DEPARTMENT OF MEDICAID SERVICES
PHARMACY TECHNICAL ADVISORY COMMITTEE

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AUGUST 21, 2024
1:00 P.M.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Ron Poole, Chair
Matt Carrico
Rosemary Smith
Meredith Figg
Paula Straub
Jill McCormack
Philip Almeter (not present)

MS. BICKERS: It is a little after 1 o'clock p.m. and our waiting room is cleared, so if you would like to begin, I will turn it over to the TAC.

MR. POOLE: Okay, thank you, Erin. I appreciate it. I've counted six out of the seven of us on the call, so we definitely have a quorum.

I just need a motion to approve the minutes from the previous meeting on February 14th of 2024.

MS. SMITH: So moved.

MR. CARRICO: So moved.

MR. POOLE: First by Rosemary, seconded by Matt. Any further discussion? All those in favor say, "Aye."

TAC MEMBERS: Aye.

MS. BICKERS: Can all voting members please have your camera on?

MR. POOLE: Okay.

MS. BICKERS: Thank you.

MR. POOLE: And then under old business. One thing I want to bring up, obviously the list came out for Kentucky on all of the providers that can manage

and order for community health workers and, of course, we weren't on it. I need some action items, because I know the government affairs committee, KPHA, were at least considering some community health worker statutes that can put us in there because it's, in my opinion, if Kentucky Medicaid wanted to have the most hands on people to be community health workers, you would be enlisting every pharmacy technician that you could, managed by pharmacists, because in other states, they are the ones doing the bulk of the work. Things that we do on a normal daily basis, like well checks, a lot of our delivery folks are pretty consistent with -- especially our homebound people or even bedridden people -- obviously, if something is out of order, then we go ahead and do well checks, or at least get the police to do a well check on somebody. Just simple things like that that we do all the time, and our people could be doing that.

So I would like a motion from

somebody that we would encourage Kentucky Medicaid to include pharmacists on the lists that can supervise and provide and manage community health workers, and we are going to be obviously looking at this, too, on the statute side, so it is going to get taken care of one way or the other. It is just a shame that it wasn't done initially for Kentucky.

So does anybody have any comments on that, or a motion?

MS. FIGG: Ron, this is Meredith.

I'll make a motion to pursue adding pharmacists as prescribers to order CHWs, or I guess, to allow CHWs and pharmacies and pharmacists to be able to order those services.

MR. POOLE: Okay. We have a motion by Meredith. Do I have a second?

MS. STRAUB: I'll second that.

MS. SMITH: Second.

MR. POOLE: Okay. A second by Rosemary or Paula. Second by Rosemary. Any further discussion? Okay. All those

in favor say, "Aye."

TAC MEMBERS: Aye.

MR. POOLE: Any opposed? Okay. I encourage you to look at the US Pharmacists article they have on community health workers, and I believe it is Tripp Logan in Missouri that have like 18 of them in the services they are providing. And it is really -- it is a whole lot more enjoyable for the technicians, because they can work two to four hours on community health workers and the rest of the day they're working as pharmacy technicians, and a lot of those jobs go hand-in-hand. But anyway, we've unofficially had some really good intervention success stories ourselves, and I'm sure every pharmacist can say that, especially in the community, and being part of your community.

I don't know if Jennifer is on here from -- account executive MedImpact, or anyone else who wants to -- the lady from Anthem, even, that was helping out with the HPV vaccine update, because I

know that has been going on for some time, and we don't, as far as I know, have an official protocol as of yet, so I don't know if there is somebody on the call who can shed some light on where we are with that HPV statewide issued protocol.

MS. ALI: Yeah. Angela, do you want to give any updates? I know some of it is still in review with DMS, so we are hoping to get the ball rolling and continue to review it.

MS. KAMER-LAY: Hi, Fatima and Ron. It's Angela --

MR. POOLE: Yes.

MS. KAMER-LAY: With Blue Cross Blue Shield.

We have the protocol. We have the point of sale messaging. The MCOs have sent the files to the members for the point of sale messaging to come up on your all's end, so we are just working with MedImpact finishing up that part.

MR. POOLE: So basically, is it going to do, through our software systems, is it going to be able to pop up at the

point of sale for people who are eligible to just get us to have a vaccine counseling service or intervention?

