DEPARTMENT OF MEDICAID SERVICES
PHARMACY TECHNICAL ADVISORY COMMITTEE

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WEDNESDAY, OCTOBER 2, 2024
10:00 A.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 McCormick
Philip Almeter

MS. BICKERS: Good afternoon. This is Erin with the Department of Medicaid. It is just now 1 o'clock and our waiting room is still clearing out so we will give it just a few moments before we get started.

MR. POOLE: Okay. We have four people on here which makes up a quorum. So we can go to the top of our agenda.

MS. BICKERS: We are at approval of minutes.

MR. POOLE: Okay. Okay. I sent out the minutes and the recorded minutes prior to -- actually, as soon as I received them, I sent them out. Does anyone have any additions or edits? If not, could I have a motion to approve?

MS. BICKERS: Ron, we have to have your camera on for voting, please.

MR. POOLE: Okay. Sorry.

MS. BICKERS: And we are also still clearing the waiting room, just FYI.

MR. POOLE: Okay. Do we have a motion to approve the minutes?

MS. SMITH: I'll make a motion.

MS. STRAUB: I'll second.

MR. POOLE: Motion by Rosemary, second by Paula.

All those in favor say, "aye."

TAC MEMBERS: Aye.

MR. POOLE: Okay. Any opposed? Okay. Motion carries.

As far as Old Business goes, I wanted to just give everybody an update that we certainly are going to be looking at taking care of -- since it was a standard in so many other states where pharmacists and pharmacy technicians are leading the way with community health workers, we are going to take care of ours by statute since Medicaid doesn't see that pharmacists are -- shouldn't be involved in this situation, even though there has been plenty of documentation nationwide being as it is the nature of community pharmacy to already be involved in our customers and patients lives, to the point where we are helping them with transportation already; we are helping them get the services that they need

already.

So it's very disappointing that every time something new comes out, the state of Kentucky thinks pharmacists are the doormat of healthcare and everybody can wipe their feet on us. It just gets a little old, because we already are considered, by statute and everything else, to be providers, so it's just very disappointing.

So we are going to be looking at -- even I put in here at point 2 there where Idaho and Alaska, their Medicaid is making strides in going ahead and writing statutes for their departments that pharmacists are part of the healthcare team and providers. And I will just go ahead and pull up my agenda so I can --

I wanted to give the rest of you, Meredith, Paula, Rosemary, if you had any other comments about the topic of community health workers and pharmacists being recognized by Medicaid in other states. Okay.

MS. FIGG: I will just say that

I agree. These are services that we are providing and we are well connected in order to provide, and we have that access point with the patient, so that is the biggest benefit I feel that we provide, is just having that touch point with them and then also being so involved with the community and knowing where those resources are.

I am like you. I see on NCPA and I get emails almost weekly about states that their Medicaid programs are doing things with pharmacists as providers or providing some sort of, either compliance packaging, or counseling, or whatever it is. It just seems to be a trend upward by a lot of states, so I don't think we are asking for anything that other states aren't pursuing and adopting as well.

MR. POOLE: Yeah. Thank you.

MS. SMITH: I agree with that as well.

MS. STRAUB: As well. Yes. I can't say anymore than what has already

been said. Agree.

MR. POOLE: Okay. Do we have -- I saw Dr. Theriot on the line. Can somebody give us an update on the HPV vaccine? I know the protocol is specifically for Medicaid patients, and I just want somebody to give us an update, please.

DR. THERIOT: It is. The protocol is out there. We finalized it and it is only for Medicaid patients, and then it just specifies the ages. So if you get both vaccines or two vaccines before you are 15, that's all you need; if you wait till after 15 years of age, you need three. I think it says everything that it needs to say.

MR. POOLE: Okay.

DR. THERIOT: Thank you.

MR. POOLE: And where can we -- where can people go that are listening in on getting that protocol?

DR. THERIOT: I think it was sent out already, but I will double check on that.

DR. ALI: Yeah, I will have to check on that to make sure it is on the MedImpact website, but that is where it should be.

