TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

Kentucky Medicaid Advisory Committee Annual Report

June 30, 2026

Contents

Executive Summary

In State Fiscal Year 2026 (SFY26), Kentucky's Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) carried out their responsibilities under **42 CFR §431.12**. These groups advise the Department for Medicaid Services (DMS) on Medicaid policies, program operations, and how services are delivered.

The MAC includes a mix of providers, advocates, state staff, community partners, and Medicaid members. The committee meets regularly to review program updates and make recommendations to DMS.

The BAC is made up of Medicaid members and caregivers. This group focuses on sharing real-life experiences, including challenges people face when trying to get care and how policies affect them day to day.

Together, the MAC and BAC provide both technical expertise and firsthand perspectives, helping DMS make more informed decisions.

During SFY26, DMS used a coordinated approach to connect the MAC, BAC, and 17 Technical Advisory Committees (TACs). TACs were created by KRS 205.590 to act as advisors to the MAC. The groups were linked through shared members, regular reporting, and formal processes for making recommendations. This structure ensured that feedback from members, providers, and subject-matter experts was not only gathered, but also brought forward into MAC discussions and considered in DMS decision-making.

DMS also took steps to make it easier for people to participate. Meetings were offered both in person and virtually, materials were shared in advance, and staff provided direct support to members. BAC members received additional support, including one-on-one outreach, communication between meetings, and follow-up surveys. These efforts helped members stay engaged and share their input more effectively.

Key outcomes from SFY26 included fully integrating beneficiary representatives into the MAC, improving coordination with TACs, and maintaining active discussion on major policy issues such as federal Medicaid changes, waiver programs, and transparency efforts. The MAC submitted several formal recommendations to DMS, and the BAC provided additional input that helped improve areas such as access to services and communication with members.

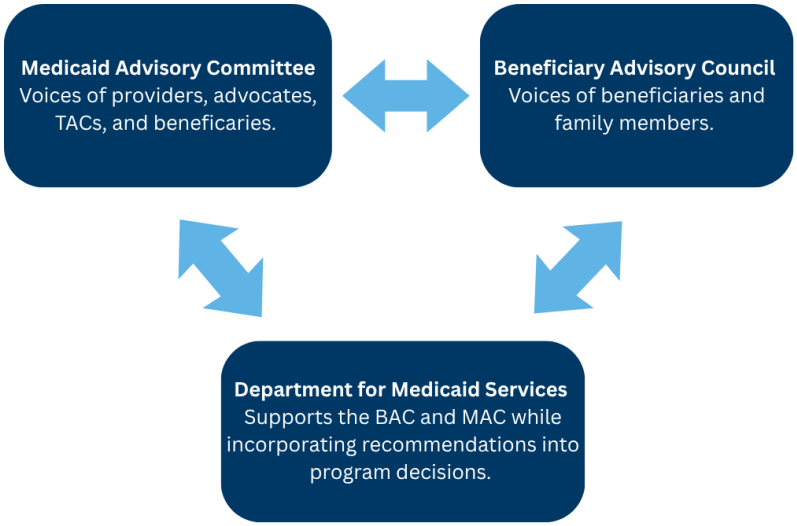
Overall, these efforts increased transparency, strengthened accountability, and ensured that both stakeholder and beneficiary voices played a meaningful role in shaping Kentucky's Medicaid program.

Introduction

The MAC and BAC are Kentucky's main groups for getting public input on how Medicaid works. They help DMS hear from both program partners and Medicaid members, as required by federal rules.

The MAC gives advice to DMS on Medicaid policies and how the program runs. Its members include providers, advocates, state staff, and Medicaid representatives. The MAC meets regularly to review updates, talk about issues, and make recommendations. It also receives input from TACs. This helps make sure decisions are based on real experience and knowledge of the program.

The BAC focuses on the voices of Medicaid members and their families. Its members include people who use Medicaid, and caregivers. The BAC shares feedback on access to care, services, and member experiences. The group helps point out challenges and explain how policies affect people in daily life. Through its connection to the MAC, this feedback is included in larger discussions and recommendations.



To meet federal and state requirements, DMS makes sure the MAC, BAC, and TACs work closely together. Some members serve on more than one group, and there are clear ways to share updates and recommendations. This helps DMS get input from different viewpoints, including technical experts and people with lived experience.

DMS also works to make it easier for people to take part. Members are encouraged to share input during and between meetings. This helps ensure feedback is heard and used in program decisions throughout the year.

This report explains how the MAC and BAC are organized, how they meet, and how they gather input. It also highlights key topics discussed and recommendations made. The report shows how DMS works with both groups to support a Medicaid program that is open, inclusive, and responsive to the people it serves.

Medicaid Advisory Committee (MAC)

Overview

The Medicaid Advisory Committee was created under KRS 205.540 as the Advisory Committee on Medical Assistance and has advised Kentucky's Medicaid program since 1960. The Ensuring Access to Medicaid Services final rule made changes to 42 CFR §431.12 in 2024. Kentucky updated the MAC to meet the new requirements that went into effect on July 9, 2025.

These changes included setting term limits for members, expanding the membership to include representation from managed care and state agencies, and having members formally appointed by the DMS Commissioner. The changes also required that a certain percentage of the MAC be comprised of members from the new Beneficiary Advisory Council. In addition, the MAC bylaws were updated to reflect new responsibilities and procedures under state and federal rules.

The MAC's role is to provide advice and recommendations to DMS Medicaid policy and program operations. This includes topics such as benefits and services, provider participation, program changes, and the effects of state and federal laws.

The MAC brings together a wide range of participants. Members include healthcare providers, health plans, professional groups, advocates, Medicaid members, and state agency staff. The group provides a place for these stakeholders to share ideas, discuss issues, and help guide the direction of Kentucky's Medicaid program.

Kentucky's Implementation Plan

In response to the new federal requirements for the MAC and BAC, DMS held virtual forums, conducted surveys, and presented on key takeaways and proposed legislation throughout the end of 2024 and into 2025.

DMS then outlined areas to highlight among MAC membership including the expansion of member roles.

Using this information, DMS outlined a implementation plan to appoint members to the MAC in compliance with the new federal regulations. This approach was also used for the BAC.

MAC Membership

During this reporting period, the MAC had 31 members with staggered terms to support continuity. These members represented many different groups across Kentucky. The MAC included 14 members from provider organizations, 5 members from consumer advocacy groups, and 5 state officials serving in an ex-officio role from agencies that support Medicaid members.

The MAC also included 7 members from the BAC, making up 25% of the MAC. These members were Medicaid recipients or caregivers of Medicaid recipients. Adding BAC

members ensured that people who use Medicaid services have a direct voice in MAC discussions.

This mix of state officials, providers, advocates, and beneficiaries helped ensure that many perspectives were included, as required by federal rules. It also supported discussion between those who design and manage the program and those who provide and receive services.

Kentucky law (KRS 205.540(1)) requires the MAC to include a wider range of members than federal rules. Because of this, the MAC meets all membership requirements under 42 CFR §431.12(d)(1) and 42 CFR §431.12(d)(2) and also includes additional roles listed in state law. These include more specific types of providers and structured participation from beneficiaries through the BAC. **Table 1** provides more detail on MAC membership.

Table 1: Kentucky MAC Membership Overview

MAC Member	Statutory Authority	Current Term End Date
KY Association of Health Plans	Not required under KRS 205.540(1); Aligned with 42 CFR §431.12 (d)(2)(C)	6/30/2026
KY Association of Hospice and Palliative Care	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2027
KY Home Care Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2027
KY Medical Equipment Suppliers Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2027
KY Podiatry Medical Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2027
Christian Care Communities / LeadingAge (Formerly KY Association of Homes and Services for Aging)	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2027
KY Medical Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2028
KY Nurses Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2028
KY Optometric Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2028
KY Pharmacist Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2028

KY Association of Healthcare Facilities	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2029
KY Dental Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2029
KY Hospital Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2029
KY Primary Care Association	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(B)	6/30/2029
Consumer Advocacy Group (Individuals with Disabilities)	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(A)	6/30/2027
Consumer Advocacy Group (Older Adults)	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(A)	6/30/2028
Consumer Advocacy Group (Minority Groups)	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(A)	6/30/2028
Consumer Advocacy Group (Incarcerated Persons Reentering Society)	Aligned with A)	6/30/2029
Consumer Advocacy Group (Women)	Aligned with KRS 205.540(1) and 42 CFR §431.12 (d)(2)(A)	6/30/2029
BAC - Medicaid Beneficiary	Three "medical assistance recipients" aligned with KRS 205.540(1) and under 42 CFR §431.12 (d)(1)	6/30/2027
BAC - Medicaid Beneficiary	Three "medical assistance recipients" aligned with KRS 205.540(1) and under 42 CFR §431.12 (d)(1)	6/30/2027
BAC - Medicaid Beneficiary	Three "medical assistance recipients" aligned with KRS 205.540(1) and under 42 CFR §431.12 (d)(1)	6/30/2028
BAC - Medicaid Beneficiary	Three "medical assistance recipients" aligned with KRS 205.540(1) and under 42 CFR §431.12 (d)(1)	6/30/2029
BAC - Family/Guardian/Caregiver of Medicaid Beneficiary	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(1)	6/30/2027
BAC - Family/Guardian/Caregiver of Medicaid Beneficiary	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(1)	6/30/2028
BAC - Family/Guardian/Caregiver of Medicaid Beneficiary	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(1)	6/30/2029
Cabinet for Health and Family Services (*Ex-Officio)*	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(2)(D)	N/A

Department for Medicaid Services (*Ex-Officio*)	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(2)(D)	N/A
Department for Public Health (*Ex-Officio*)	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(2)(D)	N/A
Department for Behavioral Health, Developmental and Intellectual Disabilities (*Ex-Officio*)	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(2)(D)	N/A
Department for Community Based Services (*Ex-Officio*)	Not required under KRS 205.540(1); aligned with 42 CFR §431.12 (d)(2)(D)	N/A

MAC Formation, Governance, and Operations

Member Recruitment and Onboarding

Members of the MAC were recruited using an updated process launched in August 2025. This process included new public webpages and shared materials, such as an overview slide deck and a list of frequently asked questions (FAQs). These resources explained the purpose of the MAC and BAC and encouraged a wide range of people to apply and take part.

After members were selected, DMS used a structured onboarding process to prepare them. In September 2025, DMS held four virtual orientation sessions, each lasting 90 minutes and offered at different times to support participation. These sessions were open to all MAC and BAC members, including returning members.

The sessions explained each group's role, how they are organized, and how meetings and decision-making processes work. This helped ensure that all members understood their roles and were ready to take part in the updated MAC and newly established BAC.

MAC Governance

The MAC's structure is guided by updated bylaws that follow 42 CFR §431.12 and state requirements. These bylaws explain leadership roles, how voting works, and how many members are needed to make decisions (quorum). They also include Open Meetings Act requirements and define how the BAC and TACs take part in MAC activities.

The MAC is led by a Chair and Vice Chair, with support from a Secretary. Members nominate themselves and vote to fill these roles. Officers are elected by a majority vote, serve set terms, and are re-elected each year to support shared leadership and continuity.

The MAC began meeting every two months starting in February 2026, after an initial setup period. During this time, DMS focused on appointing members, holding orientations, finalizing bylaws, and organizing meetings.

The MAC held its first meeting on November 2, 2025, and then met on February 5, April 2, and June 4, 2026. Meetings were held every two months from 10:00 AM to 12:00 PM, at times chosen by members to support participation (42 CFR §431.12(f)(6)). At the June meeting, MAC members voted to make future meetings longer. Starting at the next meeting, they will be held from 10:00 AM to 12:30 PM.

BAC meetings were held in the months between MAC meetings. These meetings took place before MAC meetings so that beneficiary input could be shared and considered as part of MAC discussions (42 CFR §431.12(e)(2)).

MAC Operations and DMS Support

MAC meetings are planned together by MAC leadership and DMS. Meetings are designed to be clear, open, and support good decision-making. Regular agenda items include updates from DMS, presentations on program changes, and discussion of state and federal issues.

Meetings also include input from TACs, usually shared by TAC Chairs or their representatives. There is time for public comment and for MAC members to discuss and vote on recommendations. Based on experience in MAC meetings this year, time for these activities will be moved to early in the meeting to promote improved participation and ensure a quorum for voting to advance recommendations. The BAC Chair also provides updates during each meeting so that BAC feedback is included in MAC discussions. Time is set aside for members to share any conflicts of interest, as required by **42 CFR §431.12(f)(3)**.

DMS provides ongoing support to help members take part. This includes help with travel reimbursement, meeting planning, and communication. Members receive materials ahead of time to prepare for meetings. Meetings are offered in both in-person and virtual formats, and accommodations are provided as needed, in line with **42 CFR §431.12(f)(7)**.

Collaboration with Leaders

DMS met with MAC leadership before each meeting to plan agendas, review materials, and discuss ideas or concerns. This helped ensure that meetings were planned together and reflected input from MAC members.

DMS also shares key documents before and after meetings. Before meetings, members receive agendas and background materials. After meetings, DMS shares presentations, recordings, and meeting minutes. These materials are also posted publicly within 30 days, as required by **42 CFR §431.12(f)(1)** and

§431.12(h)(2). These steps support transparency and help keep members and the public informed.

During the reporting period, the MAC worked to keep all member positions filled. Three organization members—the Kentucky Association of Homes and Services for Aging, the Kentucky Dental Association, and the Alzheimer's Association—left their positions. In each case, DMS followed the MAC bylaws and worked with the organizations to find qualified replacements using the same process as the original appointments.

To improve this process, the MAC and DMS created a standard vacancy process in March and April 2026. This included a nomination letter and a short overview of member qualifications and expectations. These steps helped fill vacancies more quickly and keep the MAC fully staffed and engaged.

Coordination Activities

As required by **42 CFR §431.12**, DMS operates both a MAC and a BAC. Each group has a different but related role. The BAC is a place for Medicaid members, family members, and caregivers to share their experiences and provide direct feedback. The MAC is the main public group that reviews Medicaid policy, program operations, and oversight.

The BAC and MAC are connected in ways that ensure member voices are included in decision-making, while still keeping the BAC's independent role. Some BAC members also serve on the MAC. In addition, the BAC Chair gives updates at every MAC meeting to share key themes, concerns, and recommendations. This helps bring beneficiary input into MAC discussions and formal recommendations.

At the same time, the MAC works with TACs to get more detailed, topic-specific input. TACs provide technical knowledge and analysis on different program areas.

Together, these connections help DMS receive input from many perspectives. This includes lived experience from members, technical expertise, and broader system views. This multi-level approach is an important part of how Kentucky gathers input and supports Medicaid decision-making.

DMS Collaboration Approach

1. Clear Structure for Working Together
DMS and the MAC use a clear structure to bring together input from the BAC and TACs. This helps make sure decisions include both expert advice and real-life experiences from members.

2. Using Feedback in Decision-Making
DMS and the MAC gather feedback from members, providers, and families. This feedback is shared in meetings and considered when making decisions.

3. Ongoing Communication and Improvement
DMS and the MAC stay in regular contact and keep improving how they work together. They use shared processes and regular updates to keep information moving and address issues quickly.

Integration of BAC Input

During this reporting period, DMS took strong steps to include beneficiary input in MAC activities. As noted, seven BAC members joined the MAC, and the BAC Chair gave regular updates during MAC meetings.

DMS and the MAC worked to create an inclusive environment. Orientation materials for new members highlighted the importance of listening to different perspectives. DMS also provided supports, such as assistive technology and expense reimbursement, to help all members take part.

The MAC Chair and Vice Chair stayed in regular contact with BAC leadership between meetings. This helped ensure beneficiary concerns were shared with the MAC in a timely way. Members agreed this process should be more formalized in the future.

MAC meeting agendas also reflected this focus. BAC updates were placed early in meetings, and discussions often returned to how policies would affect Medicaid members.

Coordination with TACs

DMS has 17 TACs, of which 16 are created under KRS 205.590 and one under a Governor's Executive Order. These groups provide detailed input on specific services or topic areas. TACs cover areas such as behavioral health, children's health, primary care, long-term care, dental, and pharmacy. Members include experts, providers, and advocates with knowledge or experience in these fields.

TACs help bring informed input into Medicaid discussions. They include people with lived experience, professional expertise, and knowledge of how programs work. TACs share their input with the MAC by making recommendations and raising key issues in their areas.

TACs meet at different times depending on need. Some meet every two months, some meet quarterly, and others meet as needed. During meetings, TACs may vote on recommendations. If enough members are present (a quorum) and approve a recommendation, it can move forward to the MAC. The TAC Chair then submits the recommendation and any supporting materials to MAC leadership before the next MAC meeting.

During this reporting period, DMS created a new, more consistent way for TACs to submit recommendations. This included a standard submission form to help track and share recommendations more easily. This process helped ensure TAC input was available to MAC leadership, shared with members in a timely way, and not delayed if TAC representatives could not attend MAC meetings. It also reflected the importance placed on TAC expertise.

The MAC's membership structure also helps connect TACs and the MAC. Many MAC members serve as TAC Chairs or representatives, which creates strong communication between the groups. For example, MAC membership includes representatives from provider associations and advocacy groups that lead TACs, as well as consumer advocates.

Established Kentucky TACs

- Behavioral Health
- Children's Health
- Dental
- Disparity and Equity
- Emergency Medical Services
- Home Health
- Hospital Care
- Intellectual and Developmental Disabilities
- Nursing Home Care
- Nursing Services
- Optometric

The MAC also worked with DMS to clearly define TAC processes in its bylaws. The bylaws explain how TAC recommendations are reviewed and shared. TACs must have a quorum to approve a recommendation and submit it in writing within seven days. The MAC can then accept these recommendations without holding a separate vote.

Even when TACs do not make formal recommendations, they still share updates. TAC Chairs regularly report on key issues during MAC meetings. This helps the MAC stay informed about new or ongoing concerns.

During this reporting period, TACs shared input on topics such as dental provider networks and reimbursement, and behavioral health workforce credentialing. This input helped

guide MAC discussions and informed follow-up actions by DMS, even outside of the formal recommendation process.

Key Topics Discussed by the MAC

MAC meetings included updates from the BAC, recommendations and issue updates from TACs, and reports from DMS. These DMS reports shared updates on Medicaid policy, how the program is operating, and upcoming changes. Over this reporting period, the MAC discussed many important topics, including:

- **Federal Policy Changes**: A major focus in FY26 was new federal requirements affecting Medicaid. DMS shared updates on changes such as reducing retroactive coverage from 90 days to 60 days, as well as new community engagement and cost-sharing requirements for some members. The MAC discussed the challenges of putting these changes into place. Members stressed the need for clear communication so beneficiaries understand the new rules. They also raised questions about how to track community engagement hours and how to help members keep their coverage. DMS shared that it is developing guidance, education materials, and system updates to support these changes.
- **Waiver Programs and Access to Services**: The MAC received regular updates on Home and Community-Based Services (HCBS) waiver programs, including efforts to reduce waiting lists. At multiple meetings, DMS shared the latest data and updates on work to improve access. The MAC discussed the challenges faced by people waiting for services, including many individuals with intellectual and developmental disabilities. Members stressed the need for clear tracking of available slots and waitlists. They also shared ideas to improve access, such as increasing the number of providers in underserved areas. The MAC also reviewed policy changes that affect waiver programs, including federal requirements like Electronic Visit Verification, and discussed how these changes affect members and providers.
- **Budget and Oversight Developments**: The MAC received updates on Medicaid funding and state policy changes. DMS shared information about the Governor's Medicaid budget and related legislation. Members discussed how these changes could affect provider payments and services. They highlighted the importance of protecting key services, even during budget challenges. The MAC also learned about the new Medicaid Oversight and Advisory Board (MOAB), created through House Bill 695 (2025). DMS shared early findings from MOAB and explained how the MAC's work connects to it. Some MAC members who also serve on MOAB shared updates, including a focus on improvements in rural health and care delivery.
- **Healthcare Delivery and Quality Initiatives**: The MAC discussed several programs and efforts to improve care. This included updates on the new Rural Health

Transformation Program (RHTP), which aims to strengthen rural hospitals and improve care quality. Members gave feedback on how the program should measure success and involve stakeholders. They also discussed ways to improve quality, such as value-based payment models in Medicaid managed care. The MAC supported ideas like creating a workgroup to better align these efforts. Additional discussions included maternal and child health, behavioral health services, and workforce challenges. TACs shared input on these topics. For example, the Behavioral Health TAC raised the need for more peer support services and better tracking of quality measures.

- **Administrative Procedures and Transparency**: The MAC also worked to improve its own processes and increase transparency. Members developed clearer guidance for reporting conflicts of interest and supported creating a standard disclosure form. The MAC set up a formal public comment process, including a way for the public to sign up to speak at meetings. DMS committed to posting meeting materials, recordings, and minutes online within 30 days. MAC members also review meeting materials and the annual report each year, as required by the bylaws. These steps have helped improve how meetings are run, increase transparency, and support accountability to the public.

Recommendations and DMS Responses (MAC/TAC)

During this reporting period, the MAC sent nine formal recommendations to DMS. All nine recommendations were first developed and approved by TACs and then reviewed and supported by the MAC.

Table 2 provides a summary of each recommendation, including which TAC it came from and DMS's written response or action. Each response was shared in a formal letter from the DMS Commissioner to the MAC Chair and then provided to all members, following state requirements.

Responses to recommendations made at the June 2026 meeting are still being developed by DMS. Those recommendations and responses are not included in this report.

Table 2. MAC Recommendations and DMS Responses

Recommendation	DMS Responses
Improve how Medicaid eligibility and enrollment information is shared with providers, so they can better reach and support patients. *Origin: Primary Care TAC*	DMS will work with Managed Care Organizations (MCOs) to improve how providers get real-time information about patient enrollment status, such as through online eligibility and claims systems. DMS also plans to explore better ways to notify providers so they can more easily confirm coverage and see changes in their patient lists.
Create a workgroup with DMS, MCOs, and providers to better align and simplify value-based payment programs, reducing administrative burden and differences in quality reporting across plans. *Origin: Primary Care TAC*	DMS will create a workgroup with MCOs and providers to review current value-based payment programs. The group will look for ways to better align performance measures and simplify reporting requirements across plans. Findings from this work will help guide future policy or contract changes.
Update the Medicaid Level of Care and Preadmission Screening and Resident Review (PASRR) process to help nursing facility patients move out of hospitals more quickly. This includes allowing a short period after admission to complete Level of Care decisions and allowing more qualified hospital staff to complete initial PASRR screenings. *Origin: Nursing Facility TAC*	DMS is reviewing options to allow a short time after admission to complete Level of Care determinations, which may reduce hospital discharge delays. DMS will also consider allowing more qualified providers to complete PASRR Level I screenings. DMS will work with state partners and federal agencies to ensure any changes meet program requirements.
Improve how quickly Medicaid processes long-term care applications, so nursing facility residents receive timely coverage, especially with the new 60-day limit on retroactive eligibility. *Origin: Nursing Facility TAC*	DMS is tracking how long it takes to process long-term care applications and is taking steps to speed up decisions. This includes adding staff and reviewing internal processes. DMS will also share baseline processing data with the MAC and TACs to help track progress and ensure applications are completed on time.
Update 1915(c) waiver policies on involuntary discharge to better protect participants, so they do not lose services or have to change service types for reasons outside their control. *Origin: Intellectual & Developmental Disabilities (IDD) TAC*	DMS is reviewing proposed policy updates for the Supports for Community Living (SCL) waiver. Draft changes would limit when services can be ended, require advance notice, and ensure person-centered planning during transitions. DMS will review these changes through its policy process, including public input if needed. In the meantime, DMS confirmed that participants will not lose waiver slots due to caregiver or representative issues and can continue receiving services through other options if needed.

Requests DMS personnel provide a progress report at each IDD TAC meeting addressing items related to work on the processes utilized to arrive at a holistic regulatory change that can benefit all home and community-based providers and participants with regard to involuntary termination of a service. *Origin: Intellectual & Developmental Disabilities (IDD) TAC*	Responses to recommendations made at the June 2026 meeting are still being developed by DMS.
Rescind request made by WellCare MCO to begin requiring prior authorization for outpatient individual, family and group therapy. *Origin: Behavioral Health TAC*	Responses to recommendations made at the June 2026 meeting are still being developed by DMS.
Require MCOs to notify providers at least 30 days prior to implementing any changes that affect the provision of services or the requirements for payment and require the MCOs to post on the MCO's website. *Origin: Behavioral Health TAC*	Responses to recommendations made at the June 2026 meeting are still being developed by DMS.
Require MCOs to make any new Prior Authorizations available to providers immediately upon approval by DMS through email notification and by addition to the MCOs' posted list of current prior authorizations. *Origin: Behavioral Health TAC*	Responses to recommendations made at the June 2026 meeting are still being developed by DMS.

During this reporting period, the MAC made important changes to how it is structured and works. Even with these changes, the activities and recommendations described above show the value of the input and guidance provided by members.

The next section focuses on the BAC. It highlights how the group is structured, what it worked on, and how the experiences of Medicaid members and families help inform and strengthen the MAC's work.

Beneficiary Advisory Council (BAC)

Overview

The BAC helps make sure that Medicaid members and their families have a clear voice in advising DMS. The group focuses on how policies affect access to care, quality of services, and member experience.

The BAC works alongside the MAC as a separate but connected advisory group. It meets every other month, usually in the month before MAC meetings. During meetings, members talk through issues and share ideas and feedback with DMS. While the BAC can vote on formal recommendations, much of its value comes from open discussion and sharing experiences to identify needs and solutions.

DMS staff often attend BAC meetings to provide updates and hear feedback directly from members. The BAC Chair and six other BAC members also serve on the MAC. This helps make sure BAC input is shared in MAC discussions and decisions.

The BAC first started meeting in October 2025 as part of Kentucky's updated approach to gathering input from Medicaid members and families.

BAC Formation, Governance, and Operations

Member Recruitment and Onboarding

BAC members were selected through a statewide outreach and application process led by DMS in 2025. This process included sharing information about the BAC, giving presentations on its purpose, and offering an open application for Medicaid members and caregivers across Kentucky.

DMS worked to build a council that reflects the people served by Medicaid. Final members were chosen by the Commissioner after reviewing applications, recommendations, and input from advocacy groups. The BAC includes members with a wide range of lived experiences including three members who were reappointed from the Advisory Council on

Medical Assistance. This mix of member types helped make sure the BAC reflects the voices and experiences of Medicaid members across Kentucky.

After members were selected, DMS provided onboarding to help them prepare. Orientation sessions gave an overview of Kentucky Medicaid, explained the role of the BAC, and reviewed how the council works. The BAC officially began meeting in October 2025.

BAC Recruitment

Applications
DMS received 35 applications from Kentuckians interested in serving on the BAC.

Selection Process
DMS carefully reviewed applications, selecting members that represent Kentucky's unique Medicaid landscape according to the implementation plan.

Membership Appointments
DMS appointed 15 members to the BAC representing populations such as 1915(c) Waiver recipients, parents and caregivers of Medicaid beneficiaries, Behavioral Health Service recipients, and more.

BAC Governance

At its first meeting, the BAC set up how it would operate. Members approved bylaws and chose leaders through a member-led process where individuals could nominate themselves and vote. The BAC is led by a Chair and Vice Chair, with support from a Secretary. All leaders were chosen by a majority vote, following the bylaws.

The BAC met every other month. Meetings were held on the second Monday of the month from 2:00 to 4:00 PM, a time chosen to support participation. In line with federal requirements (42 CFR §431.12(e)(2) and §431.12(f)(6)), BAC meetings took place in the months before MAC meetings so member input could help guide those discussions.

During this reporting period, the BAC met in October 2025 and in January, March, and May 2026. Meeting agendas were developed together by BAC leadership and DMS. Agendas included program updates, policy discussions, and time for members to share their experiences and raise concerns.

Meetings also included time for discussion, developing recommendations, and sharing any conflicts of interest, as required by 42 CFR §431.12(f)(3).

BAC Operations and DMS Support

DMS provided ongoing support to help BAC members take part in meetings. This included help with travel reimbursement, sharing materials in advance, and organizing meeting logistics. Meetings were offered both in person and online. Accommodations were also provided as needed, in line with 42 CFR §431.12(f)(7).

DMS shared materials before and after each meeting. Before meetings, members received agendas and background information. After meetings, DMS shared presentations, summaries, and meeting minutes. The meeting minutes were also posted publicly within 30 days, as required by 42 CFR §431.12(f)(1) and §431.12(h)(2).

DMS also supported engagement through regular communication with members. Staff reached out by phone, text or email before the first meeting to confirm participation and help with any technology or accessibility needs. During the reporting period, members received reminders, follow-up messages, and continued access to materials to support their participation. DMS also used post-meeting surveys to gather feedback and make improvements to meetings and supports.

BAC Member Liaisons

To support BAC members, DMS assigned a BAC liaison to each member. These liaisons worked one-on-one with members to help meet their needs and support full participation.

Liaisons helped members before and after meetings and served as a main point of contact for questions or concerns. They also checked in with members regularly through outreach calls and ongoing communication.

This support helped ensure that all members could stay engaged and fully take part in BAC activities.

During this reporting period, the BAC showed strong participation as a new advisory group. A quorum was reached at every meeting, and members stayed actively involved. When vacancies occurred, DMS used an open application and selection process to fill them. By the end of the reporting period, most original members remained active, showing the success of these engagement efforts.

Coordination Activities

Coordination with DMS and MAC

The BAC built a strong working relationship with both DMS and the MAC. DMS leaders, including the Commissioner and senior staff, regularly attended BAC meetings to share updates and hear feedback directly from members. The BAC Chair and DMS staff helped support this two-way communication.

The BAC Chair gave a report at every MAC meeting. In addition, the BAC Chair and BAC members who served on the MAC shared updates about MAC discussions at BAC meetings.

For example, when BAC members raised concerns about a new Electronic Visit Verification (EVV) policy, DMS addressed the issue during the BAC meeting and also

shared it with the MAC for further discussion. This helped make sure beneficiary concerns were heard more broadly and considered in decision-making.

From the beginning, the BAC focused on clear documentation and transparency. With support from DMS, each meeting included detailed meeting minutes, presentation materials, and recordings for internal use. These materials were shared with members, including those who could not attend.

DMS also shared summaries of BAC meetings with MAC members to keep them informed of key discussions and concerns. BAC leadership had the opportunity to review this annual report and provide input as part of documenting the group's work.

These efforts help track progress, keep members informed, and ensure that BAC input continues to support Medicaid program decisions over time.

Topics Discussed by the BAC

As outlined above, BAC meetings usually included updates and informational presentations from DMS on important issues and time for members to discuss issues and share their own experiences. During the reporting period, the BAC discussed many topics affecting Medicaid members like:

- **HCBS Waiver Experiences and Access**: A main focus of the BAC was the experience of members receiving HCBS under Kentucky's 1915(c) waiver programs. Members shared personal stories about challenges like getting services, including long waiting lists and trouble finding providers, especially in rural areas. Members also talked about ways to improve the system. These included better communication about one's waitlist status and finding ways to increase the number of providers. The BAC also discussed how new federal changes could affect waiver participants. Members stressed the need to protect access to services. DMS used this feedback to help guide its work on waiver programs.
- **Electronic Visit Verification (EVV) System Challenges**: The EVV system, a technology required by federal law to track home care visits, was a topic that came up more than once. Members shared concerns about how the system works and how it affects caregivers and members. For example, some caregivers were unsure how to record visits that happen outside the home. In January 2026, the BAC voted to recommend that DMS provide clearer guidance. At a later meeting, DMS staff shared more information about EVV rules and gathered feedback from members. This helped DMS improve training materials and consider updates to the system. These discussions also helped DMS better understand where more support is needed to make sure EVV does not create barriers to care.

- **Medicaid Policy Changes & Communication with Members**: DMS regularly updated the BAC on new policies and asked for feedback on how to share this information with members. For example, DMS talked to members about changes to Medicaid happening because of federal H.R. 1. During the presentations, members were able to ask questions and provide their opinions. Members stressed the importance of clear, easy-to-understand communication. They recommended using plain language and working with community groups to help share information. They also asked for materials in different languages and formats. DMS used this feedback to improve its communication efforts, including updating website content and working with partners to share information with members.
- **Healthcare Access and System Navigation**: The BAC often discussed challenges in getting care and understanding how to use Medicaid services. Common issues included finding providers, understanding managed care rules, and dealing with paperwork. Members noted that even with coverage, it can still be hard to get care, especially in rural areas. They also shared that communication gaps can make it hard to know what steps to take. DMS is exploring ways to improve support for members, such as better care coordination and clearer communication. These discussions also helped inform the MAC, as provider representatives heard directly about member challenges and began exploring solutions.

Recommendations and DMS Responses (BAC)

During this reporting period, the BAC made three formal recommendations to DMS. One of these recommendations was approved in January 2026 and sent to DMS. It was based directly on members' personal experiences with HCBS waiver programs in Kentucky. **Table 3** provides a summary of the BAC's recommendations and DMS's response.

Table 3. BAC Recommendations and DMS Responses

Recommendation	DMS Responses
Ensure waiver participants do not lose services when problems are caused by their caregiver or representative, and not by the participant.	DMS confirmed that current policy already requires a Corrective Action Plan (CAP) if issues arise with a caregiver or representative. If the issue cannot be resolved, the participant may move to traditional services but will not lose their waiver slot or access to services. DMS also developed draft updates to the Supports for Community Living (SCL) waiver to strengthen these protections. Proposed changes include limits on service terminations, required advance notice, and clear communication to all involved parties. DMS is reviewing these updates through its

	policy process and working with state and federal partners to determine next steps.
Provide clear, consistent guidance on how Electronic Visit Verification (EVV) should be used when services are provided in the community including on clock in/clock-out practices and when technology issues like power outages or internet outages occur.	DMS confirmed that current EVV policy allows exceptions and overrides when standard check-in is not possible, such as during power or internet outages. DMS is providing additional guidance and training to help ensure providers use EVV consistently across the state. This includes updated materials that explain how to document services in the community and when to use exceptions. DMS will continue to share guidance and address questions to make sure EVV supports service tracking without creating barriers to care.
Distribute an additional detailed letter to mental health providers clarifying that psychoeducation services may continue to be delivered and billed as part of bundled treatment.	DMS confirmed that although psychoeducation will no longer be reimbursed as a standalone code per House Bill 470, it may continue to be delivered as part of other behavioral health services, such as Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP), when clinically appropriate. Providers must ensure services are coded and billed in accordance with applicable requirements. Psychoeducation may not be billed separately on or after July 15, 2026.

Future Outlook: Sustaining and Enhancing Engagement

As DMS moves beyond the first year of the updated MAC and BAC, several opportunities have been identified to strengthen engagement with members and stakeholders:

- **Continued Integration of MAC & BAC Efforts**: The MAC and BAC will continue to work closely together, and formal processes to solidify their coordination will be put in place in the future. BAC members will remain active on the MAC to ensure the member perspective is always included in discussions and decisions. BAC and MAC leadership will also keep working together to make sure concerns and input brought up at BAC meetings are also talked about at MAC meetings when needed, ensuring that Medicaid member voice is part of MAC meetings, decisions, and recommendations. DMS will also continue to help support the BAC and its members, making sure that they are comfortable sharing their experiences and are able to fully participate in BAC meetings, and MAC meetings if they serve on both.

- **Ongoing Recruitment and Outreach**: DMS will continue outreach to keep both groups active and representative. As member terms end, new members will be recruited to fill open positions. The BAC application process will be improved based on lessons learned, such as making the application easier and working with community groups to reach more people. The MAC will continue to share openings through provider groups and advocacy organizations using processes like sending organizations standard nomination letters and vacancy one-pagers developed this year. Both groups will also work to include more diverse voices, including people from rural areas and those with different program experiences.
- **Process Improvements**: The DMS, the MAC, and the BAC will continue to review and improve how they work. For example, the new TAC recommendation process will be reviewed after a full year to see what improvements are needed. DMS will also continue to make sure meeting materials are shared on time and posted publicly within 30 days, as required. The BAC may also try new ways to gather input between meetings, such as using surveys or hosting office hours.
- **Monitoring MAC/BAC Impact**: An important next step is for DMS to track how MAC and BAC input leads to real program changes. Updates will continue to be shared at meetings on the status of recommendations, including actions taken or reasons why changes may not be possible. The BAC will also receive updates on issues they have raised, such as EVV and waiver changes. Sharing these updates helps show the value of member input and keeps members engaged.

Conclusion

In summary, the first year of the MAC and BAC under the new federal requirements was productive and meaningful. Both groups met regularly, shared recommendations, and helped support open and collaborative discussion about Kentucky's Medicaid program.

Looking ahead, Kentucky is in a strong position to build on this work. DMS will continue to use input from members and stakeholders to guide decisions. This will help ensure the program meets the needs of both providers and the people who rely on Medicaid.

The continued partnership between DMS, the MAC, the BAC, and the TACs, will play an important role in creating a Medicaid program that is more inclusive, effective, and focused on members.