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

****

Via Videoconference
February 8, 2023
Commencing at 1:00 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Ron Poole, TAC Chair

Philip J. Almeter

Matt Carrico

Meredith Figg

Jill McCormack (not present)

Rosemary Smith

Paula Straub

CHAIRMAN POOLE: I want to welcome everybody to our Pharmacy Technical Advisory Committee meeting. We have established a quorum. Thanks, Ms. Sheets.

Has -- I always send the minutes out as soon as I get them from Erin. So does anybody have any corrections for the minutes from the October 28th meeting?

MS. STRAUB: I do not. This is Paula.

CHAIRMAN POOLE: Okay. So if there's not any corrections, I need a motion and second to approve.

MS. FIGG: Ron. This is Meredith. I make a motion to approve the minutes.

CHAIRMAN POOLE: Okay. Motion by Meredith. Do I have a second?

MR. CARRICO: This is Matt. I'll second.

CHAIRMAN POOLE: All right. Second by Matt. Any further discussion?

(No response.)

CHAIRMAN POOLE: All those in favor, say aye.

(Aye.)

CHAIRMAN POOLE: Any opposed?

(No response.)

CHAIRMAN POOLE: Okay. Looking at old business -- and I apologize. I didn't pay attention to what meeting I was trying to get on. And it was the PTAC all right, but it was the Physician's TAC.

So, anyway, I was trying to see who all was on the meeting here. Do we have Fatima on the line?

MS. SHEETS: She is joining right now. I just admitted her through the waiting room so just a second.

CHAIRMAN POOLE: Okay.

MS. ALI: Hi, Ron. Good afternoon.

CHAIRMAN POOLE: Welcome. Glad you could make it.

MS. ALI: Thank you.

CHAIRMAN POOLE: Obviously, I don't want you to feel like a dartboard, Fatima, but you are the person that, you know, is either our lead contact or can get us answers.

So, you know, we're just -- you know, obviously, some of these topics are old

topics, and some are new. But we just, you know, try to get some answers from you. And if you've got to say, hey, I've got to get back with you on that, that's fine. I understand that.

Just on -- starting with old business on the Senate Bill 50 Savings Report or whatever the -- you know, the report is called. I've even had Representative Comer's office call me from Congressional District 1 in western Kentucky and his lead health aide, Sophie Kauffmann, to ask, you know for the result or for this report or at least an update on when you feel it's -- it's going to be ready.

MS. ALI: Yeah. So, you know, with regards to the Senate Bill 50 Savings Report, we just got an update this week that it's ready for DMS review in a PowerPoint slide format. And then one of our vendors still has to, you know, kind of put it in that report format that's available for further review by DMS leadership and then we'll be able to get that going.

CHAIRMAN POOLE: Okay. But you don't even have an approximate date when

that'll be ready yet because of all those reviews?

MS. ALI: Right. Yeah. I'm not sure how long the DMS review process will take but, you know, we're looking at potentially the end of this month, early next month.

CHAIRMAN POOLE: Okay. And you call it the SB 50 standing report. Is that what you said?

MS. ALI: Savings report is fine as well.

CHAIRMAN POOLE: Okay.

MS. ALI: Really, it's a SB 50 analysis.

CHAIRMAN POOLE: Okay. I just want to get the right terminology, is why.

MS. ALI: Sure.

CHAIRMAN POOLE: Okay. Well, thanks for the update on that. I'm glad to hear that we're getting to -- to the end on that and get a report out.

Meredith, on the MedImpact audit response, that was your topic. I wanted to give you the floor on that.

MS. FIGG: Yep. Thanks, Ron. I just know we talked about -- in October about some issues we were having with MedImpact and the audit response. So I have -- I was audited last summer, in 2022. And, you know, final audit probably came through about July or August and was very uninformative about what would be taken back per claim on issues that were found. And I just wanted to report back and see if anybody else had any feedback as far as --

Last month in January, I did receive a much more detailed explanation of the audit and any adjustments and reversals that would be made. This report seems much more informative than the past, and it looks more like what I'm used to seeing as far as audits from other payers.

So I just wanted to update the group that I think we're making progress on this. You know, it has a column for originally paid amount, the new paid amount, and the total chargeback as well as obviously the discrepancy identified. So that was much better than the final response I had gotten

last summer.

I know that at our last meeting, Rosemary had brought up some issues as far as the DAWs and how confusing that is, on whether to use them or not use them, especially on these products where, you know, Medicaid is wanting us to use the brand name.

So I don't have the answers on that. I don't know if we've gotten anywhere on that subject, but I just wanted to update everybody that the report does look much better.

