Kentucky Medicaid Oversight & Advisory Board

Findings and Recommendations

Based on the Medicaid Oversight and Advisory Board's (the Board) progress since its initial meeting on June 25, 2025, the Board has heard testimony from many stakeholders, including community members, beneficiaries, providers, advocates, managed care organizations, and Cabinet for Health and Family Services leadership including from the Department for Medicaid Services. The Board also has reviewed available data, consulted with research firms, and engaged with many other individuals and organizations regarding how to improve the Medicaid program in Kentucky.

One overarching thing is very clear: the current program is not sustainable, and there will be significant financial repercussions to the Commonwealth's budget and operations if sustainability of the Kentucky Medicaid Program is not addressed during the 2026 Session. Most importantly, however, we are not fulfilling our obligation to help those individuals who are covered by Medicaid to improve their quality of health.

As the Board concludes its 2025 meetings, the general observations of Kentucky's Medicaid Program are as follows:

1. The Medicaid budget has more than doubled over the past five years to over $20 billion annually.
2. The Medicaid population has grown from one-fifth of the total population to one-third of the total population in Kentucky.
3. Cost per enrollee has increased by more than 100%.
4. Cost per individual taxpayer has swelled by over 200%.
5. Leading healthcare indicators have not improved significantly, if at all.
6. The number of Medicaid recipients has significantly increased due to further expansion of the program.

In addition to these general observations, it's clear that the program suffers from weak eligibility criteria compliance, poor data and resource management, lack of oversight and administration of the program, incentivizing organizations contracted with DMS to enroll people, inefficient process and duplication of functions in waiver programs, lack of accountability, and little focus on outcome, measurement-oriented results.

Program Alignment with HR 1

Finding 1 — Administrative process inefficiencies negatively affect service operations, service delivery, and provider participation

Recommendations:

- Tighten and modernize eligibility processes, including better data-matching and duplicate-enrollment checks, to reduce rework, error corrections, and conflicting eligibility determinations across programs.
- Clarify and streamline overlapping HCBS waiver services to reduce duplication, simplify provider contracting, and standardize processes across programs and contractors.

Finding 2 — Medicaid program is not aligned with workforce participation to comply with HR1

Recommendations:

- Create statutes required to codify federal law regarding Medicaid work/community engagement requirements by:
    - Establishing compliant work/community engagement standards effective 1/1/2027.
    - Creating urban/rural partnership programs for state fiscal year 2026-27 that intentionally connect Medicaid enrollees to workforce, education, and community engagement supports. These partnership programs will lay the groundwork for statewide scaling of work/community engagement connections and supports that enable continuity of care using a holistic approach.
    - Providing a structured pathway for enrollees with work capacity to transition from long-term public assistance into sustainable employment.
    - Creating direct connections for those entering the job market and transitioning to employer-based health care coverage from Medicaid.
    - Ensuring clear definition and communication to individuals who would be exempt from the work/community engagement requirement.

Finding 3 — Medicaid budget growth is unsustainable

Recommendation:

- Adopt a set of fiscal integrity and cost-control measures, including:
    - Bringing statutes into conformity with federal law by permitting appropriate cost sharing for certain eligibility groups, adding a modest front-end utilization and cost-sharing tool while preserving protections for vulnerable populations as required by federal rules.
    - Requiring the State Auditor to conduct a comprehensive audit of all aspects of the Medicaid program every five years, with interim compliance reviews, to identify cost drivers, program integrity issues, and opportunities for structural savings across MCOs, waivers, and fee-for-service.
    - Conducting a comprehensive review of Medicaid covered services to determine if services are essential, duplicative, or prone to fraud, waste, and abuse.

Finding 4 — Rural Health Transformation Fund development lacked transparency and legislative involvement

Recommendations:

- Require disclosure of the CHFS Rural Health Transformation Fund application, which is consistent with more than 30 other states, and require disclosure of subsequent scoring and any resulting funding award.
- Require CHFS/DPH to provide a detailed update on funding and progress at each Board meeting as well as in writing.

Finding 5 — HR 1 requires provider tax changes and state-directed payment program changes that will significantly impact Medicaid providers

Recommendations:

- In collaboration and cooperation between the Board, CHFS/DMS, the Interim Joint Committee on Health Services, Interim Joint Committee on Families and Children, and the Budget Review Subcommittee for Health and Families Services, require DMS to develop a detailed plan of action with solutions for the upcoming provider tax changes.
- In collaboration and cooperation between the Board, CHFS/DMS, the Interim Joint Committee on Health Services, Interim Joint Committee on Families and Children, and the Budget Review Subcommittee for Health and Families Services, require DMS to develop a detailed plan of action with solutions for the upcoming state directed payment changes.

Additional Findings

Finding 6 — Insufficient transparency into Medicaid spending and performance

Recommendations:

- Authorize the LRC Office of Health Data Analytics to access CHFS data and systems to enable oversight of DMS, inform policy and funding decisions, and allow LRC to verify fiscal impacts provided by the Agency.
- Require the development of a public, web-based transparency dashboard that centralizes Medicaid cost and utilization data and displays key health and performance indicators, as defined by the Medicaid Oversight and Advisory Board, for DMS and the MCOs.
- Engage the Office of Health Data Analytics (CHFS) to assist with the data sharing dashboards in order to leverage existing capacity.

Finding 7 — Network adequacy reporting is inaccurate, leading to insufficient access to medically necessary services.

Recommendations:

- Require MCOs to maintain an adequate network and report only providers who are actively taking Medicaid patients and providing services, and not providers who are credentialed but not actively seeing patients and billing for services. Require monetary penalties for non-compliance.
- Require and hold DMS accountable to develop and implement a rate review schedule for each provider group, including a baseline rate study for all provider types that will guide the department, the Medicaid Oversight and Advisory Board, and the General Assembly to address upcoming federal changes and set appropriate rate ranges for provider reimbursement rates, while prioritizing those provider groups whose rates have remained unchanged and/or for which there are significant shortages, particularly in rural areas. Require regular updates to the Board on progress with updating rates to adequate levels.
- Develop an alternative dental delivery model.
- Improve dental provider participation, network adequacy, and reimbursement rates.

Finding 8 — Current Medicaid delivery model in place since 2011 is not significantly improving health outcomes of the overall population of Kentucky relative to Medicaid expenditures, yet the budget is growing unsustainably

Recommendations:

- Research and evaluate alternative Medicaid delivery models.
- Develop and codify stronger, enforceable MCO contract standards—including clear performance requirements, audit, claw back authority, and monetary penalties for non-compliance.
- Implement monetary penalties for MCOs not following timelines for audits or violating regulations.
- Amend the Non-Emergency Medical Transportation (NEMT) contract to include performance withhold requirements. Determine what changes could improve access to transportation, including provider types not currently included in the broker system.

Finding 9 — DMS oversight and accountability for the Medicaid program is inconsistent

Recommendation:

- Strengthen Board and General Assembly oversight by advancing a core oversight package:
    - Giving LRC ongoing, real-time access to CHFS/DMS data systems for independent analysis.
    - Requiring a unified, web-based Medicaid performance dashboard with standardized measures across MCOs and key program areas.
    - Mandating recurring, comprehensive Medicaid audits with follow-up compliance checks on corrective actions.
    - Codifying and enforcing specific contract standards and penalties for MCO performance failures, including audit-driven claw backs.

Finding 10 — Lack of solutions and follow-up to stakeholder feedback and questions

Recommendation:

- Establish a process for receiving questions and feedback from providers, stakeholders, and legislators that provides transparent and timely responses.
- Incorporate standard enrollee and provider experience metrics into a Medicaid transparency dashboard and use those metrics to guide structured stakeholder engagement and annual program improvement reports.

Finding 11 — Behavioral Health service delivery is fragmented and not integrated with physical health services

Recommendations:

- Recommend delivering behavioral health services through the CCBHC model by moving from the current four regions to a statewide program.
- Investigate the use of recovery coordinators, recovery housing, and a comparison data

outcomes at various lengths of stay.