer systems (related only to the prescription department).
- Depreciation directly related to the prescription department.
- Professional education and training.
- Costs attributable to managing 340B participation as a covered entity.
- Other prescription department-specific costs not identified elsewhere.

Expenses for compounding prescription drugs were excluded from the dispensing fee calculation as additional compensation for compounding is reimbursed based on the time spent compounding the prescription drugs, ranging from $9.45 to $22.16. The average cost of compounding expenses, not including pharmacist time or compensation, was $7.79 per compounded script during CY2015. Excluding compounding costs from the community retail rate tiers lowered each tier by $0.06.

Facility expenses, allocated based on area ratio, included:
- Rent.
- Utilities (gas, electric, water and sewer).
- Real estate taxes.
- Facility insurance.
- Maintenance and cleaning.
- Depreciation (not included depreciation directly related to the prescription department).
- Mortgage interest.
- Other facility-specific costs not identified elsewhere.

Other expenses, allocated based on sales ratio, included:
- Professional services (for example, accounting, legal, consulting).
- Telephone and data communication.
- Transaction fees, merchant fees and credit card fees.
- Computer system and support.
- Other depreciation not captured elsewhere.
- Office supplies.
- Other insurance.
- Franchise fees.

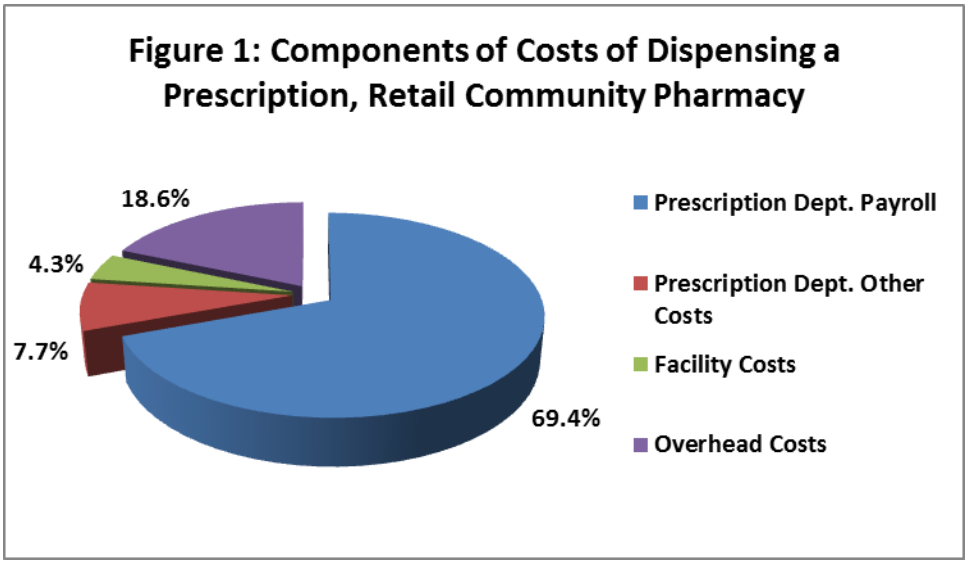
- Other interest.
- Corporate overhead.
- Other costs not included elsewhere.

Total pharmacy operational expenses, including overhead and labor costs, are obtained by summing payroll expenses, prescription or pharmacy department expenses, facility expenses and other store expenses allocated to the prescription department. Cost of dispensing a prescription is obtained by dividing the total pharmacy operational expenses by total number of prescriptions reported in the time period.

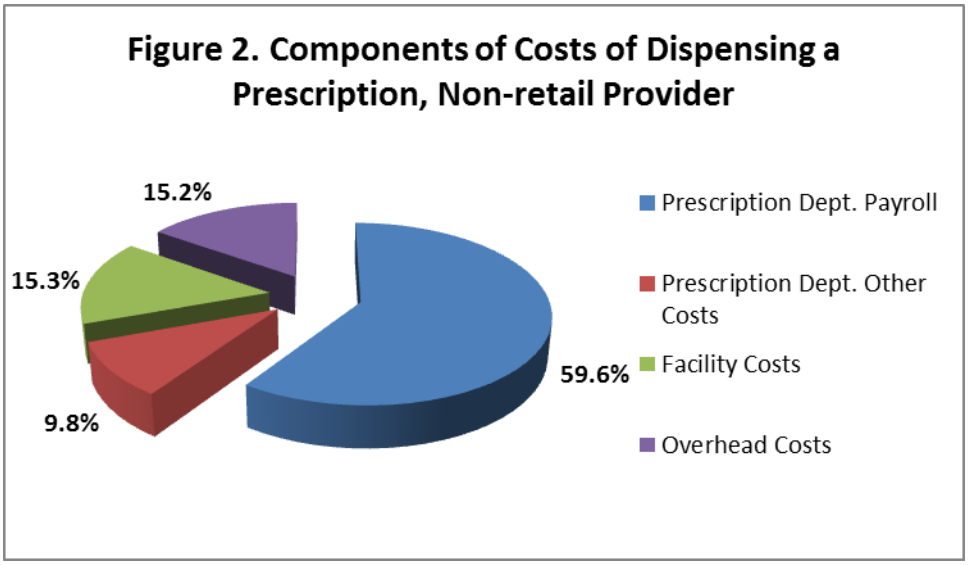
In the calculation of average cost of dispensing, the following expenses were not included, although they were requested as part of the survey. These were bad debts for prescriptions, including uncollected copays; marketing and advertising expenditures; charitable contributions; and taxes other than real estate, payroll or sales. These expenses were excluded from the analysis based on the interpretations of CMS's definition of cost of dispensing, which is consistent with treatment in other states as well as provisions of the Federal Provider Reimbursement Manual CMS Pub 15-1, Section 304 (bad debt), Section 2136.2 (advertising), and Section 2122.2 (tax). Mercer notes that these expenses were substantially different for retail community pharmacies, non-retail providers and specialty/Home Infusion pharmacies, as shown in Table 5.

Table 5: Costs not included based on CMS cost of dispensing guidelines

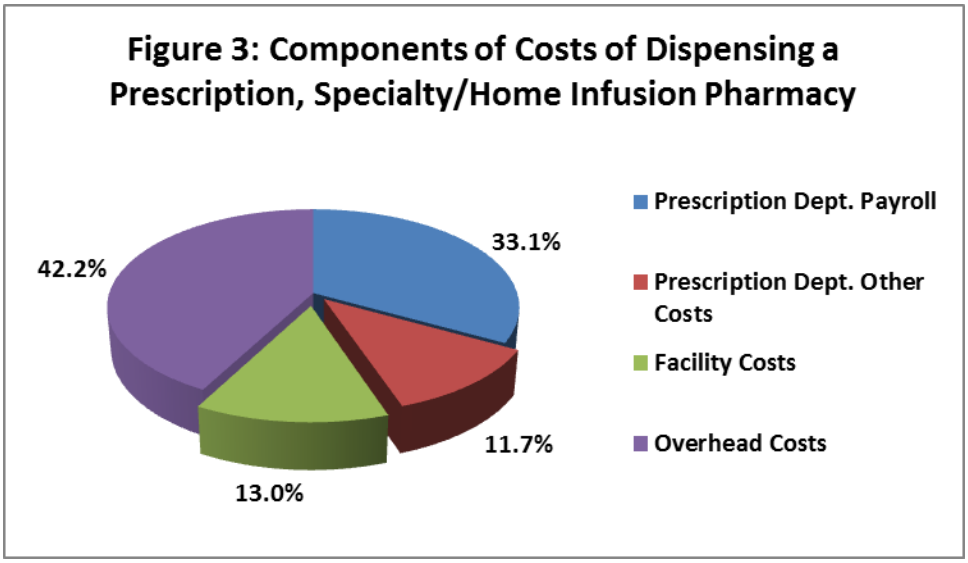
Unallowable Cost	Retail Community	Family Planning Clinic/FQHC	Specialty/Home Infusion	Clinic/ Outpatient
Bad Debt Cost per Prescription	$0.07	$1.31	$64.83	$0.03
Marketing Cost per Prescription	$0.43	$0.54	$12.05	$0.92
Charity Cost per Prescription	$0.01	$0.00	$3.58	$0.25
Other Tax Cost per Prescription	$0.11	$0.00	$3.80	$0.14



Components of the cost of dispensing also varied considerably between retail community pharmacies, non-retail providers and specialty/Home Infusion pharmacies. Of the average cost of dispensing observed, for retail community pharmacies (Figure 1) 69.4% of costs were accounted for by prescription department payroll, 18.6% by overhead costs, 7.7% by prescription department costs and 4.3% by facility-related costs.



For non-retail providers (Figure 2), 59.6% of costs were accounted for by prescription department payroll, 15.2% by overhead costs, 9.8% by prescription department costs and 15.3% by facility-related costs.



For specialty/home, infusion pharmacies (Figure 3) 33.1% of costs were accounted for by prescription department payroll, 42.2% by overhead costs, 11.7% by prescription department costs and 13.0% by facility-related costs.

Inflation Adjustments

The Consumer Price Index (CPI) published by Bureau of Labor Statistics was used to standardize total pharmacy operational expenses, including overhead and labor costs, to the same time period ending on June 30, 2016 for all urban consumers. Fiscal period end dates reported by pharmacies ranged from December 2014 to June 2016. Table 6 shows the fiscal period begin and end dates, mid-point CPI index, terminal month CPI index, inflation factor and number of pharmacies, with the corresponding year end date included in the analysis.

