CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
PHARMACY
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
August 9, 2023
Commencing at 1:01 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Ron Poole, TAC Chair

Philip J. Almeter

Matt Carrico (not present)

Meredith Figg

Jill McCormack (not present)

Rosemary Smith

Paula Straub

P R O C E E D I N G S

CHAIRMAN POOLE: All right. Let's call the meeting to order. We've established our quorum and then we have our minutes from our February 8th meeting. So I sent those out again to you, and does anybody have any changes to make to the minutes? And if not, do I have a motion to approve?

MS. STRAUB: I give a motion to approve.

MR. ALMETER: Second.

CHAIRMAN POOLE: All right. Paula and the second, Philip.

Any further questions or discussion?

(No response.)

CHAIRMAN POOLE: All those in favor, say aye.

(Aye.)

CHAIRMAN POOLE: And any opposed?

(No response.)

CHAIRMAN POOLE: Okay. I didn't have a chance to get the updated list of people on the meeting here. Is Fatima Ali on the meeting?

MS. SHEETS: I don't believe that

Fatima is, but I believe April Prather is.

DR. PRATHER: Fatima is on her way to join, though. She should be here shortly.

CHAIRMAN POOLE: Okay. Well, let me get 4(B), then, out of the way. That's just contacts for MedImpact and then we can even do 4(C) for now. That's the portals to look under either MedImpact or Magellan for NADAC updates. And we'll discuss those -- concerning new business on those a little later.

But what I was -- Ms. Prather, what I was wanting Fatima to comment on -- and maybe you can -- is the Senate Bill Savings Report that is -- it's been lurking out there for a very long time. And the last time we talked in February, we were told it would be out by sometime at the end of March. And we're still not seeing it.

And I guess the question -- the obvious question is, you know: Why hasn't it been publicized yet?

DR. PRATHER: Okay. It looks like Fatima just kicked out of the meeting, but she did want to speak to that personally. So

I will defer --

DR. ALI: I'm back.

DR. PRATHER: -- to her when she returns. Okay. There she is.

DR. ALI: Yeah. Can everyone hear me okay?

CHAIRMAN POOLE: Yes, ma'am.

DR. ALI: Okay. Excellent. Sorry about that. My computer has had some issues lately.

I presume we're on Senate Bill 50 savings?

CHAIRMAN POOLE: Yes, ma'am.

DR. ALI: Okay. So, you know, I know that pharmacy providers and really a lot of the pharmacy community has been anxiously awaiting the report. I will say that, you know, there are a lot of pieces that go into creating the report and a lot of steps to approval, you know, that take time to complete.

So, you know, I know that that's not the answer that you all are looking to hear, and you're all very anxiously awaiting the report. But I do ask that, you know, you all

remain patient with the Department and work with us as we try to get you the best and accurate -- the most accurate information as possible with regards to Senate Bill 50.

You know, as you know, Senate Bill 50 is the first of its kind in the state, so, you know, there are a lot of things that go into it and a lot of factors that play a huge, huge role in, you know, determining what the quote, unquote, savings are. And I refrain from using that word a little bit because of, you know, what it could imply.

And we certainly don't want to give off the wrong message, if that makes sense. So please bear with us as we finish working through the report and get it through the appropriate channels for approval.

CHAIRMAN POOLE: Well, it -- you know, when we look at other states that have done this, like West Virginia, they were more than proud to bring it out as soon as they possibly could, what the savings were. And the legislators are keenly aware of the delay and wanting to know what the problem is, so maybe that's something that Commissioner Lee

can deal with them in other meetings.

Because, I mean, like when West Virginia showed the savings that they did by -- I mean, they had a total carve-out till there wasn't any limitations at all. And the savings that they showed, they were rather proud of it. So that's the part that doesn't make sense.

DR. ALI: I wouldn't consider our single PBM model as a carve-out. A full carve-out would mean that everything trickles over into fee for service. Again, we are the first in the country to have a model that is like Senate Bill 50 with a single MCO PBM. So, again, I would not call it a carve-out and --

CHAIRMAN POOLE: Well, maybe you misunderstood me. I --

DR. ALI: And even if it was a carve-out --

CHAIRMAN POOLE: Maybe you misunderstood me because I said West Virginia had the full carve-out, and --

DR. ALI: Right.

