

**Kentucky Medicaid Program Public Notice**  
**PROPOSED CHANGES IN METHODS AND STANDARDS FOR ESTABLISHING**  
**MEDICAID PAYMENT RATES FOR PROGRAM OF ALL-INCLUSIVE CARE FOR THE**  
**ELDERLY (PACE)**

April 17, 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 PACE organizations. The proposed effective date of change is July 1, 2026.

The Department is amending its State Plan to ensure PACE rates are consistent with the PACE Medicaid rate requirements of 42 CFR 460.182.

Previously, PACE rates were determined using a standard discount from the amount that would otherwise have been paid (AWOP) for PACE-comparable members. Under the revised methodology, DMS will allow for variations in the discount based on region and cohort. These adjustments will be informed by cost and utilization analysis, as well as other financial information provided by PACE organizations.

The new methodology will set rates by age category and region as a percentage discount off the AWOP. Key factors influencing the determination of the percentage discount include the Commonwealth's goals for access to PACE services, cost savings achieved through PACE compared to fee-for-service (FFS) delivery, the financial sustainability of PACE organizations, and negotiations with these organizations. Rate computations will continue to comply with federal regulations under 42 CFR 460.182 and Centers for Medicare & Medicaid Services (CMS) guidelines. This change aims to ensure a fair and sustainable rate-setting process while maintaining access to high-quality care for PACE participants across Kentucky.

The Department for Medicaid Services estimates the total fiscal impact will be \$0.00. 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](mailto:DMSSPAS@KY.GOV).

## **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.**



**Andy Beshear**  
GOVERNOR

**CABINET FOR HEALTH AND FAMILY SERVICES**  
**DEPARTMENT FOR MEDICAID SERVICES**

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SECRETARY

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**Lisa Lee**  
COMMISSIONER

April 21, 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 26-0002

Dear Ms. Miller:

Please find attached Kentucky SPA 26-0002. The Kentucky Department for Medicaid Services is requesting approval from CMS for changes to the methods and standards by which the Department will reimburse PACE organizations. The proposed effective date of change is July 1, 2026.

The Department is amending its State Plan to ensure PACE rates are consistent with the PACE Medicaid rate requirements of 42 CFR 460.182.

Previously, PACE rates were determined using a standard discount from the amount that would otherwise have been paid (AWOP) for PACE-comparable members. Under the revised methodology, DMS will allow for variations in the discount based on region and cohort. These adjustments will be informed by cost and utilization analysis, as well as other financial information provided by PACE organizations.

The new methodology will set rates by age category and region as a percentage discount off the AWOP. Key factors influencing the determination of the percentage discount include the Commonwealth's goals for access to PACE services, cost savings achieved through PACE compared to fee-for-service (FFS) delivery, the financial sustainability of PACE organizations, and negotiations with these organizations. Rate computations will continue to comply with

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federal regulations under 42 CFR 460.182 and Centers for Medicare & Medicaid Services (CMS) guidelines. This change aims to ensure a fair and sustainable rate-setting process while maintaining access to high-quality care for PACE participants across Kentucky.

If you should have any questions, please contact Daryl Osborne at [dosborne@ky.gov](mailto:dosborne@ky.gov) or Amanda Trent at [amanda.trent@ky.gov](mailto:amanda.trent@ky.gov).

Sincerely,

A handwritten signature in cursive script that reads "Lisa D. Lee".

Lisa Lee, Commissioner

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER ____ _	2. STATE ____
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3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI
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TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
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5. FEDERAL STATUTE/REGULATION CITATION
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6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY _____ \$ _____
b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
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8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
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9. SUBJECT OF AMENDMENT
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10. GOVERNOR'S REVIEW (Check One)	OTHER, AS SPECIFIED:
GOVERNOR'S OFFICE REPORTED NO COMMENT	
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

11. SIGNATURE OF STATE AGENCY OFFICIAL 
12. TYPED NAME
13. TITLE
14. DATE SUBMITTED

15. RETURN TO
---------------

<b>FOR CMS USE ONLY</b>	
16. DATE RECEIVED	17. DATE APPROVED

<b>PLAN APPROVED - ONE COPY ATTACHED</b>	
18. EFFECTIVE DATE OF APPROVED MATERIAL	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL	21. TITLE OF APPROVING OFFICIAL

22. REMARKS
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II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. X Rates are set at a percent of the amount that would otherwise been paid for a comparable population.
2.      Experience-based (contractors/State’s cost experience or encounter date) (please describe)
3.      Adjusted Community Rate (please describe)
4.      Other (please describe)