Table 6: Inflation factors used to standardize costs to June 2016

Fiscal Period Begin Date	Fiscal Period End Date	Mid-point CPI	Terminal Month CPI (June 2016)	Inflation Factor	Number of Pharmacies
1/1/2014	12/31/2014	238.297	241.038	1.0115046	4
6/1/2014	5/31/2015	235.482	241.038	1.0235963	4
6/29/2014	6/27/2015	234.260	241.038	1.0289359	5
7/1/2014	6/30/2015	234.260	241.038	1.0289359	51

Fiscal Period Begin Date	Fiscal Period End Date	Mid-point CPI	Terminal Month CPI (June 2016)	Inflation Factor	Number of Pharmacies
9/1/2014	8/31/2015	235.421	241.038	1.0238616	259
9/28/2014	9/26/2015	236.359	241.038	1.0197962	1
9/29/2014	9/27/2015	236.359	241.038	1.0197962	3
10/1/2014	9/30/2015	236.359	241.038	1.0197962	54
12/27/2014	12/26/2015	238.646	241.038	1.0100232	48
1/1/2015	12/1/2015	238.638	241.038	1.0100571	1
1/1/2015	12/30/2015	238.646	241.038	1.0100232	1
1/1/2015	12/31/2015	238.646	241.038	1.0100232	335
2/1/2015	1/30/2016	238.485	241.038	1.0107051	65
2/1/2015	1/31/2016	238.485	241.038	1.0107051	114
3/1/2015	12/31/2015	238.485	241.038	1.0107051	1
3/1/2015	2/27/2016	238.131	241.038	1.0122097	2
3/1/2015	2/29/2016	238.131	241.038	1.0122097	1
4/1/2015	3/31/2016	237.892	241.038	1.0132266	5
5/1/2015	4/30/2016	237.587	241.038	1.0145252	1
5/1/2015	5/2/2016	237.587	241.038	1.0145252	1
6/7/2015	6/7/2016	236.931	241.038	1.0173363	1
7/1/2015	5/31/2016	236.525	241.038	1.0190804	9

Regression Analysis of Pharmacy Characteristics

A multivariable linear regression model was carried out to examine the relationship between a set of pharmacy characteristics and the average cost of dispensing for each pharmacy, weighted by response probability. The regression modeling informs the cost analysis after initial results are reviewed. The regression model generates results that are representative of all 1335 pharmacies meeting the study criteria across the State. This statistical method simultaneously considers a set of pharmacy characteristics and their relationship with the average cost of dispensing a prescription. The model performance, R-squared, measures how well the model fits the data and denotes the percentage of variation in average cost of dispensing accounted for by a set of the pharmacy characteristics. Because costs are right skewed and great differences in costs were seen between pharmacy types, the cost of dispensing was log normal transformed. Right skewed refers to the fact that the average cost to dispense cannot go below $0.00 but there is no limit on how high the average can go. Log normal transformation creates a more symmetric distribution of the data following a normal curve which allows for more accurate statistical analysis. The regression coefficient for each predictor variable represents a multiplier of the average cost of dispensing per unit change in the predictor variable, holding all other variables constant.

Based on the survey design, the following pharmacy characteristics were included in the regression model:

- Type of pharmacies.
- Pharmacist(s) also an owner.
- Medicaid prescription volume.
- Percent of prescriptions accounted for by Medicaid.
- Total prescription volume.
- Number of Medicaid prescriptions compounded.
- Whether enhanced services, including delivery of Medicaid prescriptions are offered.
- Whether the pharmacy was a 340B Covered Entity.

Table 7 shows the results of the regression analysis, examining the relationship between pharmacy characteristics and an average cost of dispensing. Each pharmacy characteristic is represented as a categorical variable, where the reference (base) case is a pharmacy with the following characteristics:

- Retail chain.
- Does not own its building.
- No owner-pharmacist(s).
- 35,000 or greater total prescriptions annually.
- <10% of prescriptions accounted for by Medicaid.
- < 1% prescriptions compounded.
- No delivery of Medicaid prescriptions.
- Not a 340B covered entity.

The intercept of the regression analysis represents the average cost per prescription for a pharmacy with these characteristics. For each characteristic, the results for the reference pharmacy are displayed as NA, since they are captured by the intercept. Because the cost of dispensing was log normal transformed, the result for each non-reference category represents the multiplier of the cost of dispensing to the base case, holding all other characteristics constant. For each characteristic that varies from the base case, the base cost is multiplied by its associated factor.

Overall, the regression model explained 67.0% of the variance in average cost of dispensing a prescription. Based on the tests of the regression coefficients, ten comparisons to the reference case were significantly related to cost of dispensing.

The characteristics that had a significant relationship to the cost of dispensing included:

- Pharmacy type compared to Retail Chain:
  - Clinic/Outpatient.
  - Family Planning Clinic.
  - Home Infusion.
  - Specialty.

  - LTC (moderately significant).
  - Independent Retail (slightly significant).
- Prescription volume from 0–34,999 compared to 35,000 or more.
- Percent Medicaid prescriptions compared to 0–9.99%:
  - 20% or more.
- Being a 340B covered entity.

Being an independent retail pharmacy or FQHC, building ownership, delivery of Medicaid prescriptions, percent of Medicaid prescriptions of 10–19.99% (compared to 0–9.99%), percent of prescriptions compounded and a pharmacist as an owner were not significantly related to cost of dispensing after all other characteristics had been accounted for in the base model.

The results for the intercept indicate that the average cost of dispensing was $9.26 for the base case (retail chain pharmacy with no owner-pharmacist(s); 35,000 or greater total prescriptions; < 10% of prescriptions accounted for by Medicaid; < 1% prescriptions compounded; no delivery of Medicaid prescriptions, and not a 340B covered entity). The base case represents the most common combination of attributes described above. The 95% confidence interval of the average cost of dispensing for the base case was [$8.74, $9.81].

The regression model showed that clinic/outpatient pharmacies had an average cost 46.1% higher than chain pharmacies. Specialty pharmacies had costs 14.1 times those of chain pharmacies and Home Infusion pharmacies had costs 10.2 times that of chain pharmacies. Family planning clinics had average costs 89.7% higher than that of retail chain pharmacies. Each of these provider types described previously had high statistical significance ($p < 0.001$) while LTC pharmacies had average costs 22.8% higher than that of retail chain pharmacies which while still significant was less so than other provider types (< 0.01). A slightly statistically significant difference was seen between independent retail pharmacies or FQHCs compared to chain pharmacies (< 0.05).

Lower total prescription volume was associated with higher average costs as demonstrated by statistical significance with p-value < 0.001. Pharmacies with fewer than 35,000 total prescriptions had significantly higher costs than pharmacies with 35,000 or greater total prescriptions. Compared to pharmacies with 35,000 or greater prescriptions, pharmacies with 0–34,999 prescription had costs 1.646 times as much (64.6% more).

A higher percentage of prescriptions accounted for by Medicaid were associated with significantly higher costs. Pharmacies in which Medicaid accounted for 20% or more of prescriptions had average costs that were 1.131 times that (13.1% higher) of pharmacies in which Medicaid accounted for 0–9.99% of prescriptions. However, there were no significant differences between pharmacies with 0–9.99% and 10–19.99% of prescriptions accounted for by Medicaid.

Table 7: Regression analysis examining the relationship between pharmacy characteristics and an average cost of dispensing — log of cost of dispensing

Model Predictor	Level	Base and Multipliers	95% Confidence Interval		P-Value
			Lower Bound	Upper Bound	
Intercept		$9.26	$8.74	$9.81	
Type of Pharmacies	Clinic/Outpatient	1.461	1.309	1.630	***
	Family Planning Clinic	1.897	1.491	2.412	***
	FQHC	1.515	1.079	2.128	*
	Home Infusion	10.169	7.596	13.614	***
	Independent Retail	1.119	1.011	1.240	*
	LTC	1.228	1.068	1.413	**
	Retail Chain	Base	NA	NA	
	Specialty	14.104	11.258	17.671	***
Own the Building	No	Base	NA	NA	
	Yes	1.007	0.919	1.103	NS
Pharmacist(s) also an Owner	No	Base	NA	NA	
	Yes	1.095	0.983	1.220	NS
Prescription Volume	0–34,999	1.646	1.531	1.770	***
	35,000 or greater	Base	NA	NA	
Percent Medicaid Prescription	0–9.99%	Base	NA	NA	
	10–19.99%	0.955	0.891	1.024	NS
	20% or more	1.131	1.045	1.224	**
Percent Prescriptions Compounded	0–0.99%	Base	NA	NA	
	1–4.99%	1.271	1.078	1.498	**
	5% or more	1.000	0.799	1.250	NS
Delivery	No	Base	NA	NA	
	Yes	0.985	0.911	1.065	NS
340B Covered Entity	No	Base	NA	NA	
	Yes	1.432	1.172	1.749	***

* $p < 0.05$, **$p < 0.01$, ***$p < 0.001$, NS = not significant

The regression analysis is designed to identify error from the base model. Therefore, during the regression analysis, data is not winsorized. The most statistically significant characteristics were

based on prescription volume and provider type. However, some characteristics were explained in Mercer's model simply by the distribution to provider type. For example, 340B pharmacies were primarily made up of family planning clinics. The characteristic of Medicaid volume greater than or equal to 20% was accounted for in the tiered dispensing fee model as 37% of the pharmacies that met this characteristic fell into the lowest volume tier. Two characteristics, the FQHC pharmacy type characteristic and pharmacies with a pharmacist owner characteristic, showed moderate significance (p-values of 0.016). While these characteristics trended toward significance, they were not impactful enough to necessitate additional consideration when compared to prescription volume and pharmacy type.

Analysis and Findings

Mercer's initial analysis caused Mercer to focus on the differences in costs between pharmacy types and overall prescription volume and therefore Mercer first modeled cost of dispensing averages by those characteristics. Table 8 presents means, medians, winsorized means, twenty-fifth percentile and seventy-fifth percentile for each pharmacy type weighted by response probability. As illustrated in the table, the reported costs of dispensing for Home Infusion and specialty pharmacies are estimated as an order of magnitude greater than those for all other pharmacy types. Also noted in the table, the number of respondents in these pharmacy types is very low. Not shown in the table are the response rates for these pharmacy types, which were just 22.7% for Home Infusion and 50.0% for specialty pharmacies. Mercer believes it is likely that a large portion of these costs may not be attributable to dispensing alone and further study of these pharmacies is warranted. Therefore, Mercer has segmented the sample into three groups, a) retail community pharmacy, b) non-retail providers and c) Home Infusion and specialty pharmacies. Mercer will devote most of the remainder of the result discussion to retail community pharmacies and non-retail providers.