MR. POOLE: Okay.

And then, any update -- we have vaccine counseling. Last time we updated it was three out of the six MCOs. Passport, Anthem, and United Healthcare are processing paid claims, where Humana, WellCare, and Aetna had not processed any yet.

Does anybody have any update for us? Are all MCOs processing that or is there a standardization that, you know, instead of learning six different ways to bill, is there a standardization that is out there for this billing?

MS. GATEWOOD: Yeah. Hey, Ron. It's Emily Gatewood.

I can update that Humana is now successfully paying claims. They were able to reach out to Availity, which is the platform that we have been billing most of the MCOs through, and we were able

to reach out to -- Humana reached out to Availity and was able to take off the rejection requirement of having a referring provider that was not a pharmacists off of the claim submission. So now that that has been removed, claims seem to be going through. I do not believe we have got check-in-hand from any of those, but we are at least not getting a rejection at this time from Humana.

MR. POOLE: Okay.

MS. GATEWOOD: Ben may be able to update a little bit more on WellCare. WellCare was having the same issue as Humana, and I believe that they have started that process of making the change in Availity, but Ben was the one communicating with them, so I'm not sure if they have gotten back. We do have some claims ready to go as soon as we get the okay from WellCare that that rejection has been turned off, and we can test those claims.

MR. POOLE: Okay.

MR. MUDD: Yeah, I can chime in.

We do have paid claims from Humana now, and they are processing through Availity; and then WellCare, the claims rejected initially on Availity, for the referring provider. I have been told by them that they are still going to pay those claims even though they were rejected, and they are working to put a fix in Availity, but I can't confirm if the fix has been put in or not. I do know, for Humana, the claims are processing through Availity, as they are supposed to.

That leaves Aetna, that I personally have not confirmed that claims are going through or not. And we are still working through, you know, like, I had some Anthem issues last week and we thought they were fine but, you know, we did outreach to them and they fixed it, so I don't know how to communicate that with people, but I think Emily is a good resource if you have problems with any specific MCO and billing.

We are glad to -- KPHA is glad to coordinate and help get those claims

paid, but all in all, I think they are starting to pay them, except for WellCare. That's the only one that is not processing that we know of.

MR. POOLE: Is Aetna now going through, too?

MR. MUDD: I don't know. Because I haven't talked to anybody that has --

MR. POOLE: Okay.

MR. MUDD: -- billed claims, so. They are not on Availity -- at least on the free version of Availity, so I just haven't had anybody that's had claims with them.

MR. POOLE: Okay.

MR. MUDD: It seems like maybe their population of members -- maybe they don't have as many members in our area, or what, but they don't have any claims yet.

MR. POOLE: Okay. And are you aware of any other softwares, besides Availity, that anybody is using, just curious?

MR. MUDD: I'm not. So you can

use any -- most pharmacies that do DME have their own way of doing medical billing. They should all be going through, I mean.

MR. POOLE: Okay.

MR. MUDD: It's just converting. It's all going through the 1500 form eventually. But we just recommended Availity, because there is no cost to use it. Once you get set up, it's really very simple to bill these claims, and then you always have the option to paper bill, too, if that's something pharmacies want to do.

Honestly, Ron, you probably get a return paid claim quicker if you do a paper claim, but that would take a lot of time to fill that out, but, you know, it is a manual process and more likely to pay.

MR. POOLE: Okay. Thank you.

MR. MUDD: You're welcome.

MR. POOLE: I asked for a response on -- Medicaid's response on action items from our meeting on 8/21. Cathy Hannah was given my report in the

MAC meeting. It was conveyed to them, or people on the MAC, that an action report was not submitted, but there was a mixup because I did submit it three hours after our meeting, and Erin did say that she did get it.

So I don't know if, Fatima, if you have had a chance to -- or anybody at Medicaid -- had a response to where we would like the motion passed for Kentucky Department of Medicaid Services to accept pharmacists as providers, that are able to order, manage, and bill for community health workers, patient interventions, visits and encounters.