MS. ALI: Yeah. And just to add to that, Meredith -- I'm happy to hear that. We've been working extensively with MedImpact to make the audit process as seamless and transparent as possible. We've also, you know, developed some additional documentation that really outlines everything that a provider would need to know should they be audited.

So those documents are going to, you know, come your way soon, and we'll also be updating the provider portal with those documents. But I'm glad to hear that, you

know, the changes have been made and that we're in agreement with those changes.

CHAIRMAN POOLE: And, Fatima, on that subject, is -- it would be helpful for every pharmacy out there regardless of ownership, whether it's chain or independent or hospital-owned or whatever, to know if -- to know the red flags. You know, are there red flags that -- that lead the MedImpact team to choose a particular pharmacy to audit, or is it -- or is it totally random?

MS. ALI: So they have a proprietary algorithm that they use as do --

CHAIRMAN POOLE: Okay.

MS. ALI: -- other PBMs, not just in the Medicaid world but in the commercial world as well. So, you know, that's how pharmacies are chosen.

CHAIRMAN POOLE: Well, if you -- I mean, it would be nice if we could at least have a top-five list of problems that they're seeing. That can help every -- every pharmacy provider out there to -- to abide by, you know, what their guidelines are to where -- you know, hopefully, you get those

top five taken care of, you have less and less audits. And MedImpact -- you know, most of the time, a PBM will enjoy the fact that people are compliant.

But if it's a third party, a hired third party, then, obviously, they're looking for their percentages of recoupment. But it would be nice if we could at least get, you know, top-three, top-five problems that they saw to where -- you know, for obvious reasons, to help us to be in compliance and know what -- know what to look for and prevent anything from happening.

MS. ALI: Yeah. So I think -- and I don't know if anyone from MedImpact was able to join. But if anyone is on, please feel free to chime in.

You know, the audit process is such that, you know, the algorithm chooses those pharmacies. It's more so randomized than anything else. You know, even if you're in good standing, you're doing everything you need to do, there's a chance that you could still be audited. That's just the nature of the business.

So, you know, we can -- we can look into sending some topics, some trends that have been observed via the audit team. I think that's, you know, certainly a suggestion we can make, but there are certain rules that we have to follow. And, you know, the -- I do want to clarify that the MedImpact audit team is separate from the account team that we work closely with, so I just want to put that on everyone's radar.

CHAIRMAN POOLE: Okay. Thank you.

MR. CARRICO: Ron, this is Matt. I just kind of want to echo Meredith's results. I was audited last spring, and for the follow-up, it didn't really give much information. And last month, I did get the similar reports that is much more detailed. So it looks like things might be back how they should be for everyone going forward.

I did have an audit question for Fatima or whoever might know the answer to this. And it's on the Suboxone KASPER reports. Say I have a prescription sent in on Tuesday. It's due on Wednesday. I queue it up for Wednesday. Are we able to run the report on

Tuesday, and that will meet the audit requirements for KASPER and Suboxone, or does it have to be on the day that it is dispensed?

MS. ALI: Sorry. So you might have to repeat some of that for me. So you run the report the day before or the day after?

MR. CARRICO: Well, like, say we received the prescription today. It's due to be filled tomorrow. If I just -- while I queue up the prescription to fill tomorrow morning, can I run the KASPER today and just check it out and make sure everything is on the up and up, so I can just kind of streamline it for the next day?

MS. ALI: Yes. That should be fine. It's -- it's really --

MS. CONNER: That's not a question for Fatima.

MS. ALI: Sorry. Can you hear me?

CHAIRMAN POOLE: Yes, we can.

MS. ALI: Okay. So yes, that -- checking the KASPER. Let me just double-check and make sure that that's the -- that's the guidance that we've put out. I

don't want to misspeak on that, so let me get back to you on that.

CHAIRMAN POOLE: Okay. Thank you.

Okay. 4(c), again, Fatima and, of course, it doesn't appear that we have anybody on here from MedImpact. Is Adrienne McCormick still the pharmacist in charge of this at MedImpact?

MS. ALI: So she's not a pharmacist by training, but she was the account executive. There has been a staffing change within MedImpact, so she's still with MedImpact but more so on the sales side now. Her replacement is Jennifer Lakstins-Alvarez, so she'll be the new account executive.

MR. BEUGLASS: Yeah. And, Fatima, this is Dean. I'm on, and Jennifer is also on.

MS. ALI: Okay. Great. Thank you.

MR. BEUGLASS: You're welcome.

CHAIRMAN POOLE: Okay. Well, welcome, the people from MedImpact. And Jennifer or the other gentleman can chime in any time you want to.

