Purpose of This Survey
The Ohio Department of Medicaid (ODM) has engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct a survey of Medicaid-enrolled outpatient pharmacy providers to better understand and determine the approximate cost of dispensing prescription drugs to Medicaid beneficiaries.

Provider participation and timely response is crucial, as the information collected from this survey will be critical data for the ODM to better understand the current pharmacy cost of dispensing. Submit any questions about this survey via email to RxPDFS@Mercer.com or call the pharmacy survey hotline at 1 (877) 854-6776.

Please complete this survey for each Ohio Medicaid participating pharmacy location in your company. If you would prefer to complete the survey on an Excel template rather than using this online tool, the template can be found at the survey website for this project here: https://ghscapps.mercer.com/ohpharmacy/

1. *Enter your pharmacy’s National Provider Identifier (NPI).
   Enter the National Provider Identifier (NPI) of the Ohio Medicaid provider.
   The NPI should be 10 digits long.

2. *Enter the name of your pharmacy.
   Enter the name of the Ohio Medicaid provider

3. *Enter the street address of the provider.

4. Enter the provider address suite or mail stop.

5. *Enter the city where the pharmacy is located.


7. *Enter your pharmacy’s zip code.
   Enter the nine-digit ZIP code where the provider is located. If the four-digit extension of the ZIP code is unknown, enter the five-digit ZIP code.

8. Enter the county where the pharmacy is located.

9. *Enter the name of your pharmacy’s contact person for this survey.
10. *Enter an email address for the contact person at your pharmacy.

11. *Enter the telephone number, including area code, where the contact person may be reached.

12. Enter the fax number, including area code, for the contact person.

13. *Does your pharmacy dispense 340B drugs?
   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.
   - Yes
   - No

14. *Choose the ownership type of your pharmacy.
   Indicate the type of ownership (e.g., independent, franchise, chain, or other).
   Select:

15. Was there a change in pharmacy ownership during the reporting period?
   Note: The reporting period is the period covered by your most recently completed fiscal year. If your fiscal year is a calendar year, then the reporting period would be from 1/1/2015 to 12/31/2015.
   - Yes
   - No

16. Please list the date of the ownership change (mm/dd/yyyy).

17. *Was the pharmacy open the entire year?
   If the pharmacy was open all 12 months of the reporting year, click Yes. If not, click No.
   - Yes
   - No

18. *Please enter the number of months the pharmacy was open.

19. *Please select your pharmacy type
   If you qualify for more than one, please select the type with the highest percentage of sales. See instructions for pharmacy type definitions.
   Select:

20. *Please select the location of this pharmacy.
   Select:
21. *How many years has this location been open as a pharmacy?*
   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.

   

22. *Is one or more of the pharmacists who fill prescriptions at this location also an owner of the store or chain?*
   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.

   ○ Yes
   ○ No

23. *How many hours per week is the pharmacy department open?*
   The maximum number of hours is 168 (24 hours times 7 days per week).

   


24. *At the end of the reporting period, what was the square footage of the prescription area?*
   The prescription area will be defined as the medication receiving, storage, preparation, packaging, sales, and professional service areas, regardless of whether or not the pharmacist is present.

25. At the end of the reporting period, what was the square footage of the non-prescription area?

26. At the end of the reporting period, what was the total square footage (prescription area + non-prescription area)?
27. *What was the number of Medicaid-covered prescriptions filled by this pharmacy in the reporting period?*

Prescriptions provided to Medicaid members

Note: The reporting period is the most recently completed fiscal year and should correspond to the same time frame as your financial statements or tax returns.

28. *What was the number of Medicare-covered prescriptions filled by this pharmacy in the reporting period (if available)?*

Medicare Parts B, C, and D-covered prescriptions (If available)

29. What was the number of all other prescriptions filled in the reporting period?

All other prescriptions (not Medicaid or Medicare)

30. What was the total number of all prescriptions filled in the reporting period (Medicaid, Medicare, & All Other)?

31. *How many prescriptions were compounded?*

If none, enter 0.