MS. BICKERS: Ron, I did want to apologize, again, that I did miss the recommendations in your report. I do apologize and I did send that out to staff as soon as it was received, and they do have 45 days from the MAC to respond, so I don't want to speak for Dr. Ali, but I do want to apologize to the TAC for not being on top of my game on that one.

MR. POOLE: That's okay.

MR. DEARINGER: This is Justin Dearinger with the Division of Healthcare Policy.

I just wanted to talk about community health workers being billed for under pharmacists. We are aware of the recommendation that you all have sent. We have been looking at that for a couple months now, done research, and that is under review and advisement. I just wanted to let you all know that we are still working on that, and haven't come to a decision just yet, but that is in the Commissioner's office, and we are reviewing that currently.

MR. POOLE: Okay.

We have actually had people -- when this was coming down the pipe for community health workers, that had their pharmacy technicians go ahead and get the community health worker training, so we have had quite a bit of people out there already that are qualified. We just didn't know that the brakes was going to be put on it.

MR. DEARINGER: One of the questions that I did want to ask is with that -- we do CPT code billing. And I know you all do some vaccine billing administration or vaccine education billing through CPT codes, but the utilization, I wasn't sure on that side what kind of utilization we were getting. Are you all using that billing on the medical side more frequently or more often? Is that --

MR. POOLE: That is the biggest growth area that we have right now, is to continue to develop more and more programs and expand our medical billing.

Obviously, with House Bill 48, that I have referenced further down there, where, you know, I think everybody can think of as 2021 House Bill 48 passed, and I think since then, other states -- I think the state of Washington was the first to start delving into the medical billing world, and probably had a six or seven year start on us, but as we know, whatever strides or success stories you

have in one state, it doesn't convey it to the next state, because of the differences in all of those third-party administrative plans are basically state-to-state level.

Obviously, you have some insurances like Anthem that credentialed pharmacists have been willing to work with us, and we are just trying to build that network of clinical services that can, obviously, be paid for and we are also trying to work through those softwares, too.

Certainly, the CPT codes aren't the issue. It's just getting, you know, just like myself, because of the Kentucky Board of Pharmacy protocols, I've done 300 TB skin tests with the Medicare population, and I am still trying my best to get paid for because of the limitations in Medicare.

I've obviously got an ordering physician, but I'm the one doing the work. So that is just an example. But that is certainly a huge push in priority for pharmacy right now, to answer you with a

lot of words here, but it is certainly the biggest growth area for us currently.

MR. DEARINGER: Services for pharmacy is definitely a priority for us, and we have that as one of our top projects. Just so you all know we are currently, actively, working on that.

MR. POOLE: Okay. Thank you.

DR. HANNA: This is Cathy. I just wanted to reiterate that I was able to give the action item report at the MAC meeting, so they did, you know, the other MAC members did hear it, and so I think that that is a good thing, because the head of the MAC, Sheila Schuster, was very receptive, especially on the point of the administration for our long-acting antipsychotics, because we had discussed that in the past as well, but that is very much needed in our communities. You've got the patient there, and you can't give it to them, to make that patient have to go somewhere else, or, like, many pharmacies are having issues being reimbursed for administration costs. So

they are very receptive and I hope that there is some movement in that area, too.

MR. POOLE: Thanks, Cathy, and things for bringing that topic up.

I've got -- two of my pharmacies have counseling centers -- one of them is next door to one of my pharmacies, and one is very close, within a mile, and they have a huge need, because I have met with them, and these are people who -- these are centers that work with addiction medicine, and also mental health. So we are having -- they are having, really, a tough time, because not only are these two counseling centers, you know, working with both of those people, they also deal with housing shortages. So I didn't realize this until I met with them. Just in Central City alone, which has a population of 5,500, they are housing 100 people in Central City. So it is amazing, the needs that are out there, and so they really need our help, because obviously, we have the computer systems that can keep up with, you know, for Medsync or Autofill to

help them manage these patients, like, let's just say they are supposed to come in every 90 days, yes, they can keep track of that, too, but we are the ones that certainly has programs geared towards calling people ahead of time, reminding them about getting their medicine filled, reminding them about, it so important to stay compliant on their medication. And I know we do a lot of that, too, but they really, between managing the rest of their patients' lives, especially the ones that they house, they've got a lot to do, and they certainly have just asked for that.

Now, I understand, depending on the insurance, that has been a deterrent in some cases where the insurance isn't paying for -- all the way paying 100 percent for the drug, and then they won't pay for an admin fee, so that is rather discouraging and disappointing that when we are trying to help manage these patients, I know there are some barriers to care, and certainly they aren't getting properly reimbursed instead of below your

cost is a real issue.

So I am hoping that the Department of Medicaid services, and I know they aren't covering all of the patients that I am talking about, but they do cover a majority that they will, kind of, be a watchdog on this to make sure that those reimbursement rates are where they should be in order for these people to get the care they need.

And I know it is a huge need in being already consulting and working with these people as reaching out to us with the issues that they have in managing their patients.

I didn't know if anybody else had a comment on that. I just mentioned more and more on item B, there. It just seems like more and more patients are asking us to help out with any kind of administration they have, whether it is allergy shots, B12 shots, testosterone shots.

Patients are, for one, it is going to save money where a patient

doesn't have to go for a physician's office visit. If they can just go get the administration of whatever medication, it just seems like it has gotten a whole lot more in number in popularity, because people aren't just willing to sit for two hours in a doctor's office waiting to get their B12 shot, or their testosterone shot.

The huge need is there, so I'm just hoping that a lot more will be opened up in just paying for administration fees for these people.

I mean, there is even Depo-Provera for patients seeking -- just people in my world of people needing the help. So I hope that does -- I hope a lot more insurance companies understand that for compliance measures, the public is demanding that we assist them with their administration of various medications.

Okay. As far as FYI, I always have that in there for the main contacts. And then as far as vaccine counseling billing, it's got the allowable in there

and what it should pay. There are the contacts for each of the MCOs that are available.

Could you move the agenda on down, please?

Okay. New business, unless somebody had another comment about what we discussed so far.

It's kind of what we've already talked about, having those standard procedures for pharmacies to use for medical billing; for vaccine counseling or other medical billing that is currently paid for, or should be scheduled to be paid for.

And it kind of goes along with what I referenced down below. There has been references, or some comments made in the past, about examining these situations for duplication of services.

Well, certainly, nurse practitioners are a complete duplication of what a physician can do. So that should not be a deterrent. The thing about it is, we already have a shortage of

physicians, and that's going to get worse. Not by my surveys, that is by national surveys, and certainly, to reach out to patients to get basic or more fundamental health services, we need pharmacists to be able to help out with those.

So I hope there are people at the Department of Medicaid Services that understand that, because of the touch points and the access that people have to us, that a lot more healthcare can be delivered, just the basic fundamental services, and certainly the more dynamic and diagnostic services are still going to be with the nurse practitioners and physicians, and give them more time to see those patients.

I am just hoping that Medicaid, eventually, will, certainly, write the format or get the format built for us to be able to -- just like right now, there is insurances out there that are paying for medication therapy management and complete medication reviews, even medication reconciliation, because it

seems like when we are getting ready for complete review, paid for by the commercial plans, and part D plans, it seems as though, when we are doing those metrics, that is where we are finding some pretty big errors.

My worst-case scenario happened a few years ago in doing a complete medication review and doing the metric before, this patient was on two drugs that had been recalled, taken off the market. And that is because they were going through mail order, and had stockpiled several months worth.

So obviously, in these, there are a lot of Medicaids across the country that are paying for complete medication reviews, and other targeted drug therapy-related interventions.

So I don't know if the team if you want to comment on -- is their anybody in Medicaid that is looking into developing these other services that we have mentioned many times before?

DR. ALI: Yeah, so just from a

general perspective, I think a lot of these requests need a thorough fiscal analysis to see what the cost to the department would be, what the current utilization of a lot of these products, like what these antipsychotics look like, and what a reasonable administration fee would be.

I think, in terms of pharmacists as provider status, it has been something that floats around from year to year, and obviously, there hasn't been a firm decision on adding pharmacists as providers. You know, I think a lot of this will require extensive systematic changes and just a lot of financial changes as well.

So from a budgetary perspective, there are a lot of players, like finance, Justin's team, our team, so on and so forth, so I think, kind of, one step at a time right now. We have the vaccine counseling that is being billed via the CPT codes, and we are monitoring that pretty closely to see how many claims and

how heavily that is being utilized.

I consider the vaccine counseling as almost a pilot approach to potentially adding some more CPT codes in the future, obviously, after those analyses are completed.

So I will say that a lot of this requires some extensive research. You know, that is currently being reviewed by the department, to Justin's point, at least from a CHW perspective.

MR. POOLE: Okay. And certainly, we are not -- we obviously see where other healthcare entities have made requests, and it seems like Medicaid has not had an issue building out, for whether it is optometrists or some other, dental -- other entities that are out there that have made requests, and it seems that that got built in a pretty quick fashion.

I am still trying to understand with House Bill 48 being three years old, and, certainly, when you can look, just how chronic-care management is managed

by -- successful chronic-care management is managed by hospital care pharmacists and clinical pharmacists in that role, it certainly seems like that would be a win-win when you are having people's drug therapy managed.

Yes, it is still under instant to billing, but the successful programs are ran by pharmacists, so it is just something that I would like to consider. I would like the Department of Medicaid Services to actually consider, especially being that this is being paid for in other states.

And I was asked, does anybody else have any other comments on medical billing or --

DR. ALI: I think Justin has his -- oh, sorry.

MR. DEARINGER: Yeah, really quick. I just wanted to comment.

I know it does seem like it has taken us maybe an extra long time on this issue. I think there are some things with pharmacy of why it's different and why it

takes us a little longer.

We have set up in our state plan amendment, through CMS, exactly the way that each provider type is able to bill, the way that they are able to be reimbursed.

And then, in addition to that, we have our funding and the budget set up on exactly what things and amounts that those provider types are going to be billed for. So when we add any kind of service, one of the steps -- we have to look at all of the other states, the surrounding states that touch Kentucky, and then we have to expand that to even more states, and then we have to look at CMS requirements and guidelines, and then we look at private insurance on top of that, and we pull all of that together.

So we have to do all of those different steps, and then on top of that, we have to look at the budget and exactly how all of that fits, because we don't know, it is different than adding a service for dental because -- a dental

service or dental, let's say we add a CPT code to the dental fee schedule, we already know how much utilization is there, we know if it is going to remove or take away from other dental codes or not, adding services, medical services, for physicians -- or for pharmacists is not something that we don't have built into our financial model, so it just takes a lot more time.

On top of that, we have our whole system, which right now, you may or may not know we are moving from a MMIS system to the MCAF system, so our entire system is changing. We are trying to work that out and configure that in addition to making sure that all the different provider types can bill the same and have those issues.

There is a lot more that goes into it for pharmacy, but when you talk about all the different things that you all can do for the medical benefit, we see that, and we are excited to possibly implement that, but it takes us a lot of

time to review that, to put all of that together, to come up with an informed final decision. And it is not just one decision about CHW workers or diabetes counseling, because once that door opens, it will open the door for all of those things and make it a lot easier to include all of those things.

And I know it is not maybe what -- I'm just trying to give you some understanding on the process of what we all go through and the reason for the timeframe that it just takes a little bit longer, possibly.

MR. POOLE: I appreciate your explanation. You educated me quite a bit over there.

Ben, you've got your hand up?

MR. MUDD: Yeah, Ron, thank you. I think it all boils down to one thing and that is that we need payment purity. That is going to be our priority here in SKPHA in the future.

All of these things that we have talked about, these aren't services that

are covered specifically for pharmacy. They are covered for all different provider types, and all we are asking for is a level playing field there.

So I appreciate all of the comments that have been made, but we have this conversation over and over again, and I think we need, as a profession, to get behind that concept of doing what we did with House Bill 48 and applying those same principles to Medicaid, and doing that in a transparent manner through the legislature that everybody can comment on.

So I look forward to continuing that, but I did want to follow up on the concept of, we're using vaccine counseling as a pilot, and I think that can be really good or bad. And you can look at it and say: Well, nobody is doing it.

And if we implement payment purity, then it's not going to cost very much money, because pharmacists aren't participating, so you can look at it that way, or you can look at it and say: Well, pharmacies aren't participating, so they

must not want to -- they must really not want to bill the medical benefit.

So I don't know --

MR. POOLE: And Ben, as you well know, a lot of pharmacists have tried to bill that, and got discouraged early on, and didn't get paid for, so -- a lot of them, especially when you're talking about the amount of money we are talking about here, they spent how much time -- full-time employee time to try to bill something that, in the matter of an hour, you spent that money, paying employees to help you do it, so that is part, as you know, that is part of the issue.

MR. MUDD: Yes. All of this plays. And I am not speaking positive or negative. I'm just saying that is the reality of using that as an example. Like, you can look at that either way however, you want to, but I'm sure there will be a fiscal impact of moving forward with this but, you know, the way that I think about it is, if somebody needs to get a long-acting injectable administered,

somebody is going to bill for that service, unless there are pharmacies that are doing it for free today, perhaps that exist, but they are going to take that back to clinic. Somebody is going to administer it, Medicaid is going to pay for it.

If somebody has strep throat, they have to get tested, somebody is going to pay for that. I don't think that when we score these things, they are looking at the potential cost savings of, you know, how many people are we going to keep from going to the emergency room or urgent care where those visits are more expensive and bogging down our ERs across Kentucky. I don't know that those things get factored for. Perhaps they do, maybe Jason can talk about that, but, you know, like I said, at the end of the day, we just need to really get behind this concept as a profession and push it forward together, and I think it would be great if we could have the support of Medicaid when we have those conversations that they are with the

profession and not working against us and it sounds like that is where we are going and I speak with joy that that is where I think we are going, so whatever we can do to continue those conversations, let's do that.

MR. POOLE: Thanks Ben, for your comments.

Hopefully, Cathy is on here with us. Because I know very little about this topic, but I put it on here: What can pharmacists help out with, with to-do list services, which was Senate bill 74. Cathy, are you still on here?

DR. HANNA: I am on here. And I really don't have a lot to say. I don't know on that.

Fatima, do you know on the doula services? That came up in the MAC meeting, but I don't know exactly where we might play a role there.

MS. GATEWOOD: Right. And I think a lot of the SMEs on this topic are not on this call, so if you want to send that to us in writing with some additional

context, that would be helpful for us.

MR. POOLE: Okay, because I am learning about this too, and Cathy, it sounds like you heard it in the MAC meeting, so if you can help me make some comments. I just put the SB 7 -- I don't know if it is the whole -- I think it is a whole -- SB 74. I didn't put it in the format because it reformatted when I did it, but anyway, we will send that to you, Fatima, and hopefully we will get some more clarification on what Medicaid needs

MS. GATEWOOD: Okay.

MR. POOLE: For pharmacists to help out there.

DR. THERIOT: And right now the cabinet is putting together a doula report. Basically, looking at what other states are doing, how many other states are covering doulas, and how are they covering them and what are they paying them and, you know, how is it working out for the Medicaid population, and what can Kentucky do as far as doulas go. So that report will be out at the end of the year.

MR. POOLE: Okay.

DR. THERIOT: Kind of go from there. But that is mainly what that bill was saying was about doulas. They wanted us to do a report on doulas.

MR. POOLE: Am I correct that this is in the infancy, or the billing phase?

DR. THERIOT: Yes, yes.

MR. POOLE: Okay. Thank you, Doc.

DR. THERIOT: Thanks.