~~The Kentucky Department for Medicaid Services provides their rate setting vendor with their most recent statewide FFS claims data, and enrollment information for the same period for the nursing home certifiable population in the state. This included both the nursing home and waiver populations in the state (institutional and non institutional). The PACE comparable population is then identified by limiting to members that are at least 55 years of age and reside in counties within the PACE service area. Once the PACE comparable population is identified, the PACE amounts that would otherwise have been paid (AWOPs) are developed using the appropriate rating cohorts.~~

AWOP Development

~~The Kentucky Department for Medicaid Services (DMS) collaborates with its contractor to determine the amounts that would otherwise have been paid (AWOP) for the population eligible for, but not enrolled in, the Program of All-Inclusive Care for the Elderly (PACE).~~

~~The process begins with the provision of the state’s rate setting vendor, with assistance from an actuarial firm uses the most recent statewide fee-for-service (FFS) available claims data and enrollment information for the nursing facility certifiable population, which encompasses institutional (nursing home) and non-institutional (waiver) populations in the state, as the base data for the AWOP development. The PACE-comparable population is derived by identifying individuals aged 55 years and older who reside in counties included in the PACE service area. The FFS claims include all Medicaid covered services for the population eligible for, but not enrolled in, PACE.~~

~~AWOPs are developed for the PACE-comparable population by appropriately defining The base data is summarized by rating cohorts and service categories appropriate for a capitated rate structure described in the annual AWOP methodology letter. y service and then A series of several adjustments are is applied to ensure the data accurately reflects the expected/anticipated experience induring the upcoming contract period. The a adjustments that are made to the base data to arrive at the projected AWOPs include, but are not limited to:~~

- ~~IBNR (incurred but not reported)~~
- ~~Nursing Facility Reimbursement Adjustments (Nursing Facility, HCBS, etc.)~~
- ~~Prospective Trend Adjustments Patient Liability Reduction~~
- ~~Non-Medical Cost Administrative Loadings~~

~~Once the above adjustments are made to the data, a regional cost analysis is subsequently conducted to~~

~~split/adjust the experience between/among the counties within the PACE service area. Separate per-member-per-month (PMPM) rates by cohort and region are calculated by blending AWOPs for nursing home and waiver populations. Finally, the nursing home and waiver AWOPs are blended to create separate PMPMs by age category for each county. The population mix of the PACE-comparable group is established to blend the nursing home and waiver populations into the final rating cohorts used for payment. No members enrolled with any PACE organizations operational in the state, or their claims, are included in development of the AWOP. The Kentucky Department for Medicaid Services establishes the Medicaid rates at a percentage of the calculated AWOPs.~~

#### Determination of the PACE Capitation Rate

The DMS determines rates as a percentage discount off the AWOP that may vary by cohort and region based on the following considerations:

1. The Commonwealth's expectations regarding PACE savings compared to FFS delivery by rating cohort and region.
2. Review of financial data reported by PACE organization(s) (PO).
3. Financial sustainability of PACE program.

PACE rates are determined in compliance with 42 CFR 460.182 and CMS guidance.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

### III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

## II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. X Rates are set at a percent of the amount that would otherwise been paid for a comparable population.
2. \_\_\_ Experience-based (contractors/State's cost experience or encounter date) (please describe)
3. \_\_\_ Adjusted Community Rate (please describe)
4. \_\_\_ Other (please describe)

### AWOP Development

The Kentucky Department for Medicaid Services (DMS) collaborates with its contractor to determine the amounts that would otherwise have been paid (AWOP) for the population eligible for, but not enrolled in, the Program of All-Inclusive Care for the Elderly (PACE).

The process begins with the provision of the most recent statewide fee-for-service (FFS) claims data and enrollment information for the nursing facility certifiable population, which encompasses institutional (nursing home) and non-institutional (waiver) populations in the state. The PACE-comparable population is derived by identifying individuals aged 55 years and older who reside in counties included in the PACE service area. The FFS claims include all Medicaid covered services for the population eligible for, but not enrolled in, PACE.

AWOPs are developed for the PACE-comparable population by appropriately defining rating cohorts and service categories appropriate for a capitated rate structure described in the annual AWOP methodology letter. A series of adjustments is applied to ensure the data accurately reflects the anticipated experience during the upcoming contract period. Adjustments to the base data include, but are not limited to:

- IBNR (incurred but not reported)
- Reimbursement Adjustments (Nursing Facility, HCBS, etc.)
- Prospective Trend Adjustments
- Non-Medical Cost Loadings

A regional cost analysis is subsequently conducted to adjust the experience among the counties within the PACE service area. Separate per-member-per-month (PMPM) rates by cohort and region are calculated by blending AWOPs for nursing home and waiver populations. The population mix of the PACE-comparable group is established to blend the nursing home and waiver populations into the final rating cohorts used for payment. No members enrolled with any PACE organizations operational in the state, or their claims, are included in development of the AWOP.

Determination of the PACE Capitation Rate

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