Table 8: Means, medians and percentile distribution of cost of dispensing by pharmacy type weighted by response probability.

Pharmacy Type	Number in Sample	Mean	Winsorized Mean*	Median	Twenty-Fifth Percentile	Seventy-Fifth Percentile
Clinic/Outpatient	167	$17.67	$16.31	$14.10	$12.09	$17.29
Family Planning Clinic	51	$56.90	$56.52	$52.97	$33.94	$68.62
FQHC	6	$24.92	$24.92	$20.68	$19.97	$27.87
Home Infusion	5	$267.00	$267.00	$99.80	$77.72	$251.49
Independent Retail	166	$15.66	$13.16	$11.67	$9.76	$14.86
LTC	32	$16.11	$12.77	$11.96	$9.03	$13.90
Retail Chain	526	$11.35	$10.89	$9.13	$8.23	$11.72
Specialty	12	$417.16	$316.64	$282.46	$52.21	$341.77

*Winsorization approach was used to minimize the impact of outliers by setting the cost of dispensing that was below the fifth percentile to fifth percentile and those that were higher than ninety-fifth percentile to ninety-fifth percentile.

Descriptive statistics and measures of central tendency, namely means and medians, are used to determine an average cost of dispensing a prescription by Wisconsin providers. Table 9 and Table 10 present means and medians weighted by: unweighted, response probability, total number of prescriptions, and total number of Medicaid prescriptions for retail community pharmacies and non-retail providers, respectively.

Unweighted means and medians represent an average cost per prescription per pharmacy for pharmacies in the sample. Means and medians weighted by the response probability allow these measures to be generalized to the full population of pharmacies and denote an average cost per prescription per pharmacy for all pharmacies meeting the study criteria across the State. This approach gives equal weight to each individual pharmacy meeting the study criteria.

Alternatively, means and medians weighted by the total number of prescriptions or number of Medicaid prescriptions are used to determine an average cost for all prescriptions in the sample, rather than the average cost per prescription across all pharmacies. This method is equivalent to summing all of the total pharmacy operational costs in the sample divided by the total of all prescriptions in the sample. This approach gives a higher weight to pharmacies with a high volume relative to pharmacies with a low volume.

To minimize the impact of low or high outliers in the calculation of average costs, a Winsorization approach was used by setting the cost of dispensing that was below the fifth percentile to the fifth percentile and those that were higher than the ninety-fifth percentile to the ninety-fifth percentile prior to calculating the statewide average costs. Winsorization was performed separately for retail community pharmacies, FQHCs and family planning clinics, clinic/outpatient pharmacies, and specialty/Home Infusion pharmacies. The unadjusted means, winsorized means, medians and twenty-fifth and seventy-fifth percentiles of the average cost per prescription estimated according to each weighting method are shown in Table 9 for retail community pharmacies, in Table 10 for non-retail providers (FQHCs and family planning clinics), in Table 11 for Specialty/Home Infusion providers and in Table 12 for Clinic/Outpatient providers.

In addition to calculating the cost of dispensing a prescription on a statewide basis, the study determined the average costs of dispensing for subgroups of pharmacies classified by various pharmacy characteristics (Appendix A).

Table 9: Means, medians and percentile distribution of cost of dispensing, retail community pharmacies

Method	Mean	Winsorized Mean*	Median	Twenty-fifth Percentile	Seventy-fifth Percentile
Unweighted	$12.55	$11.50	$9.68	$8.44	$12.96
Weighted by response probability	$12.82	$11.62	$9.83	$8.48	$13.27
Weighted by total prescription volume	$10.30	$10.04	$8.82	$7.98	$10.51

Method	Mean	Winsorized Mean*	Median	Twenty-fifth Percentile	Seventy-fifth Percentile
Weighted by Medicaid prescription volume	$10.78	$10.03	$8.82	$8.06	$10.12

*Winsorization approach was used to minimize the impact of outliers by setting the cost of dispensing that was below the fifth percentile to fifth percentile and those that were higher than ninety-fifth percentile to ninety-fifth percentile.

Table 10: Means, medians and percentile distribution of cost of dispensing, non-retail providers

Method	Mean	Winsorized Mean*	Median	Twenty-fifth Percentile	Seventy-fifth Percentile
Unweighted	$53.53	$53.19	$49.52	$24.66	$68.27
Weighted by response probability	$52.56	$52.23	$49.46	$23.38	$68.27
Weighted by total prescription volume	$30.25	$30.73	$21.36	$15.28	$45.04
Weighted by Medicaid prescription volume	$34.98	$35.72	$33.94	$10.01	$49.52

*Winsorization approach was used to minimize the impact of outliers by setting the cost of dispensing that was below the fifth percentile to fifth percentile and those that were higher than ninety-fifth percentile to ninety-fifth percentile.

Table 11: Means, medians and percentile distribution of cost of dispensing, specialty/Home Infusion providers

Method	Mean	Winsorized Mean*	Median	Twenty-Fifth Percentile	Seventy-Fifth Percentile
Unweighted	$373.00	$302.04	$223.18	$65.64	$341.77
Weighted by response probability	$345.35	$292.90	$199.52	$65.64	$341.77
Weighted by total prescription volume	$105.19	$104.03	$38.79	$38.79	$38.79
Weighted by Medicaid prescription volume	$53.76	$54.07	$38.79	$38.79	$38.79

*Winsorization approach was used to minimize the impact of outliers by setting the cost of dispensing that was below the fifth percentile to fifth percentile and those that were higher than ninety-fifth percentile to ninety-fifth percentile.

Table 12: Means, medians and percentile distribution of cost of dispensing, clinic/outpatient providers

Method	Mean	Winsorized Mean*	Median	Twenty-Fifth Percentile	Seventy-Fifth Percentile
Unweighted	$17.67	$16.31	$14.10	$12.09	$17.29
Weighted by response probability	$17.67	$16.31	$14.10	$12.09	$17.29
Weighted by total prescription volume	$13.86	$13.96	$12.96	$10.88	$14.72
Weighted by Medicaid prescription volume	$18.92	$17.05	$14.81	$11.80	$19.21

*Winsorization approach was used to minimize the impact of outliers by setting the cost of dispensing that was below the fifth percentile to fifth percentile and those that were higher than ninety-fifth percentile to ninety-fifth percentile.

Recommendations

Section 1902(a)(30)(A) of the Social Security Act requires states to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[2]

Mercer believes the data provided by the study supports the tiered reimbursement structure and is an accurate way of capturing the efficiency and economy of cost associated with the dispensing of covered outpatient drugs to ForwardHealth members and complying with this requirement. Overall, the data collected through the COD survey supports using a tiered dispensing fee based on total prescription volume for the majority of the ForwardHealth pharmacy providers to ensure access in low-volume pharmacies but share in the cost-saving efficiency of higher volume pharmacies.

Given the significant effect of prescription volume on the cost of dispensing, the study examined a tiered rate structures for community retail pharmacies based on annual total prescription volume, using the winsorized mean weighted by response probability as the rate within each tier (Table 13). Mercer chose two prescription volume tiers because of the significant shift in average cost to dispense between the tiers and because there was a highly significant statistical difference between the low volume tier and the base case. Based on Mercer's analysis, Mercer recommend this two-tier structure for retail community pharmacies. As shown in Table 14, several states have received approval from CMS to implement a tiered dispensing fee method so acceptance by CMS is not unprecedented.

Additionally, although clinic/outpatient providers do not fall into the definition of community retail pharmacy under the final Covered Outpatient Drug rule, the same dispensing fee tiers listed below should be used for reimbursement because most clinic/outpatient providers would fall in the lower prescription volume tiers and the higher dispensing fee compensation would cover their costs related to retail prescription dispensing. The primary driver of costs for clinic/outpatient pharmacies is pharmacy department wages per prescription, which is 48% higher in clinic/outpatient hospital settings than in community retail settings, often due to activities billed through medical claims not eligible for a dispensing fee.

For LTC pharmacies, the winsorized means and medians aligned between independent retail and retail chain pharmacies, and were therefore incorporated into the grouping of community retail pharmacies for our calculation of tiered rates. Average LTC dispensing costs ($12.77) were similar to retail chain ($10.89) and independent retail pharmacies ($13.16) as shown in Appendix A. However, LTC provider type showed moderate statistical significance, showing costs 22.8% greater than retail chain in the regression. The LTC provider description does not fall into the definition of community retail pharmacies under the final Covered Outpatient Drug

[2] Section 1902(a)(30)(A) of the Social Security Act viewable at https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

rule. CY2015 claims data reflected that LTC pharmacies frequently included separate charges for repackaging of medications for ForwardHealth members. Therefore, Mercer recommends continuing the repackaging reimbursement of $0.015 per unit to address the moderate statistical significance associated with these pharmacies.

Table 13: Tiered rate structure for retail community pharmacies and clinic/outpatient based on annual total prescription volume

Annual Total Prescription Volume	Cost of Dispensing Rate
0–34,999	$15.69
35,000 or more	$10.51

FQHCs (both community health centers and tribal health clinics) receive cost-based reimbursement. The purpose of including FQHCs in this study was not to use the data as a rate-setting tool, but to understand the differences in costs to dispense between provider types. FQHCs do not fall within the definition of community retail pharmacies and will not be reimbursed according to the above tiered rate structure. FQHCs will continue to receive cost-based reimbursement for overall care. DHS will work with the tribal clinics and community health centers to ensure that overall models of total reimbursement appropriately compensate them. As interim payments, tribal FQHCs will be allowed $24.92 for a professional dispensing fee. Community health centers will be reimbursed for dispensing fee through their prospective payment system (PPS) rate. Reimbursement at $24.92 is higher than current rates and is likely to provide sufficient cash flow for the FQHCs until cost-based reimbursement settlements.

Mercer recommends the State consider no longer compensating family planning clinics with NDC-based reimbursement. Instead, the State should consider other methods of reimbursement, such as billing for services on medical claims using the appropriate Health Care Procedure Coding System (HCPCS) codes, due to the limited number of drugs dispensed and additional services provided during family planning activities, which results in significantly higher cost to dispense drugs for this provider type.

Specialty pharmacies and Home Infusion pharmacies require further investigation due to the low volume of response rates and the disparity in average cost to dispense. Mercer recommends the State does not establish a separate dispensing fee for these provider types until the costs are further studied to determine the reasons for the strikingly higher costs due to the inconsistent and varied nature of the usable data received. Since the Covered Outpatient Drug rule does not require that drugs not typically dispensed through retail community pharmacies be subject to reimbursement methodologies based on actual acquisition cost and professional dispensing fee, Mercer recommend that the State reimburse these pharmacy providers utilizing the tiered professional dispensing fees until additional studies are performed. The majority of these providers will fall into the low volume tier, which will provide a higher dispensing fee than the current rate.

Comparison to Other States

Rate tiers are becoming more common as states look to reimburse professional dispensing fees more accurately. Tiers in Alaska, Colorado, Idaho, North Carolina and Oregon are part of a growing trend.

Table 14: Medicaid Comparator Dispensing Fees for States Reimbursing AAC Based Ingredient Cost

State	Ingredient Cost (State AAC or NADAC)	Dispensing Fee
Alabama	Ingredient cost is AAC or if not available WAC, or U/C; ASP + 6% (blood clotting factors)	$10.64
Alaska	NADAC, if not available WAC + 1%	Dispensing fee is $13.36 (pharmacy located on the road system); $16.58 (mediset pharmacy); $21.28 (pharmacy not located on the road system); $10.76 (out-of-state pharmacy).
Colorado	Ingredient cost for all drugs for retail pharmacies, 340B pharmacies, institutional pharmacies, government pharmacies and mail order pharmacies shall be based upon the lower of: • The usual and customary charge to the public minus the client's copayment. • The allowed ingredient cost: the lesser of AAC or submitted ingredient cost. If AAC is not available, then the lesser of WAC or the submitted drug ingredient cost. Submitted Ingredient Cost is a pharmacy's calculated ingredient cost. For drugs purchased through the 340B Drug Pricing Program, the submitted ingredient cost means the 340B purchase price. Ingredient cost for designated rural pharmacies: • AAC. If AAC is not available, then WAC.	Retail, 340B, institutional and mail order pharmacies are tiered based upon annual total prescription volume. Tiers; < 60,000 total per year = $13.40. 60,000–90,000 per year = $11.49. 90,000–110,000 per year = $10.25. > 110,000 per year = $9.31. Dispensing fee is $14.41 (rural pharmacies – state definition); no dispensing fee (government pharmacies). Weighted, winsorized mean for responding pharmacies in 2012: $11.67 and in 2013: $8.06.
Delaware	NADAC	$10.00

State	Ingredient Cost (State AAC or NADAC)	Dispensing Fee
Idaho	Ingredient cost is AAC, or where there is no AAC reimbursement is WAC.	Tiered dispensing fees: • < 39,999 claims per year = $15.11. • Between 40,000 and 69,999 claims per year = $12.35. • 70,000 or more claims per year = $11.51. The average (mean) cost of dispensing, weighted by total prescription volume: $12.19.
Iowa	Ingredient cost is AAC as determined from surveys or where there is no AAC reimbursement is WAC.	$11.73
Louisiana	Ingredient cost is AAC of the drug dispensed or where there is no AAC reimbursement is WAC. Reimbursement for Cost of the Influenza Vaccine at: $17. 37 for intramuscular injected influenza vaccine—preservative free, $13.22 for intramuscular injected influenza vaccine, and $22.03 for intranasal influenza vaccine or billed charges, whichever is the lesser amount.	$10.51 includes State provider fee; $10.51 for drugs obtained through the 340B Drug Pricing Program which includes the State provider fee.
Nevada	Ingredient cost is NADAC	Dispensing fee is $9.47
North Carolina	Ingredient cost is NADAC. If NADAC pricing is not available, AAC will be WAC + 0%. Physician administered drugs ASP + 6% or AWP - 10%; for the contraceptive drugs (Implanon and Mirena) WAC + 6%.	Tiered professional dispensing fee: • $13.00 when 85% or more of claims per quarter are for generic or preferred brand drugs. • $7.88 when < 85% of claims per quarter is for generic or preferred brand drugs. • $3.98 for non-preferred brand drugs.
Oregon	Ingredient cost for single source and multiple source drugs is AAC.	Dispensing fee varies by claims volume: • < 30,000 claims a year is $14.01. • 30,000–49,999 claims per year are $10.14. • 50,000 or more claims per year are $9.68.

Centers for Medicare and Medicaid Services (CMS), Medicaid Covered Outpatient Drug Reimbursement Information by State. Quarter Ending June 2016. Viewable at, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/downloads/xxxreimbursement-chart-current-qtr.pdf

APPENDIX A

Pharmacy Statistics

Pharmacy characteristics and average cost of dispensing a prescription — by pharmacy type

				Winsorized Means Weighted By:				Medians Weighted By:			
Pharmacy Type	n	N	%	Unweighted	Response probability	Total Rx Volume	Medicaid Rx Volume	Unweighted	Response probability	Total Rx Volume	Medicaid Rx Volume
Clinic/Outpatient	167	200	15.0%	$16.31	$16.31	$13.96	$17.05	$14.10	$14.10	$12.96	$14.81
Family Planning Clinic	51	70	5.3%	$56.52	$56.52	$37.56	$37.52	$52.97	$52.97	$43.69	$43.69
Federally Qualified Health Center	6	11	0.8%	$24.92	$24.92	$22.65	$26.65	$20.68	$20.68	$20.00	$20.00
Home Infusion	5	22	1.7%	$267.00	$267.00	$87.31	$94.75	$99.80	$99.80	$77.72	$99.80
Independent Retail	166	255	19.1%	$13.16	$13.16	$12.28	$13.20	$11.67	$11.67	$11.32	$11.73
Long Term Care	32	79	5.9%	$12.77	$12.77	$10.12	$12.42	$11.96	$11.96	$8.71	$11.44
Retail Chain	526	671	50.4%	$10.89	$10.89	$9.55	$9.35	$9.13	$9.13	$8.65	$8.63
Specialty	12	24	1.8%	$316.64	$316.64	$104.46	$52.87	$282.46	$282.46	$38.79	$38.79

Pharmacy characteristics and average cost of dispensing a prescription – retail community pharmacies

				Winsorized Means Weighted By:				Medians Weighted By:			
Characteristic	n	N	%	Unweighted	Response probability	Total Rx Volume	Medicaid Rx Volume	Unweighted	Response probability	Total Rx Volume	Medicaid Rx Volume
Pharmacist is Also Owner											
No	853	1151	86.4%	$20.57	$25.95	$14.74	$12.94	$10.88	$11.10	$9.11	$8.84
Yes	112	181	13.6%	$14.91	$15.30	$11.85	$13.56	$12.07	$12.15	$10.62	$11.91
Total Yearly Prescription Volume											
0–34,999	253	365	27.4%	$41.47	$55.52	$22.26	$27.68	$18.03	$9.07	$8.98	$8.94
35,000 or more	712	967	72.6%	$12.25	$12.80	$13.90	$11.46	$9.72	$8.32	$8.21	$8.33
Yearly Medicaid Prescription Volume											
0–2,499	275	385	28.9%	$35.31	$49.31	$16.92	$27.93	$14.45	$14.60	$11.85	$14.81
3,000–5,999	193	263	19.7%	$15.43	$15.42	$11.25	$15.48	$11.38	$11.51	$9.65	$11.32
6,000–11,999	235	326	24.5%	$15.34	$16.86	$19.83	$15.48	$10.12	$10.27	$9.29	$9.98
12,000 or more	262	358	26.9%	$11.15	$11.47	$11.55	$11.54	$8.84	$8.91	$8.75	$8.79
Percent Medicaid Prescription											
0–9.99%	380	522	39.2%	$18.40	$21.35	$17.38	$13.75	$11.62	$11.67	$9.72	$8.97
10–19.99%	327	451	33.9%	$12.80	$14.57	$12.72	$12.66	$10.36	$10.60	$9.29	$9.29
20% or more	258	359	26.9%	$31.14	$41.59	$11.49	$13.08	$11.20	$12.33	$8.85	$8.85
Deliver Medicaid Prescription											
No	698	909	68.2%	$14.78	$17.69	$10.40	$10.81	$10.22	$10.27	$8.95	$8.76
Yes	267	423	31.8%	$33.32	$39.13	$24.66	$19.05	$13.48	$13.50	$11.46	$12.85
Percent Compounded Prescriptions											
0–0.99%	920	1257	94.3%	$19.58	$23.47	$14.42	$12.74	$10.93	$11.11	$9.20	$8.91
1–4.99%	29	40	3.0%	$16.36	$16.09	$14.12	$16.51	$12.44	$12.15	$11.91	$12.09
5% or more	16	36	2.7%	$45.46	$70.50	$15.35	$28.13	$27.49	$62.92	$7.79	$25.55
340B Covered Entity											
No	891	1229	92.3%	1678.6%	2130.5%	1428.5%	1182.5%	1062.5%	1077.4%	924.8%	$8.82
Yes	74	103	7.7%	$57.54	$62.71	$19.82	$30.99	$45.45	$45.04	$12.09	$15.97