MS. KAMER-LAY: Correct. To let you know if, you know, they need a vaccine, prompt a vaccine counseling session, and an immunization with you all for that immunization there. But if not, at least that vaccine counseling can take place.

MR. POOLE: Okay. Are you going to just identify the age group of the patient, or are you going to be able to identify parents that have children of the proper age?

MS. KAMER-LAY: Right now, the age group of the patient can take in the medical records if they have had one vaccination, if they have had none there.

MR. POOLE: Okay. It would be nice if we could evolve the database to include, obviously, parents, and even grandparents who raise their grandchildren, it would be great if they would identify that link to where, because

obviously, that is the person that we are going to have to get approval from anyway to get that vaccine. So anyway, it would be nice. And I know databases, how they work. But that would be nice to identify those people, too. I think we get more contacts that way, because for the most part, the eligibility or ideal age group for that vaccine are pretty healthy people, so they don't come into the pharmacy that much.

MS. KAMER-LAY: I agree. The pharmacy directors, we will take that back and brainstorm on that, because that is a really good idea.

MS. STRAUB: Angela, this is Paula. Do we have an ETA on that?

MS. KAMER-LAY: Let me get that for you, Paula.

MS. STRAUB: Okay.

MS. KAMER-LAY: Because I believe it's fourth quarter this year, but let me follow up on that.

MS. STRAUB: Okay. Thank you.

MS. KAMER-LAY: You're welcome.

MS. FIGG: Do we have a statewide protocol already for if they do want the vaccine? Is that out yet?

MR. POOLE: Did you hear that Angela?

MS. KAMER-LAY: Yeah. And the one that Dr. Theriot did for HPV -- of course, that is for Medicaid only. Are you asking if it is for any line of business? I'm sorry. I don't understand.

MS. FIGG: I wasn't aware she had actually completed one. That was my question, if that was out and available.

MS. KAMER-LAY: We have at least seen a draft. I don't know if it is an official, you know, we are in business now with it. Let me follow up with that too.

MS. FIGG: Okay, thank you.

MS. KAMER-LAY: You're welcome.

MR. POOLE: When it is official, Angela, that would be great to share with us, obviously KPHA and KPPA, and different organizations to get that out to everybody.

MS. ALI: Yeah.

Angela, let's take that back and see when we can send out a provider notice with the protocol itself.

MS. McCORMACK: Does the -- this is Jill from NACDS. Does the Board of Pharmacy have a protocol? For HPV vaccines?

MR. POOLE: It falls already under our already immunization protocols.

MS. McCORMACK: Right.

MR. POOLE: As long as you have a medical director, you can do it now. But in those meetings, we just decided it would be nice to go ahead and issue a statewide protocol to where there wouldn't be a barrier for somebody getting the vaccine.

MS. McCORMACK: Yes, I understand the program. I just thought the Board of Pharmacy had one that could be used in the interim if that is what Meredith was asking. Understanding that --

MR. POOLE: If you already have one with your medical director, that

doesn't prevent you from going ahead --

MS. McCORMACK: Not a medical director, but statewide on the Board of Pharmacy. I will look it up. Thank you.

MR. POOLE: It's not under -- it's going to be under immunizations. It's not under the Kentucky Board of Pharmacy approved protocols.

MS. McCORMACK: Okay. Thank you.

MR. POOLE: Okay. Any further discussion on that topic?

Okay. The vaccine counseling billing. Matt Carrico, if you want to make your comments.

MR. CARRICO: Sure. I've been starting to try to chip away to make sure I'm getting this ironed out before flu shot season, still working on it. I finally got a first plan through Passport. Thank you, Passport. One question I had is do they have or will they put one out -- Medicaid that is, an AOB, like a standard AOB for patients to sign. Medical billing is kind of new to

pharmacists, so we are still trying to fill out the policies and procedures and from my understanding is, not sure we can get a standardized AOB for patients to sign before we start doing this. Didn't know if one of those was available. I think we are having some issues with some of the MCOs, and I was going to see if Emily Wilkerson could -- I'm sorry, I forget her new last name -- could step in and take the lead on this, because she is the vaccine counseling guru.

