LEGISLATIVE OVERSIGHT & INVESTIGATIONS COMMITTEE

Minutes

August 13, 2026

Call to Order and Roll Call

The fifth meeting of the Legislative Oversight and Investigations Committee was held on Thursday, August 13, 2026, at 1 p.m. ET/12 p.m. CT in Room 131 of the Capitol Annex. Senator Greg Elkins, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Senator Greg Elkins, Co-Chair; Representative Scott Sharp, Co-Chair; Senator Jason Howell, Vice Chair; Senators Gerald A. Neal, Aaron Reed, and Reginald L. Thomas; Representatives John Blanton, Lindsey Burke, Adrielle Camuel, Matt Lockett, Steve Riley, and Tom Smith.

Guests: Alex Magera, general counsel, Office of Legal and Records Services, Auditor of Public Accounts; Tom Stephens, president and CEO, Kentucky Association of Health Plans; Chris Lindy, CEO, Aetna Better Health of Kentucky; Jeb Duke, health plan leader, Humana; Ryan Sadler, plan president and CEO, Molina Passport; Corey Ewing, plan president and CEO, WellCare of Kentucky; and Krista Hensel, CEO, Community Plan of Kentucky, UnitedHealthcare.

LRC Staff: Jacob Blevins, Austin Fraley, Christopher T. Hall, Taylor Johnston, Maegan Mohr, Jonathan Rickett, William Spears, Austin Sprinkles, Shane Stevens, Joel S. Thomas, Holly Tracy, and Olivia Walton.

Approve Minutes from July 6, 2026

Upon motion by Representative Blanton and second by Representative Lockett the minutes for the July 6, 2026, meeting were approved without objection.

2026 RS HB 500 Operational Expenditure Report Templates

Chair Elkins explained the Legislative Oversight and Investigations Committee was assigned to create forms to collect operational expenditure information from budget units through 2026 RS HB 500. The secretary called a roll call vote and the forms were adopted by the committee.

Potential Medicaid Issues Observed By Auditor Of Public Accounts

Alex Magera, general counsel, Office of Legal and Records Services, Office of the Auditor of Public Accounts (APA), presented a brief account of issues APA found while auditing Medicaid in Kentucky. Mr. Magera stated the three main goals of APA are to protect taxpayer dollars, preserve programs for people who need them, and ensure Kentucky maintains a federal funding stream for programs. In APA's September 2025 report, *How Kentucky Failed To Prevent Over*

$800 Million Of Medicaid Waste, the auditor identified instances of concurrent state enrollment. Each capitation payment is an actuarially estimated amount each beneficiary is allotted through managed care organizations (MCOs) for care every month. Individuals are only allowed to be in one state's Medicaid program but APA found individuals registered in multiple states. Mr. Magera summarized the findings of the September 2025 APA report which can be found on the APA website.

In response to Representative Lockett, Mr. Magera said capitation payments are paid to MCOs regardless of treatment received by the patient but a settlement process takes place at the end of the year, at which time MCOs work with the Cabinet for Health and Family Services (CHFS) to calculate overages. During its investigation, APA discovered instances where Medicaid caseworkers were told not to follow up on Public Assistance Reporting Information System (PARIS) alerts.

In response to Representative Blanton, Mr. Magera believed caseworkers were told not to follow up on PARIS alerts because they were lower priority.

Representative Blanton expressed concern that Medicaid fraud was going unreported due to the fear that Kentucky would be responsible for paying back 75 cents for every dollar of fraud to the federal government. Chair Elkins stated that CHFS would be present at the next meeting to answer any questions.

In response to Representative Smith, Mr. Magera interpreted the phrase "Medicaid for all" to mean whatever the General Assembly defined it to mean in statute.

In response to Representative Camuel, Mr. Magera said that CHFS's other priorities were not discovered during APA's investigation and CHFS would be better suited to answer the question.

In response to Co-Chair Sharp, Mr. Magera said caseworkers were told not to process PARIS alerts and did not have training to process the alerts at the time the APA's report was published, but CHFS could give an update. He does not know the cost of CHFS adding 50 employees to process backlogged PARIS alerts.

In response to Chair Elkins, Mr. Magera believes the General Assembly provided ample guardrails during the last session to fix the issues, but it is the executive branch's responsibility to execute the law.

Responses From Medicaid Managed Care Organizations

Tom Stephens, president and CEO, Kentucky Association of Health Plans, presented an opening statement describing MCO involvement with Medicaid. The MCOs believe Medicaid dollars should be spent appropriately and problems should be fixed. A data match identifying a potential duplicate enrollment does not mean an improper payment was made. APA's report covered a time period that included the COVID-19 public health emergency as well as continuous enrollment, which limited states' ability to disenroll members as a condition of

continuing enhanced federal funding. This distinction contextualizes some dual enrollments. Many issues in the report have already been addressed at the state and federal levels, including scheduled redetermination and enhanced data usage to verify eligibility. Medicaid eligibility and enrollment are determined by the state. MCOs receive lists of eligible patients. MCOs cannot terminate eligibility, decide which state is responsible, or return capitation payments when there is not a verified match, but they do report information that helps determine eligibility.

Chris Lindy, CEO, Aetna Better Health of Kentucky; Jeb Duke, health plan leader, Humana; Ryan Sadler, plan president and CEO, Molina Passport; Corey Ewing, plan president and CEO, WellCare of Kentucky; and Krista Hensel, CEO, Community Plan of Kentucky, UnitedHealthcare were available to take questions.

In response to Representative Blanton, Mr. Stephens said the Department for Medicaid Services under CHFS decides who is eligible for Medicaid. MCOs are told who is eligible to be insured by them.

In response to Senator Howell, Mr. Duke said MCOs are required to reach out to all eligible members to run a risk assessment but it is up to the patient to decide in which state they would like to reside and receive benefits. The MCOs coordinate with the federal and state governments to data match to catch duplicate enrollments. For most concurrent enrollments, their claims and acuity of care are low; if there are no costs for the patient, they would not be incorporated into capitation rates. Ms. Hensel said no rate setting process is perfect but safeguards ensure the state recaptures funds. Mr. Sadler said Kentucky has the most aggressive profit cap of any managed care program in the country. Mr. Duke said data matching with federal rolls is active in Kentucky and thousands of members were disenrolled due to duplicate enrollment. Ms. Hensel believes the guardrails enacted by the General Assembly have been helpful and this issue is nationwide. It is more efficient to catch fraud, waste, and abuse early so she advocates for more real-time data exchange. Mr. Lindy said work needs to continue to clarify details and definitions driving the six-month redetermination process, such as defining *frailty*. He believes the state has taken a significant step forward with the new legislation.

In response to Representative Lockett, Mr. Lindy said if the MCOs are not expending 90 cents for every capitation dollar on direct medical care, then that money must be refunded. Of the remaining total capitation rates, 9% is allocated to supporting functions like personnel with 1% left over for company profit. Mr. Ewing confirmed that dual enrollment is now being identified by the MCOs. Mr. Sadler said MCOs can only flag dual enrollment, not decide which state is responsible for the member. Mr. Lindy said if dual enrollment is identified, the MCOs must disclose it. It is up to the states to identify which state is the actual residence. Mr. Sadler said it is sometimes appropriate to be dually enrolled in the same month, particularly if the member moves midmonth.

In response to Representative Smith, Mr. Duke said he was unsure whether data regarding undocumented recipients was captured by the new safeguards, but he would get back to Representative Smith. MCOs have access to why their recipients are eligible. Mr. Sadler said the

new six-month redetermination requirements will help catch updates faster than in the past. The state has a process where it can retroactively disenroll someone who is no longer eligible and the MCOs refund those dollars.

In response to Representative Burke, Ms. Hensel agreed with the suggestion that it may be best to let the effects of 2026 RS HB 2 settle before implementing more changes. Mr. Duke suggested a collaborative relationship as the General Assembly implements additional changes to the Medicaid program.

In response to Representative Camuel, Mr. Lindy agreed that the majority of the data in the APA's report took place during the COVID-19 pandemic when states were required to keep people enrolled in Medicaid or face steep penalties. The unwinding of COVID-era provisions was completed a couple months ago.

In response to Co-Chair Sharp, Ms. Hensel said MCOs are notified of eligibility through an eligibility file, EDI 834, that refreshes daily in the MCOs' healthcare systems; the outreach process for Medicaid recipients is the same for all the MCOs. Mr. Sadler said the constant system update works well to ensure recipients receive care as they need it. The file also identifies the period in which the recipient is eligible. Molina Passport's program and system integrity tools are the same across all markets in the United States. Mr. Lindy suggested more consistent and thorough validations prior to receipt of eligibility and faster investigations by the state on flagged cases. Ms. Hensel suggested increased contact options for recipients. Mr. Duke said the MCOs might have suggestions for small adjustments that allow for a greater impact, such as flagging providers. Ms. Hensel agreed with the suggestion of flagging providers.

In response to Senator Thomas, Mr. Duke said there is no benefit to MCOs to either keep or disenroll members who are dually enrolled.

Adjournment

Upon motion by Representative Lockett and second by Representative Camuel, the meeting was adjourned at 2:37 p.m. ET/1:37 p.m. CT.