Pharmacy characteristics and average cost of dispensing a prescription – non-retail provider

				Winsorized Means Weighted By:				Medians Weighted By:			
Characteristic	n	N	%	Unweighted	Response probability	Total Rx Volume	Medicaid Rx Volume	Unweighted	Response probability	Total Rx Volume	Medicaid Rx Volume
Pharmacist is Also Owner											
No	57	81	100.0%	$53.19	$52.23	$30.73	$35.72	$49.52	$49.46	$21.36	$33.94
Total Yearly Prescription Volume											
0–34,999	51	71	87.6%	$57.07	$56.64	$44.35	$45.67	$52.97	$52.97	$45.85	$46.49
35,000 or more	6	10	12.4%	$20.22	$21.17	$19.35	$16.62	$17.64	$20.00	$20.00	$9.07
Yearly Medicaid Prescription Volume											
0–2,499	19	27	32.8%	$73.38	$72.47	$31.19	$60.90	$64.48	$64.48	$21.36	$64.48
3,000–5,999	16	22	27.7%	$46.49	$45.95	$43.47	$47.30	$49.73	$46.49	$46.49	$52.97
6,000–11,999	11	16	19.2%	$48.88	$48.26	$46.55	$48.29	$50.97	$50.97	$49.21	$49.21
12,000 or more	11	16	20.3%	$32.38	$31.91	$24.09	$25.60	$20.00	$20.00	$18.73	$15.28
Percent Medicaid Prescription											
0–9.99%	1	2	2.3%	$21.36	$21.36	$21.36	$21.36	$21.36	$21.36	$21.36	$21.36
20% or more	56	79	97.7%	$53.76	$52.94	$32.10	$35.72	$50.24	$49.52	$20.00	$33.94
Deliver Medicaid Prescription											
No	26	38	46.9%	$55.19	$53.40	$36.85	$46.65	$51.80	$50.97	$33.94	$45.85
Yes	31	43	53.1%	$51.51	$51.19	$22.47	$22.84	$46.39	$46.39	$18.73	$10.01
Percent Compounded Prescriptions											
0–0.99%	57	81	100.0%	$53.19	$52.23	$30.73	$35.72	$49.52	$49.46	$21.36	$33.94
340B Covered Entity											
No	2	4	4.5%	$17.64	$17.64	$17.98	$18.08	$17.64	$17.64	$20.00	$20.00
Yes	55	77	95.5%	$54.48	$53.87	$34.60	$37.52	$50.97	$49.52	$27.87	$43.69

APPENDIX B

Survey Template and Instructions

Providers could submit responses either online or using an Excel template. The Excel Template questions are shown below.

WISCONSIN DEPARTMENT OF HEALTH SERVICES
PROFESSIONAL DISPENSING FEE SURVEY

SECTION I — PHARMACY PROFILE									
By Location		Store Location Number / Identifier							
Pharmacy Profile		1	2	3	4	5	6	7	8
1	Wisconsin Medicaid Identification Number								
2	National Provider Identifier (NPI)								
3	Provider Name								
4	Street Address								
5	Street Address (Additional)								
6	City								
7	State								
8	ZIP Code								
9	County								
10	Contact Person								
11	Contact Person Email								
12	Telephone Number								
13	Fax Number								
14	Does the provider dispense 340B Drug Pricing Program (340B) drugs?								
15	Type of Ownership								
16	Was there a change in pharmacy ownership during the reporting period?								
16a	Date of Ownership Change (MM/DD/YYYY)								
17	Was the pharmacy open the entire year?								
17a	If no, list the number of months the pharmacy was open.								
18	Select the appropriate provider type.								
19	Select the location of the provider.								
20	How many years has this location been in business as a pharmacy?								
21	Is one or more of the pharmacists who fill prescriptions at this location also an owner of the store or chain?								
22	How many hours per week is the pharmacy department open? (Maximum of 168)								
Square Footage (Required. Survey responses for this section should use the same time period as reported in the financial information section.)									
23	What was the square footage for the following areas at the end of the reporting period?								
	a. Prescription area								
	b. Non-prescription area								
	c. Total square footage (Sum of a and b)	-	-	-	-	-	-	-	-
24	Did the pharmacy area change during the reporting period?								
	a. What was the date of the change?								
	What was the square footage for the following areas **before** the remodel?								
	b. Prescription area								
	c. Non-prescription area								
	d. Total square footage (Sum of b and c)	-	-	-	-	-	-	-	-

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Prescriptions (Required. Survey responses for this section should use the same time period as reported in the financial information section.)									
25	What was the number of prescriptions filled by this pharmacy for the following categories during the reporting period?								
	a. Medicaid, BadgerCare Plus, and SeniorCare-covered prescriptions								
	b. Medicare Parts B, C, and D-covered prescriptions (If available)								
	c. All other prescriptions (not Medicaid, BadgerCare Plus, SeniorCare, or Medicare)								
	d. Total prescriptions (Sum of a–c)	-	-	-	-	-	-	-	-
26	How many prescriptions were compounded?								
27	How many Medicaid, BadgerCare Plus, and SeniorCare prescriptions were compounded?								
28	How many prescriptions were delivered?								
29	How many Medicaid, BadgerCare Plus, and SeniorCare prescriptions were delivered to members?								
30	How many prescriptions during the reporting period were dispensed for long-term care (LTC) facilities (by the following dispensing categories)?								
	a. Unit dose								
	b. Modified unit dose (bingo card / blister packs)								
	c. No unit dose dispensing								
	d. Traditional packaging								
	e. Other method not described above (Explain in the Comments section) (Explain: _____)								
	f. Total prescriptions dispensed for LTC facilities (Sum of a–e)	-	-	-	-	-	-	-	-
31	How many prescriptions were dispensed to all nursing homes and/or assisted living facilities?								

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PROFESSIONAL DISPENSING FEE SURVEY

SECTION II — 340B DRUG PRICING PROGRAM (340B) PHARMACY INFORMATION										
By Location		Store Location Number / Identifier								
Pharmacy Profile		1	2	3	4	5	6	7	8	Total
32	Type of 340B Provider									
33	Covered Entity or Contract									
34	Does the provider purchase drugs through the 340B prime vendor program?									
35	Does the provider use a 340B administrator?									
36	Enter the total number of 340B prescriptions filled during the reporting period.									
37	Enter the total number of 340B prescriptions billed to Medicaid, BadgerCare Plus, and SeniorCare.									

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PROFESSIONAL DISPENSING FEE SURVEY

SECTION III — FINANCIAL INFORMATION — SALES AND DIRECT EXPENSES

		Store Location Number / Identifier								
By Location		1	2	3	4	5	6	7	8	Total
38	a. Enter beginning date range of financial reports.									
	b. Enter ending date range of financial reports.									
Sales										
39	What were the sales for the following categories?									
	a. Prescription sales other than over-the-counter [OTC] dispensed by a pharmacist or 340B sales									
	b. OTC sales dispensed by pharmacy department									
	c. OTC sales dispensed by staff not in pharmacy department									
	d. Sales of drugs purchased through the 340B program									
	e. Portion of federal grants attributable to pharmacy, if any									
	f. Revenue received for Medication Therapy Management (MTM): Intervention-based services									
	g. Revenue received for MTM: Comprehensive medication reviews									
	h. Other sales such as retail sales and services									
	i. Total sales (Sum of a–h)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Costs and Expenses										
40	a. Cost of goods sold (COGS): pharmaceuticals (*Note:* This will not be included in the dispensing fee calculation.)									
	b. Non-pharmacy COGS									
	c. Total COGS (Sum of a and b)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Personnel and Labor Costs										
41	a. Units Billed for MTM Intervention-based services									
	b. Units Billed for MTM Comprehensive medication reviews									
	c. Pharmacist Full-Time Employees (FTEs)									
42	Other Pharmacy Department FTEs (Do not include pharmacist counted in 41c.)									
	Enter Salaries, Wages, Bonuses, and guaranteed payments for Elements 43–47.									
43	Pharmacist Manager (Owner)									
44	Pharmacist Manager (Non-owner)									
45	Staff Pharmacist									
46	Technician									
47	Non-pharmacist Personnel Working in Pharmacy Department (Allocated)									
48	Pharmacy Department Payroll Taxes									
49	Pharmacy Department Benefits (Including health insurance and pension / profit sharing / retirement expenses)									
50	Prescription Department Payroll (Sum of 43–49)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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Non-pharmacy Personnel										
51	Wages, Payroll Taxes, and Benefits for Personnel Directly Attributed to Non-pharmacy Services									
52	Wages, Payroll Taxes, and Benefits for Personnel Directly Attributed to Administrative or Shared Services									
53	General Employee Expenses Attributable to All Employee Types									
54	Non-prescription Department Payroll (Sum of 51–53)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
55	Total Payroll Expense (Sum of 50 and 54)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Department Expenditures										
56	Prescription Containers, Label, and Other Pharmacy Supplies									
57	Professional Liability Insurance for Pharmacists									
58	Prescription Department Licenses, Permits, and Fees									
59	Dues, Subscriptions, and Continuing Education for the Prescription Department									
60	Delivery Expenses (Prescription related)									
61	Expenses for Compounding (Including depreciation on compounding equipment)									
62	Bad Debts for Prescriptions (Including uncollected copayments)									
63	Computer Systems Costs Related Only to the Prescription Department (Not including depreciation)									
64	Depreciation — Directly Related to Pharmacy Department (Including computers, software, and equipment)									
65	Professional Education and Training									
66	Inventory Carrying Costs (Including shrinkage due to expiration, theft, or loss inventory)									
67	Costs Directly Attributable to 340B									
	a. 340B program management									
	b. Other (List other costs in Comments Section)									
68	Other Prescription Department-Specific Costs Not Identified Elsewhere									
69	Total Prescription Department Non-payroll Costs (Sum of 56–68)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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SECTION IV — FINANCIAL INFORMATION — OVERHEAD