CHAIRMAN POOLE: -- they were more

than happy to show the savings on it. So I don't see where going to a single PBM or MCO for pharmacy would delay the statistics that much further. But since there was a lot of negative comments about how -- that this was not going to show much savings from legislators and people from Medicaid, that certainly bears -- enters your mind that, you know, there's people that don't want this to show the savings because they were against it in the first place so...

But, you know, the longer you wait, the more suspicious it seems.

DR. ALI: So I think there's a distinction to make between West Virginia and Kentucky. You know, West Virginia is a full carve-out, meaning that everything goes over to fee for service. And here, we're trickling everything over into a single PBM, single PDL with a lot of other factors to take into consideration. And, again, this model is pretty novel and new. And we're trying to get you the most accurate information as possible.

You know, again, Commissioner Lee and

Veronica -- or Senior Deputy Commissioner Cecil are well aware of this. And, you know, they're being asked about it as well, but, you know, you need to understand that it needs to go through the proper channels before we can release it to the public.

CHAIRMAN POOLE: Well, right. But I also look at how long it's been since the data has been completed. You know, we're not continuing --

DR. ALI: Well, I understand that, but, you know, we are looking at pharmacy claims experience over a span of four years, from 2018 through the end of 2022. So, you know, compiling all of that data, again, is a lot of work, and it takes time. And it goes through multiple rounds of review and approval, and this is something that we haven't done before. So we need to be cognizant of those factors.

CHAIRMAN POOLE: All right.

MS. FIGG: Do we have an anticipated release?

DR. ALI: Unfortunately, no, because it's pretty variable right now with

the amount of approval it needs to go through, and, you know, every ounce of feedback that is given to us is incorporated into the report. But trust me, I do -- I do understand the frustration, and we are trying to expedite the process as quickly as we can.

CHAIRMAN POOLE: Anybody else have any comments on 4(C) -- or 4(A), I mean? I'm sorry.

(No response.)

CHAIRMAN POOLE: Okay. And just -- is there anybody else on the PTAC that is having pressure from their own legislators in trying to get that report? Because I've been -- since day one that that fiscal year was over with, I've just been hit hard every time. And, heck, I've even had a new -- well, two new legislators, and they're still asking me. Because of redistricting, I got a new senator and then we had an election. My representative wants to know, too, so...

Anyway, as far as -- we already went over 4(B) and 4(C). 4(D), as far as community health workers, the question that, you know, we tried to bring up: Is pharmacy

owners going to qualify as providers -- or, excuse me, pharmacies are qualified as Medicaid providers?

So it looks like the verbiage where -- I can pull up on my phone here. Let me do it that way. Basically, the people who are eligible to have community health workers, another Medicaid-participating provider approved by the Department of Medicaid Services.

Obviously, in other states, this has been spelled out where pharmacies and pharmacists and staff working under pharmacists have been able to go ahead and move forward with these things. The thing that most pharmacists understand is that we've already been doing a lot of these programs for some time and getting paid nothing for them but trying to do what's best for the patient.

And the sad part is a lot of these programs cost money; and, therefore, the only people who can afford some of the help that a community health worker would be eligible to do, you know, they have to pay cash for it.

And so, basically, right now, a lot of these services that community health workers can do are being paid for. But as far as trying to get health equity going in this state, a big move would be to open it up -- open the community health worker waiver up to put pharmacists and the pharmacy technician staff.

Because those of you who don't work in a pharmacy, these things happen all the time. We could go on and on for days, I mean, especially those of us who have been pharmacy owners for years and years, all the things that we've done to assist people in getting -- getting their medications, getting to and from office visits. Or any kind of deficit that they have in attaining health care, we've been working with them for quite some time.

Ben Mudd, are you on the phone? Are you on the call today?

MR. MUDD: Yeah. I'm here, Ron.

CHAIRMAN POOLE: Would you mind to comment on your thoughts on this?

MR. MUDD: Well, I think, you know,

we -- KPHA definitely supports the ability for pharmacies to be listed as providers here with pharmacists and technicians being the one that obviously would be providing the service. I'm still a little confused on the why not of why this can't happen.

