

ISSUE BRIEF

What CMS's New Medicaid Quality Pledge Means for the Future of Measurement

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INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) launched the Investing in Health Outcomes (IHO) initiative September 25, 2026, with a founding group of 37 states that have made a voluntary Medicaid Quality Pledge to shift their Medicaid and Children's Health Insurance Program (CHIP) quality strategy toward the outcomes that matter to enrollees. The goal is to redirect policy, tools, data, and improvement resources away from an expansive inventory of process-oriented requirements and toward a more focused system that can demonstrate progress in prevention, chronic disease management, and behavioral health.

That shift matters now because Medicaid agencies, managed care entities, providers, and vendors are being asked to improve outcomes while managing extensive and often duplicative performance reporting expectations. CMS reported that its review of managed care programs in 42 states identified approximately 450 reporting requirements corresponding to roughly 260 unique quality measures, many focused on processes and utilization. A smaller, more coherent portfolio could reduce administrative burden, but only if the measures selected are meaningful, the data are trusted, and accountability is built into the policy and contractual structures that drive delivery system behavior.

Through this voluntary pledge, CMS is encouraging, rather than requiring participating states to apply the four principles outlined below, as they develop health outcome targets and consider outcomes-oriented measures for state quality strategies and upcoming procurements. A disciplined, multiyear approach focused on a limited number of priorities is therefore best understood as an implementation strategy that states may use to make the pledge actionable and establish a credible performance trajectory.

FOUR PRINCIPLES FOR AN OUTCOME-FOCUSED MEDICAID QUALITY SYSTEM

1. Prioritize outcomes over process

CMS's call for greater emphasis on health outcomes represents a meaningful shift in what states expect managed care organizations (MCOs), other Medicaid managed care entities, and providers to achieve and how performance is evaluated. CMS's pledge moves the focus beyond documenting whether healthcare activities occurred to understanding whether they contributed to better health. Process measures will continue to play a role; however, the larger objective is to connect those activities to measurable changes in health and to avoid equating completion of a process with improved outcomes for beneficiaries.

That shift is appropriate, but outcomes are inherently more difficult to measure than care processes that occur at a fixed point in time. Health outcomes reflect the combined influence of clinical care, individual circumstances, socioeconomic conditions, community resources, behavioral health needs, and other factors that extend beyond a single encounter, provider, or organization. For example, a reduction in avoidable hospitalizations for a beneficiary with diabetes may reflect contributions from primary care providers, specialists, care managers, community-based organizations, and the healthcare plan. Determining how to recognize those contributions is often more challenging than measuring whether a hospitalization occurred.

States should define a prioritized set of outcomes that addresses the distinct needs of their populations and advances program priorities. They should then align quality strategies, payment approaches, procurement requirements, managed care contracts, and external quality reviews around those priorities. Because outcomes are produced across settings and organizations, states must address attribution, risk adjustment, performance benchmarks, and the treatment of populations with greater clinical and social needs openly and consistently. As states adopt this approach, the focus for plans and providers will shift from reporting compliance to shared accountability for quality improvement.

2. Rationalize quality measure inventories without weakening accountability

CMS designed the IHO initiative to redirect resources currently used to collect, validate, and reconcile overlapping requirements toward measures that are useful for managing performance and driving action. Clarifying the goals and desired clinical outcomes should be useful in identifying what matters most to enrollees, reduce conflicting specifications, and make it easier for state leaders, plans, and providers to determine whether the delivery system is improving. Rationalizing quality measure inventories is a necessary response to overlapping programs, varying specifications, and multiple measures that assess similar concepts in different ways, but fewer measures do not necessarily mean reduced burden. CMS and states are requiring a smaller set of measures to do more: represent meaningful outcomes, work across diverse populations and delivery systems, support improvement and accountability, and increasingly inform payment.

A more focused portfolio therefore raises the stakes for states, which must ensure that each measure is sufficiently reliable for its intended use, feasible across delivery systems, and meaningful to the organizations expected to act on the results. Yet relatively few outcome measures are ready to meet all those demands. Because not every measure is ready for every purpose, states should carefully match each measure to its intended use—learning, public reporting, contractual accountability, or payment.

3. Use digital quality measurement as an enabler

The pledge creates an opportunity to build a digital measurement ecosystem that can determine whether individuals and communities are becoming healthier, reveal where improvement is needed, and support timely action. CMS envisions near real-time data increasingly replacing retrospective manual chart abstraction where feasible, enabling timelier feedback, greater automation, and stronger connections between measurement and improvement. A shift to digital quality measures (dQMs) could help states and delivery system partners identify gaps earlier, target interventions, and assess whether improvement strategies are working.

The successful transition to dQMs is not fundamentally a technology challenge; it requires broader transformation of the quality measurement enterprise. Although dQMs, FHIR (Fast Healthcare Interoperability Resources) application programming interfaces (APIs), and modern interoperability capabilities might reduce reporting burden, they do not eliminate the underlying complexity of an outcome-focused measurement strategy that uses modern data sources while remaining meaningful to both clinicians and beneficiaries.

A transition to dQMs will require foundational investment and shared governance. States, plans, vendors, health systems, clinics, and other providers will need common specifications, clear responsibility for data quality, and practical feedback loops that resolve discrepancies. A shift to dQMs might reduce burden and improve timeliness, but it will not automatically produce trusted results without sustained work on interoperability, documentation, validation, and governance.

4. Align financial accountability with outcomes

The pledge's expectation that payment will meaningfully reward performance on outcomes-oriented measures could have significant implications for Medicaid delivery systems. Participation by more than two-thirds of states signals broad interest in determining whether services, delivery models, and partnerships improve health by preventing disease, strengthening chronic disease and behavioral health management, reducing avoidable utilization, and producing better outcomes for beneficiaries. This approach moves accountability beyond determining whether MCOs and providers completed required activities to whether those efforts produced measurable improvement.

CMS has long used payment models to incentivize quality reporting, yet linking payment to outcomes magnifies the importance of sound methodology and trusted data. Many value-based arrangements rely heavily on claims data because they are standardized, auditable, and broadly available. As accountability shifts toward clinical and digitally derived outcomes, states and their partners must resolve questions that are no longer merely technical, but also financial and policy-related, including:

- Who should receive credit for an outcome?
- How should performance be assessed when beneficiaries receive care across multiple organizations?
- How can accountability promote improvement without penalizing organizations that serve populations with greater needs?

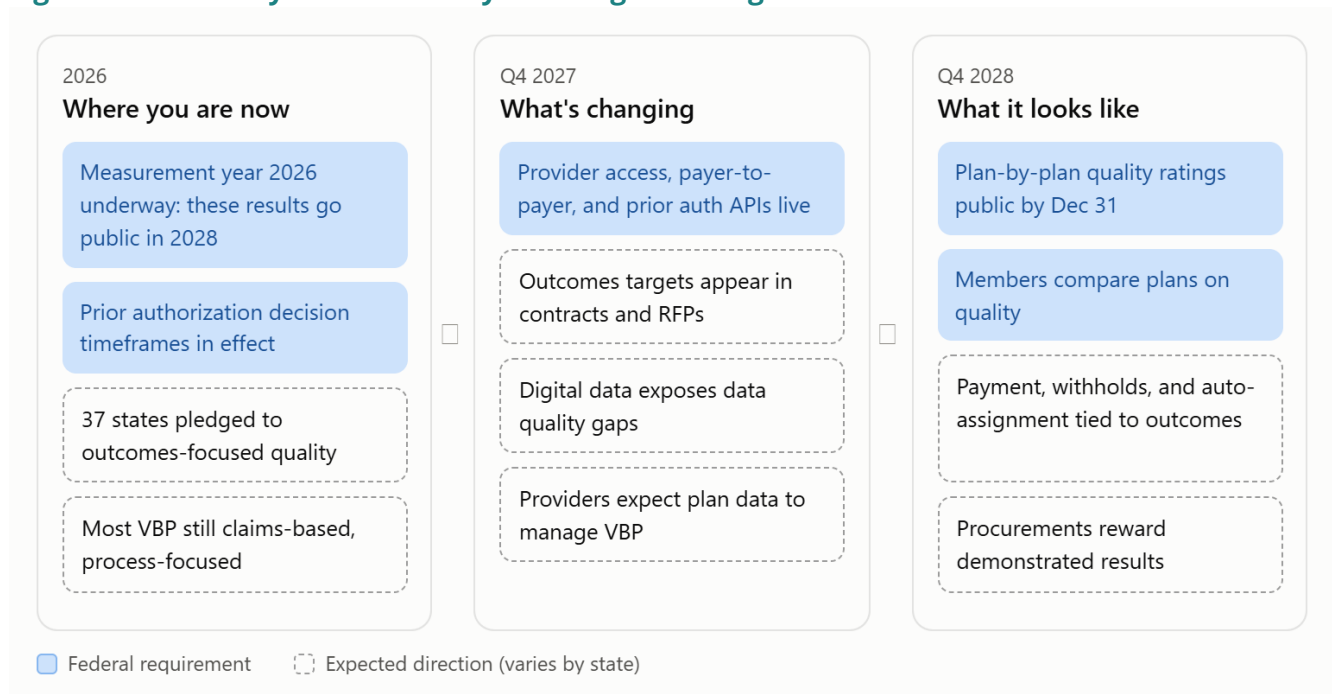
These considerations reinforce the central point: The future of quality measurement depends on an integrated strategy that connects policy, measurement science, governance, technology, operations, and quality improvement.

Managed care procurements and contracts are primary levers for converting priorities into operating requirements. States have often used requests for proposals (RFPs) to describe desired capabilities without fully translating them into contractual expectations that establish accountability and demonstrate value. The initiative signals that CMS and states both wish to address that gap through explicit outcome priorities, performance targets, and financial incentives or consequences. Those mechanisms should reflect the maturity of the measures and data, the time needed to affect an outcome, and the degree of control each stakeholder has. Plans, in turn, will need to align provider payment arrangements, care management programs, network strategies, and data-sharing expectations around those same priorities.

WHAT THE PLEDGE MEANS AND HOW HMA CAN HELP

The pledge sets an ambitious direction, but states, health plans, and their partners must translate its principles into practical decisions about policy, operations, data, and accountability. HMA brings together expertise in Medicaid policy, quality measurement, interoperability, data governance, value-based payment, and organizational change to help each stakeholder chart a workable path forward (see **Figure 1** on the next page).

Figure 1. A Pathway to Successfully Fulfilling the Pledge



For States

Implementation begins with states, which set the policy, contractual, and oversight framework for the broader Medicaid delivery system. Medicaid agencies must align outcomes priorities across quality strategies, managed care procurements and contracts, external quality review, value-based payment, data investments, and oversight. HMA helps states develop actionable roadmaps that define priority outcomes, align policy and operational requirements, assess stakeholder readiness, establish governance, and phased implementations. We also help address data quality, attribution, risk adjustment, and benchmarking issues that can undermine confidence in results.

For Health Plans

As states translate the pledge into policy and contracts, health plans must turn those expectations into operational practice. Plans will experience the pledge through new contract terms, reporting specifications, and performance targets, often on timelines driven by state procurement cycles. HMA helps plans interpret evolving expectations, identify gaps in data and operational readiness, and resolve them before they become compliance questions. Beyond compliance, we help clinical and technology leaders prioritize investments in data infrastructure, care management, provider partnerships, and value-based arrangements that can improve outcomes, strengthen procurement performance, and reduce avoidable costs.

For Health Plan and Provider Associations

Because individual plans often face common implementation challenges, plan and provider associations can convert their shared experience into a powerful collective voice. Associations can shape how the pledge is implemented, particularly for local and safety-net providers serving members with complex medical and social needs. HMA helps associations turn policy and technical issues into shared positions on phased timelines, measure selection, attribution, risk adjustment, and realistic data expectations. These positions can support accountability that rewards improvement without disadvantaging plans that serve populations with greater needs.

For Providers

Providers are essential to translating state and health plan outcome priorities into clinical practice and measurable improvement. Because they often bear much of the operational burden associated with workflow changes, data capture, and reporting, they need clear expectations, aligned requirements, and practical implementation support. HMA helps provider organizations assess how evolving requirements affect strategy and reimbursement, identify gaps in quality and data infrastructure, align improvement initiatives with priority Medicaid outcomes, and prepare for value-based payment and shared accountability.

HMA also helps providers strengthen care coordination, establish governance and information-sharing approaches across clinical and community partners, develop performance dashboards, and evaluate whether interventions are improving outcomes. For organizations participating in multiple health plan arrangements, we identify opportunities to align measures and reduce duplicative reporting while preserving the information needed for clinical management and accountability.

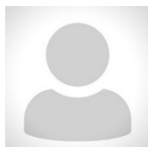
THE ROAD AHEAD

The IHO pledge establishes an ambitious direction for the future of Medicaid and CHIP. Its four principles are mutually reinforcing: meaningful outcomes require focused measure portfolios; digital measurement requires trusted data and interoperability; and financial accountability requires confidence in both the measures and the methods behind them.

The opportunity before the industry is not simply to modernize reporting. It is to create a more focused, trustworthy, and actionable quality measurement ecosystem. Reaching that future will require technology, but it will depend equally on reengineered measurement models, disciplined data governance, continuous data quality assessment, effective interoperability, and the organizational capacity to turn measurement into improvement.

The defining question is whether states and their partners can build the knowledge and accountability systems needed to answer the question that matters most: Are we helping people become healthier?

ABOUT THE AUTHORS

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ABOUT HMA

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With multidisciplinary consultants coast to coast, HMA's expertise, services, and team are always within client reach.

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