Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 East Main Street, 6W-A
Frankfort, Kentucky 40621

@chfsky | CHFS.KY.GOV

Steven Stack, MD
SECRETARY

Lisa D. Lee
COMMISSIONER

July 8, 2026

Legislative Research Commission
Capitol Building, Room 300
Frankfort, KY 40601

Dear Legislative Members:

Enclosed is a copy of State Plan Amendment (SPA) 26-0006. Pursuant to Section 6 of House Bill 695 (2025 Regular Session), the Cabinet for Health and Family Services is required to provide a copy of this amendment to the Legislative Research Commission concurrent with its submission to the Centers for Medicare and Medicaid Services (CMS). The State Plan Amendment was submitted to CMS on July 8, 2026.

SPA 26-0006 is necessitated by the passage of House Bill 3 (2026 Regular Session). HB 3 requires pharmacists to be reimbursed by Medicaid and KCHIP for all services within their scope of practice and at a rate not less than other non-physician practitioners are paid for the same services. The SPA adds pharmacists to the list of providers who are reimbursed at 85 percent of the physician rate.

If you have questions regarding this submission, please contact Jonathan Scott, Chief Legislative and Regulatory Officer for the Department for Medicaid Services, at JonathanT.Scott@ky.gov.

Sincerely,

Lisa D. Lee

Lisa D. Lee
Commissioner
Department for Medicaid Services

Transmittal No. 26-0006

Kentucky Medicaid Program Public Notice

PROPOSED CHANGES IN METHODS AND STANDARDS FOR ESTABLISHING MEDICAID PAYMENT RATES FOR THE PHARMACY PROGRAM

July 7, 2026

The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (the Department) in accordance with 42 CFR 447.205, hereby provides public notice of proposed changes to the methods and standards by which the Department will reimburse Pharmacists. The proposed effective date of change is February 1, 2027.

The Department is amending its State Plan to comply with HB 3, which requires Medicaid and KCHIP to adhere to the pharmacy reimbursement requirements established in KRS 304.12-237.

Pharmacists will be reimbursed for all services provided within the legal scope of practice at a rate not less than other non-physician practitioners. Pharmacist reimbursement will be based on a step-down methodology, calculated at 85% of the physician rate.

The Department for Medicaid Services estimates the total fiscal impact will be:

$39,250.00 (reimbursement)
$128,100 (system changes)

The proposed change is subject to approval by the federal Centers for Medicare & Medicaid Services and may be modified or revised during the approval process.

Public Comments:

Any interested party may submit questions or comments concerning these proposed changes in reimbursement methods and standards. A copy of this notice is available for public review at the Department for Medicaid Services at the address listed below. It is recommended to include the name of the public notice in the subject line. Comments or inquiries must be submitted in writing within thirty (30) days of the publication date of this notice to the Division of Healthcare Policy at DMSSPAS@KY.GOV.

Andy Beshear
GOVERNOR

Justin Dearinger
DIRECTOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
Division of Health Care Policy
275 East Main Street 6 W-D
Frankfort, Kentucky 40621
(502) 564-6890
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Steven Stack, MD
SECRETARY

Lisa Lee
COMMISSIONER

July 8, 2026

Courtney Miller, Director
Center for Medicaid & CHIP Services
Medicaid & CHIP Operations Group
Division of Program Operations
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: State Plan Amendment KY 26-0006

Dear Ms. Miller:

Please find attached Kentucky SPA 26-0006. Pursuant to Ky. H.B. 3, the Department for Medicaid Services is requesting approval for changes to the State Plan in order that Pharmacists be reimbursed for all services provided within their legal scope of practice at a rate not less than other non-physician practitioners. Pharmacist reimbursement will be based on a step-down methodology, calculated at 85% of the physician rate. The proposed effective date for this SPA is February 1, 2027.

Should you have any questions, please contact Daryl Osborne at dosborne@ky.gov and Danielle Davis at danielle.davis@ky.gov.

Sincerely,

Lisa D. Lee

Lisa Lee, Commissioner

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   DMS response – The providers receive and retain the total Medicaid expenditures for all eligible expenses.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;

   (ii) the operational nature of the entity (state, county, city, other);

   (iii) the total amounts transferred or certified by each entity;

   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

DMS Response – The non-federal share of all expenditures for which Kentucky requests Federal matching funds are obtained from appropriations from the Kentucky General Assembly and provider assessment fees.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

DMS Response – Supplemental payments are not made to any provider impacted by the rate change reflected in this SPA.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

DMS Response – N/A

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

DMS Response – No. If payments were to exceed cost, unless otherwise approved, the federal share would be returned.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0006

2. STATE: KY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 2/1/27

5. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(30)(A)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2027 $ 18,317
b. FFY 2028 $ 9,158

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 4.19-B, Pg. 20.15(1)(d)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: 4.19-B, Pg. 20.15(1)(d)

9. SUBJECT OF AMENDMENT

Pharmacists will be reimbursed for all services provided within their legal scope of practice at a rate not less than other non-physician practitioners. Pharmacist reimbursement will be based on a step-down methodology, calculated at 85% of the physician rate.

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL: Lisa D. Lee

12. TYPED NAME: Lisa D. Lee

13. TITLE: Commissioner

14. DATE SUBMITTED: 7/8/26

15. RETURN TO
Lisa Lee
275 E. Main St. 6 W-A
Frankfort, KY 40601

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

~~XIX.~~ XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. Effective 2/1/27, o~~O~~ther practitioners providing the service (listed in 1, 2, 3, 4, and 5 below) will be reimbursed based on a step down methodology calculated as a percentage of the physician rate (75% of the current Kentucky-specific Medicare Physician rate, or the established Medicaid rate if a current Kentucky-specific Medicare rate does not exist). The step down includes:

(1) 85% - Advanced Practice Registered Nurse (APRN), Licensed Psychologist (LP), Physician Assistant (PA), Pharmacist (RPh/PharmD).

(2) 80% - Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Psychological Practitioner (LPP), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), Licensed Behavior Analyst (LBA), Licensed Clinical Alcohol and Drug Counselor (LCADC), or Certified Psychologist with autonomous functioning.

(3) 70% - Licensed Psychological Associate (LPA), Licensed Marriage and Family Therapist Associate (LMFTA), Licensed Professional Counselor Associate (LPCA), Certified Social Worker, Masters Level (CSW), Licensed Professional Art Therapist Associate (LPATA), Licensed Assistant Behavior Analyst (LABA), Licensed Clinical Alcohol and Drug Counselor Associate (LCADCA), Licensed Alcohol and Drug Counselor, or Certified psychologist without autonomous functioning. The billing provider is either the supervisor, a provider group, or licensed organization.

(4) 50%- Certified alcohol and drug counselor (CADC) and Behavioral Health Associate.

(5) 40%- Other non-bachelors-level providers

C. Reimbursement for the following services shall be as established on the Behavioral Health and Substance Abuse Services Outpatient (Non-Facility) fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the following services. The agency's fee schedule rate was set as of 7/1/2019 and is effective for services provided on or after that date. All rates are published on the agency's website at ~~https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx~~ Fee Schedules - Cabinet for Health and Family Services

(1) Screening, brief intervention and referral to treatment (SBIRT)

(2) Service planning

(3) Day treatment

(4) Comprehensive community support services
(5) Peer support services
(6) Intensive outpatient program services
(7) Partial hospitalization services

~~Reimbursement for these services will be reviewed and may be adjusted annually according to the Medicare Economic Index.~~

~~TN No: 23-016~~
~~Supersedes~~
~~TN No: 19-002~~

~~Approval Date:**07/20/2023** Effective Date: October 1, 2023~~

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. Effective 2/1/27, other practitioners providing the service (listed in 1, 2, 3, 4, and 5 below) will be reimbursed based on a step down methodology calculated as a percentage of the physician rate (75% of the current Kentucky-specific Medicare Physician rate, or the established Medicaid rate if a current Kentucky-specific Medicare rate does not exist). The step down includes:

(1) 85% - Advanced Practice Registered Nurse (APRN), Licensed Psychologist (LP), Physician Assistant (PA), Pharmacist (RPh/PharmD).

(2) 80% - Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Psychological Practitioner (LPP), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), Licensed Behavior Analyst (LBA), Licensed Clinical Alcohol and Drug Counselor (LCADC), or Certified Psychologist with autonomous functioning.

(3) 70% - Licensed Psychological Associate (LPA), Licensed Marriage and Family Therapist Associate (LMFTA), Licensed Professional Counselor Associate (LPCA), Certified Social Worker, Masters Level (CSW), Licensed Professional Art Therapist Associate (LPATA), Licensed Assistant Behavior Analyst (LABA), Licensed Clinical Alcohol and Drug Counselor Associate (LCADCA), Licensed Alcohol and Drug Counselor, or Certified psychologist without autonomous functioning. The billing provider is either the supervisor, a provider group, or licensed organization.

(4) 50%- Certified alcohol and drug counselor (CADC) and Behavioral Health Associate.

(5) 40%- Other non-bachelors-level providers

C. Reimbursement for the following services shall be as established on the Behavioral Health and Substance Abuse Services Outpatient (Non-Facility) fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the following services. The agency's fee schedule rate was set as of 7/1/2019 and is effective for services provided on or after that date. All rates are published on the agency's website at Fee Schedules - Cabinet for Health and Family Services

(1) Screening, brief intervention and referral to treatment (SBIRT)

(2) Service planning

(3) Day treatment

(4) Comprehensive community support services

(5) Peer support services

(6) Intensive outpatient program services

(7) Partial hospitalization services