MS. GATEWOOD: Yes. Thanks, Matt. Emily Gatewood here, with the Kentucky Pharmacists Association, and Ben Mudd and myself have been chipping away at this over the last year or so, and I will say that we are pretty much halfway there. We have three of the six MCOs that are paying claims at this point, and that is Passport, Anthem, and United Healthcare. Humana, WellCare, and Aetna, we are still working to get paid claims through them. A lot of the issues that we have are coming back to the fact that

pharmacists are not recognized as a provider type, so the claims are wanting a referring provider that is not a pharmacist or pharmacy on the claims. My understanding is the other MCOs are getting around that by processing these claims manually. But we are working with those three MCOs to get across the finish line, if you will.

Most of the MCOs are on the Availity platform, which is how we have currently been billing claims, and the pharmacies that we have been working with are billing the claims through Availity. Besides from United Healthcare that has their own portal, and they have a form available for pharmacists to be able to, essentially, sign up as providers and then they are able to bill claims in that way.

Aetna is the other one that is not on Availity -- I should say they are not on the free portion of Availity. You can pay $25 a month to get the Availity essentials plus subscription, and Aetna should be able to be available to bill or

sign up for that of subscription. We have not tested that out just yet or know what that looks like when those claims get submitted. I do worry that, at least starting out, that maybe a limiting factor for some pharmacies, not knowing exactly how many Aetna patients they have, because all we can see is that their PBM is net impact without looking up each patient individually. Pharmacies can't see exactly the breakdown of their MCOs. So that might be a problem starting out, but $25 a month isn't too terrible. So that is kind of where we are at right now. I'm happy to answer any questions if anybody has any specific questions.

MR. POOLE: Emily, would you please repeat the three that are not -- that you are not having success with, please.

MS. GATEWOOD: It's currently Humana, WellCare, and Aetna that we have not had a paid claim from just yet.

MR. CARRICO: Are the ones that you're getting paid claims from, the

payment the same across the board, or is there variation?

MS. GATEWOOD: I don't have an exact answer, Matt. I know the price that it is supposed to be is $25 and some change. We believe we are getting paid 80 percent of that, which comes out to be $20 and some change. I have not seen a paid claim -- an amount on a paid claim from Anthem and UHC to speak to those two, so I don't have a solid answer for you on that.

MR. POOLE: Fatima, have you been in conversation with Ben and Emily to try to assist with those three that are not on so far?

MS. ALI: Yes. If it is not myself, it is someone on the pharmacy team that is part of the conversations and keeping track of what is going on.

And you know, I know some MCO pharmacy directors are on this call if they want to speak to some of the more specific issues or we can handle it off-line as well. But we do encourage

that communication.

MR. POOLE: Okay.

MR. HAMMOND: Ron, this is Michael Hammond with Humana. I know I have been in contact with Ben over the past few days on working through this. We have had paid claims from other pharmacy providers. I know Ben ran into some issues as he was trying to process it through Availity and, like I said, there was open dialogue the past couple days to work through those issues, just to make sure it is easy, and that they are receiving the pay rate of $25.64, which should be standard across all of the pharmacies.

MR. POOLE: Okay. Thank you, Michael.

MR. CARRICO: Fatima, do you know, is there a standardized AOB form, or do we just need to find one, or where do we find one? I'm not even sure how doctors -- I can ask doctors in my area, but like I said, this is kind of new to all of us.

MS. ALI: So, I apologize, I'm not familiar with the AOB terminology or maybe we call it something else, but it might be something that I need to follow up on, but if you can clarify what you mean by AOB, that would be great.

MR. CARRICO: Authorization to bill. The permission to bill their insurance for what we are doing.

MS. ALI: Okay. If you can shoot that to me via email, I can certainly look into that.

MR. CARRICO: Thank you.

MS. SHUCK: This is Cindy at United Healthcare. I am showing on my report from where we pay vaccine counseling claims, that we did pay $25.64, so I think if you are getting less than that, I'm wondering if there is some sort of, like, I don't know, processing fee on whoever you are using, but I wouldn't think with United, since it is our own platform, so please let me know if you are finding that you are not being reimbursed $25.64.

MR. CARRICO: I received 20 and some change. It wasn't from United, it was from a different one, but it said that it exceeded the maximum allowable amount. So I am not sure if that is how we are supposed to be getting paid or not, but I was getting about 80 percent of the amount you stated from another MCO.

MR. POOLE: Matt, with your email to Fatima, would you let her know which one that was, please.

MR. CARRICO: Yes, sir.

MR. POOLE: Any further discussion on the vaccine counseling billing?

Okay. Just got some FYI section there, that if, just to let people know that if any of those names change for the account executive or the managing principal at MedImpact, please let me know, Fatima, so I can update the contact information.

Right now, I have Jennifer Velazquez Alvarez as the account executive at MedImpact, and Dean Beuglass -- I don't

know if I am pronouncing that right -- is managing principal.

MS. ALI: Yeah, that's correct. And for any MedImpact related issues, I would encourage you all to send emails to the general mailbox for a quicker turnaround time. Not saying that these folks won't respond in a timely manner, but it helps funnel the questions to the right individuals. I will throw that in the chat.

MR. POOLE: Okay. Thank you.

Okay. Under new business, this is something that has been going on in the last couple months, but pharmacy reimbursement with NADAC.

I would like to clarify something, that submission. We had a PBM/pharmacy owner submit low price data that pushed a lot of the prices down, and the comment that everybody likes to make is, well, since they are buying at such a low rate at independence, well my buying group buys, I think, it's around $20 billion worth of drugs a year, so it

is not a fact of not being able to buy as low, it is just another way for this entity to hurt their competition. They are betting that they can lower reimbursement, and accept it, and of course, when they are their own PBM, they don't lose as much money as we do.

So I don't know if Matt or Rosemary or Meredith has any further comments on that, but to me, it has come up on the federal level and even the state level, and we all belong to different buying groups, and we are all, when we are comparing, when we do see data, it is not the fact that somebody is buying so much lower than somebody else, it is other considerations are going on at the same time.

Rosemary, I didn't know if you had a comment on that.

MS. SMITH: Ron, we have seen the same things from our members. Everybody has been seeing these claims and asking what is going on, and I don't know what we can do. I think we will probably

going to have to go to NADAC; don't you? To go to the root of the cause --

MR. POOLE: Right.

MS. SMITH: -- and see what is going on. Because something has to be going on, because it has been drastic.

MR. POOLE: Yeah.

MS. SMITH: And I think we do need to encourage all of our independent pharmacies to submit the data to Myers and Stauffer. Just from our aspect, you know, at Jordan Drug, I used to get these all of the time. With all of the stores that we have, I usually would say, well, I am not going to submit those, but, of course, that changed years ago. We do those now. We now have at least one or two per month, and I think that we really need to encourage independent pharmacists to really send in the data. But something is wrong, because we are not even getting the cost of our drugs now. The NADAC price that I have seen, you know, I looked through our financials last night; I looked at what our six stores did last

night; and there were very few, the cost of our drug was NADAC, what we were getting paid. It was so much higher than that, so I don't know what we need to do, but I think, as a group, we need to get together and I don't think we can do anything at the state level. Fatima can answer that probably. But we just need to get together to see what we can do, you know, federally. I don't know the answer.

MS. ALI: Yeah, Rosemary, I would agree with that. Sorry, Ron, to cut you off. I would like to say that we are aware of it. Unfortunately, NADAC is completely out of our control. It is handled by CMS, and they contract with the vendor, Myers and Stauffer, who manages the rates. You know, theirs and NADAC helped us, but can work with pharmacy providers to better understand the methodology.

Speaking of the methodology, it was updated earlier this year, and I can throw some of those links in the chat if you are interested in taking a look. And

as you all probably know, pharmacies are -- any pharmacies are allowed to participate in that survey, so I guess this time, or this year, we might have seen some unprecedented responses or unexpected responses. Again, out of the state's control, but we do encourage you to use the helpdesk and the email address that is associated.

MR. POOLE: And Fatima, just to, maybe, educate you all on the history, this has been the problem in dealing with PBMs over my career, certainly in the last two decades, where we will have a pricing standard that is accepted either by the state or the federal government, and it will be manipulated by the PBM so badly that somebody else or legislators or somebody else is looking for -- or even the Medicaid department is looking for another pricing standard to go with, and that is -- we just had a representative at Comber sign on to HR 9096 on the federal level, and that was his concern and his staff's concern, that what is referenced

in there for the pricing standard is NADAC and, of course, he even understands how the PBMs, because of his three oversight committee hearings that he has had with them, that they can manipulate that pricing standard however they want to. So they find different ways to do it. So it is a real problem. It is a major problem. Because, when you look, just like Rosemary, when you look at your bottom line and see what has happened to your reimbursements going way, way down and it is supposed to be a national standard, somebody is manipulating the market. I'm not saying it is NADAC, at all, but when people have the wrong motives out there, they can do this.

