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  

Suzanne Francis  
CHAIR  

Matt Carrico  
Paula Miller  
Cynthia Gray  
TAC MEMBERS  

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Carol Steckel
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Jessin Joseph
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Jessica Jump
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MEDICAID SERVICES

Carrie Armstrong
PASSPORT

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](http://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 scabicidal 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
DR. FRANCIS: I will go ahead and call us to order now that we have a quorum and we’ll just make sure that we go around the room and make sure we know everyone that’s here.

(INTRODUCTIONS)

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

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

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

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

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

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

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

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

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

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

DR. FRANCIS: We’ll update that.

MS. STEPHENS: And there will be a lot more information coming out on that.
COMMISSIONER STECKEL: This may be inappropriate for me to ask, and if it is, just tell me, but it’s my understanding it’s a business decision CareSource has made nationally to kind of move out of the Medicaid market.

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

COMMISSIONER STECKEL: Okay.

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

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

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

DR. VENNARI: Yes. We’re just bringing it in-house rather than having CareSource contract it out.

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

DR. VENNARI: I’ll still be here.

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

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

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

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

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

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

MS. MILLER: I’ll make a motion to approve with the amendments.
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---

-9-
DR. FRANCIS: Well, I never see the transcript. I just need to know the process.

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

So, the changes that you’re making are to the minutes’ document.

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

MS. HUGHES: Right. Okay.

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

MS. HUGHES: Those can’t be changed.

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

DR. FRANCIS: Okay. Thanks for that. All right. We’re getting there.

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

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

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

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

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

DR. FRANCIS: No, they’re not broken down by MCO yet.

MS. GRAY: What does the MCO column signify?

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

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

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

DR. JOSEPH: Yes.

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

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

DR. JOSEPH: No. It was just
an update because I don’t think it had been touched
in a year and then it hadn’t been broken down by
exactly which vaccines are which.

DR. FRANCIS: Like,
pneumococcal was on there but it wasn’t specified
PPSV23 and PCV13.

DR. JOSEPH: And I’ll send that
out.

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

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

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

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

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

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

DR. JOSEPH: And Doug.

DR. FRANCIS: And Doug. Both
of you.

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

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

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

DR. JOSEPH: I’m going to defer to the MCOs. We’re not going to do it on the fee-for-service side just because we would prefer our patients go to the providers who are enrolled in
Vaccines for Children but I don’t know if you guys have discussed this at all.

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

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

DR. FRANCIS: It could be either.

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

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

DR. JOSEPH: I understand that. I think sometimes they have stores that will say my store doesn’t want to take that liability and will say we won’t fill this prescription or we won’t do
this. That’s just from what I’ve heard.

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

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

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

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

COMMISSIONER STECKEL: Now,
that I understand, and I could understand one or two kids, but a large volume of kids, I don’t understand why that’s not happening already. They should have a primary care provider, and I would imagine you all are pushing vaccines just as much as all of us for obvious reasons.

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

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

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

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

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

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

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

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

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

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

DR. JOSEPH: They’d have to enroll and I don’t think we have enrolled them before.

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

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

DR. FRANCIS: There has been an issue, I know, just with like the transport of VFC
things but I assume that not every district has a school-based clinic as a VFC.

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

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

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

COMMISSIONER STECKEL: As long as we have the link to the primary care providers in
the MCOs, then, I mean, in my mind, and I say this not knowing the dollar amounts, getting these kids immunized is the priority, but we also can’t blow our budget out. So, let us look some more into this and see if there’s not a middle ground.

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

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

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

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

DR. FRANCIS: Ideally, yes. And I know that MCOs just from working in the primary care side are trying to get kids in, encouraging well checks and encouraging immunizations through quality
measures and things like that and I know that some physicians’ offices I work with are working on working their list of patients that show care gaps in vaccinations but there’s still obviously some work to be done.

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

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

DR. ROGERS: So, that’s in their record.

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

DR. ROGERS: Oh, yeah, that’s beyond your control.

DR. FRANCIS: How about you, Matt? Since you’re more in a remote area in Eastern Kentucky, are you getting any immunizations or is it pretty much all VFC for children?
DR. CARRICO: If I start giving kids immunizations, I feel like the providers think I’m infringing on their turf. So, that’s not a battle I’m willing to have.

DR. FRANCIS: So, they’re set for school.

DR. CARRICO: Yes. They’re contracted with Mountain Comp.

DR. FRANCIS: Okay. I’m sure it’s different in every school district. Okay.

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

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

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

COMMISSIONER STECKEL: Sure.
DR. JOSEPH: I have it open. I can send it to you.

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

DR. VENNARI: Humana-CareSource does not either.

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

DR. FRANCIS: Nine. Okay.

MR. RUDD: Same for us, too.

DR. COX: And nine for Aetna.

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

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

COMMISSIONER STECKEL: July 1st.

DR. FRANCIS: Okay. That was a typo.
COMMISSIONER STECKEL: And yes.

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

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

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

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

And Anne Hollen and David Gray from downstairs were there and answered questions and so forth that people had.
DR. FRANCIS: Are we able to go back and look at that?

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

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

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

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

COMMISSIONER STECKEL: Nothing that we’ve not already talked about.

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

DR. JOSEPH: So, it’s not just the drug itself. It’s administration of the social services around it, too, but I think we’ve discussed
DR. FRANCIS: Okay. I’m glad to see that.

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

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

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

MR. GLASPER: Can you re-send it?

DR. OYLER: Sure.

DR. CARRICO: My question is and if I understand this correctly from last meeting,
after they reach so much out of pocket per quarter, it goes to zero.

DR. OYLER: Yes.

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

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

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

DR. JOSEPH: I think we discussed this earlier about giving everybody access to that, or, sorry, at some point this was discussed, but we were afraid that if we did that, then, you would basically be forcing a pharmacist--I mean, if you wanted to just check, that’s an available option;
but I think what it does is it slows the process of when you’re filling a prescription because their initial thought was the pharmacist has to check every time before a pharmacy can dispense the medication for the patient, so, monitor that on their own end. So, basically logging out of your system and signing on to the web portal and, then, signing into Kentucky HEALTH and figuring that out itself.

I’d have to talk to Stephanie about giving everyone access to that.

COMMISSIONER STECKEL: But private pay insurers don’t do that.

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

DR. JOSEPH: We’d have to build that in.

COMMISSIONER STECKEL: Let’s look at it and see.

DR. FRANCIS: Or the patient currently has access to go in and maybe look on their
in portal to see how much their spend has been? I don’t know.

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

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

COMMISSIONER STECKEL: That makes sense.

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

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

COMMISSIONER STECKEL: You would just need a talking point or a card that they could have because even if we can do the system
change, system changes don’t happen in our lifetime.

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

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

DR. CARRICO: I hear that often. I don’t know what I’m paying when I come here. I don’t either. I’m sorry.

COMMISSIONER STECKEL: We’ll look into it.

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

DR. VENNARI: It’s in the comment field, isn’t it?

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

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

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

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

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

DR. FRANCIS: And, then, the last thing was, as you know, Chris Betz, who is not here today, attended the MAC meeting for me in May. And Dr. Schuster from the Behavioral Health TAC said that she would like to provide some education to the Pharmacy TAC and the Primary Care TAC about behavioral health copays and what she is seeing on her end.

COMMISSIONER STECKEL: We would ask that you not do that. This TAC is an advisory
committee to the MAC which is an advisory committee to us. It’s not a function to create the opportunity for advocates to sit before the TACs and talk about their agenda.

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

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

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

DR. FRANCIS: Okay.

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

Now, this TAC and the Department have a good relationship that we would like to maintain, and we’re a better agency because of the work that you’re doing and the advice you’re
And, then, when we have to bring other pharmacists and all of that, I would hate to see — and it sounds like a threat and it’s not, I promise — the problems we’re having with Sheila and the Behavioral Health TAC needs to stay in that.

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

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

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

MR. GRAY: My apologies for being late.

DR. FRANCIS: No. I appreciate it. David joined us just in time and you had suggested that we could review the Kentucky HEALTH website if we have any feedback to you. I believe there was some feedback——
MR. GRAY: And, Paula, I’m going to get with you after the meeting.

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

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

And I know Paula has provided some input on that, but certainly any other comments, please get that to us. The intent was to actually make it easier to use, consolidate some things.

Screens that needed to be maybe earlier on in the flow have gotten moved forward with regards to some
information and that may be something that you
accessed a lot and it was on the sixth page
previously and it’s earlier now in that.

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

All right. so, Senate Bill 5.

I’ll let you all talk.

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

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

And, then, CMS is contemplating
taking a look at a route—so, not all drugs have a
NDAQ price. So, CMS is taking a look at using a
modified version of I want to say it’s AWP minus a
certain percentage for certain drugs, depending on
the number of labelers.

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

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

COMMISSIONER STECKEL: Is it appropriate to talk about the percentage that we’re going to deny?

DR. JOSEPH: No, not yet.

COMMISSIONER STECKEL: Okay.

That’s what I was afraid of. Never mind.

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

MS. MILLER: Did you say you
were comparing reimbursement prices to NDAQ?

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

   MS. MILLER: Okay.

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

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

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

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

   DR. FRANCIS: So, do you feel
like you’ve made progress with the analysis for the April through June analysis?

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

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

 COMMISSIONER STECKEL: So, one of the things that I would like us to start engaging in the debate and discussion is in July of 2020, they’re not going to be able to charge the post-
adjudication fees.

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

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

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

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

DR. FRANCIS: Clinical
services.

COMMISSIONER STECKEL: Correct.

So, I would like us to start discussing that.

DR. FRANCIS: That’s great.

MS. MILLER: That’S the model
in the fee-for-service side. No?

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

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

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

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

DR. CARRICO: I’ll just say

right now in the current fee-for-service, I’m amazed
at how accurate it is. I can only think of like one
to two drugs where it’s noticeably off and
underpaying but everything else, I’m like that’s
within four cents almost every time.

COMMISSIONER STECKEL: Okay.

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

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

COMMISSIONER STECKEL: Jessin
and I have been talking about this. If we could come
up with a draft proposal or an idea - I don’t even
want to call it a proposal - but here is something we
could do using the new technology, using NDAQ and
everything that we know now and put something on the
table and, then, bring in the retail pharmacists, the
independent pharmacists.

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

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

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

COMMISSIONER STECKEL: And it’s
transparent. Again, it goes to that transparency and
how can we be assured that these - and we all play
the games in all of our financing mechanisms - but
the spread, let’s define it and put it somewhere,
whether it’s savings for Medicaid, whether it’s pharmacy reimbursement for dispensing or to cover the ingredient cost. Are you following?

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

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

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

They’ll pay them $2 for the dispensing fee but, then, they will pay them $4 over
what would be an average acquisition cost or an actual acquisition cost to offset that and I don’t know what all is going in in that equation.

 MS. MILLER: Right.

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

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

 COMMISSIONER STECKEL: The prices you’re paying for the----

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

 One thing we can’t see is if you guys are getting any GERs on the back end because I don’t know if those have come out yet. I’ve been
talking to some of the independent pharmacists and
they said they haven’t. Have you guys seen anything?

MS. MILLER: I’m not sure.

DR. CARRICO: I’m still waiting
for a 2018----

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

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

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

-46-
states have done.

DR. JOSEPH: Sure.

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

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

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

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

DR. JOSEPH: You know what might help is the day that you get your GERs - and I think - you guys won’t know this because this is a fight that you guys are putting up - but when those GERs come out, if you can get the claim level
adjudication for how they reprocessed them because I know that’s possible through some of the PSAO’s.

MS. MILLER: Do you know if that’s possible?

DR. CARRICO: Elevate told me it wasn’t possible but I heard through Epic it was possible.

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

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

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

COMMISSIONER STECKEL: And here’s what I don’t want to have happen. I really do want us to take the work that we’ve all done together on SB 5 and the PBMs and everything and take it to the next level.
I don’t want us to get in a situation where pharmacies are asking for an increase in the dispensing fee and I’m saying it’s going to be $25 million if we do it and we don’t have it in the budget and we don’t have the data to show whether it’s valid or not valid. Is it $25 million or is it $10 million, the difference that you’re talking about?

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

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

DR. JOSEPH: Yes. We’re doing that right now.

MS. MILLER: So, how does that compare to what was paid?
MR. JOSEPH: It’s not done.

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

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

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

We are not going to take a position on it. All we’re going to do is share the data. This is what happens if you carve it out. Here’s what happens if you keep it in. With our real data, we’re replicating the West Virginia study. We’re recreating exactly what you said - what would happen - and it’s up to them to make a decision.
DR. JOSEPH: And just to add on top of that, because you can’t necessarily just put in the data and I can’t just say, well, this looks like this is what’s going to happen. There are other pieces of it. Rebates is one issue. So, we’re doing a separate analysis on what happens to our state and federal rebates if we—or federal and supplement rebates if we were to move to a carve-out.

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

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

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

DR. FRANCIS: You said you want to collect this data from independent pharmacies but also I assume chain and community pharmacies and
specialty pharmacies because there’s a lot of
clinical services that go into the specialty
pharmacies.

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

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

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

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

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

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

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

DR. FRANCIS: Yes.

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

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

COMMISSIONER STECKEL: And,
then, we’re hoping to make it electronic.

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

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

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

DR. FRANCIS: Of those 5% changes.

MS. GRAY: Of what they’re saying.

DR. JOSEPH: Like an actual report.

COMMISSIONER STECKEL: Just to us so we know what’s going on.

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

DR. JOSEPH: I understand.

COMMISSIONER STECKEL: We’re going to have to do that.

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

-54-
hard to say something and then make it definitive.

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

DR. FRANCIS: Okay. Great.

Anything else on Senate Bill 5?

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

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

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

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

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

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

DR. JOSEPH: Sure. I think
we’ll have to be careful about what we exactly put in
those outlines. I don’t think this is necessary for
us to put any fine details to but just have lines on
exactly what we’re working on, project updates or
anything like that.
DR. FRANCIS: And I just had this one here in case there was anything but it leads across to your initiative of the Pharmacy Department project management update. Is there anything else that we haven’t talked about that we should know what’s going in the Department?

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

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

DR. JOSEPH: That pertains to reimbursement.

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

DR. JOSEPH: Okay. So, I guess we’re talking about both reimbursement to the providers. We’re just going to be changing it to...
exactly what the SPA says and that was passed in
2017. It just hadn’t been implemented. So, we’re
implementing it now and it will go live on 8/1.
We’ll be hopefully
restructuring our PAD program on 12/1 is the
anticipated date. So, we’ll have a new PAD list come
out and we’ll post it on our website as it’s
required, but, again, this is all for the fee-for-
service population. So, we’re just moving forward
and getting the systems all in place. So, that means
bringing DXC on board, bringing Magellan on board
and, then, setting up our clinical criteria.

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

DR. JOSEPH: Yes. We take
calls from the physicians and the pharmacists who
have either seen that this drug isn’t on our PAD list
already. So, we’re still welcoming those calls.
The other project we should
probably mention is starting by 1/1/20, we will be
having electronic PA’s in place for the fee-for-
service population and I think some of you guys
already have that in place, too.

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

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

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

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

DR. VENNARI: Well, it’s always been co-branded Humana-CareSource. So, they’re going to be familiar with the Humana name anyway. As far as they’ll get new cards and it will be a different
adjudicating process but that’s no different, and there will be communications going out.

DR. FRANCIS: Okay. April.

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

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

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

So, we are in the process of expanding. We’re looking at fifteen additional
pharmacies across the state, so, we will be branching outside of the Bowling Green/Western Kentucky area. Right now we’re just waiting to--we’re having them submit sample care plans because what we found with this initial pilot, all the pharmacies use different vendors and some vendors are a little more compatible with our system than others and, so, we are vetting them out.

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

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

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

DR. COX: So, that’s where we’re headed now. We have another pharmacist that’s working on compiling that data and I don’t have anything to share yet because we’re still kind of gauging what this looks like. And, so, we’ve made
some revisions to our referral forms, trying to make sure we’re capturing the most common areas that the pharmacists are seeing.

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

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

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

DR. COX: And gaps in care obviously is one of the ones that’s on there. So, we have several different categories, and, so, we’re just now starting to review those care plans that have been closed and identify the areas that were identified as issues, making sure we’re pulling those
in the correct area so that we can get some accurate
numbers to report out.

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

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

MS. MILLER: Rice has two,
don’t they?

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

DR. FRANCIS: I’d be interested
to see provider satisfaction and pharmacist
satisfaction.

DR. COX: We actually have
received--we’ve had minimal response on the surveys
but CPESN is sending out surveys on our behalf, and
so far the responses we’re getting, the pharmacists have been very engaged and the members that actually completed the survey, everybody gave high remarks. And, so, if that’s something you want to see next time I can report actually out on.

DR. FRANCIS: I think it would be.

DR. COX: Okay.

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

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

DR. COX: I can share some survey results. Other than CPESN, we are working on our de-prescribing initiatives at the plan. We have a PPI one that we’re starting to see data back from practitioners basically where we provided some education and information, I guess basically suggestions on pulling their members off PPI’s. So, is this clinically appropriate.
So, we made some suggestions and we’re getting some information back from the providers on whether or not they took our recommendations. So, that’s our first de-prescribing initiative and we are working on a second one for psychotropic medication utilization in the foster care population. That one is not off the ground yet. It’s in its infancy. Right now we’re in the data-pulling phase.

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

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

DR. FRANCIS: Thank you. Thea.
DR. ROGERS: So, really, we’re
working on our EPA implementation actually when we do
go live with that, and as soon as I have a formal
communication, I’ll be sure to share that with you,
Mark, so you can share it. It’s mainly acting on
prescribers. So, just as an FYI in case you’re
interfacing with that, that would be good for you to
know.

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

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

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

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

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

All right. Anthem.

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

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

And, so, we’ve since added some
of those additional codes so that it opened the
access to Vivitrol without PA for the pharmacies. I
haven’t heard anything back from St. Matthews, so,
I’m assuming that it’s working. So, they have been in contact with us about that. So, that’s really the only update I have.

DR. FRANCIS: Thank you.

Passport.

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

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

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

MS. ARMSTRONG: We will. Since everyone was talking about behavioral health, we do have our behavioral health psychotropic drug program that’s still in place. That started in 2014. It’s
addressing polypharmacy and duplicate therapy, that
sort of thing. So, that’s still in place.

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

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

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

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

MS. HUGHES: Yes. That will be
posted.

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

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

COMMISSIONER STECKEL: Give us two weeks but we’re hoping next week.

DR. FRANCIS: When that’s available, Sharley, could you----

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

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

MS. HUGHES: Okay.

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

COMMISSIONER STECKEL: Right, and vice versa.

DR. FRANCIS: Yes. And, then, just two previous items – the 90-day supply for medications covered by Medicaid. That was going to be taken back and considered to improve adherence. Typically, 90-day supplies haven’t been covered by
Medicaid and there was a pharmacist that had brought that up and we brought it to the last meeting. That’s fine. We can still take it back. That’s why I have it on here on previous agenda items.

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

DR. FRANCIS: But an option----

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

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

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

DR. VENNARI: There’s already an option today. I think it’s a conscious decision, I think, and we can have a discussion and go back and forth on this, but because folks come in and off the rolls, if you’re dispensing a 90-day supply, then, you really should be picked up by another carrier if they go to another job. So, that’s been a conscious
decision. Yes, is it better for use, yes, sure, better for a lot of different reasons but it’s kind of a give and take. So, we have to take a look at what we want to provide for ninety days. It’s not that it’s not doable. It’s very doable.

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

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

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

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

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

DR. FRANCIS: Right. And, then, there was looking at the Medsync copays
proration. I listed Senate Bill 44 there that says that there are Medsync Programs available but typically I think they were charged like the full copay on Medicaid if they were going to be synced up rather than prorate like Medicare does.

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

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

COMMISSIONER STECKEL: Nobody fills in the gaps.

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

MS. MILLER: I have not seen it one way or the other. Do your plans allow proration of the copays for Medsync? So, as far as you know, it should be happening?
MS. ARMSTRONG: I don’t think so but we’re looking into the capability.

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

COMMISSIONER STECKEL: So, we’ve heard from Passport. Aetna?

DR. COX: We don’t at this time.

DR. ROGERS: I’d have to take it back. I’m not sure.

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

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

DR. CARRICO: Sure. So,
Spinosad used to be on the formulary for I don’t think all the MCOs but some of them, at least WellCare I remember, and especially with school coming back, we do a lot of lice medication, and it seems to be that it’s taken off the formulary since then.

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

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

I mean, nothing is really working for the kids and there wasn’t really many problems were people were using this a year ago. I have more information I can bring to actually prove some of this stuff – the science behind it and the numbers if need be but it was something that I just wanted to bring up for discussion or at least
MS. ARMSTRONG: So, Passport right now has it preferred without a PA, but if there’s any issues getting this to go through, I want to know so we can clear those up.

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

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

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

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

COMMISSIONER STECKEL: But do
we pay for it in fee-for-service?

DR. JOSEPH: Yes, we cover it on fee-for-service.

COMMISSIONER STECKEL: So, that means it has a rebate.

DR. JOSEPH: We cover Spinosad. Are you talking about Nix?

MS. MILLER: So, the only available product is not rebateable. Is that what you’re saying?

DR. FRANCIS: That is what Andrew is saying.

DR. OYLER: We have the 5%.

DR. JOSEPH: But that’s on the short list.

DR. ROGERS: So, the other Permethrine you’re saying is rebateable.

DR. JOSEPH: The 5%.

DR. ROGERS: Right, and you’re saying that that’s not.

DR. CARRICO: It’s not covered as a first line.

DR. OYLER: But that’s not what is available or anything else. So, we have the brand Spinosad on our Preferred Drug List within fee-for-
service.

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

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

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

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

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

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

MS. HUGHES: If you want to provide a summary, I can certainly send that to them.
They may prefer to see that than——

COMMISSIONER STECKEL: I think that’s a good idea.

DR. FRANCIS: I’ll be attending on Thursday.

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

DR. FRANCIS: Sure and that’s why we do it.

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

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

Anything else. Then, I will adjourn.

MEETING ADJOURNED