Is it an interpretation of the statute? Is it just -- I don't know how to say this. Is it just Medicaid doesn't feel like this is an appropriate thing for pharmacies to be doing, or that's not the right place for this to occur? So I guess some clarification on the "why not" would be a good place to start.

CHAIRMAN POOLE: Yeah.

DR. ALI: So --

CHAIRMAN POOLE: And just so that you know, Fatima, in other states, there's -- I've got colleagues in other states that have 12 community health workers on their staff, and they're doing all the support for these people to attain health care and all the -- you know, the ones with barriers, and they're getting paid for it through their Medicaid program. So it's being done already in other states so...

Anyway, go ahead.

DR. ALI: Sure. So I'll be honest but -- you know, this is, you know, something that I'm not fully in charge of. You know, I can certainly have discussions with those who are in charge of this waiver within the department.

But what I would need from this group is, you know, the estimated costs that, you know, could come our way and what this would look like. Just a written proposal would really be helpful here for us to consider something like this.

CHAIRMAN POOLE: Did the other people that were approved on this list, did they have to come up with an estimation of cost to provide care under community health workers?

DR. ALI: That's something I'm -- I'm unsure of. But, again, I was not -- you know, this is not something that I've been taking the lead on. You know, I think we might need to have a comprehensive discussion with the individuals who did make those decisions and see where we can go from there.

CHAIRMAN POOLE: Well, would you mind to provide me and everybody else -- or at least Erin or Kelli -- the contact people, so we could address the appropriate people and -- because we're trying to figure out why we're always left out. That's the main thing.

DR. ALI: Yeah. I'll correspond with Erin and Kelli, and we'll see, you know, where we can go from there. But I would highly encourage a written proposal from this group.

MS. FIGG: Yeah. Ron, I agree. I'd love to know if the other people -- I pulled up the provider letter that went out from the Cabinet on community health workers and all the entities that were addressed, you know: Physicians, school-based services, community health centers, dental providers.

You know, I'm not really sure why pharmacy wouldn't be the obvious choice to be included on this list, and I'm like you. I would like to know if what we're being asked to do was done by all these other people listed on this list.

And I'd love to be in contact with the right people that can help answer some of those questions because I think it's a valuable service and, you know, in the long run does save money. And I think pharmacy is -- as the accessible providers that we are, are in line to provide those services.

MS. PARKER: Fatima, this is -- this is Angie Parker. I'm the director of quality and population health, and I've been involved in some of the CHW discussions. Now, our health policy division -- healthcare policy division is the one who's been developing these.

As you all know, this is a new process that just started July 1st. So we are looking at any input from any other providers to this subject and any changes that we could potentially make. So as what Fatima had -- what Dr. Ali had mentioned, it would be good to have that information from you on how you would like to add pharmacy to this, and we can certainly send this to the correct division to do some investigation.

It's -- you know, we are making changes

as we go, as we get additional information, so it's very helpful. I don't think it was meant to be a -- I can't think of the right word -- to eliminate you all from this process but -- and I -- you know, there's some questions that I can't answer as far as: Are you able to bill those specific codes that are currently listed on the -- that would be accepted for a CHW? Do you currently employ CHWs? Are you looking to certify them?

Because there are a lot of requirements for this, so if that is something that pharmacies are doing elsewhere and -- in other states, please send your -- as Dr. Ali stated, what your proposal is, and we can -- it can certainly be reviewed.

CHAIRMAN POOLE: We'll be more than glad to do that because we already have examples being done. And it seems like a lot of states, the community health workers were thought of as working under the pharmacy since we're the most accessible health care out there.

So a lot of -- a lot of states didn't

forget the most accessible profession out there. And we already have people that do a lot of these programs or these -- that just any barrier to care that we have, we work with the patient to help them attain whatever health care they need. So I think it's -- we'll be more than glad to make comments because I understand they're working on the regulations as we speak so...

MS. PARKER: Yes.

CHAIRMAN POOLE: That pertain to this statute, so we'll be more than glad to. And thank you, Ms. Parker, for your comments.

MS. PARKER: That would be very helpful. Thank you very much.

CHAIRMAN POOLE: Okay. On new business --

MR. MUDD: Hey, Ron.

