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March 3, 2026

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

Dear 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 July 25, 2025, and a final revised preprint was received on February 3, 2026. The proposal has a control name of KY\_VBP.Fee\_IPH.OPH.AMC2\_Renewal\_20260101-20261231.

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

- Quality payment and uniform dollar increase for inpatient hospital services, outpatient hospital services, and professional services at an academic medical center for the rating period covering January 1, 2026 through December 31, 2026, incorporated in the capitation rates through a separate payment term amount up to \$135,747,624.

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, the SDP proposal with the control name of, KY\_VBP.Fee\_IPH.OPH.AMC2\_Renewal\_20250101-20251231, submitted on August 28, 2024 with a total dollar amount of \$135,747,624, likely qualified 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 \$135,747,624 for the grandfathered SDP, named KY\_VBP.Fee\_IPH.OPH.AMC2\_Renewal\_20250101-

20251231, submitted on August 28, 2024 (as specified in item 4 of the applicable 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: 2026.03.03  
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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: \$135,747,624
  - a. Identify the estimated federal share of this state directed payment: \$108,598,099
  - b. Identify the estimated non-federal share of this state directed payment: \$27,149,525

*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:  
1/1/2025 - 12/31/2025
  - 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:
- Due to the guidance received from CMS on 9/9/2025 (in regards to their interpretation of the grandfathering rules set forth in the OBBA), KDMS has revised the preprint "KY\_VBP.Fee\_IPH.OPH.AMC2\_20260101-20261231"
- 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).

Providers will be eligible for payments up to the Average Commercial Rate (ACR), but 20% of the total payment amount will be withheld until the end of the performance period and depend on providers' performance on a menu of quality metrics (see response to question 12). For the inpatient and outpatient hospital services portions of the payment, the room under the ACR will be calculated inclusive of payments under Kentucky's Hospital Rate Improvement Program (HRIP) state directed payment, as shown in Table 2. A pro rata reduction will then be applied to ensure that the aggregate payments made under HRIP and this KTHRI directed payment program do not exceed 100% of Kentucky's statewide ACR limit. Uniform (non-quality) payment amounts will be based on actual quarterly paid utilization, following the end of each quarter. Providers will then receive the at-risk portion of the payment at the end of the program period based on meeting quality metrics.

- 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).

Kentucky is expanding upon its successful State University Provider SDP with this program, the Kentucky Trauma Hospital Rate Improvement (KTHRI), which will continue to emphasize access to Medicaid services and training the next generation of health care providers for the state. The state will require MCOs to have network provider agreements with all eligible providers. Kentucky's quality goals are focused on reducing the burden of chronic diseases and substance use disorders; increasing preventive services to improve population health; reducing unnecessary and wasteful care; maintaining timely access to high-quality care for Medicaid beneficiaries and improving care and outcomes for children and adults. The directed payments will accelerate the move to paying for value; encourage the development of population-based innovative care delivery models that improve health outcomes; ensure timely access to treatment; and prevent and treat opioid use disorder.

The eligible providers play a unique role in training the next generation of health care providers, ensuring access to trauma care services, and increasing access to care in counties with high Medicaid need.

Providers are eligible to earn enhanced payments from MCOs for the services provided (inpatient hospital, outpatient hospital and professional services). The MCOs will make quarterly directed payments to eligible providers based on claims utilization paid in the quarter, following the end of each quarter, with a withhold of 20% for quality. Payment of the quality withhold will be made annually and will depend on performance on the quality measures contained in Table 1.

**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> 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.

The performance targets are identical to those used in the University Provider SDP and have been set as a 2% improvement over the most recent program year's established targets. As performance measures progress to their near clinical maximum improvement they are moved into a maintenance phase, with the improvement target remaining static. To qualify for evaluation, a measure must have a minimum criteria of 20 cases in the denominator. Measures not meeting this case rate threshold will be considered a reporting-only measure and not be considered in determining the value-based payments.

- 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?

Providers must meet performance targets on at least eight measures listed in Table 1A to receive the quality performance withhold. There is no partial payment of the performance withhold.

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

There are two state developed measures:

1. Post-Partum Depression Screening: This measure was modeled after the specifications for NQF #1517 (PPC-AD) Post-Partum Care. It measures the percentage of patients delivering in a participant hospital who had a documented result for depression screening using an age-appropriate standardized instrument, performed by a participant provider, during the 7-84 days following the date of delivery.

2. Social Determinants of Health Screening and Follow-up: This measure was developed in alignment with the CMS Inpatient Quality Reporting measure for Health-related Social Needs Screening but is focused on the ambulatory clinic setting.

**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.

This arrangement is expected to continue after this approval for CY 2026. Additionally, this program is modeled on an existing and ongoing program targeting State University providers which began in 2020. KTHRI will expand that program beyond just state university providers to continue supporting access to Medicaid and training the next generation of health care providers for the state.

**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))

<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?)  
**See separate attachment.**
- 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).

The uniform increase will be paid quarterly minus the quality performance withhold. Quarterly uniform payments will be based on actual encounters paid during the quarter and will be calculated following the completion of each quarter. Quality payments will be paid on an annual basis following the rating period after quality results are submitted and evaluated.

For the last quarter of the rating period, the add-ons will be evaluated for potential revision based on actual utilization during the entire rating period to ensure the total amount listed in question 4 is distributed to eligible providers. The revised add-ons will not exceed the approved grandfathered amount and will not exceed the calculated ACR.

- 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 is tied to services delivered under the contract rating period where the total payment, including the quality withhold, is less than or equal to the ACR for actual utilization of services. The payments for hospital services will be adjusted to ensure that they do not cause total aggregate payments to hospitals under both the KTHRI and Kentucky's Hospital Rate Improvement Program state directed payment to exceed the statewide ACR limit. KTHRI eligible providers are defined under state law. The use of the ACR reflects a commitment to equitable access between Medicaid beneficiaries and commercially insured patients.

### 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).

The class of providers eligible for this payment arrangement are (1) hospitals participating in Kentucky's Hospital Rate Improvement Program with a Level II, III, or IV trauma center, which are located in a county with a higher proportion of residents enrolled in Medicaid than the statewide median, and which have an agreement for clinical rotations to train providers with a university-affiliated graduate medical education program and (2) pediatric teaching hospitals as defined in state law, which are only eligible for payments for services provided to patients eighteen (18) years of age or younger. The providers eligible for this payment arrangement are defined in the following classes:  
1. Level II Trauma Center Hospital – Inpatient services (defined in 902 KAR 28.010)  
2. Level IV Trauma Center Hospital – Inpatient services (defined in 902 KAR 28.010)  
3. Pediatric Teaching Hospital – Inpatient services (defined in KRS 205.565)  
4. Level II Trauma Center Hospital – Outpatient services (defined in 902 KAR 28.010)  
5. Level IV Trauma Center Hospital – Outpatient services (defined in 902 KAR 28.010)  
6. Pediatric Teaching Hospital – Outpatient services (defined in KRS 205.565)  
7. Level II Trauma Center Hospital – Professional services (defined in 902 KAR 28.010)  
8. Level IV Trauma Center Hospital – Professional services (defined in 902 KAR 28.010)

- 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.

The provider class is defined by the state legislature in SB 280, enacted into law in 2024.

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.

The methodology for determining the rate increase for (a) inpatient hospital services, (b) outpatient hospital services, and (c) professional services will be applied equally to all providers within the class. Specifically, all providers will be paid a uniform dollar increase calculated pursuant to a uniform methodology designed to increase payments up to their respective average commercial rates (with adjustments to ensure that aggregate HRIP and KTHRI payments do not exceed the statewide ACR limit).

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. See separate attachment					
b.					
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/outpatient services, to determine the average commercial rate gap, commercial claims data was collected from eligible providers. The average commercial payment per day/visit were then determined. Similarly, the average Medicaid MCO payment per day/visit, inclusive of the HRIP uniform increase, were also determined. The ACR gap per day/visit was then multiplied by MCO days/visits for the provider to determine the ACR gap for the IP/OP funding pools. Those pools were then compared to the remaining ACR gap in HRIP, and adjusted on a pro rata basis to ensure that aggregate HRIP and KTHRI payments do not exceed the statewide ACR limit. The funding pools were then divided by IP days / OP visits respectively to determine the program add-ons.

For professional services, Medicaid MCO claims volume was priced at the average commercial rate on a procedure code basis. Medicaid payments were then subtracted from the estimated commercial reimbursement to determine the ACR gap for the professional funding pools. The funding pool was then divided by professional units of service to determine the program add-ons.

For CY 2026, the ACR gap exceeded the CY 2025 limit so therefore, the ACR GAP was reduced down to the 2025 limit and then divided by projected utilization to calculate a reduced add-on. Reducing the add-on helps to ensure payments do not exceed the 2025 limit.

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

The increase is tied to services delivered under the contract rating period where the total payment, including the quality withhold, is less than or equal to the ACR for actual utilization of services. The selection of eligible providers reflects the critical role of the KTHRI providers in expanding access to services for Medicaid beneficiaries, as evidenced by recent growth. The use of the ACR reflects a commitment to equitable access for Medicaid beneficiaries and commercially insured patients.

#### 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?

N/A

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

Existing managed care contracts have a requirement that MCOs must comply with directed payment arrangements (“Attachment #3 – Question #29”). Additionally, this directed payment arrangement is described in Kentucky statute, which

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

**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.

N/A

- 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.
- The state has opted to structure the payment as a separate payment term because this structure reduces the administrative burden on the state agency and MCOs by allowing ease of tracking a verification and limiting the need to change systems to integrate directed payment into cap and PMPM rates.  
A summary of the dollar amounts for each separate payment term for CY 2026 is listed below:  
1) VBP for inpatient hospital services – \$11,648,470  
2) VBP for outpatient hospital services - \$13,044,563  
3) VBP for professional services at an academic medical center – \$2,456,792  
4) Uniform add-on for inpatient hospital services – \$46,592,680  
5) Uniform add-on for outpatient hospital services – \$52,178,250  
6) Uniform add-on for professional services at an academic medical center – \$9,827,170
- 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. University of Kentucky	State	\$ 15,996,144.00	No	\$15,996,144	No
ii. University of Louisville	State	\$ 11,153,380.00	No	\$11,153,380	No
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.

No such agreements exist.

**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.						
ii.						
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.			
ii.			
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-qh/Documents/KYQualityStrategyDraft2023.pdf>
  - b. The effective date of quality strategy. **November 16, 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
<b>a.</b> Improved screening and treatment retention for individuals with behavioral health conditions	Increase utilization of psychological care	13
<b>b.</b> Improved outcomes for individuals with chronic diseases	Promote evidence-based treatment for individuals with: Hypertension Type II Diabetes	13
<b>c.</b> Increased use of preventative services	Increase preventive cancer screenings Increase childhood wellness visits Support tobacco and smoking cessation	13
<b>d.</b> Improved assessment, referral, and follow-up for social determinants of health	Increase the number of enrollees who receive a SDOH assessment	13

**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.

This plan is an expansion of a multi-year effort by Kentucky Medicaid to accelerate the transition to value-based payment models, improve care and outcomes for chronic conditions, improve prevention, reduce costs and improve overall health system performance in Kentucky. Substantially the same quality goals and expectations will apply to providers participating in KTHRI as providers participating in the State University Providers program. The eligible providers play a crucial role in the education of the Kentucky health care work force and in ensuring access to care for high Medicaid need communities. The payment arrangement helps ensure that these organizations improve performance and move toward value-based payment models at a rapid rate. Additionally, these organization are key partners in the work to reduce opioid use and substance use disorders, ensure timely access to treatment and recovery services and preventing death from overdose.

The program requires eligible organizations to report to Kentucky Medicaid a set of performance metrics which are common to Medicare’s Quality Payment Program and the adult and child cores sets and frequently used by commercial insurers in value-based programs. The measure set closely aligns with the goals and objectives outlined above, spanning the following focus areas: chronic conditions, preventative services, behavioral health, cost of care and pediatric health. Eligible attributed populations for reporting have been defined throughout this program as: Medicaid Managed Care patients who have been seen by a primary care provider of the participant organization within the last 18-months at the time of the reporting. The state proposes to use this attribution definition for 2026 reporting for consistent program evaluation.

**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> See attached Table 8				
<b>ii.</b>				
<b>iii.</b>				
<b>iv.</b>				

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.

**PREPRINT SUBSECTION IIA: VALUE-BASED PAYMENT/DELIVERY SYSTEM REFORM  
ADDENDUM TABLE 1.A. PAYMENT ARRANGEMENT PROVIDER PERFORMANCE MEASURES**

*Directions* 1. In Table 1.A below, use the rows to add more measure(s) to Table 1 that the State will tie to provider performance under this value-based payment or delivery system reform arrangement (provider performance measures). States may also use Table 1.A in lieu of completing Table 1 in the preprint. Input data only in beige cells in columns B - H. States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 1 in the preprint, please delete Tabs 2.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

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

Column 1	Measure Name and NQF # (if applicable)	Measure Steward/ Developer Set values (select one)	Baseline Year Year (CY or FY YYYY)	Baseline Statistic Percent (%)	Performance Measurement Period	Performance Target Percent (%)	Notes Free text
			Baseline year must be added after the first year of the payment arrangement	Baseline percentage must be added after the first year of the payment arrangement	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		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
<i>Example:</i>	<i>Residents with Pressure Ulcers - Long Stay</i>	<i>Centers for Medicare &amp; Medicaid Services</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8.00%</i>	
a.	Breast Cancer Screening	NQF 2372 / CMS 125	CY 2025	69.1%	PY2 Calendar 2026	≥55.2%	Note for all Measures: Participants will be evaluated independently. Baselines will be updated after end of CY2025. Where provided, performance targets are established by the KY Dept for Medicaid Services consistent with the State University Directed Payment Program as authorized by KRS 205.6412(1)(c)
b.	Colorectal Cancer Screening	NQF 34 / CMS 130	CY 2025	59.3%	PY2 Calendar 2026	≥61.6 %	
c.	Tobacco Use: Screening and Cessation Intervention	NQF 28 / CMS 138	CY2025	89.4%	PY2 Calendar 2026	≥79.6%	
d.	Screening for Clinical Depression and Follow-up Plan	NQF 418 / CMS 2	CY2025	51.9%	PY2 Calendar 2026	≥69%	
e.	Diabetes Care: Hemoglobin (HBA1c) Poor Control (>9.0%)	NQF 59 / CMS 122	CY2025	21.6%	PY2 Calendar 2026	≤37.6%	
f.	Controlling High Blood Pressure Hypertension)	NQF 18 / CMS 165	CY2025	70.9%	PY2 Calendar 2026	≥58.4%	
g.	Statin Therapy for Patients with Cardiovascular Disease	CMS PREV-13; CMS 347	CY2025	77.9%	PY2 Calendar 2026	≥84.9%	
h.	Body Mass Index (BMI) Screening and Follow-up	NQF 421 / CMS 69	CY2025	63.0%	PY2 Calendar 2026	≥74.3%	
i.	Medication Reconciliation Post Discharge	NQF 97	CY2025	76.7%	PY2 Calendar 2026	≥74.3%	
j.	30 Day All Cause Unplanned Readmission	State-specific	CY2025	7.8%	PY2 Calendar 2026	≤10.10%	State specific measure with target defined by the Kentucky Hospital Rate Improvement Program. Numerator: All patients who are readmitted within 30 days of discharge. Inpatients returning as an acute care inpatient within 30 days of an inpatient discharge, to any facility, except for certain planned admissions. Denominator: All patients discharged during any given month meeting the discharge inclusion/exclusion criteria.
k.	Use of Opioids at High Dosage	NQF 2940 - PQA measure steward	CY2025	0.6%	PY2 Calendar 2026	≤1.5%	
l.	Well Child Visits, 3-6 years	NQF 1516	CY2025	32.3%	PY2 Calendar 2026	≥90%	
m.	Well Child Visits, Rate 1: First 15 months	NQF 1392	CY2025	48.4%	PY2 Calendar 2026	≥79.6%	
n.	Well Child Visits, Rate 2: 15-30 months	NQF 1392	CY2025	66.5%	PY2 Calendar 2026	≥81.8%	
o.	Screening for Depression and Follow-Up Plan: Ages 12 to 17	NQF 0418 /0418e / CMS 2	CY2025	86.3%	PY2 Calendar 2026	≥77.7%	
p.	Body Mass Index (BMI) Screening and Follow-up: Ages 12-17	NQF 421 / CMS 69	CY2025	66.1%	PY2 Calendar 2026	≥61.5%	State Developed Measure: Numerator: Patients with a documented BMI-for-age during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Denominator: Patients who reached the age of 12-17 years during the measurement period and had at least one visit with primary care provider in the measurement period. Normal Parameters: Age 12 to 17 years and BMI-for-age* >5th percentile and <95th percentile; BMI-for-age = BMI percentile calculated for age and sex of the child, according to CDC guidelines
q.	Postpartum Depression Screening	State-specific	CY2025	96.0%	PY2 Calendar 2026	≥77.8%	State Developed Measure: Numerator: Patients in the denominator who had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7-84 days following the date of delivery. Denominator: Patients delivering in a participant hospital during the 12 months ending 90 days prior to the end of the reporting period, who had an in person or telehealth clinic visit with a participating OB/GYN provider within 84 days following delivery.
r.	SDOH Screening and Follow Up	State-specific	CY2025	28.4%	PY2 Calendar 2026	≥19.9%	State Developed Measure: Numerator: The number of attributed patients seen by a primary care provider in clinic who were screened using a SDOH screening tool that is aligned with CMS requirements. Denominator: Attributed patients seen by a primary care provider in clinic during the measurement period

**PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS  
ADDENDUM TABLE 2: PROVIDER PAYMENT ANALYSIS**

2. 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.).

*Directions*

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.

**TABLE 2.A: Provider Payment Analysis**

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of 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)
Data Format	Free text	Percent (%)	Percent (%)	Percent (%) or N/A	Percent (%) or N/A	Percent (%)
<i>Example:</i>	<i>Rural Inpatient Hospital Services</i>	80.0%	20.0%	N/A	N/A	100.0%
a.	IP Level II Trauma Center Hospital	38.86%	8.63%	24.47%	N/A	71.95%
b.	IP Level IV Trauma Center Hospital	30.69%	6.41%	30.14%	N/A	67.24%
c.	IP Pediatric Teaching Hospital	31.10%	13.22%	23.38%	N/A	67.70%
d.	OP Level II Trauma Center Hospital	32.88%	10.97%	39.64%	N/A	83.49%
e.	OP Level IV Trauma Center Hospital	32.66%	11.98%	39.37%	N/A	84.01%
f.	OP Pediatric Teaching Hospital	34.68%	9.92%	47.86%	N/A	92.45%
g.	Hospital	53.17%	46.83%	0.00%	N/A	100.00%
h.	Hospital	60.22%	39.78%	0.00%	N/A	100.00%

**PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS**  
**ADDENDUM TABLE 8.A. EVALUATION MEASURES, BASELINE AND PERFORMANCE TARGETS**

8. Use Table 8.A below to add each measure the State intends to use in the evaluation of this payment arrangement, including (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. States may also use Table 8.A in lieu of completing Table 8 in the preprint. Input data only in beige cells in columns B - F.

*Directions*

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 8 in the preprint, please delete Tabs 1.A - 7.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

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

Column 1	Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes
<b>Data Format</b>	<b>Free text</b>	<b>Free text</b>	<b>Percentage (%)</b>	<b>Percentage (%)</b>	<b>Free text. If the State will deviate from the measure specification, please describe here. If the State is using a state-specific measure, please define the numerator and denominator here. In addition, describe any planned data or measure stratifications (for example, age, race, or ethnicity) the State will use to evaluate the payment arrangement</b>
<i>Example:</i>	<i>Flu Vaccinations for Adults Ages 19 - 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34.0%</i>	<i>34.0%</i>	
i.	Breast Cancer Screening	CY2025	69.1%	≥55.2%	<b>Note for all Measures except 30 day Readmissions as noted below:</b> Targets established by the KY Dept for Medicaid Services consistent with the State University Directed Payment Program as authorized by KRS 205.6412(1)(c)
ii.	Colorectal Cancer Screening	CY2025	59.3%	≥61.6 %	
iii.	Tobacco Use: Screening and Cessation Intervention	CY2025	89.4%	≥79.6%	
iv.	Screening for Clinical Depression and Follow-up Plan	CY2025	51.9%	≥69%	
v.	Diabetes Care: Hemoglobin (HBA1c) Poor Control (>9.0%)	CY2025	21.6%	≤37.6%	
vi.	Controlling High Blood Pressure Hypertension)	CY2025	70.9%	≥58.4%	
vii.	Statin Therapy for Patients with Cardiovascular Disease	CY2025	77.9%	≥84.9%	
viii.	Body Mass Index (BMI) Screening and Follow-up	CY2025	63.0%	≥74.3%	
ix.	Medication Reconciliation Post-Discharge	CY2025	76.7%	≥74.3%	
x.	30 Day All Cause Unplanned Readmission	CY2025	7.8%	≤10.10%	State specific measure with target defined by the Kentucky Hospital Rate Improvement Program: Numerator: All patients who are readmitted within 30 days of discharge. Inpatients returning as an acute care inpatient within 30 days of an inpatient discharge, to any facility, except for certain planned admissions. Denominator: All patients discharged during any given month meeting the discharge inclusion/exclusion criteria.
xi.	Use of Opioids at High Dosage	CY2025	0.6%	≤1.5%	
xiii.	Well Child Visits, 3-6 years	CY2025	32.3%	≥90%	
xiv.	Well Child Visits, Rate 1: First 15 months	CY2025	48.4%	≥79.6%	
xv.	Well Child Visits, Rate 2: 15-30 months	CY2025	66.5%	≥81.8%	
xvi.	Screening for Depression and Follow-Up Plan: Ages 12 to 17	CY2025	86.3%	≥77.7%	
xvii.	Body Mass Index (BMI) Screening and Follow-up: Ages 12-17	CY2025	66.1%	≥61.5%	State Developed Measure: Numerator: Patients with a documented BMI-for-age during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Denominator: Patients who reached the age of 12-17 years during the measurement period and had at least one visit with primary care provider in the measurement period. Normal Parameters: Age 12 to 17 years and BMI-for-age* >5th percentile and <95th percentile; BMI-for-age = BMI percentile calculated for age and sex of the child, according to CDC guidelines
xviii.	Postpartum Depression Screening	CY2025	96.0%	≥77.8%	State Developed Measure: Numerator: Patients in the denominator who had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the date of delivery. Denominator: Patients delivering in a participant hospital during the 12 months ending 90 days prior to the end of the reporting period, who had an in person or telehealth clinic visit with a participating OB/GYN provider within 84 days following delivery.
xix.	SDOH Screening and Follow Up	CY2025	28.4%	≥19.9%	State Developed Measure: Numerator: The number of attributed patients seen by a primary care provider in clinic who were screened using a SDOH screening tool that is aligned with CMS requirements. Denominator: : Attributed patients seen by a primary care provider in clinic during the measurement period