Okay. Erin, or whoever is controlling, could you go on down, please?

And that's just a list of different things that pharmacists are doing that's getting paid for. Actually, our Kentucky Board of Pharmacy, I had the privilege of being on a committee to develop a lot of these protocols, and then I had the privilege of serving on the Board of Pharmacy. I didn't know at the time that I was going to be on the board with Cathy Hanna, who is also on the call here, to pass some of the first ones and

certainly one that is not on their -- would be, you know, diabetic self-management education and there's obviously some federal guidelines on that, complete medication reviews, which are again, it's not a protocol, but it is done every day in the pharmacy, working with the part D plans mainly, but also other private insurances, too.

The compliance, compliance packaging. That is something that, Fatima, in other states that Medicaid is paying a little bit more for because obviously, this is something that we all can quote the stats about. If somebody is compliant, how much healthier they are, how much less access to other forms of healthcare out there, so it saves money, you can go on and on. The number one reason why people are admitted into the hospital or nursing home is because of poor drug management. So again, we can go on and on and on about this.

It might be Mr. Dearinger makes a comment on this, too, but has this

conversation happened at all if somebody is part of a compliance packaging program, of being able to get a little bit more of a reimbursement when providing that service?

DR. ALI: So I might not be too familiar, but, I guess, is the service such that the member is compliant and that's where the reimbursement comes from? Am I understanding that correctly?

MR. POOLE: No. It is people that are more medical at home.

DR. ALI: Oh, I see.

MR. POOLE: Obviously in the nursing home there is a difference in reimbursement, but these are people who, in order for somebody's mother, father, grandparent to stay-at-home, a lot of either their children or even grandchildren will say: Hey, I know that this is going to help out mom to be able to manage her medicine. Because again, that is why they get admitted into nursing homes and other facilities. So there are certain insurances across the nation that

will pay more for compliance packaging, whether it is multi-dose compliance packaging, or even unit dose or Bingo cards. Basically, looking at the people who are homebound and it allows them to stay out of the more expensive healthcare facilities to be able to manage their drug therapy at home.

DR. ALI: Yeah, so that is something we have had in place historically. I believe it is a 2-cent per unit dose reimbursement. You know, I'm not sure that we have lettered on it in a very long time, probably before my time even, but that is implemented in our system for long-term care members.

MR. POOLE: Well, but how about for those people who are medical at home? They are not, technically, now they have designated those as long-term care, but they are not getting -- the Medicaid is not paying for any other long-term care benefits, and basically, the insurance companies that are paying for medical at home, it is the designation of the patient

that cues the insurance in for a little bit better reimbursement on the drugs, because they all are being packaged for compliance purposes. So it is different from somebody who is just in a skilled nursing facility, or a registered group home, or any kind of licensed facility. So that is more what the question -- and this has come to me from several of my colleagues, and not only that, even a chain pharmacy that is doing compliance packaging.

DR. ALI: So is that based on the members place of service code?

MR. POOLE: Yes.

DR. ALI: Okay. Let me take this one back and just double check on what we have coded in our system, and I can follow up in via email.

MR. POOLE: And I will do a better job of listing the options that we have right now with the different patients that are not in a skilled nursing facility where their insurance companies are paying a little bit more. So I will look at

these different designees persons codes and I will send information on that, too.

DR. ALI: Okay. Sounds good.

MR. POOLE: Okay.

I think, Erin, do you have -- or does anybody else have anything to go before the P-TAC committee today? And if not, Erin, do you have the date of the next P-TAC meeting?

MS. BICKERS: Give me one second. My mouse is just moving really slow today.

MR. POOLE: I forgot to put that on there.

MS. BICKERS: It is December 4th.

MR. POOLE: All right. December 4th.

MS. BICKERS: And I am currently working on the 2025 schedule as well.

MR. POOLE: Okay. This schedule seemed to work out pretty good the way you did it. So I know the second week in October is a big date for a lot of people for fall break with our public school

system, so that is why we had it early on. And December is just getting a little further away from the holiday season.