CHAIRMAN POOLE: Yes. Go ahead.

MR. MUDD: Question for Ms. Parker. Would the most appropriate way to handle that be through official comments on the regulation, or how -- what's the most appropriate way to get that request --

MS. PARKER: You could do both.

MR. MUDD: Okay.

MS. PARKER: You know, you're bringing it up in the TAC, and this is a concern. And you can certainly provide what you would like to see DMS to do, and you can do it -- provide your comments on the regulation comments as well.

CHAIRMAN POOLE: Okay.

MS. PARKER: We are working through this. As I said, this became effective July 1st, so we want to make sure that we are including -- because we have the same concerns regarding access to care and ensuring that we -- and we look to see the CHWs to fill a hole that's not been there.

MR. MUDD: I think there are some examples in Kentucky and beyond but, you know, it's -- if patients don't have electricity or food to eat, then that probably becomes No. 1 priority over taking care of a diabetic foot ulcer. If they don't have clean water, how are they supposed to clean that and take care of it?

We need -- you know, and pharmacies see that because they deliver to their homes, and

they see what they're going through. So it's a great opportunity for an intervention. But not everybody realizes, you know, or recognizes that pharmacy has that opportunity. So we look forward to the opportunity to present those comments.

MS. PARKER: We will -- we're more than welcome to see what you have to -- the information that you have. Appreciate it.

MR. MUDD: Thanks.

CHAIRMAN POOLE: Yeah. We -- we've delivered to patients' homes before where they have dirt floors for floors so...

Okay. On -- moving on to new patient -- or new business. I put that in there because it's already been taken care of and addressed, but we had a situation in Central City where a physician group that takes care of addiction medicine was prescribing stimulants for an un- -- for a condition that is not approved by either -- by the DEA or even by MSDS, the disease state management book.

So anyway, that got resolved because when they understood that, that that's the

reason why somebody was denied a stimulant drug when we had so many of them being prescribed for meth addiction, which I believe in the next few years, you'll -- I mean, that'll be some -- some semblance of that will be the standard. But as of right now, it is not.

So that's what happened in that case, and it's been -- I think Dr. Schuster has had a conversation with a colleague of mine to explain that. But it wasn't somebody denying somebody a legitimate prescription for a legitimate disease so...

Looking at -- just to report a little bit more on the brand name and generic shortages. We still -- it's amazing to me -- you know, we thought that this was what we were going to endure during the pandemic. And I realize we still, you know, have an uptick of positive COVID cases right now. But -- so a lot of people like to think we're out of the pandemic. But whatever your particular take on that is fine with me.

But we -- now we're starting to see, you know, shortages on generics that are not --

you know, it shouldn't be that way. So we have, you know, a lot of brand names certainly and generics that we normally don't see a problem with, with hydroxyzine and lidocaine viscous and hydroxyzine syrup.

So I just want to bring that to your attention, that we're getting inundated with people that are having issues obtaining medicine. They're wanting to report us to the Board of Pharmacy. They're wanting to report us to whoever they can talk to because we just can't simply get the medicine. And we have gone through every means possible.

I am now -- when I look for all of my pharmacies, I now have over 105 secondary wholesalers that I can check. There's four or five different entities that represent 30 and 25 secondaries, so it's not like I'm doing 105 different websites. It does amount to about 15.

But anyway, it's still amazing. You go through all of them, and you can't find the product. And it's not like it used to be 10, 15 years ago. You have such strict requirements to order. A lot of these drugs

are your CII drugs, and you have such strict criteria to meet in trying to order anything else beside from your primary wholesaler on CIIs that I only have two other ones that I can even try to order from and then I still have to jump through their hoops to get it ordered.

So if I order a bottle of 100 of anything, then I have to order 300 of a noncontrolled from this entity to get it, or I have to have a dollar amount that I average over the last three months that I've ordered from them in order to order a CII.

So there are secondaries out there with these products, but if you haven't ordered anything from them in two months, then you're out of luck. And so it's the worst I've ever seen in my almost 33 years in trying to just obtain drugs every day. I mean, I have my staff email me all the list of drugs that they don't have, and it just continues to build, it seems like, every day.