		Store Location Number / Identifier								
By Location		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
Facility										
70	Does the provider lease or own the building?									
	a. Building Cost Basis (Depreciable Amount)									
	b. Building Accumulated Depreciation									
Facility Expenses										
71	Rent									
72	Utilities (Gas, Electric, Water, and Sewer)									
73	Real Estate Taxes									
74	Facility Insurance									
75	Maintenance and Cleaning									
76	Depreciation Expense (e.g., Building, Leasehold Improvements, Furniture, and Fixtures)									
77	Mortgage Interest									
78	Other Facility-Specific Costs not Identified Elsewhere									
79	Total Facility Cost (Sum of 71–78)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Store / Location Expenses										
80	Marketing and Advertising									
81	Professional Services (e.g., accounting, legal, consulting)									
82	Telephone and Data Communication									
83	Transaction Fees / Merchant Fees / Credit Card Fees									
84	Computer Systems and Support									
85	Depreciation (Including equipment, furniture, computers)									
86	Amortization									
87	Office Supplies									
88	Other Insurance									
89	Taxes Other Than Real Estate, Payroll, or Sales									
90	Franchise Fees (If Applicable)									
91	Other Interest									
92	Charitable Contributions									
93	Corporate Overhead									
94	Other Costs Not Included Elsewhere									
95	Total Other Store / Location Costs (Sum of 80–94)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
96	Total Overhead (Sum of 79 and 95)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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SECTION V — COMMENTS

The Comments section is for comments and clarifications. If reporting more than one location, be specific as to which location the comment pertains. If comments are provided in response to a question, be specific as to which question the comment pertains.

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SECTION VI — CERTIFICATION

	I declare that I have examined this cost report including accompanying schedules and to the best of my knowledge and belief, it is true, correct, and complete.
	Name and Signature
	Position / Title

SECTION VII — STATEMENT OF PREPARER (If the preparer is someone other than the provider.)

	I have prepared this cost report and to the best of my knowledge and belief, it is true, correct, and complete.
	Name and Signature
	Position / Title
	Name — Company

PROFESSIONAL DISPENSING FEE SURVEY COMPLETION INSTRUCTIONS

Survey Overview

Purpose of This Survey

The Wisconsin Department of Health Services (DHS) has engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, in conjunction with Hewlett Packard Enterprise, to conduct a survey of Medicaid-enrolled providers to better understand and determine the approximate cost of dispensing prescription drugs to ForwardHealth members in Wisconsin.

Provider participation and timely response is crucial, as the information collected from this survey will be critical data for DHS to better understand the current pharmacy cost of dispensing. Submit any questions about this survey via email to *CODSurvey@mercer.com* or call the pharmacy survey hotline at 844-294-9982.

Who Should Participate

All Wisconsin Medicaid-enrolled providers that have billed covered outpatient drugs in calendar year 2015 are required to participate.

How to Submit Completed Surveys

Surveys may be completed online at *https://survey.mercer.com/2016CODWI.aspx* by June 24, 2016.

A username and password will be mailed to providers separately. Providers may call 844-294-9982 for assistance with the assigned password.

If the provider is unable to submit the survey information online, he or she may access, download and email the completed Microsoft Excel version of the survey to *CODSurvey@mercer.com*.

The survey must be received no later than Friday, June 24, 2016.

Average Professional Dispensing Fee Calculation

The survey is created using Medicare and Medicaid cost principles as defined in 2 CFR 200.400–475, but is governed by the definition of a professional dispensing fee as defined in 42 CFR 447.502:

> Professional dispensing fee means the professional fee which:
> 1. Is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed;

2. Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and
3. Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including systems costs for interfacing with pharmacies.

To calculate the portion of costs allocable to a professional dispensing fee, costs are categorized as direct pharmacy expenses, direct non-pharmacy expenses, indirect costs (overhead), and unallowable costs. Indirect costs are then allocated into direct pharmacy expenses or direct non-pharmacy expenses by either a percentage of square footage (for facility costs) or a percentage of sales (for non-facility costs). The average dispensing fee is calculated as the direct pharmacy expenses plus the allocated indirect expenses divided by the number of scripts.

SECTION I — PHARMACY PROFILE

The purpose of the Pharmacy Profile is to report provider-specific information used for identification and for statistical categorization. Providers that have multiple locations should enter the information for the location that serves as their administrative location.

Element 1 — Wisconsin Medicaid Identification Number

Enter the eight- or nine-digit Wisconsin Medicaid provider number.

Element 2 — National Provider Identifier (NPI)

Enter the National Provider Identifier (NPI) of the Wisconsin Medicaid provider.

Element 3 — Provider Name

Enter the name of the Wisconsin Medicaid provider.

Element 4–8 — Address (Street, City, State, ZIP Code)
Enter the street address, suite or second address (if applicable); address suite or mail stop, city, state, and nine-digit ZIP code where the provider is located. If the four-digit extension of the ZIP code is unknown, enter 0000; do not use dashes or spaces.

Element 9 — County
Enter the county where the provider is located.

Element 10 — Contact Person
Enter the name of the individual to contact if there are any questions about the survey responses.

Element 11 — Contact Person Email
Enter an email address where the contact person may be reached.

Element 12 — Telephone Number
Enter the telephone number, including area code, where the contact person may be reached.

Element 13 — Fax Number
Enter the fax number, including area code, for the contact person.

Element 14 — 340B Program Participation
Indicate whether or not the provider dispenses drugs under the 340B Drug Pricing Program. Drugs dispensed under this program are reduced price outpatient drugs provided by drug manufacturers to eligible health care organizations or covered entities with disproportionately high Medicaid populations.

Element 15 — Type of Ownership
Indicate the type of ownership (e.g., independent, franchise, chain, or other).

Element 16 — Change of Ownership
Indicate whether or not there was a change in pharmacy ownership during the reporting period.

Element 16a — Date of Ownership Change
If there was a change in pharmacy ownership during the reporting period, enter the date of the ownership change (in MM/DD/YYYY format).

Element 17
Indicate whether or not the pharmacy was open the entire year.
Element 17a

If the pharmacy was **not** open the entire year, enter the number of months the pharmacy was open.

Note: For providers that have been open less than 12 months, only complete Elements 1–22. The remainder of the survey should not be completed.

Element 18 — Provider Type

Select the provider type from the following list. If more than one provider type applies, select the type that represents the provider's highest percentage of sales. Hospital pharmacies that also dispense outpatient drugs should choose Outpatient/Clinic Pharmacy:

- **Long-term care (LTC) pharmacy** — A provider that dispenses medicinal preparations delivered to members residing in an intermediate or skilled nursing facility, including facilities for the developmentally disabled, hospices, assisted living facilities, group homes, and other forms of congregate living arrangement.
- **Home infusion pharmacy** — A provider with expertise in sterile drug compounding that provides care to members with acute or chronic conditions pertaining to parenteral administration of drugs, biologics, and nutritional formulae administered through catheters and/or needles in home and alternate sites. (Extensive professional provider services, care coordination, infusion nursing services, supplies, and equipment are provided to optimize effectiveness and compliance.)
- **Family planning clinic** — A clinic that meets the definition of Wis. Admin. Code DHS 105.36, provides services as a function of family planning, and dispenses family planning-related drugs.
- **Narcotic treatment center** — A center that primarily provides narcotic treatment services for opiate addiction as authorized under Wis. Admin. Code DHS 75.15 (which meets Wisconsin Medicaid's Wis. Admin Code DHS 105 requirement) with an NPI of entity Type 2.
- **Federally qualified health center (FQHC)** — An entity that is either designated by the United States Department of Health and Human Services as an FQHC or receives funds under the Indian Self-Determination Act (Public Law 93-638). An FQHC, other than a pharmacy, dispenses medicinal preparations under the supervision of a physician to members for self-administration (e.g., physician offices, emergency rooms, urgent care centers).
- **Compounding pharmacy** — A provider that specializes in the preparation of components into a drug preparation as the result of a practitioner's prescription drug order or initiative based on the practitioner/member/pharmacist's relationship in the course of professional practice, or when a member's need cannot be met by commercially available drugs. (A compounding provider utilizes specialized equipment and specially designed facilities necessary to meet the legal and quality requirements of its scope of compounding practice.)
- **Specialty pharmacy** — A provider who dispenses generally low-volume and high-cost medicinal preparations to members who are undergoing intensive therapies for illnesses that are generally chronic, complex, and potentially life threatening. (Often, these therapies require specialized delivery and administration, but are not previously described.)
- **Clinic/outpatient pharmacy** — A provider in a clinic or hospital outpatient setting who dispenses medications to outpatient members.
- **Independent retail pharmacy** — A provider whose ownership group(s) owns three or fewer locations in which pharmacists store, prepare, and dispense medicinal preparations and/or prescriptions for a local member population in accordance with federal and state law; council members and caregivers (sometimes independent of the dispensing process); and provide other professional services associated with pharmaceutical care, such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes.

- **Retail chain (default)** — A provider whose ownership group(s) owns four or more locations in which pharmacists store, prepare, and dispense medicinal preparations and/or prescriptions for a local member population in accordance with federal and state law; council members and caregivers (sometimes independent of the dispensing process); and provide other professional services associated with pharmaceutical care, such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes.

Element 19

Select the location type of the provider from the following list:

- Medical office building
- Shopping center (stand-alone)
- Grocery store/mass merchandiser
- Hospital outpatient
- Other

Element 20

Indicate the number of years a pharmacy has operated at this location. This information is used in demographic analysis of the data. The response allows Mercer to understand depreciation, or lack of depreciation, for older buildings where market-based rent may need to be substituted if a building is fully depreciated.

