Workshop 1: Measuring Health Outcomes

Investing in Health Outcomes Pledge Workshop

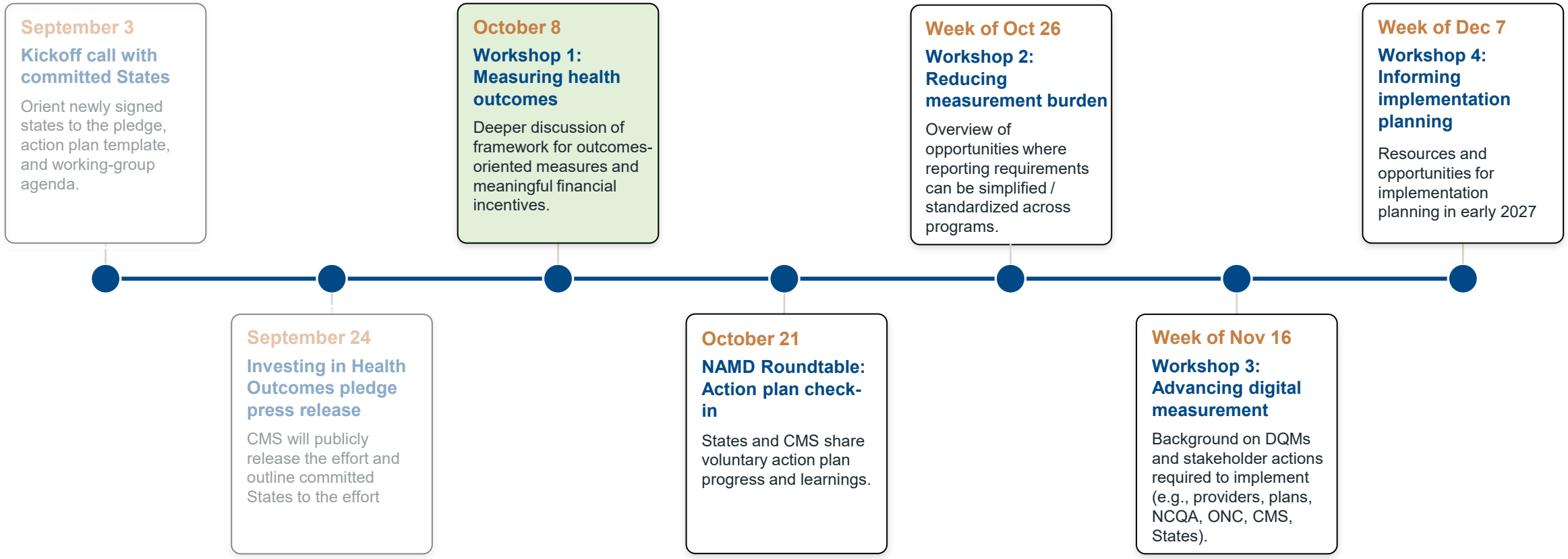
October 8, 2026

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CMS will host a series of educational workshops through the end of the year

Technical assistance is available for States throughout the fall outside of workshops to help inform action plan development; dates subject to change



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Learning objectives for Workshop 1: Measuring health outcomes

1. Review the process-to-outcome continuum

Place quality measures along the process-to-outcome continuum and connect it to the pledge's shift toward outcome-oriented reporting

2. Apply a tiered framework for outcomes-oriented measures

Use the tiered framework to define outcomes-oriented measures, drawing on examples of its application to existing programs

3. Identify priority outcomes and select aligned measures

Identify the State's priority health outcomes and select measures that reflect those priorities

4. Weigh approaches to financial accountability

Assess approaches for tying financial accountability to outcomes measures in Medicaid (e.g., pay for performance)

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Using the Donabedian framework, measures have historically been organized into three types: structure, process, and outcome

Structure

Does the provider have the capacity to deliver quality care?

What it measures

A health care provider's capacity, systems, and processes to provide high-quality care

Examples

- Whether the organization uses electronic medical records or medication order entry systems
- Number or proportion of board-certified physicians
- Ratio of providers to patients

Process

Is the provider doing the right things?

What it measures

What a provider does to maintain or improve health for healthy people or those with a condition; typically reflects accepted clinical recommendations

Examples

- Percentage of people receiving preventive services (e.g., mammograms, immunizations)
- Percentage of people with a follow-up visit after depression screening or ED visit

Outcome

Did patients' health improve?

