

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PHARMACY TAC

November 5, 2019
9:30 A.M.
Department for Medicaid Services
Café Conference Room
275 East Main Street
Frankfort, Kentucky

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AGENDA

1. Call to Order, Welcome & Introductions
2. Approval of Minutes/Report from the September 17, 2019 PTAC meeting
3. Roundtable Report out on Current State of Affairs
 - * Department of Medicaid
 - Copays - can amount member has paid out of pocket toward quarterly max be communicated during adjudication or on kyhealth.net portal
 - Feedback on accuracy of data from pharmacies
 - SB 5 Data Report Release Update if needed
 - 340B Policy Update
 - MCO Contract/RFP/Open Enrollment
 - * CareSource
 - New ID cards for Humana Medicaid to start 1/1/20
 - * Aetna
 - defer CPESN update to next meeting
 - * WellCare
 - * Anthem
 - Ingenio Rx Go Live 10/1/19
 - * Passport
 - * PTAC Committee members
4. Follow-up on previous agenda items
 - * Pharmacist reporting immunizations to KYIR update
 - * DMS Quality Strategy - how can pharmacists in KY help
5. New Business/Take-aways
6. Reports and recommendations from the PTAC to the MAC
7. Other Business
8. Next Steps
 - * Next MAC meeting - November 21, 2019
 - * Appointment of PTAC Member Representative at the MAC meeting
 - * Next PTAC meeting - February 4, 2020
9. Adjourn

1 DR. FRANCIS: We will go ahead
2 and call the Pharmacy TAC meeting to order today and
3 we'll start with introductions.

4 (INTRODUCTIONS)

5 DR. FRANCIS: Great. Thank you
6 all for coming. I appreciate it. If everybody could
7 say their name before they speak, it just helps our
8 court reporter here with minutes and the
9 transcription.

10 So, I just wanted to go over
11 and get an approval of the September 17th minutes. I
12 didn't have physical minutes but I had the transcript
13 and I sent those out. I did just ask Sharley to
14 please post both minutes and the transcript to the
15 TAC website so that everybody could refer back there.

16 So, just as a norm, whenever
17 the court reporter has those ready for Sharley, she
18 will post them, alert me and----

19 MS. HUGHES: I don't post them
20 until after they are approved.

21 DR. FRANCIS: Okay. So,
22 previous meetings you'll post.

23 MS. HUGHES: Right.

24 DR. FRANCIS: I did read the
25 transcript from the September 17th meeting and I

1 noticed two clarifications potentially to make just
2 for the record. One, on Page 7, Line 18, it
3 identified Mark Glasper as responding but it was
4 actually Chris Palutis from KPhA, Chair of the Board.
5 So, I'm just noting that.

6 And, then, also, David Gray and
7 I had some conversations just to refer for the
8 KyHealth.net web address is actually that actual
9 physical address that I have here on our agenda, the
10 kymmis. You can search KyHealth but if you're giving
11 someone a web address, this one actually gets you to
12 the right location, and, thanks, Matt, for bringing
13 that up.

14 Do we have approval of the
15 minutes other than that?

16 MS. GRAY: I make a motion to
17 approve.

18 DR. BETZ: I'll second.

19 DR. FRANCIS: Cindy and Chris
20 approved those. Thank you.

21 So, we will start into our
22 roundtable. We'll let DMS go first as normal, and I
23 just had some followups from our last discussion on
24 there but Jessin or Commissioner.

25 DR. JOSEPH: So, the copay

1 amounts, again, system changes were to be required.
2 So, I don't know if we're going to go down that route
3 to put the actual dollar amount in because it changes
4 every day.

5 And, so, right now, it's being
6 utilized by the daily files that are sent over at
7 night and that's really the extent of KYMMIS.

8 From my understanding at last
9 month's or two months ago's meeting, not everybody
10 was aware of it. So, we have created the document or
11 the cheat sheet for pharmacists. So, we just have to
12 send that over to Mark for distribution to the other
13 pharmacists.

14 Again, it's as accurate as what
15 we get back in our data. And, so, that's going to be
16 the case for everything. The way it's set up is it's
17 set on basically a threshold or a trigger. So, once
18 it meets a certain dollar amount, then, the "N"
19 changes to a "Y" that, yes, they have met their copay
20 or their cost share for that quarter.

21 DR. FRANCIS: At our last
22 meeting, you had said you had a few meetings coming
23 up with pharmacists just to check the accuracy. Had
24 you had any issues with that?

25 DR. JOSEPH: No, I haven't had

1 any issues yet. So, I'll keep my eyes out for that.
2 So, if you guys see issues while you're working,
3 then, let us know and we can act pretty quickly on
4 that.

5 COMMISSIONER STECKEL: And
6 specifics, please, specifics.

7 DR. JOSEPH: Patient name,
8 member ID, all those things because then we can just
9 dive right in and figure out what's going on. That's
10 the extent for a copay.

11 The SB 5 Data Report, we're
12 still monitoring MAT prices. We did have a meeting
13 with some pharmacists about a month ago. There were
14 issues around what we were allowing to be approved
15 and what we were disapproving.

16 The mechanism, the algorithm
17 that we use right now according to what we're seeing
18 in the field is still accurate. The bigger issue is
19 the dispensing fee, I think, and that's being
20 negotiated with the pharmacies; but in terms of the
21 MAT prices, the ingredient costs that we all agreed
22 to when SB 5 and those reimbursements dropped, what
23 we decided at that time was we can monitor the
24 ingredient costs, so, the MAT price that comes to our
25 files. And, so, that's what we're basing everything

1 off of, right, what's going on in the actual market,
2 the national market and, then, the acquisition cost.

3 So, when we approve those, we
4 know that the data that we get is approved based off
5 of what's on national benchmarks. And what we saw at
6 that meeting with the other pharmacists not too long
7 ago was that the national markets may not be
8 reflective of Kentucky.

9 Again, we stressed that from
10 the get-go saying this is a national data set, so,
11 it's not like it's always going to be accurate. And,
12 so, the Commissioner and I have had the conversation
13 of using actual acquisition costs.

14 So, just like how NADAC is for
15 National Average Drug Acquisition Cost, we may - we
16 have to discuss it a little bit more - but using a
17 Kentucky-specific actual acquisition cost. The same
18 process there. You would have a random sample of
19 pharmacies. Pharmacists would be required to fill
20 out the survey, send it back and, then, we would
21 calculate what that acquisition cost is for the state
22 or the average acquisition cost for the state.

23 However, we haven't fully gone
24 down that route yet because the NADAC is still there
25 and we're still utilizing the NADAC in our SPA. So,

1 there's a number of changes that would be required if
2 we moved down that route. That's really it for SB 5.

3 Anthem is now live with
4 Ingenio. And, so, those rates were approved by us.
5 Humana is moving to Humana Pharmacy Solution starting
6 1/1 and we'll be evaluating those rates as well. So,
7 that will be coming and approvals or disapprovals
8 will come as time goes on.

9 The only other thing is the
10 340B policy update. We have taken all the feedback
11 so far from all the covered entities. We have
12 compiled responses. Again, a lot of it was similar
13 to one another because the document wasn't the
14 longest but it raised the same concerns from all the
15 covered entities.

16 So, what we're doing right now
17 is we've addressed it. We're just running it through
18 the proper folks here before we put it out on our
19 website for final effective dates.

20 The current effective date is
21 1/1. We are planning on changing that effective date
22 and providing a grace period for pharmacists and
23 covered entities. So, while our system - and I think
24 a lot of pharmacies received a notice that you can
25 start putting the claimable identifiers on the

1 claims. That notice was just because our system
2 administrator now has a field to capture those
3 claimable identifiers. That didn't mean that it was
4 going live.

5 So, we did address those
6 concerns pretty quick, but moving forward now that we
7 have this ability, 1/1, we will start being able to
8 fully take those on and, then, the grace period will
9 be until 4/1/2020 where everything will go live and
10 it will be effective.

11 So, our rebate invoicing
12 process for right now will change on 4/1/2020. We
13 have to start it at the start of a quarter due to CMS
14 rebates being calculated at the end of the quarter.

15 We'll put out a final notice on
16 everything in the next few days.

17 DR. FRANCIS: In the next few
18 days?

19 DR. JOSEPH: Yes. And we have
20 a list of a number of pharmacy organizations,
21 hospital organizations----

22 DR. FRANCIS: Anyone that
23 submitted comments, will they get a specific
24 response?

25 DR. JOSEPH: Yes. Everybody

1 who has submitted a comment will get the final
2 feedback and comments and responses.

3 COMMISSIONER STECKEL: Now, if
4 they're like comments, we're going to group them
5 together and give one answer, but, yes, absolutely.

6 DR. JOSEPH: Yes, and we tried
7 to address everything as much as we can. So, if
8 there's something that we didn't address and your
9 entity or your group position has sent in a comment
10 that we haven't addressed, let me know and we can
11 figure out why we didn't address it or get you an
12 actual response; but from my understanding, we have
13 gone through all of them and at least touched on all
14 the points that everyone has made.

15 MS. HUGHES: Will that also be
16 on the website?

17 DR. JOSEPH: Yes. That will be
18 on the DMS Pharmacy website.

19 I will let the Commissioner
20 talk about the MCO contract.

21 COMMISSIONER STECKEL: We can't
22 talk about it. That was easy. We're hoping by
23 December 1st, hoping to have a public announcement
24 but I would not hold my breath. So, we will release
25 the new contractors as soon as we are able to.

1 DR. CARRICO: I have a
2 question. Matt Carrico. Jessin, you're basically
3 talking about doing like a Kentucky NADAC study.

4 DR. JOSEPH: Yes.

5 DR. CARRICO: Will that be just
6 from primary wholesalers because most of the site
7 wholesalers, those prices at times are not accurate
8 because they're short dates and stuff like that.

9 DR. JOSEPH: So, we won't go to
10 the wholesalers. We'll go to you.

11 DR. CARRICO: Is it going to be
12 like CMS does where they ask you, can you send in all
13 your invoices?

14 DR. JOSEPH: Yes.

15 DR. CARRICO: All right. So,
16 would you guys throw out like short-date stuff, like
17 those outliers?

18 DR. JOSEPH: We'll have to talk
19 to the study team on that. That won't be coming from
20 us.

21 COMMISSIONER STECKEL: Talk to
22 your peers in Alabama. They've gone through this
23 very similar thing that we're thinking about. So,
24 they can explain what they felt like about it.

25 DR. CARRICO: Okay. How often

1 would it be updated? Is it like an annual thing?

2 DR. JOSEPH: No, no. That
3 would be too hard, too long of a gap. So, my
4 understanding is we would do it at least monthly.

5 DR. CARRICO: Oh, nice.

6 DR. JOSEPH: So, we would send
7 those reports out monthly. You all would file it
8 back, send it back. There is going to be a lag until
9 the data is compiled and put together.

10 So, while the surveys are sent
11 out monthly and the random samples are decided
12 monthly, the rates would be just like a one-month lag
13 or a few-week lag on those. From my understanding,
14 CMS actually just has--they've been pretty effective
15 on CMS' end where they do it weekly but they have a
16 much larger pool.

17 COMMISSIONER STECKEL: And it
18 can be done biweekly, every two weeks, whatever that
19 is. And there's a mechanism also for lack of access,
20 so, if the manufacturer stops producing it or
21 whatever, so,, you've got mechanisms to override the
22 system if there are unusual circumstances.

23 But we promise you all and I
24 think we've proven that we live up to this that you
25 all will be involved in the discussions of this if we

1 move forward with it, intimately involved, probably
2 more than you want to be involved in how we develop
3 it and how we move forward, what's on the survey,
4 what's not on the survey.

5 DR. JOSEPH: Let me ask this.
6 When a pharmacist gets a NADAC survey, are you
7 filling it out every time?

8 DR. CARRICO: Maybe once every
9 year.

10 COMMISSIONER STECKEL: Is that
11 the survey, you get it once a year or you fill it out
12 once a year?

13 DR. CARRICO: I feel like I see
14 it maybe twice a year, but it takes a while because
15 you have to send out the stuff to that wholesaler and
16 have them send them back.

17 DR. JOSEPH: So, if we did a
18 State AAC, one of the things that we would ask is we
19 would probably make it a requirement for pharmacists
20 to fill it out only because that's the most accurate
21 way that we'll get the actual acquisition cost.

22 I don't want to add undue
23 burden on you all to send in invoices or things like
24 that, but, really, if we want to get to what the cost
25 should be for a drug, then, we may have to just

1 require it. I'm just putting it on the table but
2 that is an option that we would consider.

3 COMMISSIONER STECKEL: Well, it
4 would have to be required, but there are ways. What
5 we did is we divided the pharmacies up and one group
6 of pharmacies got it one month, another group got it
7 the next month so that you weren't having to fill out
8 a survey every month and trying to ease the burden.

9 And the one thing about going
10 behind states is we can figure out ways to ease the
11 burden from the experience of the previous states.
12 Does Tennessee do an AAC?

13 DR. JOSEPH: Yes, Tennessee
14 does one.

15 COMMISSIONER STECKEL: So, I
16 thought it was Alabama, Tennessee and who else? Is
17 there another one?

18 DR. JOSEPH: I know we use
19 Alabama and Tennessee. We'll look at Alabama and
20 Tennessee.

21 COMMISSIONER STECKEL: So, we
22 can learn from their experience to figure out how we
23 can make this as easy as possible.

24 DR. CARRICO: Okay. Another
25 one was with the \$10.64 dispensing fee, is the State

1 looking at doing their own study in how much it costs
2 because, I mean, I like it but it's been the same for
3 a while. Things get more expensive. Inflation
4 happens. Employees get raises. I mean, I like
5 \$10.64 but I don't want to be making \$10.64 in seven
6 years because it's not the same as now.

7 DR. JOSEPH: So, yeah, the
8 cost-of-dispensing fee is going to be a necessity if
9 there is a carve-out. I don't know if we've
10 discussed it if there isn't a carve-out. All my
11 conversations so far has been if we carve out, we do
12 want to start taking a closer look at our dispensing
13 fee.

14 From my understanding, too,
15 historically, what Kentucky did was we submitted a
16 State Plan Amendment for something like \$6 or \$7, got
17 rejected by CMS, went up to \$8 or \$9, got rejected by
18 CMS until we went to \$10.64.

19 COMMISSIONER STECKEL: You have
20 to find out where their floor is. So, you go in low.
21 I'm just teasing.

22 DR. JOSEPH: But what that
23 means is the State hasn't done one yet, right? The
24 State has basically been leveraging what other states
25 have done to get to \$10.64. So, I think it's prudent

1 that we do one at some point, but what that is I
2 don't know.

3 DR. CARRICO: I just wondered
4 because I heard Wisconsin is like sixteen something
5 and I just have a hard time thinking you get 60%
6 more.

7 COMMISSIONER STECKEL: Well,
8 don't even go down that road.

9 DR. CARRICO: I just have a
10 hard time thinking if they're that much higher than
11 us to fill a prescription.

12 DR. FRANCIS: Shannon.

13 MS. STIGLITZ: Just a
14 clarification going back. It was my understanding at
15 least two years ago from the former Commissioner that
16 the feds actually wanted Kentucky to pay over \$13 and
17 Kentucky Medicaid said we can't afford that and they
18 negotiated down to like \$10.64. That's what
19 Commissioner Miller told us in a meeting two years
20 ago.

21 COMMISSIONER STECKEL: Well,
22 he's not here anymore, is he?

23 MS. STIGLITZ: No, he's not,
24 but just for historical reference for you of what the
25 federal government at that time paid.

1 design of both surveys and were comfortable and
2 approved both surveys and it ended up saving the
3 State money. So, just so you know that that's what
4 happened but the dispensing fee went up four or five
5 dollars.

6 So, if we pay pharmacists their
7 actual acquisition cost, so, there's no spread,
8 you're not having to consider are you making enough
9 on the spread to cover your cost of providing the
10 services you provide, then, it works out and it
11 worked out for the state. So, that's what I'm hoping
12 happens here.

13 Now, next year, I'll just start
14 preparing you that the budget is horrific, I mean
15 horrific. So, we are not going to be in a situation
16 or I cannot imagine being in a situation where we are
17 going to be able to increase our budget any more than
18 we're having to do just to maintain the baseline.

19 So, if we work it out and it
20 works out the way I think it will, then, good for all
21 of us. We can do it that way, but it's not going to
22 be a situation where I have a fiscal note attached to
23 it. We won't be able to do it then.

24 But let's work through it.
25 Let's work through the issues. Let's be at the table

1 and knowing that that's an issue. Just like carve-
2 out and carve-in is an issue that we'll have to deal
3 with, let's see how we can improve this program.

4 The budget is going to be
5 horrific. The State is--I'm sorry, Madam Chair.

6 DR. FRANCIS: No. Please talk.

7 COMMISSIONER STECKEL: The
8 State is anticipating new revenues of 247, and
9 Medicaid, just to run the baseline, to keep the
10 program running at its current level, needs 227 of
11 that.

12 MR. GRAY: Keep in mind, the
13 superintendents across the state were saying they
14 needed a billion, so, just to put that in
15 perspective.

16 MS. GRAY: Would you say that
17 again? Would you say that again, the budget?

18 COMMISSIONER STECKEL: Yes.
19 The State is anticipating an additional revenue of
20 \$247 million for 2021.

21 MR. GRAY: I think that's over
22 the biennium.

23 COMMISSIONER STECKEL: Oh, good
24 gosh. For the first year of the biennium, Medicaid
25 needs \$227 million.

1 MR. GRAY: And the revenue, I'm
2 not clear whether that's over the two years versus
3 one year.

4 COMMISSIONER STECKEL: And
5 that's just to pay for the FMAP change, inflation.
6 We did some rate increases, legislative-mandated rate
7 increases. That's just to keep the baseline program
8 running.

9 MS. GRAY: Just so that the
10 Commissioner doesn't have to deliver all the cheery
11 news today, just a reminder, the expansion number at
12 roughly 400,000 people, the federal match in January
13 of 2020 goes to 90/10.

14 It's been a more generous
15 match. It started like at 95/5. And, so, January 1,
16 we now get to the 90/10. We have not been to where
17 the State puts in 10%. We've been putting in a
18 smaller percentage of that.

19 The FMAP, which is the federal
20 match relative to how much the federal government
21 puts in and the State puts in, because the economy is
22 better in Kentucky, nationwide, the federal
23 government uses a three-year rolling average.

24 And, so, as we've had a good
25 economy these last two or three years, the amount of

1 money that the federal government will match to
2 Kentucky, and we are very dependent upon that match,
3 is getting reduced small percentages, but small
4 percentages on big numbers result in big numbers, and
5 those are two things that are happening in 2020
6 relative to the Medicaid budget which puts tremendous
7 pressure on the current Medicaid budget to cover the
8 roughly 1.4 million people in the State of Kentucky.

9 That's just the facts of the
10 Medicaid budget.

11 COMMISSIONER STECKEL: But we
12 have to continue to improve the program. This is an
13 area that we've talked about a lot that I think is
14 cost effective for the state, but when we look at
15 acquisition costs and dispensing fees, we've got to
16 do it in a way that it either saves the state money
17 or it's budget neutral.

18 So, I think, and it's up to you
19 all, but I think it's worth engaging the debate,
20 getting the data, figuring out how to do it and,
21 then, seeing what the results are and whether we can
22 or cannot do it. Do you want to add anything?

23 DR. JOSEPH: The carve-out
24 study was submitted to us late last night. So, we're
25 reviewing it now. It will be in the hands of whoever

1 gets in soon but we're just checking the numbers and
2 making sure everything was accounted for
3 appropriately.

4 COMMISSIONER STECKEL: So, I
5 know Senator Max Wise is interested in having another
6 meeting of House and Senate members and pharmacists
7 to talk about the carve-out study and the legislation
8 that they are drafting. So, we'll work with him on
9 that.

10 And, again, depending on what
11 the study says, we'll either be neutral on it or--we
12 will provide the data regardless so they can decide.
13 If it costs us money, if it doesn't, they'll have
14 that information.

15 Now that we've thrown out the
16 depressing news, any other questions?

17 DR. CARRICO: I'm afraid to ask
18 any more.

19 COMMISSIONER STECKEL: Go ahead
20 and ask.

21 DR. CARRICO: No. I'm done.

22 COMMISSIONER STECKEL: The FMAP
23 is one of those, when it's so ironic being a Medicaid
24 Commissioner, because going to the Secretary or to
25 the Governor saying good news - the economy is

1 booming, everything is going well, unemployment is
2 down - I need \$50 million more because the FMAP has
3 moved up. And, so, it becomes quite the challenge
4 but it is what it is.

5 DR. FRANCIS: So, as a civilian
6 in the state, you're telling me that the
7 superintendents are asking for five times the amount
8 of what DMS needs?

9 MR. GRAY: I'm just saying
10 that's the number. When they met recently, they said
11 that that's their funding shortfall.

12 DR. CARRICO: How many students
13 are there?

14 MR. GRAY: I'm just reporting
15 what they have communicated.

16 DR. FRANCIS: Two hundred and
17 twenty-seven million DMS needs and the
18 superintendents are asking for \$1 billion and we have
19 1.4 million members roughly on Medicaid in Kentucky.
20 I know that because I read the Quality Strategy.
21 It's 1.33, I think.

22 Okay. We'll move to
23 CareSource, Joe, the last time I can say CareSource,
24 I think.

25 DR. VENNARI: Yes, until the

1 end of the year. Basically what's going on with us
2 is the transition from systems and have been spending
3 every day on the phone. Everything is going well
4 there to making that systems change and we're in the
5 testing phase and so far everything has gone well.
6 That has taken up the bulk of my time.

7 DR. FRANCIS: I think that
8 whenever a transition like this happens, whether it
9 be with CareSource to Humana, Anthem to Ingenio, just
10 changeover of cards, it always helps our pharmacists
11 to be able to serve our patients faster to send out
12 or refer them again to the KYHealth website or
13 something to where they can get the new card because
14 inevitably no one comes in with their insurance card
15 with their new numbers.

16 So, I think it would be helpful
17 for us to say January 1st, this will be whoever is
18 enrolled with Humana and this will be the BIN number,
19 PCN number.

20 DR. VENNARI: We have the BIN
21 and PCN number. Jessin has it.

22 DR. FRANCIS: Can we put an
23 email blast out from KPhA?

24 DR. VENNARI: We did. There
25 will be a mailed letter going out to all the

1 pharmacies and providers.

2 DR. JOSEPH: And, then, we'll
3 post it on our website.

4 DR. FRANCIS: And this is maybe
5 a good time to say also there is a pretty robust, I
6 guess, Facebook good group of pharmacists in the
7 State of Kentucky because, let's face it, people are
8 on social media more than they are reading their
9 emails sometimes, but we did make mention that if
10 anyone had questions related to anything Medicaid or
11 MCOs, that they could submit questions to me and that
12 way they can channel to get the answers that they
13 need to get.

14 So, we have put that out and I
15 think that it's a group of well over 1,000
16 pharmacists.

17 DR. VENNARI: Are you compiling
18 all the questions and moving them on?

19 DR. FRANCIS: Yes. There was a
20 day, I guess, that if an MCO shut down or the
21 computer wasn't working and that group lit up. So,
22 we're trying to get people to be aware of where they
23 can go for resources. Anything else? Is that your
24 main thing is switching over to Humana?

25 DR. VENNARI: Yes, that's it.

1 That's a lot.

2 DR. FRANCIS: Okay. And,
3 Jenny, on behalf of Aetna Better Health.

4 MS. HANDLEY: I am just here
5 taking notes today. So, if there's any take-backs
6 that I need to take back with me, I can take them
7 back. I guess April is out of town right now, so,
8 she will have to give an update.

9 DR. FRANCIS: She told us she
10 would have to miss this meeting. She also said that
11 in the January meeting, and I will touch base with
12 her and put it on the agenda next time, that she
13 would like to provide an update on the CPESN pilot in
14 Western Kentucky.

15 So, I anticipate that to happen
16 at our next meeting. We have to talk about exactly
17 what date that is but at our next meeting.

18 WellCare, Thea.

19 MS. ROGERS: No real big
20 updates. We do have some formulary changes coming
21 for 2020. So, what I will do is, Mark, maybe send
22 those to you if that's okay to disseminate and
23 they're also posted on our website, too.

24 DR. FRANCIS: That was helpful.
25 Thank you for your response to me for the formulary

1 change. So, that is always helpful for us to help
2 our providers so a patient doesn't go without therapy
3 to make sure we get those switched on to the covered
4 drug.

5 Andrew and Anthem.

6 MR. RUDD: The really big thing
7 is Ingenio Rx went live on 10/1 and that was
8 basically five states that migrated on 10/1 to the
9 new platform. Kentucky went very smoothly. We
10 didn't have any major issues or complaints.

11 The one thing talking about the
12 fax blast out, I did have one specific issue with
13 Kroger and you may pay attention to this.

14 Kroger apparently didn't pass
15 the information down to their individual stores
16 because when I actually spoke to a pharmacist from a
17 location, they had not received anything from
18 corporate but we had confirmed that it had been sent
19 to Kroger corporate and, so, they did not send a
20 notification.

21 So, again, that probably
22 reinforces the idea of KPhA also having that
23 information.

24 We sent another fax blast to
25 Kroger and we have since not received any other

1 complaints from Kroger about not knowing the BIN and
2 PCN.

3 DR. FRANCIS: So, was the
4 complaints from patients that couldn't get their
5 medicine or complaints from pharmacists that didn't
6 know?

7 MR. RUDD: It was from a
8 pharmacist. A pharmacist had contacted me and said,
9 hey, what is your BIN and, I'm like, well, I sent a
10 secondary messaging that tells you what the new BIN
11 and PCN is, walked them through that and then asked
12 them just kind of casually, did you not get anything
13 from your corporate support about the change and they
14 said no.

15 So, that's when I looped back
16 around to make sure that, in fact, something had been
17 sent to the pharmacist which it had but for whatever
18 reason it had not picked up and relayed, and it may
19 be that pharmacist didn't check their corporate
20 email. Who knows.

21 We re-sent the fax blast and,
22 again, the information was in the secondary message
23 of a rejected claim telling them which BIN and PCN to
24 use. So, the information was readily available, and
25 that's all I have.

1 DR. FRANCIS: Passport, Carrie.

2 MS. ARMSTRONG: Not a lot of
3 updates for Passport. We have our meeting next week.
4 So, any changes to the formulary that go through
5 we'll update in our fourth quarter newsletter and
6 we'll disseminate that out to the pharmacies as well,
7 and that should come out either at the end of this
8 month or in December.

9 DR. FRANCIS: PTAC members, do
10 you have anything to bring up? Paula, anything on
11 CPESN?

12 MS. MILLER: Not right now.
13 It's all in process.

14 DR. FRANCIS: All right. So,
15 page 2 on the back. So, a few things I wanted to
16 follow up on previous agenda items.

17 Jessin had asked if we had an
18 update on pharmacists reporting to the Kentucky
19 Immunization Registry, and I have been working quite
20 a bit on that with other--we have a workgroup trying
21 to focus on improving reporting to the Registry
22 through KHIE. And, actually, I have a meeting after
23 this meeting on that here in Frankfort.

24 I've been working with the
25 Board of Pharmacy. There are about 1,300 registered

1 pharmacies that I have gotten--I think the actual
2 number is about 1,325, but if you take out the
3 nuclear pharmacies and the mail order pharmacies that
4 probably won't be giving immunizations, it's right
5 around 1,298, 1,299 registered pharmacies. And I
6 actually sat down with KHIE and went through the list
7 of who is putting data through KHIE onto KYIR and,
8 then, who receives data back. So, there's some
9 pharmacies at different stages there.

10 And, so, based on that, we
11 actually have about 13% of pharmacies registered in
12 Kentucky that are actually putting data onto the
13 Registry. When they're giving immunization through
14 their dispensing system, it does go through KHIE and
15 get onto the Immunization Registry.

16 About 8%, 7-1/2 to 8% are
17 getting the Registry feedback, so, I will say pulling
18 back so they can see if a patient has gotten the
19 vaccine before they give it.

20 So, actually better than I
21 thought it might be at this stage and just as we're
22 starting embarking on this, and now our mission from
23 here is to how do we get the other 90% on board and
24 what obstacles or education is needed to get them
25 there.

1 they will tell you that and it's free. However, for
2 pharmacists to be able to integrate with KHIE is not
3 free in many cases.

4 Now, Matt, I know that you are
5 now on the Registry. You are actually one pushing
6 and pulling, getting both ways. Is it working okay
7 from your end?

8 DR. CARRICO: It was. I
9 stopped my membership with whoever is integrating
10 this.

11 DR. FRANCIS: With
12 PrescribeWellness or Rx30?

13 DR. CARRICO: It was Rx30,
14 whoever they use as a third party.

15 DR. FRANCIS: So, many
16 pharmacists are using Rx30 and there is a fee for the
17 pharmacist. So, many pharmacists - and that's the
18 push-back we're going to get - 1,300 pharmacies,
19 they're going to say why am I paying to help with
20 public health.

21 Now, I want to help. Paula is
22 paying to help with public health and things like
23 that, but, again, how can we not get data
24 transmission, sort of like KASPER has data
25 transmission, that we can get these records without

1 having to charge the pharmacy a fee for that.

2 DR. VENNARI: Is that a one-
3 time setup fee?

4 DR. FRANCIS: Monthly.

5 DR. CARRICO: Monthly, and,
6 then, if you go previous, you have to pay per
7 immunization that you submit. Every time you pull a
8 report down, you have to pay per report.

9 DR. VENNARI: So, you not only
10 have to pay for access to the system, you have to pay
11 for usage.

12 DR. FRANCIS: Yes. Now, that's
13 Rx30. That's a vendor that gets you to align with
14 KHIE. So, that's not KHIE charging that. So, either
15 Matt has to find a different computer system that
16 would align with KHIE or make a pharmacy dispensing
17 system. And pretty much every independent I'm seeing
18 just from the independent pharmacists I've talked to,
19 they have to use PrescribeWellness or Rx30 or
20 something.

21 So, it's not like they just
22 chose a bad pharmacy dispensing system.

23 MS. ROGERS: There's no direct
24 interface with KHIE. You have to go through a
25 vendor.

1 DR. FRANCIS: That is correct.
2 So, when I initially embarked on this journey for the
3 Registry, why can't we just go directly to KYIR? To
4 go directly to KYIR and report doesn't require all of
5 this data needs, but, then, because it's mandated in
6 our state. I think Secretary Meier said that you
7 have to report through KHIE to the Registry.

8 KHIE is great. You'll get
9 labs. You'll get progress notes. You'll get an
10 alert if somebody was admitted to the ED. You can
11 get a lot of things if your system takes that, but it
12 also, just to report immunizations which is 1/13th, I
13 think, of the data that KHIE will take, they take all
14 these things, immunizations is the last one, it's a
15 burden. So, it's a consideration. Shannon.

16 MS. STIGLITZ: Suzi, correct me
17 if I'm wrong. It is not a federal requirement that
18 you use KHIE. In fact, other states allow for direct
19 access to their vaccine registries.

20 DR. FRANCIS: That's correct.
21 That was Kentucky.

22 MS. STIGLITZ: One thing I was
23 thinking in the last Session or two Sessions ago, I
24 believe, and while this is not the exact same thing,
25 is there a way, if the State is going to continue its

1 policy in mandating KHIE as their mode, is there a
2 way that we could build, like, for example, the
3 Hospital Association passed legislation that allows
4 them to serve as the nonprofit credentialing agency,
5 I think, for within Medicaid. I may be totally
6 messing that legislation up. If I am, please correct
7 me.

8 But is there a way to allow,
9 for example, like KPhA or something to build
10 something that just interacts with KHIE so that
11 pharmacists aren't being overly charged to do a
12 wellness behavior?

13 MS. MILLER: We can get on the
14 KYIR website directly, but the burden comes from am I
15 going to do the ten immunizations I did today and go
16 later and log in and manually upload?

17 MS. STIGLITZ: Okay. If I
18 think about it in terms of KASPER, you are mandated
19 to submit information to KASPER. Every day, what, at
20 the end of the day, your log dumps.

21 MS. MILLER: Right. That
22 doesn't cost anything.

23 MS. STIGLITZ: Does that cost
24 you anything?

25 MS. FRANCIS: No.

1 DR. JOSEPH: There's a civil
2 case for that right now.

3 DR. CARRICO: I'm sure the
4 taxpayers----

5 MS. MILLER: Well, it was
6 mandated of our dispensing systems that they comply.

7 MS. STIGLITZ: Okay. So, could
8 you pass legislation that mandates that your
9 dispensing systems comply with putting in information
10 in the vaccine registry if a pharmacy is signed up
11 with KHIE?

12 DR. FRANCIS: So, ultimately,
13 probably that would go into the charge of the
14 dispensing system.

15 MS. STIGLITZ: So, there's no
16 way to get around the charge. What I'm trying to
17 figure out if Kentucky is going to continue its
18 mandatory policy of using KHIE which they never
19 wanted to abandon that in the last ten years at
20 least, or more than that, twenty years.

21 DR. FRANCIS: I think it just
22 requires more investigation. I just hate to put
23 that burden on pharmacists because I don't have a
24 strong argument in this day and age as to why they
25 should pay to do a public health need, but I strongly

1 feel that we should report immunizations.

2 MS. STIGLITZ: Right, but I'm
3 trying to figure out how do we get around paying a
4 premium to report data because none of us want
5 barriers to immunizations or reporting.

6 DR. JOSEPH: Suzi, who did you
7 talk to at KHIE?

8 DR. FRANCIS: Andrew Bledsoe.
9 And, again, I am meeting with him after this meeting,
10 so, if there's something I should be asking. Again,
11 I wish I knew more about IT to know what HL-7
12 integration requires.

13 DR. JOSEPH: A flat question we
14 can ask is why is immunization--if you can present
15 the problem with the cost and say does the
16 Immunization Registry have to run through KHIE? Does
17 it have to run through KHIE?

18 COMMISSIONER STECKEL: It seems
19 to me that you all are connecting with us on HL-7,
20 whatever that term is. Why can it not connect to
21 KHIE?

22 DR. FRANCIS: I don't know. I
23 don't know at this point.

24 DR. JOSEPH: It's the vendor.

25 DR. CARRICO: Is DMS able to

1 connect to them for Medicaid patients at least and
2 get that information?

3 DR. JOSEPH: To KHIE?

4 DR. CARRICO: Yes, for
5 immunizations?

6 DR. JOSEPH: Theoretically.

7 COMMISSIONER STECKEL: Ask your
8 question again. I'm sorry.

9 DR. CARRICO: Would DMS be able
10 to transmit their immunization records for Medicaid
11 patients to KHIE and at least Medicaid patients will
12 be able to get uploaded that way?

13 COMMISSIONER STECKEL: Well,
14 that's what I was thinking. If you all are already
15 connected. Let us think about it and look at it.

16 DR. JOSEPH: From a dispensing
17 standpoint, I think that makes sense, but what about
18 those----

19 MR. GRAY: Remember, KHIE is
20 beyond Medicaid. It's really trying to get all
21 payors, all entities.

22 COMMISSIONER STECKEL: So, for
23 Medicaid beneficiaries, we could do that, but if you
24 immunize a Blue Cross----

25 DR. CARRICO: Right, but at

1 least it's a step in the right direction.

2 DR. FRANCIS: And I don't want
3 to say that anyone is wrong. I just want to figure
4 it out because there are a lot of good things about
5 KHIE. You can get VA data and things that could help
6 coordinate care better, but, again, something as
7 simple as being able to report to a registry with
8 charging a monthly fee or a look-up fee, that's a
9 little harsh.

10 MR. RUDD: Let me ask a
11 question. Pharmacy30 - that's the vendor you're
12 using now.

13 DR. CARRICO: Rx30 is the
14 operating system.

15 MR. RUDD: Rx30. So, that is
16 your operating system and that's provided by your
17 PASO?

18 DR. CARRICO: No. It's like
19 QS1, Rx30.

20 MS. MILLER: We buy it.

21 MR. RUDD: And, so, there's not
22 a third vendor that's charging you for the
23 vaccine----

24 MS. MILLER: Yes, there is.

25 DR. CARRICO: They hire a third

1 party and that's where the disconnect is.

2 MS. MILLER: What I've learned
3 is it's a lot harder for two systems to have their
4 data connect than I thought it was. So, there's a
5 third party in between us and the Registry, actually
6 two third parties, really.

7 COMMISSIONER STECKEL: We'll be
8 glad to look internally.

9 DR. JOSEPH: That's a good idea
10 to see if we can just get it from our MMIS to get
11 into the Registry. I can start talking to Andrew
12 about that. I don't know how far we can go with it
13 but that's a potential solution, I think, at least
14 for Medicaid patients, only for those that are billed
15 through Medicaid.

16 DR. CARRICO: How is it
17 uploaded from doctors' offices?

18 DR. FRANCIS: Through their
19 eMAR but I don't know the technology. I work with
20 Epic and Epic transmits its data to KHIE.

21 DR. CARRICO: Do you know if
22 they have to pay fees like this?

23 DR. FRANCIS: I don't know but,
24 again, that's another question I would ask. I guess
25 I better learn it by tomorrow when my newsletter is

1 due.

2 So, the next thing on the
3 agenda, I gave everyone fair warning to read the
4 Kentucky Medicaid Managed Care Quality Strategy
5 because I find it interesting to see--I want to align
6 goals of efforts to improve quality and through
7 clinical care from pharmacists with something that
8 DMS wants to also work towards. So, if it's
9 important to DMS, I want pharmacists to be able to
10 help with this.

11 So, just looking at the five
12 goals of this Quality Strategy which is in draft
13 stage - it's not yet in - and I asked the
14 Commissioner earlier - I don't believe there has been
15 anything and it is tied to the 1115 Waiver; but if
16 this does pass and it does go through, these would be
17 potential goals for Kentucky Medicaid and the MCOs.

18 So, looking at this, with
19 behavioral health and substance use disorder, with
20 chronic disease management, with wellness and
21 prevention, health transformation and value-based
22 care, and focus on special populations, I think that
23 pharmacists are in a great position to help with all
24 five of those things.

25 And, so, I think that we need

1 to leverage pharmacists in Kentucky to work towards
2 this, and I did speak with Jessin and the
3 Commissioner just before and really just as to their
4 stance on, even if we don't have this Quality
5 Strategy but how can pharmacists help improve
6 outcomes, and really ultimately looking at it from
7 the budgetary side to save money in the long run.

8 So, if we're helping to improve
9 quality, that helps the MCOs with their
10 reimbursement, that it helps fiscally and, then, it
11 also helps our patients out.

12 So, one thing that we are
13 looking at as pharmacists in the state is potentially
14 introducing a way that we could compensate
15 pharmacists for services that is already within their
16 scope of practice to do.

17 So, we're not asking for
18 anything new, any new scope, any new ability to do
19 things but things that pharmacists are already able
20 to do by current scope of practice through, say,
21 immunizations, collaborative care agreements,
22 Naloxone education, things like that, that we could,
23 then, encourage pharmacists to do because there is a
24 payment model for it.

25 So, I just wanted to see what

1 MCOs' thoughts were on that and has that been
2 discussed within the MCOs themselves. I know that's
3 a loaded question but I have some homework that I'm
4 going to be working on over the next month or so as
5 it relates to - let me get all my homework - if we
6 were to look into see what pharmacists could do. I
7 mean, we'll gather data. We know there's data out
8 there.

9 I joked about our residents,
10 Juliet and Abby, getting the bibliography of this
11 research together, but we will get together a
12 bibliography of studies and cost savings that
13 pharmacists can provide, and especially around maybe
14 dealing with these quality aims or ones similar to
15 those.

16 And, then, if there's any
17 potential unintended consequences for pharmacists or
18 pharmacies, they would be able to be compensated for
19 services more on the medical end rather than
20 typically they're paid for their product.

21 And, then, the other thing is,
22 is it being done anywhere else in other states with
23 MCOs.

24 So, I just wanted to introduce
25 that idea for the MCOs today. I'm hoping over the

1 next month to really get some information back on
2 this but I think it's exciting. I think that we
3 could really--I mean, Aetna has shown us a small,
4 small pilot with CPESN and how we could potentially
5 leverage community pharmacies and transmit this data
6 to providers and health systems and payors but I
7 think there's also pharmacists in various disciplines
8 across the state and ambulatory care or wherever, and
9 it's not that they would have to submit payment but
10 they would have the option to submit payment so there
11 is a viable payment model for that service.

12 Shannon, you look like you want
13 to say something.

14 MS. STIGLITZ: No.

15 DR. VENNARI: Well, the devil
16 is really in the details on how you're calculating
17 the savings, how that's going to be made, what the
18 impact is going to be. Is there risk with any of it?
19 Are you paying for the services on the front end?
20 And, then, if there's not any savings on the back
21 end, is there a recoupment? The devil is all going
22 to be in the detail on how you want to set this up.

23 DR. FRANCIS: So, I would say
24 it would be very similar to what----

25 DR. VENNARI: We talked

1 something about this in the past, I think, probably
2 about a year or so ago on trying to do something like
3 this.

4 DR. FRANCIS: But I think now
5 that you are going to hear this being introduced
6 probably in the legislation more toward the
7 commercial end of things within the state, but
8 speaking about for the Medicaid population and what
9 it would take for that.

10 If you would pay a nurse
11 practitioner for it who is working under a
12 collaborative care and it's within the pharmacist's
13 scope of practice to do it, what would it take to get
14 the MCO, the logistics of everything, to also pay a
15 pharmacist to do it.

16 DR. VENNARI: I think one of
17 the issues is provider status. That's one issue.

18 DR. FRANCIS: So, that's what
19 we're working on, that we may be compensated for
20 services.

21 MS. MILLER: The question that
22 I had is in all of your data, what does it save you
23 for a medication to be discontinued? We see every
24 day in the community--we do it because it makes our
25 patients feel good. They don't want to take a drug

1 they don't need.

2 We try to help them save money
3 because it hurts their pocketbook; but when we do
4 those things, we're hurting ourselves because we're
5 only being paid to fill a prescription, right, so
6 that if you had data that showed in a certain
7 category by modifying or reducing medication use, how
8 would we get paid for precipitating that and having
9 that happen.

10 DR. VENNARI: Okay. Let's say
11 you have a generic drug that's five bucks a month,
12 okay. How many months do you want to be paid for de-
13 c'ing that med?

14 MS. MILLER: Well, and that's
15 kind of what I'm asking you. What's it worth to you
16 to have less--we know that it's good for our
17 patients. So, how does that translate to you
18 financially?

19 DR. VENNARI: It depends on how
20 long they were on it and what you would save by them
21 being off of it and how long you would have that
22 member. There's a lot of variables you could put
23 into this.

24 MS. MILLER: Right.

25 DR. FRANCIS: And just the

1 whole fact, we were driving down here and Paula was
2 telling me about a patient that was sick and couldn't
3 get to the primary care doctor. So, she coordinated
4 the call to the primary care doctor and got her
5 Prednisone and an antibiotic and saved her from a
6 hospital admission for COPD exacerbation. What would
7 a hospital admission cost because she was about two
8 hours away from calling an ambulance to take her to
9 the hospital and she saved her from that.

10 DR. CARRICO: Or even education
11 on someone improperly using an inhaler and getting it
12 filled every sixteen days, showing them how they're
13 using it incorrectly. Now they're just filling it
14 every thirty-two days.

15 DR. THERIOT: I was actually
16 thinking of the flip side, like the Type II diabetic
17 that doesn't necessarily take the medicine because
18 they don't understand how important it is and, then,
19 the pharmacy person talked to them because they trust
20 the pharmacist and, then, they take the medicine
21 properly and then you don't have them in kidney
22 failure five years down the road.

23 DR. FRANCIS: Yes. I mean,
24 there's so many situations there.

25 DR. VENNARI: And that would be

1 an increase in cost on the pharmacy side, but, then,
2 you're looking at possibly saving costs on the
3 medical side.

4 MS. MILLER: That's the key.

5 DR. FRANCIS: That's exactly
6 it.

7 MS. MILLER: That is the key.

8 DR. BETZ: I guess this is the
9 big push back all the time because----

10 DR. VENNARI: That's the Holy
11 Grail, though.

12 DR. BETZ: ----because I work
13 with two really expensive service lines like advanced
14 heart failure and transplant and, then,
15 cardiovascular surgery. There isn't anything that we
16 do that saves costs. I mean, a CABG, if somebody
17 demised, it's cheaper. All the devices we implant
18 are not cheaper as well.

19 And I know I'm preaching to the
20 choir because you guys are pharmacists, but we always
21 seem to come back to this and this argument that,
22 well, how can you be cost neutral but nobody else is
23 cost neutral.

24 So, if there's inherent savings
25 that are better for the system that keep patients out

1 of a hospital which is the biggest thing for me,
2 there's the value-added.

3 And, for me, what I would love
4 to see is if we can divorce the pharmacist providers
5 like myself from having to be linked to a pharmacy
6 because there's a lot of great stuff that I do that
7 kind of I think falls under the other providers I
8 work with because there's not an effective way for me
9 to bill for it.

10 And I don't really want a pat
11 on the back. I just want a way for other people to
12 be able to do this and for the students or residents
13 that we're training to be able to do this as well.

14 So, I know that's preaching to
15 the choir but that's been a rub.

16 DR. FRANCIS: Well, that's
17 exactly it. My clinic sees Hepatitis C patients.
18 So, we treat their Hepatitis C. It costs money
19 obviously for their Hep C drugs but we keep them out
20 of liver failure. We keep them out of the hospital
21 and we cure them, and the same thing with HIV
22 patients.

23 DR. VENNARI: Well, those drugs
24 are priced basically for the cost to offset a liver
25 transplant. When you look at cost----

1 DR. FRANCIS: What about
2 hospitalizations?

3 DR. VENNARI: When it first
4 came out, that's what they were priced against. They
5 weren't really priced about what they cost to
6 manufacture. I mean, you can get these Hep C
7 medications in other countries for like eight bucks a
8 month. So, the U.S. ends up subsidizing the rest of
9 the world for Hep C utilization and drug use. That's
10 how they priced it.

11 So, yeah, essentially you've
12 cured them or you paid to keep them out of the
13 hospital and that transplant already in the drug.

14 The devil is all in the
15 details, so, you really have to take a look at this
16 comprehensively.

17 DR. FRANCIS: But I'm looking
18 at these - chronic disease management. My clinic has
19 reduced Alc's 1.8% in just a year and that's with
20 Medicaid patients on a pilot that we're doing.
21 So, what types of down-the-road costs are we
22 preventing?

23 You would pay a nurse
24 practitioner for that type of care. So, why wouldn't
25 you pay a pharmacist for that?

1 DR. VENNARI: It's not like I'm
2 disagreeing. I'm a pharmacist and I would love----

3 DR. FRANCIS: Yes.

4 DR. VENNARI: ----but I'm
5 looking for, you know, we go back. You've got to
6 have a solid strategy that saves all the way around
7 and not just paying for. We have to show those
8 savings somewhere.

9 DR. FRANCIS: So, that's where
10 the bibliography comes in. I think there's been lots
11 of research on this already that has come up but it's
12 the logistics of putting it into place.

13 DR. THERIOT: And I think the
14 problem is showing savings right away and I think
15 companies want to see a savings this year and next
16 year from what they did and they don't want to wait
17 five years down the road to look at the long-term
18 savings because they're focused on this year.

19 So, it's forcing the health
20 care system and MCOs or whatever to look long term
21 instead of just at what's in front of them.

22 DR. FRANCIS: Yes, and that's
23 really the premise of all value-based.

24 DR. VENNARI: And maybe value-
25 based contracting would come into play. I mean,

1 there's so many different things you could look at.

2 MS. STIGLITZ: Does everyone
3 understand what the thirteen available protocols are
4 in place for pharmacists within their scope of
5 practice now, I mean, because we're not talking about
6 expansion of scope or practice. I just didn't know
7 if it would be a value for us to send that list.

8 DR. FRANCIS: So, the Board-
9 approved protocols is what she's talking about. If
10 it becomes beneficial for a member to see a
11 pharmacist at Matt's Booneville Discount Drugs rather
12 than going to an emergency room or something to get a
13 strep test or a flu test.

14 DR. VENNARI: Aren't those
15 collaborative care agreements, though?

16 DR. FRANCIS: That's a Board-
17 approved protocol. Now, a collaborative care
18 agreement might be something that we use to manage
19 diabetes or heart failure and things like that.

20 MS. STIGLITZ: So, in 2016,
21 there was a bill that passed that allowed for the
22 Kentucky Board of Pharmacy to establish Board-
23 authorized protocols and, then, they subsequently
24 passed a regulation in 2018, I think, or the end of
25 2017 that essentially allows pharmacists under a

1 prescriber-approved protocol to do things - and I'm
2 not going to be able to name off all thirteen - but I
3 know travel meds, diabetic supplies, flu testing and
4 followup----

5 DR. FRANCIS: Long-acting
6 injectables.

7 MS. STIGLITZ: Long-acting
8 injectables for opioid use disorder, smoking
9 cessation. Naloxone is not under there because
10 that's statutory but there are others. I think PrEP
11 was one. I don't know that that's been established
12 yet but it's allowable.

13 DR. FRANCIS: That's another
14 one. Our clinic does that. We take walk-ins. We
15 will evaluate them and put them on PrEP therapy.
16 That's a drug cost potentially but what's the cost if
17 they get HIV and the cost down there?

18 MS. STIGLITZ: But we can
19 supply that list if it would be helpful to the group
20 to understand.

21 DR. FRANCIS: Yes.

22 MS. STIGLITZ: That we're
23 talking about collaborative agreements and the
24 protocols.

25 DR. FRANCIS: Collaborative

1 care, protocols, immunizations, Naloxone.

2 DR. CARRICO: Well, we talk
3 about how they want returned investments now and I
4 get that. In health care, as we said, it's difficult
5 to do that but sometimes you can do it. I didn't see
6 it as much when I worked in urban areas but in the
7 rural areas, nothing infuriates me more than
8 ridiculous ER visits and you see them all the time.
9 My patients go there to get a shave. I will shave
10 them if you pay me a fourth of their ER visit.

11 I've given free over-the-
12 counter Zyrtec to prevent someone from going to the
13 ER because the doctor's offices in the county are
14 closed at six. I'm like save your forty-minute drive
15 and the State money. Here is a \$2 bottle of Zyrtec,
16 or I've told this story before and it makes me cringe
17 to think about it.

18 I hate feet. I went and
19 clipped someone's toenails because they had an
20 ingrown toenail and they were going to go to the ER.
21 I almost threw up but I did it. I don't know what an
22 ER gets. I would just take a percentage of it, a
23 fraction of it.

24 That stuff you can prove right
25 there it will save the system money off the top, just

1 an ER visit. I feel that's the most abused part of
2 health care right now.

3 DR. FRANCIS: Yes. And when
4 you talk about accessibility. Like Paula said, this
5 poor lady, she just didn't want to find a ride to get
6 to the doctor. So, she was able to explain that to
7 the patient's doctor and prevent that.

8 But I think that we need to
9 look at this. And when I think about your comments,
10 Joe, you have quality measures with CareSource or
11 Humana and we're helping you meet those quality
12 measures. You're getting paid for those, just the
13 same way if a primary care doctor or a nurse
14 practitioner or a cardiologist or an endocrinologist
15 with diabetes helps you meet those quality measures,
16 same things. Under that scope, we feel that there
17 should be some reimbursement for services.

18 So, in summary, my point on
19 this, it improves quality, it saves money and it
20 improves access. We should figure it out.

21 So, action items. What's
22 probably going to happen with the Quality Strategy
23 and payment for pharmacists for services is we're
24 going to reach out after the announcement is made as
25 to which MCOs hopefully after December 1st, if that

1 deadline holds.

2 After that announcement is made
3 is we'll probably reach out to the MCOs and invite to
4 a meeting as to how we can figure out and work
5 through the logistics to make this happen between
6 Medicaid and the MCOs.

7 Does anyone else have any other
8 new business? I didn't have time to think about
9 anything else new.

10 And for PTAC, do we have any
11 reports or recommendations for the MAC? The next MAC
12 meeting is on November 21st. I will be attending
13 that but I would say that we'll give them a report.
14 You have the report that I gave them at the September
15 meeting and I don't have any formal recommendations
16 at this time.

17 One thing I do need to go over
18 is Sharley revised the 2020 Pharmacy TAC schedule.
19 And whether you look at it as before or after the MAC
20 meetings, it would be about a month before the MAC
21 meeting, the subsequent MAC meeting or a month after
22 the previous one.

23 So, the only one we wouldn't
24 have a PTAC meeting before the MAC meeting would be
25 the January MAC meeting, but is everybody okay with

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these Tuesday dates that Sharley drafted?

Sharley, those are supposed to be Tuesdays. I think they're all Tuesdays, the dates. The wording just might not have gotten changed and I apologize for that. It should all be Tuesdays. So, pay no attention to that Thursday.

Sharley, does that match your schedule?

MS. HUGHES: I think so.

DR. FRANCIS: I think so, too. So, we will approve that meeting schedule for the Pharmacy TAC.

Does anyone have anything else that I didn't get to or bring up that they wanted to add? Then, we will go ahead and adjourn.

MEETING ADJOURNED