CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHEAD Statewide Population Health Accountability Plan (PHAP): 2027 Overview and Guidance

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I. Introduction to the Statewide PHAP

To support accountability for population health improvement, participating states in the Centers for Medicare & Medicaid Services (CMS) AHEAD Model are required to develop and submit a Population Health Accountability Plan (PHAP). The Statewide PHAP is a core component of the AHEAD Model, serving as the primary vehicle through which states articulate a long-term vision for population health improvement and align stakeholders around shared goals for care transformation. In the Statewide PHAP, states will outline their state- or sub-state-specific[1] population health goals, aligned measures and targets, and the activities planned under the model. CMS will use the targets established in the Statewide PHAP to monitor progress of population health and care transformation in each state over the course of the model.

The Statewide PHAP guides states in translating the AHEAD Model's Care Transformation Framework into a state-specific vision for care redesign, reflecting each state's population health priorities, baseline performance and progress, and policy and delivery system context and strategies. CMS sets the overarching framework for care transformation, defining the aims, quality measures, investments, and incentives and adjustments. States use the PHAP development process to set a coherent, forward-looking population health direction and align state resources, partners, and Model Participants to execute around a shared vision. In doing so, the Statewide PHAP creates the conditions for sustained population health improvement and system-level transformation throughout the model period.

How to Use This Guidance Document

This document provides states and their Model Governance Structure (MGS) or another state-selected governing body with step-by-step guidance around the timelines, processes and requirements for developing and submitting the Statewide PHAP.

It is organized to outline the sequence the state will follow as they develop and submit the Statewide PHAP. While the guidance is presented in a stepwise manner, several steps are closely interconnected and should be considered iteratively rather than sequentially. For example, Steps 2 (Identifying State Population Health Focus Areas) and 4 (Obtaining, Stratifying and Entering Baseline Data) are tightly linked, as the MGS will need to examine baseline performance, including disparities across populations, in Step 2 to inform which priority areas and groups to focus on in Step 4. Similarly, later steps, such as setting the statewide quality and population health targets (Step 5), will be influenced by the implementation plan (Step 6). States and the MGS will benefit from reviewing this document before they embark on the Statewide PHAP

[1] Throughout this document, the term state is used to refer to the AHEAD state or sub-state region.

process to learn about reporting expectations and requirements. They will also benefit from consulting this document throughout the process for resources and instructions to support decision making, data preparation, and submissions. A sample PDF of the Statewide PHAP can be found in the 4i Knowledge Library.

More specifically, this document covers the following topics:

I. Introduction to the Statewide PHAP
II. The Statewide PHAP Development Process and Timeline
III. Developing The Statewide PHAP – A Step-By-Step Approach
- Step 1 – Identifying State Population Characteristics
- Step 2 – Identifying State Population Health Focus Areas
- Step 3 – Selecting Quality Measures
- Step 4 – Obtaining, Stratifying and Entering Baseline Data
- Step 5 – Setting Statewide Quality and Population Health Targets
- Step 6 – Developing a Comprehensive Statewide PHAP Implementation Plan

IV. Submitting the Statewide PHAP into 4i

Note: CMS will release additional guidance for setting the statewide quality and population health targets in Summer 2026.

II. The Statewide PHAP Development Process and Timeline

Overview

The Statewide Population Health Accountability Plan (PHAP) defines the state's population health priorities and establishes a clear accountability framework for achieving measurable improvement under the AHEAD Model. The PHAP articulates what the state is seeking to improve, how progress will be measured, and which strategies and levers will be used to drive change across prevention, chronic disease, behavioral health, health care quality and utilization, population health, and a required supplemental domain.

Specifically, the PHAP identifies statewide population health focus areas; sets measurable goals and associated quality and population health targets; and outlines evidence-based, actionable strategies to achieve those goals. It also describes the policy, regulatory, financing, and programmatic levers the state may deploy to support implementation and includes a

communication approach to ensure relevant stakeholders are informed and engaged in advancing the state's population health goals.

Each state will establish a Model Governance Structure (MGS) or another state-selected governing body to lead Statewide PHAP development, submission, and annual updates. The MGS will provide cross-sector input into goal-setting, strategy development, progress assessment, and alignment across Hospital PHAPs. Together, the PHAP content and governance structure establish the statewide blueprint for population health accountability under the AHEAD Model.

Statewide PHAP development will likely require a structured six-month process, though the exact timing will vary by state. The development process involves accessing and reviewing health needs data; engaging stakeholders (e.g., public health agencies, provider associations, consumer representatives, data and quality experts); identifying priority population health needs; selecting measures and targets; and defining associated strategies, investments, and communication plans. The MGS will also develop a process for hospitals to develop and submit hospital-level PHAPs. The Hospital PHAP (a separate form and process from the Statewide PHAP) will align to the state population health focus areas and measures identified in the Statewide PHAP and reinforce coordinated care transformation efforts in the state. While the MGS is required to convene quarterly, at a minimum, and maintain meeting minutes for review upon request, this process will likely require additional meetings and documentation.

In the initial phase of the Statewide PHAP development, the MGS will select state population health focus areas through population health surveys, such as a Community Health Needs Assessment or a State Health Improvement Plan. Next, the MGS will identify goals for each population health focus area for the duration of the AHEAD Model, describing the desired outcomes and defining specific, measurable improvement strategies aligned to these goals.

Once goals and associated strategies are established, the MGS must select measures from the pre-approved CMS list for Statewide Quality Measures (see Appendix B: Simplified Quality Measure Descriptions) or propose alternative measures that will undergo CMS review for approval. If the MGS chooses to propose alternative measures, they will need to notify CMS at least six months prior to the initial PHAP submission and obtain CMS approval that the proposed measure is technically valid, aligns with AHEAD Model goals, and can produce robust data and analytic results. Additional information on the approval criteria will be detailed in the upcoming Target Setting Guidance, which will be posted in the 4i Knowledge Library when available. Once the MGS receives CMS-approval for its selected measures, the state will obtain data for baseline performance reporting and set targets.

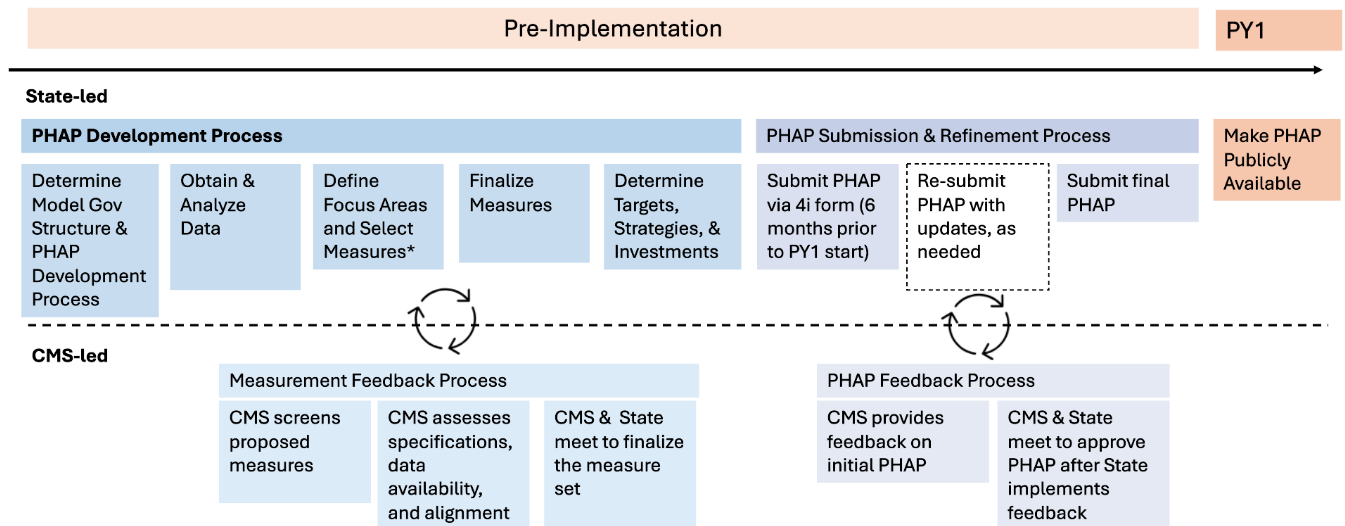
The process will result in a draft Statewide PHAP that the MGS will submit to CMS via the 4i Portal (4i), an online portal the MGS will utilize for data submissions to CMS, at least six months before Performance Year (PY) 1 begins. CMS will review the initial submission and provide technical feedback. The MGS will then work with CMS to incorporate revisions and receive approval for the Statewide PHAP by the start of PY1. Following approval, states will publicly post a summary of their Statewide PHAP.

On an annual basis, the MGS will update their Statewide PHAP submission with new data no more than three months following the end of the PY. CMS will monitor performance across participating states, share best practices, and refine guidance as needed.

Timeline

Exhibit 1 outlines the Statewide PHAP development process timeline, with the MGS leading plan development and CMS conducting iterative review and approval through finalization. The process culminates with the state publicly posting the CMS-approved Statewide PHAP.

Exhibit 1: Initial Statewide PHAP Development Timeline for Cohort 2 and 3 States



III. Developing the Statewide PHAP – A Step-by-Step Approach

This section describes the Statewide PHAP development process with links to resources, guidance and considerations for states and the MGS. Detailed guidance about entering the Statewide PHAP submission into the 4i can be found in Section IV – Submitting the Statewide PHAP into 4i.

Data to Gather, Review and Submit

Before embarking on the Statewide PHAP development process, the state will identify and convene its MGS, share the Statewide PHAP requirements and determine the best process for obtaining and analyzing data to inform decisions. While the MGS has flexibility on its Statewide PHAP approach, the MGS must include the information summarized in Exhibit 2 and submit annual updates into 4i. The Statewide PHAP form is organized into six tabs that mirror the PHAP development process.

1) Core Population Characteristics
2) Health Needs Assessment
3) Population Health Focus Areas
4) Quality and Population Health Targets
5) Health Promotion Activity Investments and Supports
6) Engagement Strategy

Exhibit 2 summarizes the required data, decisions, and information that the state will submit in the Statewide PHAP, organized by the tabs in 4i.

Exhibit 2: Planning for the Statewide PHAP Submission into 4i

Tab	Description	Prep Required	Information to Report
Tab 1: Core Population Characteristics	Summary of state's core population characteristics.	MGS will review existing reports (Kaiser Family Foundation Report; Census, American Community Survey; Other) to identify core population characteristics	• Population size (by age; sex; dual-eligibility status; payer mix; geography; [optional] medically underserved areas) • Data source/year
Tab 2: Health Needs Assessment	Summary of state's health needs associated with each core domain and at least one required supplemental domain.	MGS will review existing state health needs assessments (Community Health Needs Assessments, State Health Improvement Plans, 2025 State Strategic Plan) to identify key state health needs for each core domain and at least one required supplemental domains	For each core domain and at least one required supplemental domain, the MGS will submit: • Identified health need and its data source • Past initiatives and resources to address the identified state health need • Gaps and opportunities to improve initiatives under AHEAD

Tab	Description	Prep Required	Information to Report
Tab 3: State Population Health Focus Areas	Summary of how the state will address the health needs identified in the prior section.	MGS will specify the population health focus area to address health needs by identifying improvement strategies and selecting measures to monitor progress and set targets.	For each core domain and at least one required supplemental domain, MGS will submit: • State health needs (auto-populates from Tab 2) • Selected measure, measure source and baseline year • Population health improvement strategies during AHEAD • Overall population final target and reporting approach • (Optional) Sub-population health differences & sub-population target

Tab 4*: Baseline and Annual Reporting	Baseline & annual reporting data for each selected measure overall and stratified.	MGS will obtain stratified data for its selected measures (identified in Tab 3) and calculate the rates for each measure.	For each core domain and at least one required supplemental domain, MGS will submit:
			• State health needs (auto-populates from Tab 2)
			• Selected measure, measure source, and baseline year (auto-populates from Tab 3)
			• Baseline & Annual data for each measure (from Tab 3) by:
			  • Overall population
			  • Medicare Fee-for-Service (FFS), Medicare Advantage, Medicaid, Commercial
			  • Dual-eligible, not dual-eligible
			  • Metro/non-metro, Urban/rural†
			  • Other sub-population (if identified in Tab 3)
			Note: While it may not initially be feasible for states to report by all stratifications, states should develop a plan for reporting on all strata over the course of the model.

Tab 4*: Targets	Interim and final performance targets for each identified state population health focus area in PY2, PY4, PY6, PY8, and PY10.[§]	MGS will reflect on data and engage experts in a process of identifying evidence-based, clinically meaningful, and achievable targets to which they will be held accountable.[¶]	For each core domain and at least one required supplemental domain, MGS will enter: • Overall population targets for PY2, PY4, PY6, PY8, and PY10.[§] • (Optional) Sub-population targets stratified by payer, dual-eligible status, geography, or other (if identified in Tab 3)

Tab	Description	Prep Required	Information to Report
Tab 5: Health Promotion Activity Investments and Supports	Existing or new policies and investments states will leverage to advance their population health goals and support Participant Hospitals and Participant Primary Care Practices in connecting patients to services that address health promotion activities (e.g., housing, food access, nutrition, physical activity, and transportation).	The MGS should also detail the rationale behind the chosen investments and strategies, explaining how these efforts align with the state's population health goals and contribute to improved health outcomes for their population.	• State-level investments or strategies to address health promotion activities • Rationale for considering efforts
Tab 6: Engagement Strategy	Engagement and communication strategies to promote aligned care transformation.	MGS and state will share communications plan, engagement and alignment with participants, community partners, and tribal entities (if applicable).	State will submit data on: • MGS composition and meeting frequency • Alignment and communication strategy for state participants and stakeholders • Plan for integrating community feedback • Potential barriers to Statewide PHAP implementation • Tribal entity engagement (optional)

**The Statewide PHAP Form is comprised of six tabs (Tab 1-6). Uniquely, Tab 4 breaks down further into three sections (Baseline Reporting, Annual Reporting, Quality and Population Health Targets). Some measures have multiple values.*

[†]Rural is defined as any area located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA); non-metropolitan counties: areas outside of urban areas with populations of 50,000 or more.

[§]Only cohort 1 states will set a PY10 target.

[¶]A Target Setting Guidance is forthcoming with additional guidance on the target setting methodology, required documentation, and approval criteria. This guidance will be available in the 4i Knowledge Library.

Step 1 - Identify State Population Characteristics

The MGS will begin by reviewing existing reports (e.g., American Community Survey, Census, and Kaiser Family Foundation State Reports) to assess their population profile. States are required to examine their overall population across key dimensions, including age, sex, dual-eligibility status, payer mix, and geography, and may optionally include analyses of medically underserved areas as defined by the Health Resources and Service Administration.

The MGS will submit the population size data, the data source (including a URL to access the data) and the year. This information will be entered in Tab 1 of the Statewide PHAP Form in 4i.

Step 2 - Identify State Health Needs/State Population Health Focus Areas

Next, the MGS will review plans and needs assessments from existing state-based population health initiatives to identify and prioritize needs that align with AHEAD goals. The MGS will identify and summarize the state's health needs across each of the five core domains—Population Health; Prevention & Wellness; Chronic Conditions; Behavioral Health; and Health Care Quality and Utilization—as well as at least one required supplemental domain—Maternal Health Outcomes; Prevention Measures; or Health Promotion Activities (Exhibit 3).

Exhibit 3: CMS-approved Core and Required Supplemental Measures and Potential Data Sources

Domain	Measure Domain	Measure Name	Data Source
Core Domains Measures (Choose at least one measure from each domain)	Behavioral Health	Use of Pharmacotherapy for Opioid Use Disorder	Administrative Claims
		Follow-Up After Hospitalization for Mental Illness*	Administrative Claims
		Follow-Up after Emergency Department (ED) Visit for Substance Use*	Administrative Claims
	Chronic Condition	Controlling High Blood Pressure	Administrative Claims or EHR
		Glycemic Status Assessment for Patients with Diabetes (GSD)	Administrative Claims or Hybrid data or EHR
	Health Care Quality and Utilization	Plan All-Cause Unplanned Readmission	Administrative Claims
	Population Health	General Health Status	BRFSS Survey
	Prevention & Wellness	Colorectal Cancer Screening	Administrative Claims or EHR
		Breast Cancer Screening: Mammography	Administrative Claims or EHR

Domain	Measure Domain	Measure Name	Data Source
Required Supplemental Domain Measures (Choose at least one)	Maternal Health	Live Births Weighing Less than 2500 grams	Centers for Disease Control and Prevention Wonder
		Prenatal and Postpartum Care†	Administrative Claims or Hybrid Data
	Prevention Measures	Adult Immunization Status§	Administrative Claims or Hybrid Data
		Prevalence of Obesity	BRFSS Survey
		Emergency Department Visits for Adverse Events Associated with Use of Opioids and Alcohol	Administrative Claims
	Health Promotion Activities	Food Insecurity	BRFSS Survey
		Housing Quality	BRFSS Survey

**States must report on both 7-day and 30-day follow-up.*
†States must report both prenatal and postpartum care.
§Adult Immunization Status has five values depending on the state's reporting choices. The flu immunization is mandatory for reporting.

State Health Needs/State Population Health Focus Area Considerations (Tab 2)

The MGS will review a variety of existing data sources to identify their state health needs (e.g., Community Health Needs Assessments, State Health Improvement Plans, 2025 State Strategic Plan) and reflect on:

- **Current efforts targeting the identified state health need,** including relevant programs, activities, and resources already in place or previously implemented (e.g., To date, the state has…).
- **Gaps and opportunities in existing efforts,** including areas where initiatives could be strengthened, expanded, or better aligned with AHEAD goals, as applicable.

States will submit the identified state health needs, data source, current efforts, and gaps and opportunities in Tab 2 in the Statewide PHAP Form in 4i.

Step 3 - Select Quality Measures

The state's health needs identified in Step 2 represent the state population health focus areas in Tab 3. The MGS will access and evaluate the available data associated with each of these state population health focus areas and select one measure aligned with each state population health focus area (See Step 4 for more details on necessary data). The MGS will then use these measures to set targets and track progress through annual reporting. States should invest time and resources in analyzing available data, including its quality and clinical usefulness, and consider the future relevance of measures within the context of the state's population.

Quality Measure Selection Considerations (Tab 3)

When selecting quality measures, in addition to alignment with the state's population health focus areas, the MGS should take the following considerations into account:

Measure Criteria and Requirements - Measures should meet core requirements, including:

- Use of the CMS-approved measure set for the full performance year, unless CMS authorizes changes due to data limitations or updated national guidance

Data Source Selection and Consistency - Develop an approach to selecting and maintaining data sources:

- Use of a single, consistent data source for each measure across PYs to ensure comparability
- Acceptable data sources may include administrative claims, electronic health records (EHRs), hybrid claims and medical record review, vital statistics, or Behavioral Risk Factor Surveillance System (BRFSS) survey data
- For chronic condition measures, states may consider using EHR-derived data (including data used to calculate electronically specified clinical quality measures [eCQMs]), or aggregated clinical data accessed through Health Information Exchanges (HIEs), where appropriate.
- While the Statewide PHAP is intended to allow for reflection about the entire state's population, leveraging the EHR data may be more accurate than claims data, particularly for the measures within the Chronic Conditions domain

Data Availability, Quality, and Sustainability - Assess data availability and quality, including comparison to CMS AHEAD core and required supplemental measure sets. States should consider:

- Measure sustainability over time
- Stratification-specific considerations (see Appendix A), including
  - Availability of data elements needed for stratification and linkage across sources. For example, survey-based data sources such as BRFSS generally do not support stratification by dual-eligibility status, while other data sources may allow for more limited or variable stratification.
  - For measures calculated using EHR-derived data (including data supporting eCQMs), states should assess whether relevant payer indicators or coverage flags are available, standardized, and reliable, recognizing that EHR-based data may not consistently capture payer information in the same way as claims data.
- Sampling considerations (e.g., survey-based measures may have low response rates; reliable reporting requires a minimum of 10 responses per group or stratum)
- Interpretation and privacy considerations (e.g., the data source, such as clinical documentation versus billed events, can affect results and may carry different privacy responsibilities for participants)

Payer Data and Claims Access - Identify strategies to ensure comprehensive payer data coverage, including:

- Consider collaboration with commercial payers to access claims data, either directly or through all-payer claims databases or HIE.
- Inclusion of Medicare FFS and all-payer claims data
- Separate reporting of Medicare Advantage data from commercial data, where possible

To inform these considerations, Appendix B serves as a complete guide to pre-calculate required measures and ensure that available stratifications are applied correctly. For strata where data are not available, states can enter 0 into the Statewide PHAP Form.

The MGS is expected to keep the measures and data sources consistent over the course of the model, to the extent possible.

The MGS will need CMS Approval *before* finalizing their measure list and moving onto Step 4. For details of the approval process see Exhibit 1. Additionally, the MGS should contact their State Lead if considering measures other than those included in the CMS-approved list (see Exhibit 3) at least six months prior to the initial Statewide PHAP submission and/or anticipating changes to BRFSS or other data sources impacting measure selection. The MGS will document their selected quality measures and data sources in Tab 3 in the Statewide PHAP Form in 4i.

Step 4 - Obtain, Stratify, and Enter Baseline Data

Once states select and receive CMS approval for their Statewide PHAP measures, they will need to review the necessary data and enter baseline performance results - overall and stratified by payer, dual-eligibility status, and geography (Exhibit 4).

Exhibit 4: Required Stratification of Baseline, Targets and Performance Data

Requirement	Stratification	Notes
All Payer	• Overall	Overall measure score across the entire state population using all-payer data.
Payer	• Medicare FFS • Medicare Advantage • Medicaid • Commercial	Payer variables may vary by data source. States are advised to consider the primary payer information wherever possible. For dually eligible individuals, states should count those individuals once under Medicare.
Dual-Eligibility Status	• Dual-Eligible • Not Dual-Eligible	States may already have dual-eligibility status information available for linkage to quality measures.
Geography	• Urban/Rural • Metropolitan/non-metropolitan	States may already have geography information available for linkage to quality measures. States can use urban/rural or metropolitan/non-metropolitan definitions based on county and available data.

AHEAD, as an all-payer model, requires states to report data for each selected measure from all major payer types in the state (Medicare FFS, Medicare Advantage, Medicaid, Commercial). The overall rate serves as the primary population-level measure used by CMS to assess progress in the AHEAD Model. Reporting overall population results ensures that no single payer group disproportionately drives observed performance and that states are accounting for population health outcomes for all beneficiaries across the AHEAD state or sub-state region.

The MGS will develop a process for obtaining baseline data and updating it annually, as performance will be reported for every PY. Obtaining and preparing the data for baseline submissions will likely require significant effort upfront, but once a process is established, replicating it for annual submissions should be easier. The MGS may use different approaches to compile measure results depending on their data infrastructure and governance model. Baseline data may be derived through:

- Centralized calculation by the state or its vendor, which may include securing raw data, cleaning and standardizing inputs, applying measure specifications, calculating scores, and performing required stratifications; and/or
- Distributed reporting approaches, in which payers or other data submitters calculate and report measure numerators and denominators using standardized measure specifications applied to data they already maintain (e.g., health plans calculating Healthcare Effectiveness Data and Information Set (HEDIS) measures by line of business, consistent with existing NCQA (National Committee for Quality Assurance) reporting processes).

The MGS is expected to leverage comprehensive all-payer data as available. CMS recognizes states may need time to develop comprehensive all payer data (as data are available across multiple data sources) and in the meantime are expected to provide the best overall rate estimates and make notes of data limitations within the form.

For the Statewide PHAP submission, states will need to populate the appropriate values for the six measures they choose, stratified by the appropriate demographic variables. The MGS should refer to Appendix A as they plan for stratification. The MGS is encouraged to pre-calculate required measures and ensure that all appropriate stratifications are available prior to entering into 4i**.** The tables in Appendix A include details on the stratification variables for each data source (BRFSS, EHRs, hybrid data, administrative data, and Centers for Disease Control and Prevention (CDC) Wonder), limitations, and instructions for stratifying.

If the MGS is unable to stratify a particular measure, they can indicate this in their Statewide PHAP submission form in 4i. States will submit baseline data in Tab 4 in the Statewide PHAP Form in 4i.

Step 5a – Setting Statewide Quality and Population Health Targets

The MGS will establish interim and final performance targets at the overall population level for each measure. Targets will be set for every even performance year (i.e., PY2, PY4). CMS evaluation of statewide targets may consider the state's baseline, national and state average performance rates and trends, data context, measure type, and available levers among other

pertinent information. CMS evaluation process will be iterative and in collaboration with the state with the goal of setting targets that are attainable and rigorous. To monitor progress, states are required to submit performance data for the selected measures annually under the terms of the state agreement beginning with data for PY1. In odd PYs (i.e., PY1, PY3), CMS will use the annual reporting process to monitor progress on the targets, whereas in the even PYs (i.e., PY2, PY4) CMS will assess state performance in the state population health focus areas against the interim and final targets. States will be held responsible for meeting interim and final targets as outlined in the State Agreement. CMS will provide States with a Target Setting Guidance document to provide additional information on how states should set their targets and how CMS will evaluate them.

Target Setting Considerations (Tab 4)
CMS will carefully review baseline data and proposed targets and iterate on reasonable targets with the state. CMS review of statewide targets will consider the state's baseline, data context, national and state performance rates and trends, measure type, and available levers. CMS will provide States and the MGS with a Target Setting Guidance document in Summer 2026 to provide additional information on how states should set their targets and how CMS will evaluate them.

CMS recognizes that factors used to set the Statewide Quality and Population Health Targets may change over the course of the AHEAD model. If there are substantive changes to factors used to set a measure quality target CMS or the state may propose a revised quality target and CMS will evaluate the proposal based on the criteria in the Target Setting Guidance document.

States will submit their targets and baseline performance data in Tab 4 in the Statewide PHAP Form in 4i.

Step 5b - Set Sub-population Targets (Optional)

States will have the option to propose additional sub-population targets if states identify disproportionate outcomes for any measure. Similar to the targets discussed above, CMS will use annual measure reporting of the sub-population to monitor progress, and in the even PYs, CMS will assess state performance against the interim and final sub-population targets.

States will submit optional sub-population target information in Tabs 3 and 4 in the Statewide PHAP Form in 4i.

Step 6 - Developing a Comprehensive Statewide PHAP Implementation Plan

Once the population health goals are identified, the MGS will develop a comprehensive and evidence based operational plan that will describe how the state plans to achieve its statewide quality and population health targets.

The MGS will identify 1-3 initiatives for each population health focus area. For example, the MGS may focus on 1) expanding peer support services and 2) connecting reentry populations to substance use disorder treatment as the interventions to improve use of pharmacotherapy for opioid use disorder (OUD). The MGS should outline whether the proposed interventions are part of or in addition to other model components (e.g., Primary Care AHEAD, Hospital Global Budgets, Geo AHEAD).

Furthermore, the MGS should identify existing or new investments, policies, or strategies that will support meeting the population health goals and be prepared to describe the rationale. The MGS should consider strategies that can support Participant Hospitals and Primary Care Practices meet the model requirement to screen for health promotion activities and connect patients to relevant services (e.g. nutrition, physical activity, housing, food access, and/or transportation supports). For example, the state could develop a statewide referral platform to support clinical-community partnerships.

Additionally, the MGS will document the composition and meeting structure of the MGS and the communication and engagement approach to keep model participants and stakeholders aligned to the state's population health goals as documented in the Statewide PHAP. This includes details on engaging tribal entities as well as identifying any potential barriers to implementing the Statewide PHAP.

States will submit their intervention strategies for each population health focus area in Tab 3, plans regarding health promotion activity investments and supports in Tab 5, and the MGS structure and communication/engagements strategy in Tab 6 of the Statewide PHAP Form in 4i.

Implementation Strategy Considerations (Tabs 3, 5 and 6)

When developing interventions to meet the population health targets (Tab 3), identifying state-level investments and policies (Tab 5) and the stakeholder communication and engagement strategy (Tab 6), the MGS should consider the following:

Population Health Focus Area Interventions (Tab 3)

Describe how the state will reach its population health targets for each population health focus area. This includes:

- Interventions (1 -3) for each population health focus area that support the state reaching its population health goals
- Relationship of interventions to other model components (e.g., primary care, hospital global budgets) and how much of the proposed improvements in targets are expected to be achieved via implementation of other model components vs identified interventions.

Initiatives to Support Aligned Care Transformation (Tab 5)

Describe state-level investments and policies to support health promotion activities in the state. This includes:

- State-level initiatives to support providers screening for health promotion activities
- Initiatives to strengthen clinical–community partnerships to support model participants (e.g., statewide referral platforms)
- Regulatory, legislative, or other policy initiatives (including Medicaid) to advance population health goals and rationale for why the chosen initiatives are envisioned to be the highest impact initiatives for the state

Communication and Alignment Strategy (Tab 6)

Describe the MGS and how it will ensure participating hospitals, primary care practices, and other stakeholders align care transformation efforts with the Statewide PHAP. This includes:

- Strategies to align efforts across the state, primary care practices, community health centers (CHCs), and hospitals
- Communication approaches with providers and community partners
- Public communication strategies, including posting the Statewide PHAP on the state's public website
- Approaches to engage community partners, including Tribal entities
- Processes for incorporating and sustaining feedback into model design, implementation, and monitoring
- Documentation of feedback received and how it informed changes

Implementation Readiness and Barrier Mitigation (Tab 6)

What are anticipated implementation barriers and strategies the state will use to proactively address them, including:

- Potential risks or challenges to implementation and planned mitigation approaches
- Areas where CMS support could help states address or mitigate barriers

IV. Submitting the Statewide PHAP into 4i

Preparing to Submit

States will submit a draft of their initial Statewide PHAP to CMS via the Statewide PHAP Form in 4i at least six months before the start of PY1. States should build time into their plans for preparing the submission. The form is located in the Document Repository in 4i, which can be accessed by selecting Operations from the left-side navigation pane and scrolling down. Step-by-step instructions for accessing and completing the form are available in the PHAP Form Tip Sheet also available in the Document Repository.

Before Getting Started: Things to Know About the 4i Portal

The Statewide PHAP Form in 4i guides States through structured data entry aligned with the Statewide PHAP development process. Before entering information, users should familiarize themselves with the Statewide PHAP Form's functionality to support efficient and accurate submission.

Saving and System Timeouts

- The system will time out after 30 minutes of inactivity, and any unsaved responses will be lost.
- Be sure to save your work regularly using the "save" feature at the bottom of each tab. Click the "Save as Draft" button at the bottom of the page and then "Confirm" to save progress.
- If the form is closed after it has been saved, select the "Edit Form" option on the PHAP form page to continue making updates.

Navigation and Required Fields

- Users cannot move to the next page or tab until all required fields on the current page are completed.
- Required fields are marked with an asterisk (*).
- If required fields on a tab are incomplete, an error message will appear, and the user will not be able to proceed until all required fields on that tab are completed.
- Once all the required sections and fields of the page have been completed and there are no more errors on the page, the "Next" button will be enabled.
- To preview the full form and upcoming tabs, refer to the PDF of the Statewide PHAP Form in 4i.

Question Types and Data Entry

- Some questions require free-text responses, while others use drop-down menus.
- If a value is missing or not applicable, enter 0.
- The form defaults to percent (%). States should calculate and enter values using the applicable measure specifications (e.g., Plan All-Cause Unplanned Readmission (PCR) is a rate).
- Selecting "clear" will remove **all** data on a tab and there is **<u>no way to undo once selected</u>**.

Auto-Population and Dependencies

- Certain fields will auto-populate based on prior drop-down selections.
- If a greyed-out field appears incorrect, return to the relevant earlier tab and update the response.

Submitting

- Once your submission is ready to submit to CMS for review, click "Submit," which will only be enabled once the certification check box has been clicked.
- An email will be sent confirming successful submission.

Accessing the Form & Getting Started

The Statewide PHAP Form in 4i is organized into the six tabs that mirror the Statewide PHAP Process: (1) Core Population Characteristics, (2) Health Needs Assessment, (3) State Population Health Focus Area, (4) Quality and Population Health Targets, (5) Health Promotion Activity Investments and Supports, and (6) Engagement Strategy. This section details how the questions are presented in 4i. Fields that have an (*) indicate a response is required to move on to the next section.

Entering Data in Each Tab

Tab 1. Core Population Characteristics

In Tab 1, Core Population Characteristics, the MGS will submit information summarizing the characteristics of their state population and stratify by age, sex, dual status, geography, and medically underserved areas (optional). Stratified data must add up to 100%.

Exhibit 5: Statewide PHAP Core Population Characteristics Data Fields

<table>
<tr><th colspan="2">Question</th><th>Response Options</th></tr>
<tr><td rowspan="4">1. Population Size in the Defined Area (State or Sub-State region)</td><td>1.1 Data Source*
Select one option from the menu of data sources above to indicate the source providing state data on the characteristic.</td><td>American Community Survey
Behavioral Risk Factor Surveillance System
State Health Improvement Plan
Census
Data.gov
KFF
Health Resources and Services Administration (HRSA)
State Reports
Vital Statistics Record
Other</td></tr>
<tr><td>1.1.2 Data Source URL
Include a link to the data source, if available.</td><td>Free text</td></tr>
<tr><td>1.2 Data Year*
Specify the year of the characteristic data you will report from the identified data source.</td><td>2020 - 2028</td></tr>
<tr><td>1.3 Data Summary*
Please provide the population size for the State or Sub-State region.</td><td>#</td></tr>
</table>

<table>
<tr><th colspan="2">Question</th><th>Response Options</th></tr>
<tr><td rowspan="8">2. Age*</td><td>2.1 Data Source*
Select one option from the menu of data sources above to indicate the source providing state data on the characteristic.</td><td>American Community Survey
Behavioral Risk Factor Surveillance System
State Health Improvement Plan
Census
Data.gov
KFF
Health Resources and Services Administration (HRSA)
State Reports
Vital Statistics Record
Other</td></tr>
<tr><td>2.2 Data Source URL
Include a link to the data source, if available.</td><td>Free text</td></tr>
<tr><td>2.3 Data Year*
Specify the year of the characteristic data you will report from the identified data source.</td><td>2020 - 2028</td></tr>
<tr><td>2.4 Data Summary*
Please provide % of individuals in each category.
Note: Fields must add up to equal 100%.</td><td>Instruction</td></tr>
<tr><td>2.4.1 % Under 5 years old*</td><td>%</td></tr>
<tr><td>2.4.2 % 5-18 years old*</td><td>%</td></tr>
<tr><td>2.4.3 % 19-64 years old*</td><td>%</td></tr>
<tr><td>2.4.4 % 65 and over*</td><td>%</td></tr>
<tr><td rowspan="3">3. Sex*</td><td>3.1 Data Source*
Select one option from the menu of data sources above to indicate the source providing state data on the characteristic.</td><td>American Community Survey
Behavioral Risk Factor Surveillance System
State Health Improvement Plan
Census
Data.gov
KFF
Health Resources and Services Administration (HRSA)
State Reports
Vital Statistics Record
Other</td></tr>
<tr><td>3.2 Data Source URL
Include a link to the data source, if available.</td><td>Free text</td></tr>
<tr><td>3.3 Data Year*
Specify the year of the characteristic data you will report from the identified data source.</td><td>2020 - 2028</td></tr>
</table>

Question		Response Options
3. Sex* (cont.)	**3.4 Data Summary*** Please provide % of individuals in each category. Note: Fields must add up to equal 100%.	Instruction
	3.4.1 % Male*	%
	3.4.2 % Female*	%
	3.4.3 % Prefer not to answer*	%
4. Dual Status*	**4.1 Data Source*** Select one option from the menu of data sources above to indicate the source providing state data on the characteristic.	American Community Survey Behavioral Risk Factor Surveillance System State Health Improvement Plan Census Data.gov KFF Health Resources and Services Administration (HRSA) State Reports Vital Statistics Record Other
	4.2 Data Source URL Include a link to the data source, if available.	Free text
	4.3 Data Year* Specify the year of the characteristic data you will report from the identified data source.	2020 - 2028
	4.4 Data Summary* Please provide % of individuals in each category. Note: Fields must add up to equal 100%.	Instruction
	4.4.1 % Dual Eligible*	%
	4.4.2 % Non-Dual Eligible*	%
5. Payer Mix*	**5.1 Data Source*** Select one option from the menu of data sources above to indicate the source providing state data on the characteristic. Suggested source: KFF Analysis of ACS Data.	American Community Survey Behavioral Risk Factor Surveillance System State Health Improvement Plan Census Data.gov KFF Health Resources and Services Administration (HRSA) State Reports Vital Statistics Record Other
	5.2 Data Source URL Include a link to the data source, if available.	Free text

Question		Response Options
5. Payer Mix* (cont.)	**5.3 Data Year*** Specify the year of the characteristic data you will report from the identified data source.	2020 - 2028
	5.4 Data Summary* Please provide % of individuals in each category.	Instruction
	5.4.1 % Medicare FFS*	%
	5.4.2 % Medicare Advantage*	%
	5.4.3 % Medicaid*	%
	5.4.4 % Commercial*	%
	5.4.5 % Uninsured*	%
6. Geography*	**6.1 Data Source*** Select one option from the menu of data sources above to indicate the source providing state data on the characteristic.	American Community Survey Behavioral Risk Factor Surveillance System State Health Improvement Plan Census Data.gov KFF Health Resources and Services Administration (HRSA) State Reports Vital Statistics Record Other
	6.1.2 Data Source URL Include a link to the data source, if available.	Free text
	6.2 Data Year* Specify the year of the characteristic data you will report from the identified data source.	2020 - 2028
	6.3 Data Summary* Please provide % of individuals for either of the options below: Note: Fields must add up to equal 100%.	Instruction
	6.3.1 Choose geographic category*	Metro Rural
	6.3.1.1 % Metro*	%
	6.3.1.2 % Non-metro*	%
	6.3.2.1 % Rural*	%
	6.3.2.2 % Urban*	%
	6.3.2.3 % Suburban*	%

<table>
<tr><th colspan="2">Question</th><th>Response Options</th></tr>
<tr><td rowspan="5">7. Medically Underserved Areas</td><td>7.1 Data Source
Select one option from the menu of data sources above to indicate the source providing state data on the characteristic. Suggested source: HRSA MUA Find Tool.</td><td>American Community Survey
Behavioral Risk Factor Surveillance System
State Health Improvement Plan
Census
Data.gov
KFF
Health Resources and Services Administration (HRSA)
State Reports
Vital Statistics Record
Other</td></tr>
<tr><td>7.1.2 Data Source URL
Include a link to the data source, if available.</td><td>Free text</td></tr>
<tr><td>7.2 Data Year
Specify the year of the characteristic data you will report from the identified data source.</td><td>2020 - 2028</td></tr>
<tr><td>7.3 Data Summary
Please report number of counties designated as Medically Underserved Areas for primary care.</td><td>Instruction</td></tr>
<tr><td>7.3.1 Enter county details</td><td>Free text</td></tr>
</table>

*Note: * Indicates a required field*

Tab 2. Health Needs Assessment

In the Health Needs Assessment Tab, the MGS will summarize findings from existing state health needs assessments for each of the five core domains and at least one required supplemental domain to identify state health needs in AHEAD-aligned domains. The fields listed below will apply to all six domains.

Exhibit 6: Statewide PHAP Health Needs Assessment Data Fields

Question		Response Options
1. Core Domain or Required Supplemental Domain	**1.1 State Health Need*** List the identified health need pulled from existing assessments.	Free text
	1.2 Data Source* Identify the data source.	Community Health Needs Assessments (CHNA) State Health Improvement Plans (SHIP) State Strategic Plan Other
	1.3 Ongoing Initiatives* Describe how the State has addressed the health need and what resources are available and/or have been recently used to address the need.	Free text
	1.4 Gap Areas/Opportunities for Improvement under the Model* List opportunities to address gaps and/or improve initiatives through AHEAD.	Free text

*Note: * Indicates a required field*

Tab 3. Population Health Focus Areas

The MGS will use Tab 3 to submit their population health focus areas for each of the core domains and at least one of the required supplemental domains, aligned with the needs summarized in Tab 2. They will also identify which measure from the AHEAD quality measure set they will use to measure progress on each state population health focus area and the measure source. The MGS may also opt to identify observed differences for a sub-population and set targets.

Exhibit 7: Statewide PHAP Population Health Focus Areas Data Fields

Question		Response Options
1. Core Domain or Required Supplemental Domain	**1.1 State Health Need*** List the identified health need pulled from existing assessments.	Auto-populated
	1.2 Measure* Identify the measure that aligns with the population health focus area.	See Exhibit 3 for CMS-approved measure list Other
	1.3 Measure Source* Select the data source of the identified measure.	Administrative (e.g., claims data) Electronic health record (EHR) Hybrid (e.g., multiple data sources such as administrative claims and medical record review) Survey (e.g., BRFSS) Vital records (e.g., state or local vital records)
	1.4 Measure Baseline Year* Specify the baseline year used to set measure targets.	2020 - 2028
	1.5 Population Health Focus Area Improvement Strategy* Specify the overall population interim and final target (e.g., increase rate by X% to Y% by 2036). Describe what methods were used to set the target (e.g., comparing national trends). Describe the intervention strategies the state will use to improve clinical outcomes. Describe how the interventions align with other model components (e.g., primary care, hospital global budgets). Describe the approach to data reporting (e.g., data lags) and how the state will improve data quality (e.g., improve sub-population reporting).	Free text
	1.6 Sub-Population Differences Describe differences in sub-population findings at baseline.	Free text
	1.7 Sub-Population Target Specify the final target (e.g., increase rate by X% by 2036) for a sub-population and describe interventions to improve sub-population outcomes.	Free text

*Note: * Indicates a required field*

Tab 4. Quality and Population Health Targets

In Tab 4, the MGS will propose interim and final targets for the measures selected in Tab 3, which CMS will use to assess progress in the state's population health focus areas. The MGS will provide data for baseline reporting, interim and annual targets, and annual reporting for each measure domain. The baseline and annual reporting sections will require data for the overall population and stratified by payer, dual-eligibility status, and geography. Annual reporting will not be completed for the initial Statewide PHAP submissions but will be provided annually, beginning with the availability of PY1 data, using the same instructions outlined for the baseline reporting. States should use consistent variable definitions including stratification variables, data sources, and methodologies to ensure comparability over time. The target section will require targets for the overall population and the MGS can opt to add sub-population targets.

If the MGS is unable to report a stratified value for a particular measure or if a field is not applicable (e.g., PY10 for cohort 2 and 3 states), enter 0 in that field. Multiple rates can be reported, if required for a measure. Additional details can be found in Appendix B.

Exhibit 8: Statewide PHAP State Quality and Population Health Targets Data Fields

Question		Response Options
Core Domain or Required Supplemental Domain	**State Health Need**	Auto-populated
	Measure	Auto-populated
	Measure Source	Auto-populated
	Measure Baseline Year	Auto-populated
Baseline Reporting	**Overall Population Rate***	%
	Medicare FFS Rate*	%
	Medicare Advantage Rate*	%
	Medicaid Rate*	%
	Commercial Rate*	%
	Dual Eligible Rate*	%
	Non-Dual Eligible Rate*	%
	Metro or Urban*	%
	Non-metro or Rural*	%
Targets	**Overall Population Target***	% PY2, % PY4, % PY6, % PY8, % PY10 targets
	Optional Additional Target	% PY2, % PY4, % PY6, % PY8, % PY10 targets

Question		Response Options
Annual Reporting	**Overall Population***	%
	Medicare FFS*	%
	Medicare Advantage*	%
	Medicaid*	%
	Commercial*	%
	Dual Eligible*	%
	Non-Dual Eligible*	%
	Metro or Urban*	%
	Non-metro or Rural*	%

*Note: * Indicates a required field*

Tab 5. Health Promotion Activity Investments and Supports

In Tab 5, the MGS will report on state-level investments and strategies to support health promotion activities (e.g., screening or services for nutrition, physical activity, housing, food access, transportation) including any existing or new authorities they intend to pursue. States will also share their rationale behind these investments and strategies.

Exhibit 9: Statewide PHAP Health Promotion Activity Investments and Supports Data Fields

Question		Response Options
1. Health Promotion Activity Investments and Supports	**1. State Investment in Health Promotion Activity*** Describe the state-level investments, policies, or strategies that will be implemented to support successful clinical-community partnerships to support health promotion activities (e.g. statewide referral platforms).	Free text
	2. Rationale* Describe how the identified investment, policy, or strategy will support health promotion activity screening and improve health outcomes.	Free text

*Note: * Indicates a required field*

Tab 6. Engagement Strategy

In Tab 6, States will detail their engagement and communication strategy, engaging stakeholders and governance committee members, as well as model participants in the program design and communicating out the vision to ensure alignment of on-the-ground transformation efforts.

This tab will include details on MGS composition and meeting frequency, alignment strategy, community engagement plan, tribal entities plan (if applicable), and potential implementation barriers.

Exhibit 10: Statewide PHAP Communication and Community Engagement Strategy Data Fields

Question		Response Options
1. Communication and Community Engagement Strategy	**1 Model Governance Structure*** Please describe the composition and established meeting frequency for the Model Governance Structure or another State-selected governing board.	Free text
	2. Alignment Strategy* Please describe your strategy for alignment between the State, Primary Care Practices, and Hospitals. Also, describe your communication strategy for Participating Primary Care Practices and Hospitals to align on Statewide PHAP targets.	Free text
	3. Sharing Information* Does the State intend to share information about the MGS and Statewide PHAP with the public?	Yes / No
	Will materials and/or information be posted to a State public website?*	Yes / No
	4. Community Engagement Plan* Please describe your plan to engage community partners and integrate their feedback into Model implementation alongside state and other local partners. Address the communication strategy of how community engagement will be sustained in the design, implementation, and monitoring of the Model and how results will be reported to community members.	Free text
	5. Tribal Entities Plan If applicable, please include your plan for ensuring tribal entities are being considered in the state health equity planning and funding distribution.	Free text
	6. Statewide PHAP Implementation Barriers* Please identify potential barriers to implementing Statewide PHAP communication, population health, and health promotion strategies and any way CMS can support your State in addressing or mitigating these barriers.	Free text

*Note: * Indicates a required field*

Submitting the Statewide PHAP

Once states have entered data into Tabs 1-6, they will be asked to certify that they have entered the most up-to-date information and attest to understanding that CMS will use this information to hold the state accountable for performance on interim and final targets. Lastly, they will click the submit button to notify CMS that the Statewide PHAP is ready for review. (Note: The submit button will not be available until the certification check mark has been clicked.)

CMS Review and Approval

Following state's initial submission of the Statewide PHAP, CMS will be notified and begin its review. If CMS has questions or comments, these will be added to the Statewide PHAP and shared with the state via 4i. Comments will specify which tab and section of the Statewide PHAP they are referring to. States will be able to review the comments in response to the Statewide PHAP following CMS's review. If CMS requests updates, an email will be sent to inform the state of the updates needed. State will be able to click through all pages of the form and make the required updates. The form can be edited and saved or submitted to CMS for review. When CMS has reviewed the submitted form and accepts the form, CMS will mark the form as "Accepted" and send an email notification. The status on the PHAP form page will update to "Accepted," and there is nothing further required for the submission. CMMI will send a memo notifying states of Statewide PHAP approval.

Support

For questions or technical assistance while completing the Form, please utilize the support provided by CMS.

- AHEAD@cms.hhs.gov
- 1-888-734-6433, select Option 8 for the AHEAD Model.

Appendix A: Quality Measure Stratification Guidance

Appendix A provides information on stratification variable considerations across the different data sources for the measures in the core and required supplemental domains. This section can help states as they obtain and analyze their data and prepare stratifications for baseline measures, annual reporting, and target setting.

Crosswalk of Core and Supplemental Measure and Data Sources

Data Source (Measure Steward)	Measure Names
Behavioral Risk Factor Surveillance System (BRFSS) Survey (CDC)	• General Health Status • Food Insecurity • Housing Quality • Prevalence of Obesity
Administrative Claims, hybrid data, or Electronic Health Record (EHR)* (NCQA)	• Breast Cancer Screening: Mammography • Colorectal Cancer Screening • Controlling High Blood Pressure • Glycemic Status Assessment for Patients with Diabetes
Administrative Claims (CMS/Yale CORE (Center for Outcomes Research & Evaluation) and NCQA)	• Emergency Department Visits for Adverse Events Associated with Use of Opioids and Alcohol Substance Use • Follow-Up After Emergency Department (ED) Visit for Substance Use • Follow-Up After Hospitalization for Mental Illness • Plan All-Cause Unplanned Readmission • Use of Pharmacotherapy for Opioid Use Disorder
Centers for Disease Control and Prevention Wonder (CDC)	• Live Births Weighing Less than 2500 grams
Administrative Claims or Hybrid Data (NCQA)	• Prenatal and Postpartum Care • Adult Immunization Status

**CMMI recommends utilizing electronic versions of the Breast Cancer Screening: Mammography; Colorectal Cancer Screening; Controlling High Blood Pressure; and Glycemic Status Assessment for Patients with Diabetes measures when feasible to ensure accurate lab values are available. CMMI acknowledges that electronic data sources may result in less sub-population data.*

BRFSS Measures Stratification Details

Statewide PHAP Stratification Category	BRFSS Variable Name (Question)	Relevant Categories for Stratification	Instructions for Use
Payer	PRIMINS1 (Source of your primary health insurance)	• Commercial=1,2 • Medicare=3,4 • Medicaid=5,6 • Other=7-10 • Uninsured=88	PRIMINS1 captures the respondent's primary source of health insurance. CMMI recommends re-coding this variable to create corresponding payer categories following the below groupings. *Note:* Medicare Advantage is not an available option to select in BRFSS.
Dual-Eligibility Status	-NA-	-NA-	BRFSS only reports the respondent's primary source of health insurance. As a result, it is not possible to definitively identify individuals with dual enrollment.
Geography	_URBSTAT (Urban Rural Status)	• Urban • Rural • Suburban	This variable distinguishes respondents residing in urban and rural counties.
	_METSTAT (Metropolitan Status)	• Metro • Non-Metro	This variable categorizes respondents based on their location in metropolitan and non-metropolitan counties.

Data Source Stratification Instructions for Use

Data Source	Instructions for Use
Electronic Health Record (EHR)	Payer, Dual-Eligibility Status, and Geography variable names are dependent on the Electronic Health Record (EHR) the Participant uses. Participants will consult with EHR data dictionaries and / or vendors to determine the most reliable variable for stratifications. • **Payer Information**: is typically captured in EHR data. • **Dual-Eligibility Status:** is typically a calculated variable based on payer coverage types (e.g., primary, secondary, tertiary) and coordination of benefits fields within an EHR system. • **Geography:** in EHR data typically includes patient geography information (e.g., residential address), which can be linked with other publicly available datasets to identify desired stratification group (e.g., rural vs. non-rural). The datasets should match the specific measure specifications (e.g., 2026 specifications for cohort 2 and 3).

<table>
<tr><th>Data Source</th><th>Instructions for Use</th></tr>
<tr><td>Hybrid Data</td><td>

Payer and Dual-Eligibility Status variables are dependent on the data source.
States will need to identify the appropriate respective variables for stratification within hybrid data.
Payer Information: Ensure the source of payment is correctly mapped across claims and medical records. Include secondary and tertiary forms of insurance to account for all beneficiaries attributable to a payer source but stratify only by primary payer.
Dual-Eligibility Status: Harmonize payer information on the claims and the medical record data to derive patient dual enrollment status.
Geography: Harmonize patient geography information on claims and medical records. The level of detail may vary between different claims databases and EHR systems. Harmonized geographic identifiers can be linked with other publicly available datasets to identify desired stratification group (e.g., rural vs. non-rural).

</td></tr>
<tr><td>Administrative Claims</td><td>

Payer Information:

Varies by claim type (Medicaid, Commercial, Medicare, or Medicare Advantage).
In the HEDIS specifications, payer is referred to as "product line."

For manual calculation, states should consider the primary payer.
Certain HEDIS measures can be programmed to calculate product line automatically in state-specific reports.

Dual-Eligibility Status:

For HEDIS measures, CMMI recommends combining the "LIS/DE", "Disability and LIS/DE", and "Disability" categories as a proxy for identifying dual-eligibility status individuals.
For Medicare only, HEDIS is typically stratified by socioeconomic status (SES) with six categories that incorporate dual-eligibility status.
With electronic data, certain HEDIS measures can be programmed to calculate SES automatically.
In claims, instructions for calculating dual-eligibility status are available through the Chronic Conditions Warehouse (CCW) guides such as "Options for Determining which CMS Medicare Beneficiaries are Dually Eligible for Medicare and Medicaid Benefits."

Geography: Variable names vary by data source. HEDIS measures can be stratified by linking to county level demographic information for the measurement year.

</td></tr>
<tr><td>Centers for Disease Control and Prevention (CDC) Wonder</td><td>

Payer Information:

The CDC natality file includes information on the primary source of payment for the delivery (the variable name is PAY), which can be used to infer health insurance status.
National Center for Health Statistics (NCHS) unit data offers a recoded payment source with Medicaid, Private Insurance, Self Pay, Other, and Unknown as valid response options. Self-pay is generally considered to indicate uninsured deliveries.

Dual-Eligibility Status: The natality data file only includes a single source of payment for delivery; thus, it <u>cannot</u> be used to determine dual-eligibility status.
Geography: the CDC Wonder tool provides aggregated natality statistics by states; thus, this data source does not allow for further geographic stratification.

</td></tr>
</table>

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Appendix B: Simplified Quality Measure Descriptions

Appendix B provides a high-level summary of the HEDIS quality measure specifications for each Core and Required Supplemental measures for the AHEAD Model. The summary tables provide a description of the measure and details on numerator, denominator, exclusions, continuous enrollment definitions, outliers, survey weights, and survey questions (if applicable). States can use this appendix for reference but will need to review the value sets and full measure specifications for complete information. **For Cohort 2 & 3 states, we expect states to use 2026 measure specifications or the most recent available measure specifications for the Statewide PHAP submission.**

Links to Measure Specifications

<table>
<tr><th>Domain</th><th>Measure Domain</th><th>Measure Name</th></tr>
<tr><td rowspan="9">Core Domain Measures (Choose at least one measure from each domain)</td><td rowspan="3">Behavioral Health</td><td>Use of Pharmacotherapy for Opioid Use Disorder</td></tr>
<tr><td>Follow-Up After Hospitalization for Mental Illness</td></tr>
<tr><td>Follow-up after Emergency Department (ED) Visit for Substance Use</td></tr>
<tr><td rowspan="2">Chronic Condition</td><td>Controlling High Blood Pressure</td></tr>
<tr><td>Glycemic Status Assessment for Patients with Diabetes</td></tr>
<tr><td>Health Care Quality and Utilization</td><td>Plan All-Cause Unplanned Readmission</td></tr>
<tr><td>Population Health</td><td>General Health Status</td></tr>
<tr><td rowspan="2">Prevention & Wellness</td><td>Colorectal Cancer Screening</td></tr>
<tr><td>Breast Cancer Screening: Mammography</td></tr>
<tr><td rowspan="7">Required Supplemental Domain Measures (Choose at least one)</td><td rowspan="2">Maternal Health</td><td>Live Births Weighing Less than 2500 grams</td></tr>
<tr><td>Prenatal and Postpartum Care</td></tr>
<tr><td rowspan="3">Prevention Measures</td><td>Adult Immunization Status</td></tr>
<tr><td>Prevalence of Obesity</td></tr>
<tr><td>Emergency Department Visits for Adverse Events Associated with Use of Opioids and Alcohol Substance Use</td></tr>
<tr><td rowspan="2">Health Promotion Activities</td><td>Food Insecurity</td></tr>
<tr><td>Housing Quality</td></tr>
</table>

A. Core Domain Measures

a. Behavioral Health – Use of Pharmacotherapy for Opioid Use Disorder (POD)

Use of Pharmacotherapy of Opioid Use Disorder (POD) Measure Specification Summary	
Description	The percentage of members aged 18 to 64 with an OUD who filled a prescription for or were administered or dispensed a Food and Drug Administration (FDA)-approved medication for the disorder during the measurement year.
Numerator	Patients who received any medications used in medication assisted treatment of opioid dependence and addiction, and four separate rates representing the following FDA-approved drug products: (1) Buprenorphine, (2) Oral naltrexone, (3) Long-acting, injectable naltrexone, and (4) Methadone.
Denominator	Patients ages 18 to 64 years who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.
Exclusions	Not continuously enrolled during the measurement year.
Continuous enrollment definition	The measurement year
Outliers	-NA-
Survey weights	-NA-

b. Behavioral Health – Follow-up After Hospitalization for Mental Illness (FUH)

Follow-Up After Hospitalization for Mental Illness Measure Specification Summary	
Description	Percent of discharges who had a seven day and/or 30-day follow-up after a mental illness (defined as intentional self-harm or principal diagnosis of mental illness) related hospitalization within the measurement timeframe
Numerator	There are two different numerators in this measure: Numerator 1: seven-day follow-up Numerator 2: 30-day follow-up Follow-up could include telehealth visit, residential follow-up for mental health, outpatient visit with behavioral health provider, partial hospitalization and others [see full specifications for all eligible visits]
Denominator	Denominator 1 and 2: Members 18 years of age and older who were hospitalized and discharged for principal diagnosis of mental illness, or any diagnosis of intentional self-harm
Exclusions	Hospice and individuals who died during the measurement year
Continuous enrollment definition	30 days following discharge
Outliers	-NA-
Survey weights	-NA-

c. Behavioral Health – Follow-Up After Emergency Department Visit for Substance Use (FUA)

Follow-up After Emergency Department Visit for Substance Use Measure Specification Summary	
Description	Percent of ED visits who had a seven day and/or 30-day follow-up after a substance abuse (defined as any diagnosis of drug abuse or principal diagnosis of substance abuse) within the measurement timeframe
Numerator	There are two different numerators in this measure: Numerator 1) seven-day follow-up Numerator 2) 30-day follow-up Follow up visits with a mental health provider in a variety of settings (such as inpatient, outpatient, telehealth, counseling support) and/or dispensing of pharmacotherapy that occur on or after the ED visit. (see specifications for a full list of eligible settings, pharmacotherapy events and screenings)
Denominator	Denominator 1 and 2: Based on discharges between January 1 and December 1 of the measurement year that have a substance abuse and/or drug abuse related diagnosis, with a requirement that only one ED visit be counted per 31-day period
Exclusions	Hospice and/or death at any time during the measurement year; measure also excludes ED visits that result in admission to psychiatric/rehab facilities. Also exclude ED visits that resulted in transfer/inpatient admission.
Continuous enrollment definition	Date of ED visit and 30 days post ED visit
Outliers	-NA-
Survey weights	-NA-

d. Chronic Conditions – Controlling High Blood Pressure (HBP)

Controlling High Blood Pressure Measure Specification Summary	
Description	Percentage of patients 18-85 years of age who had a diagnosis of hypertension starting before and continuing into or starting during the first six months of the measurement year, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement year.
Numerator	Number of patients 18-85 years of age whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement year.
Denominator	Patients 18-85 years of age who had a visit and diagnosis of hypertension starting before and continuing into or starting during the first six months of the measurement year.
Exclusions	Use of hospice services and/or death during the measurement year Received palliative care; Have diagnosis/procedure indicating end-stage renal disease; Have diagnosis of pregnancy; Member 66 years of age and older either enrolled in an Institutional Special Needs Plan (I-SNP) or lived long-term in an institution; Members 66-80 years of age with indications of frailty and advanced illness; Members 81 years of age and older with indications of frailty.
Continuous enrollment definition	Continuously enrolled (with no more than 45 days of coverage gap) in the measurement year.

Controlling High Blood Pressure Measure Specification Summary	
Outliers	-NA-
Survey weights	-NA-

e. Chronic Conditions – Glycemic Status Assessment for Patients with Diabetes (GSD)

Glycemic Status Assessment for Patients with Diabetes Measure Specification Summary	
Description	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (sub- Hemoglobin A1c [HbA1c] or glucose management indicator (GMI) was at the following levels during the measurement year: • Glycemic Status >9.0% (states only report this)
Numerator	Member with most recent HbA1c or GMI during the measurement year: 1) > 9.0%.
Denominator	Patients 18 - 75 years of age with diabetes (types 1 and 2) with a visit during the measurement year.
Exclusions	Received palliative care; Member 66 years of age and older either enrolled in an I-SNP or lived long-term in an institution; Members 66 years of age and older with indications of frailty and advanced illness. Use of hospice services and/or death during the measurement year.
Continuous enrollment definition	Continuously enrolled (with no more than 45 days of coverage gap) in the measurement year.
Outliers	-NA-
Survey weights	-NA-

f. Health Care Quality and Utilization – Plan All-Cause Unplanned Readmission at the State-level (PCR)

Plan All-Cause Unplanned Readmission at the State Level Measure Specification Summary	
Description	The risk-adjusted ratio of Observed/Expected unplanned all-cause readmissions based on discharges between January 1 and December 1 of the measurement year at the plan level.
Numerator	The observed numerator is all unplanned eligible observation stays and readmissions within 30 days of an eligible discharge. The expected numerator is weighted based on measure specifications.
Denominator	Eligible index hospital stays (acute inpatient and observation discharges) for members meeting measure criteria during the measurement year. Unplanned readmissions occurring within 30 days of discharge are evaluated for each eligible index stay.
Exclusions	Hospice and/or death at any time during the measurement year; Perinatal admissions, potentially planned procedures, organ transplant, chemotherapy, and psychiatric/rehab facilities and transfer/inpatient admission are also excluded.
Continuous enrollment definition	The year prior to index admission up until 30 days post index admission
Outliers	Individuals with four or more admissions during the measurement year
Survey weights	Note, this measure is risk-adjusted and can be stratified by age, payer and SNF/DE status based on predetermined weights within the specifications.

g. Population Health – General Health Status (Good or Better Health)

General Health Status Measure Specification Summary	
Description	The CDC general health status self-perceived health: • Question 1: Would you say that in general your health is: ○ Excellent, very good or good (GENHLTH = 1, 2, or 3) ○ Fair or poor (GENHLTH = 4 or 5) ○ Don't know/Not Sure, Refused (GENHLTH = 7 or 9)
Numerator	The numerator is the count of BRFSS survey respondents who chose excellent, very good or good general health (1, 2, or 3).
Denominator	The denominator is the total number of BRFSS survey respondents who reply by selecting any available options (1, 2, 3, 4, 5, 7, 9).
Exclusions	-NA-
Continuous enrollment definition	-NA-
Outliers	-NA-
Survey weights	Use BRFSS variable _LLCPWT variable for weighting, variable _STSTR for stratification, and the variable _PSU for primary sampling unit.
Survey question	Q1. Would you say that in general your health is: 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor 7 Don't know/Not sure 9 Refused

h. Prevention & Wellness – Colorectal Cancer Screening

Colorectal Cancer Screening Measure Specification Summary	
Description	46–75-year-old individuals who meet criteria to receive colorectal cancer screening in accordance with United States Preventive Task Force (USPTF) guidelines (note, this includes up to a ten year look back period)
Numerator	People who have one or more screening codes for stool tests (fecal occult blood test, stool immunochemical test and/or appropriate imaging such as colonoscopy, CT colonography, and/or sigmoidoscopy)
Denominator	The number of eligible 46–75-year-old individuals after removing exclusions for advanced illness, skilled nursing facility (SNF) and palliative care
Exclusions	People 66+ are excluded if they are in a SNF or institutional facility. Any individual who receives palliative care is excluded; People who meet criteria for both advanced illness AND frailty are excluded
Continuous enrollment definition	-NA-
Outliers	-NA-
Survey weights	-NA-

i. Prevention & Wellness – Breast Cancer Screening: Mammography

Breast Cancer Screening: Mammography Measure Specification Summary	
Description	Routine breast cancer screening among eligible women who are continuously enrolled age 50-74 during the measurement year (January to December)
Numerator	Appropriate routine breast cancer screening in measurement year or the year prior to measurement year in accordance with USPTF guidance
Denominator	Eligible population of continuously enrolled individuals after removing exclusions listed below
Exclusions	Hospice enrollment, receive palliative care, advanced illness AND frailty, bilateral mastectomy during/before measurement year
Continuous enrollment definition	Continuously enrolled (with no more than 45 days of coverage gap) in the measurement year, prior year and two years prior to measurement year
Outliers	-NA-
Survey weights	-NA-

B. Required Supplemental Domain Measures

a. Maternal Health – Live Births Weighing Less than 2500 grams

Live Births Weighing Less than 2500 grams Measure Specification Summary	
Description	Percentage of live births that weighed less than 2,500 grams at birth during the measurement year.
Numerator	Live births weighing less than 2500 g as stated on the birth certificate
Denominator	Live births during the preceding calendar year (ex. FY2024 is calendar year 2023) to women age 18 or older
Exclusions	Unknown or not stated birth weight as stated on the birth certificate
Continuous enrollment definition	-NA-
Outliers	-NA-
Survey weights	-NA-

b. Maternal Health – Prenatal and Postpartum Care (PPC)

Prenatal and Postpartum Care Measure Specification Summary	
Description	Percentage of deliveries of live births that received (1) prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization; (2) deliveries that had a postpartum visit on or between 7 and 84 days after delivery
Numerator	Numerator 1: prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization Numerator 2: deliveries that had a postpartum visit on or between 7 and 84 days after delivery
Denominator	Denominator 1 and 2: Members aged 18 and over who delivered a live birth during the measurement year
Exclusions	Use of hospice services and/or death during the measurement year

Prenatal and Postpartum Care Measure Specification Summary	
Continuous enrollment definition	43 days prior to delivery through 60 days after delivery.
Outliers	-NA-
Survey weights	-NA-

c. Prevention Measures – Adult Immunization Status (AIS)

Adult Immunization Status Measure Specification Summary	
Description	The percentage of adults 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal and hepatitis B in calendar year January 1 through December 31; This measure includes five subpopulations to reflect the different age requirements for being "up-to-date" on the vaccinations. The lookback period for each measure reflects immunization guidelines for each type of illness.
Numerator	Numerator 1: flu immunization status (lookback to July of prior year) Numerator 2: td/Tdap immunization status (lookback 9 years prior to measurement year) Numerator 3: Zoster immunization status (two shots since October 17, 2017) Numerator 4: Pneumococcal immunization status (since 19th birthday) Numerator 5: Hepatitis B immunization status (lookback to birth/childhood)
Denominator	Denominator 1 and 2: All adults 19 and older on January 1 of measurement year Denominator 3: Adults 50 and older on January 1 of measurement year Denominator 4: Adults 65 and older on January 1 of measurement year Denominator 5: Adults 19-59 on January 1 of measurement year
Exclusions	Use of hospice services and/or death during the measurement year
Continuous enrollment definition	-NA-
Outliers	-NA-
Risk adjustment	-NA-

d. Prevention Measures – Prevalence of Obesity

Prevalence of Obesity Measure Specification Summary	
Description	Measure of obesity rate based on self-reported weight and height from the BRFSS surveys.
Numerator	BRFSS survey respondents with valid self-reported height and weight and whose calculated body mass index (BMI) is greater or equal to 30 (_BMI5CAT=4).
Denominator	BRFSS survey respondents with valid self-reported height and weight (_BMI5CAT=1,2,3,4).
Exclusions	-NA-
Continuous enrollment definition	-NA-
Outliers	-NA-
Survey weights	Use BRFSS variable _LLCPWT variable for weighting, variable _STSTR for stratification, and the variable _PSU for primary sampling unit.

Prevalence of Obesity Measure Specification Summary	
Survey question	Calculated variable of four-categories of BMI: 1. Underweight Respondents classified as underweight based on body mass index. (_BMI5 < 18.50) 2. Normal Weight Respondents classified as normal weight based on BMI. (18.50 <= _BMI5 < 25.00) 3. Overweight Respondents classified as overweight based on BMI. (25.00 <= _BMI5 < 30.00) 4. Obese Respondents classified as obese based on BMI. (30.00 <= _BMI5 < 99.99). 5. Don't know/ Refused/ Missing Respondents with an unknown, refused, or missing value for BMI. (_BMI5=.)

e. Prevention Measures – Emergency Department Visits for Adverse Events Associated with Use of Opioids and Alcohol

Emergency Department Visits for Adverse Events Associated with Use of Opioids and Alcohol Measure Specification Summary*	
Description	Rate per 1000 ED visits
Numerator	ED visits for substance use
Denominator	Eligible population 18 and over

**States interested in this measure should consider talking with CMMI about specifications.*

f. Health Promotion Activity – Food Insecurity

Food Insecurity Measure Specification Summary	
Description	Measure of food insecurity based on responses to the BRFSS survey question that assesses food insecurity over the past year. The question asks respondents to reflect on how frequently they experienced situations where their food supply ran out, and they lacked the financial resources to purchase more.
Numerator	BRFSS survey respondents who reported "Always" to the survey question (SDHFOOD1=1,2,3).
Denominator	BRFSS survey respondents who reported "Always", "Usually", "Sometimes", "Rarely", or "Never" to the survey question (SDHFOOD1=1,2,3,4,5).
Exclusions	-NA-
Continuous enrollment definition	-NA-
Outliers	-NA-
Survey weights	Use BRFSS variable _LLCPWT variable for weighting, variable _STSTR for stratification, and the variable _PSU for primary sampling unit.

Food Insecurity Measure Specification Summary	
Survey question	During the past 12 months how often did the food that you bought not last, and you didn't have money to get more? Was that… 1 Always 2 Usually 3 Sometimes 4 Rarely 5 Never 7 Don't know/not sure 9 Refused

g. Health Promotion Activity – Housing Quality

Housing Quality Measure Specification Summary	
Description	Measure of housing quality based on responses to the BRFSS survey question that asks respondents to reflect whether there was any period during the last 12 months when they were unable to pay essential housing-related expenses, such as mortgage, rent, or utility bills.
Numerator	BRFSS survey respondents who reported "Yes" to the survey question (variable Name: SDHBILLS=1).
Denominator	BRFSS survey respondents who reported "Yes", "No" to the survey question (Variable Name: SDHBILLS=1,2).
Exclusions	-NA-
Continuous enrollment definition	-NA-
Outliers	-NA-
Survey weights	Use BRFSS variable _LLCPWT variable for weighting, variable _STSTR for stratification, and the variable _PSU for primary sampling unit.
Survey question	During the last 12 months, was there a time when you were not able to pay your mortg age, rent or utility bills? 1 Yes 2 No 7 Don't Know/ Not sure 9 Refused

Appendix C: Acronym Table

Appendix C provides a list of acronyms and their definitions that have been used throughout the document.

C1: Acronym Table

Acronym	Definition
AHEAD	Achieving Healthcare Efficiency through Accountable Design
AIS	Adult Immunization Status
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CCW	Chronic Conditions Warehouse
CDC	Centers for Disease Control and Prevention
CHC	Community Health Centers
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CORE	Center for Outcomes Research & Evaluation
CT	Computed Tomographic
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
EHR	Electronic Health Record
FDA	Food and Drug Administration
FFS	Fee-For-Service
FUA	Follow-Up After Emergency Department Visit for Substance Use
FUH	Follow-Up After Hospitalization for Mental Illness
GMI	Glucose Management Indicator
GSD	Glycemic Status Assessment for Patients with Diabetes
HbA1c	Hemoglobin A1c
HBP	Controlling High Blood Pressure
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchanges
I-SNP	Institutional Special Needs Plan
KFF	Kaiser Family Foundation

Acronym	Definition
LIS	Low-Income Subsidy
LIS/DE	Low-Income Subsidy / Disability Eligibility
MGS	Model Governance Structure
MSA	Metropolitan Statistical Area
NCHS	National Center for Health Statistics
NCQA	National Committee for Quality Assurance
NECMA	New England County Metropolitan Area
OUD	Opioid Use Disorder
PCR	Plan All-Cause Unplanned Readmission
PHAP	Population Health Accountability Plan
POD	Pharmacotherapy for Opioid Use Disorder
PPC	Prenatal and Postpartum Care
PSU	Primary Sampling Unit
PY	Performance Year
SES	Socioeconomic Status
SNF	Skilled Nursing Facility
Td	Tetanus and diphtheria
Tdap	Tetanus, diphtheria, and acellular pertussis
USPTF	United States Preventive Task Force