Element 21

Indicate whether or not one or more of the pharmacists who fill prescriptions has been an owner of the pharmacy at any time during the reporting period.

Element 22

Enter the number of hours per week the pharmacy department is open. The maximum number of hours is 168 (24 hours times 7 days per week).

Square Footage (Required. Survey responses for this section should use the same time period as reported in the financial information section)

For the purposes of this survey, the prescription area will be defined as the professional service area as defined in Wis. Admin. Code Phar. 6.04 (1) and (2), regardless of whether or not the pharmacist is present. Square footage is used to allocate indirect facility costs such as rent, utilities, and real estate taxes between pharmacy and non-pharmacy expenses.

Element 23

Enter the pharmacy department's square footage as of the end of the reporting period:

a. Prescription area — List the actual square footage of the prescription area. Measure; do not estimate.
b. Non-prescription area — List the actual square footage of the rest of the pharmacy. Measure; do not estimate.
c. Total square footage (Sum of a and b)

Element 24

Indicate whether or not the square footage of the pharmacy department changed during the year:

a. Enter the date that the square footage changed (in MM/DD/YYYY format).

Enter the actual square footage for the following areas **before** the remodel:

Prescription area

Non-prescription area

Total square footage (Sum of b and c)

Prescriptions (Required. Survey responses for this section should use the same time period as reported in the financial information section.)

Element 25

Enter the number of prescriptions filled by this pharmacy for the following categories during the reporting period:

a. Prescriptions provided to Medicaid, BadgerCare Plus, and SeniorCare members
a. Medicare Parts B, C, and D-covered prescriptions (If available)

All other prescriptions (not Medicaid, BadgerCare Plus, SeniorCare or Medicare)

Total prescriptions (Sum of a–c)

Element 26

Enter the number of prescriptions compounded. If none, enter 0.

Element 27

Enter the number of Medicaid, BadgerCare Plus, and SeniorCare prescriptions compounded. If none, enter 0.

Element 28

Enter the number of prescriptions delivered during the reporting period.

Element 29

Enter the number of Medicaid, BadgerCare Plus, and SeniorCare prescriptions delivered to members.

Element 30

Enter the number of prescriptions that were dispensed for LTC pharmacies for each of the following methods:

a. Unit dose

Modified unit dose (Bingo card/blister packs)

No unit dose dispensing

Traditional packaging

Other method not described above (Explain in the Comments section)

Total prescriptions dispensed for LTC facilities (Sum of a–e)

Element 31

Enter the number of prescriptions that were dispensed to all nursing homes and/or assisted living facilities.

SECTION II — 340B DRUG PRICING PROGRAM (340B) PHARMACY INFORMATION

The purpose of the 340B Drug Pricing Program (340B) Pharmacy Information section is to better understand the provider's involvement with the 340B program. Provide the following detail regarding which drugs are prescribed under the 340B program and how those drugs are obtained.

Element 32 — Type of 340B Provider

Enter the type of 340B provider from the following list:

- Black lung clinic
- Children's hospital
- Comprehensive hemophilia treatment center
- Consolidated health center program
- Contract pharmacy
- Critical access hospital
- Disproportionate share hospital
- Family planning
- FQHC look-alike
- HIV/AIDS clinic
- Rural health clinic
- Urban Indian organization
- Other

Element 33 — Covered Entity or Contract

Select whether or not this is a covered entity or contract.

Element 34

Select whether or not the provider purchases drugs through the 340B prime vendor program.

Element 35

Select whether or not the provider uses a 340B administrator.

Element 36

Enter the total number of 340B prescriptions filled during the reporting period.

Element 37

Enter the total number of 340B prescriptions billed to Medicaid, BadgerCare Plus, and SeniorCare.

SECTION III — FINANCIAL INFORMATION — SALES AND DIRECT EXPENSES

Expenses such as administration, central operating, or other general expenses incurred by multiple location pharmacies should be allocated to individual locations. Methods of allocation must be reasonable and conform to generally accepted accounting principles. Explain any allocation procedures used to allocate expenses in the Comments section. Enter the following financial information.

Element 38

Enter the dates of the reporting period. This should be the provider's last complete fiscal year and should correspond to the report dates of your financial statements or tax returns:

a. Beginning date range of financial reports

Ending date range of financial reports

Sales

Percentages of sales in the categories below determine allocation rates for certain administrative costs to the pharmacy department as a cost of dispensing. Enter the following sales information rounded to the nearest dollar.

Element 39

Enter the sales for this location for the following categories:

a. Prescription sales other than over-the-counter sales dispensed by a pharmacist or 340B sales
b. Over-the-counter sales dispensed by pharmacy department
c. Over-the-counter sales dispensed by staff not in pharmacy department
d. Sales of drugs purchased through the 340B program
e. Portion of federal grants attributable to pharmacy, if any
f. Revenue received for Medication Therapy Management (MTM): intervention-based services (Use modifiers U1–U8.)
g. Revenue received for MTM: comprehensive medication reviews (Use modifiers UA and UB.)

h. Other sales such as retail sales and services (If amounts exceed 5.0 percent of total sales, comment on the nature of the other sales and provide more detail.)
i. Total sales (Sum of a–h)

Costs and Expenses

Enter the following costs and expenses information.

Element 40

Cost of goods sold (COGS) is used for reference in validating the provider's responses to his or her financial statements or tax returns, as requested:

a. Cost of goods sold: pharmaceuticals (*Note:* This will not be included in the dispensing fee calculation.)
b. Non-pharmacy COGS
c. Total COGS (Sum of a and b)

Pharmacy Personnel and Labor Costs

Note: Store costs should be categorized into three distinct areas — direct costs related to pharmacy services, direct costs related to non-pharmacy services, and indirect costs related to all product lines. For Elements 42–50, include wages only for direct costs for pharmacy services (pharmacy department).

For Element 41, list pharmacist full-time equivalent (FTE) positions including those who provide MTM services (intervention-based services and/or comprehensive medication reviews) and those who do not provide MTM services.

For Elements 42–50, round to the nearest whole dollar amount:

- For each employee group, list wages, salary, bonuses and guaranteed payments.
- List payroll taxes to reflect the employer's share of payroll tax expense.
- List pension/profit-sharing/retirement expenses to include any employer contributions to profit-sharing, pensions, or retirement accounts.
- List other employee benefits, such as employer's contribution toward health insurance.

Element 41

MTM units:

a. Enter the number of 15-minute units billed to Medicaid for MTM intervention-based services (modifiers U1–U8). For instance, a 60-minute intervention would be entered as 4 (60/15 minutes = 4).

Enter the number of 15-minute units billed to Medicaid for MTM comprehensive medication reviews (modifiers UA and UB).

Enter the number of Pharmacist full-time employees (FTEs) (2,080 hours per year). (*Note:* Pharmacist costs listed in Elements 43 and 44 will be allocated by time to MTM services versus professional dispensing fee services.)

Element 42 — Other Pharmacy Department FTEs
Enter the salaries, wages, and bonuses for employees listed in Elements 43—47. Do not include pharmacists counted in 41c.

For Elements 43–47, enter the sum of salaries, wages, bonuses, and guaranteed payments.

Element 43 — Pharmacist Manager (Owner)

Element 44 — Pharmacist Manager (Non-owner)

Element 45 — Staff Pharmacist

Element 46 — Technician

Element 47 — Non-pharmacist Personnel Working in Pharmacy Department (Allocated)

Element 48 — Pharmacy Department Payroll Taxes

Element 49 — Pharmacy Department Benefits (Including health insurance and pension/profit sharing/retirement expenses)

Element 50 — Prescription Department Payroll
Enter the total prescription department payroll amount. (Sum of 43–49**.)**

Non-pharmacy Personnel
Note: Store costs should be categorized into three distinct areas — direct costs related to pharmacy services, direct costs related to non-pharmacy services, and indirect costs related to all product lines. For Element 51, include wages only for direct costs to non-pharmacy services. For example, retail marketing personnel costs would be considered a direct cost for non-pharmacy services. For Element 52, include indirect personnel costs such as accounting, information technology (IT), legal, or human resources.

Element 51 — Wages, Payroll Taxes, and Benefits for Personnel Directly Attributed to Non-pharmacy Services
Enter wages, payroll taxes, and benefits for personnel directly attributed to non-pharmacy services. This is for personnel who do not provide any services to the pharmacy department but are dedicated to non-pharmacy sales. Do not include wages for administrative personnel (accounting, legal, IT, human resources, corporate).

Element 52 — Wages, Payroll Taxes, and Benefits for Personnel Directly Attributed to Administrative or Shared Services
Enter wages, payroll taxes, and benefits for personnel directly attributed to administrative or shared services.

Element 53 — General Employee Expenses Attributable to All Employee Types
Enter general employee expenses attributable to all employee types.

Element 54 — Non-prescription Department Payroll
Enter non-prescription department payroll. (Sum of 51–53)

Element 55 — Total Payroll Expense
Enter the total payroll expense. (Sum of 50 and 54)

Pharmacy Department Expenditures
Do not include ingredient costs in any of the questions in this section.

Element 56 — Prescription Containers, Labels, and Other Pharmacy Supplies
Enter the costs of the prescription containers, labels, and other pharmacy supplies in whole dollar amounts.

Element 57 — Professional Liability Insurance for Pharmacists
Enter the costs of the professional liability insurance for pharmacists in whole dollar amounts.

Element 58 — Prescription Department Licenses, Permits, and Fees
Enter the costs of the prescription department licenses, permits, and fees in whole dollar amounts.

Element 59 — Dues, Subscriptions, and Continuing Education for the Prescription Department
Enter the costs of the dues, subscriptions, and continuing education for the prescription department in whole dollar amounts.

Element 60 — Delivery Expenses
Enter the costs of prescription-related delivery expenses in whole dollar amounts.