32. *How many Medicaid prescriptions were compounded?*

33. How many prescriptions were delivered to the recipient? Do not include mail order.

34. *How many Medicaid prescriptions were delivered to the recipient?*

35. Enter the radius of the delivery area for Medicaid prescriptions in miles.

For the following questions, enter the number of prescriptions that were dispensed to residents of Long Term Care facilities.

36. Unit dose:

37. Modified unit dose (bingo card/blister packs)
38. **No unit dosing**

39. **Traditional packaging**

40. **Other method not previously described (please explain in comments section)**

41. **How many prescriptions were dispensed to nursing homes and/or assisted living facilities?**

   Sum of Unit Dose, Modified Unit Dose, No Unit Dose, Traditional, and Other packaging categories.
42. What type of 340B pharmacy are you?

Select:

43. Is your pharmacy a 340B covered entity or contract pharmacy?

Select:

44. Do you purchase drugs through the 340B prime vendor program?

- Yes
- No

45. Do you use a 340B administrator?

- Yes
- No

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

47. List the total number of 340B prescriptions billed to Medicaid.

Enter the total number of 340B prescriptions billed to Medicaid.
Enter the number of Specialty prescriptions dispensed in the following categories:

48. *Home Infusion & Sterile Compounding

49. *Blood Factor

50. *All Other Specialty

51. *Total Specialty Scripts
   Sum of Home Infusion, Blood Factor, Sterile Compounding, and all other Specialty.

Enter the Specialty revenue for each category (sales dollars received for Specialty drugs).

52. *Home Infusion & Sterile Compounding

53. *Blood Factor

54. *All Other Specialty

55. *Total Specialty Revenue
   Sum of Home Infusion, Blood Factor, Sterile Compounding, and all other Specialty.
56. Mercer gives you the option of completing the financial questions or uploading your most recent tax return. Would you like to upload your tax return?

- Yes
- No

57. *Click to upload your tax return

Select file to upload...

Allowed file type(s): .csv, .doc, .docx, .gif, .jpeg, .jpg, .pdf, .txt, .xls, .xlsx
58. *Please enter beginning date range of financial reports.*
   This is the beginning date of the reporting period.

59. *Please enter the ending date range of financial reports.*
   This is the ending date of the reporting period.

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.

60. *What were your prescription sales other than 340B (not including over-the-counter (OTC) sales)?

61. *What were the OTC sales (dispensed by pharmacy department)?

62. What were the OTC sales (not dispensed by the pharmacy department)?

63. *What were the sales of drugs purchased through the 340B program?

64. *What portion of federal grants, if any, are attributable to pharmacy?

65. What were the sales from professional pharmacy services billed through medical (non-pharmacy) claims?

66. List the amount of other sales (e.g., services). If greater than 5% of total sales, please explain the nature of the revenue in the comments section.
67. Enter cost of goods sold (COGS) for all pharmaceuticals. (Note - this will not be included in the dispensing fee calculation).
   This amount will be used for validation purposes only.

68. Enter all non-pharmacy cost of goods sold (COGS).

69. Total COGS

70. *List the number of pharmacist full-time equivalents (FTEs).
   A full time equivalent works 2080 hours per year.

71. *List the amount of other pharmacy department FTEs.

72. *List salary, wage and bonus for pharmacist manager (owner).

73. List salary, wage and bonus for pharmacist manager (non-owner).

74. *List salary, wage and bonus for staff pharmacists.

75. List salary, wage and bonus for technicians.

76. *List salary, wage and bonus for other unlicensed personnel working in pharmacy department.

77. *What are the pharmacy department’s payroll taxes?

78. *What are the pharmacy department's benefits expenses, including health insurance, pensions, profit sharing and retirement?

Non-pharmacy Personnel:
79. List wages, payroll taxes and benefits expenses for personnel that are directly attributed to non-pharmacy services.
   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.

80. *List wages, payroll taxes and benefits expenses for personnel that are directly attributed to administrative or shared services.
   Include indirect personnel costs such as accounting, information technology (IT), legal, or human resources.

81. List general employee expenses attributable to all employee types not included elsewhere.
Pharmacy Department Expenditures
Do not include ingredient costs in any of the questions in this section.

82. *List pharmacy department expenditures for prescription containers, labels, and other pharmacy supplies.

83. *List pharmacy department expenditures for professional liability insurance for licensed personnel.

84. *List pharmacy department expenditures for prescription department licenses, permits and fees.

85. *List pharmacy department expenditures for dues, subscriptions, and continuing education.

86. *List pharmacy department expenditures for prescription related delivery expenses.

87. List expenses for compounding, including depreciation for compounding equipment.

88. *List pharmacy department expenditures for bad debts for prescriptions (including uncollected copayments).

89. *List pharmacy department expenditures for computer systems costs related only to the prescription department (not including depreciation).

90. *List pharmacy department expenditures for depreciation - directly related to pharmacy department, including computers, software, and equipment.

91. *List pharmacy department expenditures for professional education and training.

92. *List inventory carrying costs, including shrinkage due to expiration, theft, or loss inventory.
94. *List pharmacy department expenditures for other costs directly attributable to 340B (Please list in comments section).

95. *List pharmacy department expenditures for other prescription department-specific costs not identified elsewhere (if greater than 5% of the total prescription department costs). Please explain in the comments section.
Facility Costs
Background information is needed to ensure appropriate expenses are captured and to identify potential outliers that require adjustment or exclusion. Most facility costs are allocated to the costs of dispensing by percentage of square footage.

96. *Do you own the building?
   - Yes
   - No

97. *What is the building cost basis (depreciable amount)?

98. *How much depreciation has your building accumulated?

99. *What are your rent expenses?
   If you own the building, please explain any rent expenses in the comments section.

100. *What are your utilities expenses (gas, electric, water and sewer)?

101. List the amount of your real estate taxes.

102. List the amount of facility insurance expenses.

103. List the amount of the maintenance and cleaning expenses.

104. List the amount of the depreciation expenses for the building, leasehold improvements, furniture and fixtures.

105. List the amount of the mortgage interest expenses.

Other Store/Location Expenses
Allowable other store/location expenses are allocated to the pharmacy dispensing fee calculation as a percentage of sales. Do not include payroll expenses previously reported.
106. List the amount of the marketing and advertising expenses.

107. List the amount of professional expenses (e.g., accounting, legal, consulting).

108. List the amount of security expenses
   Enter the costs for security systems and monitoring.

109. List the amount of telephone and data communication expenses.

110. List the amount of transaction, merchant and credit card fee expenses.

111. List the amount of computer systems and support expenses.
   Do not include costs reported previously as pharmacy department computer system costs.

112. List the amount of depreciation expenses (all other - including non-pharmacy equipment and computers).
   Do not include depreciation previously reported.

113. List the amount of amortization expenses.

114. List the amount of office supply expenses.

115. List the amount of other insurance expenses.

116. List the amount of tax expenses (other than real estate, payroll and sales).

117. List the amount of franchise fees (if applicable).

118. List the amount of other interest expenses.
   Do not include mortgage interest previously reported.

119. List the amount of charitable contributions.
120. List corporate overhead.

121. List the amount of other costs not included elsewhere (if greater than 5% of the total other store/location costs, please explain in the comments section).

122. *What are the total net sales on your financial statements for this location?*

123. *What are the payroll expenses from your financial statements (wages, benefits, and payroll taxes)?*

124. *What are the total expenses on your financial statements, including payroll, pharmacy expenses, facility costs and other overhead? Do not include cost of goods sold.*
125. Enter any comments or clarification to any previous questions here. Please clearly identify the topic for which you are entering comments or clarification.
126. **Survey 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.

For your electronic signature please enter your name.

127. **Position**

Please enter your position/title.

You have answered all of the questions. Please click Finish below to complete the survey.
Thank you for taking the survey.

(User Survey Response)

To complete the survey for another location, please click this link to re-start the survey again, using the same username and password.

Repeat Survey for Another Location

If you have any questions about the survey process, please email us at RxPDFS@mercer.com.

Thank you for completing the survey!