

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

IN RE: PHARMACY TAC

July 23, 2019
9:30 A.M.
Department for Medicaid Services
Commissioner's Conference Room
275 East Main Street
Frankfort, Kentucky

APPEARANCES

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Paula Miller
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Carol Steckel
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MEDICAID SERVICES

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Andrew Rudd
ANTHEM

Joe Vennari
Cathy Stephens
HUMANA-CARESOURCE

Thea Rogers
WELLCARE

April Cox
AETNA BETTER HEALTH

Mark Glasper
KENTUCKY PHARMACISTS
ASSOCIATION

AGENDA

1. Call to Order, Welcome & Introductions
2. Approval of Minutes/Report from the May 21, 2019 PTAC meeting
3. Additional Discussion Topics/Reports/Action Items
 - * Roundtable report out on current state of affairs
 - * Department of Medicaid
 - DMS MCO Coverage of Pharmacy-Based Immunizations Chart final draft review
 - Options for pharmacy immunization coverage via prescription for children <9
 - Substance Use Disorder 1115 Demonstration Waiver as a part of the KYHEALTH Waiver
 - Update: Adjudication message to include FPL for copays
 - * Copay info to be sent from Doug Oyler to KPhA/PTAC to inform KY pharmacists via email blast
 - * Behavioral Health TAC would like to provide education to PTAC and Primary Care TAC about BH copays
 - www.kyhealth.net website feedback to David Gray
 - * Member MCO pharmacy ID numbers on website suggested via email 6/26/19
 - SB 5 Data Report Release Update
 - * Findings of April 1 - June 1, 2019 MAC pricing changes review
 - * Potential statute revision needed to avoid daily price changes by PBMs
 - Communication collaboration between DMS and KPhA (Jessin Joseph and Sarah Franklin)
 - DMS Pharmacy Department Project Management Update
 - * CareSource
 - * Aetna
 - CPESN pilot project update
 - * WellCare
 - * Anthem
 - * Passport
 - * PTAC Committee members

AGENDA
(Continued)

4. Follow-up on previous agenda items
 - * Potential pilot programs to improve outcomes
 - * Improving quality of care by leveraging pharmacists in Kentucky
 - * Update from DMS: focus for improving outcomes
 - * 90-day supply for medications covered by Medicaid MCO plans
 - * Medicaid proration of copays for patient's first fill in a MedSync program
 - SB 44 (Jan. 1, 2016) states DMS/MCO are to provide a program for synchronization
5. New Business/Take-aways
 - * Potential addition of Spinosad (Natroba) to Medicaid/MCO formulary, a scabicial agent for treatment of lice. Current formulary includes Nix only which is unavailable and no longer a first-line agent
6. Reports and recommendations from the PTAC to the MAC
7. Other Business
8. Next Steps
 - * Next MAC meeting - July 25, 2019
 - * Next PTAC meeting - September 17, 2019
9. Adjourn

1 DR. FRANCIS: I will go ahead
2 and call us to order now that we have a quorum and
3 we'll just make sure that we go around the room and
4 make sure we know everyone that's here.

5 (INTRODUCTIONS)

6 MR. JOSEPH: I think Jessica
7 introduced herself last time around; but if everyone
8 knows Leeta, her last day is next Wednesday, and, so,
9 Jessica will be taking over for her.

10 COMMISSIONER STECKEL: And,
11 Jessica, you are welcome to stay if you want or
12 you're welcome to go. I just wanted to have them be
13 able to put a name to a face.

14 MS. JUMP: You guys have a
15 great day and I look forward to seeing you all again.

16 DR. FRANCIS: So, yesterday, I
17 had sent out - I think most people in this room
18 received it - I tried to because I was delayed in
19 editing the minutes - but I had sent out a copy of
20 the minutes that Sharley had provided me with some
21 additions and changes that I had edited.

22 So, for the Pharmacy TAC
23 members, if you've had a chance to review those, if
24 we have any approvals.

25 There was one thing I wanted to

1 make sure I was correct and that was I believe with
2 Joe. I had put in there that CareSource will, in
3 fact, switch to Rx Innovations and Express Scripts
4 Processor as their PBM on January 1st. Is that
5 correct?

6 DR. VENNARI: Yes, if we stay
7 with CareSource. Actually, we're transitioning a lot
8 of it over to Humana and that will be the lead by
9 January 1st.

10 MS. STEPHENS: So, on the 1st,
11 it will actually be Humana.

12 DR. FRANCIS: Okay. So, should
13 I scratch Rx Innovations and Express Scripts
14 Processor and put Humana? I just don't want to put
15 an incorrect statement in the minutes.

16 COMMISSIONER STECKEL: So,
17 after January 1st, the contractor for Medicaid MCO
18 will be Humana. CareSource is doing what they just
19 described but Humana is the contractor; and after
20 January 1st, CareSource will no longer be part of
21 that equation. Does that help?

22 DR. FRANCIS: We'll update
23 that.

24 MS. STEPHENS: And there will
25 be a lot more information coming out on that.

1 COMMISSIONER STECKEL: This may
2 be inappropriate for me to ask, and if it is, just
3 tell me, but it's my understanding it's a business
4 decision CareSource has made nationally to kind of
5 move out of the Medicaid market.

6 DR. VENNARI: No. No. This
7 was just an alliance relationship with Humana and
8 CareSource and that went its term. That's all.

9 COMMISSIONER STECKEL: Okay.

10 DR. FRANCIS: Would you
11 recommend that I keep it the way it is in the
12 minutes, the May minutes?

13 DR. VENNARI: Well, Humana will
14 be taking over January 1st. You can make that
15 correction.

16 DR. FRANCIS: Humana will be
17 the contractor for the MCO as of January 1st.

18 DR. VENNARI: Yes. We're just
19 bringing it in-house rather than having CareSource
20 contract it out.

21 MS. STEPHENS: And Joe will
22 still be in his role.

23 DR. VENNARI: I'll still be
24 here.

25 DR. FRANCIS: Thanks for the

1 clarification.

2 Was there anything else on the
3 minutes that anybody had? And typically just for my
4 benefit, as we're transitioning to this, Sharley,
5 when these minutes are ready, could you just go ahead
6 and send them to me and then I will try to have
7 everything out earlier? I feel like the last two
8 times I've had to ask for them.

9 MS. HUGHES: I'm sorry. When
10 Terri sends them to me, I save them and----

11 DR. FRANCIS: I'm just trying
12 to get myself on a better time line for everyone
13 else, too.

14 MS. HUGHES: I apologize. I
15 obviously have messed up there. So, I will do
16 better, I promise.

17 DR. FRANCIS: And it's been
18 kind of hard because we've been right before the MAC
19 the past couple of times. I think in September, we
20 have a little bit more time. Then, that will give
21 everybody some more time to review them.

22 All right. So, do we have any
23 approvals for the minutes?

24 MS. MILLER: I'll make a motion
25 to approve with the amendments.

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MS. GRAY: I'll second.

DR. FRANCIS: Paula approves and Cindy Gray seconds with the amendments, the changes that I put in there.

Now, Sharley, for my clarification, too, since we have been right before the MAC, I know the minutes haven't been ready for the MAC but does the MAC get these official reports?

MS. HUGHES: Yes. They get them, yes. They won't have them before the MAC meeting.

DR. FRANCIS: But, like, they'll have the May ones with edits.

MS. HUGHES: Right, but what I send to them is the actual transcript of the meeting. That way they have everything that took place if they want to see what has taken place.

DR. FRANCIS: So, what about with the edits that I made to the transcript of the meeting which is what you gave me, I believe, right?

MS. HUGHES: Right.

DR. FRANCIS: With the edits that I made, will you give that to the MAC?

MS. HUGHES: Were your edits to the transcript or to the----

1 DR. FRANCIS: Well, I never see
2 the transcript. I just need to know the process.

3 MS. HUGHES: Normally I send
4 both because Terri--well, let me back up. On some of
5 the TACs, I get minutes that are a couple of pages
6 long plus the transcript. When I do that, I normally
7 send both out to the TAC members usually the day I
8 get them. Obviously, I have fallen down.

9 So, the changes that you're
10 making are to the minutes' document.

11 DR. FRANCIS: Okay. So, I
12 would like to be able to look at obviously the
13 transcript and the minutes before it's officially
14 given to the MAC, if that's okay.

15 MS. HUGHES: Right. Okay.

16 COMMISSIONER STECKEL: But the
17 transcripts are what they are. They're verbatim.
18 So, there cannot be any changes made to them.

19 MS. HUGHES: Those can't be
20 changed.

21 COMMISSIONER STECKEL: We're
22 welcome to share them with you but they're not to be
23 changed. They are literally a verbatim, close to
24 verbatim. If she doesn't recognize who is speaking,
25 it may say Person instead of your name, but other

1 than that, it's verbatim.

2 DR. FRANCIS: Okay. Thanks for
3 that. All right. We're getting there.

4 So, we might as well hop right
5 into the agenda, then. The first thing that we have,
6 of course, is the Roundtable and I tried to break
7 down some of the different points that I think we
8 were reviewing and some of the new things that I had
9 been given to bring up on the agenda for DMS.

10 So, the first thing I put on
11 here was the Pharmacy-Based Immunization Chart, and
12 Jessin and I have worked together on that and you
13 have a copy of it in front of you.

14 Basically, it should have all
15 of the immunizations clarified according to ACIP
16 recommendations. And I wanted everybody to be able
17 to look and make sure that they don't see any
18 different edits that needs to happen.

19 And, then, what will need to
20 happen is each MCO - and fee-for-service doesn't
21 currently cover any pharmacy immunizations - but
22 Jessin will add which MCOs are covered, and this is a
23 really helpful resource for our pharmacies to
24 increase access to immunizations and know which ones
25 are covered by each plan. So, we're just updating

1 that.

2 MS. GRAY: So, this means that
3 the MCOs are covering these specific or they don't?

4 DR. FRANCIS: No, they're not
5 broken down by MCO yet.

6 MS. GRAY: What does the MCO
7 column signify?

8 DR. JOSEPH: They're going to
9 cross off whether or not they do cover it. So, we're
10 going to get this out to all the MCOs and they will
11 fill it out just like the last time around.

12 DR. FRANCIS: What we did is
13 make sure the correct immunizations, like Zostavax
14 was still on here and Shingrix wasn't on here. So, I
15 went through there----

16 COMMISSIONER STECKEL: So, will
17 there be five columns here?

18 DR. JOSEPH: Yes.

19 MS. GRAY: So, this is just to
20 make sure that all covered vaccines----

21 DR. FRANCIS: Yes. And, so,
22 that was the main updates that we did. Jessin, was
23 there anything else that you wanted to bring up on
24 that?

25 DR. JOSEPH: No. It was just

1 an update because I don't think it had been touched
2 in a year and then it hadn't been broken down by
3 exactly which vaccines are which.

4 DR. FRANCIS: Like,
5 pneumococcal was on there but it wasn't specified
6 PPSV23 and PCV13.

7 DR. JOSEPH: And I'll send that
8 out.

9 DR. FRANCIS: So, Jessin, will
10 you take care of working with the MCOs on their
11 coverage?

12 DR. JOSEPH: Yes. We'll send
13 it out and we'll just set the timelines for when we
14 want it back and then we'll send it to everyone.

15 DR. FRANCIS: Okay. Perfect.
16 And I think it would be nice to send an email blast
17 out to our pharmacists in the state so they know.

18 DR. JOSEPH: Yes. Would it be
19 beneficial if I just worked with Sarah on that, Mark?

20 MR. GLASPER: Absolutely,
21 either me or Sarah, either one.

22 DR. FRANCIS: I appreciate your
23 help with that, Jessin.

24 DR. JOSEPH: And Doug.

25 DR. FRANCIS: And Doug. Both

1 of you.

2 So, one thing that we had
3 talked about two meetings ago was it is very good
4 that all immunizations are covered without Vaccines
5 for Children Program at the pharmacy within a
6 pharmacist's scope of practice in nine and up, but
7 also in the State of Kentucky that a pharmacist could
8 administer an immunization to below age nine with a
9 prescription and how would Medicaid know that it is
10 by prescription or would that be able to be covered
11 at a pharmacy.

12 For example, I'm going to be
13 giving Kentucky County school children immunizations
14 Thursday and several of them are going into
15 kindergarten and we're getting prescriptions for
16 them; but if they have Medicaid, they wouldn't be
17 covered at the pharmacy and then I have to send them
18 somewhere else.

19 So, is there a provision we can
20 put in place, whether it be - I don't know - a prior
21 authorization? Any ideas there?

22 DR. JOSEPH: I'm going to defer
23 to the MCOs. We're not going to do it on the fee-
24 for-service side just because we would prefer our
25 patients go to the providers who are enrolled in

1 Vaccines for Children but I don't know if you guys
2 have discussed this at all.

3 MS. ARMSTRONG: Passport
4 doesn't have an age limit. So, it would still
5 process for us without a PA.

6 DR. JOSEPH: I think the bigger
7 struggle and you might know more about this, Suzi, is
8 are these children going to clinic pharmacies or are
9 they going to retail pharmacies?

10 DR. FRANCIS: It could be
11 either.

12 DR. JOSEPH: Okay, because I
13 think one of the things that might be coming up is
14 retail pharmacies having their own policies in place
15 for the stores themselves. I've seen it in CVS where
16 they have like an age cutoff but that would be my
17 only thing.

18 DR. FRANCIS: Well, I mean,
19 with protocol, it would be age nine; but with a
20 prescription, it would be the practice of pharmacy
21 and it could be less than nine.

22 DR. JOSEPH: I understand that.
23 I think sometimes they have stores that will say my
24 store doesn't want to take that liability and will
25 say we won't fill this prescription or we won't do

1 this. That's just from what I've heard.

2 DR. FRANCIS: I mean, I didn't
3 at Kroger and I don't currently at St. Elizabeth.
4 Like, I know there's 3,500 children that aren't going
5 to be able to get to school in Kenton County, so,
6 we're trying to do everything we can in Northern
7 Kentucky to increase accessibility to vaccines,
8 working through that.

9 As that might come up, and it
10 would be great to get them to a VFC provider. That
11 would be the ideal thing and we're checking to make
12 sure that they're not due for well checks and other
13 things like that; but, in the meantime, that might
14 take time if they don't have a primary care provider
15 to get them in rather than just get them immunized
16 for school.

17 COMMISSIONER STECKEL: Well,
18 but they all should have a primary care provider if
19 they're in Kentucky Medicaid. So, why would that be
20 an issue?

21 DR. FRANCIS: The school nurses
22 are working hard and parents say they don't have
23 insurance at all. And, so, then, we're trying to get
24 them referred to get started----

25 COMMISSIONER STECKEL: Now,

1 that I understand, and I could understand one or two
2 kids, but a large volume of kids, I don't understand
3 why that's not happening already. They should have a
4 primary care provider, and I would imagine you all
5 are pushing vaccines just as much as all of us for
6 obvious reasons.

7 DR. FRANCIS: And I know they
8 are trying to get them in for well checks and things
9 like that. It just may be that they declare one but
10 they haven't been seen or had an initial appointment
11 and that's educating the parents and things like that
12 to get them in. Some of them have private insurance.
13 They just haven't been immunized.

14 Okay. So, Passport, no age
15 limits. Anything else?

16 DR. ROGERS: Suzi, have some of
17 the limitations been worked out around reporting to
18 the Registry? I know when we talked about this
19 before, what the pharmacists are doing on reporting
20 to the Registry so that the PCP does know.

21 DR. FRANCIS: We're working
22 hard on that. There's a lot going on with that. So,
23 I do have a pharmacist workgroup that we are working
24 on to try to get why aren't pharmacists reporting to
25 the Registry; and if they're not, what can we do to

1 help that.

2 So, a survey that KPhA sent out
3 to pharmacists, it surveyed about seventy pharmacists
4 across the state, and most of them, it was because
5 they were unaware of how to.

6 So, we have Joel Thornberry
7 and Erica Davis from the Registry and they have a
8 meeting next week - I'm actually on vacation, so, I
9 don't know if I will be able to attend that - but
10 they have a meeting next week to talk about first
11 steps as to how to educate pharmacists to get on the
12 Registry.

13 DR. CARRICO: I can tell you
14 why I stopped doing it. I was getting charged every
15 time it went on there. And if you wanted to put
16 someone's old immunizations on there, they charge you
17 even more to do it - not the Registry but software
18 vendors to get it on there. If I could manually
19 enter it, I would do it myself.

20 DR. FRANCIS: About 10% of
21 people that responded, pharmacists responded said
22 there were charges with their software vendor, not
23 KY-HI but with their software vendors to be able to
24 integrate with KY-HI. I also found out that KY-HI is
25 not live yet until mid-August and I thought that was

1 going to be fixed.

2 So, there's several things
3 going on with that, but what we are doing with the
4 school system is the schools are manually going into
5 the Registry, checking that, going into the school
6 immunization, that database. And, then, we're also
7 checking for patients that are coming to our Pharm D
8 checking Epic for any like provider record. So,
9 we're doing the best to cross reference as much as we
10 can.

11 COMMISSIONER STECKEL: Can our
12 school-based clinics qualify as VFC?

13 DR. JOSEPH: They'd have to
14 enroll and I don't think we have enrolled them
15 before.

16 COMMISSIONER STECKEL: Well,
17 with our new School-Based Free Care Program----

18 DR. JOSEPH: I'd have to talk
19 Erica about that, but the VFC Program itself has its
20 own issues, or, administratively they have to
21 understand where the vaccines are coming from. I
22 don't know. I'd have to talk to Erica but that's
23 something we can bring up.

24 DR. FRANCIS: There has been an
25 issue, I know, just with like the transport of VFC

1 things but I assume that not every district has a
2 school-based clinic as a VFC.

3 COMMISSIONER STECKEL: Then the
4 question becomes, too, what's more important - the
5 VFC price difference or getting the kids immunized?
6 And how much are we talking about? I'm speaking way
7 out school here.

8 DR. JOSEPH: There is a
9 potential pilot program going to be set up through
10 DPH to get the patients basically signed up and
11 enrolled and eligibility and everything checked
12 before they get to school and, then, once they're
13 there, set up a program to just start immunizing that
14 day because, then, hopefully the kids have taken all
15 the paperwork back to their parents and have
16 everything filled out and we can just run the claims
17 through, but I don't know if that's been remotely
18 operationalized.

19 I think that's still kind of a
20 thought process. That actually started with Dr.
21 Theriot and Erica as well. So, we'll probably have
22 to wait until August before we pick that discussion
23 back up, but, yes, that's an option.

24 COMMISSIONER STECKEL: As long
25 as we have the link to the primary care providers in

1 the MCOs, then, I mean, in my mind, and I say this
2 not knowing the dollar amounts, getting these kids
3 immunized is the priority, but we also can't blow our
4 budget out. So, let us look some more into this and
5 see if there's not a middle ground.

6 And in this vein, I'd be
7 interested to know what you all, the MCOs, are doing
8 to encourage vaccinations for kids.

9 MS. HUGHES: Can I just ask a
10 question. Are you saying with a prescription, well,
11 they have to get the prescription from the doctor,
12 right? So, it's not a case that they're not going to
13 the primary care doctor, correct?

14 DR. FRANCIS: Well, the
15 pharmacy could call if they have a declared doctor
16 and get a script or they could have a prescriber
17 onsite that could say, yes, this six-year-old needs
18 this vaccine and they prescribe it.