Another thing -- I know Rosemary and I this point 2 out here, this NADAC, the part of the brand-name drugs for us is getting to a tremendous pain point. So much so that it is a consideration to just turn away some of the brand name prescriptions, because we are not meeting our matrix to get our biggest discount,

and I don't know if Matt is struggling, but I sure am struggling with it. I even took those brand names out of the equation, and I thought well, gosh, I wouldn't have any problem making those matrix, and we are talking about generic performance rate, brand performance rate, and generic compliance rate, is what we are talking about with our wholesalers and that is a real problem, also. It is getting to a point where I am glad that the state is making good money off of the rebates, but it is also helping to hurt the providers out there.

So Rosemary, or Matt, or Meredith, I don't know if you have more to comment on that.

MR. CARRICO: I think you hit the nail on the head run. It is definitely difficult, because a lot of that stuff is brand name that we use a lot of, such as inhalers, and some ADD medicines for kids and adults, but it is making a lot of things difficult. There are a lot of things to address on

different fronts, but this pricing and NADAC. I am wondering, do we know what percentage of Medicaid claims are actually paid at NADAC?

MS. ALI: Not off the top of my head. It is something that we would have to do an analysis for.

MR. CARRICO: Okay. I was just wondering. Do you know what the second most common price point, like, is it MAC is the second most common one, or, do you know that?

MR. POOLE: That would be nice, Fatima, if you get that breakdown for us, because, I mean, that just helps us to evaluate.

MS. ALI: Sure.

MR. POOLE: And that, obviously, could be given to all of the providers. I think everybody, normal chain and independent, alike, would like to know the breakdown of that. Okay.

MS. FIGG: It might be interesting to look at that over the last couple of years as well, how that has

changed, not just how it looks now, but how it has changed over the last few years.

MS. McCORMACK: Agreed.

MS. FIGG: But I agree with you, Ron, about the brand-name drugs. I think you also have to consider that we are potentially getting into a state of an access issue, because pharmacies are not going to be able to afford to stock these medications and, you know, unfortunately that could lead to Medicaid patients having difficulty just obtaining their medications.

MR. POOLE: Yeah. I agree.

This is something that has been brought to my attention on reimbursement for long-acting antipsychotic reimbursements and admin fees.

I've got two treatment centers close to me that are asking me about this, because their patients are having a hard time obtaining the drugs, because if your reimbursement is below your cost of drug, forget about cost of dispensing, and the

admin fees, if we are the ones in charge of giving these injections every three months, if they are negligent, or negligible, then it is very hard to offer that service, if it is a lose-lose proposition. So Fatima, it would be nice if we can look at some of those long-acting antipsychotic reimbursements and see what is going on with them, because even the providers and the nurse practitioners and the MDs that are seeing these patients, they are frustrated because they don't understand why the people cannot get their medications because of a reimbursement issue. I mean, everybody else works off of a different matrix system for reimbursement, they just can't understand. And unfortunately, a lot of people are being told that the pharmacies can't stock the items. Well, we know what the reality is, the reality is they can't afford to stock the items when you are getting reimbursed well below your cost on them. And it is not a buying issue, it is a reimbursement issue.

MS. McCORMACK: Ron, I believe it is particularly egregious in this, you know, with these types of drugs where folks who can't get them on time or can't obtain them, we have folks falling back off the wagon and raising addiction and overdose death rates.

MR. POOLE: Yeah. I agree.

MS. ALI: Is this something that surfaced because of the lower NADAC, or is it just an overall?

MS. McCORMACK: I think it comes around, most pharmacies are getting reimbursed on some of the most widely-used drugs and therefore are not stocking -- we will make a decision not to stock them because we are being under-reimbursed for them.

So I think it is particularly painful with these types of drugs, but as Ron was saying earlier, it is happening nationally, on a state level and a national level, everywhere, all across the country with manipulations behind the scenes of drug pricing by PNS, and driving

their prescriptions to their affiliate pharmacies, and paying them more than they would pay, let's say, Ron's pharmacy or a Walgreens.

MS. ALI: Yeah, so I would say from Kentucky's perspective, and with Senate Bill 50, a lot of that has been eliminated, and I, obviously, only speak for the state. I think, perhaps, in other states things work a little bit differently.

MS. McCORMACK: Right.

MS. ALI: At least for us, we have transparent pricing, you know, no affiliated specialty pharmacies with PBMs, so.

MS. McCORMACK: How do you police that? How does the department know that steering isn't happening? How do you know that -- how do you -- I'm asking not -- I'm asking purely also out of curiosity, because I know it's hard to obtain the data in some states, I know it's hard for enforcement because some states can't actually get the data from

the PBMs, or not the data they actually need.

MS. ALI: So we have complete oversight of the single MCO PBM, and now the single PBM overall, even for fee-for-service members, so, you know, with that oversight, we can monitor where our members are going. We, obviously, take any concerns that come from members or providers very seriously, if someone is trying to steer patients towards a specific pharmacy. There is no associated specialty pharmacy with MedImpact either, so I think we've dotted our I's and crossed our T's from that perspective.

If MedImpact wants to add anything, feel free.

MS. McCORMACK: I'm just wondering how do you monitor that. I understand what the loss has, and that's a great one and for other states, just wondering, how you -- do you run numbers every six months to see how many prescriptions for certain drugs are going here rather than there, or just how do you

ongoing, kind of, enforce the rules in place?

MS. ALI: Well, I guess the one thing that is different now with the single PBM, is that DMS manages the provider network, so there is a provider clause, and members have the right to choose the pharmacy that they are going to, as long as they are valid and enrolled within Kentucky Medicaid's network.

Prior to the single PBM as you know, we had each MCOs managing their own pharmacy network, so we do have that oversight, and if we receive any complaints, we take it very seriously and ensure that it is handled.

MS. McCORMACK: Okay, but is it a process where if a pharmacy feels like they are getting way underpaid on a drug that they have to make that appeal to the department, or is that something that MedImpact, kind of, runs numbers on and periodically, to see if the compliance is there.

MS. ALI: So with our pricing

methodology, the lowest of logic, we do have ways to ensure that our claims are priced appropriately, and that is reviewed annually as well. So from that end, the expectation is that all claims are priced appropriately. If there are requests for appeals like MAC appeals will go directly to MedImpact, NADAC appeals, since we don't manage the NADAC, those go to CMS and Myers & Stauffer. Unfortunately, the WAC and FUL, those are things that aren't eligible for the appeal process, but again, it does, we do require the lowest of logic, and, you know, the MAC appeals, again, can be sent to MedImpact.

So, essentially, from an overall perspective, the claims are monitored, the pricing is monitored, and if there any issues or any concerns, feel free to reach out to us.

MS. McCORMACK: Okay, thank you. That clarified for me. Appreciate it. Mixing up some structures in some states, but still interested in how the enforcement happens. The issues -- the

issues shouldn't exist, is really the answer in the structure between DMS and MedImpact.

MS. ALVAREZ: This is Jennifer from MedImpact.

As Fatima stated, DMS does run the program and we only take direction from the DMS, so our pricing logic is stated at the lowest of. There is no pricing manipulation. We use what we get from First Data Bank and Medi-Span, as well as the information, you know, the FUL and the NADAC come from CMS, but through those vendors, so there is no changing in pricing. And then all of our preferred products are presented to DMS. They are the ones who make the decisions on all of that. There is nothing done that they are not aware of. We are 100 percent transparent.

MS. McCORMACK: Thank you. Sorry to take the time on that.

MR. POOLE: That's fine. Those are some good questions.

And also, Fatima, I have not

known any pharmacist who has been able to bill for any of the long-acting antipsychotic reimbursement injections, because a lot of the doctors offices and counseling centers that have nurse practitioners and MDs, they realize that our hours are a lot more flexible and are open more than their offices are, because a lot of these are, kind of, regional places and they may be here Monday, Wednesday, Friday, another county Tuesday and Thursday. So they do want the help, but the pharmacist, being able to administer these antipsychotics, and for that matter, Vivitrol, and different things that they are needing our help on. So I am not getting any feedback from pharmacists that they are actually being reimbursed for those admin fees.

So I will send an email to you and give you some examples of drugs that pharmacists are delivering -- administering for these particular prescribing providers, because of just lack of access, patient access to their

offices because they are covered up as they already exist. Just trying to meet the demands of mental health.

MS. ALI: Sure. And just from that perspective, if there is a request to look into that further from our end, it would require fiscal analysis, leadership approval, and possibly erect change as well. So just want to put that out there as kind of the process that we would take to look into something like that.

MR. POOLE: Okay. But hopefully, you all can understand the flexibility and greater access that patients would have in us helping to manage that patient's therapy. Especially when a lot of these clinics are only open for certain days and certain hours in even different regions of the area, especially in rural Kentucky.

MS. FIGG: And the cost-saving that is involved in keeping these patients on these medications and not relapsed.

MR. POOLE: Right. Great point.

Fatima, the next topic there is,

well, I will tell you what. Can we please have an action item on that, Meredith, that we would like for Medicaid to look into the admin fees on non-vaccination prescriptions for antipsychotics, for substance abuse injections?

MS. FIGG: So moved.

MR. POOLE: Okay. First motion by Meredith.

MS. SMITH: I'll second.

MR. POOLE: Second by Rosemary. Any further discussion? All those in favor say, "aye."

TAC MEMBERS: Aye.

MR. POOLE: Any opposed? Okay. Thank you.

Okay. And then, Fatima, what is the proper procedure for changing a patient's lock-in status. Because that is something that pops up every so often that somebody wants to come to our pharmacy and is locked in somewhere, and it takes quite a bit to get that changed.

MS. ALI: So I will defer that to our MCO partners. That is a program

that they manage. The other thing I will say is that we have a provider communication that will be going out in the near future that outlines each MCOs lock-in policies and how to get in touch with the respective MCO. Just a helpful fact sheet, if you will.

MR. POOLE: Okay. Any of the MedImpact people on the call today want to --

MS. ALI: Yes --

MS. ALVAREZ: Yeah, MedImpact is not --

MS. SHUCK: It may vary by MCO. This is Cindy at United Healthcare. The member has to call to request a pharmacy change and they need to call, you know, whichever MCO. So for United, it would be for United, and that can be -- that is usually done within one business day. Typically, within just a few business hours, but if it is on a Friday and it comes in late, it could be a problem in one business day, so it might not be taken care of until Monday, and I

will let the other MCOs speak to that.

MR. POOLE: Okay, thank you.

MS. PATEL: For Passport by Molina, it is also required of the member to give us that change, and we also strive for a 24-hour turnaround.

MR. POOLE: Okay. Thank you.

MS. TOLBERT: The same with WellCare as well. The member can call in or their care manager. We try to roll our members into our care management team so they can help facilitate that change as well, and again, we adhere to a 24-hour turnaround time.

MS. GIPSON: Hi, it's LaVeda with Aetna. It is the same process with Aetna. The member has to call in and request it, and again, 24 hours for our turnaround time.

MR. POOLE: Is a just a phone number on the back of their card?

MS. GIPSON: For Aetna, yes. It's our helpdesk that they would get in contact with.

MS. TOLBERT: Yep. Same with

WellCare.

MS. KAMER-LAY: This is Angela with Anthem. It's the same process for us.

MR. POOLE: Okay.

MR. HAMMOND: This is Michael with Humana. We actually have our -- the person that runs our pharmacy lock-in program, Margaret, are you able to speak to what our process is?

MS. JOHNSON: Yes, this is Margaret Johnson with Humana, and we do the same. The member must give us a phone call to request the change in pharmacy and we strive for a one business day turnaround time.

MR. POOLE: Okay. Thank you.

I think we have already discussed D up above there, and we are going to be working on that. And then I just listed some things that, it is kind of odd in our nation right now, that different states have different medical billing regulations and rules and opportunities for pharmacists in certain

states, and then in another state they don't. So it is kind of like if you get a program going with ABC insurance for diabetes self-management education, or even compliance counseling, or any of those I've listed there, in one state, and then that same ABC insurance in Kentucky or another state, it's like starting all over again with the process. So that has been a really tough nut to crack there, trying to figure out the end roads, because you would think that if you are talking about a national insurance company, then you can just refer to the fact that this is going on in Texas, and again, that is very difficult. So I don't know if any of the MCOs would be interested in commenting on that, but it is a real, I guess, frustrating point for us in trying to, you know, House Bill 48 was passed in 2022, and we have been trying to, you know, get paid for various clinical work that we do, and just other states -- and even Kentucky -- Kentucky may have something that we are getting

paid for, and then another state is struggling to get that same thing with the same insurance. Anyway, I don't know if anybody wanted to comment on that or not. Or if anybody on the call, period, as pharmacists, would want to comment because it just seems to be breaking down the same barriers that have been broken down in other states.

Jennifer, did you want to say something?

MS. ALVAREZ: Oh, I was just going to ask a clarifying question. So are you basically saying, like, why does Anthem not have the same coverage across states since they are the same insurer?

MR. POOLE: Yeah. And, again, you know, I have been in this world 33 years, but, yes. That is exactly what I'm talking about. They may start paying for a service, whatever the service is in another state, but in Kentucky, they don't, so I didn't know if you --

MS. ALVAREZ: And I'm going to base this off of an assumption, and I

don't know if anybody else wants to speak to it, but most the time, any insurers contracted by someone just as PBMs are, so Anthem, from a medical claims perspective, and a PBM perspective, would be contracted by a client who then makes the decisions on what is covered and what is not covered, so unfortunately, it is not a national -- just as Medicare D plans, they can be national, but they can have different coverage depending on which plan you choose. So, I mean, I think that's a bigger than us problem.

MR. POOLE: Okay.

MS. SHUCK: This is Cindy at United.

I think, Ron, that it varies by state, so different states have different priorities. So in Kentucky, we're -- this state is covering vaccine counseling. In other states, they may have chosen tobacco cessation or MTM. Just speaking from, you know, I guess what is covered in some of the other Medicaid pharmacy director states. I think it's -- so I think that

is just a question of, you know, of state priorities and budget, because it is always a budget concern as well.

MR. POOLE: Okay. And I will send some information, too, Fatima for what I am talking about a little bit more in detail, but I appreciate your answers.

MS. ALI: Good. And just to echo the budget piece of it. You know, there are different budgets across the board, depending on lives and well, really, the lives is the most important thing, how many members do we have an our Medicaid bucket. So just from that perspective, the federal match and just a lot of factors that play into how much money each state receives to manage their Medicare programs. So a lot of that needs to be analyzed by our finance team, you know, before we can make any drastic changes, so just wanted to make a note of that.

MR. POOLE: Okay. All right.

I didn't have anything else on the agenda.

And I forgot, Erin, to put the date of our next meeting down. If you are on here, because we had to postpone this one a couple of weeks. If Erin is still on here, and if not, I can certainly --

MS. BICKERS: I am, give just a second.

MR. POOLE: I apologize.

MS. BICKERS: October 2nd.

MR. POOLE: Okay. All right.

MR. CARRICO: Is that put to the MAC, like, the first motion from Meredith for CHW, or anything we have done? Is everything automatically getting sent to the MAC?

MR. POOLE: Yes. Between me and KPHA and Kathy Hannah, we make sure that that is representative to the MAC. And if I can't do it, then they do allow Kathy to mention it, and I usually send out an email to someone on the TAC for somebody else to present it, if I can't.

MR. CARRICO: And one other thing is to circle back on our last point about medical billing in other states, and

I understand the budgetary concerns within our own state. Do we know if any of these programs that are happening in other states have resulted in cost savings for the program?

MR. POOLE: I don't have that data, but certainly, I think that is why you have places -- organizations like CPSN and different ones that are trying to compile the data to show the cost savings. I don't know if Fatima has a resource for that or not.

MS. ALI: So, the states that do cover it, I'm not sure if they have published any cost savings data, but if you all have any, we would be happy to review it.

MR. POOLE: Okay.

MS. BICKERS: And Ron, this is Erin. If you don't mind to follow up those recommendations in writing for me, I just to make sure that I capture everything appropriately.

MR. POOLE: Okay. I sure will.

MS. BICKERS: I do my best, but

not being a subject expert, sometimes I do struggle.

MR. POOLE: Okay. That's fine. No problem.

Do I hear a motion to adjourn?

MS. SMITH: I'll make a motion to adjourn.

MS. STRAUB: I will second it.

MR. POOLE: Okay. Rosemary and then Paula. Any further discussion? All those in favor say, "aye?"

TAC MEMBERS: Aye.

MR. POOLE: Any opposed? Thank you all. Thanks everyone on the call. Have a good afternoon.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 28th day of August, 2024

/s/ Stefanie L. Sweet

Stefanie L. Sweet, CVR, RCP-M