So it's a constant that every pharmacy is having a problem with right now, and I don't remember a worse time. I can maybe

remember a time when digoxin was being shorted. And, of course, there's not an alternative to it. But that's the only thing I can liken to the situation we're in now.

I don't know if anybody else had any comments on just the supply chain problems.

DR. ALI: From a Medicaid perspective, I will say that, you know, we are aware of these shortages, and we're trying to work with pharmacies as best as possible to -- you know, if the brand is preferred, allow the generic to pay and vice versa in warranted situations.

So, you know, as these issues come up, certainly bring them to us, and we can work with you. We certainly understand it's a big problem, unfortunately out of our control. But, you know, if there is something that you see, please let us know.

CHAIRMAN POOLE: Okay. And on the -- I just wanted to present this to the Medicaid department. This is just Pooles Pharmacy Care. Because we're not able to meet our generic compliance rate because of the -- brand name preference is part of it.

It's not all of it. The other is such a high demand for GLP-1 drugs that adds to that.

But, basically, just by not being able to meet those measurements, annually, it's going to be somewhere projected between 30,000 and $42,000 annually that it's costing. So Medicaid may be benefiting from the brand names for the rebate program, but it does have a cost to your providers.

And I have just looked at our particular buying group, and before these -- before we started having the preferred brand names on the Medicaid program, we were at an 80 percent clip of being able to meet those -- what they call GCRs, generic compliance rate. And now we're at a 42 percent of people that can meet their GCRs.

So it does have a financial impact, and here we're trying our best to take care of Medicaid patients. But, you know, others may choose to just say, well, we don't have that medication or whatever. But that's where people are looking at as: What financial impact is this having and, you know, what's their -- their means to deal with it?

And some are choosing to just -- saying we don't have it. So just want to bring that to your attention. And I don't know if anybody else has done the evaluation of what that cost them, but anyway.

MS. SMITH: Ron, I can say from our company, Jordan Drug, our estimate is about the same, maybe a little bit higher. We have six stores. And from hearing from my KPHA members across the state, there is -- it's been a huge impact on losing our rebates for GCR. So it is definitely an issue across the state.

CHAIRMAN POOLE: Okay. Okay. Moving on. Go ahead.

MR. ALMETER: Just let me comment and add that the availability right now of GLP-1s is -- anybody on here who works in a pharmacy knows that it's driving everybody crazy. Patients get emotional, very emotional at the counter if you have it. They get emotional if you don't have it.

And it's -- I do appreciate the board coming out against some of the -- some of the practices. But I think it -- I've never

seen -- and I've not been a pharmacist as long as some of you have been a pharmacist, obviously. But I've never seen so much hype over FDA-approved, on-label/off-label indications in my career, ever. So it's definitely having an impact on the profession.

CHAIRMAN POOLE: Yep. I appreciate those comments. That's -- that's for sure.

And the last, I just started the -- I mean, I wrote a lot on this next topic here, answers from Ms. Lakstins-Alvarez and Mr. Beuglass, if I'm pronouncing his name right.

But I just started the conversation with them, and I -- we used to have an ad hoc committee for Medicaid and compounding formulary. UK Med Center really weighed in a lot with that. And I was able to just come up with just some simple things that would really help -- help them out in patient care.

Because a lot of times, they're compounding for -- because it's just that much better for the patient. And, of course, they're not getting reimbursed for that. And

I've just started the conversation. Whether it's compounding, whether it's nutritional supplements that are needed for autistic patients or ADD or ADHD, so many times, patients are getting referred from their physicians and obviously from myself.

And, you know, the nutrition they need, just -- they can't afford it as far as nutritional supplements. You know, with autism, you know, glutathione, essential fatty acids, you know, all those do add up as far as expense, whether it's taurine or zinc or any of those.

So in looking at, you know, all four of those topics there, I've just started -- you know, other states -- we're all trying to work with not only Medicaid but all third-party payers on pharmacists, clinical services. We're all, you know, looking at these kind of -- you know, because this is -- right now is the change.

You know, the state of Washington was the first ones eight or nine years ago to get legislation changed, and they're still working on their not only private but

Medicaid population to try to see where they can help improve quality of care and save money, which is the main thing for most third parties and Medicaid, too.

