Long-term Enhanced Accountable Care Organization Design (LEAD) Model

PY 2027 Quality Measurement Methodology Report

August 2026

Version History

Version Number	Update	Date
1.0	First release	August 19, 2026

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Introduction

The Quality Measurement Methodology Report (QMMR) describes how the Centers for Medicare & Medicaid Services (CMS) will assess quality performance for Accountable Care Organizations (ACOs) participating in the Long-term Enhanced ACO Design (LEAD) Model. The report outlines the quality measurement framework for the model and provides detailed requirements for Performance Year (PY) 2027. CMS may update this report periodically to reflect policies applicable to future performance years.

Section 1 provides a summary of the LEAD Model and background on the model's quality strategy.

Section 2 outlines the quality performance assessment process and how performance assessment will be applied in PY 2027.

Section 3 describes the quality performance assessment process, including benchmark creation and quality scoring and how quality assessment will be applied to the Final Financial Settlement.

Section 4 details the design of the Quality Measures during PY 2027 of the LEAD Model.

Section 5 presents examples that illustrate how the quality strategy is applied to determine the Quality Withhold Earn Back.

1. Model Background: Context for Quality Approach

1.1 LEAD Model Overview

The LEAD Model builds on the Center for Medicare and Medicaid Innovation's (Innovation Center's) prior accountable care initiatives and incorporates enhanced benchmarking approaches that support participation by a broader range of health care providers, including those serving specialized patient populations and those with limited or no prior ACO experience (e.g., smaller independent and rural practices). With a 10-year performance period, the LEAD Model provides a longer time horizon than prior CMS accountable care models to support participant investments in care transformation and delivery system change. LEAD offers a predictable performance period without rebasing and supports sustainable long-term benchmarks and savings. The model also emphasizes coordinated care for High Needs beneficiaries and integration of care for dually eligible beneficiaries.

LEAD is designed to achieve the following goals:

1. Attract health care providers that have had limited participation in ACOs previously;

2. Encourage health care providers to deliver preventive care;
3. Empower beneficiaries to be more actively involved in their care; and
4. Support health care providers who serve High Needs and dually eligible beneficiaries to improve care and reduce costs.

The remainder of **Section 1** describes LEAD Model features that influence the model's quality strategy.

1.2 Beneficiary Alignment

Eligible beneficiaries are aligned to LEAD ACOs via claims-based and voluntary alignment. Prior to the start of each PY, LEAD ACOs must meet minimum counts of beneficiary alignment (see **Table 1.1**). These minimum aligned beneficiary requirements impact the construction of Quality Performance Benchmarks (QPBs). **Table 1.1** provides a summary of the minimum beneficiary alignment requirements by LEAD ACO type for each PY. These apply to all LEAD ACOs regardless of when they begin model participation.

Table 1.1. Minimum Counts of Aligned Medicare FFS Beneficiaries Required by Year

Performance Year	LEAD PY Alignment Minimum	Claims-Based Alignment Minimum in BY	LEAD PY Alignment Minimums for Newly Entering ACOs	Claims-Based Alignment Minimum in BY for Newly Entering ACOs	LEAD PY Alignment Minimums for High Needs/ESRD Eligible ACOs	Claims-Based Alignment Minimum in BY for High Needs/ESRD Eligible ACOs
2027	5,000	3,000	1,000	600	800	500
2028	5,000	3,000	2,000	1,200	1,000	625
2029	5,000	3,000	3,000	1,800	1,200	750
2030	5,000	3,000	4,000	2,400	1,400	825
2031	5,000	3,000	5,000	3,000	1,600	1,000
2032	5,000	3,000	5,000	3,000	1,600	1,000
2033	5,000	3,000	5,000	3,000	1,600	1,000
2034	5,000	3,000	5,000	3,000	1,600	1,000
2035	5,000	3,000	5,000	3,000	1,600	1,000
2036	5,000	3,000	5,000	3,000	1,600	1,000

ACO = Accountable care organization; BY = Base year; ESRD = End stage renal disease; FFS = Fee-for-service; PY = Performance year.

2. Quality Overview

2.1 Quality Measures

CMS expects LEAD ACOs to meet goals for improved quality of care and health outcomes for the Medicare beneficiaries they serve. The LEAD Model quality strategy establishes achievable performance criteria that incentivize changes in care delivery to reduce unnecessary utilization while improving quality of care.

To accomplish these goals, the LEAD Model will evaluate quality performance during each performance year using Quality Measures. Performance on these measures will affect the PY Benchmark for Final Financial Settlement.

1. ***Risk-Standardized All-Condition Readmission (ACR)*** measures how many hospital stays result in a readmission within 30 days after patient discharge.
2. ***All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)*** measures unplanned hospital admissions among Medicare FFS beneficiaries who are 66 years of age or older with multiple chronic conditions.
3. ***Days at Home for Patients with Complex, Chronic Conditions (DAH)*** measures the number of days that adults with complex, chronic disease spend at home or in community settings—not in acute and post-acute care settings (such as inpatient hospital or emergent care settings or post-acute skilled nursing).
4. ***Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU)*** is defined as the percentage of acute events related to one of six chronic conditions where follow-up care was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting. Acute events are those that require either an emergency department visit or hospitalization. The six chronic conditions include hypertension (HTN), asthma, heart failure, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and diabetes.
5. ***Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey***. The LEAD CAHPS Survey will use the CAHPS for ACO Survey and derive CAHPS Summary Survey Measures for scoring, which will then be combined into a single CAHPS Composite Score. LEAD will utilize a singular survey across all LEAD ACOs. This differs from the previous approach used in ACO REACH which utilized different survey versions across ACO types. LEAD ACOs must contract with a CMS-approved CAHPS Survey vendor for each reporting year to administer the CAHPS Survey.
6. ***Controlling High Blood Pressure (CBP)*** measures the percentage of patients ages 18 to 85 with a diagnosis of essential hypertension whose most recent blood pressure is adequately controlled during the measurement period. For PY 2027 LEAD ACOs can either report digital quality measures (dQMs) or electronic clinical quality measures (eCQMs) versions of the measure. dQMs are quality measures that use standardized

digital data captured from one or more health information sources and exchanged through interoperable systems. They rely on standards-based specifications that are computable within an integrated environment.[1] eCQMs are a subset of dQMs that primarily assess whether care delivered to patients aligns with evidence-based medicine or clinical guidelines. Traditionally, eCQMs have used retrospective data from electronic health records (EHR) to evaluate clinical performance.[2]

7. ***Diabetes: Glycemic Status Assessment Greater Than 9% (GSD)*** measures the percentage of patients ages 18 to 75 with diabetes whose most recent A1c or Glucose Management Indicator (GMI) is poorly controlled during the measurement period. This measure is intended to reflect the quality of services provided for patients with diabetes. For 2027, LEAD ACOs can either report dQM or eCQM versions of the measure.

In PY 2027, LEAD ACOs will be assessed using the following quality measures: ACR, UAMCC, DAH, TFU, and the CAHPS Survey. During PY 2027 and PY 2028, reporting of CBP and GSD through dQM/eCQM will be optional and may allow LEAD ACOs to receive an upward adjustment to their Initial Quality Score. These measures will become required for Quality Measures in PY 2029. **Section 3.4** provides additional information on the dQM/eCQM Reporting Adjustment.

Table 2.1 provides details on the LEAD Quality Measure set by PY, including each measure's scoring designation (e.g., Pay-for-performance). Quality Measures and timing are subject to change. Before each PY, CMS will provide quality guidance that informs LEAD ACOs of any changes to the quality approach.

Table 2.1. Summary Table of Quality Measures Used by Year

Measure	PY 2027	PY 2028	PY 2029	PY 2030	PY 2031	PY 2032	PY 2033	PY 2034	PY 2035	PY 2036	Method of Data Submission
ACR	X	X	X	X	X	X	X	X	X	X	CMS calculates from claims
UAMCC	X	X	X	X	X	X	X	X	X	X	CMS calculates from claims
DAH	X	X	X	X	X	X	X	X	X	X	CMS calculates from claims
TFU	X	X	X	X	X	X	X	X	X	X	CMS calculates from claims

Measure	PY 2027	PY 2028	PY 2029	PY 2030	PY 2031	PY 2032	PY 2033	PY 2034	PY 2035	PY 2036	Method of Data Submission
CAHPS	X	X	X	X	X	X	X	X	X	X	LEAD ACO contracts with CMS-approved CAHPS vendor
CBP	Y	Y	Z	Z	X	X	X	X	X	X	LEAD ACO submits via FHIR API, Excel, or QRDA
GSD	Y	Y	Z	Z	X	X	X	X	X	X	LEAD ACO submits via FHIR API, Excel, or QRDA

X = Pay-for-performance

Y = Optional reporting period, bonus offered for successful reporting.

Z = Pay-for-reporting

ACR = All-Condition Readmission; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CBP = Controlling High Blood Pressure; DAH = Days at Home; GSD = Diabetes: Glycemic Status Assessment Greater Than 9%; PY = Performance Year; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions; dQM/eCQM = electronic Clinical Quality Measure.

2.2 Quality Withhold

In PY 2027, 3% of a LEAD ACO's Financial Benchmark (the Quality Withhold) will be held "at risk." A LEAD ACO can earn part or all of it back, depending on Quality Measure performance and other related adjustments. **Table 2.2** summarizes how quality performance impacts the Final Financial Settlement through the Quality Withhold for each model PY and how the measures in **Table 2.1** map to the Quality Withhold breakdown.

In PYs 2027 and 2028, the dQMs/eCQMs (CBP and GSD) are excluded from calculation of the Initial Quality Score. The remaining five quality measures are weighted equally in determining the Initial Quality Score. In PY 2029 and 2030, CBP and GSD will transition to pay-for-reporting. Throughout PY 2029–2036, all seven Quality Measures will be weighted equally in determining the Initial Quality Score, regardless of their pay-for-reporting or pay-for-performance status. CBP and GSD will transition to pay-for-performance beginning in PY 2031.

Table 2.2. Portions of Quality Withhold Tied to Reporting by Performance Year*

PY	Quality Withhold	Portion Tied to Reporting (P4R)	Portion Tied to Performance (P4P)
PY 2027 – PY 2028	3%	Not Applicable	Total = 3.0% ▪ 0.60% = ACR ▪ 0.60% = UAMCC ▪ 0.60% = DAH ▪ 0.60% = TFU ▪ 0.60% = CAHPS
PY 2029 – PY 2030	3%	Total = 0.86% ▪ 0.43% = CBP ▪ 0.43% = GSD	Total = 2.14% ▪ 0.43% = ACR ▪ 0.43% = UAMCC ▪ 0.43% = DAH ▪ 0.43% = TFU ▪ 0.43% = CAHPS
PY 2031 – PY 2036	3%	Not Applicable	Total = 3.0% ▪ 0.43% = ACR ▪ 0.43% = UAMCC ▪ 0.43% = DAH ▪ 0.43% = TFU ▪ 0.43% = CAHPS ▪ 0.43% = CBP ▪ 0.43% = GSD

* Numbers in table are rounded for simplicity. Actual weights will be split evenly between all measures and will not exceed 3%.

ACR = All-Condition Readmission; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CBP = Controlling High Blood Pressure; DAH = Days at Home; GSD = Diabetes: Glycemic Status Assessment Greater Than 9%; P4R = Pay-for-Reporting; P4P = Pay-for-Performance; PY = Performance Year; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions.

CMS maintains the authority to revert measures from pay-for-performance (P4P) back to pay-for-reporting (P4R) if the measure owner determines that an appropriate benchmark to evaluate performance cannot be established, the measure causes patient harm, or the measure no longer aligns with clinical practice. CMS may also remove measures from use in the evaluation of quality performance.

2.3 Total Quality Score and Quality Withhold Earn Back

To calculate a Total Quality Score in PY 2027 (between 0% and 100% for each LEAD ACO in each PY), CMS will use the Quality Measures (**Table 2.1**), the dQM/eCQM Adjustment (applicable in PY 2027 and PY 2028 only), and the Prevention and Quality Plan (PQP) Reporting Adjustment (see **Section 2.3.4**). Beginning in PY 2028, the Continuous Improvement/Sustained Exceptional Improvement (CI/SEP) criteria will be included in the Total Quality Score calculation. CMS will use the Total Quality Score to determine what portion of the 3% Quality Withhold the LEAD ACO earns back when calculating its financial benchmark. For example, a Total Quality Score of

100% would result in a LEAD ACO earning back the entire 3% Quality Withhold, and a Total Quality Score of 50% would result in a LEAD ACO earning back 1.5% of the 3% Quality Withhold.

2.3.1 Initial Quality Score

In PY 2027 and PY 2028 there will be five Quality Measures, each worth 10 points, that CMS will use to calculate an **Initial Quality Score** for each LEAD ACO. Beginning in PY 2029, there will be seven Quality Measures, each worth ten points, that CMS will use to calculate an Initial Quality Score. The Initial Quality Score is equal to the percentage of possible points earned by the LEAD ACO.

In PY 2027, CMS will apply two adjustments to the Initial Quality Score to arrive at the Total Quality Score: (1) the dQM/eCQM Reporting Adjustment, and (2) the PQP Reporting Adjustment. In PY 2028, CMS will apply three adjustments to arrive at the Total Quality Score: (1) CI/SEP criteria, (2) the dQM/eCQM Reporting Adjustment, and (3) the PQP Adjustment. Beginning in PY 2029, LEAD ACOs will no longer be eligible for the dQM/eCQM Reporting Adjustment as CBP and GSD reporting becomes mandatory. **Table 2.3** outlines eligible adjustments for each performance year.

Table 2.3. Initial Quality Score Adjustments Applicable by Performance Year

	PY 2027	PY 2028	PY 2029 – PY 2036
CI/SEP criteria		X	X
dQM/eCQM Reporting Adjustment	X	X	
PQP Reporting Adjustment	X	X	X

2.3.2 Quality Performance Benchmarks (QBP) Overview

CMS will establish QPBs to assess each LEAD ACO's performance on each individual Quality Measure. In PY 2027, the comparison of a LEAD ACO's individual Quality Measure score to the QPB distribution will be used to determine the contribution to the Initial Quality Score for each P4P Quality Measure (out of 10 points). In remaining performance years, QPBs will also be used to assess the Sustained Exceptional Performance component of the CI/SEP criteria and determine which LEAD ACOs are eligible for the High Performers Pool (HPP), discussed in **Section 2.4**. **Section 3.1** includes more detailed information about the construction of the QPBs.

2.3.3 Overview of Adjustment to the Initial Quality Score (1 of 2): dQM/eCQM Reporting Adjustment (applicable in PY 2027 and PY 2028 only)

After calculating the LEAD ACO's Initial Quality Score, CMS applies the dQM/eCQM Reporting Adjustment. CMS determines the adjustment amount based on whether the LEAD ACO has successfully submitted dQM/eCQM data for the measures Controlling High Blood Pressure (CBP) and Diabetes: Glycemic Status Assessment Greater Than 9% (GSD) via one of the approved submission pathways (see **Section 4.7**). The dQM/eCQM Reporting Adjustment is only available to LEAD ACOs in PY 2027 and PY 2028. Beginning in PY 2029, CBP and GSD reporting will transition to a mandatory reporting requirement, and the dQM/eCQM Reporting Adjustment will no longer be applicable. Reporting of dQM/eCQM data is optional during PY 2027 and PY 2028. No downward adjustment will be given to LEAD ACOs that choose not to submit dQM/eCQM data during these PYs. LEAD ACOs that choose to submit dQM/eCQM data will be eligible for an upward adjustment of up to 2.50 percentage points, with each measure worth 1.25 percentage points. For example, in PY 2027, a LEAD ACO with an Initial Quality Score of 80% who is eligible for the full dQM/eCQM Reporting Adjustment will earn a Total Quality Score of 82.5%.

Table 2.4 shows how the dQM/eCQM Reporting Adjustment might affect a LEAD ACO's Initial Quality Score for each PY.

2.3.4 Overview of Adjustment to the Initial Quality Score (2 of 2): PQP Reporting Adjustment

Once CMS determines the LEAD ACO's Initial Quality Score, CMS will apply the PQP Reporting Adjustment to determine the LEAD ACO's Total Quality Score and final Quality Withhold Earn Back. **Section 3.5** provides additional information on the PQP requirements.

Table 2.4 provides details on how the PQP Reporting Adjustment might affect a LEAD ACO's Initial Quality Score for each PY. CMS will not adjust an Initial Quality Score downward for the failure to report required data. Instead, LEAD ACOs may earn an upward adjustment of up to 5 percentage points in PY 2027 and PY 2028 and an upward adjustment of up to 10 percentage points in PY 2029–2036 for reporting on required components of the PQP. CMS will share a PQP reporting template and a scoring rubric for PY 2027 with LEAD ACOs prior to the start of the performance year.

Table 2.4. dQM/eCQM and PQP Reporting Adjustments Impact on Initial Quality Score by PY

	PY 2027 – PY 2028	PY 2029 – PY 2036
dQM/eCQM Reporting Adjustment	2.50 percentage points	Not Applicable*

PQP Reporting Adjustment	5 percentage points	10 percentage points
Total	7.50 percentage points	10 percentage points

* CBP and GSD reporting will transition to a mandatory reporting requirement, and the dQM/eCQM Reporting Adjustment will no longer be applicable after PY 2028.

2.3.5 Calculating the Total Quality Score and the Quality Withhold Earn Back

The Total Quality Score is calculated by taking the Initial Quality Score and applying the two adjustments described above: (1) the dQM/eCQM Reporting Adjustment and (2) the PQP Reporting Adjustment. See **Section 3.7.3** for sample calculation. The Total Quality Score is capped between 0% and 100%. For example, if the Initial Quality Score plus the dQM/eCQM and PQP Reporting Adjustments exceed 100%, the Total Quality Score is 100%.

To determine the Quality Withhold Earn Back, the Total Quality Score is multiplied by the 3% Quality Withhold. For example, a Total Quality Score of 100% would result in a LEAD ACO earning back the entire 3% Quality Withhold, and a Total Quality Score of 50% would result in a LEAD ACO earning back half of the 3% Quality Withhold.

2.4 Future PY Adjustments to the Initial Quality Score and HPP

While CI/SEP criteria are not included in PY 2027 quality performance measurement, LEAD ACOs will be evaluated against these criteria in future performance years. Eligibility for the HPP bonus is based on CI/SEP performance; therefore, HPP bonuses begin in PY 2028.

2.4.1 Continuous Improvement/Sustained Exceptional Performance (CI/SEP) Criteria

Beginning in PY 2028, CMS will evaluate all LEAD ACOs against the CI/SEP criteria described in **Section 3.3**. Based on that evaluation, CMS will apply a CI/SEP Multiplier to the Initial Quality Score. LEAD ACOs that meet the CI/SEP criteria receive a multiplier of 1.0, leaving the Initial Quality Score unchanged. LEAD ACOs that score zero points receive a multiplier of 0.9. LEAD ACOs that score less than zero points receive a multiplier of 0.85, reducing the Initial Quality Score by 15%. For example, a LEAD ACO with an Initial Quality Score of 75% that meets the CI/SEP criteria would retain a Total Quality Score of 75%. In contrast, a LEAD ACO with an Initial Quality Score of 75% that scores less than zero points on the CI/SEP criteria would receive a multiplier of 0.85, resulting in a Total Quality Score of 63.75%.

2.4.2 High Performers Pool (HPP)

The HPP provides an opportunity for a bonus payment based on quality performance or improvement. Beginning in PY 2028, LEAD ACOs will be eligible to receive additional funds from

the HPP if they meet one of the following criteria: (1) receive a CI/SEP score of 1, or (2) receive a CI/SEP score of 0 and the full PQP Reporting Adjustment. To be eligible under either criterion, LEAD ACOs must also have an average percentile rank of 70 percent or higher across the measures. The HPP is funded through a portion of the Quality Withhold amounts that LEAD ACOs do not earn back. Specifically, 50% of the remaining unearned Quality Withhold amounts are allocated to the HPP.

The HPP rewards high-performing ACOs while accounting for differences in organization size. For example, if an ACO earns back 2.85% of its 3% Performance Year Benchmark, then 50% of the remaining 0.15% Quality Withhold contributes to the HPP. CMS distributes HPP funds proportionally based on beneficiary alignment-months. Consequently, the highest-performing ACOs may receive payments that exceed their original 3% Quality Withhold through a combination of earned-back Quality Withhold and HPP bonus payments. See **Section 3.6** for additional details on how the HPP is identified.

2.5 Overview of Application of Quality Assessment to Final Financial Settlement

To calculate the Quality Withhold Earn Back in PY 2027, CMS first evaluates the performance of the Quality Measures and calculates the Initial Quality Score. Next, the dQM/eCQM Reporting Adjustment and the PQP Reporting Adjustment are added to the Initial Quality Score to get the Total Quality Score. This is multiplied up to 3% by the Quality Withhold to determine the Quality Withhold Earn Back. In future PYs, CI/SEP criteria will be included in calculations of the Quality Withhold Earn Back.

2.1 summarizes the process CMS uses to convert quality measure performance into a Quality Withhold Earn Back amount for PY 2027. CMS first calculates an Initial Quality Score based on performance on five quality measures, applies any eligible reporting adjustments, and then determines the Total Quality Score. The Total Quality Score is used to calculate the percentage of the 3% Quality Withhold that the LEAD ACO earns back through the Final Financial Settlement.

Figure 2.1. Application of Quality Assessment to Final Financial Settlement – PY 2027

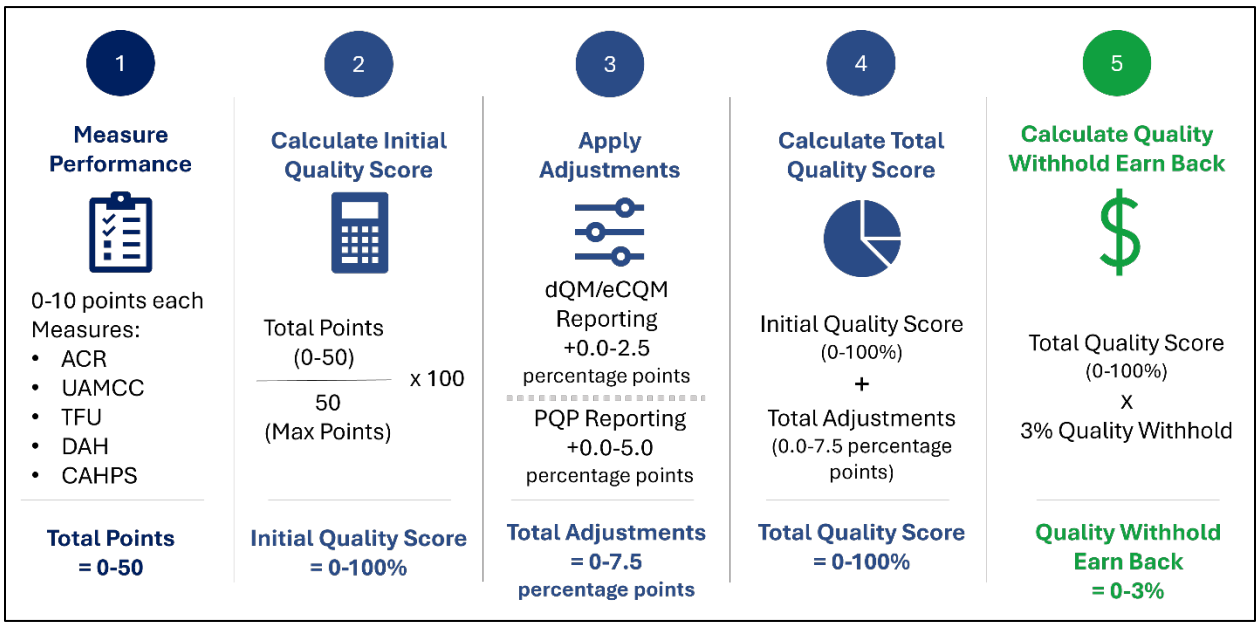


Figure 2.2 summarizes the process CMS uses to apply quality assessment to the Final Financial Settlement in PY 2028. As in PY 2027, CMS calculates an Initial Quality Score from performance on the quality measures and applies any eligible reporting adjustments. Beginning in PY 2028, CMS also applies the CI/SEP Multiplier and determines eligibility for a High Performers Pool (HPP) bonus. The resulting Total Quality Score determines the percentage of the Quality Withhold earned back, while qualifying LEAD ACOs may receive additional payments through the HPP.

Figure 2.2. Application of Quality Assessment to Final Financial Settlement – PY 2028

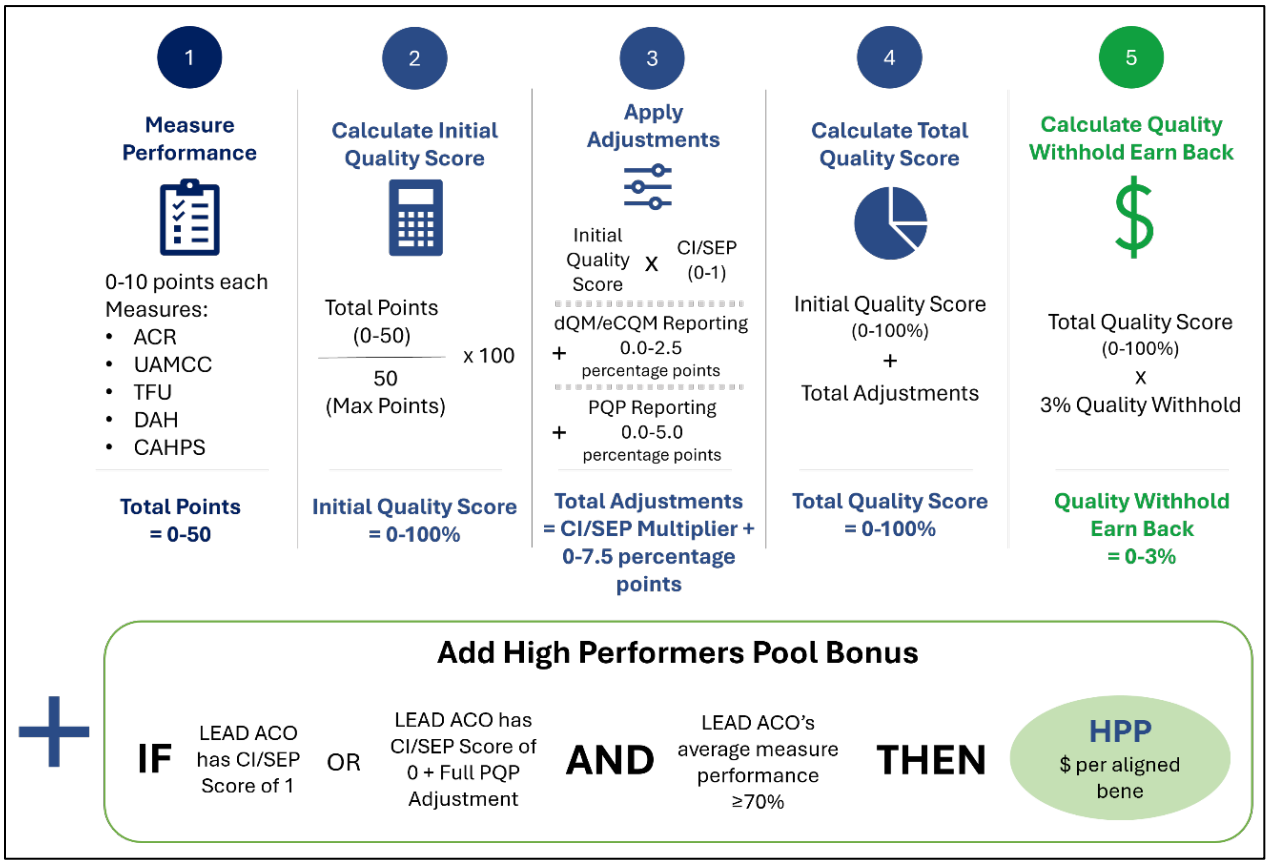
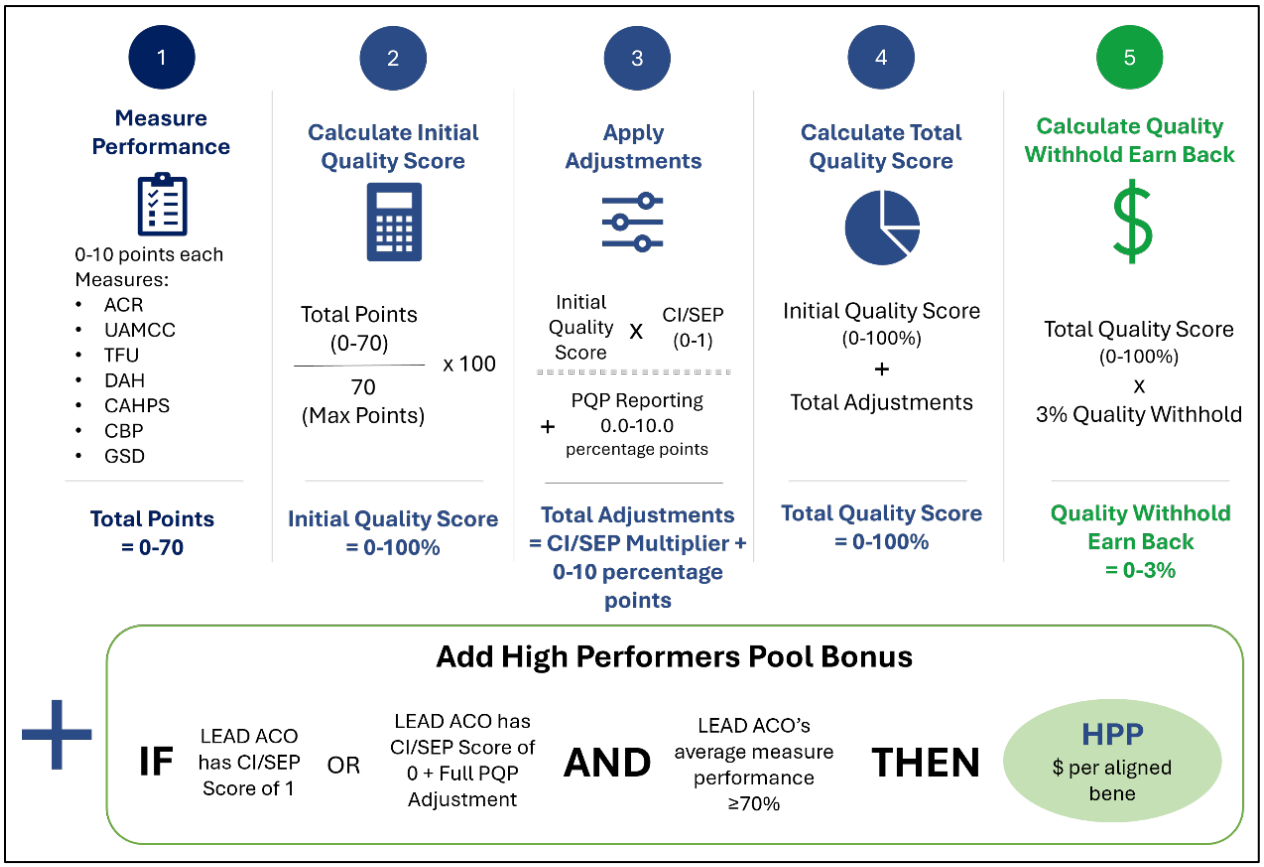


Figure 2.3 summarizes the process CMS uses to apply quality assessment to the Final Financial Settlement beginning in PY 2029. CMS calculates an Initial Quality Score based on performance across seven quality measures, applies the CI/SEP Multiplier and any eligible PQP Reporting Adjustment, and then determines the Total Quality Score. The Total Quality Score determines the percentage of the Quality Withhold earned back. LEAD ACOs that meet the HPP eligibility criteria may also receive additional payments through the High Performers Pool.

Figure 2.3. Application of Quality Assessment to Final Financial Settlement – PY 2029–PY 2036



ACR = All-Condition Readmission; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CI/SEP = Continuous Improvement/Sustained Exceptional Performance; CBP = Controlling High Blood Pressure; DAH = Days at Home; GSD = Diabetes: Glycemic Status Assessment Greater Than 9%; dQM/eCQM = electronic Clinical Quality Measure; HPP = High Performers Pool; PQP = Prevention and Quality Plan; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions.

See **Section 3.6** for more detail on the application of quality assessment to the Final Financial Settlement and **Section 5** for examples.

3. Quality Performance Scoring and Determination of Quality Withhold Earn Back

3.1 Creation of QPBs

As discussed in **Section 2.3.2**, CMS will establish Quality Performance Benchmarks (QPBs) to assess each LEAD ACO's performance on each individual Quality Measure. CMS releases benchmarks annually for all P4P measures, including ACR, UAMCC, DAH, TFU, and CAHPS. Because dQM/eCQM reporting is optional in PY 2027 and PY 2028 and will be P4R in PY 2029 and PY 2030, CMS will not release benchmarks until these measures become required in PY 2031. The comparison of a LEAD ACO's individual Quality Measure score to the QPB distribution will be used to calculate each P4P Quality Measure's contribution to the Initial Quality Score and, beginning in PY 2028, to assess the Sustained Exceptional Performance component of the CI/SEP criteria and determine eligibility for the HPP.

This section describes the construction of QPBs for claims-based and CAHPS measures. For additional information on how QPBs will be used in the application of quality assessment to Final Financial Settlement, see **Section 3.6**.

3.1.1 Claims-Based Measure Benchmarks

For all claims-based measures, CMS will use scores from both LEAD ACOs and non-LEAD ACO provider groups to create the QPB distributions used to evaluate performance. Non-LEAD ACO provider groups include individual physicians, group practices, hospital TINs, and CCNs that meet minimum beneficiary count requirements for inclusion. To be included in the QPB distribution, TINs and CCNs must meet the minimum aligned beneficiary requirement of at least 500 aligned beneficiaries.

Unlike the ACO REACH Model, the LEAD Model will not distinguish between Standard/New Entrant ACOs and High Needs Population ACOs. Instead, CMS will assess ACO performance using one set of QPBs for each measure rather than separate High Needs and Standard/New Entrant benchmarks. CMS may assess whether benchmark changes will be needed in the future.

3.1.2 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Benchmarks

3.1.2.1 CAHPS QPBs

The CAHPS QPBs are based on entity-level, patient mix–adjusted data. For each Summary Survey Measure (SSM), CMS pools entity-level data to create the SSM-specific QPB distribution

and identify decile thresholds for scoring. CMS will then compare each ACO's SSM scores to this set of decile thresholds. The PY 2027 benchmarks will serve as the baseline for the LEAD ACOs.

For PY 2027, the LEAD ACO CAHPS SSM-specific QPB distributions will be based on pooled data from Merit-Based Incentive Payment System (MIPS) participants and Shared Savings Program ACOs from PYs 2023–2025, combined with data for REACH ACOs from PYs 2024–2026. CMS will recalculate the Medicare Shared Savings Program, MIPS, and ACO REACH scores adjusting for the percentage of beneficiaries who meet the LEAD Model definition of High Needs. **Table 3.1** shows the data sources and performance years included in the LEAD ACO CAHPS SSM benchmarks for PY 2027 through PY 2030. Three years of data from LEAD ACOs will be used for the QPBs beginning in PY 2030.

Table 3.1. Data Sources and Time Periods for LEAD ACOs

Data Source	PY 2027 LEAD ACO CAHPS Benchmark, Comprising Performance Scores from:	PY 2028 LEAD ACO CAHPS Benchmark Comprising Performance Scores from:	PY 2029 LEAD ACO CAHPS Benchmark, Comprising Performance Scores from:	PY 2030 LEAD ACO CAHPS Benchmark, Comprising Performance Scores from:
LEAD ACOs	Not applicable	PY 2027	PY 2028 PY 2027	PY 2029 PY 2028 PY 2027
REACH ACOs	PY 2026 PY 2025 PY 2024	PY 2026 PY 2025 PY 2024	PY 2026 PY 2025	PY2026
MIPS (includes ACOs from the Medicare Shared Savings Program)	PY 2025 PY 2024 PY 2023	PY 2026 PY 2025 PY 2024	PY 2027 PY 2026 PY 2025	PY 2028 PY 2027 PY 2026

ACO = Accountable care organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; MIPS = Merit-Based Incentive Payment System; PY = Performance year; QPB = Quality Performance Benchmark

3.2 Quality Measure Scoring for the Initial Quality Score

Once LEAD ACO-specific measure data are collected and measure performance rates are calculated, CMS calculates how many points a LEAD ACO has earned for each measure. An ACO can earn up to 10 points on each measure. In PY 2027 and PY 2028, the total maximum Quality Measure Points available to be earned is 50. Starting in PY 2029 and continuing through the remainder of the model, the total maximum Quality Measure Points available to be earned will be 70.

A LEAD ACO earns points for each measure based on how it performs compared to measure-specific QPBs. If no beneficiaries are eligible for a claims-based measure's denominator, the LEAD ACO will be exempt from scoring on that measure, and that measure will not count toward the total number of points possible. Likewise, CAHPS requires a LEAD ACO to meet a minimum number of surveyable beneficiaries before it can proceed with the survey. Any ACO that does not meet these thresholds will be exempt from CAHPS. In PY 2027, the total number of quality points possible for a LEAD ACO that is exempt from CAHPS will be 40; that is, 10 points for each claims-based measure. LEAD ACOs that are *not* exempt from the requirement to administer a CAHPS Survey but do not administer the survey and/or do not transmit any data to CMS will earn zero out of 10 points for CAHPS.

The Initial Quality Score is calculated as the points earned from all measures divided by the total points possible (40 points). Additional details on the application of quality assessment to Final Financial Settlement are presented in **Section 3.7**.

3.2.1 Claims-Based Measure Scoring

For all risk-adjusted measures (ACR, UAMCC, and DAH), scoring is determined using a weighted stratification approach. For these measures, each ACO's beneficiary population will be divided into High Needs and non-High Needs beneficiaries. Separate measure scores will be calculated for each entity across all three measures, then blended based on the volume of High Needs beneficiaries to create a composite measure score for each ACO. For TFU, CMS will not use a weighted stratification approach because TFU is a non-risk-adjusted measure designed to apply uniformly across all beneficiary populations.

Table 3.2 presents the distribution of points (out of 10) awarded for each claims-based Quality Measure. Across all performance years of the LEAD Model, claims-based measures include ACR, UAMCC, DAH, and TFU. Points awarded are based on how the LEAD ACO's Quality Measure score for the PY compares to the benchmark percentile thresholds (for more on the development of the QPBs, see **Section 3.7.1**). If a LEAD ACO's quality score falls below the 30th percentile benchmark, CMS awards zero points for a measure. As shown in the table, LEAD ACOs that meet the 30th percentile benchmark receive 7.5 points; the points awarded increase at 5 percentile increments until the 90th percentile, where the full 10 points are awarded for the measure.

Table 3.2. Points Awarded Based on Quality Performance for Claims-Based Measures

Percentile Threshold Met	< 30%	≥ 30%	≥ 35%	≥ 40%	≥ 45%	≥ 50%	≥ 55%	≥ 60%	≥ 65%	≥ 70%	≥ 75%	≥ 80%	≥ 85%	≥ 90%
Points Awarded	0	7.5	7.75	8	8.25	8.5	8.75	9	9.25	9.5	9.625	9.75	9.875	10

3.2.2 CAHPS Scoring

A LEAD ACO's CAHPS Composite Score accounts for 10 points out of the total 40 possible points awarded based on Quality Measure performance used to determine a LEAD ACO's Initial Quality Score. A LEAD ACO's performance on the eight SSMs listed in **Section 4.5.3** determines how many of the 10 possible points for CAHPS it earns.

3.2.2.1 SSM Scoring Against Benchmarks

To arrive at the final number of points—out of 10—that a LEAD ACO will be awarded for its CAHPS performance, CMS first needs to roll up a LEAD ACO's performance on the separate SSMs into a single summary number referred to as the "CAHPS Composite Score."

A LEAD ACO can earn 10 SSM points for each SSM, up to 80 total SSM points. To figure out the allocation of points, CMS compares the LEAD ACO's SSM performance against a QPB distribution. **Table 3.3** shows the SSM points awarded at each benchmark threshold. As with the scoring system for claims-based measures, there are no SSM points awarded for SSM scores that fall below the 30th percentile benchmark.

Table 3.3. SSM Points Awarded by Quality Performance for CAHPS SSMs

Percentile Threshold Met	< 30%	30%	40%	50%	60%	70%	80%	90%
Points Awarded	0	5.5	6.25	7	7.75	8.5	9.25	10

CAHPS = Consumer Assessment of Healthcare Providers and Systems; SSM = Summary survey measure.

3.2.2.2. LEAD ACOs Scoring and Final CAHPS Composite Score Construction

CMS scores each SSM on a 0-10-point scale using the same general approach used for the claims-based measures. The proportion of 80 possible SSM points earned by the LEAD ACO determines the final CAHPS Composite Score. This CAHPS Composite Score is multiplied by 10 to determine the number of CAHPS points earned out of 10 that will be included in the ACO's

Initial Quality Score calculation. For example, a LEAD ACO that earns the maximum score on all eight SSMs would receive 80 SSM points (8 × 10 points). This results in a CAHPS Composite Score of 1.0 (80/80), which translates to the full 10 CAHPS points available in the Initial Quality Score calculation.

3.2.2.3 The Impact of Unscored SSMs on the CAHPS Composite Score

For a given ACO, CMS will not assign SSM points if an SSM is based on data from 19 or fewer survey respondents, and CMS will reduce the number of possible SSM points—the denominator of the CAHPS Composite Score—by 10. For example, if one of an ACO's eight SSMs has 19 or fewer respondents, CMS will score the ACO only on the seven SSMs with sufficient respondents, and the maximum number of SSM points the ACO can earn will be 70. The denominator for the CAHPS Composite Score will therefore be 70 instead of 80. An ACO must have SSM points assigned for at least 50%, or four of the eight SSMs, to receive a CAHPS Composite Score. SSM results with 19 or fewer survey respondents will not be reported in the Annual Quality Report because of case minimum requirements. To protect patient confidentiality, percentages and numbers at the question level will not be reported if fewer than 11 respondents answered in any category. If an ACO does not receive a CAHPS Composite Score, CMS will reduce that ACO's total quality points possible used in the Initial Quality Score calculation by 10. In other words, the ACO's Initial Quality Score will be based on points earned out of 30 total possible points instead of 40.

3.3 CI/SEP Criteria

The CI/SEP criteria promote continuous improvement and recognize sustained high performance on claims-based quality measures. The CI/SEP criteria determine the CI/SEP Multiplier that is applied to the Initial Quality Score. LEAD ACOs that meet the CI/SEP criteria receive a multiplier of 1.0, leaving the Initial Quality Score unchanged. LEAD ACOs that score zero receive a multiplier of 0.9, while LEAD ACOs that do not meet the CI/SEP criteria by scoring less than zero receive a multiplier of 0.85, reducing the Initial Quality Score by 15%. Aside from any other adjustments, a LEAD ACO with an Initial Quality Score of 75% that met the CI/SEP criteria would have a Total Quality Score of 75%. A LEAD ACO that earns less than zero points for the CI/SEP criteria and earns an Initial Quality Score of 75% would have a Total Quality Score of 64%.

Beginning in PY 2028, CMS will evaluate all LEAD ACOs using the claims-based measures (ACR, DAH, UAMCC, and TFU). The CI/SEP criteria compare performance in the current performance year with performance in the prior performance year. CMS uses the following steps to determine whether a LEAD ACO meets the CI/SEP criteria in PY 2027:

1. ***Continuous Improvement*:** CI/SEP points are awarded for each claims-based Quality Measure on the basis of statistically significant change from the previous performance year to the current performance year (e.g., PY 2027 to PY 2028):
    a. -1 point for **declining performance**
    b. 0 points for **no change in performance**
    c. +1 point for **improving performance**
2. ***Sustained Exceptional Performance***: Regardless of the change in performance over time, CI/SEP points for a given measure will be set to +1 if a LEAD ACO **meets or exceeds** the respective 70th percentile benchmark values starting in PY 2028. In other words, if a LEAD ACO has a statistically significant decline in UAMCC from PY 2027 to PY 2028 but exhibits Sustained Exceptional Performance (its score is better than or equal to the 70th percentile in both periods), it will still receive +1 CI/SEP points for that measure.
3. CI/SEP points are added across all four claims-based measures for the Total CI/SEP points.
4. Using the gradient approach, a LEAD multiplier will be assigned on the ACO's Total CI/SEP points.

For PY 2028–PY 2036, the CI/SEP criteria will determine the value of the CI/SEP multiplier applied to the LEAD ACO's Initial Quality Score. Unlike the REACH Model, the LEAD Model will use gradient scoring rather than using a binary determination. See **Table 3.4**.

Table 3.4. CI/SEP Tiered Multiplier

Total CI/SEP Points	LEAD Multiplier
-4 to -1	0.85
0	0.90
1 to 4	1.00

For example, if a LEAD ACO earns 0 Total CI/SEP points, its Initial Quality Score will be multiplied by 0.90. If the LEAD ACO scores below zero, its Initial Quality Score will be multiplied by 0.85, resulting in a 15% reduction. For PY 2028, this means the maximum Quality Withhold Earn Back for a LEAD ACO scoring below zero would be 2.55%, or 85% of the 3% Quality Withhold.

3.3.1 Standardized Score Components

CMS will use standardized score components to evaluate continuous improvement (CI) under the CI/SEP criteria. The CI component compares Quality Measure performance across two measurement periods. Continuous improvement is determined by using standardized score components, except for TFU. These standardized scores provide a consistent framework for interpreting performance across different assessments and subtests.

3.3.2 Process for Determining Continuous Improvement

For each Quality Measure, CMS determines whether LEAD ACOs exhibit statistically significant improvement, no statistically significant change, or a statistically significant decline in performance on the measure scores (standardized score components for ACR, UAMCC, and DAH, and observed measure scores for TFU).

3.4 dQM/eCQM Reporting Adjustment

To align with CMS's broader shift toward digital quality measures (dQMs), LEAD will phase in two dQMs, Controlling High Blood Pressure (CBP) and Diabetes: Glycemic Status Assessment Greater Than 9% (GSD), during the model. CMS will offer incentives, reporting flexibility, and support to encourage implementation during the phase-in period. The two new measures will be optional for PY 2027 and PY 2028, measured on a pay-for-reporting basis for PY 2029 and PY 2030, and transitioned to P4P beginning in PY 2031 through PY 2036. Making these measures optional for the first two years before moving to P4R will give ACOs time to acclimate to collecting and reporting data derived from electronic medical records.

3.4.1 Required Data Elements

CMS specifies the data elements that must be available in an ACO's certified EHR or health IT system to support measure calculation and reporting. There will be two reporting options to facilitate sharing the necessary data for dQM reporting. For submitting data via the upload of an Excel spreadsheet, the Innovation Support Platform (ISP) will provide an Excel template through the Health Data Reporting (HDR) application that includes all the required data elements. For submitting data via an HL7 Fast Healthcare Interoperability Resources (FHIR)-based Application Programing Interface (API), CMS will provide a LEAD Implementation Guide (IG) that details the required data elements, necessary FHIR resources and profiles, terminology and value set constraints, validation rules, and API workflows for submitting data to CMS. The FHIR IG and HDR-Excel spreadsheet will be made available at a later date.

For LEAD participants currently submitting these measures as eCQMs using a Quality Reporting Document Architecture (QRDA) reporting method, these measures will be accepted for LEAD for PY 2027 and PY 2028. These data elements are defined in eCQI Resource Center's Electronic Clinical Quality Measure (eCQM) Data Element Repository (DERep) and are linked to each measure's Quality Data Model (QDM) elements. **Note: ACOs that are not currently using QRDA should select from the other available reporting options, including HDR-Excel and FHIR-based reporting, to support long-term alignment with CMS reporting requirements.**

3.4.2 dQM/eCQM Reporting Adjustment Scoring Methodology

For PY 2027 and PY 2028, LEAD ACOs that submit dQM or eCQM data may qualify for an upward adjustment of up to 2.50 percentage points. Each measure (CBP and GSD) is worth 1.25

percentage points. To receive credit, LEAD ACOs must successfully submit the required dQM and eCQM data in accordance with CMS reporting specifications, through an approved submission pathway, and with all data elements needed to calculate each measure. For submissions through the HDR application, CMS will identify the attributed beneficiary population for each LEAD ACO and provide the final list of eligible beneficiaries to the LEAD ACO. The LEAD ACO should submit complete and accurate clinical data, including all required data elements, for at least 75% of beneficiaries eligible for each measure. These measures also must meet or exceed the minimum case volume of 20 eligible cases so they can be reliably measured. CMS will apply the Clinical Quality Language (CQL) logic to the submitted data to calculate the measures. LEAD ACOs that do not adequately report dQMs or eCQMs, or do not report them, will not receive an upward adjustment.

3.5 PQP Reporting Adjustment

The Prevention and Quality Plan (PQP) is a required annual submission for all LEAD ACOs beginning in Performance Year 2027. Through the PQP, ACOs will outline their strategy for developing, implementing, and sustaining a prevention-focused intervention designed to improve health outcomes for their aligned Medicare beneficiaries throughout the 10-year model period. Throughout the model, PQP reporting provides an opportunity for ACOs to earn additional percentage points toward their Total Quality Score.

As part of the PQP, CMS requires every LEAD ACO to:

- Assess the prevention needs of their beneficiary population.
- Design a new or expanded evidence-based prevention intervention tailored to those needs.
- Launch and actively implement the intervention.
- Report annually on program engagement, outcomes, and progress toward ACO-defined goals.

CMS defines prevention broadly, spanning primary prevention (preventing chronic disease before onset), secondary prevention (early diagnosis and intervention), and tertiary prevention (improving quality of life and preventing complications for those already diagnosed). ACOs have flexibility to design interventions that address the needs of their specific populations.

In Year 1 of model participation, LEAD ACOs are expected to report on planning for their intervention. In Year 2 and subsequent performance years, LEAD ACOs will be expected to implement their intervention. LEAD ACOs may choose from one of the following three paths for their intervention. Reporting requirements vary by intervention path.

- ***New Intervention Path:*** ACOs develop a new prevention intervention that was not formally in place prior to participation in the LEAD Model.

- ***Existing Intervention Path:*** ACOs significantly expand upon an existing prevention intervention. Existing intervention implementations must have a defined target eligible population, be actively serving beneficiaries, and the ACO must be able to provide data on participation and outcomes. ACOs choosing this path will be expected to demonstrate at least one of the following throughout model participation: (1) expanded reach, (2) enhanced intervention, or (3) expanded community capacity.
- ***RISE/CARA Intervention Path:*** Available only to ACOs who have selected the Global Risk Option, participate in CMS-Administered Risk Arrangements (CARA), and choose the RISE to Age in Place falls prevention episode. For eligible ACOs, RISE will satisfy PQP intervention requirements, though ACOs will still be required to complete annual PQP reporting.

More detailed guidance on PQP requirements and reporting will be provided before the start of PY 2027.

3.5.1 Required Data Elements

Table 3.5 summarizes reporting requirements for each LEAD intervention pathway in Year 1. Year 1 is the planning year. CMS does not expect a fully implemented intervention by the end of PY 2027. The goal is to conduct a structured needs assessment, select a prevention focus, and develop a clear plan for launching the intervention in Year 2. Year 1 reporting requirements are separated into three categories outlined below. Specific requirements in each category vary by intervention path type.

- Category 1 (Screening & Needs Assessment): Focuses on how the ACO identifies needs using screening tools and/or data and how those findings are linked to the chosen intervention.
- Category 2 (Population & Partnerships): Defines the target population, data sources used to identify it and any required growth or expansion thresholds, along with community partnerships.
- Category 3 (Intervention Design & Goals): Covers the description of the intervention itself, required evidence, and how Program Engagement goals are set and measured.

Each pathway builds on these categories differently:

- New Intervention Path: Focuses on using data to design and launch a new program.
- Existing Intervention Path: Requires the ACO to show how it will expand or improve an existing program and address unmet needs.
- RISE/CARA Path: Uses a falls prevention program and standardized measures to track beneficiary participation and engagement.

Table 3.5. Year 1 PQP Reporting Requirements by Intervention Path

Category	New Intervention Path	Existing Intervention Path	RISE / CARA Path
Category 1: Screening & Needs Assessment	• Describe the prevention areas you currently track, the screening tools (including screening for non-medical needs) you use, and how you follow up with beneficiaries after screening. • Explain how your ACO's data and findings led you to choose this intervention. • If you do not currently use screening tools, describe your plans to implement them and identify the data sources you will use (such as claims data, Community Health Needs Assessments (CHNAs), census data, or other public data sources). • Responses based only on national statistics, without ACO-specific data, will receive partial credit.	• In addition to the Category 1 New Intervention requirements, ACOs must complete a gap analysis that includes: • The number and percentage of eligible beneficiaries served in the past 12 months. • Gaps or unmet needs identified using beneficiary or population data. • How the LEAD intervention will address those gaps. • Responses that do not include a gap analysis will receive partial credit. If no clear gap can be identified, the existing Intervention path may not be the best fit.	▪ Identify RISE as your selected intervention and confirm participation in CARA. • Describe how you identify beneficiaries at risk for falls using claims data, such as prior falls, emergency department visits, or use of high-risk medications. • Describe why RISE will be impactful and what percentage of aligned beneficiaries are in the target population of the intervention.
Category 2: Population Identification & Partnerships	• Identify the condition category, target population, number of eligible beneficiaries, data sources, and whether there are community partnerships in place that help the ACO address the needs of these beneficiaries or will assist in implementing the intervention (yes/no and details). • The target population must be at least 5% of total aligned beneficiaries to receive full credit. Smaller populations must be clearly justified.	• Same required elements as the New Intervention pathway. ACOs in this category should demonstrate a reasonable increase in their target population or meet another approved expansion criterion (an increase of approximately 20% is generally considered meaningful, though smaller increases may qualify if the ACO demonstrates high existing reach or limited opportunities for further expansion).	• Identify the falls-risk population using claims-based criteria (e.g., at least 5% of total aligned beneficiaries). • Describe any community partnerships that support falls prevention or care coordination.
Category 3: Draft Intervention & Goals	• Describe the intervention name, activities, how it is delivered, and how long it lasts. Include at least three evidence sources.	• Describe the current program and the LEAD expansion, clearly showing what is new or different. Include at least three evidence sources, with at	• Program Engagement goal specifications: Numerator: RISE episode initiation rate Denominator: Falls-risk eligible population

Category	New Intervention Path	Existing Intervention Path	RISE / CARA Path
	• Set a Program Engagement goal based on program capacity or available data.	least one focused on expansion. • Set a Program Engagement goal based on baseline.	• Describe how this goal will impact the target population.

Category 3 goals are established in Year 1 and may be refined in Year 2. The Program Engagement goal is required across the full model, and improvement in program engagement and maintaining an engagement threshold becomes an accountability measure starting in Year 3. More details about the Program Engagement goal, including targets and thresholds, will be provided in forthcoming PQP Methodology Guidance.

The selected pathway (New, Existing, or RISE/CARA) in Year 1 determines scoring for the duration of the model and may only be changed with CMS approval. To assist LEAD ACOs in developing a PQP, CMS will provide a standardized, user-friendly form that can be completed and updated annually. LEAD ACOs will submit PQP data to CMS in a form and manner, and by a date, specified by CMS. Before each submission deadline, CMS will provide a list of required components for inclusion in the annual submission. CMS will release additional information on reporting timelines and related guidance later this year.

3.5.2 PQP Adjustment Scoring Methodology

Table 3.6 shows how ACOs are scored in Year 1 when developing interventions. It compares New Intervention, Existing Intervention, and RISE/CARA across needs, design, and goals. Each pathway has the same total points, but different requirements based on path type.

Table 3.6. PQP Scoring

Area	Points	New Intervention	Existing Intervention	RISE / CARA
1. Needs Assessment / Population Identification	2.0	To receive full credit, ACOs must provide ACO-specific data, clearly define screening, referral to clinical or community-based resources, and follow-up processes, and identify appropriate data sources.	Includes a clear description of current screening activities and a complete gap analysis identifying the percentage of eligible beneficiaries served, unmet needs or care gaps, and how the intervention addresses those gaps.	Provides a claims-based approach to identifying the falls-risk population and includes confirmation of RISE selection and CARA participation.
2. Intervention Plan	2.0	Describes a new intervention using required design	Provides a plan outlining meaningful expansion of the intervention,	Provides a clear RISE delivery plan (services, processes, care team).

		elements; target population ≥5% of aligned beneficiaries.	including the target population, proposed increase in reach and relevant community-clinical partnerships.	Demonstrates a clearly defined falls-risk cohort and identifies community-clinical partnerships that support implementation.
3. Goals	1.0	Provides a complete intervention design supported by at least three strong evidence sources and a clearly defined program engagement goal.	Demonstrates a clear baseline and program expansion, supported by at least three evidence sources, and establishes a goal based on measurable improvement from baseline performance.	RISE episode initiation goal with clearly defined denominator
Total	5.0			

3.5.3 PQP Submission, Review and Approval Process

The PQP submission, approval process, and timeline will be included in the detailed guidance document released in Fall 2026.

3.6 HPP Bonus Determination

Beginning in PY 2028, LEAD ACOs will be eligible to receive additional payments from the HPP if they (1) receive a CI/SEP score of 1 or receive both a CI/SEP score of 0 and the full PQP Reporting Adjustment and (2) have an average percentile rank of 70% or greater across all claims-based Quality Measures.

The steps to determine whether a LEAD ACO receives an HPP bonus payment are below:

1. ***Determine HPP total fund amount ($)***: The HPP will be funded from the amount of the quality withholds not earned back by LEAD ACOs with 50% of the remaining, unearned withhold amount contributing to the HPP. For example, if an ACO earns back 2.85% of its 3% quality withhold, it contributes 50% of the remaining 0.15% to the HPP.
2. ***Apply HPP eligibility criteria***: CMS determines which LEAD ACOs qualify for the HPP. Eligible ACOs are those that: Receive a CI/SEP score of at least 1 or receive both a CI/SEP score of 0 and the full PQP Reporting Adjustment; and achieve an average percentile rank of at least 70% across the LEAD quality measure set for the Performance Year.

3. ***Count total number of HPP beneficiary months***: CMS adds the number of aligned beneficiary months in the Performance Year across each LEAD ACO that meets the HPP criteria.
4. ***Determine HPP per beneficiary per month (PBPM) bonus rate ($)***: CMS divides the HPP total fund amount (from Step 1) by the total number of HPP beneficiary months (from Step 3).
5. ***HPP bonus applied***: ACOs that are eligible for the HPP receive a bonus that is the product of the HPP PBPM bonus rate (from Step 4) multiplied by the LEAD ACO's number of model eligible months across aligned beneficiaries. The HPP bonus is added to the ACO's Other Monies Owed during Final Financial Settlement. For a high-performing LEAD ACO, the value of the Quality Withhold Earned Back plus the HPP bonus may exceed the LEAD ACO's initial 3% Performance Year Benchmark Withhold.

3.7 Application of Quality Assessment to Final Financial Settlement

This section summarizes the process for determining how quality measurement and performance affect Final Financial Settlement, using PY 2027 as an example. The steps are:

1. CMS develops QPBs for each pay for performance (P4P) measure.
2. Quality Measure points are awarded: P4P Quality Measures are compared to their respective QPBs to determine performance levels and the corresponding number of points earned (each measure is worth 10 points).
3. The Initial Quality Score is calculated as the percentage of points earned from all measures out of the total possible points (50).
4. The Initial Quality Score is adjusted based on dQM/eCQM and PQP reporting. For PY 2027, LEAD ACOs can earn up to an additional 2.5 percentage points for reporting dQM/eCQM data and up to an additional 5 percentage points for PQP reporting. The Total Quality Score is capped at 100%.
5. The Quality Score percentage is multiplied by the 3% Quality Withhold to calculate the Quality Withhold Earn Back. For PY 2027, the maximum Quality Withhold Earn Back is 3%.

3.7.1 CMS Develops QPBs for Each P4P Measure (Step 1)

The LEAD Model will not differentiate between High Needs and non-High Needs population ACOs. Instead, support for High Needs beneficiaries will be incorporated across all ACOs. CMS will assess ACO performance using a single set of QPBs for each measure, rather than separate benchmarks by ACO type.

For ACR, DAH, and UAMCC, CMS will apply High Needs stratification to ensure a fair and accurate measurement approach for ACOs that care for High Needs beneficiaries. Each ACO's beneficiary population will be divided into High Needs and non-High Needs groups, with CMS

determining which beneficiaries meet the High Needs eligibility criteria. CMS will calculate separate scores for each of the three measures for both groups. Those scores will then be standardized and blended, weighted by the volume of High Needs beneficiaries, to produce a composite measure score for each ACO. CMS will compare each composite score against a single set of QPBs for the applicable measure, regardless of ACO type or the proportion of High Needs beneficiaries.

CMS will not use weighted stratification for TFU because it is a non-risk-adjusted measure designed to apply uniformly across all beneficiary populations. CMS will use a single TFU benchmark for all ACOs without modifications.

Using DAH as an example, if an ACO's High Needs beneficiaries represent 77% of its population, the High Needs mean score is 318.08 days, and the non-High Needs score is 354.52 days, then the High Needs and non-High Needs Weighted Stratification Composite score is 326.46 days ([318.08 × 0.77] + [354.52 × 0.23]).

Table 3.7 shows how a LEAD ACO's performance scores would be placed into percentile groups. In this example, an ACR WSC score of 14.90% would place the ACO in the 50th percentile group. A DAH WSC score of 340.94 mean days would place it in the 75th percentile group, and a TFU follow-up rate of 75.52% would place it in the 85th percentile group. The UAMCC WSC score of 37.81 admissions per 100 person-years would fall below the 30th percentile.

Table 3.7 illustrates a hypothetical example. **These are not the final QPBs** and are not intended to indicate the final QPBs.

Table 3.7. Hypothetical QPBs for ACO Claims Measure Scores

Percentile	30th	35th	40th	45th	50th	55th	60th	65th	70th	75th	80th	85th	90th
ACR	15.11	15.06	15.01	14.97	14.92	14.88	14.84	14.80	14.75	14.71	14.66	14.59	14.51
DAH	325.23	326.45	328.12	330.78	331.56	332.84	334.02	336.45	338.32	339.80	340.24	341.35	342.09
TFU	63.73	64.94	65.82	66.85	67.65	68.48	69.47	70.34	71.25	72.34	73.56	75.00	76.77
UAMCC	34.68	34.07	33.45	32.87	32.37	31.79	31.25	30.70	30.14	29.46	28.87	28.10	27.06

ACR = All-condition readmission; DAH = Days at Home; QPB = Quality Performance Benchmark; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

One benefit of using concurrent benchmarks is that CMS can calculate a corresponding set of QPBs for any performance period. CMS will provide provisional claim-based QPBs to LEAD ACOs in their quarterly reports; these provisional QPBs will be calculated using data from the same reporting period (for example, April 1, 2026–March 31, 2027, for PY 2027 Q1). CMS will update the provisional claim-based QPBs in each subsequent quarterly report with data from the same

period being used to measure scores. Because the LEAD ACO performance scores and QPBs will be based on the same time period and have the same risk-adjustment coefficients, LEAD ACOs will have a more accurate picture from quarter to quarter of their performance relative to the QPBs.

3.7.2 Quality Measure Points Awarded: P4P Quality Measures Are Compared Against Their QPBs to Determine Performance Levels (Step 2)

Each Quality Measure will be worth 10 points. For PY 2027 LEAD ACOs can earn up to 50 points based on five quality measures. CMS will use the QPBs to determine the number of points each LEAD ACO will earn for each Quality Measure. ACOs scoring below the 30th percentile will receive no points for that measure. ACOs scoring at or above the 90th percentile will receive the full 10 points possible for that measure. ACOs scoring between the 30th and 90th percentiles will earn points for the Quality Measure, as indicated in **Section 3.2**.

3.7.3 Calculate the Initial Quality Score (Step 3)

After determining performance levels and points awarded for each measure, CMS calculates the Initial Quality Score.

The Initial Quality Score is equal to the percentage of total possible points earned across all measures. There are five Quality Measures (CAHPS, ACR, DAH, TFU and UAMCC). Each measure is worth 10 points, with a total of 50 possible points. Thus, the Initial Quality Score is the sum of the individual Quality Measure points divided by 50 and converted to a percentage value. The Initial Quality Score is a percentage with a possible range from 0% to 100%.

Initial Quality Score = [∑ (Quality Measure Points) / 50] ×100%

3.7.4 Calculate the dQM/eCQM Reporting Adjustment (Step 4)

For PY 2027 and PY 2028, dQM/eCQM data may be eligible for an upward adjustment of up to 2.50 percentage points. Each measure, CBP and GSD, is worth 1.25 percentage points. To receive credit, LEAD ACOs must successfully submit the required dQM/eCQM data in accordance with CMS reporting specifications, use an approved submission pathway, and include all data elements needed to calculate each measure.

3.7.5 Calculate the PQP Reporting Adjustment (Step 5)

Year 1 is the PQP planning year, during which LEAD ACOs may receive an adjustment of up to 5 percentage points. This adjustment includes up to 2 percentage points for *Needs Assessment/Population Identification*, up to 2 percentage points for the *Intervention Plan*, and up to 1 percentage point for *Goals*. Additional information on the PQP Reporting Adjustment is available in **Section 3.7.2**.

3.7.6 Total Quality Score Is Multiplied by the Quality Withhold to Determine a LEAD ACO's Quality Withhold Earn Back (Step 6)

In PY 2027, the dQM/eCQM and PQP Reporting Adjustments will be added to the Initial Quality Score. These adjustments cannot increase the resulting Total Quality Score above 100%. For example, if a LEAD ACO has an Initial Quality Score of 95% and receives the maximum dQM/eCQM/PQP Reporting Adjustment of 7.5%, the LEAD ACO's Total Quality Score would be capped at 100%. CMS will calculate the Quality Withhold Earn Back by multiplying the Total Quality Score by the 3% Quality Withhold. The Quality Withhold Earn Back will always be between 0% and 3%.

Total Quality Score (capped at 100%) = (Initial Quality Score) + dQM/eCQM Reporting Adjustment + PQP Reporting Adjustment

Quality Withold Earn Back = Total Quality Score x 3%

4. Quality Measures, Data Collection, and Performance Rate Calculations

For PY 2027, CMS will measure quality of care for LEAD ACOs using five measures (see **Table 2.1**). Submission of data for two dQMs/eCQMs will be optional in PY 2027 and PY 2028. Beginning in PY 2029, CMS will measure quality of care for LEAD ACOs using a total of seven measures. Measures will apply to all LEAD ACOs. Measure Information Forms (MIFs) and Value Sets, which contain more detailed information on the measures, will be made available at a later date.

For PY 2027, the final Quality Measure scores will be based on a performance period that covers January 1, 2027, through December 31, 2027. Aligned beneficiaries with one or more alignment-eligible months during this performance period will be included in the Quality Measure calculations if they meet the Quality Measure inclusion criteria. The full 12-month performance period will be used for beneficiaries aligned at the beginning of the year.

This section describes the quality measures used to assess LEAD ACO performance. For each measure, the section provides a measure summary, rationale, denominator and numerator definitions, eligibility criteria, exclusions, and key calculation details. Together, these specifications define the population included in each measure, the outcomes or processes being assessed, and the methodology CMS will use to calculate measure performance. Unless otherwise specified, the measures apply to all LEAD ACOs participating in the model.

4.1 ACR

4.1.1 ACR Summary

Description: Risk-adjusted percentage of hospitalizations of LEAD ACO-assigned beneficiaries that result in an *unplanned* readmission to a hospital within 30 days following discharge from the index hospital admission.[3]

Measure Overview: ACR is an outcome measure calculated using 12 consecutive months of Medicare FFS claims data. The measure is a risk-standardized readmission rate (RSRR) that adjusts for stay-level factors and clinical and demographic characteristics. Lower RSRRs indicate better performance. This Quality Measure is adapted from CMS's Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Quality Measure.[4]

Rationale: Hospital readmissions are costly and often preventable.[5] They also disrupt patients and caregivers and put patients at additional risk of hospital-acquired infections and complications.[6] Some readmissions are unavoidable, but studies have shown that readmissions also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. High readmission rates and institutional variations in readmission rates indicate an opportunity for improvement. Given that interventions have been able to reduce 30-day readmission rates for a variety of medical conditions, it is important to include an all-condition 30-day readmission rate as a Quality Measure.

4.1.2 ACR Denominator and Numerator Information

Denominator Statement*:* All relevant hospitalizations for LEAD ACO–aligned beneficiaries 65 years of age or older at nonfederal, short-stay acute care, or critical access hospitals.

1. Admissions are eligible for inclusion in the denominator if the following criteria are met:
2. Patient is enrolled in Medicare FFS.
3. Patient is actively aligned to a LEAD ACO.
4. Patient is 65 years of age or older.
5. Patient was discharged from a nonfederal acute care hospital.
6. Patient did not die in the hospital.
7. Patient was not transferred to another acute care facility upon discharge.
8. Patient is enrolled in Medicare Part A for the 12 months before and including the date of the index admission.

A hospital readmission within 30 days will be eligible to be counted as an index admission included in the measure denominator calculation if the patient meets all other eligibility criteria. This allows the measure to capture repeated readmissions for the same patient, whether at the same hospital or another.

Denominator Exclusions:

1. Admissions for patients without 30 days of post-discharge data.
2. Admissions for patients lacking a complete enrollment history for the 12 months before admission.
3. Admissions to a Prospective Payment System–exempt cancer hospital.
4. Admissions for patients with medical treatment of cancer.
5. Admissions for primary psychiatric disease.
6. Admissions for rehabilitation care.
7. Admissions for patients discharged against medical advice.
8. Admissions for non-claims-based-aligned patients who were voluntarily aligned after January 1, 2027.

Numerator Statement: Risk-adjusted unplanned readmissions at a nonfederal, short-stay, acute care, or critical access hospital within 30 days of discharge from an index admission included in the denominator.

Numerator Exclusions: Planned readmissions are excluded—scheduled admissions are not considered signals of low-quality care. Planned readmissions are identified using procedure and diagnosis codes.

4.2 UAMCC

4.2.1 UAMCC Summary

Description: Rate of risk-standardized, acute, unplanned hospital admissions per 100 person-years among beneficiaries who are 66 years or older at the start of the measurement period, have multiple chronic conditions, and are aligned to the LEAD ACO.

Measure Overview: Like ACR, UAMCC is an outcome measure calculated using 12 consecutive months of Medicare FFS claims data. The measure is a risk-standardized acute admission rate (RSAAR) that adjusts for age, chronic disease categories, and other clinical and frailty risk factors present at the start of the 12-month measurement period. Lower RSAARs indicate better performance. This Quality Measure is adapted from the CMS hospital RSAAR Quality Measure.

Rationale: Patients with multiple chronic conditions account for a significant proportion of Medicare beneficiaries; they experience high morbidity and costs associated with their diseases and are more likely to have unplanned hospital admissions. Unplanned admissions are costly and potentially dangerous. However, research shows that effective health care can lower the risk of admission for patients with chronic diseases.[7,8,9,10,11,12] LEAD ACO program goals are fully aligned with the objective of lowering patient risk of acute care admissions—LEAD ACOs are expected to improve quality and outcomes by providing patient-centered care, engaging in

effective chronic disease management, promoting care coordination, adopting evidence-based practices, and supporting clinical process improvement.

4.2.2 UAMCC Denominator and Numerator Information

Denominator Statement: All LEAD ACO–aligned beneficiaries 66 years of age or older at the start of the measurement period with International Classification of Diseases, Version 10 (ICD-10) codes that fall into two or more of nine chronic disease groups: (1) acute myocardial infarction, (2) Alzheimer's disease and related disorders of senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) COPD and asthma, (6) depression, (7) heart failure, (8) stroke and transient ischemic attack, and (9) diabetes.

Denominator Exclusions:

1. Beneficiaries who do not have 12 months of continuous enrollment in Medicare Part A and Part B during the year before the measurement year (to ensure adequate claims data to identify beneficiaries).
2. Beneficiaries who do not have 12 months continuous enrollment in Medicare Parts A and B during the measurement year. Beneficiaries who die or enter hospice during the measurement period are not excluded if they are continuously enrolled in Medicare Parts A and B until death or entering hospice (the 12-month requirement is relaxed for these beneficiaries).
3. Patients enrolled in hospice during the year before the measurement year or at the start of the measurement year.
4. Patients without any visits (Primary Care Qualified Evaluation & Management or other) with any of the providers associated with the attributed LEAD ACOs during the measurement year and the year before the measurement year. Providers are linked to ACOs via Tax Identification Number (TIN) and National Provider ID combinations or CMS Certification Number (CCN) and National Provider ID combinations.
5. Patients not at risk for hospitalization at any time during the measurement year.
6. Non-claims-based-aligned patients who were voluntarily aligned after January 1, 2027.

Numerator Statement: Number of acute *unplanned* admissions per 100 person-years at risk for admission. Persons are considered at risk for admission if they are included in the denominator (as described above), alive, enrolled in FFS Medicare, and not currently admitted to an acute care hospital. The outcome includes inpatient admissions to an acute care hospital for any cause during the measurement year unless an admission is identified as "planned."

Numerator Exclusions:

1. Planned admissions are excluded—scheduled admissions are not considered signals of low-quality care. Planned admissions are identified using procedure and diagnosis codes.

2. Admissions that occur directly from a skilled nursing facility (SNF) or acute rehabilitation facility.
3. Admissions that occur within a 10-day "buffer period" after discharge from a hospital, SNF, or acute rehabilitation facility.
4. Admissions that occur after the patient has entered hospice.
5. Admissions related to complications from procedures or surgeries.
6. Admissions related to accidents or injuries.
7. Admissions that occur prior to the first visit with the assigned LEAD ACO.

4.3 DAH

4.3.1 DAH Summary

Description: Risk factor–adjusted, mortality-adjusted, nursing home transition–adjusted days at home, averaged over all patients within a LEAD ACO.

Measure Overview: This is a LEAD ACO–level measure of days spent at home or in community settings (in other words, not in acute care, such as inpatient hospital or emergent care settings, or post-acute settings, such as SNFs). The measure looks at adult Medicare FFS beneficiaries with complex, chronic conditions who are aligned to participating LEAD ACOs. An additional adjustment that accounts for patients' risk of transitioning to a long-term nursing home is also applied to incentivize community-based care in alignment with the Centers for Medicare & Medicaid Services (CMS) policy goals. A higher risk-adjusted score indicates better performance.

Rationale: The primary goal of the DAH measure is to promote high-quality coordinated care to keep adults with complex, chronic conditions in home or community settings and out of select acute, post-acute, or long-term care settings.

Generally, patients prefer to remain at home and avoid unnecessary hospitalizations and time in institutional settings. Days at home are associated with other important outcomes, including social activity and avoiding depression.[13] Timely and appropriate primary care and end-of-life care services can increase the number of days patients spend at home.[14] Several studies demonstrate that time spent at home differs substantially among older patients, which suggests that the quality of care and resulting days at home could be improved for the elderly population.[15,16]

4.3.2 DAH Denominator and Numerator Information

Denominator Statement: Eligible beneficiaries aligned to participating LEAD ACOs. Eligible beneficiaries must meet the following criteria:

1. Adult (18 years of age or older).
2. Alive as of the first day of the PY.
3. Continuously enrolled in Medicare FFS parts A and B during the full PY (up to date of death among patients who died) and one full year prior to the start of the PY.
4. An average Hierarchical Condition Category composite risk score ≥ 2.0 in the year before the PY.

The measure includes eligible beneficiaries who are aligned to a participating LEAD ACO, as determined by the model.

Denominator Exclusions: All patients meeting the denominator inclusion criteria are included, except for non-claims-based-aligned patients who were voluntarily aligned after January 1, 2027, who are excluded from the denominator.

Numerator Statement: The outcome measured for each eligible beneficiary is number of days spent "at home," adjusted for clinical risk factors and stratifications, risk of death, and risk of transitioning to a long-term nursing home. DAH are defined as those days when a beneficiary is alive and not in care.

A "day in care" is defined as any eligible patient day in the measurement year when a patient receives care in one or more of the following specified care settings: inpatient acute and post-acute facilities (short-term acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term care hospitals, and SNFs), emergency departments, and observation stays. There are two exceptions:

1. A patient is always considered "at home" if they are enrolled in hospice, even if they receive care in settings normally counted as "days in care" (in other words, a patient will have no measured days in care if they are in hospice).

   Rationale: to promote effective and appropriate care for terminally ill patients

2. Hospital admissions for childbirth, miscarriage, or termination are not counted as "days in care."

   Rationale: obstetric admissions may not indicate lower quality of care; counting these admissions may create perverse incentives in the care of pregnant patients

A "day at home" is defined as any eligible day that is not considered a "day in care" based on the above definition. "Eligible days" are all days in the measurement year that the beneficiary is alive.

Numerator Exclusions: Care in settings not listed above (including outpatient visits and procedures, hospice, residential psychiatric and substance abuse facilities, assisted living facilities and group homes, and home health and telehealth services) are not considered "days in care" in this measure; rather, they are treated as "days at home."

Finally, days spent in a long-term or residential nursing home (except for SNF care) are not counted as "days in care" by this definition. However, to encourage home- and community-based care in alignment with CMS' policy goals, this measure includes an adjustment that accounts for patients' risk of transitioning to a long-term nursing home.

4.4 TFU

4.4.1 TFU Summary

Description: LEAD ACO–level rate of follow-up for patients with chronic conditions who have experienced an acute exacerbation for one of six conditions of interest, which can be attributed to providers participating in the model.

Measure Overview: This is a measure of provider follow-up for patients with chronic conditions who have experienced an acute exacerbation of hypertension, asthma, heart failure, CAD, COPD, or diabetes. Specifically, this measure examines follow-up that can be attributed to providers participating in the Innovation Center LEAD Model. Results of the measure are aggregated at the LEAD ACO level. The Yale New Haven Health Services Corporation–Center for Outcomes Research & Evaluation respecified the TFU measure, which IMPAQ originally codified (Partnership for Quality Measurement #3455).

Rationale: Patients hospitalized or seen acutely in the emergency department and hospital outpatient departments for exacerbations of chronic conditions are at high risk of readmission and poorly coordinated care, which may increase health care spending, worsen health care outcomes, and result in poor quality of life. Evidence has shown that delivering clinically appropriate follow-up care and improving care coordination can improve health care outcomes, reduce readmissions, and reduce health care costs. The intent of the TFU measure is to encourage appropriate follow-up care and improve care coordination at discharge. A systematic review has demonstrated that, when coupled with other types of discharge support, TFU does positively contribute to health outcomes and is a key component of high-quality health care. We expect the TFU measure will encourage model participants to improve care coordination and produce long-term savings for their health care systems.

4.4.2 TFU Denominator and Numerator Information

Denominator Statement: The count of the LEAD ACO–level acute exacerbations for patients ages 18 years and older that require either an emergency department visit, observation stay, or inpatient stay (in other words, the count of acute events) for any of the following eight

condition cohorts: high-acuity CAD, high-acuity hypertension, asthma, heart failure, high-acuity diabetes, COPD, medium-acuity hypertension, and low-acuity CAD.

An acute encounter is assigned to one of the eight conditions if:

- The principal diagnosis is a sufficient code for that condition or
- The principal diagnosis is a related code for that condition AND at least one additional diagnosis is a sufficient code for that condition.

For conditions with different levels of acuity, the encounter is then assigned to the highest-acuity condition for which a code is present.

If the acute encounter meets the criteria for more than one condition cohort, the encounter is assigned to the condition cohort with a higher follow-up priority in the following order: CAD, high-acuity diabetes, heart failure, asthma, high-acuity hypertension, medium-acuity hypertension, COPD, and low-acuity CAD.

If a beneficiary has an acute encounter that begins on the same day or the day following another acute encounter, the claims are considered part of one continuous acute event. If the acute encounters that make up an acute event are assigned to different condition cohorts, the acute event is assigned to the condition cohort that occurs last chronologically. Following this methodology, only one condition is recorded in the denominator per acute encounter.

***Denominator Exclusions*:**

The measure excludes events with the following:

1. Subsequent acute events that occur 2 days after the prior discharge, but still during the follow-up interval of the prior event for the same reason. To prevent double counting, only the first acute event will be included in the denominator.
2. Acute events after which the patient does not have continuous enrollment for 2 months for all the condition groups, except the low-acuity CAD group, which requires continuous enrollment of 3 months.
3. Acute events where the discharge status of the last claim is not “to community” (note: “Left against medical advice” is not considered a discharge to community).
4. Acute events for which the calendar year ends before the follow-up window ends (for example, acute asthma events ending fewer than 14 days before December 31).
5. Acute events where the patient enters an SNF, non-acute care, or hospice care within the follow-up interval.
6. Acute events for non-claims-based-aligned patients who were voluntarily aligned after January 1, 2026.

7. Acute events for patients who are participating in the Guiding an Improved Dementia Experience (GUIDE) Model.
8. Acute events for patients less than 18 years of age.

Numerator Statement: The count of the LEAD ACO–level TFU denominator events (emergency room, observation hospital stays, or inpatient hospital stay for hypertension, asthma, heart failure, CAD, COPD, or diabetes for patients ages 18 years and older) where follow-up was received within the time frame recommended by clinical practice guidelines, as detailed below:

1. Hypertension: Follow-up within 14 days for high-acuity patients and 30 days for medium-acuity patients.
2. Asthma: Follow-up within 14 days of the date of discharge.
3. Heart failure: Follow-up within 14 days of the date of discharge.
4. CAD: Follow-up within 7 days for high-acuity patients or within 6 weeks for low-acuity patients.
5. COPD: Follow-up within 30 days of the date of discharge.
6. Diabetes: Follow-up within 14 days for high-acuity patients.

This measure is defined at the LEAD ACO level, meaning that results are aggregated for each participating entity in the ACO LEAD Model. The follow-up visit must occur within the condition-specific time frame to be considered timely and for the conditions of the numerator/measure to be met. A TFU visit is defined as a claim for the same patient after the acute event discharge date that is a non-emergency outpatient visit and has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up.

Numerator Exclusions: There are currently no numerator exclusions or exceptions for the measure. All patients meeting the numerator inclusion criteria are included.

4.5 CAHPS

4.5.1 CAHPS Composite Score Description

Description: A LEAD ACO–level summary of patient experience of care among beneficiaries surveyed through CAHPS. This measure, which is a composite of results across different CAHPS domains, applies to all LEAD ACOs. LEAD ACOs are required to collect and report this measure to CMS, which is done by contracting with and paying for a CAHPS Survey vendor. The vendor conducts the survey using mail and telephone follow-up and reports results to CMS. CMS may consider implementing a web-based mode for survey administration in the future.

Measure Overview: The CAHPS questionnaire used in LEAD is the CAHPS for ACO Survey with modifications relevant to patient/caregiver experience with care delivered by a LEAD ACO. The questionnaire asks patients about their experience with primary care services received from their provider during the past 6 months. Domains in the questionnaire include the extent to which patients could access care and information in a timely manner when needed, how well the patient's provider communicated with them, and whether the provider spoke with the patient about things they could do to promote their health.

Rationale: Person and family engagement in care is important to CMS and is part of the agency's quality strategy. Research shows that patients and families who have positive experiences with providers are more likely to be engaged with their care and adhere better to provider health care guidelines.[17,18,19]

Adherence to recommended guidelines, such as weight and blood sugar control, results in improved population health for all LEAD ACO–aligned beneficiaries. Additional research finds that positive patient experience indicates that providers have given high-quality care[20]; furthermore, positive patient experience is associated with improved clinical outcomes[21,22] and reduced costs[23] in some settings. Thus, patient experience is a lever capable of not only providing our beneficiaries with a better experience—which itself is valuable—but also spurring long-term benefits in clinical outcomes, population health, and costs within the LEAD Model.

CMS measures patient experience by applying CAHPS measurement science. This methodology asks patients to what extent certain provider behaviors took place. All the behaviors posed in the surveys are desirable and are hallmarks of quality care. CAHPS surveys give a standardized and objective measure that allows for equitable comparisons between entities.

4.5.2 Survey Administration and Procedures

LEAD ACOs will be responsible for selecting and contracting with a CMS-approved vendor to administer the CAHPS Survey. In Fall 2026, CMS will publish information on LEAD ACOs' CAHPS-related responsibilities and timelines in the 4i Knowledge Library. LEAD ACOs will need to select and contract with their CAHPS vendor by July 2027. The CMS LEAD Newsletter will proactively notify LEAD ACOs of all CAHPS information.

The CAHPS Survey uses mixed-mode data collection procedures. Sampled beneficiaries in the mail with telephone follow-up protocol will receive a pre-notification postcard via mail, followed by up to two survey mailings. After several weeks, sampled beneficiaries who do not respond by mail are contacted by telephone and invited to answer the survey via an interview. Beneficiaries may receive up to six telephone calls.

4.5.3 CAHPS Summary Survey Measure (SSM) Domains

The CAHPS measures are referred to as SSMs because the survey includes multiple questions for most of the measures. The SSMs included in the CAHPS Composite Score used in the calculation of the Initial Quality Score are:

1. Getting Timely Appointments, Care, and Information
2. How Well Providers Communicate
3. Care Coordination
4. Shared Decision Making
5. Patient Rating of Provider
6. Courteous and Helpful Office Staff

4.5.4 CAHPS Denominator and Numerator Information

Denominator Statement: The population of interest for the denominator is FFS beneficiaries of each LEAD ACO with recent visits for primary care services. We reach this population in several steps:

1. Create a sample of beneficiaries from claims for primary care services among LEAD ACO participating providers.
2. Send a survey to all sampled beneficiaries; follow up by telephone for nonresponse. This "mail with nonresponse telephone follow-up" survey methodology ensures enough responses to allow sufficient statistical precision to reliably distinguish between LEAD ACOs.
3. Create the denominator from all beneficiaries who answered the survey questions.

Denominator Exclusions: The following beneficiaries are excluded from the CAHPS Measure:

1. Beneficiaries who received care in recent visits but are now deceased.
2. Beneficiaries who are less than 18 years of age.
3. Beneficiaries in institutions.
4. Beneficiaries receiving the hospice benefit.
5. Beneficiaries sampled for some other concurrent CAHPS surveys.
6. Beneficiaries residing outside the United States, Puerto Rico, or the Virgin Islands.
7. Beneficiaries who received less than two primary care service visits with a provider from the LEAD ACO during the lookup period.
8. Beneficiaries who have a language or disability barrier that prevents them from completing the survey and do not have someone who can assist them or act as a proxy for them.

A LEAD ACO can be excluded from the CAHPS data collection for a particular PY if that LEAD ACO does not have enough beneficiaries with recent primary care visits for a reliable CAHPS Survey to be conducted.

Numerator Statement: We will assign values to survey questions included in each SSM; values will be based on patient responses and combined to calculate the SSMs. Each question in an SSM will be equally weighted (see **Section 4.5.5**).

Numerator Exclusions: Beneficiaries who elect to not answer a question are excluded from calculation. Similarly, beneficiaries who screen out of a question are excluded from the calculation. An example screening question is whether the provider ordered a blood test, x-ray, or other test in the last 6 months. If the beneficiary answered "no" to the screening question, the beneficiary would screen out of the measure question about whether someone followed up with them about the results of that test.

4.5.5 Calculation of CAHPS SSM Performance Rates

After the LEAD CAHPS Survey data are collected, the scoring phase begins. We will use the CAHPS Macro to calculate the patient-mix adjusted SSMs for each LEAD ACO. We will use the same set of patient-mix adjusters as the Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program with two exceptions. The patient-mix adjusters will also potentially include age, education, overall and mental health, indicators of Medicaid dual eligibility/eligibility for low-income subsidy status, and whether another person helped the respondent complete the survey.

Using the CAHPS Macro, we will re-estimate the patient-mix adjuster coefficients for each survey period.

4.6 dQMs/eCQMs

4.6.1 Controlling High Blood Pressure Measure (CBP) Summary

Description: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

Measure Overview: Controlling High Blood Pressure is an outcome measure that evaluates the percentage of patients aged 18–85 years with diagnosed hypertension whose blood pressure is adequately controlled during the measurement period. The measure assesses whether a patient's most recent blood pressure reading is below the established threshold for control, supporting the prevention of cardiovascular complications associated with hypertension.

Higher performance rates indicate more effective blood pressure management and improved quality of care for patients with hypertension.

Rationale: High blood pressure is common; according to the American Heart Association, between 2013-2016, approximately 121.5 million US adults >= 20 years of age had HBP and the prevalence of hypertension among US adults 65 and older was 77.0 percent.[24] In an analysis of adults with hypertension in National Health and Nutrition Examination Survey (NHANES), the estimated age-adjusted proportion with controlled blood pressure (BP) increased from 31.8 percent in 1999 to 53.8 percent in 2014. However, that proportion declined to 43.7 percent in 2017 to 2018.[25]

HBP increases risks of heart disease and stroke which are two of the leading causes of death in the US.[26] A person who has HBP is four times more likely to die from a stroke and three times more likely to die from heart disease.[26] The National Center for Health Statistics reported that in 2020 there were over 670,000 deaths with HBP as a primary or contributing cause.[27] Between 2009 and 2019 the number of deaths due to HBP rose by 65.3 percent.[28] Managing and treating HBP would reduce cardiovascular disease mortality for males and females by 30.4 percent and 38.0 percent, respectively.[28] HBP costs the U.S. approximately 131 billion dollars each year, averaged over 12 years from 2003 to 2014.[29] A study on cost-effectiveness on treating hypertension found that controlling HBP in patients with cardiovascular disease and systolic blood pressures (SBP) of >= 160 mmHg could be effective and cost-saving.[30]

4.6.2 CBP Denominator and Numerator Information

Denominator Statement: Patients 18-85 years of age by the end of the measurement period who had a visit during the measurement period and diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period.

Denominator Exclusions:

1. Exclude patients who are in hospice care for any part of the measurement period.
2. Exclude patients 66-80 by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
    a. Advanced illness diagnosis during the measurement period or the year prior
    b. OR taking dementia medications during the measurement period or the year prior.
3. Exclude patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period.

4. Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
5. Exclude patients receiving palliative care for any part of the measurement period.
6. Exclude patients with evidence of end stage renal disease (ESRD), dialysis, or kidney transplant before or during the measurement period.
7. Exclude patients with a diagnosis of pregnancy during the measurement period.

Numerator Statement: Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Numerator Exclusions: None.

For additional information on the dQM/eCQM specifications, please refer to CMS 165v15 - Controlling High Blood Pressure listed on the eCQI Resource Center. For data submissions through the Innovation Support Platform's (ISP) Health Data Reporting (HDR) application, documentation will be provided at a later date.

4.6.3 Diabetes: Glycemic Status Assessment Greater Than 9% (GSD) Measure Summary

Description: Percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) > 9.0% during the measurement period.

Measure Overview: Diabetes: Glycemic Status Assessment Greater Than 9% is an outcome measure calculated by dividing the number of patients aged 18–75 years with diabetes whose most recent hemoglobin A1c (HbA1c) level during the measurement period is greater than 9.0%, or who did not have an HbA1c test performed during the measurement period, by the total number of eligible patients with diabetes in the denominator. The resulting percentage represents the proportion of diabetic patients with inadequate glycemic management. Lower performance rates on this measure reflect better quality of care, as they indicate fewer patients with inadequately controlled blood glucose levels. This measure is used to assess the effectiveness of diabetes management and highlights patients who may be at increased risk for diabetes-related complications.

Rationale: Diabetes is the eighth leading cause of death in the United States. In 2021, diabetes affected more than 38 million Americans (11.6 percent of the U.S. population) and killed more than 103,000 people.[31] Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly.[32] People with diabetes are

at increased risk of serious health complications including vision loss, heart disease, stroke, kidney damage, amputation of feet or legs, and premature death.[33]

In 2022, diabetes cost the U.S. an estimated $413 billion: $307 billion in direct medical costs and $106 billion in reduced productivity. The direct medical cost of diabetes increased by 7 percent between 2017 and 2022.[34]

Controlling A1c blood levels helps reduce the risk of microvascular complications (eye, kidney and nerve diseases). [33]

4.6.4 GSD Denominator and Numerator Information

Denominator Statement: Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period.

Denominator Exclusions:

1. Exclude patients who are in hospice care for any part of the measurement period.
2. Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
3. Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
    a. Advanced illness diagnosis during the measurement period or the year prior
    b. OR taking dementia medications during the measurement period or the year prior
4. Exclude patients receiving palliative care for any part of the measurement period.

Numerator Statement: Patients whose most recent glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is >9.0% or is missing or was not performed during the measurement period.

Numerator Exclusions: None.

For additional information on the eCQM specifications, please refer on the CMS 122v15 - Diabetes: Glycemic Status Assessment Greater Than 9% listed on the eCQI Resource Center. For data submissions through the Innovation Support Platform's (ISP) Health Data Reporting (HDR) application, documentation will be provided at a later date.

4.7 Submission Procedures

For LEAD ACOs that choose to submit dQMs/eCQMs data in PY 2027, must be submitted using one of the LEAD-approved submission formats. Submission of dQM data becomes required in PY 2029. Additional submission instructions for each option will be at a later date.

4.7.1 dQM/eCQM Data Submission

Submission Options:

Option 1) Excel template submitted via HDR

For participants that do not have the data infrastructure needed to support FHIR-based API submission, CMS has mapped the data elements required to report the Controlling High Blood Pressure and the Diabetes: Glycemic Status Assessment Greater Than 9% quality measures to the FHIR standard so that these data elements can be collected via an Excel-based template. ACOs can use this template to submit this data to CMS. ACOs can programmatically populate the template from their EHR or Health IT system. Reporting will be at the beneficiary level. The Excel spreadsheet must be submitted through the ISP HDR application. The template used for data submission must be the official template downloaded from the HDR application as it includes the needed metadata to support real-time validations.

CMS will provide a sample template in the coming months. This sample will provide details on the data elements that need to be collected, the data formats and value sets required, and the validation rules that will be applied to the data. There will also be a sample of accurately reported beneficiary-level data included to support you in preparing your systems to collect and share the data. The official template will be available for download closer to the start of the submission window. You will also have an opportunity in advance of the submission window to test uploading data into the HDR application.

This submission format used for HDR allows LEAD ACOs that do not yet have FHIR functionality to begin the transition to FHIR API submission by mapping their data to the necessary FHIR formats. As their capabilities evolve, LEAD ACOs can transition smoothly from the Excel template-based submission to a FHIR API transaction.

Option 2) HL7 Fast Healthcare Interoperability Resources® (FHIR®) API

FHIR APIs are designed to facilitate interoperability while maintaining the highest standards of security, privacy, and data integrity required in healthcare environments. The LEAD FHIR API will support Representational State Transfer (REST) operations to exchange FHIR resources to provide a method for secure, standards-based communication between systems.

LEAD ACOs with FHIR-enabled systems will work with their vendors/internal technology teams to establish a workflow for extracting the data elements needed to submit to CMS to facilitate calculating the Controlling High Blood Pressure and Diabetes: Glycemic Status Assessment Greater Than 9% quality measures. The required FHIR resources will be submitted to CMS via FHIR resource bundles for the two measures. These will be submitted to the CMS LEAD API endpoints. FHIR reporting will be at the beneficiary level. CMS will provide a LEAD Implementation Guide (IG) that details the required data elements; necessary FHIR resources and profiles; terminology and value set constraints; validation rules; and API workflows for submitting data to CMS.

The LEAD API will be conformant with the Office of the National Coordinator (ONC) Standardized API for patient and population services (§ 170.315(g)(10)). These are generally referred to as the "g10" standards. As of January 1, 2026, this means the APIs will be conformant with HL7 Version 4.0.1 (R4), HL7 FHIR US Core Implementation Guide (IG) 6.1.0, and the United States Core Data for Interoperability (USCDI) Version 3. The LEAD IG will include detailed examples of successful submissions and provide information to help you prepare your system to share the data. LEAD participants will have an opportunity to test FHIR-based submissions in a CMS testing environment in the months ahead of the initial submission window. Details on the testing timeline and the process for receiving testing and production credentials will be shared closer to the start of the testing window.

Both the FHIR IG and HDR-Excel spreadsheet will be made available at a later date.

Option 3) Quality Reporting Document Architecture (QRDA)

HDR-Excel and FHIR are the two primary reporting options. However, LEAD ACOs may temporarily report Controlling High Blood Pressure and Diabetes Glycemic Status Assessment data via QRDA. QRDA is the HL7 standard XML-based format that is used to submit eCQM data to CMS. If your ACO participates in QPP through the MIPS reporting pathway, QRDA III files may be submitted through your QPP submission. LEAD ACOs are encouraged to engage their EHR and quality reporting vendors to ensure that all systems and processes are aligned with current performance year's requirements.

Data validation and submission testing: All submission formats will be subject to validation checks at the time of submission. Validation ensures that submitted data meets required formatting standards and that all required data elements are present. If errors are identified, corrected data will need to be resubmitted.

CMS will provide opportunities for LEAD ACOs using the HDR Excel template and FHIR API submission options to participate in submission testing. For the HDR option, submission testing generally occurs one to two weeks prior to the start of a submission period. For FHIR API

testing, testing windows will be provided at multiple intervals prior to data submission to support API development. During these testing sessions, ACOs will be able to verify successful connection to the LEAD API endpoints, practice submitting required data elements for both the Controlling High Blood Pressure and Diabetes: Glycemic Status Assessment Greater Than 9% quality measures and validate submitted data. A successful test submission is required to receive production FHIR credentials. Further information regarding all three data submissions will be communicated at a later date.

Performance periods and submission timelines: dQM/eCQM data submission will be required for each performance year with the submission window occurring after the conclusion of the performance year. Timelines for PY 2027 and PY 2028 are detailed in **Table 4.1**. Submission timelines for PYs 2029 and beyond will be available in future iterations of the LEAD Quality Measurement Methodology Report.

Table 4.1. PY 2027 and PY 2028 dQM/eCQM Submission Timeline

Performance Year	Performance Period	Submission Period	Submission Requirement
PY 2027	1/1/2027-12/31/2027	January – March 2028*	Optional
PY 2028	1/1/2028-12/31/2028	January – March 2029*	Optional

* = Exact submission dates for PY 2027 will be available in Fall 2026.

4.8 Quality Measure Resources

MIFs and value sets for claims-based measures will be available prior to the start of PY 2027. Additional measure documentation will be made available each PY for further guidance and technical information.

5. Worked Examples of Quality Score Calculations

The following subsections provide worked examples of selected scenarios for PY 2027.

5.1 Worked Examples of the Final Earn-Back Rate Calculation for PY 2027

For PY 2027, the Quality Withhold will equal 3% of the Financial Benchmark. The Earn-Back Rate of the Quality Withhold will be determined using five P4P Quality Measures for all LEAD ACOs, with each measure weighed equally in the calculation of the Initial Quality Score. The Total Quality Score incorporates the dQM/eCQM and PQP Reporting Adjustment. The Total Quality Score can range from 0% to 100% and is used to determine the Quality Withhold Earn Back. Worked examples for PY 2027are provided below.

ACO That Meets Both Adjustments

Table 5.1 presents calculations for a hypothetical LEAD ACO that submitted data for both the dQM/eCQM and PQP Reporting Adjustments.

Table 5.1. Final Earn-Back Rate Calculation, PY 2027 Example: LEAD ACO with dQM/eCQM and PQP Reporting Adjustments

	Measure	Points Earned	Points Possible
	1. ACR	7.5	10.0
	2. UAMCC	9.25	10.0
	3. DAH	8.5	10.0
	4. TFU	0	10.0
	5. CAHPS	10.0	10.0
	Total Points	35.25	50.0
	Initial Quality Score (0%–100%) Points earned/points possible × 100	70.50%	
Adjustments to Total Quality Score	*dQM/eCQM Reporting Adjustment* a) CBP data was submitted – 1.25 percentile points b) GSD data was submitted – 1.25 percentile points	2.50%	
Adjustments to Total Quality Score	*PQP Reporting Adjustment* a) Needs Assessment / Population Identification –2 percentile points b) Intervention Plan – 2 percentile points c) Goals –1 percentile point	5.00%	

	Measure	Points Earned	Points Possible
	Total Quality Score (0%–100%) (Initial Quality Score + dQM/eCQM Reporting Adjustment + PQP Reporting Adjustment) *70.50* + 2.50 *+ 5.00*	78.00%	
Impact on Financial Settlement	*Quality Withhold Earned Back (0%–3%)* Total Quality Score × 3% Quality Withhold *78.00% × 3.00%*	2.34% of the financial benchmark	

Notes: This example assumes the following for the hypothetical ACO: (1) ACR measure score corresponding to the 32.1 percentile; (2) UAMCC measure score corresponding to the 68.9 percentile; (3) DAH measure score corresponding to the 51.0 percentile; (4) TFU measure score corresponding to the 26.8 percentile. (5) 90.0 percentile or better performance on all eight SSMs for a full 10 points for each SSM and a total of 80 out of 80 possible CAHPS SSM points earned; (6) LEAD ACO reported data on CPB and GSD measures. (7) ACO successfully reported all three PQP categories.

Appendix A: Timelines for PY 2027

Appendix B: LEAD ACO Consumer Assessment of Healthcare Providers and Systems (CAHPS)

B.1 Vendor Selection

LEAD ACOs will be responsible for selecting and contracting with a CMS-approved vendor to administer the CAHPS Survey. In Fall 2026, CMS will publish information on LEAD ACOs' CAHPS-related responsibilities and timelines in The Innovation Center's 4i Knowledge Library and on the LEAD Model website. For PY 2027, LEAD ACOs will need to select and contract with their CAHPS vendor by July 2027. The CMS LEAD ACO Newsletter will continue to proactively notify LEAD ACOs of all CAHPS information.

B.2 CAHPS Questions Making Up Each SSM

The questions making up the LEAD ACO CAHPS Survey, and the associated Summary Survey Measure (SSM) they compose, are shown in the table below.

Item #	Full CAHPS Questions Text	SSM for Scored Items
1.	Our records show that you visited the provider named below in the last 6 months [PROVIDER NAME]. Is that right? (If no, go to Q26)	N/A
2.	Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?	N/A
3.	How long have you been going to this provider?	N/A
4.	In the last 6 months, how many times did you visit this provider to get care for yourself? (If None, go to Q26)	N/A
5.	In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that needed care right away? (If no, go to Q7)	N/A
6.	In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	Getting Timely Care, Appts, Info

Item #	Full CAHPS Questions Text	SSM for Scored Items
7.	In the last 6 months, did you make any appointments for a check-up or routine care with this provider? (If no, go to Q9)	N/A
8.	In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	Getting Timely Care, Appts, Info
9.	In the last 6 months, did you contact this provider's office with a medical question during regular office hours? (If no, go to Q11)	N/A
10.	In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?	Getting Timely Care, Appts, Info
11.	In the last 6 months, how often did this provider explain things in a way that was easy to understand?	How Well Providers Communicate
12.	In the last 6 months, how often did this provider listen carefully to you?	How Well Providers Communicate
13.	In the last 6 months, how often did this provider seem to know the important information about your medical history?	Care Coordination
14.	In the last 6 months, how often did this provider show respect for what you had to say?	How Well Providers Communicate
15.	In the last 6 months, how often did this provider spend enough time with you?	How Well Providers Communicate
16.	In the last 6 months, did this provider order a blood test, x-ray, or other test for you? (If no, go to Q20)	N/A
17.	In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?	Care Coordination
18.	In the last 6 months, did you and this provider talk about starting or stopping a prescription medication? (If no, go to	N/A

Item #	Full CAHPS Questions Text	SSM for Scored Items
	Q22)	
19.	When you and this provider talked about starting or stopping a prescription medicine, did this provider ask what you thought was best for you?	Shared Decision Making
20.	In the last 6 months, did you and this provider talk about how much of your personal health information you wanted shared with your family or friends?	Shared Decision Making
21.	Using any number from 0 to 10, where 0 is the worst number and 10 is the best provider possible, what number would you use to rate this provider?	Patient's Rating
22.	In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?	Courteous and Helpful Office Staff
23.	In the last 6 months, how often did the clerks and receptionists at this provider's office treat you with courtesy and respect?	Courteous and Helpful Office Staff
24.	Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, or doctors who specialize in one area of health care. Is the provider named in Question 1 of this survey a specialist?	N/A
25.	In the last 6 months, did you try to make any appointments with specialists? (If no, go to Q29)	N/A
26.	In the last 6 months, how often was it easy to get appointments with specialists?	Access to Specialists (Not Scored)
27.	Your health care team includes all the doctors, nurses, and other people you see for health care. In the last 6 months, did you and anyone on your health care team talk about a healthy diet and healthy eating habits?	Health Promotion and Education

Item #	Full CAHPS Questions Text	SSM for Scored Items
28.	In the last 6 months, did you and anyone on your health care team talk about the exercise or physical activity you get?	Health Promotion and Education
29.	In the last 6 months, did you take any prescription medicine? (If no, go to Q34)	N/A
30.	In the last 6 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?	Care Coordination
31.	In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?	Stewardship of Patient Resources
32.	In the last 6 months, did anyone on your health care team ask you if there was a period of time when you felt sad, empty, or depressed?	N/A
33.	In the last 6 months, did you and anyone on your health care team talk about things in your life that worry you or cause you stress?	N/A
34.	In general, how would you rate your overall health?	Health Status and Functional Status (Not scored)
35.	In general, how would you rate your overall mental or emotional health?	Health Status and Functional Status (Not scored)
36.	In the last 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?	N/A
37.	Is this a condition or problem that has lasted for at least 3 months?	Health Status and Functional Status (Not scored)
38.	Do you now need or take medicine prescribed by a doctor?	N/A

Item #	Full CAHPS Questions Text	SSM for Scored Items
39	Is this medicine to treat a condition that has lasted for at least 3 months?	Health Status and Functional Status (Not scored)
40.	In the last 6 months, were any of your visits for your own health care… (In person, by phone, by video call)	N/A
41.	During the last 4 weeks, how much of the time did your physical health interfere with your social activities (like visiting with friends, relatives, etc.)?	N/A
42.	What is your age?	N/A
43.	Are you male or female?	N/A
44.	What is the highest grade or level of school that you have completed?	N/A
45.	Did someone help you complete this survey?	N/A
46.	How did that person help you? Mark one or more.	N/A

Endnote

[1] https://ecqi.healthit.gov/glossary/d
[2] https://ecqi.healthit.gov/dqm/about-dqms
[3] An index hospital admission is any eligible admission to an acute care hospital assessed in the measure for the outcome (readmitted or not within 30 days).
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