TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

SJR 26: PHARMACY PAYMENT PARITY REPORT

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Executive Summary

Senate Joint Resolution 26 (SJR 26, Acts Chapter 23) directs the Department for Medicaid Services (DMS) to prepare a report assessing the impact of permitting coverage of clinical services performed by pharmacists within their scope of practice and reimbursing for those services at a rate not less than what is paid to other nonphysician practitioners (i.e., "pharmacist payment parity") within the Kentucky Medicaid program and Kentucky Children's Health Insurance Program (KCHIP).[1] This report is to be delivered to the Legislative Research Commission no later than August 1, 2025, and must include necessary changes for compliance, anticipated effects on Medicaid and KCHIP claims and expenditures, fiscal impacts observed in other states, effects on private insurers, impacts on access to care and health outcomes, and a detailed implementation timeline.

To support report development, DMS engaged stakeholders, including representatives from six peer states (Idaho, Michigan, Pennsylvania, Virginia, Washington, and Wisconsin) and six Kentucky-based professional organizations. The collective feedback highlighted challenges such as provider confusion regarding enrollment and service reimbursement, administrative burdens, and the need for medical billing training. Peer states reported slow initial enrollment and billing activity, with a gradual increase over time. They also noted that pharmacist reimbursement for clinical services was assumed to be cost-neutral. DMS submitted a written request for information to the Kentucky Department of Insurance (DOI) requesting information regarding the effect of previous pharmacist payment parity requirements (KRS 304.12-237) on private insurers. The DOI reports that it has not assessed the impact on premiums and has not received any reports of difficulties regarding implementation of coverage of pharmacist services for private insurers.

Leveraging feedback and data received from stakeholders, as well as Kentucky-specific data, DMS and its contracted vendors modeled potential impacts on Kentucky Medicaid and KCHIP claims and expenditures. Key areas included an evaluation of professional claims, emergency department (ED) and urgent care claims, Medication Therapy Management (MTM) claims, smoking cessation services and chronic disease management claims, and diabetic testing supply claims. The analysis of fee-for-service (FFS) claims showed minimal increases in claims, with a shift of services from other providers to pharmacists, and corresponding minimal fiscal impact estimated at $156,000 by year three post-implementation. The analysis of managed care claims also showed a similar estimated impact of $966,000 for the same period.

In addition to analyzing claims and expenditure, DMS assessed how a pharmacist payment parity policy might impact access to care, health outcomes, and the overall health of Medicaid and KCHIP beneficiaries. As peer states had largely not conducted evaluations of their parity policies, DMS performed a comprehensive literature review and analyzed publicly available data from the Health Resources and Services Administration (HRSA) and the U.S. Census Bureau. These activities suggested that pharmacist-driven care has the potential to improve health outcomes and reduce healthcare costs by preventing complications, reducing hospitalizations, and improving chronic disease management. and that a Kentucky Medicaid and KCHIP parity policy could enhance access to care, particularly in rural and underserved areas, as pharmacists are highly accessible.

[1] S.J.R. 26, Acts Chapter23, 2025 Regular Session, https://apps.legislature.ky.gov/record/25rs/SJR 26.html.

An access analysis using publicly available data identified counties that were designated as medically underserved areas (MUA) or healthcare provider shortage areas (HPSA)[2] by HRSA or did not have a hospital and cross-referenced that data with pharmacies providing services under Board of Pharmacy-approved protocols. The access analysis notes that except for Robertson County, every county that is designated as an MUA, HPSA, or lacks a hospital has at least one pharmacy. This reinforces the concept that pharmacist payment parity could improve access to care. Specifically, there are 44 pharmacies in the 18 counties identified as having the least access to care, indicating 44 potential new access points where pharmacists could help improve access to care provided under Board-approved protocols. Further, there are four pharmacies already providing protocol-driven care in Fulton, Hancock, McLean, and Washington Counties.

In collaboration with stakeholders and contracted vendors, DMS identified several administrative activities associated with implementation of a pharmacist payment parity policy including a Medicaid State Plan Amendment (SPA), reimbursement rate setting and provider billing guide updates, Managed Care Organization (MCO) contract updates, claims processing system updates, credentialling and enrollment processes, outreach and education, and pharmacy workflow integration. The Department estimates a timeline of 12 to 18 months to implement payment parity for pharmacists, including related administrative activities.

Recent legislative and congressional activities at the state and federal level could impact this timeline. The recently passed Kentucky House Bill 695 requires approval from the General Assembly for changes in benefits or coverage in the Medicaid program and prior to pursuing a state plan amendment. It is not anticipated that this would affect the cost or timeline of a pharmacist payment parity initiative, assuming that any legislation put forth related to a pharmacist payment parity initiative would direct the Cabinet for Health and Family Services to pursue payment parity for pharmacists along with the necessary federal approvals. The recently passed federal budget bill (H.R.1)[3] contains fiscal measures that may affect the Kentucky Medicaid and KCHIP programs; the actual impact to the timeline or funding for this initiative is unknown at this time.

The findings in this report and the research available indicate that a pharmacist payment parity policy for Kentucky Medicaid and KCHIP may require moderate administrative changes, limited upfront investment, and coordinated stakeholder engagement. Further, there would likely be a limited fiscal impact, while offering potentially significant benefits in access to care and health outcomes; the total estimated impact by year three is $1.1 million for both the fee-for-service and managed care programs. As the legislature considers its next steps, DMS would like to offer the following considerations:

- ***Reimbursement for Full Scope of Practice Services****:* DMS may consider supporting a parity policy that would permit pharmacists to bill for a comprehensive set of clinical services that fall under Kentucky Board of Pharmacy-approved protocols.
- ***Streamlined Credentialing and Enrollment Processes****:* DMS may consider supporting a streamlined and, where feasible, centralized credentialing process across Medicaid MCOs to

[2] HRSA defines a geographic HPSA as having a shortage of providers within a geographic area and defines an MUA as which is defined as a geographic area with a lack of access to primary care services.
[3] One Big Beautiful Bill Act, H.R.1, 119th Congress (2025-2026). https://www.congress.gov/bill/119th-congress/house-bill/1/titles

reduce the administrative burden and improve provider service adoption. DMS may also consider a credentialing process that is performed by a provider organization.

- ***Education and Outreach****:* Ensure DMS has the necessary resources to develop training materials and conduct outreach efforts to pharmacists, MCOs, and patients to ensure efficient and effective policy implementation and to maximize service adoption.
- ***MCO Alignment and Coordination****:* DMS may consider encouraging MCOs to designate pharmacy liaisons and adopt standardized procedures to ensure consistent implementation across plans.
- ***Targeted Implementation****:* DMS may consider prioritizing outreach and enrollment efforts in counties with low access to primary care.

By moving forward with these strategies, the Commonwealth may have an opportunity to expand access to care, particularly in rural communities, and create a more resilient, patient-centered Medicaid program.

Introduction

In 2021, the Kentucky General Assembly passed House Bill 48 (HB 48), later codified as KRS 304.12-237, which requires private health insurers to cover clinical services performed by pharmacists within their scope of practice and to reimburse for those services at a rate not less than what is paid to other nonphysician practitioners (i.e., "pharmacist payment parity"). More recently, in 2025, the General Assembly passed Senate Joint Resolution 26 (SJR 26, as Acts Chapter 23), which directs the Department for Medicaid Services (DMS) to prepare a report on pharmacist payment parity for delivery to the Legislative Research Commission no later than August 1, 2025.[4] Specifically, SJR 26 mandates that the report include:

1) A summary of changes necessary for the Kentucky Medicaid program and the Kentucky Children's Health Insurance Program (KCHIP) to comply with KRS 304.12-237;
2) An analysis of the anticipated effect that such a requirement would have on Medicaid and KCHIP claims and expenditures;
3) A review of the fiscal impact and overall cost of similar coverage and reimbursement requirements observed in other states, if available;
4) A summary of the effect of KRS 304.12-237 on private insurers including any increase in premiums charged to consumers and observed changes in claims filed;
5) An analysis of how a requirement to comply with KRS 304.12-237 might impact access to care, health outcomes, and the overall health of Medicaid and KCHIP beneficiaries; and
6) A detailed timeline for implementing the changes necessary to comply with KRS 304.12-237 including any necessary requests for approval or authorization from the federal Centers for Medicare and Medicaid Services (CMS) or any other federal agency.

In developing the report that follows, the DMS Division of Health Care Policy's Pharmacy Policy Branch leveraged the support of its contracted vendors Myers and Stauffer LC (Myers and Stauffer) and Milliman to conduct stakeholder engagement activities, perform comprehensive research, and provide detailed analyses of claims and expenditures. For purposes of readability, the report is organized into four sections (i.e., Environmental Scan; Fiscal Impact Analysis; Public Health Impact Analysis; and Implementation Analysis and Timeline). *Table 1* is intended as a "report roadmap" and to demonstrate alignment between each report section and the specific requirements in SJR 26.

Table 1: Report Roadmap

Report Section	SJR 26 Section
Stakeholder Engagement	Sections 2(3), Section 2(4)
Fiscal Impact Analysis	Sections 2(1)(c), Section 2(2)(a) – (c)
Public Health Impact	Section 2(5)
Changes Necessary for Compliance	Sections 2(1)(a) – (e), Section 2(6)

[4] S.J.R. 26, Acts Chapter23, 2025 Regular Session, https://apps.legislature.ky.gov/record/25rs/SJR 26.html.

Background

Historically, the role of pharmacists centered around preparing and dispensing medications; however, over the past half century, this role has expanded to include clinical services, patient education, and patient advocacy. For example, many pharmacists now provide Medication Therapy Management (MTM), which involves comprehensive medication reviews, patient counseling, and the development of personalized medication management plans. In addition, it has become commonplace for pharmacists to administer vaccines and provide associated patient education.

Pharmacists licensed to practice in Kentucky generally have broad authority to provide clinical care within their scope of practice, subject to collaborative care agreements through 201 KAR 2:220.[5] These agreements, also referred to as collaborative practice agreements, create a formal relationship between a pharmacist and another health care practitioner, whereby specific functions are delegated to the pharmacist. In other words, the agreements define certain patient care functions that a pharmacist can autonomously provide under specific situations and conditions. Additionally, the Kentucky Board of Pharmacy is authorized under KRS 315.191(1)(f) to establish authorized protocols "by which pharmacists may initiate the dispensing of noncontrolled medications or other professional services."[6]

As described previously, KRS 304.12-237requires all non-government-sponsored health insurers to reimburse pharmacists for services "at a rate not less than that provided to other nonphysician practitioners if the service or procedure is: 1) within the scope of the practice of pharmacy; 2) would otherwise be covered if provided by a physician, advanced practice registered nurse (APRN), or physician assistant (PA); and is performed by the pharmacist in strict compliance their license."[7] Prior to enactment, Lewis & Ellis LLC performed a fiscal impact analysis of KRS 304.12-237, which noted that the cost to insurers would likely be minimal (i.e., $0.00 - $0.20 per member per month increase, or an increase of approximately 0.0% to 0.03%).[8]

[5] 201 KY. ADMIN. REGS. 2:220 (2023), https://apps.legislature.ky.gov/law/kar/titles/201/002/220/.
[6] KY. REV. STAT. ANN. § 315.191(1)(f), https://apps..ky.gov/law/Statutes/statute.aspx?id=54984.
[7] KY. REV. STAT. ANN. § 304.12-237, https://law.justia.com/codes/kentucky/chapter-304/subtitle-304-12/section-304-12-237/.
[8] KENTUCKY DEPARTMENT OF INSURANCE FINANCIAL IMPACT STATEMENT, LEWIS & ELLIS, INC. (2021), https://apps.legislature.ky.gov/recorddocuments/note/21RS/hb48/HM.pdf.

Stakeholder Engagement

To support overall report development, and to specifically assess the fiscal impact and overall cost of similar coverage and reimbursement requirements observed in other states, as well as the impact of KRS 304.12-237 on private insurers, DMS engaged numerous external stakeholders. Specifically, six peer states (Idaho, Michigan, Pennsylvania, Virginia, Washington, and Wisconsin) were identified based on their pharmacist payment parity policies, their history of recognizing and paying pharmacists for clinical services, and their coverage models. Representatives from Pennsylvania and Michigan's Medicaid programs responded to questions and provided relevant data via email, while representatives from Idaho, Virginia, Washington, and Wisconsin were interviewed in a live, virtual format lasting 30 to 60 minutes each. Similarly, six Kentucky-based professional organizations and advocacy groups were identified based on their knowledge and understanding of the Commonwealth's health care delivery system, providers, and patients. These entities included the Kentucky Pharmacy and Therapeutic Advisory Committee (PTAC), the Kentucky Pharmacists Association (KPhA), the Kentucky Independent Pharmacist Alliance (KIPA), and the American Pharmacy Cooperative (APCI). Finally, DMS submitted a written request for information to the Kentucky Department of Insurance (DOI) requesting information regarding the effect of KRS 304.12-237 on private insurers. What follows is a detailed summary of all stakeholder feedback received.

Peer State Observations

The following section is a summary of the information that was gathered from email communications and interviews with representatives from six state Medicaid programs. The feedback received primarily fell into three categories, each of which is addressed in turn below.

Challenges

States frequently cited provider confusion and administrative burden regarding Medicaid participation as a challenge to implementing pharmacist parity policies. Specifically, to receive Medicaid reimbursement, a provider must first enroll with Medicaid. If benefits are provided via managed care, providers must also then contract with the state's Medicaid managed care organizations (MCO).[9] In addition, states cited provider challenges regarding billing for medical services, which requires different software than prescription billing.[10] Specifically, providers often lack training on proper medical billing procedures, may not have medical billing software, and/or may be reluctant to invest in new software without clear and reliable reimbursement.

Service Adoption and Cost

Pharmacist payment parity policies are a relatively recent development in Medicaid. As such, the identified peer states have not yet conducted formal evaluations to assess the impact of these policies on service adoption or overall cost. However, states reported a consistent pattern of slow initial enrollment and billing activity, followed by a gradual, but small increase over time. As an example, one state shared its Medicaid MTM utilization data, covering calendar years 2017 through 2025. This dataset echoed anecdotal observations from other states showing a similarly modest adoption and low overall

[9] Note, Kentucky Medicaid contracts with five different MCOs.
[10] Note the potential exception of pharmacy providers that seek reimbursement for the provision of durable medical equipment (DME), which is typically billed as a medical service. As such, these pharmacies are more likely to have the training and infrastructure to bill for such services.

utilization of pharmacist-provided MTM services during the initial years of policy implementation. With respect to cost, states reported that they anticipated that pharmacist reimbursement for clinical services would be cost-neutral, particularly when focused on preventive or chronic disease management services that may reduce avoidable and costly medical services over the long term. In fact, none of the states interviewed have observed any significant impact on overall program costs or service utilization, nor have they found it necessary to implement specific utilization management policies such as prior authorization or claim edits specific to pharmacist-provided services. Only one state was able to provide specific data regarding cost, noting that they received approximately 1,500 claims, resulting in expenditures of $81,000 during the first 12 months following implementation. Similar data was not available in the other states.

Implementation

Peer states reported that implementation of pharmacist payment parity policies required several administrative changes, which took between 12 and 18 months to complete. Generally, implementation required a Medicaid State Plan Amendment (SPA), updates to MCO contracts, and updates to Medicaid Provider Manuals. These states also highlighted updates to enrollment and claims processing systems, as well as patient and provider education. Additionally, states offered several implementation recommendations based on their experience. Specifically, most states recommended maintaining a broad list of covered services, rather than implementing reimbursement for a limited list of procedure codes, as well as robust engagement with pharmacy providers and MCOs prior to and during implementation (e.g., comprehensive communications, training plans, etc.).

Kentucky-Based Stakeholder Observations

The following section is a summary of the information gathered from interviews with Kentucky-based professional organizations and advocacy groups. The feedback received primarily fell into two categories, each of which is addressed in turn below.

Challenges

Kentucky-based stakeholders consistently reported that, despite the implementation of KRS 304.12-237, many commercial insurers do not have clear policies regarding coverage of pharmacist clinical services and pharmacists are more likely to provide these services on a “cash basis” (i.e., customers pay directly at the point of sale without involving their insurance). As a result, there has been little incentive for pharmacies to provide clinical services, particularly in rural areas where fewer people can pay for these services out-of-pocket. Moreover, many pharmacies report being unable to make clinical services profitable, and that most of their revenue continues to come from dispensing services.

Like peer states, Kentucky-based stakeholders also cited several concerns regarding enrollment and contracting processes if KRS 304.12-237 were to be applied to Medicaid and KCHIP. They emphasized that these processes could be entirely new for a significant portion of the provider community, particularly those operating in independent or community-based settings. Unlike traditional pharmacy benefit enrollment, which typically occurs at the facility level with a pharmacy benefit manager (PBM), medical provider enrollment requires each individual pharmacy to enroll separately, using a National Provider Identifier (NPI), with both the Medicaid program and each participating MCO. Further, individual pharmacists anticipate being required to enroll as rendering providers.

Finally, as with peer states, Kentucky-based stakeholders stated that medical billing could present challenges for providers based on their experience with commercial plans.[11] Specifically, they described current credentialing processes as fragmented and administratively burdensome due to the variation in MCO requirements and providers' unfamiliarity with associated systems.

Implementation

To mitigate the challenges described above, Kentucky-based stakeholders offered several specific recommendations should KRS 304.12-237 be applied to Medicaid and KCHIP. First, they suggested that DMS create a centralized credentialing process whereby pharmacists could submit information once and be recognized by all necessary entities. Several best practice models were cited, including the American Pharmacists Association (APhA) Pharmacy Profiles system, an initiative managed by the Kentucky Hospital Association, and initiatives led by the Community Pharmacy Enhanced Services Networks, as they offer a streamlined approach to submitting required credentials, managing documentation, and supporting providers across multiple plans. Second, Kentucky-based stakeholders recommended that DMS provide education to both patients and providers to support service adoption. Specifically, they suggested that patients be made aware of the services they can receive from pharmacists and that DMS leverage the Commonwealth's strong training infrastructure to support providers (e.g., medical billing "bootcamps" offered by KPhA and the University of Kentucky). Third, virtually all Kentucky-based stakeholders recommended that the Commonwealth permit pharmacists to bill for any service within their scope of practice, as determined by the Kentucky Board of Pharmacy. One stakeholder, however, recommended that DMS implement coverage for one clinical service at a time, then gradually expand the program. Lastly, all stakeholders highlighted the importance of communication and collaboration with providers, MCOs, and DMS sister agencies to ensure successful service adoption.

Private Insurer Observations

The proposed fiscal impact of KRS 304.12-237suggested that the costs associated with coverage for pharmacist-provided services would be minimal, estimated at an increase of $0.00 to $0.20 per member per month, or approximately 0.0% to 0.03%.[12] DMS submitted a written request for information to the Kentucky Department of Insurance (DOI) requesting information regarding the effect of pharmacist payment parity requirements on private insurers. Since the implementation of KRS 304.12-237 in June 2021, the DOI has not evaluated the actual financial impact of this change. Additionally, the Department has not identified any challenges faced by commercial health plans or providers related to the enactment of KRS 304.12-237.

[11] Again, note the potential exception of pharmacy providers that seek reimbursement for the provision of durable medical equipment (DME).

[12] KENTUCKY DEPARTMENT OF INSURANCE FINANCIAL IMPACT STATEMENT, LEWIS & ELLIS, INC. (2021), https://apps.legislature.ky.gov/recorddocuments/note/21RS/hb48/HM.pdf.

Fiscal Impact Analysis

To analyze the anticipated effect that a requirement to comply with KRS 304.12-237 could have on Kentucky Medicaid and KCHIP claims and expenditures, specifically the impact on claims filed, the potential for offsetting claims to pharmacists or pharmacies from other providers or care sites, the impact on annual expenditures for FFS and managed care capitation payments, and any other potential fiscal impact that may result, the DMS Division of Health Care Policy's Pharmacy Policy Branch leveraged the support of its contracted vendors Myers and Stauffer LC and Milliman. The estimated managed care capitation rate impact summaries were reviewed by DMS' contracted actuary Milliman.

Methodology

Myers and Stauffer and Milliman leveraged data provided by DMS from calendar year (CY) 2023 and CY 2024 to analyze the potential impact on FFS and managed care Kentucky Medicaid and KCHIP claims and expenditures. This analysis was influenced by information gleaned from peer states who noted that, for purposes of fiscal analyses and SPAs, they assumed payment parity policies would primarily result in a shift of services from other providers/sites to pharmacies/pharmacists, as opposed to an increase in services overall, and would therefore result in minimal to no fiscal impact. Peer state policies generally mirror KRS 304.12-237, in that pharmacists are reimbursed equivalent to other non-physician practitioners such as APRNs and PAs. As in Kentucky, service adoption in these states' commercial insurance markets has also been limited, therefore, a very low level of provider "uptake" was assumed for purposes modeling changes in utilization and costs. Only one state had data available for review of pharmacy-provided clinical services; as reported above, it accounted for approximately 1,500 claims and $81,000 in expenditures year-to-date for the first year of program costs.

Leveraging the above approach, the impact on FFS and managed care Kentucky Medicaid and KCHIP claims and expenditures was modeled according to five key areas: 1) costs/savings associated with shifting professional services from current providers to pharmacists; 2) costs/savings associated with shifting emergency department (ED) and urgent care services to pharmacists; 3) costs associated with reimbursement for MTM services; 4) costs associated with an increased utilization of smoking cessation and chronic disease management services; and 5) costs associated with an increase in diabetic testing supply pharmacy claims. Each of these areas are addressed in turn below.

Professional Services Shift

To identify procedure codes that could potentially shift from other provider types to pharmacists, DMS collaborated with Myers and Stauffer, Gainwell Technologies, Milliman, peer states, and Kentucky-based stakeholders to draft a list of codes most likely to be utilized based on Kentucky Board of Pharmacy-approved protocols (e.g., tuberculin skin test, group A streptococcus testing, and injection of drug or substance). These codes, along with DMS fee schedule rates (i.e., maximum FFS rates) and utilization, are listed in Appendix A.

Fee-for-service and managed care professional claims were filtered to include only the identified procedure codes. The claims were further limited to provider types associated with physicians (i.e., provider type codes 64 and 65), nurse practitioners (i.e., NP, provider type code 78), and physician assistants (i.e., PA, provider type code 95), as services are most likely to shift from these provider types to pharmacists. To isolate outpatient services that could shift to pharmacy-based care, claims were

further limited by place of service to include ambulatory care settings (i.e., medical office, retail health clinic, or telemedicine).

Utilizing paid claims and fee schedule rates, an estimated overall amount paid for each procedure code was calculated and used to model a shift of utilization from physician-based services to pharmacy-based services. A conservative shift of 0.25% was utilized based on feedback from one peer state. Under the current policy, physicians are reimbursed the full fee schedule amount, while nonphysician providers, including NPs and PAs are reimbursed 75% of the fee schedule rate. Under payment parity policies, pharmacists would receive the same rate as other nonphysician provider types; accordingly, any shift from nonphysician providers to pharmacists would be cost neutral.

Additionally, a small increase in the number of laboratory tests was assumed, recognizing that patients may be more likely to receive testing at pharmacies, which often offer easier and more convenient access than traditional physician offices. A 0.75% increase in testing for group A streptococcus, influenza, and coronavirus (COVID-19) was utilized for modeling based on anecdotal information shared by peer states and Kentucky-based stakeholders.[13]

Given the lack of available data on adoption of these services from commercial claims in Kentucky and other peer states, a very small increase in the total number of claims was assumed, particularly during the first two years following implementation, as providers could need time to become familiar with the policy, complete enrollment and credentialing activities, and establish or expand their capacity to deliver services.

ED and Urgent Care Shift

To identify diseases and medical conditions that could be reasonably diagnosed in a pharmacy setting, Myers and Stauffer again collaborated with DMS, Gainwell Technologies, Milliman, Kentucky-based stakeholders, to draft a list of International Classification of Diseases, edition 10 (ICD-10) codes most likely to be utilized based on Kentucky Board of Pharmacy-approved protocols. These codes are listed in Appendix B. Fee-for service and managed care professional claims, were then filtered to ED or urgent care visits using place of service codes 20 and 23, respectively. This was further limited to visits with one of the identified ICD-10 codes as the primary diagnosis, inclusive of all services within the visit. Next, the average cost of an ED or urgent care visit was compared with the fee-schedule estimated cost of services provided at a pharmacy, including an evaluation and management service, a lab test, or both.

MTM Costs

As previously described, one peer state provided DMS with MTM Medicaid utilization data. The summarized claims data was leveraged to develop a proportionate financial analysis based on Kentucky Medicaid and KCHIP eligibility. As DMS has not established reimbursement rates for MTM services, the peer state's MTM reimbursement rates were used to estimate costs.[14] Real costs are likely to be less as implementation and service adoption could take time. Of note, the peer state indicated that it maintains

[13] Note, to align methodologies, DMS, Myers and Stauffer, and Milliman agreed to the 0.25% and 0.75% figures.
[14] Note, to align methodologies, DMS, Myers and Stauffer, and Milliman agreed leverage these rates as they corresponded to the utilization data received and were generally at the midpoint of all peer states reviewed.

a list of chronic conditions that beneficiaries must have to qualify for MTM services. As such, DMS may consider utilizing a similar list to best tailor this benefit for those who need it most.

Smoking Cessation and Chronic Disease Management Costs

As relevant data was not publicly available, it was assumed that the adoption of smoking cessation services and chronic disease management would be low, with an estimated 5% increase based on stakeholder feedback. Note, these services are also included in professional claims; however, these are often billed in conjunction with other office-based codes. As such, it was assumed that the shift in claims to pharmacy claims would be negligible and that any claims billed by pharmacists would be new claims.

Diabetic Supply Claims

Lastly, the modeling for diabetic testing supply claims assumed a small increase of 0.1%, which corresponds with the availability of pharmacists to prescribe necessary supplies, thereby increasing refill access to previously diagnosed diabetics.[15] To model this assumed change in utilization, the total number of Kentucky Medicaid and KCHIP claims and the corresponding amount paid for products included in the Kentucky Board of Pharmacy-authorized Diabetes Testing Supplies protocol was calculated. From this total, the average annual utilization and expenditures were calculated, and a conservative 0.1% proposed utilization increase was applied.

Analysis

Based on the above methodology, the potential effect that a requirement to comply with KRS 304.12-237 may have on Kentucky Medicaid and KCHIP claims and expenditures over three years was analyzed. *Tables 2* and *3* present the estimated shift in claims for professional services that could have been provided in an office environment (e.g., high utilization laboratory services); increases in MTM, smoking cessation, and chronic disease management services; as well as an increase in prescription claims for diabetic testing supplies. Note, as services provided in an ED are typically more expensive than services provided in urgent care or primary care settings, claims were reviewed to attempt to ascertain the level of savings if services had been provided in a non-emergency setting. The ED and urgent care claims shifting analysis did not show a significant difference in costs between the two types of care locations; however, results likely do not fully reflect the true cost differences due to several complicating factors. Specifically, claims data did not contain revenue codes typically used in an ED, making it difficult to identify claims for laboratory or physician services; outpatient charges are generally settled retrospectively using a cost-to-charge ratio formula; and ED claims in Kentucky are governed by 907 KAR 10:015 which limits reimbursement for claims which are nonemergent when provided to lock-in patients in a hospital outpatient emergency department. With respect to the latter, the impact on service delivery was not able to be quantified.

[15] Note, to align methodologies, DMS, Myers and Stauffer, and Milliman agreed to the 0.1% figure.

Table 2: FFS Claims Analysis[16]

Area of Analysis	Year 1	Year 2	Year 3
Professional Claims Shift and High-Utilization Labs	25	50	100
MTM	1,250	2,500	5,000
Smoking Cessation and Chronic Disease Management	250	500	1,000
Diabetic Testing Supply Prescription Claims	3	5	10
Total	**1,528**	**3,055**	**6,110**

Table 3: Managed Care Claims Analysis

Area of Analysis	Year 1	Year 2	Year 3
Professional Claims Shift and High-Utilization Labs	1,000	2,000	4,000
MTM	1,500	3,000	6,000
Smoking Cessation and Chronic Disease Management	600	1,200	2,400
Diabetic Testing Supply Prescription Claims	130	260	530
Total	**3,230**	**6,460**	**12,930**

Tables 4 and *5* present the estimated potential increased costs associated with MTM, smoking cessation services, chronic disease management and diabetic testing supplies, as well as potential savings associated with high utilization laboratory services and professional services. Regarding the latter, these shifts may result in modest savings since pharmacists would be reimbursed at a lower rate compared to physicians (i.e., 75% of the physician fee schedule amount).[17] As with the claims analysis above, there is no cost difference between ED and urgent care, as it is anticipated that these claims would likely shift from other providers to pharmacists. Overall, the analysis suggests a negligible increase overall Kentucky Medicaid and KCHIP expenditures over three years, as compared to total fiscal year (FY) 2024 FFS expenditures (i.e., $5.28B).[18] Total expenditures at year three for FFS and managed care are estimated at $1.1 million; this may represent a high estimate of utilization given the range of assumptions in the modeling methodology.

[16] Note, totals are rounded to demonstrate estimated changes.

[17] It is anticipated that reimbursement rates would be set at 75% of the physician fee schedule, as APRNs and PAs are generally paid 75% of the outpatient non-facility rate for services like primary care/clinical services. *See* 907 KY. ADMIN. REGS. 1:104 §2(b), https://apps.legislature.ky.gov/law/kar/titles/907/001/104/; 907 KY. ADMIN. REGS. 3:010 §10, https://apps.legislature.ky.gov/law/kar/titles/907/003/010/

[18] TEAM KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES, BUDGET OVERVIEW FOR THE DEPARTMENT FOR MEDICAID SERVICES (Sept. 28, 2024), https://apps.legislature.ky.gov/CommitteeDocuments/372/30693/Sept%2018%202024%20Medicaid%20Update%20Lee%20PowerPoint.pdf.

Table 4: FFS Expenditure Analysis[19]

Area of Analysis	Year 1	Year 2	Year 3
Professional Claims Shift and High-Utilization Labs[20]	($900)	($1,750)	($3,500)
MTM	$34,000	$68,000	$135,000
Smoking Cessation and Chronic Disease Management	$5,750	$11,500	$23,000
Diabetic Testing Supply Prescription Claims	$400	$800	$1,500
Total	**$39,250**	**$78,550**	**$156,000**

Table 55: Managed Care Expenditure Analysis[21]

Area of Analysis	Year 1	Year 2	Year 3
Professional Claims Shift and High-Utilization Labs	$153,000	$307,000	$613,000
MTM	$57,000	$114,000	$228,000
Smoking Cessation and Chronic Disease Management	$7,000	$14,000	$28,000
Diabetic Testing Supply Prescription Claims	$24,000	$48,000	$97,000
Total	**$241,000**	**$483,000**	**$966,000**

[19] Note, totals are rounded to demonstrate estimated changes.
[20] The FFS analysis demonstrated a savings as the baseline data included more claims for the claims shifting analysis than the proposed increase in laboratory services.
[21] Table 5 shows the impact for Diabetic Testing Supplies only within the prescription claims category. In Milliman's full report the fiscal impact for all Board-approved prescription protocols that could result in additional prescriptions were considered.

Public Health Impact

Myers and Stauffer leveraged a multi-pronged approach to assessing how a requirement to comply with KRS 304.12-237 might impact access to care, health outcomes, and the overall health of Medicaid and KCHIP beneficiaries. This approach included a comprehensive literature review and an analysis of publicly available data, each of which are addressed in turn below.

Literature Review

Myers and Stauffer reviewed 23 studies published between 2007 and 2024 that examined various aspects of pharmacist clinical services. Studies represented a mix of policy reviews, scoping studies, retrospective cohort studies, and peer-reviewed publications. Key findings are as follows:

- Pharmacist payment parity policies can help to alleviate the burden on the healthcare system, as pharmacies are generally more accessible than primary care practices (i.e., 90% of patients live within five miles of a community pharmacy; pharmacies are open nights and weekends; pharmacies may offer a range of services without requiring an appointment; and pharmacies tend to have shorter wait times compared to other providers).[22] Collaborative care arrangements may also help to create additional primary care practice and non-emergency medical transportation capacity, identified by both HRSA and Kentucky-based stakeholders.
- As the United States continues to see an increase in the prevalence of chronic conditions, including cardiovascular disease, diabetes, and hypertension, pharmacist payment parity policies may allow patients to seek care more frequently and ultimately aid in treating and managing chronic conditions.[23]
- Patients treated at pharmacies for minor ailments (i.e., non-serious conditions that can be self-diagnosed and managed with self-care or over-the-counter medications) receive treatment that is just as effective as care provided at EDs, urgent care centers, and primary care practices.[24] Moreover, pharmacist-driven care can drastically improve chronic conditions, such as cardiovascular disease, diabetes, and hypertension. For example, one study found reduced rates of cardiovascular disease and longer life expectancy in patients with high blood pressure who received pharmacist-led interventions including medication prescribing, compared to the typical standard of care from traditional providers.[25]
- Pharmacist provision of MTM, team-based care, and medication use reviews may reduce medication errors and inappropriate prescribing and may lead to increased compliance with medication regimens.[26]

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[22] Gloria Sachdev et al., *Current Status of Prescriptive Authority by Pharmacists in the United States,* 3 J. AM. COLL. CLIN. PHARMACY 807, 807-17 (2020), https://doi.org/10.1002/jac5.1245; J.M. Akers et al., *Expanding Access to Patient Care in Community Pharmacies for Minor Illnesses in Washington State*, 16 CLINICOECON. OUTCOMES RES. 233 (2024), https://doi.org/10.2147/CEOR.S452743.

[23] Kieran Dalton & Stephen Byrne, *Role of the Pharmacist in Reducing Healthcare Costs: Current Insights*, 6 INTEGRATED PHARMACY RES. & PRAC. 37 (2017), https://doi.org/10.2147/IPRP.S108047.

[24] U.S. Pharmacist, BIG SAVINGS WITH MORE PHARMACIST PRESCRIBING AUTHORITY (June 3, 2024), https://www.uspharmacist.com/article/big-savings-with-more-pharmacist-prescribing-authority.

[25] Dave L. Dixon et al., *Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States*, 6 JAMA NETWORK OPEN 11 (Nov. 3, 2023), https://doi.org/10.1001/jamanetworkopen.2023.41408.

[26] Kieran Dalton & Stephen Byrne, *Role of the Pharmacist in Reducing Healthcare Costs: Current Insights*, 6 INTEGRATED PHARMACY RES. & PRAC. 37 (2017), https://doi.org/10.2147/IPRP.S108047.

- The cost of treatment for minor ailments is often significantly lower when provided in pharmacies as opposed to EDs, urgent care centers, and in primary care practices. For example, one study found that treatment of a urinary tract infection costs $963 at an ED, $121 at a primary care practice, and $30 at a pharmacy.[27] Moreover, pharmacist payment parity policies may reduce overall health care system costs over time.[28]

Access Analysis

By 2030, it is estimated that the U.S. will face a shortage of 120,000 physicians nationally, and Kentucky specifically is projected to face a shortage of 2,926 physicians, 624 of which are primary care physicians.[29] Further, the Health Resources and Service Administration (HRSA) estimates that by 2025, Kentucky is expected to experience close to a 30% shortage in primary care provider adequacy.[30] Given widespread access to pharmacies, a requirement to comply with KRS 304.12-237 has the potential to significantly enhance Medicaid and KCHIP patient access to care.

To assess this potential impact, Myers and Stauffer first collected data to determine: 1) total population by county; 2) pharmacy location by county; and 3) hospital locations by county. Population by county was determined using 2024 Census data. Pharmacy locations were identified as "Community Retail Pharmacy" or "Clinic Pharmacy" using proprietary National Council for Prescription Drug Program (NCPDP) data. Hospitals were identified using the CMS publicly available Hospital General Information data set, which includes all hospitals that have been registered with Medicare. Pharmacy and hospital data were supplemented with county healthcare access designations from HRSA to determine which counties in Kentucky are designated as medically underserved areas (MUA) and/or healthcare provider shortage areas (HPSA).[31]

Leveraging the above data, Myers and Stauffer created "heatmaps" (i.e., 2-dimensional data visualization representing the magnitude of individual values within a dataset as a color) to illustrate the rural nature of Kentucky (i.e., Figure 1), as well as various provider shortage areas (i.e., *Figures 2*, *3,* and *4*). Note, with respect to *Figures 2*, *3,* and *4*, counties in gray are considered to have reasonable access to care for purposes of this report. Reasonable access was defined as a county with at least one hospital and that is not considered an HPSA or MUA. Excluding the areas immediately around Lexington,

[27] Id.
[28] Dave L. Dixon et al., *Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States*, 6 JAMA NETWORK OPEN 11 (Nov. 3, 2023), https://doi.org/10.1001/jamanetworkopen.2023.41408.
Wesley Nuffer et al., *Estimated Potential Financial Impact of Pharmacist-Delivered Disease Management Services Across a Network of Pharmacies in Rural Colorado*, 25 J. MANAGED CARE & SPECIALTY PHARMACY 984 (2019), https://doi.org/10.18553/jmcp.2019.25.9.984; Armando Silva Almodovar et al., *Return on Investment of Pharmacists' Services Among Non-Hospitalized Patients: A Scoping Review*, 21 RES. SOC. & ADMIN. PHARM. 321 (2025), https://doi.org/10.1016/j.sapharm.2025.01.012.
[29] CICERO INSTITUTE FACT SHEET (2024), https://ciceroinstitute.org/wp-content/uploads/2024/02/KY-Physician-Shortage-Facts-one-pager-2-1-2024.pdf.
[30] University of Kentucky, *Pharmacists' Authority to Deliver Protocol-Driven Care Set to Impact Patient and Public Health Across Kentucky* (May 1, 2018), https://pharmacy.uky.edu/news/pharmacists-authority-deliver-protocol-driven-care-set-impact-patient-and-public-health-across.
[31] HRSA defines a geographic HPSA as having a shortage of providers within a geographic area and defines an MUA as which is defined as a geographic area with a lack of access to primary care services.

Louisville, and Cincinnati, Ohio, metropolitan areas, the remaining areas are generally rural in nature and underserved by PCPs and hospital-based care.

Figure 1: Population by County

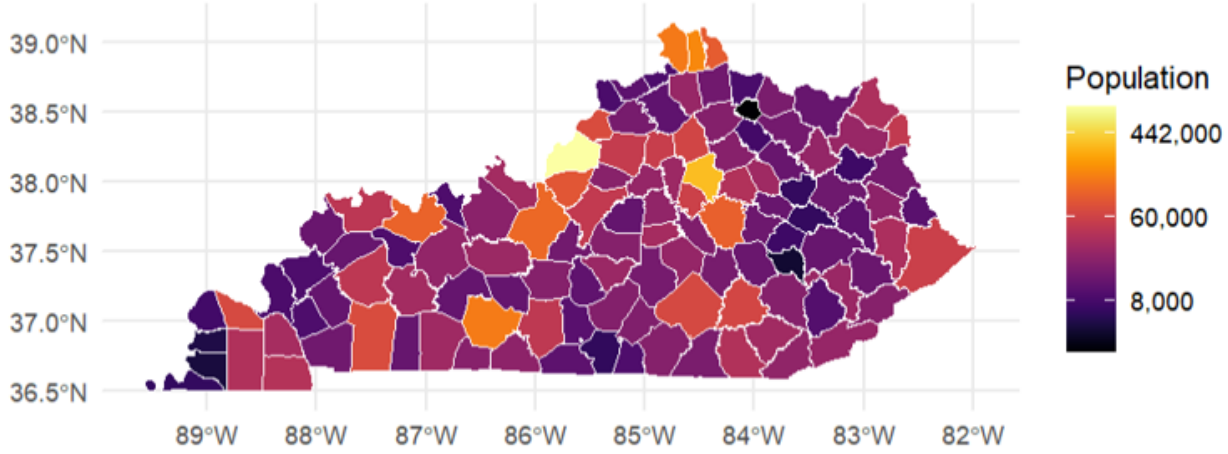
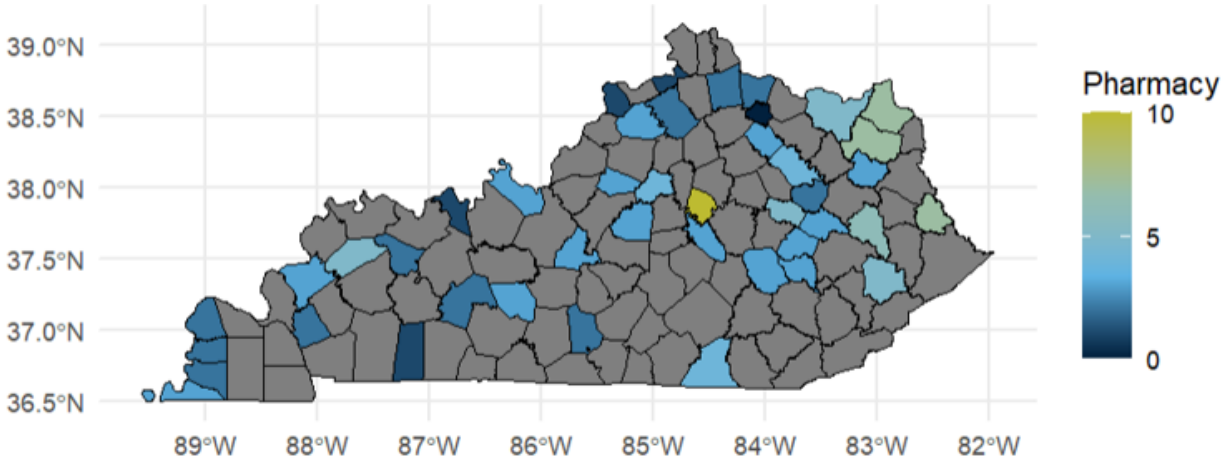
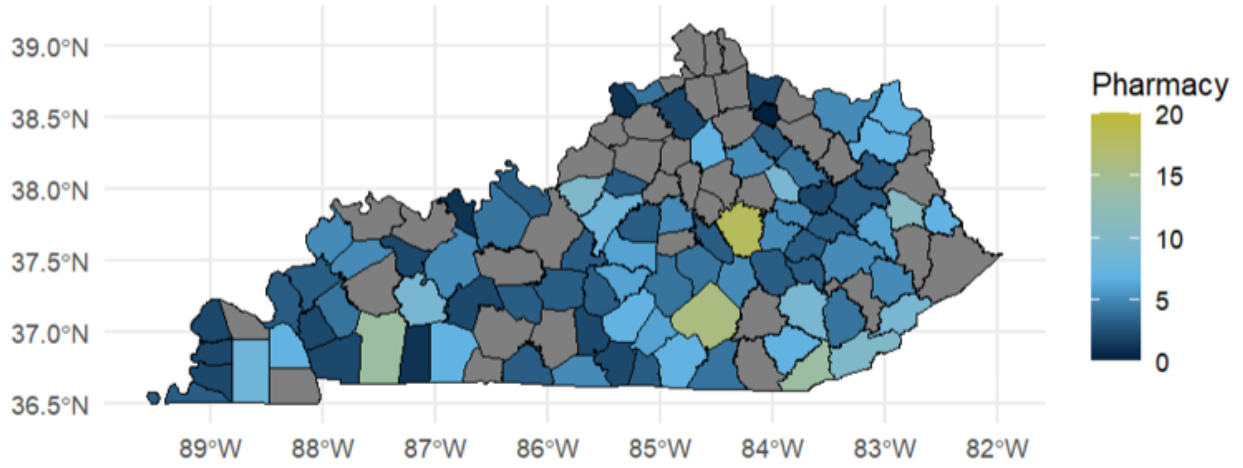


Figure 2: Number of Pharmacies in Counties without a Hospital



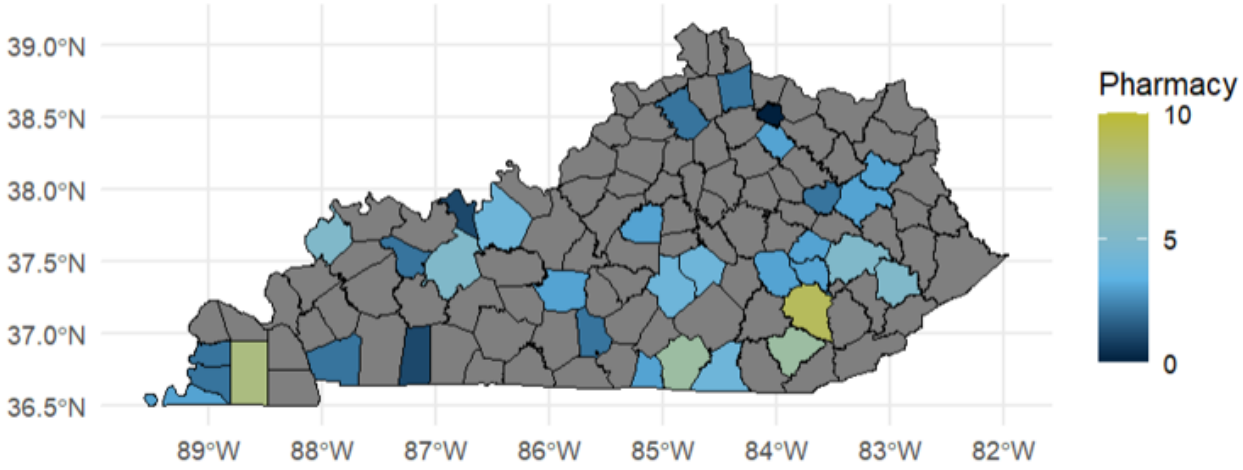
Counties in gray have at least one hospital, the color scale indicates the number of pharmacies in counties lacking a hospital.

Figure 3: Number of Pharmacies in MUA Counties



Counties in gray are not considered to be MUA; the color scale indicates the number of pharmacies in counties classified as a MUA.

Figure 4: Number of Pharmacies in HPSA Counties



Counties in gray are not considered to be HPSA; the color scale indicates the number of pharmacies in counties classified as an HPSA.

Next, Myers and Stauffer created a four-point "tiering system" to serve as a proxy for access to primary care. Each county was awarded a score from zero to three based on designations as a MUA, HPSA, and whether it has a hospital. For example, a county receives three points if it does not have a hospital and is designated as both an MUA and HPSA. A county receiving zero points has a hospital and is not designated as either an MUA or HPSA. Counties receiving a score of three were considered to have the lowest access to care. Using this tiering system, eighteen counties received a score of three, indicating a lack of access to primary care. Within these counties there is an average of 2.4 pharmacies per county, apart from Robertson County, which has no pharmacies. *Table 6* lists these counties and their

corresponding number of pharmacies. It should be noted that all 18 of the counties are classified as rural by the Kentucky Association of Counties.[32] The full scoring report is provided in *Appendix C.*

Table 66: Pharmacies in Underserved Counties

County	Number of Pharmacies	County	Number of Pharmacies
Carlisle	2	McLean	2
Elliott	3	Menifee	2
Fulton	3	Metcalfe	2
Hancock	1	Nicholas	3
Hickman	2	Owen	2
Jackson	3	Owsley	3
Knott	5	Robertson	0
Lee	3	Todd	1
McCreary	4	Washington	3

Figures 2, 3, and *4* above also serve as a visual representation of the potential impact of pharmacist payment parity on access to care. First, these maps support the previous descriptions in the literature that pharmacists are highly accessible to patients. Except for Robertson County, every county that is designated as an MUA, HPSA, or lacks a hospital has at least one pharmacy. This reinforces the concept that pharmacist payment parity could improve access to care. Specifically, there are 44 pharmacies in the 18 counties listed in *Table 6*, indicating 44 potential new access points. Further, there are four pharmacies already providing protocol-driven care in Fulton, Hancock, McLean, and Washington Counties.[33] Finally, the information in *Figures 2, 3,* and *4* could be used to target the most underserved counties, as an initial focus for intervention and an opportunity for the highest impact on patient care.

Impact of Pharmacies with Approved Protocols

Myers and Stauffer performed an additional analysis using information provided by the Kentucky Board of Pharmacy to determine the location of pharmacies with current authorization to perform services under at least one Board-approved protocol. As of May 2025, there were 146 distinct pharmacies utilizing a total of 466 active protocols. Protocols for group A strep pharyngitis infection, influenza antiviral therapy, and influenza chemoprophylaxis had the most pharmacies enrolled.[34] Currently, pharmacists provide protocol-driven clinical services in 72 of Kentucky's 120 counties. Of these, 44 counties are considered rural and have at least one pharmacy providing care under at least one protocol. Within these 44 counties, there are a total of 74 pharmacies providing protocol-based

[32]Kayla Carter Smith, *County Stats: Rural and Urban Population Breakdown*, KACO (Nov. 26, 2024), https://kaco.org/articles/county-stats-rural-and-urban-population-breakdown/.

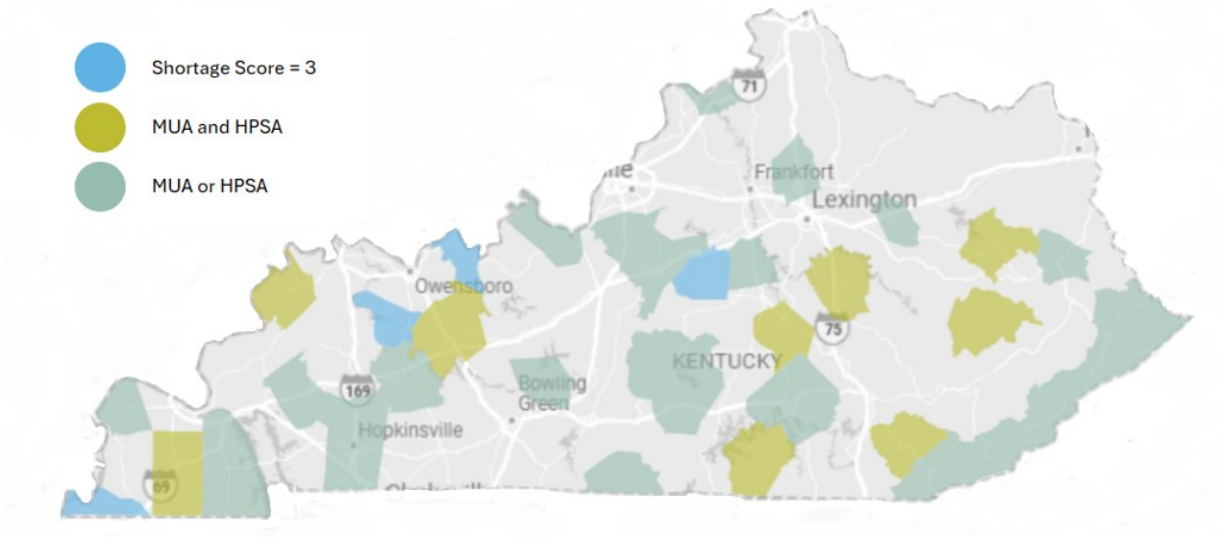
[33] Dave L. Dixon et al., *Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States*, 6 JAMA NETWORK OPEN 11 (Nov. 3, 2023), https://doi.org/10.1001/jamanetworkopen.2023.41408. Wesley Nuffer et al., *Estimated Potential Financial Impact of Pharmacist-Delivered Disease Management Services Across a Network of Pharmacies in Rural Colorado*, 25 J. MANAGED CARE & SPECIALTY PHARMACY 984 (2019) https://doi.org/10.18553/jmcp.2019.25.9.984; Armando Silva Almodovar et al., *Return on Investment of Pharmacists' Services Among Non-Hospitalized Patients: A Scoping Review*, 21 RES. SOC. & ADMIN. (2025), https://doi.org/10.1016/j.sapharm.2025.01.012.

[34] Data provided by the Kentucky Board of Pharmacy, shared 17 May 2025. Note, totals do not include immunization or naloxone protocols, as they are not reported to the Board.

services.[35] Leveraging this information, *Figure 5* further illustrates the saturation of pharmacies currently providing services through Board-approved protocols in areas that are considered underserved or shortage areas. While these are not currently reimbursable services in the Medicaid and KCHIP program, the highlighted areas are currently served by pharmacists providing clinical services under protocol and it would be reasonable to expect that services could be enhanced to serve patients more quickly. To further underscore the potential impact:

- There are 63 pharmacies with approved protocols in 37 MUA-designated counties.
- There are 18 pharmacies with approved protocols in 13 HPSA-designated counties.
- There are five pharmacies in four of the counties with a proxy access score of "3" as described above.

Figure 5: Counties with Pharmacies Enrolled in Board Protocols in Underserved or Shortage Areas



As described previously, Kentucky-based stakeholders expressed concerns regarding barriers to pharmacist provision of clinical services (i.e., enrollment, contracting, and medical claims billing). For these reasons, the fiscal impact analyses assumed a minimal "uptake" in services during year one and a slight increase in years two and three. However, it is reasonable to expect that reimbursing pharmacists for services could result in increased access over time, particularly in rural communities.

[35] A detailed list of Kentucky Board of Pharmacy approved protocols, and the number of pharmacies approved for protocol participation, is included in Appendix D.

Changes Necessary for Compliance

The DMS collaborated with Myers and Stauffer, Gainwell Technologies, Milliman, peer states, and Kentucky-based stakeholders to identify the changes necessary to comply with KRS 304.12-237. Administrative activities, associated costs, and a high-level implementation timeline are provided below.

Administrative Activities[36]

Successful implementation of pharmacist payment parity in Kentucky Medicaid and KCHIP would require a coordinated series of administrative activities including at least one SPA, reimbursement rate setting and provider billing guide updates, MCO contract updates, claims processing system updates, credentialling and enrollment processes, outreach and education, and pharmacy workflow integration.

Medicaid SPAs

States must submit a SPA when making significant changes to Medicaid services and/or provider reimbursement. This SPA represents an agreement between a state and the Federal government describing how the state administers its Medicaid and KCHIP program and provides assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. Most relevant to this report are: 1) changes to services, generally found in Attachment 3.1-A; and 2) changes to reimbursement methodology or payment for services, generally found in Section 4.19-B. Subject to CMS confirmation, Attachment 3.1-A of Commonwealth's Medicaid State Plan appears broad enough to allow pharmacists to provide clinical services as contemplated in SJR 26. Specifically, item (e) provides in part that "Licensed pharmacists may perform all services pursuant to their scope of practice and approved by the Kentucky Board of Pharmacy."[37] However, Attachment 4.19-B, would likely require an update to specify the appropriate payment rate for pharmacists providing services as contemplated in SJR 26. Prior to requesting CMS approval for this update, DMS must provide public notice and comment in accordance with 42 CFR 447.205.[38]

Reimbursement Rate Setting and Provider Billing Guide Updates

In concert with SPA submission, DMS will need to establish reimbursement rates for pharmacist-specific services not already included in the FFS fee schedule. This includes MTM services, alcohol or substance misuse assessments, and telemedicine visits. It is anticipated that rates would be set at 75% of the physician fee schedule, as APRNs and PAs are generally paid 75% of the outpatient non-facility rate for services like primary care/clinical services. In addition, DMS will need to update its Provider Billing Guide including, but not limited to, creation of a pharmacist-specific manual detailing specific Procedure Codes and Place of Service Codes, along with detailed instructions for pharmacist billing. There is no fixed timeframe for updating a Provider Billing Guide, and rate setting activities would likely be minimal. DMS will work with Milliman to determine if an adjustment to the capitation rates is required. The capitation rate setting process would include an assessment of any changes required and is expected to be

[36] Note, while the Kentucky Board of Pharmacy Board requires pharmacists performing clinical and prescribing services to submit signed protocols for approval and Board inspectors may review training records to ensure compliance with the protocols, it did not identify any changes to its current processes or additional costs that would be incurred if DMS were required to comply with KY. REV. STAT. ANN. §304.12-237.

[37] KENTUCKY STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM, Attachment 3.1-B, 17, https://www.chfs.ky.gov/agencies/dms/Documents/StatePlanr1.pdf.

[38] 42 C.F.R. § 447.205 (2024), https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-B/section-447.205.

incorporated into the Commonwealth's standard rate setting and contracting processes. DMS also anticipates a similar need for the MCOs to perform corresponding updates to billing guides and other provider documents.

Managed Care Contract Updates

The current MCO contracts require compliance with all applicable Commonwealth laws, which could include payment parity. However, in addition to capitation rate updates, DMS may amend the contracts to specifically reference pharmacist payment parity requirements. Incorporating amendments is an opportunity to formalize requirements and allowances for pharmacist billing of clinical services provided within their scope of practice. Further, MCO Contract Appendix H (i.e., Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program) lists specific EPSDT program services and in some cases associated providers. For consistency, DMS may also elect to add pharmacists to Appendix H. Finally, DMS may elect to require MCOs to update their provider contracts to include eligible pharmacy providers. Kentucky normally performs one MCO contract update annually; this process generally requires six months to complete, exclusive of CMS approval. DMS will also work with Milliman to determine if an adjustment to the capitation rates should be incorporated into the MCO contract update.

Claims Processing System Updates

To effectively reimburse pharmacy providers, DMS's claims processor will need to update its systems to include a pharmacist provider type and implement the appropriate coding and payment programming. Gainwell Technologies has indicated that this could require three to six months, including requirements gathering, programming, testing, and implementation. While not a DMS responsibility, individual providers may also require significant changes to their medical billing and documentation software. Some community pharmacies have experience with the medical claims billing process if they bill Medicaid and other payers for DME; however, others may be required to purchase and implement new software to allow for visit documentation and generation and submission of claims. Some locations may opt for standalone billing platforms, while others may opt for add-on solutions that integrate with existing pharmacy software. Note, DMS' KY HealthNet website allows Medicaid providers to submit claims online via a secure and direct data entry function. This could provide a cost-effective and easily deployable solution for pharmacists who bill limited claims, or it could serve as an interim solution for providers implementing an integrated system into their pharmacy workflow software.

Credentialing and Enrollment

As previously described, individual pharmacies would be required to enroll as medical providers with both the Medicaid FFS program and each contracted MCO. Individual pharmacists would also be required to enroll as rendering providers by submitting an online application through the Kentucky Medicaid Provider Enrollment Portal. DMS may collaborate with its contracted MCOs to determine whether pharmacists should fall under MCO credentialing requirements. If the decision is made to require credentialing, all MCOs should be required to credential pharmacists in the same manner to reduce confusion, streamline the process, and ensure consistency. KRS 205.532 requires that enrollment be completed within 60 days, and any required credentialing be completed within 30 days of receipt of a

clean application.[39] A state-led centralized credentialing process may require additional time, funding and resources; DMS may also consider a credentialing process that is led by a provider organization.

Outreach & Education

Peer states and Kentucky-based stakeholders consistently emphasized the importance of outreach and education to support implementation of the pharmacist payment parity policy. As such, DMS may begin working with providers, payers, and patients early in the implementation process to develop comprehensive training materials (e.g., bulletins, FAQs, and training webinars to guide pharmacists through enrollment, billing, and documentation processes), payer education resources, and patient outreach tools (e.g., explaining new service offerings and advertising locations of available services). These preparatory efforts could ensure that pharmacists are equipped to enroll, document, and bill for services appropriately once the pharmacist parity policy is in effect. DMS may leverage resources from peer states, Kentucky-based stakeholders (e.g., KPhA and the University of Kentucky),[40] and/or the Community Pharmacy Enhanced Services Networks (CPESN). Engagement with health systems and managed care organizations will also be integral to successful implementation.

Pharmacy Workflow Integration

Pharmacy workflow integration will play an important role in the implementation and scaling of pharmacy-based clinical services. Some pharmacy locations incorporate clinical services into existing workflows; however, more intensive services may require workflow redesign and/or hiring dedicated clinical staff. Pharmacies may invest in appointment scheduling tools to support staff planning and/or consider offering more time-consuming services (e.g., MTM) at slower times during the week. As with pharmacist education, stakeholders emphasized that education is also critical for payers and patients. Interviewees noted that commercial payers were slow to make changes after the enactment of KRS 304.12-237, which contributed to service adoption. To ease these difficulties with Medicaid MCOs, DMS will plan for ongoing engagement with the MCOs, including encouraging MCOs to designate a pharmacist liaison or other support contact to assist with the enrollment and billing processes. Both DMS and individual pharmacies must engage with patients to promote pharmacy-based clinical services. DMS may perform outreach to members regarding new offerings, and pharmacies should advertise which services are available at their locations.

Associated Costs

Costs associated with the above administrative activities would primarily result from proposed changes to the Medicaid claims processing system. Specifically, DMS's contracted vendor, Gainwell Technologies, estimated that it would cost approximately $128,050 to create a new pharmacist provider type and implement the required programming. Programming of claim edits could align with those utilized for other nonphysician providers and may be updated as claims experience with pharmacists is analyzed. This cost estimate allows for the initial programming of a select list of 48 procedure codes based on the currently approved Kentucky Board of Pharmacy protocols. Additional codes or edits could be implemented in the future and may be subject to additional costs.

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[39] KY. REV. STAT. ANN. § 205.532, https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=54016.

[40] These organizations developed and delivered extensive training to pharmacists in advance of the implementation of HB 48 and KY. REV. STAT. ANN. § 304.12-237 and are well positioned to assist during the transition period.

DMS anticipates minimal costs associated with adding pharmacists to the enrollment and credentialing process, including staff time; costs associated with developing and delivering provider training; staff time for developing and disseminating provider notices, and creation of a pharmacy-specific billing manual. Additional costs related to the development of the SPA, as well as managed care contracting and capitation rate setting are additional, and are anticipated to be included in future contracts or existing staff salaries.

Implementation Timeline

DMS estimates that the completion of the above administrative activities would take approximately 12 to 18 months, depending on federal review timelines, staffing, and system readiness. Unanticipated time constraints or fiscal impacts due to recent federal budget activities or legislative activities are not reflected in the estimates. Timeframes for specific activities are highlighted below:

- SPA development, submission, and approval could take three to six months, based on input from peer states and prior DMS experience.[41]
- MCO capitation rate setting and contract amendments could take six months to complete. MCO provider contracting and credentialing (if required) should be completed within three to four months.
- Gainwell Technologies estimates that necessary changes to the Medicaid claims processing system could take approximately three to six months.
- Implementation of updated credentialling processes could take three to six months if DMS determines such a requirement is necessary for pharmacists.
- Provider training and communication activities, including developing materials, may occur over nine to twelve months to ensure adequate opportunities for provider interaction. These activities can occur concurrently with other activities such as State Plan Amendment development, rate setting, and contracting.
- Pharmacy workflow integration depends upon individual pharmacy practice capacity, current staffing and workflow practices and the level of need for clinical and billing software acquisition and deployment. It could be expected to take six to twelve months for pharmacies to develop or expand their capabilities to provide clinical services, depending on their current abilities to provide services under a Kentucky Board of Pharmacy-approved protocol.

[41] This assumes 30 days for SPA development, a 30-day public notice and comment period, and 90-day CMS review period. Note, if CMS requires additional information, this 90-day “clock” will be suspended until a response is provided.

Conclusion

The findings in this report and the research available indicate that a pharmacist payment parity policy for Kentucky Medicaid and KCHIP that complies with KRS 304.12-237 could require moderate administrative changes, limited upfront investment, and coordinated stakeholder engagement. Further, there may be a minimal fiscal impact, while offering potentially significant benefits in access to care and health outcomes.

The anticipated timeline for implementation is 12-18 months, which allows time for systems development, communication and provider training. Recent legislative activities at the state and federal level could impact this timeline.

As the legislature considers its next steps, DMS would like to offer the following considerations:

- ***Reimbursement for Full Scope of Practice Services****:* DMS may consider supporting a parity policy that would permit pharmacists to bill for a comprehensive set of clinical services that fall under Kentucky Board of Pharmacy-approved protocols.
- ***Streamlined Credentialing and Enrollment Processes****:* DMS may consider supporting a streamlined and, where feasible, centralized credentialing process across Medicaid MCOs to reduce the administrative burden and improve provider service adoption. DMS may also consider a credentialing process that is performed by a provider organization.
- ***Education and Outreach****:* Ensure DMS has the necessary resources to develop training materials and conduct outreach efforts to pharmacists, MCOs, and patients to ensure efficient and effective policy implementation and to maximize service adoption.
- ***MCO Alignment and Coordination****:* DMS may consider encouraging MCOs to designate pharmacy liaisons and adopt standardized procedures to ensure consistent implementation across plans.
- ***Targeted Implementation****:* DMS may consider prioritizing outreach and enrollment efforts in counties with low access to primary care.

By moving forward with these strategies, the Commonwealth may have an opportunity to expand access to care, particularly in rural communities, and create a more resilient, patient-centered Medicaid program.

Appendix A: Procedure Codes and Corresponding Fee Schedule Rates

Proc. Code	Procedure Code Description	Fee Schedule Rate	2023 Physician Claims	2023 Nonphysician Claims	2024 Physician Claims	2024 Nonphysician Claims
80305	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	$12.60	2,501	475	2,100	585
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	$3.48	775	694	656	735
82565	Creatinine; blood	$5.12	427	3	393	5
86580	Skin test; tuberculosis, intradermal	$6.95	59	42	48	34
86803	Hepatitis C antibody	$14.27	4	-	2	-
87389	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immuno-sorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	$24.08	1	-	2	1
87400	Infectious agent antigen detection by immunoassay technique (EG, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; Influenza, A or B	$14.13	81	46	122	74
87426	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])	$35.33	454	576	678	579
87428	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B	$30.94	295	367	737	631
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types	$95.80	105	134	149	141
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), amplified probe technique	$51.31	196	142	227	220
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique	$142.63	301	237	299	347

87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique	$35.09	385	289	454	406
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique	$70.20	2	1	3	3
87804	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Influenza	$16.55	785	510	859	630
87811	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	$41.38	123	58	226	156
87880	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Streptococcus, group A	$16.53	1,099	957	1,276	1,055
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	$9.36	422	1,074	339	964
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	$18.10	5,398	4,102	4,421	3,441
98960	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	$22.53	-	2	5	3
98966	Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or the soonest available appointment: 5-10 minutes of medical discussion	$11.17	-	4	1	2
98967	Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or the soonest available appointment: 11-20 minutes of medical discussion	$21.80	-	4	-	3
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	$53.00	525	300	376	200
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	$79.04	6,534	2,266	6,446	2,468
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	$16.98	1,618	297	960	461

99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	$31.08	4,564	1,924	3,713	1,929
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	$42.63	59,047	34,074	55,624	37,748
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	$25.64	11	7	3	16
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	$11.34	786	489	813	580
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	$21.95	97	26	85	32
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	$20.98	1	1	3	1
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	$29.93	5,408	140	6,202	175
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	$33.25	11,471	518	11,486	591
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.	$65.84	26	57	13	44
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	$50.50	8	-	7	-
G0396	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	N/A	8	3	32	9

Appendix B: ICD-10 Codes

ICD-10 Code	ICD-10 Description
U07.1	COVID-19
Z11.52	Encounter for screening for COVID-19
Z20.822	Contact with and (suspected) exposure to COVID-19
J10.00	Influenza due to other identified influenza virus with unspecified type of pneumonia
J10.01	Influenza due to other identified influenza virus with the same other identified influenza virus pneumonia
J10.08	Influenza due to other identified influenza virus with other specified pneumonia
J10.1	Influenza due to other identified influenza virus with other respiratory manifestations
J10.2	Influenza due to other identified influenza virus with gastrointestinal manifestations
J10.81	Influenza due to other identified influenza virus with encephalopathy
J10.82	Influenza due to other identified influenza virus with myocarditis
J10.83	Influenza due to other identified influenza virus with otitis media
J10.89	Influenza due to other identified influenza virus with other manifestations
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
N39.0	Urinary tract infection, site not specified
J02.0	Streptococcal pharyngitis
B95.0	Streptococcus, group A, as the cause of diseases classified elsewhere
Z11.2	Encounter for screening for other bacterial diseases

Appendix C: Access to Care Scoring Report

County	2024 Population	Pharmacy Count	Hospital (Y/N)	MUA (Y/N)	HPSA (Y/N)	Medical Provider Access (3 = worst)
Adair	19,239	7	Y	Y	N	1
Allen	22,037	3	Y	Y	N	1
Anderson	24,883	4	N	N	N	1
Ballard	7,626	2	N	Y	N	2
Barren	45,609	15	Y	N	N	0
Bath	12,951	4	N	Y	N	2
Bell	23,051	14	Y	Y	N	1
Boone	144,135	21	Y	N	N	0
Bourbon	20,333	5	Y	Y	N	1
Boyd	47,777	16	Y	N	N	0
Boyle	31,394	7	Y	N	N	0
Bracken	8,497	2	N	Y	N	2
Breathitt	12,804	5	Y	Y	Y	2
Breckinridge	21,221	4	Y	Y	Y	2
Bullitt	85,802	10	Y	Y	N	1
Butler	12,551	2	N	Y	N	2
Caldwell	12,611	4	Y	Y	N	1
Calloway	38,975	8	Y	N	N	0
Campbell	94,008	13	Y	N	N	0
Carlisle	4,777	2	N	Y	Y	3
Carroll	11,111	4	Y	Y	N	1
Carter	26,098	7	N	Y	N	2
Casey	15,948	4	Y	Y	Y	2
Christian	71,006	14	Y	Y	N	1
Clark	37,673	9	Y	N	N	0
Clay	19,592	9	Y	Y	Y	2
Clinton	9,183	3	Y	Y	Y	2
Crittenden	8,982	3	N	Y	N	2
Cumberland	6,047	2	Y	Y	N	1
Daviess	104,457	24	Y	N	N	0
Edmonson	12,635	3	N	Y	N	2
Elliott	7,263	3	N	Y	Y	3
Estill	14,002	5	Y	Y	N	1
Fayette	329,437	71	Y	N	N	0
Fleming	15,591	3	Y	N	N	0
Floyd	34,532	26	Y	N	N	0
Franklin	52,442	7	Y	N	N	0
Fulton	6,282	3	N	Y	Y	3
Gallatin	8,805	1	N	N	N	1
Garrard	18,040	3	N	Y	N	2
Grant	25,722	5	Y	N	N	0

Graves	36,821	8	Y	Y	Y	2
Grayson	27,070	6	Y	N	N	0
Green	11,552	3	Y	Y	N	1
Greenup	35,273	7	N	Y	N	2
Hancock	9,013	1	N	Y	Y	3
Hardin	112,826	26	Y	N	N	0
Harlan	25,052	10	Y	Y	N	1
Harrison	19,525	6	Y	N	N	0
Hart	19,923	3	Y	Y	Y	2
Henderson	44,175	8	Y	N	N	0
Henry	16,198	3	N	N	N	1
Hickman	4,393	2	N	Y	Y	3
Hopkins	45,218	12	Y	N	N	0
Jackson	13,358	3	N	Y	Y	3
Jefferson	793,881	153	Y	N	N	0
Jessamine	56,495	10	N	N	N	1
Johnson	22,098	11	Y	Y	N	1
Kenton	174,862	24	Y	N	N	0
Knott	13,438	5	N	Y	Y	3
Knox	29,657	7	Y	Y	Y	2
Larue	15,128	3	N	Y	N	2
Laurel	63,353	12	Y	N	N	0
Lawrence	15,798	4	Y	N	N	0
Lee	7,313	3	N	Y	Y	3
Leslie	9,729	4	Y	Y	N	1
Letcher	20,139	9	Y	Y	N	1
Lewis	12,875	5	N	Y	N	2
Lincoln	24,910	4	Y	Y	Y	2
Livingston	8,815	3	Y	Y	N	1
Logan	28,467	7	Y	Y	N	1
Lyon	9,078	2	N	Y	N	2
Madison	99,582	18	Y	Y	N	1
Magoffin	11,118	6	N	Y	N	2
Marion	19,851	6	Y	Y	N	1
Marshall	31,734	7	Y	Y	N	1
Martin	10,696	7	N	Y	N	2
Mason	16,956	7	Y	N	N	0
McCracken	67,550	20	Y	N	N	0
McCreary	16,824	4	N	Y	Y	3
McLean	9,126	2	N	Y	Y	3
Meade	30,442	3	N	Y	N	2
Menifee	6,341	2	N	Y	Y	3
Mercer	23,515	5	Y	Y	N	1
Metcalfe	10,558	2	N	Y	Y	3
Monroe	11,163	5	Y	Y	N	1
Montgomery	28,771	9	Y	Y	N	1
Morgan	14,300	3	Y	Y	Y	2
Muhlenberg	30,512	9	Y	Y	N	1
Nelson	48,706	8	Y	Y	N	1
Nicholas	7,816	3	N	Y	Y	3

Ohio	23,933	5	Y	Y	Y	2
Oldham	70,525	10	Y	N	N	0
Owen	11,435	2	N	Y	Y	3
Owsley	3,928	3	N	Y	Y	3
Pendleton	14,844	2	N	N	Y	2
Perry	26,739	16	Y	N	N	0
Pike	55,430	33	Y	Y	N	1
Powell	12,928	5	N	Y	N	2
Pulaski	66,842	16	Y	Y	N	1
Robertson	2,382	0	N	Y	Y	3
Rockcastle	16,226	5	Y	Y	N	1
Rowan	24,675	9	Y	N	N	0
Russell	18,458	6	Y	Y	N	1
Scott	61,700	7	Y	Y	N	1
Shelby	50,124	6	Y	N	N	0
Simpson	20,350	4	Y	N	N	0
Spencer	20,823	3	N	Y	N	2
Taylor	26,809	6	Y	Y	N	1
Todd	12,757	1	N	Y	Y	3
Trigg	14,559	2	Y	Y	Y	2
Trimble	8,591	1	N	Y	N	2
Union	13,178	5	Y	Y	Y	2
Warren	147,936	25	Y	N	N	0
Washington	12,269	3	N	Y	Y	3
Wayne	19,629	7	Y	Y	Y	2
Webster	12,854	5	N	Y	N	2
Whitley	37,233	19	Y	N	N	0
Wolfe	6,364	3	N	Y	N	2
Woodford	27,728	6	Y	N	N	0

Appendix D: Board Protocols and Enrolled Providers

Protocol Name	Pharmacies Enrolled
Acute Influenza Infection: Antiviral Therapy Protocol	118
Acute Group A Streptococcal (GAS) Pharyngitis Infection Protocol	118
Acute Influenza Infection: Chemoprophylaxis Protocol	109
Self-Care Conditions Protocol: Diabetes Testing & Injection Supplies	20
Tobacco Cessation Protocol	17
SARS-CoV-2 Therapeutics Protocol	15
Anaphylaxis Treatment Protocol for Emergency Epinephrine Injection Devices	13
Colorectal Cancer [CRC] Screening Protocol	8
Protocol for Pharmacist Dispensing of Allergic Rhinitis Therapies	8
Acute Uncomplicated Urinary Tract Infection Treatment Protocol	8
Self-Care Conditions Protocol: Over-the-Counter Probiotics	6
Self-Care Conditions Protocol: Emergency Contraception	5
Self-Care Conditions Protocol: Over-the-Counter Dietary Supplement Protocol	4
Tuberculin Skin Testing One-Step Protocol	3
Travel Health Therapies Protocol	3
Nutritional Supplementation Protocol	3
Opioid Use Disorder Protocol utilizing Naltrexone-based Therapy	3
Tuberculin Skin Testing Two-Step Protocol	2
Self-Care Conditions Protocol: Hormonal Contraception	1