Okay. Does anybody else have anything to go before the P-TAC?

MS. BICKERS: Dr. Hanna has her hand raised.

MR. POOLE: Oh, I'm sorry.

DR. HANNA: Yes. Thank you. I just wanted to bring up something when Ron was talking about the compliance packaging.

I think that, in addition to the compliance packaging, which we all know can be very beneficial especially with many of the patients that we work with, there are some pharmacies that are actually tracking adherence, and I think that that is very important. That kind of falls into some of our discussion with the community health workers where some of these pharmacists interact with them on a weekly basis and the benefits of that are overwhelming, and I think that we need to look at that closely, because compliance

packaging is so critical, I think for many of our patients, for many different reasons. So very vulnerable population.

So I'm glad that Ron brought that up. Thank you.

MR. POOLE: Okay. And Fatima, in addition to her comments there, I will actually send you the monitoring that is going on in tracking that, because we do that ourselves, too. I will just send you for educational purposes, the types -- there are three different types of monitoring that goes on there. So I will send that out also.

MS. GATEWOOD: Okay. Thank you.

MR. POOLE: Okay.

MS. BICKERS: Ben has his hand raised as well.

MR. POOLE: Sorry, Ben. You are always one screen off that I missing them. Go ahead, Ben.

MR. MUDD: I just want to reiterate. All of my comments, I want to make sure it is understood those are in a positive context. I certainly appreciate

everything that Fatima and her team have done to help with vaccine counseling and the steps they have taken thus far. So I hope that my comments didn't come across anything other than that, but I look forward to continuing to work on this.

DR. ALI: Yes. Absolutely. Thank you.

MR. POOLE: Okay. Thanks, Ben.

MS. FIGG: I will just circle back to the compliance packaging once again. I know that we call it that all the time and it certainly is that. It helps with compliance, you know, whether the packages are dated or not dated. It is that nice reminder and that ease-of-use. So compliance and keeping people adhered is important, but it also helps with them taking the proper medications. These people who we are trying to keep out of long-term care facilities, who are struggling at home, oftentimes, mix up or not just forget to take it, but they might remember to take it, but not take it at the right time or

with the right thing, or maybe too much of one and not enough of another, so it helps keep people taking things correctly, in addition to compliance. And just the nature of -- you know, anybody who is involved with the packaging knows that just the nature of having to do it and get anything coordinated or filled at the same time so you can have that packaged, there's a lot of discussions that are going on with that patient that is helping them with their healthcare, from med changes to duplicate therapies. They are just getting managed, because they are getting packaged and getting filled all at the same time. They are just getting managed more thoroughly maybe than a patient that is not utilizing that service.

So we just need to remember that it is almost like compliance packaging, and complete med reviews, and all of it all at once, and it happens, to Ron's point, sometimes more than once a month, because people are being monitored on all

of those levels. So they are being monitored not just on their adherence, but many things about their healthcare in that process.

MR. POOLE: Thanks Meredith, you explained it a lot better than I did, but you are right. To me, it's more like concierge medicine, because you really are involved in order to get somebody to the end goal, where we are all trying to get, a lot of times it takes a lot of hands on and a lot of conversations with their prescribers, and even their loved ones who work with them at home and are trying to keep them at home, and obviously the majority of people at their end of life, they would rather be at home. So that is the main goal.

Okay. Did I miss anybody else with their hand up?

MS. BICKERS: No. I don't see anybody.

MR. POOLE: I didn't do a very good job today.

Okay. All right. Do I have a

motion to adjourn?

MS. FIGG: I will make a motion to adjourn.

MR. POOLE: Okay.

MS. SMITH: I'll second.

MR. POOLE: Okay. Any further discussion? All of those in favor say, "Aye."

TAC MEMBERS: Aye.

MR. POOLE: Okay. Thank you everyone have a great day.

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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 Tuesday, the 8th of October, 2024.

/s/ Stefanie L. Sweet

Stefanie Sweet, CVR, RCP-M