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February 3, 2026

Ms. Lisa Lee  
Commissioner  
Kentucky Department for Medicaid Services  
275 East Main Street 6W-A  
Frankfort, KY 40621-0001

Dear Ms. Lisa Lee:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kentucky's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on April 21, 2025, and a final revised preprint was received on July 31, 2025. The proposal has a control name of KY\_Fee.VBP\_IPH.OPH\_Renewal\_20260101-20261231.

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform increase and value-based payment established by the state for inpatient hospital services and outpatient hospital services for the rating period covering January 1, 2026 through December 31, 2026, incorporated into the capitation rates through a separate payment term amount of up to \$2,839,461,363.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

Based on CMS's preliminary determination, this SDP proposal likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS is preparing a notice of proposed rulemaking to revise 42 CFR part 438 as required under section 71116. CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of a grandfathered SDP (as specified in item 4 of the current SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the [Medicaid Managed Care Rate Development Guide](#). The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

If you have any questions concerning this letter, please contact [StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov).

Sincerely,

JOHN F.  
GILES JR -S

Digitally signed by JOHN  
F. GILES JR -S  
Date: 2026.02.03  
17:39:10 -05'00'

John Giles  
Director, Managed Care Group  
Center for Medicaid and CHIP Services

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## Section 438.6(c) Preprint

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42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to:  
[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov).

### SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):  
January 1, 2026 - December 31, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:  
Kentucky Managed Care Organization Program
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: 2,839,461,363
  - a. Identify the estimated federal share of this state directed payment: 2,271,569,090
  - b. Identify the estimated non-federal share of this state directed payment: 567,892,273

*Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.*

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement?  Yes  No

6. If this is not the initial submission for this state directed payment, please indicate if:
- a.  The State is seeking approval of an amendment to an already approved state directed payment.
  - b.  The State is seeking approval for a renewal of a state directed payment for a new rating period.
    - i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:  
July 1, 2019 through December 31, 2025
  - c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
    - Payment Type Change
    - Provider Type Change
    - Quality Metric(s) / Benchmark(s) Change
    - Other; please describe:
- No changes from previously approved preprint other than rating period(s).
7.  Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

## SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

Consistent with 42CFR 438.6, Medicaid health plans will provide a uniform dollar add-on per inpatient discharge and a uniform percentage add-on to outpatient payments to KY hospitals licensed under KRS Chapter 216B including a long-term acute hospital but excluding university hospitals and state mental hospitals defined in KRS 205.639 and KRS 205.6405. For the program year beginning 1/1/26, 10% of the annual IP and OP funding pools will be utilized for a value-based purchasing program to advance quality goals as described within later sections of this preprint.

The uniform add-on amounts will be determined by the state and remain fixed for the state calendar year. The uniform add-on amounts will be reevaluated on an annual basis.

Medicaid health plan encounter data will be used to directly link payments to utilization of inpatient services by facility for plan enrollees. Medicaid health plans are required to submit encounter data to the KY Department for Medicaid Services (KDMS) in accordance with formatting and timeliness standards set forth in their contracts with the State. Upon completion of the quarter, KDMS will calculate each hospital's uniform payment increase by MCO using valid encounters paid during the previous quarter. KDMS will then issue the hospital's uniform payment increase as a separate payment term to each Medicaid health plan based on the increase calculated for inpatient and outpatient hospital services provided to the health plan's enrollees. Due to the uniform increases being calculated after the encounter has been paid, the directed payment will occur retroactively to each health plan based on actual encounters paid during the previous quarter. Upon completion of the program year, following review of VBP components, the quality funding pool will be distributed to qualifying hospitals as one lump sum payment. Final reimbursement (combined uniform payment increase and VBP) is intended to result in spending of approximately 95% of the gap between existing MCO rates and average commercial rates based on a historical analysis of spending room for inpatient and outpatient services.

- a.  Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
- b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

See State Plan, Attachment 3.1-L, pp. ABP5-2 (ambulatory services), ABP5-7 (hospitalization)  
<https://chfs.ky.gov/agencies/dms/Documents/StatePlanr1.pdf>

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

- a.  **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

*If checked, please answer all questions in Subsection IIA.*

- b.  **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

*If checked, please answer all questions in Subsection IIB.*

### **SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):**

*This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.*

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- Quality Payment/Pay for Performance (Category 2 APM, or similar)
- Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- Multi-Payer Delivery System Reform
- Medicaid-Specific Delivery System Reform
- Performance Improvement Initiative
- Other Value-Based Purchasing Model

**11.** Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If “other” was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

For the program year beginning 1/1/26, 10% of the annual IP and OP funding pools will be withheld to advance program VBP goals. A specific funding percentage will be assigned to each goal as outlined in later preprint responses. The funding percentage assigned to each goal will be distributed at year end to all hospitals who meet or exceed the performance target, allocated by utilization within the program year. If a hospital does not achieve the target for a given measure, they will be excluded from that measure’s payment distribution and the unused dollars will be allocated among all other achieved measures.

**12.** In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#) when applicable. If the state needs more space, please use Addendum Table 1.A and check this box:

**TABLE 1: Payment Arrangement Provider Performance Measures**

Measure Name and NQF # (if applicable)	Measure Steward/ Developer <sup>1</sup>	Baseline <sup>2</sup> Year	Baseline <sup>2</sup> Statistic	Performance Measurement Period <sup>3</sup>	Performance Target	Notes <sup>4</sup>
<i>Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay</i>	<i>CMS</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8%</i>	<i>Example notes</i>
<b>a.</b> Additional Space is needed for KY response. Please see separate Attachment.						
<b>b.</b>						
<b>c.</b>						
<b>d.</b>						
<b>e.</b>						

1. Baseline data must be added after the first year of the payment arrangement  
 2. If state-developed, list State name for Steward/Developer.  
 3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.  
 4. If the State is using an established measure and will deviate from the measure steward’s measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

**13.** For the measures listed in Table 1 above, please provide the following information:

- a.** Please describe the methodology used to set the performance targets for each measure.

Performance targets were established to allow stakeholder engagement for new measures as they are added to the program. For established metrics, targets were designed to achieve either compliance with statewide/national averages OR a significant improvement in hospital-specific performance

- b.** If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

Each measure is assigned a funding percentage. If a hospital meets a given measure, they will receive a portion of that measure's payment incentive, allocated based on utilization within the program year. If a hospital does not meet a given measure, they will be ineligible for payment on that measure but will have the opportunity to earn payment for other measures.

- c.** For state-developed measures, please briefly describe how the measure was developed?

**14. Is the State seeking a multi-year approval of the state directed payment arrangement?**

Yes  No

- a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.
- b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

CY 2026 is Year 5 of a multi-year strategy. The quality portion of the funding pool is 10% in CY 2026 and future years. Additionally, the performance targets for the quality metrics proposed for the VBP payments will be evaluated and adjusted on an annual basis to monitor progress and provide incentive for continued quality improvement.

**15. Use the checkboxes below to make the following assurances:**

- a.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.
- b.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.
- c.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
- d.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

**SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:**

*This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.*

**16. Please check the type of state directed payment for which the State is seeking prior approval. Check all that apply; if none are checked, proceed to Section III.**

- a.  Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates*<sup>1</sup> (42 C.F.R. § 438.6(c)(1)(iii)(B))
- b.  Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
- c.  Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

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<sup>1</sup> Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

**17.** If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

- a.** Check the basis for the fee schedule selected above.
  - i.**  The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a).<sup>2</sup>
  - ii.**  The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
  - iii.**  The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
    - 1.** If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- b.** Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

**18.** If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

- a.**  Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- b.** Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- c.** Indicate the number of exemptions to the requirement:
  - i.** Expected in this contract rating period (estimate)
  - ii.** Granted in past years of this payment arrangement
- d.** Describe how such exemptions will be considered in rate development.

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<sup>2</sup> Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

- a. Will the state require plans to pay a  uniform dollar amount **or** a  uniform percentage increase? (*Please select only one.*)
- b. What is the magnitude of the increase (e.g., \$4 per claim or 3% increase per claim?)

IP per discharge (non-VBP): \$9,338.16, IP per discharge (VBP): \$1,037.57, OP percentage of payments (non-VBP): 108.20%, OP percentage of payments (VBP): 12.02%

- c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

Due to the uniform increases being calculated after the encounter has been paid, the directed payment will occur retroactively to each health plan based on actual encounters paid during the previous quarter.

- d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The increase was based on 95% of the gap between existing MCO rates and average commercial rates based on a historical analysis of spending room per discharge. Based on CMS guidance issued, KY believes the average commercial rate is a reasonable limit for reimbursement and the state has limited to 95% of this amount.

### SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

- a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- inpatient hospital service
- outpatient hospital service
- professional services at an academic medical center
- primary care services
- specialty physician services
- nursing facility services
- HCBS/personal care services
- behavioral health inpatient services
- behavioral health outpatient services
- dental services
- Other:

- b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Kentucky hospitals licensed under KRS Chapter 216B including long-term care hospital, but excluding university hospitals and state mental hospitals defined in KRS 205.639

- c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

State-owned hospitals are covered under separate enhanced payment programs and are therefore excluded from the Hospital Rate Improvement Program.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

Under this payment arrangement, Kentucky hospitals licensed under KRS Chapter 216B including a long-term acute hospital but excluding university hospitals and state mental hospitals defined in KRS 205.639 will receive a separate uniform payment increase for inpatient and outpatient hospital services.

Health plan encounter data will be used to directly link payments to utilization of inpatient and outpatient services for plan enrollees using the same methodology across the class. The actual uniform add-on amounts for inpatient and outpatient services for the contract year will be determined based on an analysis of the available inpatient and outpatient spending room within managed care. The specific add-ons will be evaluated on an annual basis.

Additionally, all eligible hospitals will be given the opportunity to earn quality VBP payments by meeting performance targets as indicated in the VBP section of the preprint.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:
- a.  Replace the negotiated rate(s) between the plan(s) and provider(s).
  - b.  Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).
  - c.  Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).
23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box:

**TABLE 2: Provider Payment Analysis**

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
<i>Ex: Rural Inpatient Hospital Services</i>	80%	20%	N/A	N/A	100%
a. Inpatient Hospital Services	45.29%	51.97%	2.74%		100.00%
b. Outpatient Hospital Services	44.14%	53.07%	2.79		100.00%
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- a.  Medicare payment/cost
- b.  State-plan approved rates as defined in 42 C.F.R. § 438.6(a) (*Please note, this rate cannot include supplemental payments.*)
- c.  Other; Please define: Average Commercial Rate

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b?  Yes  No

*If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.*

- 26.** Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b?  Yes  No

*If yes, please provide information requested under the column “Pass-Through Payments” in Table 2.*

- 27.** Please describe the data sources and methodology used for the analysis provided in response to Question 23.

For inpatient services, to determine the average commercial rate gap, commercial claims data was collected from eligible providers for the top 5 payors. The average commercial payment per day across all 5 payors was then determined. Similarly, the average Medicaid MCO payment per day was also determined across the Kentucky MCOs. The ACR gap per day was then multiplied by MCO days for the provider to determine the ACR limit. The limit was multiplied by 95% for each provider to determine the overall funding pool. After all provider-specific ACR gaps were determined, the aggregate statewide ACR gap was divided by statewide discharges to determine the average ACR gap per discharge. This amount was multiplied by 95% to determine the program’s prospective add-on.

For outpatient services, to determine the average commercial rate gap, commercial claims data was collected from eligible providers for the top 5 payors. The average commercial payment to charge ratio across all 5 payors was then determined. Medicaid MCO charges were also gathered across the Kentucky MCOs. MCO charges were multiplied by the commercial payment to charge ratio for the provider to determine the ACR limit. The limit was multiplied by 95% for each provider to determine the overall funding pool. After all provider-specific ACR gaps were determined, the aggregate statewide ACR gap was divided by statewide MCO OP payments to determine the ACR limit on a percentage of payments basis. This amount was multiplied by 95% to determine the program’s prospective add-on.

- 28.** Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

With over one-third of Kentucky’s entire population enrolled in Medicaid, the proposed directed payments are critical to assuring access to care in Kentucky. Furthermore, numerous Kentucky hospitals are struggling financially. Based on CMS guidance issued, we believe the average commercial rate is a reasonable limit for reimbursement and the state has limited to 95% of the ACR gap.

#### **SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS**

- 29.** States must adequately describe the contractual obligation for the state directed payment in the state’s contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment?  Yes  No

**a.** If yes:

**i.** What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

**ii.** Please indicate where (page or section) the state directed payment is captured in the contract action(s).

**b.** If no, please estimate when the state will be submitting the contract actions for review.

The contract actions will be submitted later this year.

**SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION**

*Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.*

**30.** Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS?  Yes  No

**a.** If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

12/01/2025

**b.** If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

**Table 3: Actuarial Rate Certification(s)**

<b>Control Name Provided by CMS (List each actuarial rate certification separately)</b>	<b>Date Submitted to CMS</b>	<b>Does the certification incorporate the SDP?</b>	<b>If so, indicate where the state directed payment is captured in the certification (page or section)</b>
i.			
ii.			
iii.			
iv.			
v.			

*Please note, states and actuaries should consult the most recent [Medicaid Managed Care Rate Development Guide](#) for how to document state directed payments in actuarial rate certification(s). The actuary’s certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)*

**c.** If not currently captured in the State’s actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State’s actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

**31.** Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- a.  An adjustment applied in the development of the monthly base capitation rates paid to plans.
- b.  Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- c.  Other, please describe:

**32.** States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

As noted in the response to question #31, payments associated with this state directed payment are captured in the applicable rate certification, but are paid outside of the monthly capitation rates and reconciled on a retrospective basis. Therefore, a separate payment term will be necessary to handle the payment of these funds to the health plans. The separate payment term amounts are listed below:

- Uniform increase for inpatient hospital services – \$1,037,814,616
- VBP for inpatient hospital services – \$115,312,735
- Uniform increase for outpatient hospital services – \$1,517,700,611
- VBP for outpatient hospital services - \$168,633,401

**33.**  In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

## SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

**34.** Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- a.  State general revenue
- b.  Intergovernmental transfers (IGTs) from a State or local government entity
- c.  Health Care-Related Provider tax(es) / assessment(s)
- d.  Provider donation(s)
- e.  Other, specify:

**35.** For any payment funded by **IGTs (option b in Question 34)**,

- a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box:

**Table 4: IGT Transferring Entities**

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

- b.  Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

**36. For any state directed payments funded by provider taxes/assessments (option c in Question 34),**

- a.** Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

**Table 5: Health Care-Related Provider Tax/Assessment(s)**

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Uniform per-discharge assessment, excluding CAHs	Inpatient hospital (All private and NSGO hospitals, excluding CAHs)	No	Yes	Yes		No
ii. Uniform per-discharge assessment, excluding CAHs	Outpatient hospital (All private and NSGO hospitals, excluding CAHs)	No	Yes	Yes		No
iii.						
iv.						
v.						

- b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

**Table 6: Health Care-Related Provider Tax/Assessment Waivers**

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. Uniform per-discharge assessment, excluding CAHs (Inpatient)	6/2/21	Approved	09/23/2021
ii. Uniform per-discharge assessment, excluding CAHs and REHs (Outpatient)	11/30/22	Approved	01/12/2023
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

- a. Is the donation bona-fide?  Yes  No
- b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?  
 Yes  No

38.  For all state directed payment arrangements, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

## **SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS**

- 39.**  Use the checkbox below to make the following assurance, “In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340.”
- 40.** Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:
- a.** A hyperlink to State’s most recent quality strategy: <https://www.chfs.ky.gov/agencies/dms/dpqo/mco-qb/Documents/KYQualityStrategyDraft2023.pdf>
  - b.** The effective date of quality strategy. **November 1, 2022**
- 41.** If the State is currently updating the quality strategy, please submit a draft version, and provide:
- a.** A target date for submission of the revised quality strategy (month and year):
  - b.** Note any potential changes that might be made to the goals and objectives.

*Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.*

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

**Table 7: Payment Arrangement Quality Strategy Goals and Objectives**

Goal(s)	Objective(s)	Quality strategy page
<i>Example: Improve care coordination for enrollees with behavioral health conditions</i>	<i>Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%</i>	5
a. Improving enrollee health outcomes through improved screening, recognition, and treatment retention for individuals with behavioral health conditions (Goal 1).	Objective 1.1: Improve the overall health outcomes of those with serious mental illness by minimizing risk and adverse impacts of medication treatment and increasing health screening	24
b. Improve outcomes associated with people with the chronic diseases of diabetes mellitus, hypertension, COPD, and asthma (Goal 2)	Objective 2.1: Promote evidence-based treatment for hypertension and type 2 diabetes and related complications	25
c. Promote Access to high-quality care and reduce unnecessary spending (Goal 4)	Objective 4.1: Achieve collaborative relationships between providers & MCOs to provide care strategies such as Value Based Care	27
d. Improve outcomes for identified special populations (Goal 5)  Improve assessment, referral, and follow-up for SDOH among the Medicaid members in KY (Goal 6)	Objective 5.1: Improve outcomes for pregnant moms and newborns  Objective 6.1: Improve the quality of enrollee SDOH assessment by incorporating two assessment questions to the Health Risk Assessment (HRA) to address social connectivity/isolation	27 and 28

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

Kentucky is among the poorest states in the nation and its population has historically suffered a heavy burden of disease, poor health outcomes and a lack of access to care. These factors present unique challenges for Kentucky hospitals in order to improve the health of its people. In 2021, Americas Health Rankings ranked Kentucky the 46th unhealthiest state. However, current analysis shows Kentucky has improved and is now 41st. Kentucky continues to improve the overall quality and health outcomes for patients. Over thirty-two percent (32%) of Kentucky's population is covered by Medicaid – 1.46 million Medicaid-covered individuals compared to a total population of 4.5 million. Among all states, Kentucky is the sixth poorest, has the 7th lowest median household income and its population is reliant on the Medicaid program. The Kentucky Medicaid Program serves more older, fragile, elderly recipients as Kentucky ranks sixth highest in a dual eligible Medicaid population and ranks second highest in the percent of low-income SSI beneficiaries as percent of our total population. Kentuckians also suffer the second highest rate of disability in the nation. Directed payments have inspired an industry wide emphasis on building a long term sustainable effort to measuring, evaluating, and improving quality of care in the state of Kentucky. Directed payments are essential to the state's vision for improving health equity and improving overall Kentucky healthcare.

While Table 1 outlines the Provider Performance Measures, overall industry quality improvement goals for calendar year 2026 include:

- Table 1(o): A 1% overall reduction in Readmissions (cumulative 6% reduction compared to CY 2019 benchmark since inception of this program)
- Table 1(i): Increase screenings for SDOH to 80%
- Table 1(q): A 1% overall reduction in Primary C-Section rates

For the remaining goals, we will monitor the results in CY 2026 and establish industry expectations in CY 2027. We plan to work with Kentucky hospitals to implement processes and data collection on each of the established measures. We will assist hospitals with establishing quality process improvement teams and identify dedicated resources, develop process improvement models such as Lean, IHI Improvement Model and others, use data and measurable outcomes to determine progress toward benchmarks, and assist with data collection and abstracting.

Kentucky Quality Strategy Goal Table 5 – Goal 1: Improving enrollee health outcomes through improved screening, recognition, and treatment retention for individuals with behavioral health conditions

The HRIP program has several goals which align with this objective. The HRIP program goals are intended to reduce the prescribing of opioids, thus reducing the burden of SUD and opioid addiction. These Opioid measures are part of the state Kentucky Opioid Response Effort (KORE) program which supports the Kentucky Statewide Opioid Stewardship (SOS) program aimed at reducing opioid prescribing in Kentucky.

- Table 1(e): Concurrent co-prescribing – Aligning with the SOS program to reduce the concurrent prescribing of two or more schedule II opioids or a schedule II opioid and a benzodiazepine at discharge from a hospital-based encounter.
- Table 1(i): Opioid use following vaginal delivery: Kentucky's birthing hospitals will be measured on improvement on prescribing no schedule II opioid after vaginal delivery.
- Table 1(k): Discharge with an Opioid: Kentucky's rehabilitation hospitals will track and measure performance improvement on patients discharged with an opioid prescription.
- Table 1(o): Emergency Department Opioid Use for Acute Ankle Sprain: Kentucky's non-birthing hospitals will be measured on improvements related to prescribing no opioids during an emergency department encounter for acute ankle sprain.

The HRIP program also includes a number of measures aimed at improving behavioral and mental health, through screenings of specific vulnerable populations, which aligns with the DMS Quality Plan.

- Table 1(m): Suicide screening in the ED: HRIP adopts the Joint Commission measure for acute care hospitals to improve rates of patients screened for suicide in the ED. This will improve access through identification and referral of patients needing additional services.
- Table 1(n): Post-Partum Depression and SUD Screening: Kentucky's birthing hospitals will implement processes to screen women 1-2 weeks postpartum using a standardized tool, and make referrals where indicated for additional services.

The state Quality Plan references health screening assessments, including mental health and SUD. The above screenings for suicide and SUD, as well as post-partum depression and SUD screening all align with this objective since they will identify patients who require additional services such that referrals can be made and access to care will be improved.

**44.** Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#), when applicable.

- a.**  In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

- b. Describe how and when the State will review progress on the advancement of the State’s goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State’s goals and objectives. Please attach the State’s evaluation plan for this payment arrangement.

**TABLE 8: Evaluation Measures, Baseline and Performance Targets**

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes <sup>1</sup>
<i>Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34%</i>	<i>Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year</i>	<i>Example notes</i>
<b>i.</b> 30 Day All Cause Unplanned Readmissions	CY 2019	Statewide Target: 10.10%	Reduce the percentage of 30 day all cause unplanned readmissions by 1% per year.	Medicaid discharges only  Psych hospitals are ineligible for this metric  Excludes AMA discharges
<b>ii.</b> Social Determinants of Health (Food Insecurity, Transportation, Housing, Utilities, Safety)	CY 2023	71%	Social Determinants of Health Screening with a state screening rate of 80%	Medicaid Only measure
<b>iii.</b> Primary C-Section Rates (birthing hospitals only)	CY 2024	23%	Primary C-Section rates - with a goal of 1% statewide improvement	Medicaid Only measure
<b>iv.</b> Additional measures and performance targets will be added in future periods as baseline information becomes available.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

- c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Please see Table 1 under question 12 for a full listing of metrics and deviations from measure specifications.

This preprint represents Year 5 of a multi-year effort. Previous iterations of this payment arrangement contain a different set of quality strategy goals. Evaluation results for the period from 1/1/25 through 12/31/25 are expected to become available by 6/30/26.

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**TABLE 1: Payment Arrangement Provider Performance Measures (KY Year 5 [1/1/26])**

Measure Name and NQF # (if applicable)	Measure Steward/ Developer 1	Baseline <sup>2</sup> Year	Baseline <sup>2</sup> Statistic	Performance Measurement Period <sup>3</sup>	Performance Target	Notes <sup>4</sup>
<i>Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay</i>	<i>CMS</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8%</i>	<i>Example notes</i>
<b>a. 30 Day All Cause Unplanned Readmissions</b>	CMS Aligns with CMS HQIC Program	CY 2019	Statewide Target: 10.10%	CY 2026	Goal A (1.0% funding): hospital must either - perform at or better than statewide target in CY 2026 OR achieve a 25% improvement in hospital-specific gap to statewide target from hospital baseline of CY 2019  Goal B (1.0% funding): hospital must either - perform at or better than statewide target OR in CY 2026 achieve a 30% improvement in hospital-specific gap to statewide target from hospital baseline of CY 2019	Medicaid discharges only Psych hospitals are ineligible for this metric Excludes AMA discharges Please see Encyclopedia of Measures (EOM) for detailed numerator and denominator definitions.

<b>b. Sepsis</b>	Kentucky Hospital Association (KHA) Sepsis Consortium and CMS	July through December 2025	59.31 for bundle (subject to change)	CY 2026	<p>Goal A (1.0% funding) - Screen 95% during CY 2026 AND in CY 2026 KY bundle adherence <math>\geq</math> the benchmark OR if below benchmark improve 60% of the Gap to KY benchmark</p> <p>Goal B (1.0% funding) - Screen 95% during CY 2026 AND in CY 2026 KY bundle adherence <math>\geq</math> the benchmark OR if below benchmark improve 65% of the Gap to KY benchmark</p>	<p>Medicaid Only measure</p> <p>Psych, Rehab, and LTAC hospitals are ineligible</p> <p>Please see EOM for detailed numerator and denominator definitions.</p>
<b>c. Adverse Drug Event- Hypoglycemia</b>	Kentucky Hospital Association (KHA) aligns with the CMS metric Hospital harm- Severe Hypoglycemia	July through December 2025	2.3%	CY 2026	(0.5% funding – for LTAC, 1.0%, for Rehab, 2.0%) – Hospital to improve during CY 2026 better than or equal to the Kentucky benchmark or in CY 2026 improve 10% from hospital’s Gap to Kentucky’s benchmark.	<p>Medicaid Only measure</p> <p>Psych hospitals ineligible for this metric</p> <p>Please see EOM for detailed numerator and denominator definitions.</p>
<b>d. Adverse Drug Event- Hypertension</b>	Kentucky Hospital Association (KHA) aligns with the CMS metric Hospital harm- Severe Hypertension	July through December 2025	38%	CY 2026	(0.5% funding – for LTAC, 1.0%, for Rehab, 2.0%) – Hospital to improve during CY 2026 better than or equal to the Kentucky benchmark or in CY 2026 improve 10% from	<p>Medicaid Only measure</p> <p>Psych hospitals ineligible for this metric</p> <p>Please see</p>

					hospital's Gap to Kentucky's benchmark.	EOM for detailed numerator and denominator definitions.
<b>e. Concurrent e-Prescribing (Two or more Schedule II Opioid)</b>	CMS Kentucky Statewide Opioid Stewardship (KY SOS) a part of CHFS KORE initiative	July through December 2025 (subject to change)	2.58 (Subject to Change)	CY 2026	Goal A (0.5% funding – for psych/LTAC, doubles to 1.0%) – Hospital to improve during CY 2026 10% from hospital baseline OR achieve Kentucky benchmark or better.  Goal B (0.5% funding – for psych/LTAC, doubles to 1.0%) - Hospital to improve during CY 2026 15% from hospital baseline OR achieve Kentucky benchmark or better.	Medicaid Only measure  Rehab hospitals are ineligible for this metric  Please see EOM for detailed numerator and denominator definitions.
<b>f. Social Determinants of Health (Food Insecurity, Transportation, Housing, Utilities, Safety)</b>	CMS	CY 2023	71%	CY 2026	(1.0% funding, for Psych/LTAC 2.0% funding) – Screen 90% of hospital Medicaid Inpatients using the CMS or Kynect screening tool and make referrals according to the hospital's plan during CY 2026	Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.
<b>g. Hours of Physical Restraint Use (Psych Only)</b>	Joint Commission	July through December 2025	0.09 (subject to change)	CY 2026	(2.0% funding) – In CY 2026 have performance at or better than KY benchmark OR achieve a 20% improvement in the	Medicaid Only measure  Please see EOM for detailed

					Hospital's Gap to KY benchmark	numerator and denominator definitions.
<b>h. Hours of Seclusion Use (Psych Only)</b>	Joint Commission	July through December 2025	0.04 (subject to change)	CY 2026	(2.0% funding) - In CY 2026 have performance at or better than KY benchmark OR achieve a 20% improvement in the Hospital's Gap to KY benchmark	Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.
<b>i. Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (Psych Only)</b>	Joint Commission	July through December 2025	77.46 (subject to change)	CY 2026	(2.0% funding) - In CY 2026 have performance at or better than KY benchmark OR Achieve a 20% improvement in the Hospital's Gap to KY benchmark	Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.
<b>j. Discharge to Home / Community (Rehab only)</b>	CMS	July through December 2025	77.70 (subject to change)	CY 2026	(2.0% funding) - In CY 2026 have performance at or better than KY benchmark OR achieve a 25% improvement in the Hospital's Gap to KY benchmark	Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.
<b>k. Discharge with an Opioid Rx (Rehab only)</b>	KY	July through December 2025	24.81 (subject to change)	CY 2026	Goal A (0.5% funding) – Hospital to improve during CY 2026 achieve a 15% improvement in the Hospital's Gap to KY benchmark OR achieve KY benchmark or better	Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.

					Goal B (0.5% funding) – Hospital to improve during CY 2026 achieve a 20% improvement in the Hospital's Gap to KY benchmark OR achieve KY benchmark or better	
<b>l. Opioids for Vaginal Delivery (birthing hospitals only)</b>	Align with KY SOS Metric	July through December 2025	80.00 (subject to change)	CY 2026	(0.5% funding) – Hospital to improve during CY 2026 10% from baseline OR achieve Kentucky benchmark or better	All birthing hospitals only  Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.
<b>m. Suicide Screening in the Emergency Department</b>	Align with Joint Commission Standards	(1.0% funding. .5% for birthing hospitals) – Hospitals to screen 80% of Emergency Department (ED) patients during CY 2026 (All patients age 11 years and older who present to the emergency department)				Excludes LTAC, Psych, and Rehab hospitals  Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.
<b>n. Maternal Depression and SUD Screening (birthing hospitals only)</b>	KY	January through June 2024	76.4	CY 2026	(0.5% funding) – Hospitals to screen 80% of postpartum patients during CY 2026	All birthing hospitals only  Medicaid Only

						measure  Please see EOM for detailed numerator and denominator definitions.
<b>o. Emergency Department Opioid Use for Acute Ankle Sprain (ALTO)</b>	Align with KY SOS Metric	July through December 2025	76.11 (subject to change)	CY 2026	<p>Patients, age 18 years or older, prescribed no opioids during an emergency department encounter for dislocation or acute sprain of the ankle.</p> <p>Goal A (0.5% funding) - Hospital to improve during CY 2026 15% from hospital baseline OR achieve Kentucky benchmark or better</p> <p>Goal B (0.5% funding) - Hospital to improve during CY 2026 20% from hospital baseline OR achieve Kentucky benchmark or better</p>	<p>Excludes Birthing, LTAC, Psych, and Rehab hospitals</p> <p>Medicaid Only measure</p> <p>Please see EOM for detailed numerator and denominator definitions.</p>
<b>p. Blood Culture Contamination</b>	Aligns with KY Sepsis Consortium	July through December 2025	2.04 (subject to change)	CY 2026	(1.0% funding, 2% for LTAC) – Hospital to improve during CY 2026 10% from hospital baseline OR achieve Kentucky benchmark or better	<p>Medicaid Only measure</p> <p>Rehab and Psych facilities are ineligible for this metric</p> <p>Please see EOM for detailed</p>

						numerator and denominator definitions.
<b>q. Primary C-Section Rates (birthing hospitals only)</b>	NHSN	CY 2024	23%	CY 2026	(0.5% funding) - Hospital to improve during CY 2026 5% from hospital baseline OR achieve KY benchmark or better	Medicaid Only measure  Please see EOM for detailed numerator and denominator definitions.

Baseline data must be added after baseline period completed.