Element 61 — Expenses Related to Compounding Drugs
Enter the costs of the expenses related to compounding drugs, including depreciation on compounding equipment or compounding supply costs, in whole dollar amounts.

Element 62 — Bad Debts for Prescriptions
Enter the costs of any bad debts for prescriptions, including uncollected copayments, in whole dollar amounts.

Element 63 — Computer System Costs Related Only to the Prescription Department

Enter the costs of the computer system costs, not including depreciation, related only to the prescription department in whole dollar amounts.

Element 64 — Depreciation — Directly Related to Pharmacy Department (Including computers, software, and equipment)
Enter the costs of depreciation directly related to the pharmacy department, including computers, software, and equipment, in whole dollar amounts.

Element 65 — Professional Education and Training
Enter the costs of professional education and training in whole dollar amounts.

Element 66 — Inventory Carrying Costs (Including shrinkage due to expiration, theft, or loss inventory)
Enter inventory carrying costs, including shrinkage due to expiration, theft, or lost inventory, in whole dollar amounts.

Element 67 — Costs Directly Attributable to 340B
a. 340B program management
Other (List other costs in the Comments section.)
Enter the costs directly attributable to 340B, including 340B program management or other, in whole dollar amounts. If Other, list in the Comments section of this survey.

Element 68 — Other Prescription Department-Specific Costs Not Identified Elsewhere
Enter other prescription department-specific costs not identified elsewhere in whole dollar amounts. If the amount is greater than 5.0 percent of total prescription department costs (Element 69), attach supporting details in the Comments section.

Element 69 — Total Prescription Department Non-payroll Costs
Enter the total prescription department non-payroll costs in whole dollar amounts. (Sum of 56–68)

SECTION IV — FINANCIAL INFORMATION — OVERHEAD

Facility
Background information is needed to ensure appropriate expenses are captured and to identify potential outliers that require adjustment or exclusion.

Element 70
Indicate whether or not the provider leases or owns the building. If he or she owns the building, answer questions a and b:
a. The cost basis of the building (depreciable amount)

b. The accumulated depreciation of the building

Facility Expenses

Allowable facility expenses are allocated to the pharmacy dispensing fee calculation as a percentage of square footage. Enter, in whole dollar amounts, the costs of the following:

Element 71 — Rent

Enter the cost of rent in whole dollar amounts. If the building is owned by the provider, the rent is $0.

Element 72 — Utilities

Enter the cost of utilities (e.g., gas, electric, water, and sewer) in whole dollar amounts.

Element 73 — Real Estate Taxes

Enter the cost of real estate taxes in whole dollar amounts.

Element 74 — Facility Insurance

Enter the cost of facility insurance in whole dollar amounts.

Element 75 — Maintenance and Cleaning

Enter the cost of maintenance and cleaning in whole dollar amounts.

Element 76 — Depreciation Expense

Enter the cost of depreciation expenses (e.g., building, leasehold improvements, furniture, and fixtures) in whole dollar amounts.

Element 77 — Mortgage Interest

Enter the mortgage interest in whole dollar amounts.

Element 78 — Other Facility-Specific Costs Not Identified Elsewhere

Enter the other facility-specific costs not identified elsewhere in whole dollar amounts. If the amount is greater than 5.0 percent of total facility cost (Element 79), attach supporting details in the Comments section of this survey.

Element 79 — Total Facility Costs

Enter the total facility costs. (Sum of 71–78)

Other Store/Location Expenses

Allowable other store/location expenses are allocated to the pharmacy dispensing fee calculation as a percentage of sales.

Element 80 — Marketing and Advertising
Enter the marketing and advertising costs in whole dollar amounts.

Element 81 — Professional Services
Enter the cost for professional services (e.g., accounting, legal, consulting) in whole dollar amounts.

Element 82 — Telephone and Data Communication
Enter the costs for telephone and data communication in whole dollar amounts.

Element 83 — Transaction Fees/Merchant Fees/Credit Card Fees
Enter the costs for transaction, merchant, and credit card fees in whole dollar amounts.

Element 84 — Computer Systems and Support
Enter the costs for computer systems and support in whole dollar amounts.

Element 85 — Depreciation
Enter the costs for depreciation for all other items, including equipment, furniture, and computers, in whole dollar amounts.

Element 86 — Amortization
Enter the costs for amortization in whole dollar amounts.

Element 87 — Office Supplies
Enter the costs for office supplies in whole dollar amounts.

Element 88 — Other Insurance
Enter the costs for other insurance in whole dollar amounts.

Element 89 — Taxes Other Than Real Estate, Payroll, or Sales
Enter the costs for any taxes other than real estate, payroll, or sales in whole dollar amounts.

Element 90 — Franchise Fees (If Applicable)
Enter the costs for franchise fees, if applicable, in whole dollar amounts.

Element 91 — Other Interest
Enter the costs for other interest in whole dollar amounts.

Element 92 — Charitable Contributions
Enter the amount of charitable contributions for the report period in whole dollar amounts.

Element 93 — Corporate Overhead
Enter the costs of corporate overhead in whole dollar amounts.

Element 94 — Other Costs Not Included Elsewhere
Enter any other costs not include elsewhere in whole dollar amounts. If the amount is greater than 5.0 percent of total other store/location costs (Element 95), attach supporting details in the Comments section.

Element 95 — Total Other Store/Location Costs
Enter the total other store/location costs (Sum of 80–94)

Element 96 — Total Overhead
Enter the total overhead, which is the sum of Elements 79 and 95.

SECTION V — COMMENTS

The Comments section is for comments and clarifications. If reporting more than one location, be specific as to which location the comment pertains. If comments are provided in response to a question, be specific as to which question the comment pertains.

Although providers spend time providing value-added services, few providers track the time spent providing such services. Respondents are encouraged to provide information about value-added services and identify time spent on value-added services in this section.

SECTION VI — CERTIFICATION

The Certification section requires the signature of a certifier declaring that he or she has thoroughly examined the survey and cost report and believes the information is true, correct, and complete. Printed name and position/title are also required of the certifier.

This section also requires a statement of the preparer if the preparer of the survey and cost report is different than the provider listed on the survey. The preparer’s signature, printed name, position/title, and company name is required in this section.

APPENDIX C

Sample Letters

Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY
1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711 or 800-947-3529

May 27, 2016

«Provider_Name», Attn: «Contact_Person»
«Address1», «Address2»
«City», «State», «Zip»

Dear Provider:

On January 21, 2016, the Centers for Medicare and Medicaid Services (CMS) published the federal Covered Outpatient Drugs Final Rule (CMS-2345-FC) to address the rise in prescription drug costs by ensuring that Medicaid programs reform payment methodologies for prescription drugs and to ensure drug rebates accurately account for market prices.

The regulation requires state Medicaid programs to reimburse drugs at the actual acquisition cost plus a professional dispensing fee by April 1, 2017.

The Wisconsin Department of Health Services (DHS) has contracted with a company, Mercer, to conduct a professional cost of dispensing survey in order to obtain information on the costs associated with dispensing covered outpatient drugs to ForwardHealth members.

The data collected will be used to determine the professional dispensing fee. Therefore, all Wisconsin Medicaid-enrolled pharmacies and providers who dispense drugs **are required to participate** in the survey process. The Professional Dispensing Fee Survey will be available beginning **June 1, 2016**, and must be submitted **by June 24, 2016.**

Providers may choose to complete the Professional Dispensing Fee Survey via the web-based tool or the Excel template. The web-based tool is secure and will require a username and password. You can access the web-based survey at https://survey.mercer.com/WI2016CODS.aspx using the following log in information:

- Your log in username is: «**Username**»
- Your randomly generated password is: «**Password**»

For password related questions or if you forget your password, email CODSurvey@mercer.com or call the pharmacy survey hotline at 844-294-9982.

If you prefer not to enter your survey information online, you can download a copy of the survey in Microsoft® Excel from the ForwardHealth Portal page listed below. You may also request a copy of the Microsoft® Excel template by emailing CODSurvey@mercer.com. Completed Excel surveys should be emailed back to CODSurvey@mercer.com.

dhs.wisconsin.gov

The Department of Health Services and Mercer will be hosting a technical webinar from 9:30 a.m. to 10:30 a.m. on June 9, 2016, to assist providers with navigating the survey and to answer any questions from providers.

To participate in the technical webinar online, go to https://mmc.webex.com/mmc/onstage/g.php?MTID=e2604580a11e1c0b4bcb10b90dbfe6f04. The webinar does not require a passcode. Providers who plan to attend online are encouraged to click the Register button at the bottom of the page and supply their name, email address, and the name of their company.

To participate in the technical webinar by telephone:

- Call 844-401-0574.
- Enter conference identification number: 15937242.

Providers who are unable to attend the technical call will be able to access the recorded session on the Covered Outpatient Drug Pricing page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/pharmacy/codp/codp.htm.spage. The recorded technical call will be available on the Portal by June 13, 2016.

All information collected through this survey will remain confidential. Neither DHS nor Mercer will release or otherwise make public any information that names and/or discloses the business, financial, personnel, or other information provided by providers in the course of completing this survey.

Providers with questions regarding the survey process are encouraged to contact Mercer via the pharmacy survey hotline at 844-294-9982 or by email at CODSurvey@mercer.com.

Refer to the Covered Outpatient Drug Pricing page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/pharmacy/codp/codp.htm.spage for more information on the Covered Outpatient Drugs Final Rule as well as other outpatient drug rule information. Providers are encouraged to check this page regularly for updated information. Additionally, providers are encouraged to go to the ForwardHealth Subscriptions page of the Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Subscriptions.aspx and sign up for the Outpatient Drug Rule email subscription option in order to receive important updates.

Thank you for your participation.

Sincerely,

Rachel Currans-Henry
Director, Bureau of Benefits Management

Mercer (US) Inc.
333 South 7th Street, Suite 1400
Minneapolis, MN 55402
+1 612 642 8600