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August 3, 2026

The Honorable Greg Elkins, Co-Chair
The Honorable Scott Sharp, Co-Chair
Legislative Oversight and Investigations Committee
702 Capital Avenue
Frankfort, Kentucky 40601

Co-Chairs Elkins and Sharp:

I write in response to your questions on the September 2025 Auditor of Public Accounts (APA) report on concurrent capitation payments.

A complete analysis of the underlying Medicaid enrollment data does not support the Auditor's final conclusion that Kentucky Medicaid "wasted" more than $800 (approximately $600 federal/$200 state) million dollars over a period of four years. The Auditor's report is an incomplete analysis that appears to count everyone who appeared to be enrolled in Medicaid in Kentucky and another state at the same time as wasteful spending. The Auditor fails to take any steps to determine which state was actually responsible for covering those individuals or whether any duplicate payments for medical services occurred. Because the estimate is based on enrollment overlaps rather than confirmed improper payments, the $800 million figure should not be viewed as a measure of actual waste, fraud, or abuse, nor as a verified amount of improper spending.

Question 1: Were the approximately 50 contractors hired? If so, what progress have they made on the capitation payments?

a. If the contractors were not hired, why were they not hired and were any alternative methods taken?

CHFS Response: Contractors were initially hired in August 2023 to help the Department for Community Based Services (DCBS) address a backlog of Public Assistance Reporting Information System (PARIS) tasks. PARIS provides quarterly data to states to identify individuals who may be enrolled in Medicaid in more than one state at the same time, also referred to as concurrent enrollment.

The Cabinet for Health and Family Services (CHFS) was unable to obtain federal approval to grant contractors full access to the Integrated Eligibility and Enrollment System (IEES), which is required to process PARIS matches and resolve cases. However, DCBS implemented an alternative plan to help reduce the backlog. Contractors provided support by conducting activities related to PARIS matches, including outreach to individuals and verification of supporting information, which enabled DCBS to make Medicaid eligibility determinations.

DCBS does not collect capitation payments. When a potential concurrent enrollment is identified, states coordinate to determine which enrollment is valid. Some concurrent enrollments are legitimate, such as when an individual moves between states during the same month. Because Kentucky Medicaid eligibility is month-pure, more than one state may make capitation or claim payments for the same beneficiary in a given month.

Residency updates are generally applied prospectively unless sufficient evidence supports a retroactive effective date. If a retroactive date is entered into the IEES after a capitation payment has been made, the information is sent electronically to the Medicaid Management Information System, which would then recoup the payment.

Question 2: What information is needed to recover concurrent capitation payments?

CHFS Response: To recover capitation payments, the state must first verify that concurrent Medicaid enrollment occurred and determine which state had valid responsibility for coverage during the applicable period. This generally requires confirmation of residency, eligibility dates, enrollment status and any retroactive eligibility changes.

If a retroactive change is entered into the IEES establishing that Kentucky coverage should not have been active for any prior month, the updated information is transmitted to the Medicaid Management Information System (MMIS). MMIS can then identify and recoup any capitation payment made for periods in which the individual was not eligible for Kentucky Medicaid coverage.

Question 3: How does CHFS verify residency for benefit recipients?

CHFS Response: The Centers for Medicare and Medicaid Services (CMS) require states to primarily use electronic data sources to verify information used in Medicaid eligibility determinations. Kentucky's IEES uses more than thirty-five (35) federal, state, and commercial data sources to support eligibility determinations, including sources required or recommended by CMS. These data sources are used to verify a range of eligibility criteria, including but not limited to income, employment, residency, identity, citizenship, and enrollment in other public benefit programs.

To verify residency, Kentucky Medicaid relies on several federal data sources, including the Social Security Administration's Beneficiary and Earnings Data Exchange (BENDEX) and State Data Exchange (SDX), the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) system, and the federally required PARIS. Kentucky Medicaid evaluates

all available information, including electronic data and documentation provided by the individual, to determine whether residency and other eligibility requirements are met.

After enrollment, if Kentucky receives information indicating that a Medicaid member may no longer meet Kentucky residency requirements or may be concurrently enrolled in another state's Medicaid program, additional verification is conducted before taking any action affecting eligibility. This is consistent with federal requirements governing eligibility actions and beneficiary due process protections.

Question 4: The APA recommended that the Department for Medicaid Services communicate with the federal government about gaining access to T-MSIS data for more timely identification of concurrent Medicaid enrollees (Solution 2, Recommendation, p. 16). Has CHFS explored this recommendation and does it seem feasible?

CHFS Response: As indicated in the CHFS response to the APA's draft audit, CHFS is committed to partnering with the federal government to address the issue of concurrent enrollment. CHFS also agreed that it would be beneficial to use T-MSIS as a tool to more timely identify concurrent enrollment. However, the Department for Medicaid Services does not have operational control over T-MSIS data matching processes or the timing of data available through CMS systems for identifying potential concurrent enrollment across states. In July 2025, prior to the APA's recommendation, CMS issued a press release committing to providing the necessary data to verify residency.

In December 2025, CMS provided CHFS with a file identifying potential concurrent enrollment cases covering the period from May 2024 to May 2025. CHFS reviewed and processed those cases according to CMS guidance and applicable federal Medicaid eligibility requirements. Consistent with federal requirements governing eligibility actions and beneficiary due process protections, any resulting coverage terminations were processed prospectively as sufficient verified information did not exist to support a retroactive eligibility action. No additional files have been received.

Question 5: The APA stated that workers were not given written procedures and training needed to address concurrent payments (State Issue 2, p. 18, 24). What progress has been made in disseminating training resources for addressing PARIS alerts to Kentucky Medicaid workers?

CHFS Response: The Department for Community Based Services (DCBS) maintains a Kentucky PARIS Match Task Training Guide. DCBS also provides ongoing training to staff on how to complete PARIS match tasks and address concurrent enrollment issues. Most recently, DCBS enhanced these efforts by providing in-person training for Medicaid specialists. In addition, DCBS staff are updating Medicaid policy manuals to provide further clarification and guidance regarding this process in response to recent CMS actions and federal laws related to concurrent enrollment.

Question 6: Has CHFS taken any other steps to address concurrent payments?

CHFS Response: CHFS continues to monitor the current process and developments at the federal level and Kentucky Medicaid has procedures in place to identify potential out-of-state residency or concurrent enrollment in another state's Medicaid program.

Question 7: Based on Figure 5 (p. 29) of the APA report, there were 1,605,098 concurrent capitation payments and 112,785 unique individuals associated with capitation payments from 2019 to 2022. How many of those payments have been reviewed or recovered?

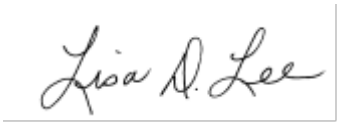
CHFS Response: The APA's findings contained significant inaccuracies, relied heavily on unsubstantiated assumptions, and did not provide sufficient verifiable evidence to independently determine whether recovery of capitation payments was warranted. Although the APA's report referenced evidence of potential concurrent enrollment, residency and eligibility determinations were not verified through the federally required Medicaid eligibility processes. CHFS was not provided with sufficient case-specific information necessary to independently validate those findings or determine whether retroactive eligibility changes were appropriate under federal requirements.

The APA's review period also occurred during the Public Health Emergency, when federal requirements limited Kentucky Medicaid's ability to disenroll individuals unless there was clear evidence that they were no longer Kentucky residents. However, Kentucky Medicaid continued to verify residency throughout the Public Health Emergency and disenrolled 56,440 individuals during the review period based on sufficient evidence that they were no longer Kentucky residents.

Without access to the underlying case-level data, it is not possible to determine whether individuals identified were Kentucky residents or whether the enrollment error may have occurred in another state's system. It would be inappropriate to assume that all instances of concurrent enrollment were improper. Certain concurrent enrollments may be valid depending on the individual circumstances, including the timing of interstate moves and eligibility determinations.

A detailed eligibility review is required for each individual case before determining whether a retroactive eligibility change or recovery of capitation payments is appropriate. Even if the necessary data were provided, the time elapsed between identification of the potential concurrent enrollment and completion of an eligibility review would make retroactive disenrollment inappropriate or unsupported under federal requirements. Medicaid members are also entitled to advance notice and appeal rights before adverse action affecting eligibility may be finalized.

Sincerely,



Lisa D. Lee, Commissioner