19 MS. HUGHES: Okay. I was like,
20 well, wait a minute, if they have to get a
21 prescription.

22 DR. FRANCIS: Ideally, yes.
23 And I know that MCOs just from working in the primary
24 care side are trying to get kids in, encouraging well
25 checks and encouraging immunizations through quality

1 measures and things like that and I know that some
2 physicians' offices I work with are working on
3 working their list of patients that show care gaps in
4 vaccinations but there's still obviously some work to
5 be done.

6 DR. ROGERS: Is what you do
7 going to be sent back to the PCP?

8 DR. FRANCIS: If they declare
9 they have a PCP----

10 DR. ROGERS: So, that's in
11 their record.

12 DR. FRANCIS: Yes, it will be
13 in their Epic record, what we do, what I do, but,
14 like if Paula gave vaccines or anybody else, you
15 wouldn't have access to their electronic medical
16 record but they do give--typically any protocol I
17 know of would fax the immunization they gave to their
18 primary care physician, too. Whether that gets into
19 the record and added----

20 DR. ROGERS: Oh, yeah, that's
21 beyond your control.

22 DR. FRANCIS: How about you,
23 Matt? Since you're more in a remote area in Eastern
24 Kentucky, are you getting any immunizations or is it
25 pretty much all VFC for children?

1 DR. CARRICO: If I start giving
2 kids immunizations, I feel like the providers think
3 I'm infringing on their turf. So, that's not a
4 battle I'm willing to have.

5 DR. FRANCIS: So, they're set
6 for school.

7 DR. CARRICO: Yes. They're
8 contracted with Mountain Comp.

9 DR. FRANCIS: Okay. I'm sure
10 it's different in every school district. Okay.

11 COMMISSIONER STECKEL: So, we
12 are now being judged on - I should have had this
13 before - a series of quality measures nationwide and
14 the percentage with a PCP visit in the past year age
15 twenty-five months to six years is 90.5%. So, we're
16 pretty good at that. The meningococcal conjugate
17 Tdap vaccines by their thirteenth birthday, 72.6%.

18 I just wanted to remind myself
19 of what these say. I know we can make improvements
20 but we seem to be doing pretty good in that one
21 measure. That's the only one they're tracking for
22 vaccines.

23 DR. FRANCIS: Is it possible to
24 get those numbers for the report just sent out?

25 COMMISSIONER STECKEL: Sure.

1 DR. JOSEPH: I have it open. I
2 can send it to you.

3 DR. FRANCIS: Thank you. So,
4 Carrie said Passport has no age limits. I'm just
5 curious on the other MCOs.

6 DR. VENNARI: Humana-CareSource
7 does not either.

8 DR. ROGERS: We have an age
9 limit to nine.

10 DR. FRANCIS: Nine. Okay.

11 MR. RUDD: Same for us, too.

12 DR. COX: And nine for Aetna.

13 DR. FRANCIS: And nine for
14 Aetna. So, unless anybody else has anything else on
15 immunizations, we can move on to Substance Use
16 Disorder.

17 What I had on here was what we
18 spent a while talking about last meeting was the
19 1115--well, there was an 1115 Demonstration Waiver as
20 part of the June 1st, implementation. Did that go
21 live June 1st?

22 COMMISSIONER STECKEL: July
23 1st.

24 DR. FRANCIS: Okay. That was a
25 typo.

1 COMMISSIONER STECKEL: And yes.

2 DR. FRANCIS: We'll have to
3 make that adjustment in the minutes. July 1, 2019,
4 it went live.

5 And I know that Sharley had
6 sent out information that there was a session held in
7 Northern Kentucky about Kentuckians Joining to Combat
8 Substance Use Disorder. In my brain, I had put this
9 was in response to this waiver going live. Maybe it
10 wasn't. I did not get to attend.

11 MS. HUGHES: It was part of it,
12 yes. Tracy Williams was there and Ben Ingram and
13 several other folks there answered questions but they
14 gave a short update.

15 It was one of the Kentucky
16 HEALTH forums that they did up in Northern Kentucky
17 and they gave a little bit of an update that the
18 State Plan Amendment had been approved and that the
19 regulations had been filed and they had an open forum
20 where you could either ask questions via Facebook
21 Live or whoever was in the audience or you could text
22 questions in, and they had several questions.

23 And Anne Hollen and David Gray
24 from downstairs were there and answered questions and
25 so forth that people had.

1 DR. FRANCIS: Are we able to go
2 back and look at that?

3 MS. HUGHES: It should be out
4 on the Cabinet's Facebook page because that's where
5 they did it Facebook Live. My age, too. I'm
6 assuming once they do a Facebook Live that it's
7 there. It lives forever on the Facebook page as a
8 video. So, I think it is.

9 COMMISSIONER STECKEL: Why
10 don't we call Communications downstairs and ask them
11 and, then, we can just send a note to everyone.

12 MS. HUGHES: Okay. I'm pretty
13 sure I saw something last Friday maybe on the Pulse
14 Newsletter that goes out. I think there was a link
15 to it but I'll make sure and send you out a link.

16 DR. FRANCIS: Thank you. And,
17 then, is there any just general update, I guess, on
18 this that went live on July 1st?

19 COMMISSIONER STECKEL: Nothing
20 that we've not already talked about.

21 MS. HUGHES: That was the big
22 change to it was the Methadone treatment.

23 DR. JOSEPH: So, it's not just
24 the drug itself. It's administration of the social
25 services around it, too, but I think we've discussed

1 this.

2 DR. FRANCIS: Okay. I'm glad
3 to see that.

4 Next, the adjudication message
5 to include the Federal Poverty Limit, FPL, for
6 copays. Doug had said that maybe he could email KPhA
7 how to inform Kentucky pharmacists on copays and the
8 whole structure.

9 DR. OYLER: Yes. We sent some
10 stuff at the end of May to Mark and Sarah that was
11 essentially the same letter. I'm not sure who the
12 letter originally went out to - the MCOs - okay -
13 and, then, I think the MCOs distributed it about the
14 copays and things.

15 So, will that work to put that
16 - I think it was a half page, a couple of paragraphs
17 essentially saying here's the copay. Once you hit
18 your 5% threshold for the quarter, that's over, and,
19 then, the message about the Federal Poverty Limit was
20 in there as well.

21 MR. GLASPER: Can you re-send
22 it?

23 DR. OYLER: Sure.

24 DR. CARRICO: My question is
25 and if I understand this correctly from last meeting,

1 after they reach so much out of pocket per quarter,
2 it goes to zero.

3 DR. OYLER: Yes.

4 DR. CARRICO: Well, I know with
5 some commercial and Part D plans, you're able to look
6 up how much has this person paid out of pocket, how
7 much do they have left.

8 Is it possible to get that when
9 you get a claim adjudicated because trying to explain
10 this to a patient who had no copays a week ago and
11 the quarter reset and they're looking at you like
12 sure, whatever you say. All of a sudden, I'm paying
13 \$12 now and last month it was zero.

14 It's kind of hard to convey
15 that message. I feel like if it would show like a
16 deductible, however much they have left, it kind of
17 makes the point better to where they understand it
18 more. When I start dropping 5% of your Federal
19 Poverty Limit, they just gloss over.

20 DR. JOSEPH: I think we
21 discussed this earlier about giving everybody access
22 to that, or, sorry, at some point this was discussed,
23 but we were afraid that if we did that, then, you
24 would basically be forcing a pharmacist--I mean, if
25 you wanted to just check, that's an available option;

1 but I think what it does is it slows the process of
2 when you're filling a prescription because their
3 initial thought was the pharmacist has to check every
4 time before a pharmacy can dispense the medication
5 for the patient, so, monitor that on their own end.
6 So, basically logging out of your system and signing
7 on to the web portal and, then, signing into Kentucky
8 HEALTH and figuring that out itself.

9 I'd have to talk to Stephanie
10 about giving everyone access to that.

11 COMMISSIONER STECKEL: But
12 private pay insurers don't do that.

13 DR. CARRICO: No. I can just
14 look up after--it says like you have a \$4 copay for
15 this brand and, then, they'll say, how much more do I
16 have to my zero on my commercial or whatever, and I
17 can say it looks like you have \$50 left on the
18 deductible or something, and I just do that without
19 even going online. It's part of the claim.

20 DR. JOSEPH: We'd have to build
21 that in.

22 COMMISSIONER STECKEL: Let'S
23 look at it and see.

24 DR. FRANCIS: Or the patient
25 currently has access to go in and maybe look on their

1 in portal to see how much their spend has been? I
2 don't know.

3 DR. JOSEPH: I think they
4 should have access to that.

5 DR. CARRICO: But it's hard to
6 explain the whole process to someone because it's a
7 little bit different setup. You don't kind of hear
8 quarterly deductibles, so to speak.

9 COMMISSIONER STECKEL: That
10 makes sense.

11 MR. MILLER: I had a patient
12 and he was just angry because he had been to one
13 pharmacy and he had to pay all of his copays. Then,
14 the next one, it was zero. So, he thought the first
15 pharmacy was ripping him off. There's a lot of
16 misunderstanding about it.

17 DR. FRANCIS: Even if we had
18 what Doug was going to send to KPhA to say here's the
19 explanation of this because most pharmacists are not
20 going to just know off the top of their head and
21 we're trying to publicize that so they have some
22 talking.

23 COMMISSIONER STECKEL: You
24 would just need a talking point or a card that they
25 could have because even if we can do the system

1 change, system changes don't happen in our lifetime.

2 DR. FRANCIS: Yes, and I hate
3 to put a ton of work and things on you but if they
4 could just know the process.

5 MS. MILLER: They have a hard
6 time planning because somebody with multiple meds may
7 be paying \$12 one month and it creates a hardship if
8 they don't know what to expect when they come to our
9 door.

10 DR. CARRICO: I hear that
11 often. I don't know what I'm paying when I come
12 here. I don't either. I'm sorry.

13 COMMISSIONER STECKEL: We'll
14 look into it.

15 DR. FRANCIS: And, then, the
16 other thing I had about this--well, two things - one,
17 that we were supposed to at the pharmacy level be
18 able to see that Federal Poverty Limit adjudication
19 message. Have you guys seen that at all?

20 DR. VENNARI: It's in the
21 comment field, isn't it?

22 DR. ROGERS: It's the second
23 screen. So, I know because I had some things I had
24 to work with some pharmacies on.

25 DR. FRANCIS: Okay.

1 DR. ROGERS: If your software
2 system doesn't show that kind of pre-form messaging,
3 if you have to go to a second screen, then, you may
4 not see it on the first screen.

5 DR. FRANCIS: Kind of like
6 where if you were hunting for remaining deductible or
7 something.

8 MS. MILLER: So, maybe could we
9 add that into the pharmacist's education because they
10 may have to contact their software vendor if the
11 messages are coming and they're not seeing it.

12 MS. ROGERS: And we can always
13 probably ask what field that is actually displayed
14 in. I thought that was in our communication but I'll
15 double check.

16 DR. FRANCIS: And, then, the
17 last thing was, as you know, Chris Betz, who is not
18 here today, attended the MAC meeting for me in May.

19 And Dr. Schuster from the
20 Behavioral Health TAC said that she would like to
21 provide some education to the Pharmacy TAC and the
22 Primary Care TAC about behavioral health copays and
23 what she is seeing on her end.

24 COMMISSIONER STECKEL: We would
25 ask that you not do that. This TAC is an advisory

1 committee to the MAC which is an advisory committee
2 to us. It's not a function to create the opportunity
3 for advocates to sit before the TACs and talk about
4 their agenda.

5 DR. FRANCIS: Okay, and I have
6 no idea what information she wanted to provide.

7 COMMISSIONER STECKEL: They
8 violently, very strongly disagree with us having
9 copays on mental health services and drugs. That is
10 their position. They've been consistent on that
11 position. It is what it is. Our position is not
12 changing.

13 So, what she wants to talk to
14 you all about I am certain is that how we are both
15 killing people, denying services to people and having
16 folks end up in institutions and jails because we're
17 charging a copay.

18 DR. FRANCIS: Okay.

19 COMMISSIONER STECKEL: Now,
20 that is more direct but that would be almost verbatim
21 what she would tell you.

22 Now, this TAC and the
23 Department have a good relationship that we would
24 like to maintain, and we're a better agency because
25 of the work that you're doing and the advice you're

1 giving us.

2 And, then, when we have to
3 bring other pharmacists and all of that, I would hate
4 to see - and it sounds like a threat and it's not, I
5 promise - the problems we're having with Sheila and
6 the Behavioral Health TAC needs to stay in that.

7 DR. FRANCIS: Well, I
8 appreciate that insight and I do pride the Pharmacy
9 TAC on making change for the better and I don't want
10 to regress.

11 COMMISSIONER STECKEL: Now, if
12 you would like us to present a specific focus on
13 mental health drugs, we can do that. If you want
14 more information on that, you can do that but
15 understand this. Our policy is not changing, and I
16 would prefer that you all not cross TACs.

17 DR. FRANCIS: All right. Next,
18 David Gray.

19 MR. GRAY: My apologies for
20 being late.

21 DR. FRANCIS: No. I appreciate
22 it. David joined us just in time and you had
23 suggested that we could review the Kentucky HEALTH
24 website if we have any feedback to you. I believe
25 there was some feedback----

1 MR. GRAY: And, Paula, I'm
2 going to get with you after the meeting.

3 So, at this point with regard
4 to the revisions that DXC - and DXC, again, is the
5 entity that does the billing for Medicaid - they have
6 made I would say 99% of the screen enhancements at
7 this point. There are still a couple that we're
8 still kind of working through with regard to the
9 updates to--kyhealth.net is what we're talking about
10 when you go online to look at the information.

11 Now, I know pharmacies also,
12 then, have your point-of-sale system. So, sometimes
13 you're not as dependent upon kyhealth.net as other
14 providers are across the state, but I would think
15 that as it looks right now - and, again, that's
16 kyhealth.net - it's about 99% of the enhancement
17 improvements that we've been able to make in that;
18 also with the caveat that the technology is older -we
19 recognize that - and we do have some limitations.

20 And I know Paula has provided
21 some input on that, but certainly any other comments,
22 please get that to us. The intent was to actually
23 make it easier to use, consolidate some things.
24 Screens that needed to be maybe earlier on in the
25 flow have gotten moved forward with regards to some

1 information and that may be something that you
2 accessed a lot and it was on the sixth page
3 previously and it's earlier now in that.

4 DR. FRANCIS: Okay, and I
5 thought that suggestion was very good to get the
6 pharmacy ID numbers on the website. So, that would
7 help a lot since sometimes they differ from the card
8 or the patient doesn't have the card.

9 All right. so, Senate Bill 5.
10 I'll let you all talk.

11 DR. JOSEPH: We're still
12 monitoring prices that are being submitted weekly.
13 We're trending them over time. What we're seeing are
14 both reimbursements going up and going down. We're
15 only looking at reimbursement changes greater than
16 5%.

17 So, what we see is what we see.
18 I can't tell you if a drug is changing at two or
19 three or four percent, but we're making decisions
20 based off of what we see on NDAQ.

21 And, then, CMS is contemplating
22 taking a look at a route--so, not all drugs have a
23 NDAQ price. So, CMS is taking a look at using a
24 modified version of I want to say it's AWP minus a
25 certain percentage for certain drugs, depending on

1 the number of labelers.

2 So, we're applying that logic
3 as well to see what is an appropriate price or what
4 was the actual acquisition cost for a pharmacy for a
5 drug and, then, we're taking into account both the
6 dispensing fee that the MCOs are paying out as well
7 just to make sure that when we're looking at the
8 final reimbursement to the pharmacy it's as fair as
9 it can be.

10 There's not much I can say
11 without going into too much detail but just know we
12 have meetings probably four times a week on this with
13 Myers & Stauffer and it's very tedious. We're
14 talking down to the penny level. So, we're
15 monitoring it. It's going to take some time.

16 COMMISSIONER STECKEL: Is it
17 appropriate to talk about the percentage that we're
18 going to deny?

19 DR. JOSEPH: No, not yet.

20 COMMISSIONER STECKEL: Okay.
21 That's what I was afraid of. Never mind.

22 DR. JOSEPH: So, we are
23 approving and denying or disapproving. It's, again,
24 just based off the logic that we have.

25 MS. MILLER: Did you say you

1 were comparing reimbursement prices to NDAQ?

2 DR. JOSEPH: Yes. We're using
3 that as a semi-benchmark. So, we're trying to have a
4 picture that the price adjustments or whatever rate
5 change they're making is appropriate to what we see
6 in the market.

7 MS. MILLER: Okay.

8 COMMISSIONER STECKEL: And
9 we're being very, as Jessin has taught me, we're
10 trying to be like PBMs almost in that we don't want
11 to reveal the full methodology because, then, they
12 work right up to that methodology.

13 And, so, we're having to do
14 something that we don't like to do and that's not be
15 crystal clear about what methodology we're using.

16 DR. JOSEPH: To be honest,
17 we're not using just NDAQ. So, we do take in a
18 couple of other factors as well, and I don't even
19 want to say we just use NDAQ as a benchmark. We use
20 it as a semi-benchmark because other factors may go
21 into play.

22 COMMISSIONER STECKEL:
23 Including is it available, is the drug available at
24 that price and all of those issues.

25 DR. FRANCIS: So, do you feel

1 like you've made progress with the analysis for the
2 April through June analysis?

3 DR. JOSEPH: Yes, definitely.
4 I think we've made leaps and bounds, but we knew
5 going in when we started this that it was going to
6 get to the point where we are today where we're going
7 to have to start doing some trial and error and
8 seeing what happens when we map it out and we kind of
9 do a distribution of the data because the drug prices
10 in this country range from a half a penny to millions
11 and millions of dollars. I mean, we knew that going
12 in.

13 It's just now we're finally
14 seeing some changes and the fact that we're getting
15 both rate changes that are increasing and decreasing.
16 Again, originally, we were just getting the
17 increasing ones which we thought was an issue but now
18 that we're getting everything, well, at least we
19 think we're getting everything, we're monitoring a
20 lot more. And the more data we have, the better we
21 can actually make decisions.

22 COMMISSIONER STECKEL: So, one
23 of the things that I would like us to start engaging
24 in the debate and discussion is in July of 2020,
25 they're not going to be able to charge the post-

1 adjudication fees.

2 We are now developing a process
3 to look at anything that's a price change of 5% up or
4 down. We are starting to get more calls from
5 independent pharmacists about the dispensing fee and
6 I understand that.

7 So, one of the things I would
8 like us to start engaging in is how do we look at the
9 spread that's in the MCO payments and our payments
10 and reflect a true ingredient cost and a true
11 dispensing fee.

12 And I've done it before, so, I
13 know it can be done. It's not an easy challenge but
14 it's one that accurately pays a pharmacist for their
15 ingredient cost and, then, accurately pays a
16 pharmacist for their dispensing fee.

17 And when I say dispensing fee,
18 I don't mean just counting pills and putting them
19 out. It's the full scope of a pharmacist.

20 DR. FRANCIS: Clinical
21 services.

22 COMMISSIONER STECKEL: Correct.
23 So, I would like us to start discussing that.

24 DR. FRANCIS: That's great.

25 MS. MILLER: That's the model

1 in the fee-for-service side. No?

2 DR. JOSEPH: It's ten sixty-
3 four and, then, we use the lowest of logic. So,
4 every drug that is sold on the fee-for-service
5 side----

6 COMMISSIONER STECKEL: But even
7 with the lowest of logic, what we found - we did this
8 in Alabama and a lot of other states have done it
9 since then - that even the lowest of, because you
10 started at AWP minus something, WAC minus or plus
11 something, that those are artificial numbers and it
12 didn't get to the true acquisition cost and all of
13 the PBM games that are being played.

14 So, I think now, as Jessin
15 said, we're getting more data. We're getting more
16 information, and I think there's a better way to look
17 at actual acquisition costs and NDAQ didn't exist
18 back then.

19 So, there may be easier ways
20 than what we had to go through making it out of whole
21 cloth but to reflect, you know, absent all the
22 discounts, all the rebates, everything else, what
23 does it cost you to buy that drug? That's what I
24 want to reimburse you. And, then, what does it cost
25 for you and your staff to provide the services we've

1 asked you to provide and pay you for that?

2 DR. CARRICO: I'll just say
3 right now in the current fee-for-service, I'm amazed
4 at how accurate it is. I can only think of like one
5 to two drugs where it's noticeably off and
6 underpaying but everything else, I'm like that's
7 within four cents almost every time.

8 COMMISSIONER STECKEL: Okay.
9 Well, then, that may be what we find out, but we're
10 not going to be able to raise the dispensing fee
11 without an equal reduction in the ingredient costs on
12 the managed care side because we just don't have it
13 in our budget and I would imagine that there is that
14 kind of spread. I know we found it in Alabama and
15 had every pharmacist in--well, not every but everyone
16 was on board with what we did, but we've got to do
17 that balance.

18 DR. FRANCIS: So, this is to me
19 really interesting. What would you say are the next
20 steps based on your experience in the past and, then,
21 newer technology and formulas out there, what do you
22 think should be our next step?

23 COMMISSIONER STECKEL: Jessin
24 and I have been talking about this. If we could come
25 up with a draft proposal or an idea - I don't even

1 want to call it a proposal - but here is something we
2 could do using the new technology, using NDAQ and
3 everything that we know now and put something on the
4 table and, then, bring in the retail pharmacists, the
5 independent pharmacists.

6 There was one twist on the
7 specialty pharmacists which is always a twist but
8 bring them to the table and talk about it. This is
9 what we're looking at, what do you think and start
10 that debate.

11 DR. JOSEPH: My hope is once
12 this thing is fully automated and I don't have to
13 touch it, this is going to run on its own like a
14 well-oiled machine but we haven't cracked it yet.
15 So, that's what we're working on. I mean, that's
16 ideal, right?

17 If we can have a system where
18 we know what we're reimbursing and, then, we know
19 that it's fair and it's something that we agree to,
20 then, I think we can move forward.

21 COMMISSIONER STECKEL: And it's
22 transparent. Again, it goes to that transparency and
23 how can we be assured that these - and we all play
24 the games in all of our financing mechanisms - but
25 the spread, let's define it and put it somewhere,

1 whether it's savings for Medicaid, whether it's
2 pharmacy reimbursement for dispensing or to cover the
3 ingredient cost. Are you following?

4 MS. MILLER: Yes. I think
5 right now, we would say in a lot of our claims, we're
6 under water on both sides. We're not being
7 reimbursed for costs to dispense and we're not even
8 getting the money to cover the drug purchase. So,
9 that is more common. So, I would love to see
10 fairness on both sides.

11 COMMISSIONER STECKEL: I don't
12 know how to say I'm not so sure I agree with you
13 without saying I just don't agree with you, but we
14 will get the data that will say one way or the other,
15 and that will be part of the process is I think one
16 thing. You think another thing. And I know you have
17 evidence, but systemic wide, is that the case?

18 Right now, we have a lot of
19 data but can we definitively say, yes, independent
20 pharmacists are not being paid enough in their
21 dispensing fee? Like, I can't tell you what the MCOs
22 are doing between the independent pharmacies and how
23 much spread.

24 They'll pay them \$2 for the
25 dispensing fee but, then, they will pay them \$4 over

1 what would be an average acquisition cost or an
2 actual acquisition cost to offset that and I don't
3 know what all is going in in that equation.

4 MS. MILLER: Right.

5 COMMISSIONER STECKEL: So, the
6 biggest thing that we would accomplish by doing this
7 is getting that information. Who is doing what to
8 whom and how and, then, what are the real numbers and
9 where do we move those numbers so that we can say to
10 the taxpayers, to the Legislature, to the Governor,
11 we now have a better sense of where this money is
12 going. It's not just the PBMs. It's the system
13 itself that is out of whack.

14 MS. MILLER: What kind of
15 information would you hope to have, like, that's on
16 our side?

17 COMMISSIONER STECKEL: The
18 prices you're paying for the----

19 DR. JOSEPH: I think what we
20 could benefit--I mean, since we get a lot from you
21 guys already now that we have a direct relationship
22 with the PBM, we can see a lot more.

23 One thing we can't see is if
24 you guys are getting any GERS on the back end because
25 I don't know if those have come out yet. I've been

1 talking to some of the independent pharmacists and
2 they said they haven't. Have you guys seen anything?

3 MS. MILLER: I'm not sure.

4 DR. CARRICO: I'm still waiting
5 for a 2018----

6 DR. JOSEPH: Yes, that's what
7 I've heard. So, I think when I first started the
8 conversation it was back in April and the expectation
9 was it was going to come out in April. So, I'm
10 assuming it's any day now but that's stuff that we
11 will never see in claims unless you guys report it to
12 us.

13 So, when those GERS come out,
14 what would be helpful is if we could see them.

15 COMMISSIONER STECKEL: Or
16 rebates that you have or how the MCOs pay. So, why
17 don't we do this. You kind of get the idea of where
18 I would like us to talk about and go. Let Jessin and
19 his team put together kind of here's what we're
20 trying to accomplish and let's have pure transparency
21 with the reimbursement, both the dispensing fee and
22 the ingredient cost, to your point and, then, here's
23 what we would like to talk about and, then, pros and
24 cons and just put a broad-brush description of the
25 idea on paper and maybe some of here's what other

1 states have done.

2 DR. JOSEPH: Sure.

3 MS. MILLER: What kind of
4 timeline can you hope to attach to this?

5 DR. JOSEPH: I mean, if we're
6 going to be honest, six months out before we see
7 anything really, not in terms of what we see in the
8 data right now but in terms of a true understanding
9 of what's fully happening.

10 If I take into account GERs, if
11 I take into account rebates, that's going to take
12 some time because that's, one, to the operational
13 issue and, then, two, how does it impact what I see
14 in the claims or what we see in the claims.

15 COMMISSIONER STECKEL: Because
16 the key is making sure the data is solid and making
17 sure the information for which we're making these
18 decisions is valid. So, that would involve a lot of
19 discussions with you all and actually getting into
20 the pharmacies, getting into the MCOs.

21 DR. JOSEPH: You know what
22 might help is the day that you get your GERs - and I
23 think - you guys won't know this because this is a
24 fight that you guys are putting up - but when those
25 GERs come out, if you can get the claim level

1 adjudication for how they reprocessed them because I
2 Know that's possible through some of the PSAO's.

3 MS. MILLER: Do you know if
4 that's possible?

5 DR. CARRICO: Elevate told me
6 it wasn't possible but I heard through Epic it was
7 possible.

8 DR. JOSEPH: Yes. So, I mean,
9 theoretically, it has to be possible because how else
10 are they getting to a number? I would push for that.

11 MS. MILLER: So, that's our
12 question, too. How are they getting to a number?

13 DR. JOSEPH: That's what I
14 would need. I mean, that's like the biggest help
15 that I've had is when I can see that. I mean,
16 they're not going to give it to you in like a
17 specific format but they'll probably give it to you
18 in an Excel sheet, but that's enough for us to at
19 least get started and take a look at what's going on
20 on that back end.

21 COMMISSIONER STECKEL: And
22 here's what I don't want to have happen. I really do
23 want us to take the work that we've all done together
24 on SB 5 and the PBMs and everything and take it to
25 the next level.

1 I don't want us to get in a
2 situation where pharmacies are asking for an increase
3 in the dispensing fee and I'm saying it's going to be
4 \$25 million if we do it and we don't have it in the
5 budget and we don't have the data to show whether
6 it's valid or not valid. Is it \$25 million or is it
7 \$10 million, the difference that you're talking
8 about?

9 So, what I want and
10 particularly in pharmacy but in every area, I want us
11 to be able to have thought through the data of what
12 is the issue? How big is it? And we may come to a
13 conclusion at the end of this that we're going to
14 disagree, but we're going to disagree with data that
15 we believe is valid. Does that make sense?

16 MS. MILLER: I don't know if
17 this is even possible - this is from a non-data
18 person - but are you able to take a year's worth of
19 drug data and do your estimated cost and add, like
20 what would that have cost the system in the fee-for-
21 service style?

22 DR. JOSEPH: Yes. We're doing
23 that right now.

24 MS. MILLER: So, how does that
25 compare to what was paid?

1 MR. JOSEPH: It's not done.

2 MS. MILLER: Okay. Well, that
3 will be interesting to know.

4 DR. JOSEPH: That's a million-
5 dollar question right there. There's a lot of things
6 we could figure out with the data. So, that's what
7 we're doing. We're reprocessing those claims from at
8 least the past two years, 2017 and 2018's data today
9 to look at what happens if we move from the MCO
10 model to a fee-for-service model. I mean, I don't
11 know what the numbers are going to say but the
12 numbers are enough for me to hand over and somebody
13 else make a final decision.

14 COMMISSIONER STECKEL: And what
15 we have pledged to the Legislature because we fully
16 expect - and I'm surprised it hasn't been prefiled -
17 but a carve-out of the Pharmacy Program from the
18 MCOs. I fully expect that to be.

19 We are not going to take a
20 position on it. All we're going to do is share the
21 data. This is what happens if you carve it out.
22 Here's what happens if you keep it in. With our real
23 data, we're replicating the West Virginia study.
24 We're recreating exactly what you said - what would
25 happen - and it's up to them to make a decision.

1 DR. JOSEPH: And just to add on
2 top of that, because you can't necessarily just put
3 in the data and I can't just say, well, this looks
4 like this is what's going to happen. There are other
5 pieces of it. Rebates is one issue. So, we're doing
6 a separate analysis on what happens to our state and
7 federal rebates if we--or federal and supplement
8 rebates if we were to move to a carve-out.

9 And, then, there is what
10 happens to admin costs. I mean, these are things
11 that aren't necessarily in claims and it's not
12 necessarily in data but it's conversations we have to
13 look at, contracts that we may have to look at.

14 So, for everybody in this room,
15 if there's something that you think should be
16 addressed or at least looked into from the MCO, from
17 the pharmacy side, let us know.

18 COMMISSIONER STECKEL: Because
19 if you've looked at the West Virginia study, most of
20 their savings are admin savings. And, so, we're
21 trying to make sure that we've got it done compared
22 to Kentucky data.

23 DR. FRANCIS: You said you want
24 to collect this data from independent pharmacies but
25 also I assume chain and community pharmacies and

1 specialty pharmacies because there's a lot of
2 clinical services that go into the specialty
3 pharmacies.

4 DR. JOSEPH: Yes. So, if there
5 are nuances like that, please let us know. I mean,
6 the smallest details help because at least we could
7 look into it and see whether or not it impacts us at
8 a systemic level.

9 COMMISSIONER STECKEL: And it's
10 a very different world we're in now, but I think the
11 more we, Medicaid, can argue this is the data, this
12 shows either what the pharmacists are saying is
13 accurate or not accurate, the better off we're going
14 to be. And if we can work out a program that creates
15 a truly transparent methodology, then, that is a
16 win/win for all of us.

17 DR. FRANCIS: Okay. Also along
18 the Senate Bill 5 path is the last time you mentioned
19 we may need potential statute revision if we're going
20 to price changes of 5% per day or whatever. I guess
21 we're waiting to see what the status is.

22 DR. JOSEPH: Yes. We're
23 talking with John Pitt who is on our floor about what
24 we want to put into that language and how we can
25 hopefully cover any holes that might be existing

1 right now.

2 COMMISSIONER STECKEL: And
3 we'll share that with you guys as we get closer to
4 better knowing how we want it to change.

5 DR. FRANCIS: Do you have an
6 expected finish date from your analysis?

7 DR. JOSEPH: So, for the 5%
8 changes?

9 DR. FRANCIS: Yes.

10 DR. JOSEPH: No, because
11 honestly this is supposed to be ongoing. I mean,
12 we're supposed to be monitoring these prices every
13 time it happens. Again, we're only monitoring the
14 MAC prices that occur right now and, then, if they
15 change a contract by any way, then, they'll let us
16 know, too, but for the most part, we just monitor the
17 MAC and the MAC changes daily but we make them change
18 it weekly.

19 So, we're monitoring that at
20 that level and then we get the files in every week.
21 So, there's no real end date on this. It's just the
22 more that we have, the better that we can make a
23 recommendation to approve or disapprove. No true end
24 date.

25 COMMISSIONER STECKEL: And,

1 then, we're hoping to make it electronic.

2 DR. JOSEPH: Yes. Our goal is
3 that we don't have to do this, sit down and talk it
4 through some of the nuances.

5 DR. FRANCIS: I guess my
6 thought was if you started in April, what did you
7 say, six months, like into October and, then, you
8 would have some time before the legislative session.

9 MS. GRAY: Are you talking
10 about for the report of----

11 DR. FRANCIS: Of those 5%
12 changes.

13 MS. GRAY: Of what they're
14 saying.

15 DR. JOSEPH: Like an actual
16 report.

17 COMMISSIONER STECKEL: Just to
18 us so we know what's going on.

19 DR. FRANCIS: Or where you're
20 confident enough in the data that you could say----

21 DR. JOSEPH: I understand.

22 COMMISSIONER STECKEL: We're
23 going to have to do that.

24 DR. JOSEPH: Yes. It's just
25 way too early right now. I'm sorry. It would be

1 hard to say something and then make it definitive.

2 COMMISSIONER STECKEL: But
3 there will be a hearing where we will be asked to
4 report this information. If not, I'll be stunned and
5 we'll be glad to share with you all.

6 DR. FRANCIS: Okay. Great.
7 Anything else on Senate Bill 5?

8 So, th e next one is a quick
9 point, I think kind of a fun point. We had talked
10 about Jessin and Sarah potentially working together
11 to develop some pharmacy communication with the
12 State.

13 DR. JOSEPH: These kind of
14 things, obviously the immunization chart is one. The
15 FPL letter is another one. This relationship is
16 probably going to be more both policy and clinical.

17 So, one of the things that we
18 were thinking about doing is if Medicaid is taking on
19 an initiative or DPH is taking on an initiative, our
20 Cabinet can reach out to KPhA and say, hey, this is
21 an opportunity for pharmacists to either get CE or if
22 they want to engage in this conversation, this
23 roundtable, this might be something that might be
24 interesting just because I think working with the
25 Commissioner, we focus on pharmacy a lot but we focus

1 on a lot of other areas as well.

2 So, immunization actually came
3 to us from DPH and, then, Dr. Theriot is obviously a
4 pediatrician and has been very involved with it as
5 well. So, those kind of things are easy to do.

6 So, that's probably going to be
7 how we look at our communications with Sarah and KPhA
8 as both clinical and anything policy-related, too.
9 If we think it's going to have a big impact on
10 pharmacy providers, then, we'll put that out through
11 KPhA as well but we'll solicit feedback on anything.

12 DR. FRANCIS: It would be nice
13 to know even this is what's going on at the State and
14 pharmacists can say I think I read something about
15 that three months ago and they can look back on
16 previous KPhA email blasts and newsletters. That's
17 kind of what I was envisioning, too, one way to
18 communicate but also like a registry of
19 communication.

20 DR. JOSEPH: Sure. I think
21 we'll have to be careful about what we exactly put in
22 those outlines. I don't think this is necessary for
23 us to put any fine details to but just have lines on
24 exactly what we're working on, project updates or
25 anything like that.

1 DR. FRANCIS: And I just had
2 this one here in case there was anything but it leads
3 across to your initiative of the Pharmacy Department
4 project management update. Is there anything else
5 that we haven't talked about that we should know
6 what's going in the Department?

7 DR. JOSEPH: PAD, but it
8 doesn't really apply to pharmacy. That's the thing.
9 Not everything is pharmacy for us. So, our
10 Physician-Administered Drug list, we'll be
11 maintaining that, the Pharmacy Department will be.
12 The only difference, it's technically a medical
13 benefit. So, we have sent out notices to providers
14 two months ago and then at the beginning of July of
15 this year.

16 DR. FRANCIS: Does that pertain
17 to formulary or what will be covered?

18 DR. JOSEPH: That pertains to
19 reimbursement.

20 DR. FRANCIS: I don't work in a
21 pharmacy. I work in a physician's office. So, that
22 does pertain to pharmacists.

23 DR. JOSEPH: Okay. So, I guess
24 we're talking about both reimbursement to the
25 providers. We're just going to be changing it to

1 exactly what the SPA says and that was passed in
2 2017. It just hadn't been implemented. So, we're
3 implementing it now and it will go live on 8/1.

4 We'll be hopefully
5 restructuring our PAD program on 12/1 is the
6 anticipated date. So, we'll have a new PAD list come
7 out and we'll post it on our website as it's
8 required, but, again, this is all for the fee-for-
9 service population. So, we're just moving forward
10 and getting the systems all in place. So, that means
11 bringing DXC on board, bringing Magellan on board
12 and, then, setting up our clinical criteria.

13 DR. FRANCIS: And I think
14 pharmacists can definitely help with that, too. I
15 mean, if your Department is monitoring it, probably
16 there's pharmacists in the state working on it in
17 some way, too.

18 DR. JOSEPH: Yes. We take
19 calls from the physicians and the pharmacists who
20 have either seen that this drug isn't on our PAD list
21 already. So, we're still welcoming those calls.

22 The other project we should
23 probably mention is starting by 1/1/20, we will be
24 having electronic PA's in place for the fee-for-
25 service population and I think some of you guys

1 already have that in place, too.

2 So, if we can hopefully get EPA
3 set up before 1/1, we'll let you guys all know
4 through KPhA.

5 DR. FRANCIS: Good, and I think
6 that would make everyone electronic PA, if I'm right.
7 So, that would be good. Anything else from DMS
8 before we move on to the MCOs? Joe.

9 DR. VENNARI: We're working on
10 that electronic PA and actually things been pretty
11 quiet since our last meeting. We've spent most of
12 our time working on the RFP and then the transition,
13 supporting the transition from CareSource to Humana
14 but most of it has been internal work. It's all
15 good.

16 DR. FRANCIS: Is there anything
17 with that transition that pharmacists or patients
18 will need to know? Maybe you don't have this level
19 of detail yet but come January 1, the pharmacists can
20 help expect at the pharmacy or help with the
21 transition?

22 DR. VENNARI: Well, it's always
23 been co-branded Humana-CareSource. So, they're going
24 to be familiar with the Humana name anyway. As far
25 as they'll get new cards and it will be a different

1 adjudicating process but that's no different, and
2 there will be communications going out.

3 DR. FRANCIS: Okay. April.

4 DR. COX: So, CPESN pilot
5 project update. I do have some numbers this time.
6 We've started pulling in some data.

7 So, from January to May of this
8 year, we have had twenty-nine case conferences
9 discussing ninety-seven members. So, these case
10 conferences occur between our nurse case manager and
11 my clinical pharmacists at the plan and, then, the
12 CPESN pharmacist. So, they actually have case
13 conferences where they discuss specific members. So,
14 twenty-nine of those have occurred and they have
15 discussed ninety-seven members.

16 We have had sixty-three member
17 care plans submitted through May. Twenty-five of
18 those have been closed. So, that means whatever
19 issues that were identified have been resolved, and
20 we actually have had five social determinants of
21 health referrals made to the plan from the CPESN
22 pharmacies and all five of those have been resolved
23 as well.

24 So, we are in the process of
25 expanding. We're looking at fifteen additional

1 pharmacies across the state, so, we will be branching
2 outside of the Bowling Green/Western Kentucky area.
3 Right now we're just waiting to--we're having them
4 submit sample care plans because what we found with
5 this initial pilot, all the pharmacies use different
6 vendors and some vendors are a little more compatible
7 with our system than others and, so, we are vetting
8 them out.

9 So, CPESN is working with them
10 to submit sample care plans to us to see if their
11 software vendor is compatible because the program
12 won't work if the vendors aren't compatible. So,
13 that's where we are with vetting out the new
14 pharmacies.

15 So, hopefully they're saying by
16 August - I was going to say September - we'll have
17 some additional pharmacies on board.

18 DR. FRANCIS: Are you looking
19 at outcomes of the patients at all, then, like
20 readmission or what outcomes are you looking at?

21 DR. COX: So, that's where
22 we're headed now. We have another pharmacist that's
23 working on compiling that data and I don't have
24 anything to share yet because we're still kind of
25 gauging what this looks like. And, so, we've made

1 some revisions to our referral forms, trying to make
2 sure we're capturing the most common areas that the
3 pharmacists are seeing.

4 One of the issues we're finding
5 in our Other category, it can be a hodgepodge of
6 things, as we were recently discussing - you know,
7 there's one area that keeps coming up in Other -
8 actually possibly making that an actual outcome that
9 we're tracking and pulling it out of the Other
10 column.

11 So, right now, it's kind of
12 trial and error but we are looking at outcomes, and
13 hopefully by next quarter, I should have some to
14 report out.

15 DR. FRANCIS: Just things that
16 come to mind like how many care gaps are closed
17 versus the controlled group, cost of care,
18 readmission rate, things like that, that would be
19 very interesting.

20 DR. COX: And gaps in care
21 obviously is one of the ones that's on there. So, we
22 have several different categories, and, so, we're
23 just now starting to review those care plans that
24 have been closed and identify the areas that were
25 identified as issues, making sure we're pulling those

1 in the correct area so that we can get some accurate
2 numbers to report out.

3 DR. FRANCIS: And are all of
4 your pharmacies independent pharmacies?

5 DR. COX: Yes, the ones we have
6 now. We have six now. Let me see if I can recite
7 them all. Rice's Pharmacy, Alford Pharmacy,
8 Stonewall, Hines - we have two locations for Hines -
9 and there's one I'm missing. There's one I'm
10 missing.

11 MS. MILLER: Rice has two,
12 don't they?

13 DR. COX: Well, we only have
14 one of the Rice but we have two Hines and there's one
15 I'm missing that I can't think of, and, so, I
16 apologize, but we do have six locations but they're
17 all independent in Western Kentucky. And the ones
18 that we're looking to spread out to are independent
19 pharmacies as well.

20 DR. FRANCIS: I'd be interested
21 to see provider satisfaction and pharmacist
22 satisfaction.

23 DR. COX: We actually have
24 received--we've had minimal response on the surveys
25 but CPESN is sending out surveys on our behalf, and

1 so far the responses we're getting, the pharmacists
2 have been very engaged and the members that actually
3 completed the survey, everybody gave high remarks.
4 And, so, if that's something you want to see next
5 time I can report actually out on.

6 DR. FRANCIS: I think it would
7 be.

8 DR. COX: Okay.

9 DR. FRANCIS: And sometimes
10 from the physician's side, you get, well, if an Aetna
11 pharmacist is talking to a community pharmacist, how
12 do we know that care is not being siloed and how does
13 it get back to the primary care provider?

14 And, so, it would be nice to
15 also get did the primary care provider find something
16 that--you know, was he alerted to something that
17 helped him in his path of care.

18 DR. COX: I can share some
19 survey results. Other than CPESN, we are working on
20 our de-prescribing initiatives at the plan. We have
21 a PPI one that we're starting to see data back from
22 practitioners basically where we provided some
23 education and information, I guess basically
24 suggestions on pulling their members off PPI's. So,
25 is this clinically appropriate.

1 So, we made some suggestions
2 and we're getting some information back from the
3 providers on whether or not they took our
4 recommendations. So, that's our first de-prescribing
5 initiative and we are working on a second one for
6 psychotropic medication utilization in the foster
7 care population. That one is not off the ground yet.
8 It's in its infancy. Right now we're in the data-
9 pulling phase.

10 So, we're looking at
11 psychotropic medications, so, your ADHD, your alpha
12 agonists, antidepressants, antipsychotics, so, all of
13 those medications as a whole and we're going to do
14 some provider outreach and education for our foster
15 members and eventually roll this out to the pediatric
16 population as a whole but we just kind of want to
17 start smaller first.

18 And, so, we're going to have
19 some recommendations, kind of like the PPI initiative
20 on best practices and that type of thing and see if
21 we get some responses back from the providers and
22 generate some conversations with our clinical
23 pharmacists at the plan.

24 DR. FRANCIS: Thank you. Thea.

25 DR. ROGERS: So, really, we're

1 working on our EPA implementation actually when we do
2 go live with that, and as soon as I have a formal
3 communication, I'll be sure to share that with you,
4 Mark, so you can share it. It's mainly acting on
5 prescribers. So, just as an FYI in case you're
6 interfacing with that, that would be good for you to
7 know.

8 Similar to April, we have
9 initiatives around appropriate psychotropic use in
10 the pediatric population. We have clinical
11 pharmacists that are working that. Strategies around
12 polypharmacy and opioid continue to be ongoing as
13 well and I think that's probably the main things.

14 DR. FRANCIS: And I think that
15 from my observation and knowing community and health
16 system pharmacy and through Population Health Work,
17 it has seemed that the missing link that we get is
18 the communication between the community pharmacist
19 and the health system provider or pharmacist.

20 And I think that's why I was
21 excited about Aetna's work because it's trying to
22 bring community pharmacists where they're seeing
23 patients in the touch point area and hopefully
24 relaying it back to the provider.

25 And, so, rather than just

1 working with providers but the community pharmacists
2 don't know what's going on or working just with
3 community pharmacists or your own internal
4 pharmacists and providers get a letter, a fax, letter
5 or something that says this patient is on a PPI,
6 let's get rid of it and they throw it in the garbage
7 rather than having that relationship.

8 So, that's where I see the big
9 opportunity for these patients. Like, all of this is
10 good work but, then, how do we bring it back so
11 everybody is on board with it.

12 All right. Anthem.

13 MR. RUDD: We have the same
14 similar programs with polypharmacy and antipsychotics
15 as everybody else. So, we're all making those
16 efforts.

17 I guess the only other
18 announcement is we expanded the ICD-10 codes on
19 Vivitrol which I think everybody did, but we had
20 initially only implemented the ICD-10's from the
21 Buprenorphine waiver.

22 And, so, we've since added some
23 of those additional codes so that it opened the
24 access to Vivitrol without PA for the pharmacies. I
25 haven't heard anything back from St. Matthews, so,

1 I'm assuming that it's working. So, they have been
2 in contact with us about that. So, that's really the
3 only update I have.

4 DR. FRANCIS: Thank you.
5 Passport.

6 MS. ARMSTRONG: A couple of
7 things. One of the things that we have put in place
8 and will actually go live on August 5th is a safety
9 edit around PPI's.

10 So, after members have been on
11 PPI's for ninety days, it will stop at the point of
12 sale and require documentation of complications or
13 medical necessity to continue treatment on PPI's, and
14 we'll also allow for additional time, too, if the
15 provider wants to taper the member off of PPI's as
16 well, but we put these in place to try to address the
17 guidelines that have come out, and, so, we're all up
18 to ninety days.

19 DR. FRANCIS: So, that is a
20 very good example of something that we need to do an
21 email blast out.

22 MS. ARMSTRONG: We will. Since
23 everyone was talking about behavioral health, we do
24 have our behavioral health psychotropic drug program
25 that's still in place. That started in 2014. It's

1 addressing polypharmacy and duplicate therapy, that
2 sort of thing. So, that's still in place.

3 And we have also engaged out
4 outreach pharmacist team to address some controlled
5 substance prescribing. So, they will be out working
6 with pharmacies and providers to have those
7 conversations around controlled substances.

8 DR. FRANCIS: Okay. PTAC. And
9 if you had already told me that we have something, I
10 didn't put it down.

11 So, let's go to the previous
12 agenda items. Potential pilots to improve outcomes.
13 I know that, Commissioner Steckel, I had wanted to
14 meet with you but you had said you were looking at
15 three to five measures across the state and I was
16 kind of waiting to see what your teams had kind of
17 thought of as those measures, if those have been
18 decided.

19 COMMISSIONER STECKEL: No, they
20 have not. So, that would be for the July 1st of 2020
21 contract with the MCOs; but in the meantime, we are
22 on the verge of having our updated quality plan
23 that's required by CMS. So, that should be coming
24 out for comment. Do we do that for comments?

25 MS. HUGHES: Yes. That will be

1 posted.

2 COMMISSIONER STECKEL: So, we
3 would appreciate your comments on that. The last one
4 was 2011, so, we're staying right on top of it.