The only thing that I would ask, if we have a representative on here from MedImpact, is that: Is there any possible way for when there's NADAC pricing updates -- which I understand tend to be two to three weeks retroactive. Is there any possible way to have it to be automated to where when you have submitted a claim that should have been with a new NADAC and, two weeks later, it is updated and it is retroactive back to that claim? Just wanted to just get that question out there. And if nobody is on here, then I'll follow up with the MedImpact administration.

DR. ALI: Yeah. So MedImpact is on, but I will say that in terms of those NADAC rates that, you know, are retroactive or -- you know, the claims that are submitted and then the NADAC comes out and then you have to retroactively go back. So that would be incumbent on the pharmacy to reverse and

reprocess those claims accordingly.

And, again, you know, NADAC is managed by CMS under their vendor, Myers and Stauffer. And I think you all have NADAC appeal information. If not, I can throw it in the chat. So, you know, it would have to really go through that process where the -- when the rate is updated, the pharmacy goes back and reverses and resubmits the claim.

CHAIRMAN POOLE: And why would -- why is that?

DR. ALI: In terms of --

CHAIRMAN POOLE: Because MedImpact has got the capability to identify those claims. And if you've ever opened up one of those portals to see the voluminous amount of material that you've got to go through to find your NDC number and then to try to determine, you know, which claims to do it on, is that the cost savings measures of the retroactive NADAC pricing updates that they get to pocket?

Because seems like to me if you're -- if you field a claim under -- when a NADAC price should have been updated to begin with, it

looks like that should have been your reimbursement, period. So to have to go through -- you're talking about, you know, procedures with Medicaid, about how this is different. Well, beings they have -- they can identify those claims overnight. I'll betcha there's a report out there that shows how many of those NADAC prices didn't get updated under Medicaid -- or under MedImpact.

So to me, it's a way of a cash flow measure for them to not have to pay the NADAC price when it should have been effective to begin with.

DR. ALI: The technology -- and, MedImpact, feel free to jump in here. I don't think that this process is really industry standard, and I don't think it happens across the board for --

CHAIRMAN POOLE: Yeah. Because most insurances can update on a very quick basis on their pricing.

DR. ALI: So are commercial PBMs helping you all reverse and reprocess claims in that fashion?

CHAIRMAN POOLE: Yeah. There's

some that will go ahead and reprocess, and there's some that will just send you a report that tells you these are the drugs that you have filled that you can go back and rebill. They don't just send a -- I mean, I don't know if you all paid attention to how many pages worth of information is in one particular report.

But last time I checked, it was 30-some pages worth of NDC numbers to try to have to find a needle in a haystack of what claims you have to -- unless you have a Microsoft Access acumen to where you can take a database and do a search and find the claims.

DR. ALI: So how frequently are these commercial PBMs sending reports to you all? Is it monthly, quarterly, weekly?

CHAIRMAN POOLE: It's monthly through most of our pharmacy administrative organizations. And we can even -- I mean, we can do reports off of some of them that'll just tell us which ones to go and rebill and then sometimes they'll just send you an email with an update of claims you need to be looking at to see if you got the proper

reimbursement.

DR. ALI: Okay.

MR. BEUGLASS: So I'm sorry. You said that your PSAOs are sending it to you because they want those adjusted? Is that what you're -- is that what I'm getting?

CHAIRMAN POOLE: They provide those for us. And in some cases --

MR. BEUGLASS: It's not the PBM. It's the PSAO who gets a little piece of the management to those and the reprocessing so --

CHAIRMAN POOLE: Well, they wouldn't know the claim unless the PBM was providing it for them.

MR. BEUGLASS: Well, right. But a lot of the providers have a PSAO receive their RAs and their 835s. So they're going through them and identifying them that way.

So, you know, identifying the claims, to your point, is one thing. But if we were to send you a list of those to process or reprocess, we would pull both; right? So it would be increases and decreases. And we would expect that all of the increases and

the decreases were both reprocessed in that situation as well.

Is that what you're also committing to if we were to send a report like that?

CHAIRMAN POOLE: Well, if we could send a report like that --

MR. BEUGLASS: We'd have to develop it, yeah.

CHAIRMAN POOLE: But right now, it's one-sided. What's the percentage of people, do you think, that are out there reprocessing? Very low.

MR. BEUGLASS: Well, but again, in Medicaid programs, this is not a standard process to go back and have an automated piece. So for us going in and doing an automated readjustment, that would be akin to rebilling and reprocessing. We'd have to check with our compliance and legal and see if that's even a viable option from that perspective. I don't know that they would agree with it.

CHAIRMAN POOLE: But you have certain Medicaid programs that use other pricing models that don't have to wait two to

three weeks for a retroactive --

MR. BEUGLASS: 48 states are based on that now. There are only two left that aren't. So most of them are using that. They do have the same limitations from the CMS process; right?

So, again, think about it from when a manufacturer makes a change and provides an update to a wholesaler around AWP or WAC, you do probably get those in your price file. And we do get those daily when they come over from that perspective.

But it's the Myers and Stauffer and the CMS process there that creates the situation where we do have that unfortunate, inherent delay in their validation verification and then ultimately the publication of those items.

So I think, you know, again, it goes to both sides; right? Because there are increases and decreases when you see these. I know, obviously, the concern here from your perspective are the increases by and large. But, you know, there are probably times when you've achieved that lower price because,

again, there -- or the price changes or you have inventory on the shelf that was at a lower price from that perspective.

So, you know, again, we'd have to take it back to Dr. Ali and see what we -- what we could provide from a reporting perspective. And then, of course, I think that would probably be something that we'd have to discuss there and then we'd have to, you know, send it out and watch and make sure that all claims are being reprocessed from your side, yeah.

But we can talk about it certainly. I mean, we're open to listen and help you guys how we can from those perspectives. We just have to remember, obviously, that we're just the benefit administrator for the -- for the state. So all of the decisions would have to come from the commonwealth and then we would be able to support whatever they decide from that perspective. Yeah.

So we're not a traditional PBM like you had with the MCOs. We're more of an administrator from that perspective. So we'd obviously listen, take back what we can, and

then work with Dr. Ali and Dr. Prather and Dr. Vangilder.

CHAIRMAN POOLE: But I'm sure you all are aware of how you're all benefiting from pharmacies not having the time and wherewithal to take a massive report and find those particular NDCs that they can go back and rebill because I have not found a colleague out there anywhere that is doing that.

MR. BEUGLASS: Well, but we're not benefiting from that in any way. This is --

CHAIRMAN POOLE: How are you not? I mean, you've got a price that should have been updated two and three weeks ago. But because of the process, it wasn't. So you're paying at a lower rate, so you are benefiting from that. And it's not getting reimbursed back --

MR. BEUGLASS: Right. But it's -- sorry. It's not our network. It's the state's network. So there's nothing that we receive on this. We're paid per member enrolled in the program from this perspective. We're not paid based upon

anything related to the claim transaction.

CHAIRMAN POOLE: Okay. So -- but Medicaid is benefiting off the NADAC two and three-week delay, but anyway.

DR. ALI: Well, I think another point to note is that, you know, the price could increase or decrease with those batch reversals, if you will. You know, it could go favorably or unfavorably for the pharmacy from that end. And, again, we have no control over what CMS does with their -- what -- their NADAC and the methodology there. I do have a NADAC document, if you'd like me to share that, with the methodology.

CHAIRMAN POOLE: No. I've seen that before, and we've tried to make that available for all the pharmacies out there, whether chain or independent, of how the process goes.

But it's been -- I mean, I've been in this business for going on 33 years, and I sure have never seen too many price decreases. As far as most of the time, you're talking about price increases. So by that not being updated, that is a benefit.

Anyway, moving on to -- let's see -- 5(E). We're having some people that are billing for the vaccine consultation. And what are they supposed to do with the denied claims? Because by Medicare mandate, we're supposed to get those paid for. So what -- where is the resource, or where can they go to report the denied claims?

DR. ALI: So you're referring to vaccine counseling reimbursement?

CHAIRMAN POOLE: Yes, ma'am.

DR. ALI: Yeah. So, you know, those are funneled through the MCOs because it is billed on the medical side. And we did share some useful billing information with Benjamin. So, you know, I think referring to that information is certainly helpful for pharmacies.

You know, for any denials, you would go through the appropriate MCO and work with them. And, you know, we're happy to triage some of those for you -- well, not some of those but really any concerns that you have from that perspective. And then we'll also be discussing it in the MedImpact provider

forum, which will be later this month.

CHAIRMAN POOLE: Okay. Ben, did you get that helpful information?

MR. MUDD: Yeah. It's available on KPHA's website, too. And there's a pending communication going out to all members as well.

CHAIRMAN POOLE: Okay. And then who's getting this -- are we sending that stuff out to the chains, also, Ben, or are you just making it available on the website?

MR. MUDD: It's just on our website, but they're going to -- they'll be going over it in the next MedImpact provider call as well.

CHAIRMAN POOLE: Okay. All right. Thanks.

Have you had anybody yet, Ben, or is it just too new to -- that the information has just now been available, or have people been successful in calling and getting them rebilled?

MR. MUDD: I mean, we've got -- I know of a couple of folks that have received paid claims so --

CHAIRMAN POOLE: Okay.

MR. MUDD: -- it's real. It's just -- you know, I think having pharmacies transition to that payment model through medical billing is -- you know, that's a hoop we've got to jump through.

CHAIRMAN POOLE: Okay.

MR. MUDD: But it's helpful, you know, when you have -- it just takes a few people to show success in getting that message out there. But, you know, at this point, even if you have -- if you're providing a vaccine consultation and patients aren't getting it, getting the vaccine because of safety concerns, you should absolutely be billing the MCO for that consultation.

And we have -- on the website, we've got sample documentation for what you're -- what a note might look like for that encounter, the codes, the CPT code and the diagnosis code that you would need to bill it. So not super complicated, but it is a little bit different so...

CHAIRMAN POOLE: Okay. All right.

Thank you, sir.

MR. MUDD: Uh-huh.

CHAIRMAN POOLE: I put 5(F) on here. I would like to star it and put it even in its own entity. But I want to thank Dr. Lee and Commissioner -- Dr. Ali and Commissioner Lee for all the work they did on getting the increased vaccination fee for reimbursements. I know that was a lot of conversation and a long time coming, but we certainly appreciate your efforts on that.

DR. ALI: Sure. Thank you.

CHAIRMAN POOLE: And I didn't have anything under general discussion or recommendations.

The next MAC meeting will be September 28th at 10:00 a.m. As far as I know, I'll be able to present that morning just our discussion that we had today.

I want to just continue on in just laying the groundwork for some discussions and possibly talking to the MedImpact people on -- possibly even have committees or whatever to discuss some of these issues on just your nontraditional pharmacy claims.

So, anyway, I'm going to be working on that. And if I make -- obviously, if we get anything going, it will have to be approved by the PTAC, so I'll let you know on that.

And our next meeting that we have scheduled is on October 25th. It'll be Wednesday at 1:00 p.m. Eastern.

Did anybody else have anything under general discussion or anything else today?

MS. FIGG: Ron, I'd just like to say, you know -- I want to thank you today for -- you know, whether we were talking about trying to manage the NADAC prices and monitoring those changes and resubmitting or, you know, how we're trying to track down drugs because of the shortages or managing the compliance ratios when we're trying to balance these high-dollar drugs that we're being forced to use when there's generics available.

You know, I think you've done a really good job about highlighting the extra time, effort, and cost that goes into, you know, providing care to Medicaid patients and how -- you know, the added effort that we

take just to make sure that there is the availability and access to care that they need. So thank you for that.

CHAIRMAN POOLE: Well, you're welcome, and thank you for your kind comments.

Okay. Anything else? If not, have a motion to adjourn?

MS. FIGG: Motion to adjourn.

MS. SMITH: Second.

CHAIRMAN POOLE: Motion by Meredith. Second by Rosemary; is that correct?

MS. SMITH: Correct.

CHAIRMAN POOLE: Okay. All those in favor, say aye.

(Aye.)

CHAIRMAN POOLE: Any opposed?

(No response.)

CHAIRMAN POOLE: Thank you all. Appreciate your time.

(Meeting concluded at 1:52 p.m.)

* * * * * * * * * * *

C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 21st day of August, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR