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## State/Territory Name: Kentucky

## State Plan Amendment (SPA)#:KY-23-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850


**Center for Medicaid and CHIP Services**

**Medical Benefits and Health Programs Group**

July 14, 2023

Lisa Lee
Commissioner
Commonwealth of Kentucky
Department for Medicaid Services
275 E. Main St
Frankfort, KY 40601

Dear Lisa Lee:

The CMS Division of Pharmacy has reviewed Kentucky's State Plan Amendment (SPA) 23-0009 received in the CMS Medicaid & CHIP Operation Group on April 28, 2023. This SPA proposes to modify language on the Pharmacy coverage pages to reflect coverage of selective non-prescription (over-the-counter) medications, as well as removing language regarding coverage of cosmetic and hair growth agents from the excluded drug list.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 23-0009 is approved with an effective date of July 1, 2023.

We are attaching a copy of the signed, revised CMS-179 form, as well as the page approved for incorporation into Kentucky's state plan. If you have any questions regarding this amendment, please contact Charlotte Hammond at (410) 786-1092 or charlotte.hammond@cms.hhs.gov.

Sincerely,

[redacted]

Mickey Morgan
Acting Deputy Director
Division of Pharmacy

cc: Kelli M. Sheets, Kentucky Medicaid, Federal Program Specialist
Christine Davidson, CMS, Medicaid and CHIP Operations Group
Keri Toback, CMS, Medicaid and CHIP Operations Group

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

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 23 — 0009

2. STATE: KY

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. 440.60

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Page 7.5.1
Attachment 3.1-A Page 15
Attachment 3.1-B Page 31
Attachment 3.1-B Page 41

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Page 7.5.1
Attachment 3.1-A Page 15
Attachment 3.1-B Page 31
Attachment 3.1-B Page 41

9. SUBJECT OF AMENDMENT

Selective non-prescription (over-the-counter) medication will be covered as listed on the state website. Removed cosmetic and hair growth from state plan per the CURES Act guidance.

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

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Lisa Lee

13. TITLE
Commissioner

14. DATE SUBMITTED
4/28/2023

15. RETURN TO
Lisa Lee
275 E. Main St.
Frankfort, KY 40601

***FOR CMS USE ONLY***

16. DATE RECEIVED
APRIL 28, 2023

17. DATE APPROVED
JULY 14, 2023

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL
JULY 1, 2023

19. [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
MICKEY MORGAN

21. ACTING DEPUTY DIRECTOR, DIVISION OF PHARMACY

22. REMARKS



***Instructions on Back***

# INSTRUCTIONS FOR COMPLETING FORM CMS-179

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Block 16–22 (FOR CMS USE ONLY).**

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

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

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

| Citation (s) | Provision (s) |
|---|---|
| 1927(d)(2) and 1935(d)(2) | 1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.<br><br>__ The following excluded drugs are covered:<br><br>☒ (a) agents when used for anorexia, weight loss, weight gain (limited weight gain only)<br><br>☐ (b) agents when used to promote fertility<br><br>☒ (c) agents when used for the symptomatic relief cough and colds<br><br>☒ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride<br><br>☒ (e) nonprescription drugs<br>Specific category of drugs:<br>Selective non-prescription ( over-the-counter) medications will be covered as listed on the state's website |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

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