5 DR. FRANCIS: So, when is that
6 anticipated to be out?

7 COMMISSIONER STECKEL: Give us
8 two weeks but we're hoping next week.

9 DR. FRANCIS: When that's
10 available, Sharley, could you----

11 MS. HUGHES: I will try my best
12 to remember.

13 COMMISSIONER STECKEL: Why
14 don't we just plan on sending that to all the TACs
15 and the MAC. That's a good idea.

16 MS. HUGHES: Okay.

17 DR. FRANCIS: It would be nice
18 to align our efforts with the State's efforts.

19 COMMISSIONER STECKEL: Right,
20 and vice versa.

21 DR. FRANCIS: Yes. And, then,
22 just two previous items - the 90-day supply for
23 medications covered by Medicaid. That was going to
24 be taken back and considered to improve adherence.
25 Typically, 90-day supplies haven't been covered by

1 Medicaid and there was a pharmacist that had brought
2 that up and we brought it to the last meeting.

3 That's fine. We can still take
4 it back. That's why I have it on here on previous
5 agenda items.

6 MS. MILLER: And I think just
7 to clarify, too, I think that nobody wants it to be a
8 mandatory thing because certain recipients would not
9 benefit from ninety and some would. So, we wouldn't
10 want it to be a mandatory----

11 DR. FRANCIS: But an
12 option----

13 MS. MILLER: ----but an option,
14 right.

15 DR. FRANCIS: ----to have a 90-
16 day supply, less trips to the pharmacy.

17 COMMISSIONER STECKEL: Does
18 Medicaid have the option----

19 DR. VENNARI: There's already
20 an option today. I think it's a conscious decision,
21 I think, and we can have a discussion and go back and
22 forth on this, but because folks come in and off the
23 rolls, if you're dispensing a 90-day supply, then,
24 you really should be picked up by another carrier if
25 they go to another job. So, that's been a conscious

1 decision. Yes, is it better for use, yes, sure,
2 better for a lot of different reasons but it's kind
3 of a give and take. So, we have to take a look at
4 what we want to provide for ninety days. It's not
5 that it's not doable. It's very doable.

6 MS. ARMSTRONG: Passport has a
7 list of drugs that we allow a 90-day supply. It's on
8 our website. It's mostly generic maintenance drugs.

9 COMMISSIONER STECKEL: So, the
10 issue for Medicaid is if they lose their eligibility
11 and we give them 90 days and the federal money for
12 those prescriptions go away for the period of time
13 that they're not eligible.

14 DR. FRANCIS: Okay. And there
15 may be valid reasons like that but I think you know
16 pharmacists are like when there's so much push to a
17 90-day supply, why can't we get---

18 COMMISSIONER STECKEL: It's all
19 tied to eligibility. It would be a slam dunk if we
20 kept someone eligible for ninety days and we knew
21 that but it's all tied to eligibility.

22 MS. MILLER: And just having
23 the knowledge and understanding can help as well.

24 DR. FRANCIS: Right. And,
25 then, there was looking at the Medsync copays

1 proration. I listed Senate Bill 44 there that says
2 that there are Medsync Programs available but
3 typically I think they were charged like the full
4 copay on Medicaid if they were going to be synced up
5 rather than prorate like Medicare does.

6 DR. OYLER: So, what I asked
7 them is we were going to look to see if there's
8 anything that forbid it or anything from our side and
9 there's not but then I think there were some
10 logistical issues with filling systems and getting
11 stuff figured out because at the time there weren't
12 copays when it was originally put together and now
13 there are.

14 So, you guys were looking at
15 getting that kind of squared away is where I have we
16 kind of left it the last time.

17 COMMISSIONER STECKEL: Nobody
18 fills in the gaps.

19 DR. OYLER: So, are there still
20 the full copays being charged for the partial fills
21 as part of the----

22 MS. MILLER: I have not seen it
23 one way or the other. Do your plans allow proration
24 of the copays for Medsync? So, as far as you know,
25 it should be happening?

1 MS. ARMSTRONG: I don't think
2 so but we're looking into the capability.

3 MS. MILLER: It's another
4 pharmacy initiative in the community to sync meds,
5 and, so, that would be more knowledge to have if we
6 could find that out.

7 COMMISSIONER STECKEL: So,
8 we've heard from Passport. Aetna?

9 DR. COX: We don't at this
10 time.

11 DR. ROGERS: I'd have to take
12 it back. I'm not sure.

13 MR. RUDD: I don't know for
14 sure, but, again, I think it's a global issue with
15 the PBMs. So, again, I think the trick is that we
16 weren't charging copays. So, let me get back to you
17 on that. I don't see why we couldn't because a copay
18 is a copay is a copay. So, I don't know why they
19 wouldn't be prorating it now but I don't know that
20 for a fact if they are or if they are not.

21 DR. FRANCIS: Thank you. And
22 one question here is just the potential - and Matt
23 brought this up - so, if you want to explain that a
24 little bit more.

25 DR. CARRICO: Sure. So,

1 Spinosad used to be on the formulary for I don't
2 think all the MCOs but some of them, at least
3 WellCare I remember, and especially with school
4 coming back, we do a lot of lice medication, and it
5 seems to be that it's taken off the formulary since
6 then.

7 The Nix Permethrine 1% is
8 covered but that's unavailable everywhere. I've just
9 been having to hand children brand name Nix and tell
10 them to pay if they can over the counter. I mean,
11 the 5%, the Elimite, that is no longer even
12 considered first line for lice. I think one of the
13 MCOs - I forget which one - will cover Spinosad after
14 you fail on the 5% but that's kind of only adding to
15 the problem of resistance.

16 So, it's one of the things I
17 would like to be considered to work because it's kind
18 of getting out of hand lice-wise.

19 I mean, nothing is really
20 working for the kids and there wasn't really many
21 problems were people were using this a year ago. I
22 have more information I can bring to actually prove
23 some of this stuff - the science behind it and the
24 numbers if need be but it was something that I just
25 wanted to bring up for discussion or at least

1 consider.

2 MS. ARMSTRONG: So, Passport
3 right now has it preferred without a PA, but if
4 there's any issues getting this to go through, I want
5 to know so we can clear those up.

6 DR. CARRICO: Sure. I'll check
7 it out. I think Passport is probably my least
8 comments, so, that's probably why I haven't seen it
9 with them.

10 DR. ROGERS: You're right.
11 WellCare does require a trial of the Nix. I was not
12 aware there was a market issue. So, let me take that
13 back to the clinical team and I'll circle back.

14 DR. CARRICO: The one NDC I
15 found available for the 1% is not covered by anyone.
16 I have no idea why. It was like an AmeriSource
17 version of it, but even the 1% is no longer
18 considered first line. I don't think it's even
19 considered second line at this point.

20 MR. RUDD: But it may be that
21 it doesn't have a CMS rebate is why it's rejecting,
22 as to why it's not processing. So, we are held to
23 that standard where if it's not a CMS-rebated
24 manufacturer, we're not allowed to cover that.

25 COMMISSIONER STECKEL: But do

1 we pay for it in fee-for-service?
2 DR. JOSEPH: Yes, we cover it
3 on fee-for-service.
4 COMMISSIONER STECKEL: So, that
5 means it has a rebate.
6 DR. JOSEPH: We cover Spinosad.
7 Are you talking about Nix?
8 MS. MILLER: So, the only
9 available product is not rebateable. Is that what
10 you're saying?
11 DR. FRANCIS: That is what
12 Andrew is saying.
13 DR. OYLER: We have the 5%.
14 DR. JOSEPH: But that's on the
15 short list.
16 DR. ROGERS: So, the other
17 Permethrine you're saying is rebateable.
18 DR. JOSEPH: The 5%.
19 DR. ROGERS: Right, and you're
20 saying that that's not.
21 DR. CARRICO: It's not covered
22 as a first line.
23 DR. OYLER: But that's not what
24 is available or anything else. So, we have the brand
25 Spinosad on our Preferred Drug List within fee-for-

1 service.

2 DR. COX: Well, usually the 5%
3 is used more for scabies anyway.

4 DR. OYLER: So, we have the
5 Natroba on our Preferred and it sounds like Passport
6 as well without clinical criteria or a PA or anything
7 like that within fee-for-service.

8 DR. CARRICO: I just wanted to
9 bring that to everyone's attention as something to
10 consider, especially with school coming back because
11 I know lice medicine is going to be flying off the
12 shelves in the next couple of months. So, it's kind
13 of becoming a problem.

14 DR. FRANCIS: All right.
15 Anything else that I have missed today?

16 I don't think we as the
17 Pharmacy TAC have any reports that we're going to
18 bring to the MAC other than we did meet and we would
19 like to be sure the May report at least gets in there
20 but this one won't be ready in time.

21 Would it be beneficial to
22 provide a summary of all that we're doing for the MAC
23 or do you think just them looking over our minutes?

24 MS. HUGHES: If you want to
25 provide a summary, I can certainly send that to them.

1 They may prefer to see that than----

2 COMMISSIONER STECKEL: I think
3 that's a good idea.

4 DR. FRANCIS: I'll be attending
5 on Thursday.

6 COMMISSIONER STECKEL: And we
7 really do appreciate the work that you all do. I
8 know it takes time away from your businesses and your
9 daily work but it helps us a lot.

10 DR. FRANCIS: Sure and that's
11 why we do it.

12 The next meeting for the Mac is
13 Thursday. So, as I said, I will attend on behalf of
14 the Pharmacy TAC.

15 The next PTAC meeting is
16 scheduled for September 17th and we'll have about a
17 week before the MAC meeting. So, I'd like to have
18 these minutes. I'll send them out hopefully within
19 the next couple of weeks as soon as they send them to
20 me so I can do edits and I'll send them out so we can
21 all have our takeaway action items and work on them
22 before then.

23 Anything else. Then, I will
24 adjourn.

25 MEETING ADJOURNED