Kentucky Department for
Medicaid Services

MEDICAID ADVISORY COMMITTEE
BENEFICIARY ADVISORY COUNCIL
New Member Orientation

SEPTEMBER 2025

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AGENDA

1. Meet the Department for Medicaid Services (DMS)
2. Meet the Kentucky Medicaid Program
3. Q & A
4. DMS Advisory Groups
5. Meeting Logistics
6. Q & A
7. What to Expect Next

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Meet the Department for Medicaid Services

LISA LEE

Commissioner
Department for Medicaid Services

VERONICA JUDY-CECIL
Senior Deputy Commissioner

DR. LESLIE HOFFMANN
Deputy Commissioner

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ORGANIZATIONAL STRUCTURE

OFFICE OF THE COMMISSIONER

Dr. Muhammad Babar, Medical Director (Aging Services)	Dr. Judy Theriot Medical Director	Dr. Fatima Ali Pharmacy Director	Steve Bechtel Chief Financial Officer
Jonathan Scott, Legislative Liaison	Meagan Hart, Human Resources	Vacant, Communications	Emily Moses, Strategic Planning

Division of Fiscal Management
Amy Richardson, Director

Division of Health Care Policy
Justin Dearinger, Director

Division of Health Plan Oversight
Edith Slone, Director

Division of Information Systems
John Hoffmann, Director

Division of Long-Term Services & Supports
Carmen Hancock, Director

Division of Program Integrity
Jennifer Dudinskie, Director

Division of Quality & Population Health
Angie Parker, Director

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Meet the Kentucky Medicaid Program

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FEDERAL/STATE PARTNERSHIP

Federal

- Defines which individuals and services must be covered by a state
- Provides federal share of funding for Medicaid expenses, known as the Federal Medical Assistance Percentage (FMAP)
- Develops policies and rules to guide how states run the Medicaid program and ensure quality
- Approves state requests for program and policy design

State

- Designs and administers their unique Medicaid program according to federal rules
- Provides state share of funding for Medicaid expenses
- Chooses whether to cover services directly (called Fee-for-Service) or contract with a company (called managed care), or use both
- Determines eligibility and enrolls based on federal rules
- Decides whether to cover more people or offer more services than what federal rules require

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OUR HISTORY

1965 → **1980s-1990s** → **2014** → **2025**

Beginning

Medicaid is signed into law as part of the National Social Security Act, focused on covering low-income families, elderly and disabled. Kentucky launches its program.

Big Changes

Federal changes to expand income limits for pregnant women and children; create home and community-based services as alternative to institutional care; and strengthened services for children through Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Expansion

Kentucky chose to expand coverage to adults age 19-64 with incomes up to 138% of the Federal Poverty Level (FPL) and increased up to 200% FPL for pregnant women and children under the Affordable Care Act passed in 2010.

Today

Today, Medicaid is Kentucky's largest healthcare access program and provides coverage for over 1.4 million people.

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HOUSE RESOLUTION 1 (119TH CONGRESS) signed into law on July 4, 2025

- Work requirements for people 19-64 in the ACA expansion group (some exceptions)

- Eligibility checks every six months for ACA expansion group (had been every 12 months)

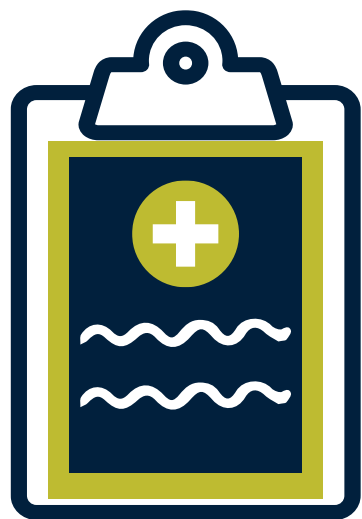- Rural Health Transformation Program

- New cost-sharing through premiums and co-pays for some adults

- Restricting immigrant eligibility through a change in definition of qualified immigrant

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BY THE NUMBERS

1.43 M
Medicaid Enrollment

73,000+
Providers serving
Medicaid Members

$20.6 B
Total Budget

26,830
Births paid for by
Medicaid
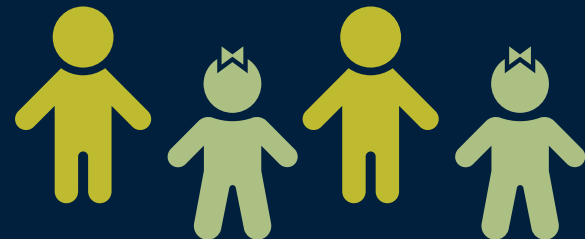
688,000
Children covered by
Medicaid

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COVERED POPULATIONS

- Deemed Eligible Newborns
- Low-Income Children
- Children in Kentucky Children's Health Insurance Program
- Current and Former Foster Children
- Children Receiving Adoption Subsidies
- Youth Involved with the Department of Juvenile Justice
- Low-Income Adults
- Parents and Caretaker Relatives
- Pregnant Women
- Individuals who Spend Down to Modified Adjusted Gross Income
- Individuals Receiving Transitional Medicaid Assistance or in Need of Emergency Time-Limited Care
- Individuals with Advance Premium Tax Credit
- KY Integrated Health Insurance Premium Payment

- Individuals Receiving Non-Social Security Income (SSI) Regular Medicaid
- Aged, Blind or Disabled Immigrants (Time-limited)
- Individuals Receiving Regular SSI or Ex Parte SSI
- Pass Through Disabled Adult Children
- Individuals Receiving State Supplementation
- Individuals Meeting Long Term Care Requirements
- Low-income People on Medicare

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COVERED SERVICES

Medically Necessary and included in a State Plan (Mandatory and Optional)

Non-Emergency Medical Transportation
- *Administered by Office of Transportation Delivery within Transportation Cabinet*

School-Based Services
- *Billed through KY Department of Education and includes administration and services*

Health Access Nurturing and Development Services (HANDS)
- *Administered by Department of Public Health*

First Steps
- *Administered by Department of Public Health*

FEE-FOR-SERVICE VS. MANAGED CARE

Fee-for-Service

Providers are Paid Directly by DMS

- Approximately 10% of the population
- Individuals in long-term care, those with intellectual or developmental disabilities in home and community based 1915(c) waivers, or those in need of supports to remain in home or community
- Costs are hard to predict, and if go over budget, services may be cut or more funding is needed
- Not able to offer value-added benefits or incentives

Managed Care Organization (MCO)

DMS Pays the MCO Each Month; MCO Pays Providers

- Approximately 90% of the population
- Children, pregnant women and adults under age 65
- Kentucky MCOs: Aetna, Humana, Passport by Molina, Wellcare, and UnitedHealthcare
- Aetna Supporting Kentucky Youth (SKY) program for children in foster care and former foster up to age 26
- Predictable budget since MCO bears risk if cost exceeds payment; 90% of funds must go to healthcare services
- Offer value-added benefits and incentives

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FEE-FOR-SERVICE VS. MANAGED CARE, CONT.

Fee-for-Service

- Pilot programs and value-based payments must be done through waivers, which require federal approval, budget neutrality, and use of limited resources for implementation, monitoring, and evaluation
- Difficult to innovate or quickly adjust to changing healthcare landscape and staff needs due to personnel limits and state hiring practices

Managed Care Organization (MCO)

- Pilot programs and value-based payments are easier to implement through agreements between the MCO and provider or vendor
- Able to quickly innovate or adjust to changing healthcare environment, including hiring staff for care management and call centers

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MEDICAID AUTHORITIES

State Plan

The State Plan is a written document describing the state's Medicaid program. It promises to follow all federal laws and cover all required groups of people. It's the "contract" between each state and the federal government.

1115 Waivers

Allows the Secretary of the United States Department of Health and Human Services (DHHS) to waive certain federal rules to let states try new and different ways to run their Medicaid programs. They are usually temporary.

1915 Waivers

States can ask the federal government to waive some rules to better serve certain groups of people. These waivers can let states give care at home or in the community instead of a facility. They can also let states use one health plan for care. These waivers last for a set time but can be renewed.

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TEAMKY 1115 WAIVER

Extends coverage to former foster care youth under age 26 years who were in foster care under the responsibility of another state on the date they turned 18 years old and who were enrolled in Medicaid.

Allows KY to provide the full array of mental health and SUD services in settings usually restricted by federal law.

Provides a set of pre-release benefits for certain individuals who are inmates in state prisons or youth correctional facilities.

Allows KY to offer certain specific housing services to address this health-related social need.

Approved for January 1, 2025–December 31, 2029. Originally approved in 2018.

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KENTUCKY'S 1915(b) WAIVERS

Managed Care

- Allows Commonwealth to use MCOs to deliver care to enrollees
- MCOs receive a monthly payment for each member and the MCO pays the providers directly
- MCOs must spend 90% of the payment on healthcare services or have a payback

Non-Emergency Transportation (NEMT)

- Operated through a contract with the Commonwealth Department of Transportation (DOT)
- DOT contracts with brokers
- Brokers contract with transportation providers
- Risk-based capitated payment model

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KENTUCKY'S 1915(c) HOME AND COMMUNITY-BASED WAIVERS

Department for Medicaid Services operates **ABI, ABI LTC,** and **Model II**

Department for Aging and Independent Living operates **HCB** and all **Participant-Directed Services (PDS)**

Department for Behavioral Health, Developmental and Intellectual Disabilities operates **SCL** and **Michelle P**

Acquired Brain Injury (ABI)

Acquired Brain Injury Long Term Care (ABI LTC)

ABI and ABI LTC: For individuals ages 18 years or older with an acquired brain injury

Home and Community Based (HCB)

Model II Waiver (MIIW)

HCB: For individuals age 65 and older or individuals of any age with a physical disability

MIIW: For individuals dependent on a ventilator 12 or more hours a day or on an active, physician monitored weaning program

Michelle P. Waiver (MPW)

Supports for Community Living (SCL)

MPW and SCL: For individuals with intellectual or developmental disabilities

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Q & A

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DMS Advisory Groups:

Medicaid Advisory Committee (MAC)
Beneficiary Advisory Council (BAC)
Technical Advisory Committees (TACs)

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Medicaid Advisory Committee (MAC): Overview

- Advises DMS regarding health and medical care services, as well as other social drivers of health
- New federal regulations released in 2024 require that Medicaid agencies make changes to their existing Advisory Council on Medical Assistance:
  - Add more members, including, including Medicaid members and caregivers
  - Increase transparency with required annual report
  - Expanded areas of focus
- To implement, Kentucky used the original Advisory Council created by KRS 205.540 and added the federal requirements

MAC Membership

- 31 members:
  - 14 nominated by an organization
  - 5 advocates
  - 7 Medicaid members and caregivers (also on the BAC); by July 2027, BAC members must be 25% of total MAC membership
  - 5 ex officio, non-voting state agency representatives who are subject matter experts and **do not** contribute to official committee recommendations or vote
- DMS Commissioner appoints members to the MAC
- Initial terms are staggered, after this each term lasts 4-year

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Beneficiary Advisory Council (BAC): Overview

- Same federal regulations that made changes to the MAC
- An advisory group consisting of former and current Medicaid members, families, and caregivers (paid or unpaid)
- The BAC can decide whether meetings will be public

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BAC Membership

- 15 members
  - Current Medicaid members
  - Former Medicaid member
  - Caregivers and family members
- DMS Commissioner appoints members
- Members represent the diverse Medicaid populations
- Initial terms are staggered, after which each term lasts 4 years
- Some BAC members also serve on the MAC

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Technical Advisory Committees (TACs)

- KRS 205.590 governs 17 TACs, including the membership for each and how they are appointed.

- TACs support the MAC by offering technical expertise, analyzing data, and providing detailed recommendations on program implementation, system changes, and policy options.

- TACs report recommendations, if any, at each MAC meeting.

KENTUCKY'S TACS

- Behavioral Health
- Children's Health
- Consumer Rights and Client Needs
- Dental Care
- Health Disparity and Equity*
- Emergency Medical Services
- Home Health Care
- Hospital Care
- Intellectual and Developmental Disabilities

- Nursing Home Care
- Nursing Services
- Optometric Care
- Persons Returning to Society from Incarceration
- Podiatric Care
- Pharmacy
- Physicians
- Primary Care
- Therapy

*Created by Executive Order

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Meeting Logistics

MAC Meeting Logistics

- The MAC elects officers each year, including a chair, vice chair, and secretary
- Meetings will be at least once a quarter
- Meetings are public and subject to Kentucky Open Records and Open Meetings statutes, KRS 61.800-884
- DMS will offer in-person, video and phone options, depending on meeting space availability
  - DMS will assist MAC members with additional support to ensure they are able to participate
- Agendas, minutes, and presentations will be posted on the MAC website
- Readings and other pre-meeting information will be emailed to members at least 10 days in advance

BAC Meeting Logistics

- The BAC elects officers each year, including a chair, vice chair, and secretary
- BAC meetings will be at least once a quarter, and prior to the MAC meetings
- BAC members can decide if they want their names to be public
- BAC members have decided the meetings will be public
- DMS will offer in-person, video, and phone options depending on meeting space availability
  - Members can receive additional support from DMS to ensure they are able to participate
- Agendas, minutes, and presentations will be posted on the BAC website
- Readings and other pre-meeting information will be emailed to members at least 10 days in advance

CONDUCTING BUSINESS

- MAC and BAC meetings should be guided by Robert's Rules of Order, which helps a group conduct business in a structured way.
- This allows the group to:
  - bring items of business
  - facilitate discussion among committee members
  - expedite decision making, while preserving the interests of minority vote
  - maintain orderly and productive interactions
  - adjourn groups when business is completed
- MAC and BAC will also create rules by adopting bylaws, which will explain how the group will be run.

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Basic Principles

Majority Rule

Respect for the Minority

Member Rights

One Question at a Time

One Person, One Vote

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EXPECTATIONS OF MEMBERS

Participate: Offer advice, opinions, ideas, and recommendations in a way that attempts to reach agreement

Prepare: Read materials and consider recommendations

Be Professional: Share experiences and consider the larger goals of the group and Medicaid; maintain confidentiality

Be Committed: Make the meetings a priority, join on time, and attend and participate fully

Be Respectful: Encourage people to share their perspectives, listen, and don't interrupt
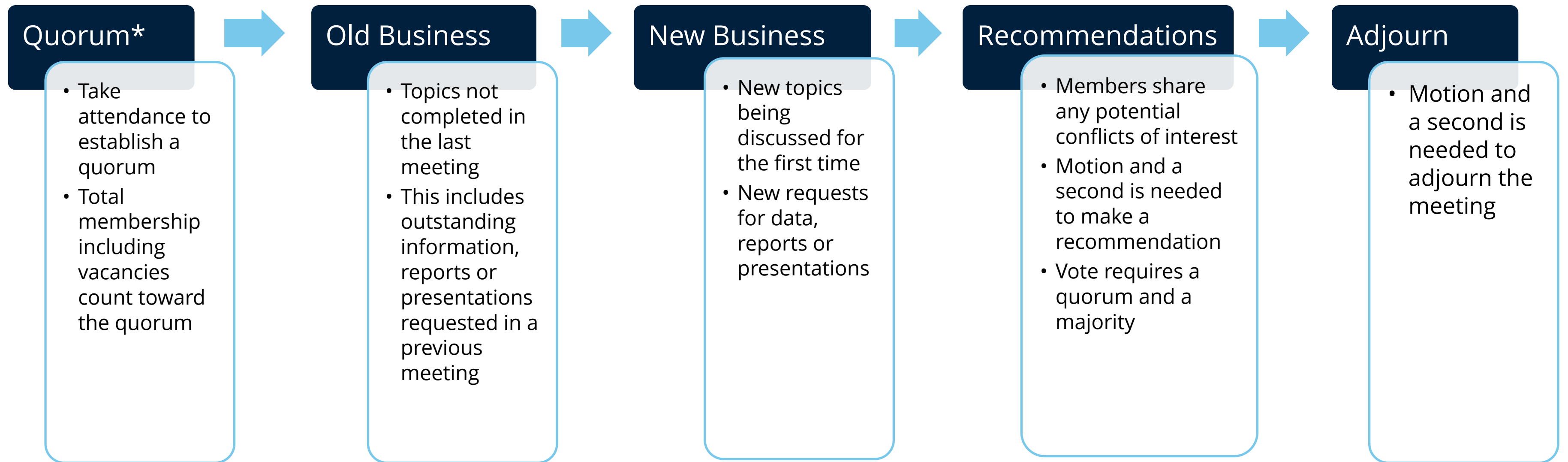
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EXPECTATIONS OF MEMBERS

Work to establish trust and build relationships with other members, Commonwealth staff, and other regular attendees

Help create an environment where people can ask questions and seek greater understanding without judgement

Be mindful of acronyms, jargon, and overly technical language; explain the meanings when they are used

Recognize that each person has their own personal experience, but the group's purpose is to help find solutions for all of Medicaid

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GENERAL DUTIES OF THE CHAIR

▶ Call the meeting to order on time, and be certain the minimum number is present to make decisions or vote

▶ Announce the business to come before the group

▶ Make sure people follow the rules and act respectfully during the meeting

▶ Recognize members who wish to speak

▶ State and put to vote all questions that come before the group

▶ Declare the meeting adjourned

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THE MEETING AGENDA

Quorum*
- Take attendance to establish a quorum
- Total membership including vacancies count toward the quorum

Old Business
- Topics not completed in the last meeting
- This includes outstanding information, reports or presentations requested in a previous meeting

New Business
- New topics being discussed for the first time
- New requests for data, reports or presentations

Recommendations
- Members share any potential conflicts of interest
- Motion and a second is needed to make a recommendation
- Vote requires a quorum and a majority

Adjourn
- Motion and a second is needed to adjourn the meeting

*A quorum is the minimum number of people who must be at a meeting to make decisions or vote. If not enough people come, the group can't take action.

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RECOMMENDATIONS

If there are enough members present, the MAC may vote to make recommendations

If approved, the MAC chair shall send the recommendations to DMS for action

DMS shall respond to MAC recommendations within 45 calendar days of the meeting

The DMS response is emailed to all MAC members, and to the TAC if the TAC made a recommendation.

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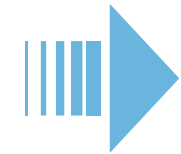
DATA REQUESTS

Requests for data may be made by the MAC and BAC.
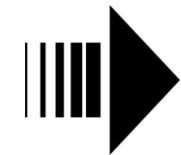
Oral requests may be made during a meeting but should be followed up in writing in an email to the MAC/BAC liaisons. It is helpful if written requests contain the following:

? *What do you want to find out or measure?*

? *How much data do you need? Define the scope, fields and timeframe.*

DMS will determine if it is able to provide the requested data, and if so, the anticipated completion date. DMS will notify the MAC or BAC if unable to complete the request.

Q & A

WHAT TO EXPECT NEXT

- Please respond to the survey(s)
  - Preferred day and time of initial meetings
  - Topics for discussion
  - Members on both the MAC and the BAC should respond to both surveys
- Invitations forthcoming

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Connect With Us!
Your Medicaid
MAC/BAC Liaisons!

KYMACTAC@ky.gov
502-218-9716

DMS.BAC@ky.gov
502-219-2170

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LINKS

MAC Webpage: https://www.chfs.ky.gov/agencies/dms/mac/Pages/default.asp

BAC Webpage: https://www.chfs.ky.gov/agencies/dms/Pages/bac.aspx

YouTube Medicaid Channel: https://www.youtube.com/channel/UCsvgVJAspohIA5Q-hgaGeKQ

DMS Webpage: https://www.chfs.ky.gov/agencies/dms/Pages/default.aspx

TAC Webpage: https://www.chfs.ky.gov/agencies/dms/tac/Pages/default.aspx

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