But we had had discussions, even --

there was even an ad hoc group that I was part of. It was myself and three other compounders from three different practice sites. So we had -- one of the biggest was UK Med Center.

And there are many times when it is better therapy for a compound in the hospital and certainly even in community. But more so, all the examples that I -- I mean, I learned a lot by listening to the gentleman from UK Med Center of all the different compounds, especially in pediatrics, that they performed and produce in order to have better treatments.

So, you know, I'm not asking for -- or this group over the course of time here -- because this has been on our radar for probably a year. But our biggest -- we would just like to even maybe come up with a -- just a strict, small formulary for us to test with MedImpact to see -- you know, to make sure that it can be done without fraud because I don't want that either.

My compounding practice has been hurt greatly by the fraudulent characters out

there. And so I want it to be a good -- a good program.

So, Jennifer, I didn't know if you had any experience with some of your other networks around the country that has at least a small formulary for compounding in multiple settings, whether it be hospital or community.

MR. BEUGLASS: I was going to say -- and this is Dean. I'm not familiar with anything that we have set up quite like that. We can certainly explore opportunities. We'd be open to working with the provider community to see what we can pull together.

Of course, all the decisions would be DMS --

CHAIRMAN POOLE: Right.

MR. BEUGLASS: -- decisions from a coverage basis and a process basis. But yeah, we're certainly open to working with you guys on that, if we can.

CHAIRMAN POOLE: Well, and again, I can reach out to the UK representative again and just really try to hit their most

prevalent, and we can come up with something and have a discussion with you.

If you don't care, my -- my email address is ron@ -- and it's poolespharmacycare.com. So p-o-o-l-e-s pharmacycare.com, and r-o-n for the front.

If you wouldn't mind to send me yours and Jennifer's contacts or your emails. And I can just send you information to look at at your pace, and we can get together and discuss it sometime.

MR. BEUGLASS: Certainly, yeah.

CHAIRMAN POOLE: Okay. Thank you.

MR. BEUGLASS: You're welcome.

MS. SHEETS: Dean, if you want to just drop those email addresses in the chat, I can send them out to the group after the meeting.

CHAIRMAN POOLE: Okay. Okay.

And then, Fatima, this is -- again, it's kind of like the compounding topic. You know, Philip, I guess, gave some really good testimony for his chronic care management department that's ran by a pharmacist at the hospital, UK Med Center. And, of course -- I

mean, you know, I can go on for 32 different clinical services that pharmacists are offering, and there are some unique services and especially with the education, whether it be diabetes self-management education, whether it be tobacco cessation, or alcohol abuse, counseling and treatment with Vivitrol.

So there's just a lot of things out there, and I guess the biggest thing that we just want the opportunity for -- and I know Trish Freeman -- Dr. Freeman and Dr. Kyle Bryan probably have been hitting you up with this topic, also. So I know that -- I mean, you get it from all angles.

So I guess, again, I would just ask if -- if we could either do some pilot programs or ones that we know that can show some big savings to Medicaid. Because, obviously, if we don't show savings, then it's not going to be worthwhile for you all to pursue. But I do think that -- I mean, I think there's less duplication of services and more hands-on clinical services we can do that can save money.

So I just -- if it's okay with you, again, I could reach out to Dean and Jennifer and just -- just, again, just have discussions on it. And then, obviously, we've got to have you involved in those discussions, too. So is that okay?

MS. ALI: Yeah. So, you know, I think what would really help here is obtaining data and true outcomes in savings and really seeing that from an overall perspective, you know, before we take any action on this. And, you know, we strive to really collaborate with you all on these types of initiatives.

So, you know, having true data and seeing the outcomes, seeing what savings could result, you know, from a -- from increased reimbursements -- because, remember, you know, the changes that would have to be made from a system perspective are extensive. It would take at least a year, if not more, to really, you know, provide reimbursement for clinical services, recognize pharmacists as provider types, you know, et cetera, et cetera.

I think we've had that discussion plenty of times, and I think it's really important for us to see the data and have it presented to the department and to leadership. And, you know, we can collaborate from there.

CHAIRMAN POOLE: That sounds great, and I certainly can work on that. I'm a member of CPESN, and they have a ton of data that can show the areas where they have affected -- or saved the most money to different networks. So yes, I'll be working on that with you and go from there.

MS. ALI: Okay.

CHAIRMAN POOLE: Does anybody else have any comments on clinical services update?

(No response.)

CHAIRMAN POOLE: Okay. On 4(e), again, this is something -- and this was brought up by a colleague of mine who is in Floyd County, and it's one of the underserved areas. It's also statistically -- whether you look at KYIR or look at the CDC, it's also in need of a lot of vaccinations. So it's an area where you definitely want to

promote vaccinations the way you can.

However, he's working with the school system. Even the Appalachian Regional Hospital nurses who work at each of those schools, they're not interested in doing the vaccination program. They feel they're busy enough.

So he's taken it upon himself to -- he's increased -- out of a whole elementary school in southern Floyd County, he's got two children -- down to two children that is needing just a few vaccines to be on schedule out of the whole school.

So he's done a lot of work, but he's also donated quite a bit of vaccinations because he doesn't get reimbursed for them, you know.

And one of those is Kinrix which is your -- you know, every pediatrician will tell you that the reason why there's an aggressive vaccination schedule is just because of the no-shows. So, obviously, when you do Kinrix and you're talking about tetanus, diptheria, pertussis, and polio myelitis, that's a good way of getting a lot

of children caught up.

So my question, Fatima, is: With all the grant money and, you know, even the FDA, CDC, everybody pointing out how we need to increase childhood vaccinations and also -- especially since the effect of the pandemic, you know, what is the answer why pharmacists who do -- you know, we did 70 percent of the vaccinations during COVID, and we do quite a bit of them now. I don't know what the overall percentage is but above the age of three right now.

But what is your comments on, you know, that particular problem, with trying to get reimbursed for getting these children caught up on vaccinations from a pharmacist?

MS. ALI: So just to clarify, is this children between three and nine with the provisions of the Public Health Emergency?

CHAIRMAN POOLE: Yes.

MS. ALI: Okay. So, you know, I think -- I think that makes sense. And I think in a previous PTAC meeting, we talked about, you know, one that would expire. At that time, we saw that it would expire

October 1st, 2024. I'm not sure if any updates have been made to that date yet.

But, you know, I think just in terms of the Public Health Emergency set to end on May 11th of this year and, you know, some of the provisions that we've allowed like COVID at-home testing and, you know, provisions of the PREP Act that allow pharmacies -- or pharmacists to administer vaccines to these children, there will be a transitionary phase. So it won't just be a cold-turkey stop on May 11th. You know, we're working through what that'll look like right now.

But, you know, in terms of vaccinations for children, I think it would -- it would certainly help. You know, we're looking at what that would look like from a cost perspective. We've pulled some data to see how many children are being vaccinated between those ages, and I certainly think we can help those numbers. And, you know, pharmacists would be a good advocate for providing those vaccinations.

So, you know, I do agree with you on -- on this concept. And from a quantitative

perspective, you know, we have the data that we have, but if you all can provide any additional data on how many children are being vaccinated since the -- since the Public Health Emergency began between those ages, we can certainly take a look at that.

CHAIRMAN POOLE: Yeah. In our government affairs meeting for KPhA yesterday, Dr. Freeman had some really recent statistics that I'll get from her, or I'll just have her get it to you. But they were quite alarming. And these were from just KYIR, and it was just for mainly public school systems. So if you included the home-schooled and the private school sector, those numbers would even go down more, or the percentages would obviously look worse.

So yes, I will get you that. And, certainly, our biggest thing right now is -- I mean, we're trying to get this taken care of statutorily to get it -- you know, to take the place when the government emergency is -- expires. And we're trying to get, as we speak, something to replace that. So when that goes away, we'll have something in

place. So we are working on that.

I just wanted to bring it to your attention, that there are some gaps in -- in the reimbursement for certain vaccinations that we'd really like to see for pharmacists, you know, to at least get paid for, to where they can offer those.

MS. ALI: So I just want to clarify. Is this from an ingredient cost perspective or from an administration fee perspective?

CHAIRMAN POOLE: Well, it could be -- it's actually both because, obviously, he's not getting reimbursed at all for any of it on Kinrix. And that's just the one he said is the most prevalent that he uses. But, certainly, if we're -- if we're trying to get children vaccinated, that would certainly help.

But, obviously, when you look at -- we just want to be reimbursed as other practitioners. And that's the main point, is that, you know, if they get paid for -- $15 for an office visit, obviously, we're doing interview. We're doing education. And then,

obviously, you have your standard admin fee that I believe is across the board. I don't think it's different per clinician, but it might be. But you would be able to tell me that.

But certainly looking at both because, right now, we're just talking about product reimbursement and then the admin fee. So the only thing extra would be the interview of children three to -- all adolescents on the COVID interview, which is mandated by Medicare.

Does anybody else have comments on this particular topic?

MS. ALI: Well, let us take the Kinrix comment back and just --

CHAIRMAN POOLE: Okay.

MS. ALI: -- stick with that and see, you know, what we cover for that specific area, the DTaP vaccination. So we can take that back and provide a response.

CHAIRMAN POOLE: Okay. Thank you. I really appreciate that, and I know he does, too.

MR. MUDD: Hey, Ron. This is Ben

from KPhA.

CHAIRMAN POOLE: Yes, sir. Go ahead.

MR. MUDD: Yeah. Just to elaborate a little bit on that. I mean, understanding that -- you know, it's our understanding that Medicaid does not get a rebate back on vaccinations. So, you know, we just want to encourage that all vaccines that are approved and are on the vaccine schedule would be covered by Medicaid and added to the PDL.

Even in the case -- let's say that, you know, the ability to administer via protocol were to go away, there's still the option to administer via patient-specific prescription. So, you know, just anything we can do to reduce barriers is helpful.

And I think, you know, the easiest thing we can do is just to -- if it's an approved product and it's on the CDC vaccine schedule, to have it covered by Medicaid. And especially if it's going to be covered on the medical benefit, it should -- there should have the same, the same coverage on the pharmacy benefit, just to have some

continuity between both sides of the benefit.

So we'd support that and then also, you know, want to keep looking at making sure that there is parity on the administration fee side, to your point, that -- just to make sure that all providers are -- of vaccinations are being treated equally.

MS. ALI: Yeah. So, Ben, just to provide some context for the group about how we, you know, choose vaccines for coverage, we reference the ACIP immunization schedule, you know, to come up with the vaccine coverage list.

So, again, we will look into the Kinrix and see if it's appropriate for coverage based on that. But I did want to, you know, just allude to ACIP.

CHAIRMAN POOLE: Okay. Thank you, Ben. Anybody else have any comments?

(No response.)

CHAIRMAN POOLE: Okay. All right. On new business, the first topic on the Amoxicillin shortage, that's Paula. And, of course, that's not the only drug that's being short, but it's a good example. So go ahead,

Paula.

MS. STRAUB: Thank you, Ron. Can everyone hear me?

CHAIRMAN POOLE: Yes.

MS. ALI: Yes.

MS. STRAUB: Okay. I really just wanted to address that on the PDL, DMS has one formulation, one generic formulation of the Amoxicillin 125 chew and then one formulation of the 250 chew on the PDL. And I know several of our providers have expressed concern, because of the shortages around the suspension, in trying to convert patients to the chewable tablets.

So any thought with DMS around opening that up and possibly adding more generic coverage for both of those medications?

MS. ALI: So just to ask a follow-up question there, the 125 and 250 that you're alluding to, are those on shortages by the three main wholesalers? What are you guying seeing from your end?

MS. STRAUB: I have reached out to several pharmacies and providers, and providers are being told they're getting

requests from pharmacies. So -- and maybe the other pharmacists on this committee can speak to that as well and let me know. But I know Norton's did a campaign as well as our providers have talked about obviously getting calls around the suspension and going to the chews and that also becoming an issue.

MS. ALI: Okay. From our perspective, it hasn't seemed to surface, you know, to a larger scale, you know. And for that reason, we have the one-time overrides in place, you know, via the call center. You can send us screen shots of, you know, what you're seeing on the wholesaler end.

I understand that it -- you know, it might be different for different pharmacies because you all might use primary and secondary wholesalers that are different across the board.

MS. STRAUB: Right.

MS. ALI: So, you know, we're more than happy to work with you all and see the evidence of the shortage and provide one-time overrides. It hasn't been as large scale as the Glargine and the Ventolin that we've

seen. So I think for now, you know, the Amoxicillin can likely just be handled through the one-time overrides.

CHAIRMAN POOLE: And, Fatima, to follow up on that and also 5(b) -- it kind of bleeds over into that topic -- it's been my experience that, you know, one -- you know, the big three wholesalers is Cardinal, AmerisourceBergen, and McKesson.

And it seems really misleading sometimes -- I mean, I use McKesson. That's my primary. And when I -- you know, when they do finally get decent availability of something, you know, it's allocated. So it's not like you can, you know, even stock up. It's kind of like you're just barely keeping up with the flow.

And sometimes you've got to make a decision that, okay, you owe five people, and you only get four in. I mean, so it's not -- it's just not a good situation sometimes.

And then even if McKesson may have it, with the allocated availability, then you talk to your colleagues that use AmerisourceBergen or Cardinal, and they're

not getting any.

So this -- I mean, this is unprecedented times, I can just tell you, for -- I mean, at least in my 32 years, of just -- you just don't know every day what's coming and what's not. You know, we try -- I mean, we have software that lets us know what we're not going to get.

But I have access, with the help of -- there's a couple of organizations that represent multiple secondary wholesalers. So I don't make 75 phone calls. But I do go through 75 different secondary wholesalers and many times strike out on what I'm trying to find. So that's a real -- I mean, it's just a real issue trying to get it in --

MS. ALI: So I do want to add -- and if everyone can mute their lines.

So, you know, I encourage the pharmacists specifically on this call to use the formulary search tools via both MedImpact and Magellan. They're both the same search tools. On the Magellan tool, you can search by NDC, which is a little different than MedImpact, but both should be providing the

same results.

And I'm looking at the MedImpact drug lookup tool right now, and I'm seeing, you know, various suspensions covered, different NDCs, different options. So those should be covered preferred without prior authorization.

And if you're having issues with those, you know, we're more than happy to look into it, and the call centers are also available.

MS. STRAUB: Yeah. But I do think there was just one generic version of the chews, the 125 and the 250. And I had MedImpact verify that because I did have some pharmacies and providers reach out that they were unable to get those.

So you're saying they need to call the help desk for individual overrides?

MS. ALI: Yes, if that is the case. But I am -- and, Dean, correct me if I'm wrong. I'm seeing different variations of those covered.

MR. BEUGLASS: Yeah. I think -- we were chatting here internally. I believe there's only one generic manufacturer of the

125 and 250s, is what we were saying, and that's what's creating that issue; right?

MS. STRAUB: Okay. Okay.

MR. BEUGLASS: Yeah.

MS. STRAUB: All right.

MR. BEUGLASS: There's only -- yeah, only one company producing it right now, is what we've been told.

MS. STRAUB: Okay.

MR. CARRICO: It's Teva, and they're supposed to have it shored up by the end of the month. But manufacturers are really good at giving you dates and then not sticking to them.

MR. BEUGLASS: Yes. Yes.

MS. ALI: We understand, and we've experienced that as well so...

Okay. Yeah. So, you know, again, those one-time overrides are options, and we also encourage you to reference the drug lookup tools.

CHAIRMAN POOLE: Do you mind, Fatima, to supply those to Ms. Sheets, so she can send those out especially to Ben Mudd, to send that out to all of KPhA to -- that they

know that formulary lookup tool is available for both Magellan and MedImpact, please?

MS. ALI: Absolutely. I can put those links in the chat right now as well.

CHAIRMAN POOLE: Thank you.

Rosemary, did you have any more comments on the brand-name shortages?

MS. SMITH: No. Really kind of just -- kind of ditto what you -- both you and Paula have said. We've seen our members across the state. But I do want to say, just as an update, that, you know, with -- Fatima has been contacting all of us to provide information, say, on the Lidoderm patches and on the Levemir. So the Department -- I want to thank Fatima for working with us on that.

And once, you know -- once they put out a PDL change, if we all realize that that isn't exactly correct, you know, it's correcting, you know, as that happened yesterday. So we are seeing just shortages across the board on all kinds of different things, and it depends on, like you say, the wholesaler. You know, we're with McKesson as well, but that changes from day to day, you

know, between McKesson, Cardinal, and AmerisourceBergen.

So I think it's just really important that Medicaid still, you know, continues to work with us, so we can provide these medications for our patients.

MS. ALI: Absolutely.

CHAIRMAN POOLE: Thanks, Rosemary.

And, Fatima, just to give you -- and this is just giving you information. I know Medicaid doesn't owe any provider, you know, a guarantee that their contractual arrangements are going to be met. But, you know, for the first time since 2015 in December, I did not meet the generic percentage rate that I needed to to get the full, I guess, bonus rebate.

And, again, it's -- and, you know, looking at it, you wouldn't think it would be -- make that big a difference on the brand-name formulary preferences where you get your rebates. But it definitely was the factor that put me, you know, under, under the percentage I should have been so -- or I strive to be.

So I just want to bring that to your attention, that obviously the more brand-name products you all bring on board for your rebate program, it does -- your providers out there are affected.

And, you know, I know at some point in time, you may have certain providers just say -- just tell their people they don't have that product because it is that big of a financial difference by meeting it versus not meeting it. So I just wanted to just give you that information.

MS. ALI: Sure.

CHAIRMAN POOLE: Okay. On the community health worker waiver, it's been submitted. Just the simple question: Are pharmacists and pharmacy technicians eligible under this waiver?

MS. ALI: Sorry. Is this for me?

CHAIRMAN POOLE: Yes.

MS. ALI: Let me look into that and get back to you.

CHAIRMAN POOLE: And my colleague, Cathy Hanna, who sits on the Medicaid Advisory Council, is on the line here, and I

know they discussed this in their meeting.

Cathy, can you unmute yourself if you have some more to add to this?

DR. HANNA: No. It was just a question, basically. Because I know in some other states, that this has been allowed, you know, where they designate that a pharmacy technician can be in this group.

We are perfectly aligned based upon the activities that we do in pharmacies and that our technicians do as well, and so it just seems like the perfect fit.

And so, you know, I've been to some national meetings where they've talked about this, and I just felt like it was something that maybe should be asked.

CHAIRMAN POOLE: Okay. All right, Fatima. Just -- if you don't mind, just if I don't -- if we don't get any answer between now and our next meeting, then obviously we'll put that on old business to -- to get your -- DMS' position on that; okay?

MS. ALI: Okay. Sounds good.

CHAIRMAN POOLE: This is just a mention in general discussion here.

Obviously, we've already talked about this because we can look at being able to, you know, add clinical services, which, again, I understand the network changes that would have to occur. But we can also do it in baby steps and, you know, do a pilot program that can show the savings before you, you know, change everything.

But anyway, it's just -- it was discussed at the prior MAC meeting. It seems like every other healthcare provider was asking for increases. And, obviously, we take a lot of pride in the fact we, you know, hear that we've helped DMS to save a lot of money with your rebate program and just looking for that consideration.

I know there's some potential bills that'll come out in this regard. But it's just on our -- on our radar, and we just wanted to -- obviously, I know this is always a discussion that Commissioner Lee and you have. And we just -- we just want the availability to talk to you about any increases or an increase in doing other clinical services.

And if there's anybody else that has comments on this, please speak up.

MS. ALI: So I think from a reimbursement perspective in terms of the cost of doing business, you know, I think that applies everywhere across the board, the cost of food, the cost of gas, so on and so forth. You know, I think from a Medicaid perspective, you know, we need to be good stewards of taxpayer dollars and ensure that there's provider parity there.

You know, I know that providers across the board are requesting increases in payments, but that doesn't mean, you know, that it will go through, you know, just because the cost of business is increasing.

We're well aware of that and, you know, I think our reimbursement rates stand as they are at this point in time. But, you know, we -- again, we are aware that the cost of business is increasing.

CHAIRMAN POOLE: Okay. Okay.

The next -- we don't have anything under recommendations.

MR. CARRICO: Ron, this is Matt. I

was wondering if I could add one thing to general discussion.

CHAIRMAN POOLE: Yeah. I'm sorry. I'm sorry, Matt. I meant to call on you there. Go ahead.

MR. CARRICO: In the last couple of months, I've been getting a number of phone calls from an -- one in particular out-of-state pharmacy that does mail order, and they're calling on my Medicaid patients. And they're saying that they want to get profiles transferred, everything but the controls. How sweet of them.

When I talk to the patients, they are saying no. They've called me. They've called me multiple times. I don't want to do this. I don't know how they got my number.

One patient, they even told them, oh, you've been taking your medication wrong. I went through their medications with them. They hadn't been taking it wrong. They're just trying to coerce people.

And the one thing I noticed with the patients are they're all under WellCare. I'm just wondering: How is an out-of-state

pharmacy getting Medicaid patient information to cold call them and try to coerce them into switching their prescriptions to them, and is this allowed?

MS. ALI: So, Matt, I will say that you are not the first person to bring this up to us. Do you have the name of the mail order pharmacy specifically that it was?

MR. CARRICO: Yes. I mean, do you want me to say it on the meeting or just email you?

MS. ALI: You can email me but, you know, again, it's not the first time we've heard of this. If you can just send us the name of the pharmacy and a brief description of what's going on, we can take it back internally.

You know, I do want to point out that there is an any willing provider clause. So, you know, out-of-state pharmacies can enroll with Medicaid as long as they meet the requirements, sign up via Medicaid, you know, through the appropriate processes that you all have done as well, to be a Medicaid provider. So, you know, that is an option.

Again, no one can be forced into utilizing mail order, so I think, you know, that was a problem before the single MCO PBM where PBMs had contracts with specialty pharmacies. And they'd be -- you know, members would be quote, unquote, forced into using that specialty pharmacy.

So, you know, that doesn't exist anymore, and it shouldn't. So members should not be forced and coerced into using a specialty pharmacy. But members also have the right to, you know, transfer their prescriptions if they choose.

MR. CARRICO: I don't disagree with that. But I'm just wondering: How are these pharmacies getting these members' numbers to call them out of nowhere?

MS. ALI: You know, that, I'm not entirely sure of their internal operations and how they're getting that information. But, again, it is -- it is something that we -- we have had come across our desk in the past, so I can discuss with you a little bit more offline.

MR. CARRICO: Okay.

MR. ALMETER: If I could, Ron --

CHAIRMAN POOLE: Yes, sir.

MR. ALMETER: -- and step in. And I'm going to say, Matt, I've had the same thing happen in our pharmacies. It's very frustrating. We have a term for it. We call it pharmacy pirates when they come and they do that.

There's another thing that -- another interesting phenomenon that happens, and this has to do with relationships that I don't understand. I understand vertically-aligned relationships to some degree, but there have been cases where -- and we've reported this to the Board of Pharmacy. They really don't know what to do with it -- where it's an expensive drug, and it has a patient assistance program.

And so you fill out information on the patient assistance program. And if you look at the information you give them, it has a lot of the elements that are needed for a prescription. And sometimes after that occurs, a pharmacy has used that information to fill a prescription when we did not

transfer anything. We've seen that kind of activity happen before. It's -- you know, it's troubling.

And we've also seen activity where we get a prior auth for a prescription and then a vertically-aligned pharmacy, after getting that prior auth, will contact the clinic and say, hey, we have a prior auth here. Can you just send us the scrip?

We've seen -- we've seen this kind of activity before, so I'm not at all surprised in what you're reporting. And we've complained to the Board of Pharmacy. I just don't know if the Board is in a position to resolve some of these issues.

CHAIRMAN POOLE: Well, Philip, you certainly would think that, by one description you just went through, that they're filling a prescription -- or they're filling an order without a prescription, without a legal prescription. So that seems like that would -- and, Meredith, if you can --

MR. ALMETER: It might have been before her --

CHAIRMAN POOLE: -- please --

MR. ALMETER: So we've made complaints in the past before so...

CHAIRMAN POOLE: Okay.

MR. ALMETER: And I'm not going to share specifically which -- like Matt, I'm not going to share who they were, but we've made complaints before. And that activity -- I would not be surprised -- like what Matt just said, I would not be surprised if that happened today in several of our pharmacies where our patients get contacted by, you know -- I mean, it wouldn't be shocking if the payer, even though they weren't -- if you have a contract with PBM, if the payer has the information to contact that patient to say, hey, we'd like you to fill that prescription with us, you know, so...

MS. SMITH: Ron, I can say across the state with our members, this is widespread. It's happened at our pharmacies where they're faxing -- tying up our fax machines at our stores for two and three hours at a time, just faxing through the same patients. We've looked at some of ours. One

of our patients was deceased. She had passed away, like, six months before. Several of the other ones that had verbal authorizations were from June of last year, and they were just being faxed through in January.

And we contacted, just personally from our company, all of these patients, and none of them agreed to this at all. And it has been two different companies. And, again, I don't think any of us want to say this online but -- so this is a widespread --

And I think I agree with Matt. How are they getting this information? This is HIPAA information. How are they getting this information? It's just not Medicaid. It's also commercial plans. So this is a very widespread issue, I think.

CHAIRMAN POOLE: Okay. Well, certainly, Fatima, we would appreciate any help that DMS can give us on this, you know, concerning your -- our network so...

I just want to point out the next MAC meeting is March 23rd. As of now, I can present just our minutes and what we discussed today.

Our next meeting is scheduled for April the 12th, be at the same day and same time, Wednesday at 1:00 Eastern, 12:00 Central.

And I just want to thank Fatima for -- you know, I know a lot of times, you may feel that, you know, you're a dartboard, and you're a target. And you're not. We rely on you heavily to get answers and to go over things and to run ideas by you. And you're always very gracious to work with us, and I just really appreciate it.

MS. ALI: Absolutely.

And I did want to just bring up one point of clarification with regards to -- so I did want to just make sure that -- you know, any dollars that are recouped by MedImpact go to the State, so I just wanted to make that clear. I know we were talking about audits beforehand and, you know, that might be a misconception.

CHAIRMAN POOLE: Okay. Thank you.

Okay. Thank you all for your time and also thank Dean and Jennifer from MedImpact today. We really appreciate you coming on, and I'll be getting some information together

for you and send it out to you just for future discussions on it, on those topics we discussed.

But do I have a motion to adjourn?

MR. CARRICO: So moved.

MS. STRAUB: I make a motion.

CHAIRMAN POOLE: Okay. Motion, I believe, by Matt. Second by Paula.

All those in favor, say aye.

(Aye.)

CHAIRMAN POOLE: Any opposed?

(No response.)

CHAIRMAN POOLE: All right. Thank you all. Have a great day.

(Meeting concluded at 1:53 p.m.)

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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 16th day of February, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR