Minnesota Department of **Human Services**

07 - 0183

February 1, 2007

Patrick E. Flahaven
Secretary of the Senate
231 Capitol
St. Paul, MN 55155

Dear Mr. Flahaven:

The enclosed report is in fulfillment of the Department's obligations under Laws of Minnesota, 2006, Chapter 282, article 16, section 15, subdivision 6. That law requires the Department to:

- convene a pharmacy reform advisory committee, and to report the findings of the advisory committee to the Minnesota Legislature.
- conduct a study to determine the average cost of dispensing Medicaid prescriptions and report the results of that study to the Legislature; and
- make recommendations to the Legislature regarding Medicaid reimbursement rates for prescription medications.

The findings of the advisory committee were sent under separate cover.

I have enclosed the results of the study regarding the cost of dispensing prescriptions, and my recommendations regarding Medicaid reimbursement rates for prescription medications.

In accordance with the requirements of Minnesota Statutes, we are sending six copies of the report to the Legislative Reference Library.

Sincerely,

Cal R. Ludeman

Cal R. Ludeman
Commissioner

Enclosure

Minnesota Department of
Human Services

Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Pharmacy Reimbursement

Laws of Minnesota 2006
Chapter 282, article 16, section 15, subdivision 6

Report to the Legislature
February 2007

DHS-4357-ENG (1/05)

Pharmacy Reimbursement

Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Report preparation	$75,000 for study
	$ 1,000 for report

Alternative formats or Additional copies

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This report is in fulfillment of the Department's obligations under Laws of Minnesota, 2006, Chapter 282, article 16, section 15, subd. 6. The law requires the Commissioner of Human Services to make recommendations to the 2007 Legislature regarding how to adequately adjust reimbursement rates to pharmacies to cover the costs of dispensing and additional costs to pharmacies. The law requires the recommendations to include:

- The current level of dispensing fees paid to providers for dispensing Medicaid prescription drugs

- An estimate of revenues required to adequately adjust reimbursement to cover the cost to pharmacies for dispensing Medicaid prescription drugs to ensure that:

    1. Reimbursement is sufficient to enlist an adequate number of participating pharmacy providers so that pharmacy services are as available for Medicaid recipients under the program as for the state's general population;

    2. Medicaid dispensing fees are adequate to reimburse pharmacy providers for the costs of dispensing prescriptions under the Medicaid program;

    3. Medicaid pharmacy reimbursement for multiple-source drugs included on the federal upper reimbursement limit is set at the level established by the federal government under the federal law governing the Medicaid program; and

    4. The new payment system does not create disincentives for pharmacist to dispense generic drugs.

Dispensing Fee

Minnesota's current dispensing fee is $3.65 per prescription. The Department engaged the consulting firm of Myers and Stauffer to measure the average cost to fill a Medicaid prescription in Minnesota. Myers and Stauffer surveyed pharmacies in Minnesota, and concluded that the statewide average cost of dispensing, weighted by Medicaid volume, was $9.59 per prescription. Myers and Stauffer also noted that there are several factors that should be considered in determining an appropriate Medicaid pharmacy reimbursement formula besides dispensing costs incurred by pharmacies. The report advises that "these factors include drug acquisition costs and market dynamics (e.g. the rates accepted from commercial third-party payers) balanced with the need to maintain sufficient access to services for Medicaid recipients throughout the state." The report also notes that any overall evaluation of the adequacy of pharmacy reimbursement rates should also consider the dispensing cost in tandem with an analysis of ingredient reimbursement and the cost pharmacies incur to acquire the medications. Myers and Stauffer estimates that pharmacies realize positive net margins in the rate of $11 to $15 per prescriptions on single-source drugs and drugs not subject to the state maximum

allowable limit, and a lower positive margin for multiple-source drugs subject to the state maximum allowable limit.

The Governor's budget proposal does not recommend any change to the pharmacy dispensing fee at this time.

Overall Pharmacy Reimbursement

The Deficit Reduction Act of 2005 (DRA) modified the federal upper limit (FUL) for multiple source drugs. The DRA changes the maximum price Medicaid pays from 150 percent of the lowest published price (usually the wholesale acquisition cost) for a drug to 250 percent of the lowest average manufacturer price (AMP). The revised limit was to take effect January 1, 2007. At the time the 2006 Legislature asked for the study and recommendations, it was expected that the new federal upper payment limits (FUL), as modified by the Deficit Reduction Act of 2005, would be known in time for this report. For a number of reasons related to the CMS' ability to collect data from manufacturers and to adopt regulations, AMP for these drugs and therefore the FUL based on AMP will not be known until at least late spring of 2007. Until the AMP data and upper limits are known, we cannot evaluate whether the current profit margins for multiple source drugs will be affected.

The Governor's budget proposal does not recommend any changes to the component of the Medicaid Assistance payment rates relating to ingredient cost.

Survey of the Average Cost of Filling a Medicaid Prescription in the State of Minnesota

Prepared for the

Minnesota Department of Human Services

December 2006

Myers and Stauffer LC

Certified Public Accountants

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EXHIBITS

I. Executive Summary

Introduction

The Minnesota Department of Human Services (Department) is required by Minnesota Statute 282.16.15 to perform a study to measure the average cost to fill a Medicaid prescription in the state of Minnesota. Under contract to the Department, Myers and Stauffer performed a study of the cost of dispensing prescription medications to Medicaid recipients in the state of Minnesota. The dispensing cost study used a proven cost survey instrument similar to one used by Myers and Stauffer in Medicaid pharmacy engagements in several other states.

There were 1,244 pharmacy providers enrolled in the Medicaid program with paid claims between January 1, 2006 and June 30, 2006. Of these providers, 1,078 were located in the state of Minnesota. All 1,078 of these in-state pharmacies were requested to submit survey information for this study. Myers and Stauffer performed desk review procedures to test completeness and accuracy for all dispensing cost surveys submitted. There were 515 pharmacies that filed cost surveys that could be included in this analysis.[1] Data from these surveys was used to calculate the average cost of dispensing at each pharmacy and results from these pharmacies were tabulated and subjected to statistical analysis.

Myers and Stauffer also compared the pharmacy dispensing fee of the Minnesota Medicaid program to the dispensing fees of other state Medicaid programs. Additionally, Myers and Stauffer has provided some general comments relating to the reimbursement rates paid by private drug plans.

Summary of Findings

The significant findings of the study are as follows:

<u>Dispensing Cost</u>

- **Per the survey of pharmacy dispensing cost for pharmacies participating in the Minnesota Medicaid program, the statewide average (mean) cost of dispensing, weighted by Medicaid volume, was $9.59 per prescription.** This figure excludes 13 specialty

[1] Some pharmacies submitted surveys that were incomplete or contained data errors that precluded their use in this study. As time permitted, pharmacies that submitted incomplete or erroneous survey information were contacted for clarification. However, not all pharmacies responded to these requests for additional information, and those surveys were not included in the final analysis.

pharmacies which exhibited a significantly different cost structure.

Table 1.1 Dispensing Cost [A, B] for Minnesota Pharmacies

Pharmacies Included in Analysis[C]	502
Unweighted Average (Mean)	$11.25
Weighted Average (Mean)[D]	$9.59
Unweighted Median	$9.61
Weighted Median[D]	$9.22

[A] Inflated to common point of June 30, 2006 (midpoint of a fiscal year ending December 31, 2006).
[B] Excludes any allowance associated with the wholesale drug distributor tax.
[C] Excludes 13 specialty pharmacies, which for purposes of this report are those pharmacies where intravenous, infusion or other specialty products constituted the majority of their prescription volume.
[D] Weighted by Medicaid volume.

Comparison of Pharmacy Reimbursement Rates

State Medicaid agencies use a wide variety of reimbursement rates in their pharmacy programs. Pharmacy dispensing fees in these programs range from under $2 to over $11. At $3.65, the dispensing fee for Minnesota Medicaid falls at approximately the 20th percentile of all state Medicaid dispensing fees. Ingredient reimbursement for brand name drug products ranges from a low of the Average Wholesale Price (AWP) minus 17% to a high of AWP minus 5%. At AWP minus 12%, the ingredient reimbursement for brand name drug products under Minnesota Medicaid falls at approximately the 72nd percentile of all state Medicaid ingredient reimbursement rates for brand name drug products.

Private third party payers generally reimburse for dispensing fees and drug ingredients at rates less than those paid by Minnesota Medicaid. On average, dispensing fees paid by private third party payers are less than the dispensing cost of most pharmacies, with one national study reporting average dispensing fees of less than $2 in 2005.[2]

Conclusions

There are several factors that should be considered in determining an appropriate Medicaid pharmacy reimbursement formula besides dispensing costs incurred by pharmacies. These factors include drug acquisition costs and market dynamics (e.g., the rates accepted from commercial third-party payers) balanced with the

[2] See *The Prescription Drug Benefit Cost and Plan Design Survey Report*, 2006 Edition, Pharmacy Benefits Management Institute, Inc. and Takeda Pharmaceuticals North America, Inc.

need to maintain sufficient access to services for Medicaid recipients throughout the state.

An overall evaluation of the adequacy of current pharmacy reimbursement rates should consider findings related to dispensing cost in tandem with an analysis of ingredient reimbursement rates and the cost pharmacies incur to acquire prescription medications. The Department's current pharmacy dispensing fee is lower than the average cost of dispensing prescriptions. However, on the average, Myers and Stauffer estimates that pharmacies realize positive net margins on Medicaid prescriptions due to margins on drug ingredient cost. Based on Myers and Stauffer's experience with drug acquisition cost and Minnesota's current reimbursement for drug ingredients, single-source drugs and multi-source drugs without a Federal Upper Limit (FUL) price or State Maximum Allowable Cost (SMAC) price may have average margins on drug ingredient cost approximately in the range of $11 to $15 per prescription. These margins potentially offset all or part of the difference between the Medicaid dispensing fee and the average dispensing cost. Margins on drug ingredient cost for drugs with an FUL or SMAC price are estimated to be lower but remain a significant factor in the margins realized on Medicaid prescriptions.

It is anticipated that margins on drug ingredient cost will be impacted by forthcoming changes in FUL prices. These changes, as required by the Deficit Reduction Act of 2005 (DRA), will reflect a calculation of FUL prices based on the "average manufacturer price" (AMP). [3]

Based on the results of the study of pharmacy dispensing cost, a dispensing fee of $9.59 would reimburse the average cost of dispensing prescriptions to Medicaid recipients. Alternately, a dispensing fee of $9.22 would reimburse the weighted median cost of dispensing. Consideration of dispensing fees less than average dispensing cost may also be reasonable due to margins realized on current levels of ingredient reimbursement.

Several alternatives for changes to dispensing fee reimbursement could be considered by the Department. Currently, the pharmacy provider community seems to be primarily concerned with equitable reimbursement for products subject to an FUL price. Although actual price revisions have not yet been made available, it is widely anticipated that FUL prices will be reduced based on provisions of the DRA. Given this concern among pharmacy stakeholders, one possible reimbursement structure would be to allow for an increased dispensing fee for products with an FUL price. Alternately, the class of products to receive an increased dispensing fee may be more broadly defined to include additional multi-source drug products such as products with either an FUL or a SMAC price

[3] See Public Law 109-171, Section 6001(a)(2).

or all "generic" drug products (though the term "generic" would require a more precise operational definition for implementation).

In addition to any changes proposed to the dispensing fee, Myers and Stauffer recommends that the Department continue to monitor and review its ingredient cost allowance. Potential modifications to reimbursement policies should consider both dispensing and ingredient aspects of reimbursement. Considerations of ingredient reimbursement should take into account the impact of the wholesale drug distributor tax.

II. Program Overview

Minnesota Medicaid Pharmacy Program Overview

The Minnesota Medicaid program includes a benefit for prescription drugs. The two primary components for Medicaid reimbursement of pharmaceuticals are the allowable drug ingredient reimbursement, plus a dispensing fee. The dispensing, or professional, fee is paid to pharmacies to cover their overhead and labor costs. Guidelines from the Centers for Medicare and Medicaid Services (CMS) on state Medicaid pharmacy dispensing fees include federal regulations at 42 CFR 447.331-333 that require states to establish a reasonable dispensing fee and to document their pharmacy reimbursement methodology in their state plan.

In accordance with MR 9505.0340, the Minnesota Medicaid program reimburses pharmacy providers for most covered prescription drugs at the lowest of the following:

1. The maximum allowable cost for a drug established by the Department of Human Services or CMS (i.e., the Federal Upper Limit or FUL) plus a dispensing fee.
2. The actual acquisition cost for a drug plus a dispensing fee.
3. The pharmacy's usual and customary charge.

"Actual acquisition cost" is defined by MR 9505.0340(1)(A) to be "the cost to the provider including quantity and other special discounts except time and cash discounts." The Department uses the lesser of the published Average Wholesale Price (AWP) minus 12% or the State Maximum Allowable Cost (SMAC) to estimate acquisition cost.

The dispensing fee is $3.65.

In accordance with MS 256B.0625, the Department uses alternate reimbursement methodologies for specialty pharmaceutical products (see Exhibit 1).

Program Utilization

Myers and Stauffer received a pharmacy provider file from the Department. This file included all pharmacies receiving reimbursement during the time period of January 1, 2006 to June 30, 2006.

Based on the information in the provider file, for the six month time period of data summarized, the Minnesota Medicaid pharmacy program reimbursed:

- Approximately 1.8 million prescriptions.
- Approximately $122.2 million for prescription drug products.

Based on the data in the provider file, approximately 1,244 pharmacy providers participate in the Minnesota Medicaid drug program. Of these 1,078 pharmacies are located in the state of Minnesota.

Approximately 64% of the in-state pharmacies in the provider file were chain-affiliated, and 36% were independently-owned stores. Chain pharmacies were responsible for approximately 57% of the Medicaid volume (in-state pharmacies only).

The average Medicaid volume for in-state pharmacies was approximately 1,654 prescriptions (for a six month time period). The median Medicaid volume for in-state pharmacies was approximately 870 prescriptions.

Myers and Stauffer obtained a drug utilization summary file for Minnesota Medicaid from the CMS web site.[4] This file summarized pharmacy claims processed for calendar year 2005.[5] Information from this file indicates that the Minnesota Medicaid pharmacy program reimbursed:

- Approximately 15,742 drug products (by NDC).
- Approximately 5.8 million prescriptions.
- Approximately $440.1 million for prescription drug products.

Although approximately 37.6% of the 15,742 drug products and 40% of the 5.8 million prescriptions were products with an FUL price, these products account for only 8.9% ($39.0 million) of the expenditures. The majority of the program's expenditures, 91.1% ($401.1 million), were for drugs without an FUL price. This includes single source (i.e., "brand name") drug products as well as multi-source products without an FUL that may have a SMAC price set by the Department.

FUL prices are set by CMS. Through December 2006, FUL prices were based on 150% of the lowest wholesale price listed in any of the various published compendia of cost information of drugs.

Recent changes enacted by the Deficit Reduction Act of 2005 (DRA) will change the methodology of calculating FUL prices. Per the DRA, beginning January 1, 2007, FUL prices will be based on 250% of the "average manufacturer price"

[4] See http://www.cms.hhs.gov/MedicaidDrugRebateProgram/SDUD/list.asp

[5] Substantial differences in the prescription volume of the Minnesota Pharmacy program between the CMS file for calendar year 2005 and the provider file for 1/1/2006 to 6/30/2006 can be partially attributed to the introduction of the Medicare Part D prescription benefit on January 1, 2006 and the subsequent removal of Medicaid prescription volume for dual-eligible beneficiaries.

(AMP).[6] The AMP was previously defined by Section 1927 of the Social Security Act as part of the Medicaid drug rebate program. Significant concern has existed among stakeholders in the pharmacy industry regarding the precise manner in which CMS will calculate FUL prices under the new statutory guidelines.[7] To date, specific regulations relating to FUL prices or revised FUL prices have not been made publicly available.

Table 2.1 Summary of Drug Program Utilization

Product Type	Number of Drug Products	Percent of Total Number of Drug Products	Number of Prescriptions	Percent of Total Number of Prescriptions	Amount Reimbursed	Percent of Program Expenditures
Products without an FUL Price	9,825	62.4%	3.44 Million	59.7%	$401.1 Million	91.1%
Products with an FUL Price	5,917	37.6%	2.32 Million	40.3%	$39.0 Million	8.9%
Total: All Products	**15,742**	**100%**	**5.76 Million**	**100%**	**$440.1 Million**	**100%**

Note: Existence of a FUL price for a product is based upon January 2006 prices. Utilization figures were obtained from the Centers for Medicare and Medicaid Services and are for calendar year 2005.

[6] See Public Law 109-171, Section 6001(a)(2).

[7] See, for example, Office of the Inspector General report A-06-06-00063, "Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005", May 2006.

III. Dispensing Cost Survey

The Minnesota Department of Human Services (Department) is required by Minnesota Statute 282.16.15 to perform a study to measure the average cost to fill a Medicaid prescription in the state of Minnesota. In order to determine costs incurred to dispense pharmaceuticals to Medicaid recipients in the state of Minnesota, Myers and Stauffer utilized a survey method consistent with the methodology of previous surveys conducted by Myers and Stauffer in several states.

Methodology of the Dispensing Cost Survey

Survey Distribution

Myers and Stauffer obtained from the Department a list of pharmacy providers currently enrolled in the Medicaid program. There were 1,244 pharmacy providers enrolled in the Medicaid program with paid claims between January 1, 2006 and June 30, 2006. Of these providers, 1,078 were located in the state of Minnesota. All 1,078 of these in-state pharmacies were requested to submit survey information for this study. Each pharmacy received a copy of the cost survey (Exhibit 2), a list of instructions (Exhibit 3), a letter of introduction from the Department of Human Services (Exhibit 4) and a letter of explanation from Myers and Stauffer (Exhibit 5a and Exhibit 5b).

Concerted efforts to encourage participation were made to enhance the survey response rate. Myers and Stauffer sent additional letters reminding pharmacies of the survey on October 24, 2006 (see Exhibits 6a and 6b) and November 3, 2006 (see Exhibits 8a and 8b). On November 13, 2006, an additional letter was mailed extending the due date for the survey by approximately two weeks (see Exhibits 9a and 9b). An official letter explaining the purpose of the study was sent to the sampled pharmacy providers by the Department of Human Services (see Exhibit 4). The Department of Human Services also solicited assistance from pharmacy associations to encourage participation in this study by responding to the survey request (see Exhibits 7 and 10). The survey forms, instructions and a letter of explanation from Myers and Stauffer offered pharmacy owners the option of having Myers and Stauffer complete certain sections of the survey form if copies of financial statements and/or tax returns were supplied. A toll-free telephone number was listed on the survey form, and pharmacists were urged to call to resolve any questions they had concerning completion of the survey form.

Of the 1,078 surveyed pharmacies, 13 pharmacies were determined to be ineligible to participate (based on the returned surveys). Providers were deemed ineligible if they had closed their pharmacy, had a change of ownership, or had less than six months of cost data available (e.g., due to a pharmacy that recently opened, or changed ownership).

As indicated in Table 3.1, there were 515 pharmacies (out of 1,065 eligible pharmacies) that submitted a usable cost survey for this study, which is a response rate of 48.4%.

Some of the submitted cost surveys contained errors or did not include complete information necessary for full evaluation. For cost surveys with such errors or omissions, the pharmacy was contacted for clarification. There were some cases in which issues on the cost survey were not resolved in time for inclusion in the final analysis. [8]

Surveys were accepted through December 8, 2006. Surveys received after that date were not logged or reviewed.

The following table, 3.1, summarizes the cost survey response rate.

Table 3.1 Pharmacies Responding to Cost Survey

Type of Pharmacy	Total Medicaid Enrolled Pharmacies	In-State Pharmacies Receiving Cost Surveys	Pharmacies Exempt or Ineligible from Filing	Eligible Pharmacies	Usable Cost Surveys Received [9]	Response Rate
Chain	743	686	2	684	347	50.7%
Independent	501	392	11	381	168	44.1%
TOTAL	**1,244**	**1,078**	**13**	**1,065**	**515**	**48.4%**

Tests for Reporting Bias

For the pharmacy traits of affiliation (i.e., chain or independent) and location (i.e., urban or rural), the sample of pharmacies was tested to determine if it was representative of the population of Medicaid provider pharmacies. Since the response rate of the sample pharmacies was less than 100 percent, the possibility of bias in the responding sample should be considered. To measure the likelihood of this possible bias, chi-square (χ^2) tests were performed. A χ^2 test evaluates differences between proportions for two or more groups in a data set.

[8] There were 17 surveys received on or before December 8, 2006 that were eventually determined to be unusable because they were substantially incomplete or missing essential information. These issues could not be resolved in a timely manner with the submitting pharmacy.

[9] There were 550 eligible pharmacies that did not respond to the survey request with a usable survey on or before December 8, 2006.

Of the 515 usable cost surveys, 168 were from independent pharmacies and 347 were from chain pharmacies. The slight over representation of chain pharmacies (a response rate of 44.1% for independent pharmacies compared to a response rate of 50.7% for chain pharmacies) could be due to several reasons. The decision of a chain organization to file or not file typically meant filing for all or none of the chain's pharmacies participating in the Minnesota Medicaid program. Also, Myers and Stauffer was able to offer chain pharmacy organizations the option of completing the survey forms via submission of a spreadsheet with data for all stores. The option for electronic submission may have provided additional convenience for chain organizations to complete cost surveys. Additionally, chain organizations typically have corporate accounting offices or third party program managers in place to handle tasks such as completing cost surveys. Owners of independent pharmacies, however, are often involved in many facets of their business operation, and consequently may be less likely to have the time or resources available to complete a cost survey. Another possible reason for a greater number of chain pharmacy surveys being available was increased difficulty of contacting independent pharmacists to resolve any issues involved with their cost report. Chain pharmacies, alternatively, could be contacted through their corporate offices where staff was in place to deal with the inquiries.

Regardless of the slight difference in response rates for independent and chain pharmacies, the results of the χ^2 test indicated that the differences observed were within sampling tolerances. A χ^2 test was also performed with respect to the urban versus rural location of the pharmacy. The results of this test indicated that any minor differences in response rates for urban and rural pharmacies were within sampling tolerances.

Receipt and Review Procedures

For confidentiality purposes, each pharmacy was randomly assigned a four-digit identification number and each cost survey was carefully examined. A desk review was performed for each survey received. This review identified incomplete cost surveys, and pharmacies submitting these cost surveys were contacted by telephone to obtain information necessary for completion.

Cost Finding Procedures

For all pharmacies, the basic formula used to determine the average dispensing cost per prescription was to calculate the total dispensing-related cost and divide it by the total number of prescriptions dispensed:

$$\text{Average Dispensing Cost} = \frac{\text{Total (Allowable) Dispensing Related Cost}}{\text{Total Number of Prescriptions Dispensed}}$$

Determining the result of this equation becomes more complex since not all costs are strictly related to the prescription dispensing function of the pharmacy. Most pharmacies are also engaged in lines of business other than the dispensing of prescription drugs. For example, many pharmacies have a retail business with sales of over-the-counter (OTC) drugs and other non-medical items. Some pharmacies are involved in the sale of durable medical equipment. The existence of these other lines of business necessitates that procedures be taken to isolate the costs involved in the prescription dispensing function of the pharmacy.

Cost finding is the process of recasting cost data using rules or formulas in order to accomplish an objective. In this study, the objective is to estimate the cost of dispensing prescriptions to Medicaid recipients. To accomplish this objective, some pharmacy costs must be allocated between the prescription dispensing function and other business activities. This process identified the reasonable and allowable costs necessary for prescription dispensing to Medicaid recipients.

Dispensing cost consists of two main components: overhead and labor. The cost finding rules employed to determine each of these components are described in the following sections.

Overhead Costs

Overhead cost per prescription was calculated by summing the allocated overhead of each pharmacy and dividing this sum by the number of prescriptions dispensed. We allocated overhead expenses that were reported for the entire pharmacy to the prescription department based on one of the following allocation methods:

- Sales ratio – prescription sales divided by total sales,
- Area ratio – prescription department floor space (in square feet) divided by total floor space,
- All, or 100% – overhead costs that are entirely related to prescription functions, or

- None, or 0% – overhead costs that are entirely related to non-prescription functions.

Overhead costs that were considered *entirely prescription-related* include:

- Prescription department licenses,
- Prescription delivery expense,
- Prescription computer expense,
- Prescription containers and labels (For many pharmacies the costs associated with prescription containers and labels is captured in their cost of goods. Subsequently, it was often the case that a pharmacy was unable to report expenses for prescription containers and labels. In order to maintain consistency, a minimum allowance for prescription containers and labels was determined to use for pharmacies that did not report an expense amount for containers and labels. The allowance was set at the 75th percentile of prescription containers and labels expense per prescription for pharmacies that did report prescription containers and labels expense: $0.2967 per prescription)
- Certain other expenses that were separately identified on lines 27-29 [10] of the cost survey (see Exhibit 2)

Overhead costs that were *not allocated as a prescription expense* include:

- Income taxes [11]
- Bad debts [12]
- Advertising [13]

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[10] "Other" expenses were analyzed to determine the appropriate basis for allocation of each expense: sales ratio, area ratio, 100% related to dispensing cost or 0% (not allocated).

[11] Income taxes are not considered an operational cost because they are based upon the profit of the pharmacy operation. Although a separate line was provided for the state income taxes of corporate filers, these costs were not included in this study as a prescription cost, in order to afford equal treatment to each pharmacy, regardless of the type of ownership.

[12] The exclusion of bad debts from the calculation of dispensing costs is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub.15-1, Section 304. "The allowance of unrecovered costs attributable to such bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that the costs of services covered by the Program will not be borne by individuals not covered, and the costs of services not covered by the Program will not be borne by the Program." It is recognized that some bad debts may be the result of Medicaid co-payments that were not collected. However, it was not possible to isolate the amount of bad debts attributable to uncollected Medicaid co-payments from the survey data. Additionally, there may be programmatic policy reasons to exclude uncollected Medicaid co-payments from the calculation of the cost of dispensing. Inclusion of cost for uncollected co-payments in the dispensing fee might serve to remove incentives for pharmacies to collect Medicaid co-payments when applicable. Given that co-payments were established to bring about some measure of cost containment, it may not be in the best interest of a Medicaid pharmacy program to allow uncollected co-payments to essentially be recaptured in a pharmacy dispensing fee.

[13] The exclusion of most types of advertising expense is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub. 15.1, Section 2136.2. "Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable."

- Charitable Contributions [14]

Certain costs reported on Lines 27, 28, and 29 of the cost survey were occasionally excluded. An example is freight expense, which usually relates only to nonprescription purchases or cost of goods sold.

The remainder of the costs was assumed to be related to *both prescription and nonprescription sales*. Joint cost allocation is necessary to avoid understating or overstating the cost of filling a prescription.

Those overhead costs allocated on the *area ratio* (as previously defined) include:

- Depreciation
- Real estate taxes
- Rent [15]
- Repairs
- Utilities

The costs in these categories were considered a function of floor space.[16] The floor space ratio was increased by 50 percent from that reported on the original cost survey to allow for waiting area for patients and prescription department office area. The resulting ratio was adjusted downward, when necessary, not to exceed the sales ratio (in order to avoid allocating 100% of these costs in the instance where the prescription department occupies the majority of the area of the store).

Overhead costs allocated using the *sales ratio* include:

- Personal property taxes

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[14] Individual proprietors and partners are not allowed to deduct charitable contributions as a business expense for federal income tax purposes. Any contributions made by their business are deducted along with personal contributions as itemized deductions. However, corporations are allowed to deduct contributions as a business expense for federal income tax purposes. Thus, while Line 19 on the cost report recorded the business contributions of a corporation, none of these costs were allocated as a prescription expense. This, again, afforded equal treatment for each type of ownership.

[15] The survey instrument included these special instructions for reporting rent: "Overhead costs reported on the cost report must be resulting from arms-length transactions between non-related parties. Related parties include, but are not limited to, those related by family, by business or financial association, and by common ownership or control. The most common non-arms-length transaction involves rental of property between related parties. The only allowable expense of such transactions for cost determination purposes would be the actual costs of ownership (depreciation, taxes, interest, etc., for the store area only)." This treatment of related-party expenses is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub. 15-2, Section 3614: "Cost applicable to home office costs, services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere."

[16] Allocation of certain expenses using a ratio based on square footage is consistent with Medicare cost reporting principles. See Provider Reimbursement Manual, CMS Pub. 15-2, Section 3617.

- Other taxes
- Insurance
- Interest
- Accounting and legal fees
- Telephone and supplies
- Dues and publications

Labor Costs

Labor costs are calculated by allocating total salaries, payroll taxes, and benefits based on the percent of time spent in the prescription department. The allocations for each labor category were summed and then divided by the number of prescriptions dispensed to calculate labor cost per prescription. There are various classifications of salaries and wages requested on the cost survey (Lines 31-44) due to the different cost treatment given to each labor classification.

Although some employee pharmacists spent a portion of their time performing nonprescription duties, it was assumed in this study that their economic productivity when performing nonprescription functions was less than their productivity when performing prescription duties. The total salaries, payroll taxes, and benefits of employee pharmacists (Lines 34-38 of the cost survey) were multiplied by a factor based upon the percent of prescription time. Therefore, a higher percentage of salaries, payroll taxes, and benefits was allocated to prescription labor costs than would have been allocated if a simple percent of time allocation were utilized. Specifically, the percent of prescription time indicated was adjusted by the following formula: [17]

$$\frac{(2)(\%Rx\ Time)}{(1+(\%Rx\ Time))}$$

The allocation of salaries, payroll taxes, and benefits for all other prescription employees (Lines 39-43) was based directly upon the percentage of time spent in the prescription department as indicated on the individual cost survey. For example, if the reported percentage of prescription time was 75 percent and total salaries were $10,000, then the allocated prescription cost would be $7,500.

[17] Example: An employee pharmacist spends 90 percent of his/her time in the prescription department. The 90 percent factor would be modified to 95 percent: (2)(0.9)/(1+0.9) = 0.95. Thus, 95 percent of the reported salaries, payroll taxes, and benefits would be allocated to the prescription department. It should be noted that most employee pharmacists spent 100 percent of their time in the prescription department.

Owner Compensation Issues

The allocation of salaries, payroll taxes, and benefits of the owner pharmacists (Lines 31-33) was based upon the same modified percentage as that used for employee pharmacists. However, limitations were placed upon the allocated salaries, payroll taxes, and benefits of owner pharmacists. Since compensation reported for owner pharmacists are not costs that have arisen from arm's length negotiations, they are not similar to other costs. A pharmacy owner has a different approach toward other expenses than toward his/her own salary. In fact, owners often pay themselves above the market costs of securing the services of an employee pharmacist. This excess effectively represents a withdrawal of business profits, not a cost of dispensing. Some owners may underpay themselves for business reasons, which would also misrepresent the true dispensing cost.

A factor considered in determining the allocation of owner's salaries was the variability in productivity. For example, one owner pharmacist may dispense 30,000 prescriptions per year while another may dispense 5,000. Those owner pharmacists who dispensed a greater number of prescriptions were allowed a higher salary than were owner pharmacists who dispensed a smaller number of prescriptions. Since variance is not nearly as great with respect to employee pharmacists, the owner pharmacist's salary was subjected to limits based upon employee pharmacists' salaries per prescription.

Determining Owner Compensation Allowances

To estimate the cost that would have been incurred had an employee been hired to perform the prescription-related functions actually performed by the owner, a statistical regression technique was used. A bivariate plot shows the correlation between an independent (predictor) variable and a dependent (predicted) variable (see Exhibit 11). The upper and lower limits on owner pharmacist salary were determined from a bivariate regression.[18] In order to accurately reflect the trend of decreasing marginal costs with increasing volume, a regression technique that fit the bivariate data to a logarithmic curve was used. The resulting regression equation to predict pharmacist labor cost at varying amounts of work performed is:

$$\textit{Labor cost} = 41{,}286 \times \ln(\textit{number of prescriptions dispensed}^{19}) - 312{,}866$$

(where $\ln$ represents the natural logarithm function)

[18] Employee pharmacist salary per prescription was used to set limitations on owner pharmacist salary estimates due to the "arm's length" nature and lack of variance in employee productivity compared with owner productivity.

[19] The number of prescriptions filled by the owner pharmacist was determined by multiplying the percent of owner-filled prescriptions (Lines 31-33 of the cost report) by the total number of prescriptions dispensed (Line a).

This equation was used to establish limits for allocating owner pharmacist costs. There was variation in actual employee salaries both above and below this regression line. This variation is measured by the equation's *standard error of the estimate*, $26,744. The standard error of the estimate was used to construct upper and lower limits of owner pharmacist labor cost:

Upper Limit = 41,286 X ln (number of prescriptions dispensed) – 268,875
Lower Limit = 41,286 X ln (number of prescriptions dispensed) – 326,891

These two constraints effectively set upper and lower thresholds at approximately the 30th and 95th percentiles of volume adjusted employee salaries. An additional constraint is a $136,469 maximum annual salary and a $15,022 minimum salary. These amounts are set at the 30th and 95th percentile of volume adjusted employee salaries.

There is no reason to believe that managerial or clerical duties performed by the non-pharmacist owners were more valuable to the prescription dispensing function than for other functions. As with other owners, the amount shown for salaries, payroll taxes, and benefits was not a result of arm's length negotiations. Therefore, an upper limit of $62,400 and a lower limit of $15,022 were placed upon these prescription costs. These limits were chosen based on experience in prior surveys. No adjustment was made to the percentage of prescription time factor for owner non-pharmacists (Lines 31-33 of the cost survey).

A sensitivity analysis of the owner pharmacist labor limits was performed in order to determine the impact of the limits on the overall analysis of pharmacy dispensing cost. Of the 515 pharmacies in the cost analysis, owner pharmacist limits impacted 91 pharmacies, or 17.9%. Of these, 33 pharmacies had costs reduced as a result of application of these limits (on the basis that a portion of owner salary "cost" appeared to represent a withdrawal of profits from the business), and 58 pharmacies had costs increased as a result of the limits (on the basis that owner salaries appeared to be below their market value). In total, the final estimate of average pharmacy dispensing cost per prescription was decreased by less than $0.01 as a result of the owner pharmacist salary limits.

Overall Labor Cost Constraints

An overall constraint was placed on the proportion of total reported labor that could be allocated as prescription labor. The constraint assumes that a functional relationship exists between the proportion of allocated prescription labor to total labor and the proportion of prescription sales to total sales. It is also assumed that a higher input of labor costs is necessary to generate prescription sales than nonprescription sales, within limits.

The parameters of the applied labor constraint are based upon an examination of data submitted by all pharmacies. These parameters are set in such a way that any resulting adjustment affects only those pharmacies with a percentage of prescription labor deemed unreasonable. For instance, the constraint would come into play for an operation that reported 75 percent pharmacy sales and 100 percent pharmacy labor (obviously, some labor must be devoted to generating the 25 percent nonprescription sales).

To determine the maximum percentage of total labor allowed, the following calculation was made:

$$\frac{0.3(\text{Sales Ratio})}{0.1+(0.2)(\text{Sales Ratio})}$$

A sensitivity analysis of the labor cost restraint was performed in order to determine the impact of the limit on the overall analysis of pharmacy cost. The analysis indicates that of the 515 pharmacies included in the dispensing cost analysis, this limit was applied to 153 pharmacies. The final estimate of average pharmacy dispensing cost per prescription was decreased by approximately $0.12 as a result of this limit.

Inflation Factors

All allocated costs for overhead and labor were totaled and multiplied by an inflation factor. Inflation factors are intended to reflect cost changes from the middle of the reporting period of a particular pharmacy to a common fiscal period ending December 31, 2006 (specifically from the *midpoint* of the pharmacy's fiscal year to the *midpoint* of the common fiscal period, June 30, 2006). The midpoint and terminal month indices used were taken from the U. S. Government Consumer Price Index (CPI), Urban Consumer (see Exhibit 12). The use of inflation factors is preferred in order for pharmacy cost data from various fiscal years to be compared uniformly.

Dispensing Cost Analysis and Findings

The dispensing costs for all pharmacies in the sample are summarized in the following tables and paragraphs. Findings for all pharmacies in the sample are presented collectively, and additionally are presented for subsets of the sample based on pharmacy characteristics. There are several statistical measurements that may be used to express the central tendency of a distribution, the most common of which are the average, or mean, and the median. Findings are presented in the forms of means and medians, both raw and weighted. [20]

As is typically the case with dispensing cost surveys, statistical "outliers" are a common occurrence. These outlier pharmacies have dispensing costs that are not typical of the majority of pharmacies. Medians are sometimes preferred to averages (i.e., the arithmetic mean) in situations where the magnitude of outlier values results in an average that does not represent what is thought of as "average" or normal in the common sense.

For all pharmacies in the sample, findings are presented in Table 3.2.

Table 3.2 Cost Per Prescription – All Pharmacies

	Dispensing Cost
Unweighted Average (Mean)	$12.46
Average (Mean) Weighted by Medicaid Volume	$11.34
Unweighted Median	$9.68
Median Weighted by Medicaid Volume	$9.29

(Dispensing Costs have been inflated to the common point of June 30, 2006)

See Exhibit 13 for a histogram of the dispensing cost for all pharmacies in the sample. There was a large range between the highest, over $150, and the lowest,

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[20] **Different Measures of Central Tendency:**
Unweighted mean: the arithmetic average cost for all pharmacies.

Weighted mean: the average cost of all prescriptions dispensed by pharmacies included in the sample, weighted by prescription volume. The resulting number is the average cost for all prescriptions, rather than the average for all pharmacies as in the unweighted mean. This implies that low volume pharmacies have a smaller impact on the weighted average than high volume pharmacies. This approach, in effect, sums all costs in the sample and divides that sum by the total of all prescriptions in the sample. The weighting factor can be either total prescription volume or Medicaid prescription volume.

Median: the value that divides a set of observations (such as dispensing cost) in half. In the case of this survey, the median is the dispensing cost such that the cost of one half of the pharmacies in the set are less than or equal to the median and the dispensing costs of the other half are greater than or equal to the median.

Weighted Median: this is determined by finding the pharmacy observation that encompasses the middle value prescription. The implication is that one half of the prescriptions were dispensed at a cost of the weighted median or less, and one half were dispensed at the cost of the weighted median or more. Suppose, for example, that there were 1,000,000 Medicaid prescriptions dispensed by the pharmacies in the sample. If the pharmacies were arrayed in order of dispensing cost, the median weighted by Medicaid volume, is the dispensing cost of the pharmacy that dispensed the middle, or 500,000th prescription.

$4.09, dispensing cost observed for pharmacies in the sample. However, the majority of pharmacies (76%) had dispensing costs between approximately $7 and $18.

Several pharmacies included in the cost analysis were identified as specialty pharmacies, which for purposes of this report are those pharmacies where intravenous, infusion or other specialty products constituted the majority of their prescription volume. The analysis revealed significantly higher cost of dispensing associated with 13 pharmacies in the sample that provided significant levels of these services. [21]

The difference in dispensing costs that were observed for providers of specialty services compared to those pharmacies that did not offer these specialty services is summarized in Table 3.3.

Table 3.3 Cost Per Prescription - Specialty Versus Other Pharmacies

Type of Pharmacy	Number of Pharmacies	Unweighted Average (Mean) Cost	Standard Deviation
Specialty Pharmacies (e.g., intravenous or infusion)	13	$59.18	$40.96
Other Pharmacies	502	$11.25	$6.71

(Dispensing costs have been inflated to the common point of June 30, 2006)

Pharmacies that dispense specialty prescriptions as a significant part of their business often have dispensing costs far in excess of those found in a traditional pharmacy. The analyses summarized in Tables 3.4 and 3.5 below exclude the 13 specialty pharmacy providers. In making this exclusion, no representation is made that the cost structure of those pharmacies is not important to understand. However, it is reasonable to address issues relevant to those pharmacies separately from the cost structure of the vast majority of Minnesota Medicaid pharmacy providers that provide "traditional" pharmacy services.

[21] In every pharmacy dispensing study where information on intravenous solution and home infusion dispensing activity has been collected by Myers and Stauffer, such activity has been found to be associated with higher dispensing costs. Discussions with pharmacists providing these services indicate that the activities and costs involved in these specialty prescriptions are significantly different from the costs incurred by the traditional retail or institutional pharmacy. The reasons for this difference include:

- Costs of special equipment for mixing and storage of specialty products.
- Higher direct labor costs because most specialty prescriptions must be prepared in the pharmacy, whereas the manual activities to fill traditional prescription are mainly limited to counting pills (or vials, etc.) and printing and affixing the label.
- There is often inconsistency in the manner in which prescriptions are counted in specialty pharmacies. A specialty pharmacy may mix and deliver many "dispensings" of a daily intravenous, home infusion or blood factor product from a single prescription, counting it in their records as only one prescription. This results in dispensing costs being spread over a number of prescriptions that is smaller than if the pharmacy had counted each refill as an additional prescription.

This latter factor, in particular, can have a dramatic impact on increasing a pharmacy's calculated cost per prescription.

Table 3.4 restates the measurements noted in Table 3.2 excluding pharmacies that dispensed significant volumes of specialty prescriptions.

Table 3.4 Cost Per Prescription – Excluding Specialty Pharmacies

	Dispensing Cost
Unweighted Average (Mean)	$11.25
Average (Mean) Weighted by Medicaid Volume	$9.59
Unweighted Median	$9.61
Median Weighted by Medicaid Volume	$9.22

(Dispensing costs have been inflated to the common point of June 30, 2006)

Additional statistical measures of pharmacy dispensing cost are provided in Exhibit 14. For measurements that refer to the urban or rural location of a pharmacy, Myers and Stauffer used the pharmacies' zip code and tables from the U.S. Census Bureau to determine if the pharmacy was located in a Metropolitan Statistical Area (MSA). Pharmacies in an MSA were assigned an "urban" location flag; other pharmacies were assigned a "rural" location flag. A table of zip codes and their designation as urban or rural is included at Exhibit 15. It should be noted that zip codes can overlap county lines; therefore the mapping of zip codes into counties and a corresponding MSA should be considered an approximation.

The relationship between total prescription volume and dispensing cost was especially pronounced. Pharmacies were classified into meaningful groups based upon their differences in total prescription volume. Dispensing costs were then analyzed based upon these volume classifications.

Table 3.5 Dispensing Cost by Pharmacy Total Annual Prescription Volume[A]

Total Annual Prescription Volume of Pharmacy	Number of Stores	Unweighted Average (Mean) Cost	Average (Mean) Weighted by Medicaid Volume
0 to 9,999	21	$32.96	$29.33
10,000 to 29,999	94	$13.96	$13.14
30,000 to 49,999	144	$10.39	$10.10
50,000 to 74,999	127	$9.25	$9.22
75,000 and Higher	116	$8.36	$9.03

[A] Excludes 13 specialty pharmacies, which for purposes of this report are those pharmacies where intravenous, infusion or other specialty products constituted the majority of their prescription volume.

There is a significant correlation between a pharmacy's total prescription volume and the dispensing cost per prescription. This result is not surprising because many of the costs associated with a business operation, including the dispensing of prescriptions, have a fixed component that does not vary significantly with

increased volume. For stores with a higher total prescription volume, these fixed costs are spread over a greater number of prescriptions resulting in lower costs per prescription. A number of relatively low volume pharmacies in the survey skew the distribution of dispensing cost and increase the measurement of the unweighted average (mean) cost of dispensing. Means weighted by either Medicaid volume or total prescription volume may provide a more realistic measurement of typical dispensing cost.

Table 3.6 Statistics for Pharmacy Total Annual Prescription Volume[A]

Statistic	Value
Mean	59,122
Standard Deviation	71,334
10th Percentile	19,256
25th Percentile	31,339
Median	48,612
75th Percentile	73,219
90th Percentile	99,780

[A] Excludes 13 specialty pharmacies, which for purposes of this report are those pharmacies where intravenous, infusion or other specialty products constituted the majority of their prescription volume.

A histogram of pharmacy total annual prescription volume is included in Exhibit 13.

Several pharmacy attributes were collected on the cost survey. A summary of these attributes is provided at Exhibit 16.

Expenses Not Allocated to the Cost of Dispensing

Wholesale Drug Distributor Tax

Pharmacies in Minnesota are subject to a state tax on prescription drug products. The wholesale drug distributor tax and corresponding provider taxes are enacted at Minnesota Statute 295.52 and impose a tax of 2% on drug purchases of pharmacies. Pharmacies are permitted by Minnesota Statute 295.582 to transfer the expense incurred by this tax to third-party payers. However, the tax may not be transferred to the Minnesota Medicaid program per Minnesota Statute 295.53.1(a)(10).

As part of the dispensing cost survey instrument, Myers and Stauffer requested that pharmacies provide the amount of wholesale drug distributor tax paid by the pharmacy. [22] Most pharmacies did not provide a response to these line items

[22] See Exhibit 1, survey page 3, Lines (9a) and (9b)

(approximately 15% of pharmacies did submit a response). There were several possible reasons that a response was not provided from most pharmacies. Some pharmacies may have been confused by the inclusion of these lines as an expense since the tax may receive special accounting treatment that is more complex than an ordinary expense. Several pharmacies reported that the tax amount was included as a component of the cost of goods sold.

Myers and Stauffer has not included the wholesale drug distributor tax in the calculation of pharmacy dispensing cost for several reasons. First, due to the low number of pharmacies that reported an amount for this cost category. Second, the imputation of such an expense was not always possible since not all pharmacies choose to report their prescription-related cost of goods sold. Approximately 29% of pharmacies did not report their prescription-related cost of goods sold with several pharmacies indicating to Myers and Stauffer that this information was considered proprietary. An additional complicating factor was the uncertainty as to whether reported prescription-related cost of goods sold were inclusive or exclusive of any wholesale drug distributor tax amounts.

Another reason to not include the wholesale drug distributor tax relates to the theoretical concept of whether the drug tax should be considered a component of dispensing cost or a component of drug ingredient cost. At AWP minus 12%, the current ingredient reimbursement level of the Minnesota Medicaid pharmacy program (for drugs without either FUL or SMAC pricing) would appear to include sufficient margin above pharmacy acquisition cost to cover the drug tax.

While the issue of the wholesale drug distributor tax is relevant to the issue of appropriate Medicaid reimbursement policies, Myers and Stauffer has chosen for the reasons cited previously to not include any provision in the reported dispensing cost for this tax on Minnesota pharmacies.

As a means of roughly estimating the impact of the wholesale drug distribution tax on a per prescription basis, the following calculations are noted:

- Based on reported prescription-related cost of goods sold and reported total prescription volume, the weighted mean cost of goods sold per prescription is $41.74 (for the 361 non-specialty pharmacies that reported prescription-related cost of goods sold).

- 2% of $41.74 is $0.835.

Other Expenses Not Included

In the following Table 3.7, measurements are provided for certain other expenses that were not included in the cost of dispensing. Reasons for not including these costs were discussed previously. For all of the expenses below, average cost per prescription was calculated using a sales ratio as the basis for allocation.

Table 3.7 Other Non-Included Expenses Per Prescription[A]

Expense Category	Unweighted Average (Mean) Cost	Average (Mean) Weighted by Medicaid Volume
Bad Debts	$0.052	$0.092
Charitable Contributions	$0.026	$0.043
Advertising	$0.391	$0.261

[A] Excludes 13 specialty pharmacies, which for purposes of this report are those pharmacies where intravenous, infusion or other specialty products constituted the majority of their prescription volume.

Conclusions

Myers and Stauffer performed a study of the cost of dispensing prescription medications to Medicaid recipients in the state of Minnesota. The dispensing cost study considered operational data, professional services data and overhead data relating to the costs of pharmacy operation. Based on our analysis of dispensing costs of pharmacies participating in the Minnesota Medicaid program, the statewide average[23] dispensing cost per prescription for all payer types was $9.59. This figure excludes 13 specialty pharmacies, which as noted previously exhibited a significantly different cost structure.

[23] The statewide average dispensing cost per prescription is the mathematical mean, weighted by each pharmacy's Medicaid volume. That is, the average dispensing cost per prescription of a pharmacy with higher Medicaid volume is weighted more in this average than a pharmacy with lower Medicaid volume.

IV. Analysis of Pharmacy Reimbursement Rates by Other Payers

State Medicaid Pharmacy Reimbursement

Dispensing fees for Medicaid programs vary from state to state and have typically been based on an analysis of costs incurred by pharmacies within the state as well as other market factors. An overview of Medicaid dispensing fees and ingredient reimbursement is included in the following table.

Table 4.1 State Medicaid Pharmacy Reimbursement Rates[24]

State	Dispensing Fee	Ingredient Reimbursement
Alabama	$5.40	AWP - 10% WAC + 9.2%
Alaska	3.45 to 11.46	AWP - 5%
Arizona	$2.00	AWP - 15%
Arkansas	$5.51	B: AWP - 14% G: AWP - 20%
California	$7.25 ($8.00 LTC)	AWP - 17%
Colorado	$4.00;$1.89 for Institutions	B: AWP - 13.5% G: AWP - 35%
Connecticut	$3.60	B: AWP - 14% G: AWP - 40%
Delaware	$3.65	AWP - 14% AWP - 16% (LTC)
DC	$4.50	AWP - 10%
Florida	$4.23	AWP - 15.45% WAC+5.75%
Georgia	$4.33 to $4.63 (+$0.50 for generics)	AWP - 11%
Hawaii	$4.67	AWP - 10.5%
Idaho	$4.94 ($5.54 for unit dose)	AWP - 12%
Illinois	B: $3.40 G: $4.60	B: AWP -12% G: AWP - 25%
Indiana	$4.90	B: AWP -16% G: AWP - 20%
Iowa	$4.26	AWP - 12%
Kansas	$3.40	B: AWP -13% G: AWP - 27%
Kentucky	$4.51	AWP - 12%
Louisiana	$5.77	AWP - 13.5% (AWP - 15% for chains)
Maine	$3.35	AWP - 15%
Maryland	B: $2.69 G: $3.69 (+$1.00 for LTC)	AWP - 12% WAC + 8%
Massachusetts	$3.50 - 5.00	WAC + 5%
Michigan	$2.50 ($2.75 LTC)	AWP - 13.5% (1-4 stores) AWP - 15.1% (5+ stores)

[24] Source: CMS, "Medicaid Prescription Reimbursement Information by State - Qtr Ending September 2006". See http://www.cms.hhs.gov/MedicaidDrugRebateProgram/08_MdPresReimInfo.asp.

State	Dispensing Fee	Ingredient Reimbursement
Minnesota	3.65 (+0.50 unit dose)	AWP - 12%
Mississippi	$3.91	B: (AWP - 12%/WAC + 9%) G: AWP - 25%
Missouri	$4.09	AWP - 10.43% WAC + 10%
Montana	$4.70	AWP - 15%
Nebraska	$3.27 to $5.00	AWP - 11%
Nevada	$4.76	AWP - 15%
New Hampshire	$1.75	AWP - 16%
New Jersey	$3.73	AWP - 12.5%
New Mexico	$3.65	AWP - 14%
New York	B:$3.50 G:$4.50	B: AWP -12.75% G: AWP - 16.5%
North Carolina	B:$4.00 G:$5.60	AWP - 10%
North Dakota	B:$4.60 G:$5.60	AWP - 10% WAC +12.5%
Ohio	$3.70	AWP - 14.4% WAC + 7%
Oklahoma	$4.15	AWP - 12.0%
Oregon	Retail: $3.50 Inst:$3.91	AWP - 15% (retail) AWP - 11% (institutional)
Pennsylvania	$4.00	AWP - 15% WAC + 6%
Rhode Island	$3.40 LTC: $2.85	WAC +5%
South Carolina	$4.05 LTC: $3.15	AWP - 10%
South Dakota	$4.75 ($5.55 for unit dose)	AWP - 10.5%
Tennessee	$2.50	AWP - 13%
Texas	$5.14	AWP - 15% WAC + 12%
Utah	$3.90 (urban) $4.40 (rural)	AWP - 15%
Vermont	$4.75	AWP - 11.9%
Virginia	$4.00 ($5.00 for unit dose)	AWP - 10.25%
Washington	$4.20 to $5.20	B: AWP - 14% G: AWP - 50%
West Virginia	B:$2.50 G:$5.30	B: AWP - 15% G: AWP - 30%
Wisconsin	$4.88	AWP - 11.25%
Wyoming	$5.00	AWP - 11%

Pharmacy dispensing fees for state Medicaid pharmacy programs range from under $2 to over $11. Ingredient reimbursement for brand name drug products ranges from a low of AWP minus 17%, to a high of AWP minus 5%. As can be observed in Table 4.1, the dispensing fee and ingredient reimbursement formulas used in various states are often based on multiple numeric values, using different factors for different drug products. In order to evaluate how Minnesota Medicaid pharmacy reimbursement policies compare to other state Medicaid programs, we estimated a single payment rate for each state's dispensing fee, and estimated a single ingredient rate for brand name drug products. With these conversions, we

developed statistics presenting average reimbursement rates for all states, which are shown in Table 4.2.

Table 4.2 Average State Medicaid Pharmacy Reimbursement – Brand Name Drugs

Pharmacy Reimbursement Component	Mean	Median
Dispensing Fee	$4.25	$4.15
Ingredient Reimbursement (Brand Name Drugs)	AWP – 12.9%	AWP – 13.0%

The dispensing fee for Minnesota Medicaid falls at approximately the 20th percentile of all state Medicaid dispensing fees (i.e., 20% of states pay equal to or less than Minnesota Medicaid). The ingredient reimbursement for brand name drug products under Minnesota Medicaid falls at approximately the 72nd percentile of all state Medicaid ingredient reimbursement rates for brand name drug products (i.e., 72% of states pay equal to or less than Minnesota Medicaid).

Private Payer Pharmacy Reimbursement

Pharmacy reimbursement rates paid by private third party payers (typically through networks operated by pharmaceutical benefits managers, or PBMs) have been researched and reported in other publications. One survey, published in 2005, reported average dispensing fees to retail pharmacies for brand name drugs of $1.87 and average ingredient reimbursement of AWP minus 15.3%. [25] Private payer pharmacy reimbursement rates have declined in recent years with respect to both the dispensing and ingredient components (relative to AWP) of reimbursement.

Conclusions

State Medicaid agencies use a wide variety of reimbursement rates in their pharmacy programs. Pharmacy dispensing fees in these programs range from under $2 to over $11. At $3.65, the dispensing fee for Minnesota Medicaid falls at approximately the 20th percentile of all state Medicaid dispensing fees. Ingredient reimbursement for brand name drug products ranges from a low of AWP minus 17% to a high of AWP minus 5%. At AWP minus 12%, the

[25] See *The Prescription Drug Benefit Cost and Plan Design Survey Report*, 2006 Edition, Pharmacy Benefits Management Institute, Inc. and Takeda Pharmaceuticals North America, Inc. Survey data is based on data collected in fall 2005. Values cited are for the Midwest region.

ingredient reimbursement for brand name drug products under Minnesota Medicaid falls at approximately the 72nd percentile of all state Medicaid ingredient reimbursement rates for brand name drug products.

Based on published data, it appears that private third party payers are reimbursing for pharmaceuticals at rates less than those paid by Minnesota Medicaid. Additionally, private third party plans appear to pay dispensing fees that are less than dispensing costs, (see discussion of dispensing cost in Chapter 3). In fact, dispensing fees paid by most third party payers are set at levels well below the dispensing cost of most pharmacies. However, the data indicates that most third party prescription plans reimburse for ingredients at levels that exceed the pharmacy's acquisition cost for prescription drug products.

Exhibit 1
Minnesota Statutes,
256B.0625

256B.0625, Minnesota Statutes 2006

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 12 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant
to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

Exhibit 2
Minnesota Medicaid
Pharmacy Cost Report

M&S Use Only

Minnesota Medicaid Pharmacy Cost Report

Medicaid Provider No.

Return Completed Forms to:
Myers and Stauffer LC
11440 Tomahawk Creek Parkway
Leawood, Kansas 66211

Myers and Stauffer LC
Certified Public Accountants

Under Contract with the Minnesota Department of Human Services

ROUND ALL AMOUNTS TO NEAREST DOLLAR OR WHOLE NUMBER
Please Complete and return by **November 17, 2006**
Instructions are enclosed. Please call toll free (800) 374-6858 if you are having difficulty completing this report.

Name of Pharmacy _____ Telephone No. ( ) _____
Street Address _____ Fax No. ( ) _____
City _____ County _____ State _____ Zip Code _____

DECLARATION BY OWNER AND PREPARER

I declare that I have examined this cost report including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the related Books or Federal Income Tax Return, except as explained in the Reconciliation. Declaration of preparer (other than owner) is based on all information of which preparer has any knowledge.

Your Signature	Print/Type Name	Title/Position	Date
Preparer's Signature (other than owner)		Title/Position	Date
Preparer's Street Address		City and State	Zip / Phone Number

SECTION IA -- PHARMACY ATTRIBUTES

(a) **List the total number of all prescriptions dispensed during the fiscal year as follows:**

New _____ **Refill** _____ **Total** _____

(b) Type of Ownership
1. ☐ Individual 2. ☐ Corporation 3. ☐ Partnership 4. ☐ Other

(c) Location
1. ☐ Medical Office Building 2. ☐ Shopping Center
3. ☐ Separate or downtown 4. ☐ Grocery Store / Mass Merchant
5. ☐ Other (specify) _____

(d) Ownership Affiliation
1. ☐ Independent (1-4 Units) 2. ☐ Chain (5 or more units nationally)
3. ☐ Institutional (service to long-term care facilities only) 4. ☐ Other Specialty (specify)_____

(e) Do you own your building or lease your building from a related party (i.e. yourself, family member, or related corporation)? If so, mark yes.
1. ☐ Yes 2. ☐ No

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Certified Public Accountants

(f)	What is the approximate percent of your prescriptions dispensed to group home facilities?_____
(g)	Do you dispense in anything other than traditional packaging to group home facilities? If yes, indicate how: 1. ☐ Unit Dose 2. ☐ Modified Unit Dose (Bingo cards/blister packs) 3. ☐ Both 4. ☐ No Unit Dose What is the approximate percent of all prescriptions dispensed in unit dose packaging? _____%
(h)	If you checked box 1, 2, or 3 of (g), what percent of unit dose packaging is: 1. Purchased from manufacturers _____% 2. Prepared in the pharmacy _____%
(i)	What is the approximate percent of your prescriptions dispensed that are compounded? _____%
(j)	How many hours per week is your pharmacy open? _____ Hours
(k)	What is the approximate percentage of prescriptions dispensed for the following classifications? 1. Medicaid _____% 2. Other 3rd Party _____% 3. Cash _____% What is the approximate percentage of payments received from the following classifications? 1. Medicaid _____% 2. Other 3rd Party _____% 3. Cash _____%
(l)	Are you presently providing home infusion or intravenous therapies? 1. ☐ Yes 2. ☐ No If yes, what is the dollar amount of your sales for those Rxs? $_____

SECTION IB -- OTHER INFORMATION

Please list any additional information you feel contributes significantly to your cost of filling a prescription. Also, if you have a significant amount of non-retail sales of drugs at cost, please note the amount and if it is included in line (1), column (1) on page 3.

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Certified Public Accountants

Round all amounts to nearest dollar or whole number.

SECTION IIA -- SALES AND FLOOR SPACE

	Prescription Drugs Only	Total Store Including Prescription Drugs	Line No.
Sales (Excluding Sales Tax)			(1)
Cost of Goods Sold			(2)
Floor Space (Retail area only). Please measure. Do not estimate.	Sq. Ft	Sq. Ft.	(3)

SECTION IIB -- OVERHEAD EXPENSES

Complete this section by referring to the line numbers in the left columns that correspond to federal income tax return lines or use internal financial statements.

The following information is from tax / fiscal year ending..... _____/_____/_____ (4)

2005 Tax Form Number 1040C	1065	1120	1120S			Total Expense	Myers and Stauffer Use Only	Line No.
13	16a	20	14a	Depreciation (this fiscal year only - not accumulated).....				(5)
23	14	17	12	Taxes	(a) Personal Property Taxes Paid.....			(6)
					(b) Real Estate Taxes.....			(7)
					(c) Payroll Taxes.....			(7a)
					(d) Sales Taxes.....			(7b)
					(e) State Income Tax (Corporations Only).....			(8)
					(f) Wholesale Drug Distributor Tax (per MS 295.52(3))			(9a)
					(g) Prescription Drug Provider Tax (per MS 295.52(4))			(9b)
					(h) Any other taxes (specify each type and amount)			(9c)
20b	13	16	11	Rent	(a) Building Rent (See Instructions, page 3).....			(10)
20a	13	16	11		(b) Equipment and Other.....			(11)
21	11	14	9	Repairs.....				(12)
15	20	26	19	Insurance	(a) Workers Comp. and Employee Medical.....			(13)
15	20	26	19		(b) Other.....			(14)
16a&b	15	18	13	Interest.....				(15)
17	20	26	19	Legal and Professional Fees.....				(16)
27	20	26	19	Dues and Publications.....				(17)
27	12	15	10	Bad Debts (this fiscal year only - not accumulated).....				(18)
		19		Charitable Contributions (Corporations Only).....				(19)
25	20	26	19	Telephone.....				(20)
25	20	26	19	Heat, Water, Lights, Sewer, Trash and other Utilities.....				(21)
18&22	20	26	19	Operating and Office Supplies (Exclude Rx containers and labels)...				(22)
8	20	23	16	Advertising.....				(23)
27	20	26	19	Rx Computer Expenses (See Instructions).....				(24)
9,27	20	26	19	Rx Delivery Expenses (See Instructions).....				(25)
27	20	26	19	Rx Containers and Labels (See Instructions).....				(26)
Various	18+	24+	17+	Other Expenses (Not included elsewhere) _____				(27)
	19+	25+	18+	(Attach Schedule if necessary) _____				(28)
	20	26	19	(Specify each item and corresponding amount)_____				(29)
				Total Overhead Expenses [Add Line (5) through Line (29)]				(30)

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Certified Public Accountants

SECTION IIC -- PERSONNEL COSTS -- List each person separately (except Line 44). Attach schedule if necessary.

	Check if RPh	Estimate Percent of Rxs Dispensed by Each RPh	Annual Salaries and/or Drawings	Myers and Stauffer Use Only	No. Weeks Employed This Fiscal Year	Average Weekly Hours: Total Store Including Rx Dept.	Average Weekly Hours: Rx Dept. Related Duties Only	Line No.
Owners, Individual Proprietors, Partners, and Stockholders.....								(31)
								(32)
								(33)
Employee and Relief Pharmacists.....								(34)
								(35)
								(36)
								(37)
Interns.....								(38)
	Subtotal:	100%	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	(38a)
Rx Delivery.....	XXX	XXXXXXXXX						(39)
	XXX	XXXXXXXXX						(40)
Other Employees with Time in Rx Dept. (Including Rx Technicians).....	XXX	XXXXXXXXX						(41)
	XXX	XXXXXXXXX						(42)
	XXX	XXXXXXXXX						(43)
All Non-Rx Employees.....	XXX	XXXXXXXXX			XXXXX	XXXXX	XXXXX	(44)
TOTALS.....	XXX	XXXXXXXXX			XXXXX	XXXXX	XXXXX	(45)

SECTION II D -- RECONCILIATION WITH TAX RETURN (OR BOOKS)

2005 Tax Form Number					Column 1	Column 2	
1040C	1065	1120	1120S		Cost Report Amounts	Books or Tax Return Amounts	
28	21	27	20	Total Expenses per Tax Return / Books (Circle one used).....			(46)
				Enter Amount from Line (30).....			(47)
				Enter Amount from Line (45).....			(48)
				Total Expenses per Cost Report [Add Lines (47) and (48)].....			(49)
				Specify Items with Amounts that are on Cost Report but not on Tax Return (or Books)_____			(50)
				_____			(51)
				Specify Items with Amounts that are on Tax Return (or Books) but not on this Cost Report_____			(52)
				_____			(53)
				Total [Add Lines (46) to (53)] Column Totals Should be Equal..			(54)

Exhibit 3
Minnesota Medicaid
Pharmacy Cost Report
Instructions

Minnesota Medicaid Pharmacy Cost Report
Instructions

Survey Forms by

Myers and Stauffer LC
Certified Public Accountants
11440 Tomahawk Creek Parkway
Leawood, Kansas 66211
800-374-6858

PURPOSE: The purpose of this survey is to determine the approximate cost of dispensing prescriptions in the State of Minnesota.

WHO SHOULD FILE THIS FORM

Except for the following, all Medicaid enrolled pharmacies should file this cost report:

- ☐ New pharmacies that were in business less than six months during the reporting period
- ☐ Pharmacies with a change of ownership that resulted in less than six months in business during the reporting period

If your pharmacy meets either of the two exceptions listed above, please check the box next to the explanation describing your business, write your pharmacy name and provider number, sign your name, and return only this page to the address above.

Medicaid Provider No.	Provider Name	Phone No.	Signature of Owner

GENERAL INSTRUCTIONS

If any assistance is needed in completing this survey, please call toll-free (800) 374-6858. Please complete these forms using your most recently completed fiscal year (e.g., December 31, 2005) and **return them by November 17, 2006**. Most retail pharmacies can complete the survey form by using their most recent federal income tax return. Most expense line items can be transferred directly from a line on the tax return to a line on the cost report. Line reference numbers of four tax forms are listed on the left side of the cost report. Simply locate the column for your tax form.

If you prefer, send us a copy of your income tax return (Form 1065, 1120, 1120S, or Schedule C of Form 1040 including supporting schedules) or your financial statements and we will complete the overhead expenses, Section IIB, Page 3 and Section IID, Page 4, for you. **You will still need to fill in the remaining sections of the cost report.** If you send a copy of your tax return, please identify any expenses that are 100% Rx-Department expenses such as continuing education, and identify any expenses that are 100% non-Rx Department expenses such as fountain expenses, etc. By sending any of these tax forms, you will not be providing us with any information other than that requested if you completed the survey yourself. We will destroy the tax forms after entering the information on the survey.

Please remember to round all amounts to the nearest dollar or whole number.

Myers and Stauffer LC
Certified Public Accountants

Retail Chain Pharmacies
Expenses incurred by chain pharmacies such as administration, central operating, or other general expenses should be allocated to individual units. Warehousing expenses must be either separately identified or included in the cost of goods sold. Methods of allocation must be reasonable and conform to generally accepted accounting principles. Please explain any allocation procedures used. Allocated costs should be clearly identified and entered on lines 27, 28 and/or 29.

SECTION IA --- PHARMACY ATTRIBUTES

The information gathered from your answers to these questions will be analyzed to determine its relationship to your cost of dispensing a prescription. It may be necessary to provide estimates for some answers; please estimate as carefully and accurately as possible.

Line (a) **"Prescriptions Dispensed."** Please report the total number of all prescriptions filled **during the fiscal year** of the costs reported on pages 3 and 4 of this cost report. This information may be kept on a daily or monthly log or on your computer.

SECTION IIA --- SALES AND FLOOR SPACE

Line (1) **Please list total store sales excluding sales tax.** Total store sales and cost of goods sold are shown on the federal income tax return. If there is no separate record of prescription drug sales, estimate it as accurately as possible. Sales of prescription drug items should **NOT** include nonprescription OTC's, durable medical equipment, or other nonprescription items. One method to estimate sales of prescription drug items is to use your sales tax return. If Rx cost of goods sold is not readily available, leave that line blank.

Line (3) Since **floor space** will be used in allocating expenses, accuracy is important. When measuring the total store, include only the retail area and exclude any storage area, i.e., basement, attic, off-the-premises areas, or freight in-out areas. When measuring the Prescription Department, exclude patient waiting area and prescription-related office. These should be included in total store area. A factor is added to the Prescription Department area to account for both waiting and office space.

SECTION IIB --- OVERHEAD EXPENSES
[TAX RETURN MAY BE SUBSTITUTED]

Overhead costs reported on the cost report must be resulting from arms-length transactions between non-related parties. Related parties include, but are not limited to, those related by family, by business or financial association, and by common ownership or control. **The most common non-arms-length transaction involves rental of property between related parties. The only allowable expense of such transactions for cost determination purposes would be the actual costs of ownership (depreciation, taxes, interest, etc., for the store area only). The rental amount will be disallowed. Please show this as a reconciling item in Section IID.**

Line (6) & (7) Include only personal property taxes or real estate taxes paid on property used in this pharmacy's business.

Line (7a) Include the employer's share of FICA and Medicare taxes, and state and federal unemployment taxes.

Line (10) Include only rent that applies to the store. **Report only rental expense incurred by transactions between non-related parties. See the first paragraph of this section for expenses allowed in lieu of rent paid to a related party.**

Line (22) Include office and operating supplies. If prescription containers and labels are included in your supplies, please exclude them from this line and show them on line (26).

Line (24) **Rx Computer Expenses.** Include expenses for a computer that is used only in the Rx Department. These expenses should not be duplicated on any other line. If your computer is used by other departments of the pharmacy, do not enter anything on this line and enter computer expenses on line (29).

Line (25) **Rx Delivery Expenses.** If you deliver Rx items only, include expenses paid for your delivery vehicle here, including expenses paid to a delivery service for delivery of Rx items. These expenses should not be duplicated on any other line. If your delivery vehicle is used by other departments of the pharmacy or for miscellaneous purposes, do not enter anything on this line and enter delivery expenses on line (29).

Line (26) **Rx Containers and Labels.** The cost of prescription containers and labels should be included here if separately identified as "other deductions" on your federal income tax return. If this expense is included in cost of goods sold on your federal income tax return and if your accounting records are such that this figure is difficult to determine, leave this line blank. An allowance will be made for Rx containers and labels based on your prescription volume.

Lines (27)-(29) On these lines identify any non-labor expenses not already included on your cost report but listed as other deductions on your federal income tax return. **Identify each item and the amount, rather than labeling all such expenses as "miscellaneous." If you wish, you may simply attach the schedule from your federal return which lists these expenses.** Please clearly label any items that are 100% Rx-related, such as pharmacist continuing education, or that are 100% non-Rx-related, such as fountain operation expenses.

SECTION IIC --- PERSONNEL COSTS [LINES (31)-(45)]

Lines (31)-(38) **"Percent of Prescriptions Dispensed."** Please provide your best estimate of the percentage of prescriptions dispensed by each pharmacist. Notice: This column must total line 38a (100%).

Lines (31)-(43) **"Average Weekly Hours."** You may not have detailed records of where each employee worked; however, please provide your best estimate of an average or "typical" week. Column 6 should show average number of hours the employee worked per week. Column 7 should show the average number of hours per week spent performing Rx-related duties. Rx-related duties are defined as time spent filling prescriptions as well as doing the related administrative work, including ordering and stocking prescription ingredients, taking inventory, maintaining prescription files and delivering prescriptions. Pharmacists providing consultation to long term care or group home facilities should be identified and listed separately. Any revenue received for those consultation services should be noted in Section IB, page 2.

Lines (31)-(33) **"Owners."** For purposes of this study, an employee who is a stockholder in the pharmacy is considered an "Owner." All individual proprietors, partners, or stockholders should list their total drawings and/or salaries for the year. Do not show net profit as the owner's salary but **only actual drawings or salary**. For those owners who took no salary or drawings, show zero to indicate you have not overlooked this line. A salary will be allocated based on time and/or prescriptions dispensed.

Lines (39)-(43) Rx Technicians, nonprofessional, clerical, and delivery personnel who perform Rx-related duties should be listed.

Line (44) **"All Non-Rx Employees."** List total salaries for all employees who spend no time in Rx-related duties.

SECTION IID --- RECONCILIATION WITH BOOKS OR FEDERAL INCOME TAX RETURN

The purpose of this reconciliation is to ensure that all expenses have been included and that none have been duplicated. For example, pharmacies operating as sole proprietors will normally need to list owner's salaries, drawings, and benefits as a reconciling item. Other examples of reconciling items are the 50% meals deduction, rent paid to related party, etc.

Exhibit 4
Letter from the Minnesota Department of Human Services Regarding Pharmacy Dispensing Cost Survey

Minnesota Department of **Human Services**

October 12, 2006

Dear Pharmacy Provider:

In compliance with Minnesota Statute 282.16.15, Minnesota's Department of Human Services is conducting a survey to determine "the average cost of filling a Medicaid prescription in the State of Minnesota." The Department has selected the accounting firm of Myers and Stauffer LC to conduct the survey. Myers and Stauffer has extensive experience in performing pharmacy cost studies and analysis for other states.

All pharmacies enrolled as service providers for Minnesota Medicaid are bound by their service agreement to participate in the survey process.

To accomplish the analysis required by statute, it is imperative that you complete and return the survey in its entirety by the date specified in the survey packet. Should you need assistance in completing the survey, you may contact Myers and Stauffer using the toll-free number included in the survey instructions. The contractor and the Department guarantee confidentiality of your survey responses. The Department will not have access to pharmacy specific data.

Results of the survey will be shared with the Pharmacy Payment Reform Committee in January and a recommendation for payment reform will be presented to the Minnesota Legislature in February 2007.

If you have any questions or concerns please contact Kristin Young, Pharmacy Manager, a member of my staff, at 651-431-2504.

Thank you for your cooperation.

Sincerely

Brian J. Osberg
Assistant Commissioner of Health Care

Exhibit 5a
Initial Letter from
Myers and Stauffer for
Dispensing Cost Survey
(Independent Pharmacies)

Sample (Independent Pharmacies)

Myers and Stauffer LC

Certified Public Accountants

October 16, 2006

«prov_no» / «random»
«prov_name»
ATTENTION: OWNER OR MANAGER
«address»
«city», «state» «zip»

Dear Pharmacy Owner or Manager:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15. All pharmacy providers in the state are requested to participate in the survey according to the following directions:

Dispensing Cost Survey

1. Complete and return the enclosed "Minnesota Medicaid Pharmacy Cost Report." Please review the survey instructions.

2. Retain a copy of the completed survey forms for your records.

3. For your convenience, we will complete a portion of the survey for you upon receipt of your business federal income tax return (Forms 1065, 1120, 1120S or Schedule C of Form 1040 and accompanying schedules). If you choose this option, you will still need to complete the following sections of the cost report prior to submission:
   a. Pages 1 and 2 – Pharmacy attributes and other information
   b. Page 3 – Line 1 (column 1) – prescription sales, and line 3 (columns 1 and 2) – prescription area and total store area.
   c. Page 4 – Personnel costs – complete lines 31-45, all columns

4. If your financial statements or tax return have not been completed for your most current fiscal year, please file a cost report using your prior year's financial statements (or tax return) and the corresponding prescription data for that year. The data will be adjusted accordingly.

11440 Tomahawk Creek Parkway • Leawood, Kansas 66211
(913) 234-1166 • (800) 374-6858 • FAX (913) 234-1104

It is very important that all pharmacies cooperate fully by filing an accurate cost report. Pharmacies are encouraged to return the requested information as soon as possible, but **no later than November 17, 2006.** Due to a pressing timeline set by the Legislature, it is very important that surveys are received in a timely manner.

Please send completed forms to:

Myers and Stauffer LC
Certified Public Accountants
11440 Tomahawk Creek Parkway
Leawood, Kansas 66211

Return the survey using the enclosed Business Reply Label with any envelope. Postage will be paid by Myers and Stauffer.

All cost reports will be reviewed by staff at Myers and Stauffer LC. If this review yields any need for additional inquiries, you will be contacted by letter or telephone. All information submitted will be held in strict confidence. If you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen

T. Allan Hansen
Project Manager

Exhibit 5b
Initial Letter from Myers and Stauffer for Dispensing Cost Survey (Chain Pharmacies)

Sample
(Chain Pharmacies)

Myers and Stauffer LC
Certified Public Accountants

October 16, 2006

«Chain_Name»
ATTN: «Corporate_Contact_Person»
«Address_1»
«City», «State» «Zip»

Re: Pharmacy Cost of Dispensing Survey

To: Minnesota Chain Pharmacy Providers:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15. All pharmacy providers in the state are requested to participate in the survey according to the following directions:

Dispensing Cost Survey

1. Enclosed is a listing of the names and addresses of your pharmacies in Minnesota. Pharmacy information is presented as shown in records from the Minnesota Department of Human Services. If this list is inaccurate, please notify Myers and Stauffer.
2. Enclosed are several copies of the "Minnesota Medicaid Pharmacy Cost Report." Please review the survey instructions. Please submit a completed survey **for each store** on the attached list. If you will require additional survey forms, please contact Myers and Stauffer for forms or make additional copies as needed. **If you would prefer to submit the data in an electronic format, please contact Myers and Stauffer to determine an acceptable format. On request, Myers and Stauffer can e-mail an Excel spreadsheet template of the survey forms to facilitate electronic survey submission (see e-mail address below).**
3. Retain a copy of the completed survey forms for your records.
4. Please describe any cost allocations used in preparing the income statement such as administrative expense, etc. Warehousing costs should be shown in cost of goods sold or listed separately.

11440 Tomahawk Creek Parkway • Leawood, Kansas 66211
(913) 234-1166 • (800) 374-6858 • FAX (913) 234-1104

It is very important that all pharmacies cooperate fully by filing an accurate cost report. Pharmacies are encouraged to return the requested information as soon as possible, but **no later than November 17, 2006.** Due to a pressing timeline set by the Legislature, it is very important that surveys are received in a timely manner.

Please send completed forms to:

Myers and Stauffer LC
Certified Public Accountants
11440 Tomahawk Creek Parkway
Leawood, Kansas 66211

If you file using the paper survey form, please return the surveys using the enclosed Business Reply Label with any envelope. Postage will be paid by Myers and Stauffer.

All cost reports will be reviewed by staff at Myers and Stauffer LC. If this review yields any need for additional inquiries, you will be contacted by letter or telephone. All information submitted will be held in strict confidence. If you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen

T. Allan Hansen
Project Manager
Phone: (913) 234-1038
E-mail: ahansen@mslc.com

Exhibit 6a
Second Letter from
Myers and Stauffer for
Dispensing Cost Survey
(Independent Pharmacies)

Sample (Independent Pharmacies)

Myers and Stauffer LC

Certified Public Accountants

October 24, 2006

«prov_no» / «random»
«prov_name»
ATTENTION: OWNER OR MANAGER
«address»
«city», «state» «zip»

Dear Pharmacy Owner or Manager:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15.

In the last week, you should have received a copy of the dispensing cost survey form and instructions. Your prompt response to the survey is very important to meeting the survey schedule set by the Legislature and the Department of Human Services. You are encouraged to submit a completed survey as soon as possible, but no later than November 17, 2006.

We are also enclosing a letter from the Minnesota Pharmacists Association and encourage you to review their comments regarding the dispensing cost survey.

If you have not received a survey form or if you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen

T. Allan Hansen
Project Manager

11440 Tomahawk Creek Parkway • Leawood, Kansas 66211
(913) 234-1166 • (800) 374-6858 • FAX (913) 234-1104

Exhibit 6b
Second Letter from
Myers and Stauffer for
Dispensing Cost Survey
(Chain Pharmacies)

Sample
(Chain Pharmacies)

Myers and Stauffer LC

Certified Public Accountants

October 24, 2006

«Chain_Name»
ATTN: «Corporate_Contact_Person»
«Address_1»
«City», «State» «Zip»

Re: Pharmacy Cost of Dispensing Survey

To: Minnesota Chain Pharmacy Providers:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15.

In the last week, you should have received copies of the dispensing cost survey form and instructions. Your prompt response to the survey is very important to meeting the survey schedule set by the Legislature and the Department of Human Services. You are encouraged to submit a completed survey as soon as possible, but no later than November 17, 2006.

As a reminder, an Excel spreadsheet template of the survey forms to facilitate electronic survey submission is available on request (please e-mail Cheryl Richter at crichter@mslc.com or use the e-mail address below).

We are also enclosing a letter from the Minnesota Pharmacists Association and encourage you to review their comments regarding the dispensing cost survey.

If you have not received a survey form or if you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen

T. Allan Hansen
Project Manager
Phone: (913) 234-1038
E-mail: ahansen@mslc.com

Exhibit 7
First Letter from the Minnesota Pharmacists Association Regarding Pharmacy Dispensing Cost Survey

Julie K. Johnson, RPh
Executive Vice President/CEO
(651) 789-3204 Direct
julie@mpha.org

October 16, 2006

Dear Minnesota Pharmacist,

You have received a request for information designed by the accounting firm of Myers and Stauffer which will be used by the Department of Human Services to determine the cost of dispensing Medicaid prescriptions in the State of Minnesota. ***The need to accurately complete this survey in its entirety in the next few days cannot be over emphasized.***

This study is being conducted as a result of the legislation that was supported by MPhA and passed during the 2006 legislative session. The legislation mandated the study be conducted, and set up a Pharmacy Payment Reform Advisory Committee to make recommendations to the Legislature on the implementation of the Deficit Reduction Act (DRA) reforms that were passed in 2006.

Please do not assume everyone else is participating in the survey so your information will not be needed. We ask that each of you participate so the required number may be exceeded. To ensure accuracy you may wish to consult your accountant. Myers and Stauffer will also provide assistance if needed.

Time is of the essence. ***Please complete and return the survey to Myers and Stauffer in a timely manner.***

Sincerely,

Julie K. Johnson, Pharm.D.
Executive Vice President & CEO

Exhibit 8a
Third Letter from
Myers and Stauffer for
Dispensing Cost Survey
(Independent Pharmacies)

Sample (Independent Pharmacies)

Myers and Stauffer LC

Certified Public Accountants

November 3, 2006

«prov_no» / «random»
«prov_name»
ATTENTION: OWNER OR MANAGER
«address»
«city», «state» «zip»

Dear Pharmacy Owner or Manager:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15.

During October, you should have received a copy of the dispensing cost survey form and instructions. Your prompt response to the survey is very important to meeting the survey schedule set by the Legislature and the Department of Human Services. You are encouraged to submit a completed survey as soon as possible, but no later than November 17, 2006.

If you have already returned the survey form, please accept our thanks for your participation.

If you have not received a survey form or need a replacement survey form, please call toll free at 1-800-374-6858 to have a survey form faxed to you. If you prefer to have a survey form e-mailed to you, please e-mail Cheryl Richter at crichter@mslc.com

If you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen

T. Allan Hansen
Project Manager

11440 Tomahawk Creek Parkway • Leawood, Kansas 66211
(913) 234-1166 • (800) 374-6858 • FAX (913) 234-1104

Exhibit 8b
Third Letter from
Myers and Stauffer for
Dispensing Cost Survey
(Chain Pharmacies)

Sample
(Chain Pharmacies)

Myers and Stauffer LC

Certified Public Accountants

November 3, 2006

«Chain_Name»
ATTN: «Corporate_Contact_Person»
«Address_1»
«City», «State» «Zip»

Re: Pharmacy Cost of Dispensing Survey

To: Minnesota Chain Pharmacy Providers:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15.

During October, you should have received copies of the dispensing cost survey form and instructions. Your prompt response to the survey is very important to meeting the survey schedule set by the Legislature and the Department of Human Services. You are encouraged to submit a completed survey as soon as possible, but no later than November 17, 2006.

If you have already returned the survey form, please accept our thanks for your participation.

If you have not received a survey form or need a replacement survey form, please call toll free at 1-800-374-6858 to have a survey form faxed to you. If you prefer to have a survey form e-mailed to you, please e-mail Cheryl Richter at crichter@mslc.com

As a reminder, an Excel spreadsheet template of the survey forms to facilitate electronic survey submission is available on request (please e-mail Cheryl Richter at crichter@mslc.com or use the e-mail address below).

If you have not received a survey form or if you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen

T. Allan Hansen
Project Manager
Phone: (913) 234-1038
E-mail: ahansen@mslc.com

Exhibit 9a
Fourth Letter from
Myers and Stauffer for
Dispensing Cost Survey
(Independent Pharmacies)

Sample (Independent Pharmacies)

Myers and Stauffer LC

Certified Public Accountants

November 13, 2006

«prov_no» / «random»
«prov_name»
ATTENTION: OWNER OR MANAGER
«address»
«city», «state» «zip»

Re: URGENT REQUEST FOR PARTICIPATION IN THE PHARMACY COST STUDY

Dear Pharmacy Owner or Manager:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15.

During October, you should have received a copy of the dispensing cost survey form and instructions. **In order to allow more pharmacies time to respond to the dispensing cost survey, Myers and Stauffer will continue to accept surveys until November 30, 2006.**

We are also enclosing a letter from the Minnesota Pharmacists Association and encourage you to review their comments regarding participation in the dispensing cost survey.

If you have already returned the survey form, please accept our thanks for your participation.

If you have not received a survey form or need a replacement survey form, please call toll free at 1-800-374-6858 to have a survey form faxed to you. If you prefer to have a survey form e-mailed to you, please e-mail Cheryl Richter at crichter@mslc.com

If you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen
Project Manager

11440 Tomahawk Creek Parkway • Leawood, Kansas 66211
(913) 234-1166 • (800) 374-6858 • FAX (913) 234-1104

Exhibit 9b
Fourth Letter from Myers and Stauffer for Dispensing Cost Survey (Chain Pharmacies)

Sample
(Chain Pharmacies)

Myers and Stauffer LC

Certified Public Accountants

November 13, 2006

«Chain_Name»
ATTN: «Corporate_Contact_Person»
«Address_1»
«City», «State» «Zip»

Re: URGENT REQUEST FOR PARTICIPATION IN THE PHARMACY COST STUDY

To: Minnesota Chain Pharmacy Providers:

The Minnesota Department of Human Services has contracted with Myers and Stauffer LC to conduct a pharmacy dispensing cost survey. This survey is required by Minnesota Statute 282.16.15.

During October, you should have received a copy of the dispensing cost survey form and instructions. **In order to allow more pharmacies time to respond to the dispensing cost survey, Myers and Stauffer will continue to accept surveys until November 30, 2006.**

We are also enclosing a letter from the Minnesota Pharmacists Association and encourage you to review their comments regarding participation in the dispensing cost survey.

If you have already returned the survey form, please accept our thanks for your participation.

If you have not received a survey form or need a replacement survey form, please call toll free at 1-800-374-6858 to have a survey form faxed to you. If you prefer to have a survey form e-mailed to you, please e-mail Cheryl Richter at crichter@mslc.com

As a reminder, an Excel spreadsheet template of the survey forms to facilitate electronic survey submission is available on request (please e-mail Cheryl Richter at crichter@mslc.com).

If you have not received a survey form or if you have any questions, please call toll free at 1-800-374-6858. Your cooperation in providing the information for this study is greatly appreciated.

Sincerely,

T. Allan Hansen

T. Allan Hansen
Project Manager
Phone: (913) 234-1038
E-mail: ahansen@mslc.com

Exhibit 10
Second Letter from the Minnesota Pharmacists Association Regarding Pharmacy Dispensing Cost Survey

Julie K. Johnson, RPh
Executive Vice President/CEO
(651) 789-3204 Direct
julie@mpha.org

November 13, 2006

Dear Minnesota Pharmacist,

URGENT!

You have received a request for information designed by the accounting firm of Myers and Stauffer which will be used by the Department of Human Services to determine the cost of dispensing Medicaid prescriptions in the State of Minnesota.

The deadline for completion has been extended to November 30, 2006. Please make every effort to return your survey by this date.

This study is being conducted as a result of the legislation that was supported by MPhA and passed during the 2006 legislative session. The legislation mandated the study be conducted, and set up a Pharmacy Payment Reform Advisory Committee to make recommendations to the Legislature on the implementation of the Deficit Reduction Act (DRA) reforms that were passed in 2006. The information gathered in this survey is important as it will help us determine accurate data about the costs of dispensing prescriptions. Data has not been gathered to study this issue in Minnesota in over twenty years.

The need to accurately complete this survey in its entirety in the next few days cannot be over emphasized.

To ensure accuracy you may wish to consult your accountant. Myers and Stauffer will also provide assistance if needed at (800) 374-6858.

Sincerely,

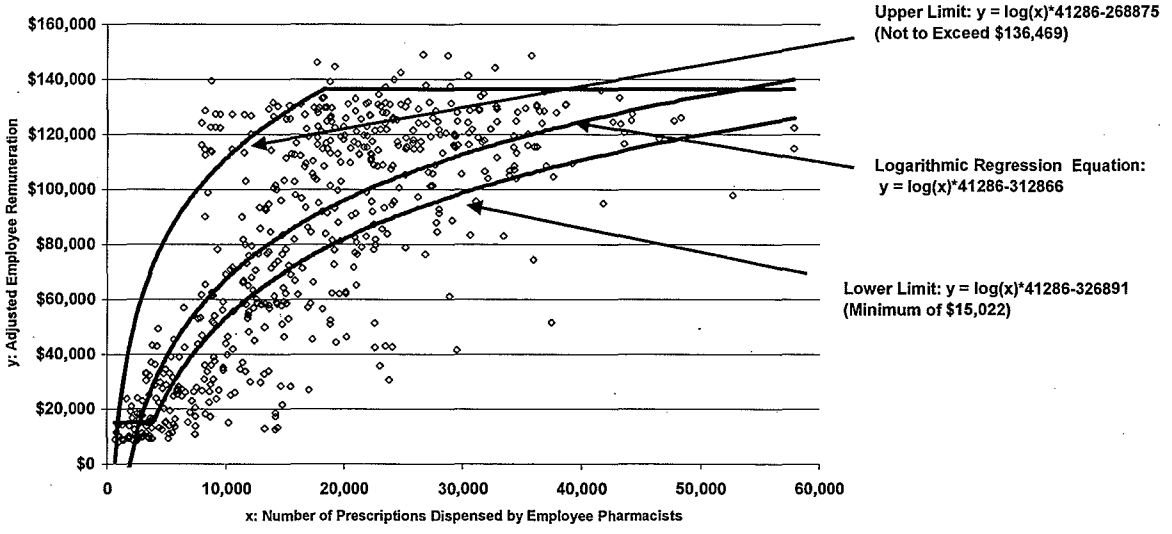
Julie K. Johnson, Pharm.D.
Executive Vice President & CEO

Exhibit 11
Construction and Application of Owner Pharmacist Salary Limits

Construction and Application of Owner Pharmacist Salary Limits

Minnesota Department of Human Services

Construction of Owner Pharmacist Salary Limits Based on Employee Pharmacist Salaries



Application of Owner Pharmacist Salary Limits

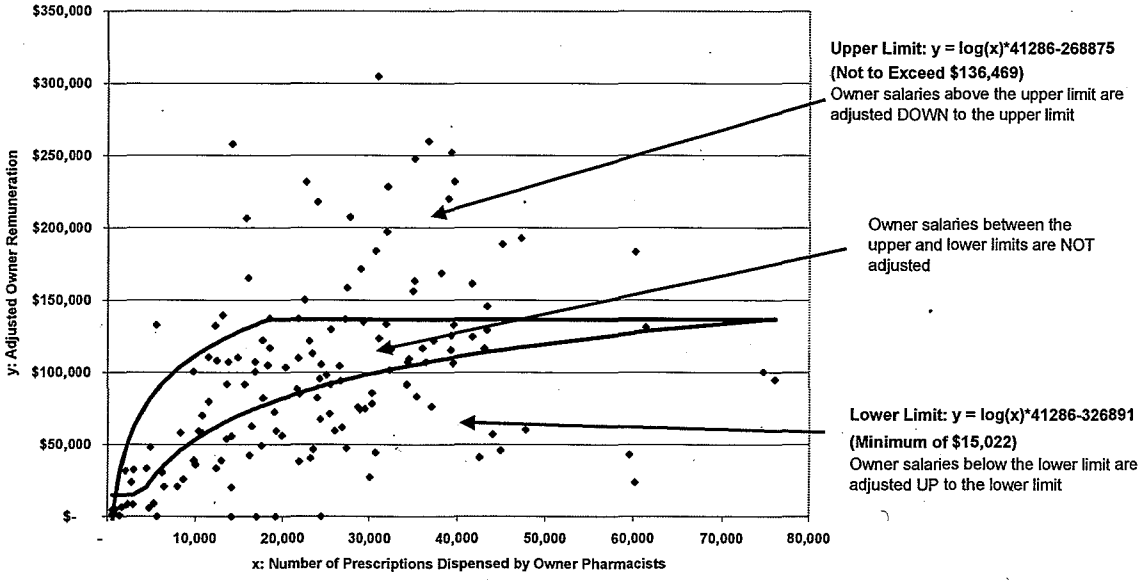


Exhibit 12
Table of Inflation Factors for Dispensing Cost Survey

Table of Inflation Factors for Dispensing Cost Survey
Minnesota Department of Human Services

Fiscal Year End Date	Midpoint Date	Midpoint Index [1]	Terminal Month Index (June 30, 2006) [1]	Inflation Factor	Number of Stores with Year End Date
3/31/2004	9/30/2003	185.2	202.9	1.096	1
4/30/2004	10/31/2003	185.0	202.9	1.097	0
5/31/2004	11/30/2003	184.5	202.9	1.100	0
6/30/2004	12/31/2003	184.3	202.9	1.101	0
7/31/2004	1/31/2004	185.2	202.9	1.096	0
8/31/2004	2/29/2004	186.2	202.9	1.090	0
9/30/2004	3/31/2004	187.4	202.9	1.083	0
10/31/2004	4/30/2004	188.0	202.9	1.079	0
11/30/2004	5/31/2004	189.1	202.9	1.073	0
12/31/2004	6/30/2004	189.7	202.9	1.070	1
1/31/2005	7/31/2004	189.4	202.9	1.071	0
2/28/2005	8/31/2004	189.5	202.9	1.071	0
3/31/2005	9/30/2004	189.9	202.9	1.068	0
4/30/2005	10/31/2004	190.9	202.9	1.063	0
5/31/2005	11/30/2004	191.0	202.9	1.062	0
6/30/2005	12/31/2004	190.3	202.9	1.066	4
7/31/2005	1/31/2005	190.7	202.9	1.064	0
8/31/2005	2/28/2005	191.8	202.9	1.058	0
9/30/2005	3/31/2005	193.3	202.9	1.050	15
10/31/2005	4/30/2005	194.6	202.9	1.043	1
11/30/2005	5/31/2005	194.4	202.9	1.044	0
12/31/2005	6/30/2005	194.5	202.9	1.043	434
1/31/2006	7/31/2005	195.4	202.9	1.038	2
2/28/2006	8/31/2005	196.4	202.9	1.033	2
3/31/2006	9/30/2005	198.8	202.9	1.021	13
4/30/2006	10/31/2005	199.2	202.9	1.019	2
5/31/2006	11/30/2005	197.6	202.9	1.027	0
6/30/2006	12/31/2005	196.8	202.9	1.031	27
7/31/2006	1/31/2006	198.3	202.9	1.023	1
8/31/2006	2/28/2006	198.7	202.9	1.021	3
9/30/2006	3/31/2006	199.8	202.9	1.016	7
10/31/2006	4/30/2006	201.5	202.9	1.007	1
11/30/2006	5/31/2006	202.5	202.9	1.002	0
12/31/2006	6/30/2006	202.9	202.9	1.000	1
Total Number of Stores					515

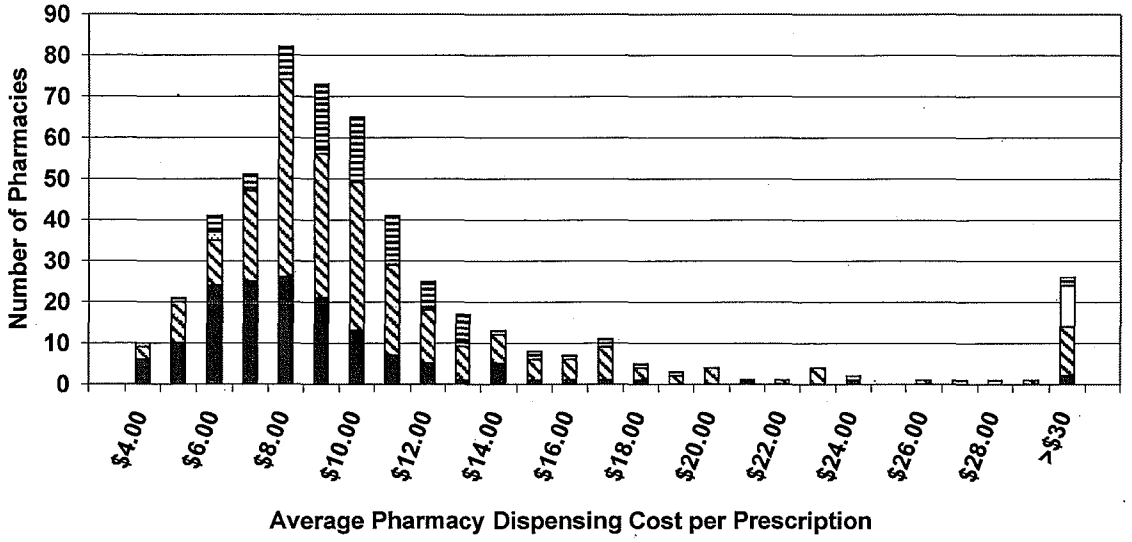
[1] Midpoint and terminal month indices were obtained from the Consumer Price Index, All Urban, as published by the Bureau of Labor Statistics (BLS).

Exhibit 13
Histograms of
Pharmacy Dispensing Cost and
Pharmacy Total
Prescription Volume

Histograms of Pharmacy Dispensing Cost and Pharmacy Total Prescription Volume

Minnesota Department of Human Services

Pharmacy Dispensing Cost



Pharmacy Total Prescription Volume

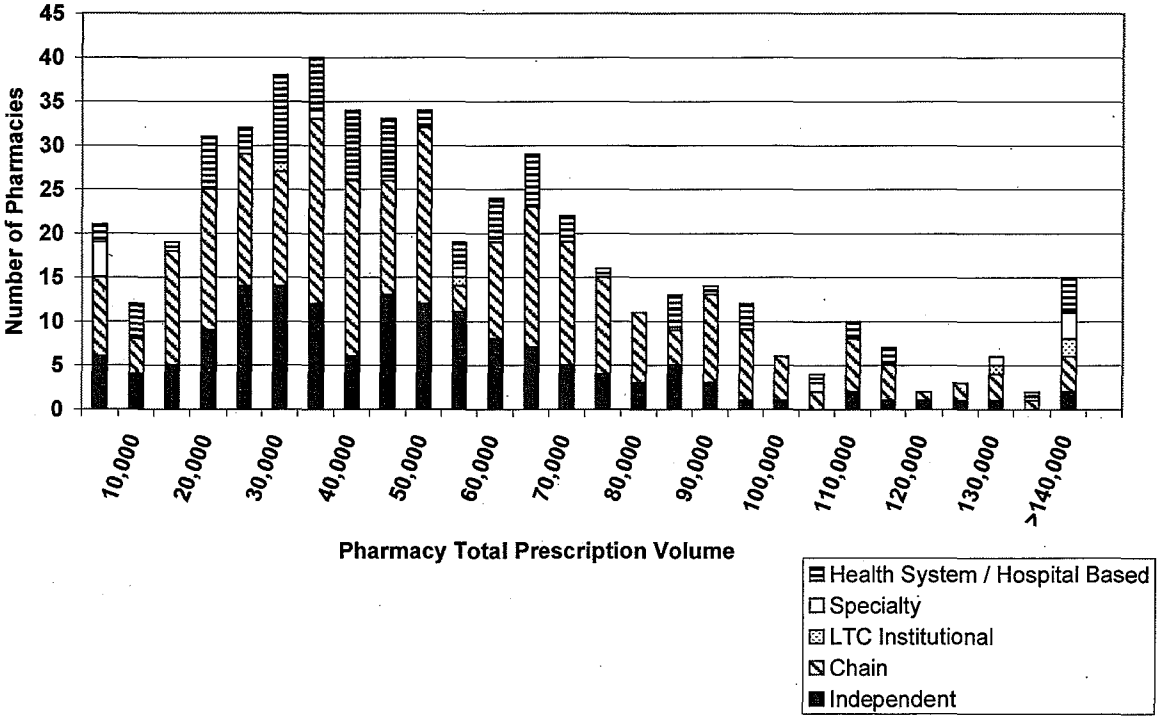


Exhibit 14
Pharmacy Dispensing Cost Survey Data – Statistical Summary

Pharmacy Dispensing Cost Survey
Statistical Summary
Minnesota Department of Human Services

Characteristic	n: Number of Pharmacies	Measurements of Central Tendency: Means: Mean	Means: Weighted by Total Rx Volume	Means: Weighted by Medicaid Rx Volume	Medians: Median	Medians: Weighted by Total Rx Volume	Medians: Weighted by Medicaid Rx Volume	Other Statistics: Standard Deviation	95% Confidence Interval for Mean (based on Student t): Lower Bound	Upper Bound	t Value (with n-1 degrees of freedom)
All Pharmacies in Sample	515	$12.46	$10.27	$11.34	$9.68	$9.08	$9.29	$11.82	$11.43	$13.48	1.96
Non Specialty Pharmacies	**502**	**$11.25**	**$9.40**	**$9.59**	**$9.61**	**$8.92**	**$9.22**	**$6.71**	**$10.66**	**$11.84**	**1.96**
Specialty Pharmacies	13	$59.18	$28.78	$47.47	$50.05	$16.15	$47.71	$40.96	$34.43	$83.93	2.18
Non Specialty Pharmacies Only											
Chain Retail Pharmacies	261	$12.29	$9.61	$9.97	$10.01	$8.93	$9.50	$8.05	$11.31	$13.27	1.97
Independent Retail Pharmacies	151	$9.27	$8.38	$8.46	$8.54	$7.88	$7.93	$4.22	$8.59	$9.95	1.98
Health System / Hospital Based Pharmacies	85	$11.72	$10.87	$10.37	$10.64	$10.56	$9.41	$4.93	$10.65	$12.78	1.99
Long-Term Care Institutional Pharmacies	5	$8.43	$7.82	$9.86	$6.41	$6.46	$6.78	$3.76	$3.76	$13.11	2.78
Location:											
Urban	322	$12.20	$9.69	$9.87	$10.01	$9.21	$9.22	$7.72	$11.35	$13.05	1.97
Rural	180	$9.54	$8.76	$8.99	$9.01	$8.63	$8.86	$3.79	$8.99	$10.10	1.97
Annual Rx Volume:											
0 to 9,999	21	$32.96	$30.43	$29.33	$34.20	$33.09	$33.13	$15.75	$25.79	$40.12	2.09
10,000 to 29,999	94	$13.96	$13.46	$13.14	$12.63	$12.46	$11.74	$5.67	$12.80	$15.13	1.99
30,000 to 49,999	144	$10.39	$10.33	$10.10	$10.11	$10.08	$10.03	$2.86	$9.92	$10.87	1.98
50,000 to 74,999	127	$9.25	$9.23	$9.22	$9.26	$9.25	$9.32	$2.25	$8.86	$9.65	1.98
75,000 and Higher	116	$8.36	$8.31	$9.03	$8.07	$8.05	$9.19	$2.30	$7.93	$8.78	1.98
Annual Medicaid Rx Volume:											
0 to 999	139	$15.63	$11.55	$13.18	$10.99	$9.89	$10.84	$10.64	$13.84	$17.41	1.98
1,000 to 1,499	78	$10.24	$9.48	$10.23	$9.24	$8.74	$9.23	$3.37	$9.48	$11.00	1.99
1,500 to 2,499	96	$9.87	$9.33	$9.89	$9.48	$9.02	$9.47	$3.05	$9.25	$10.49	1.99
2,500 to 4,999	113	$9.22	$8.84	$9.26	$8.80	$8.63	$8.84	$2.64	$8.73	$9.71	1.98
5,000 and Higher	76	$9.02	$8.70	$9.32	$9.04	$8.31	$9.16	$2.84	$8.37	$9.67	1.99
Medicaid Utilization Ratio:											
0.0% to 1.99%	131	$11.51	$9.29	$9.33	$9.55	$8.85	$8.90	$6.75	$10.35	$12.68	1.98
2.0% to 4.99%	206	$11.88	$9.92	$9.89	$9.82	$9.23	$9.24	$7.97	$10.78	$12.97	1.97
5.0% to 9.99%	107	$9.62	$8.50	$8.42	$8.99	$8.05	$7.97	$3.11	$9.02	$10.21	1.98
10.0% to 14.99%	30	$11.10	$9.95	$10.00	$10.57	$9.85	$10.13	$5.09	$9.20	$13.00	2.05
15.0% and Higher	28	$11.75	$9.98	$10.56	$10.00	$9.03	$9.99	$7.27	$8.93	$14.57	2.05

Notes:

All pharmacy dispensing costs are inflated by the CPI(U) to the common point of 6/30/2006.

Exhibit 15
Table of Zip Codes, Counties and Urban Versus Rural Designations

Table of Zip Codes, Counties and Urban Versus Rural Designations

Minnesota Department of Human Services

Zip Code	County	Urban Versus Rural Indicator
55008	ISANTI	U
55009	GOODHUE	R
55012	CHISAGO	U
55013	CHISAGO	U
55014	ANOKA	U
55016	WASHINGTON	U
55019	RICE	R
55021	RICE	R
55024	DAKOTA	U
55025	WASHINGTON	U
55033	DAKOTA	U
55037	PINE	R
55040	ISANTI	U
55041	WABASHA	R
55042	WASHINGTON	U
55044	DAKOTA	U
55045	CHISAGO	U
55046	RICE	R
55051	KANABEC	R
55055	WASHINGTON	U
55056	CHISAGO	U
55057	RICE	R
55060	STEELE	R
55063	PINE	R
55066	GOODHUE	R
55068	DAKOTA	U
55069	CHISAGO	U
55070	ANOKA	U
55072	PINE	R
55075	DAKOTA	U
55076	DAKOTA	U
55077	DAKOTA	U
55082	WASHINGTON	U
55092	CHISAGO	U
55101	RAMSEY	U
55102	RAMSEY	U
55103	RAMSEY	U
55104	RAMSEY	U
55105	RAMSEY	U
55106	RAMSEY	U
55107	RAMSEY	U
55108	RAMSEY	U
55109	RAMSEY	U
55110	RAMSEY	U
55112	RAMSEY	U
55113	RAMSEY	U
55114	RAMSEY	U
55115	WASHINGTON	U
55116	RAMSEY	U
55117	RAMSEY	U
55118	DAKOTA	U
55119	RAMSEY	U
55120	DAKOTA	U
55121	DAKOTA	U
55122	DAKOTA	U
55123	DAKOTA	U
55124	DAKOTA	U
55125	WASHINGTON	U
55126	RAMSEY	U
55127	RAMSEY	U
55128	WASHINGTON	U
55129	WASHINGTON	U
55301	WRIGHT	U
55302	WRIGHT	U
55303	ANOKA	U
55304	ANOKA	U
55305	HENNEPIN	U
55306	DAKOTA	U
55307	SIBLEY	R
55308	SHERBURNE	U
55309	SHERBURNE	U
55311	HENNEPIN	U
55313	WRIGHT	U
55316	HENNEPIN	U
55317	CARVER	U
55318	CARVER	U
55320	WRIGHT	U
55321	WRIGHT	U
55325	MEEKER	R
55328	WRIGHT	U
55330	SHERBURNE	U
55331	HENNEPIN	U
55334	SIBLEY	R
55336	MC LEOD	R
55337	DAKOTA	U
55343	HENNEPIN	U
55344	HENNEPIN	U
55345	HENNEPIN	U
55346	HENNEPIN	U
55347	HENNEPIN	U
55349	WRIGHT	U
55350	MC LEOD	R
55355	MEEKER	R
55356	HENNEPIN	U
55359	HENNEPIN	U
55362	WRIGHT	U
55364	HENNEPIN	U
55368	CARVER	U
55369	HENNEPIN	U
55371	MILLE LACS	R
55372	SCOTT	U
55374	HENNEPIN	U
55376	WRIGHT	U
55378	SCOTT	U
55379	SCOTT	U
55387	CARVER	U
55388	CARVER	U
55391	HENNEPIN	U
55395	MC LEOD	R
55396	SIBLEY	R

Table of Zip Codes, Counties and Urban Versus Rural Designations

Minnesota Department of Human Services

Zip Code	County	Urban Versus Rural Indicator
55398	SHERBURNE	U
55402	HENNEPIN	U
55403	HENNEPIN	U
55404	HENNEPIN	U
55405	HENNEPIN	U
55406	HENNEPIN	U
55407	HENNEPIN	U
55408	HENNEPIN	U
55410	HENNEPIN	U
55411	HENNEPIN	U
55412	HENNEPIN	U
55413	HENNEPIN	U
55414	HENNEPIN	U
55415	HENNEPIN	U
55416	HENNEPIN	U
55418	HENNEPIN	U
55419	HENNEPIN	U
55420	HENNEPIN	U
55421	ANOKA	U
55422	HENNEPIN	U
55423	HENNEPIN	U
55424	HENNEPIN	U
55426	HENNEPIN	U
55427	HENNEPIN	U
55428	HENNEPIN	U
55429	HENNEPIN	U
55430	HENNEPIN	U
55431	HENNEPIN	U
55432	ANOKA	U
55433	ANOKA	U
55434	ANOKA	U
55435	HENNEPIN	U
55436	HENNEPIN	U
55437	HENNEPIN	U
55438	HENNEPIN	U
55441	HENNEPIN	U
55442	HENNEPIN	U
55443	HENNEPIN	U
55444	HENNEPIN	U
55445	HENNEPIN	U
55446	HENNEPIN	U
55447	HENNEPIN	U
55448	ANOKA	U
55449	ANOKA	U
55454	HENNEPIN	U
55455	HENNEPIN	U
55604	COOK	R
55614	LAKE	R
55616	LAKE	R
55705	ST. LOUIS	U
55706	ST. LOUIS	U
55719	ST. LOUIS	U
55720	CARLTON	R
55723	ST. LOUIS	U
55731	ST. LOUIS	U
55734	ST. LOUIS	U
55744	ITASCA	R
55746	ST. LOUIS	U
55750	ST. LOUIS	U
55760	AITKIN	R
55767	CARLTON	R
55769	ITASCA	R
55771	ST. LOUIS	U
55792	ST. LOUIS	U
55802	ST. LOUIS	U
55803	ST. LOUIS	U
55804	ST. LOUIS	U
55805	ST. LOUIS	U
55806	ST. LOUIS	U
55807	ST. LOUIS	U
55810	ST. LOUIS	U
55811	ST. LOUIS	U
55901	OLMSTED	U
55902	OLMSTED	U
55904	OLMSTED	U
55905	OLMSTED	U
55906	OLMSTED	U
55909	MOWER	R
55912	MOWER	R
55917	STEELE	R
55920	OLMSTED	U
55921	HOUSTON	U
55923	FILLMORE	R
55939	FILLMORE	R
55943	HOUSTON	U
55944	DODGE	R
55946	GOODHUE	R
55947	HOUSTON	U
55963	GOODHUE	R
55964	WABASHA	R
55965	FILLMORE	R
55971	FILLMORE	R
55972	WINONA	R
55974	HOUSTON	U
55975	FILLMORE	R
55976	OLMSTED	U
55981	WABASHA	R
55987	WINONA	R
55992	GOODHUE	R
56001	BLUE EARTH	R
56003	NICOLLET	R
56007	FREEBORN	R
56011	SCOTT	U
56013	FARIBAULT	R
56019	BROWN	R
56031	MARTIN	R
56048	WASECA	R
56055	BLUE EARTH	R
56057	LE SUEUR	R
56058	LE SUEUR	R

Table of Zip Codes, Counties and Urban Versus Rural Designations
Minnesota Department of Human Services

Zip Code	County	Urban Versus Rural Indicator
56062	WATONWAN	R
56065	BLUE EARTH	R
56069	LE SUEUR	R
56071	LE SUEUR	R
56072	WASECA	R
56073	BROWN	R
56081	WATONWAN	R
56082	NICOLLET	R
56085	BROWN	R
56087	BROWN	R
56093	WASECA	R
56096	LE SUEUR	R
56097	FARIBAULT	R
56101	COTTONWOOD	R
56110	NOBLES	R
56136	LINCOLN	R
56142	LINCOLN	R
56143	JACKSON	R
56150	JACKSON	R
56152	REDWOOD	R
56156	ROCK	R
56159	COTTONWOOD	R
56164	PIPESTONE	R
56172	MURRAY	R
56175	LYON	R
56178	LINCOLN	R
56183	COTTONWOOD	R
56187	NOBLES	R
56201	KANDIYOHI	R
56208	SWIFT	R
56215	SWIFT	R
56219	TRAVERSE	R
56220	YELLOW MEDCINE	R
56222	CHIPPEWA	R
56223	YELLOW MEDCINE	R
56232	LAC QUI PARLE	R
56240	BIG STONE	R
56241	YELLOW MEDCINE	R
56248	GRANT	R
56256	LAC QUI PARLE	R
56258	LYON	R
56265	CHIPPEWA	R
56267	STEVENS	R
56277	RENVILLE	R
56278	BIG STONE	R
56283	REDWOOD	R
56284	RENVILLE	R
56288	KANDIYOHI	R
56296	TRAVERSE	R
56301	STEARNS	U
56303	STEARNS	U
56304	STEARNS	U
56307	STEARNS	U
56308	DOUGLAS	R
56309	GRANT	R

Zip Code	County	Urban Versus Rural Indicator
56312	STEARNS	U
56320	STEARNS	U
56321	STEARNS	U
56329	BENTON	U
56334	POPE	R
56342	MILLE LACS	R
56345	MORRISON	R
56347	TODD	R
56352	STEARNS	U
56353	MILLE LACS	R
56359	MILLE LACS	R
56360	DOUGLAS	R
56361	OTTER TAIL	R
56362	STEARNS	U
56364	MORRISON	R
56372	STEARNS	U
56374	STEARNS	U
56377	STEARNS	U
56378	STEARNS	U
56379	BENTON	U
56381	POPE	R
56387	STEARNS	U
56401	CROW WING	R
56425	CROW WING	R
56431	AITKIN	R
56437	TODD	R
56440	TODD	R
56441	CROW WING	R
56442	CROW WING	R
56464	WADENA	R
56466	MORRISON	R
56468	CROW WING	R
56470	HUBBARD	R
56472	CROW WING	R
56473	CASS	R
56474	CASS	R
56479	TODD	R
56482	WADENA	R
56484	CASS	R
56501	BECKER	R
56510	NORMAN	R
56514	CLAY	U
56515	OTTER TAIL	R
56520	WILKIN	R
56529	CLAY	U
56531	GRANT	R
56537	OTTER TAIL	R
56538	OTTER TAIL	R
56540	POLK	U
56542	POLK	U
56544	BECKER	R
56549	CLAY	U
56551	OTTER TAIL	R
56557	MAHNOMEN	R
56560	CLAY	U

Table of Zip Codes, Counties and Urban Versus Rural Designations
Minnesota Department of Human Services

Zip Code	County	Urban Versus Rural Indicator
56563	CLAY	U
56567	OTTER TAIL	R
56569	BECKER	R
56571	OTTER TAIL	R
56572	OTTER TAIL	R
56573	OTTER TAIL	R
56584	NORMAN	R
56601	BELTRAMI	R
56621	CLEARWATER	R
56623	LAKE OF WOODS	R
56628	ITASCA	R
56630	BELTRAMI	R
56633	CASS	R
56634	CLEARWATER	R
56636	ITASCA	R
56649	KOOCHICHING	R
56653	KOOCHICHING	R
56671	BELTRAMI	R
56701	PENNINGTON	R
56716	POLK	U
56721	POLK	U
56726	ROSEAU	R
56728	KITTSON	R
56732	KITTSON	R
56750	RED LAKE	R
56751	ROSEAU	R
56762	MARSHALL	R
56763	ROSEAU	R

Exhibit 16
Summary of Pharmacy Attributes

Summary of Pharmacy Attributes
Minnesota Department of Human Services

Attribute	Number of Pharmacies Responding	Average for Responding Pharmacies
Type of Ownership	505	Individual: 14 (2.8%) Corporation: 452 (89.5) Partnership: 27 (5.3%) Other: 12 (2.4%)
Location	505	Medical office building: 113 (22.3%) Shopping center: 24 (4.8%) Separate or downtown: 131(25.9%) Grocery store / mass merchant: 217 (43.0%) Other: 20 (4.0%)
Building ownership (or rented from related party)	446	Yes, own building (or rent from related party): 258 (57.8%) No: 188 (42.2%)
Provision of Unit Dose Services	407	Yes: 176 (43.2%) (average of 19.7% of prescriptions for pharmacies indicating provision of unit dose prescriptions. 95% of unit dose prescriptions were prepared in the pharmacy; 5% were purchased already prepared from a manufacturer) No: 231 (56.8%)
Provision of Compounding Services	—	3% for all pharmacies (assuming 0% for non-responding pharmacies)
Hours Open Per Week	502	63.29 hours
Percent of prescriptions (See Note 1)	490	Averages Medicaid: 10.7% Other third party: 81.1% Cash: 8.3%
Percent of payments (See Note 2)	490	Averages Medicaid: 11.8% Other third party: 79.8% Cash: 8.4%
Provision of intravenous or home infusion prescriptions	496	Yes: 9 (1.8%) No: 487 (98.2%)

Notes

Note 1: Based on reported total prescriptions dispensed and Medicaid prescriptions per provider file received from the Department of Human Services, Myers and Stauffer estimates average Medicaid prescription volume as 6.3%. Medicaid utilization reported by the provider is based on their fiscal year. Myers and Stauffer's estimate using Medicaid data is based on total prescriptions reported by provider for their fiscal year and annualized Medicaid volume for time period 1/1/2006 to 6/30/2006. Differences in calculated Medicaid utilization ratios may be due to differences in the reporting time period and the introduction of the Medicare Part D pharmacy benefit on 1/1/2006.

Note 2: Based on reported total prescription sales and Medicaid payments per provider file received from the Department of Human Services, Myers and Stauffer estimates average Medicaid prescription payment volume as 6.4%. Medicaid utilization reported by the provider is based on their fiscal year. Myers and Stauffer's estimate using Medicaid data is based on total prescriptions reported by provider for their fiscal year and annualized Medicaid volume for time period 1/1/2006 to 6/30/2006. Differences in calculated Medicaid utilization ratios may be due to differences in the reporting time period and the introduction of the Medicare Part D pharmacy benefit on 1/1/2006.