What it measures

The impact of a health care service or intervention on the health status of patients

Examples

- Percentage of patients who died as a result of surgery (surgical mortality rates)
- Percentage of people with diabetes who had their blood sugar tested and controlled

Source: Agency for Healthcare Research and Quality (AHRQ), Types of Health Care Quality Measures

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Most publicly reported measures today are process measures, with a desire to shift to outcomes measures where appropriate

Structure → **Process** → **Outcome**

Most measures used in public reporting today

Direction of the IHO pledge

Process measures

Value

- Inform consumers and policymakers about the medical care received for a given condition or disease
- Can contribute toward improving health outcomes

Limitation

- Show what care was delivered, not whether patients' health improved as a result

Outcome measures

Value

- May seem to represent the "gold standard" in measuring quality

Limitation

- Outcomes result from numerous factors, many beyond providers' control
- Risk adjustment can account for differing population characteristics (e.g., health status), but the science is still evolving – better methods are needed to avoid misleading or inaccurate reporting

Implication for States: Shifting toward outcomes means pairing outcome measures with credible risk adjustment and payment, while retaining reporting of essential structural and process measures that demonstrate a safe and well-functioning health system for Medicaid beneficiaries

Source: Agency for Healthcare Research and Quality (AHRQ), Types of Health Care Quality Measures

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Claims are the most accessible data today, which is a key reason public and private payers often rely on process measures

Data source	Strengths	Limitations	Measures it typically supports
Administrative / claims data Billing and encounter records (e.g., FFS claims, MCO encounters)	Already collected; covers large populations; professionally coded with standardized codes; low burden	Collected for payment, not quality; limited clinical detail, completeness, timeliness, and accuracy	Mostly process (e.g., screening rates); some utilization outcomes (e.g., readmissions, ED visits)
Medical records (paper or EHR) Clinical documentation of care delivered and results	Detailed clinical information (e.g., lab values, vital signs); richer description of care	Manual abstraction is time-intensive and requires expert staff; EHR adoption and data extraction are uneven	Intermediate clinical outcomes (e.g., blood pressure or blood sugar control), often via hybrid sampling
Patient surveys Patient experience, health status, quality of life	The only direct source of patients' own perspective on their care and health	Requires validated tools; low response rates; costly and time-intensive to field	Patient experience and patient-reported outcomes
Registries / assessments Standardized clinical data across settings	Standardized, well-validated instruments; can pull from multiple sources	Coverage limited to specific conditions or settings; may be proprietary or carry participation fees	Condition- or setting-specific outcomes (e.g., functional status)

Why Medicaid programs may lean on process measures

Digital quality measurement (Workshop 3) aims to close the clinical-data gap

- Claims and encounter data are the most complete, lowest-cost data States already hold
- Claims show a service was billed (e.g., a screening), not its clinical result (e.g., an A1c value)
- Outcome measures often require chart review or clinical data – costly to collect and needed for risk adjustment
- Enrollment churn shrinks the continuously enrolled population needed for longer-horizon outcomes

Source: AHRQ, Data Sources for Health Care Quality Measures; CMS Measures Management System (MMS) Hub, Define the Data Source(s)

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States can use a three-tier framework to test whether their existing measures are fit for purpose for a focus on outcomes

TIER 1

Next-generation outcomes measures

The actual health event or state that directly matters for targeted improvements in population health.

Example · Controlling High Blood Pressure (CBP): adults 18–85 with hypertension whose BP was adequately controlled (<140/90).

TIER 2

Outcomes-oriented measures

A predictive measure used because strong evidence shows it leads to improvements in population health.

Example · Breast Cancer Screening (BCS-E): people 40–74 recommended for routine screening who had a mammogram.

TIER 3

Developmental and / or placeholder measures

A measure with a clinical rationale, but that evaluates a care process or service delivery step, or has limited or early evidence linking it to targeted, actionable population health improvements.

Example · Follow-Up After Emergency Department Visit for Substance Use (FUA): percentage of people 13 years or older who received follow up

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Five federal and accrediting programs set most what States and MCOs measure today

Federal programs · CMS

29
measures
Child[1]
24 mandatory and 5 non-mandatory measures

For example,
Well-child Visits in the First 30 Months of Life (W30)

36
measures
Adult[1]
9 mandatory and 27 non-mandatory measures

For example,
Controlling High Blood Pressure (CBP)

15
measures
MAC QRS
15 mandatory measures

For example,
Prenatal and Postpartum Care (PPC)

26
measures
HCBS Quality Measure Set
23 mandatory measures (actual number will depend on experience of care surveys used by states)

For example,
LTSS-8: Successful Transition after Long-Term Facility Stay

Accreditation · NCQA

66
measures
HEDIS
NCQA health plan measures used for accreditation

For example,
Depression Remission or Response for Adolescents and Adults (DRR-E)

1. Non-mandatory measures are not considered part of the Child Core Set. The Adult Core Set includes both mandatory and voluntary measures. Provisional measures are not considered part of the Core Sets as defined by Social Security Act 1139A / 1139B.

Source: Review of federal Medicaid quality reporting programs (2027 Child and Adult Core Sets and proposed 2028 HCBS Quality Measure Set) and MY2026 HEDIS measures

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The federal quality reporting programs currently include a range of Tier 1, Tier 2 and Tier 3 measures

Illustrative rows from the CMS measure crosswalk

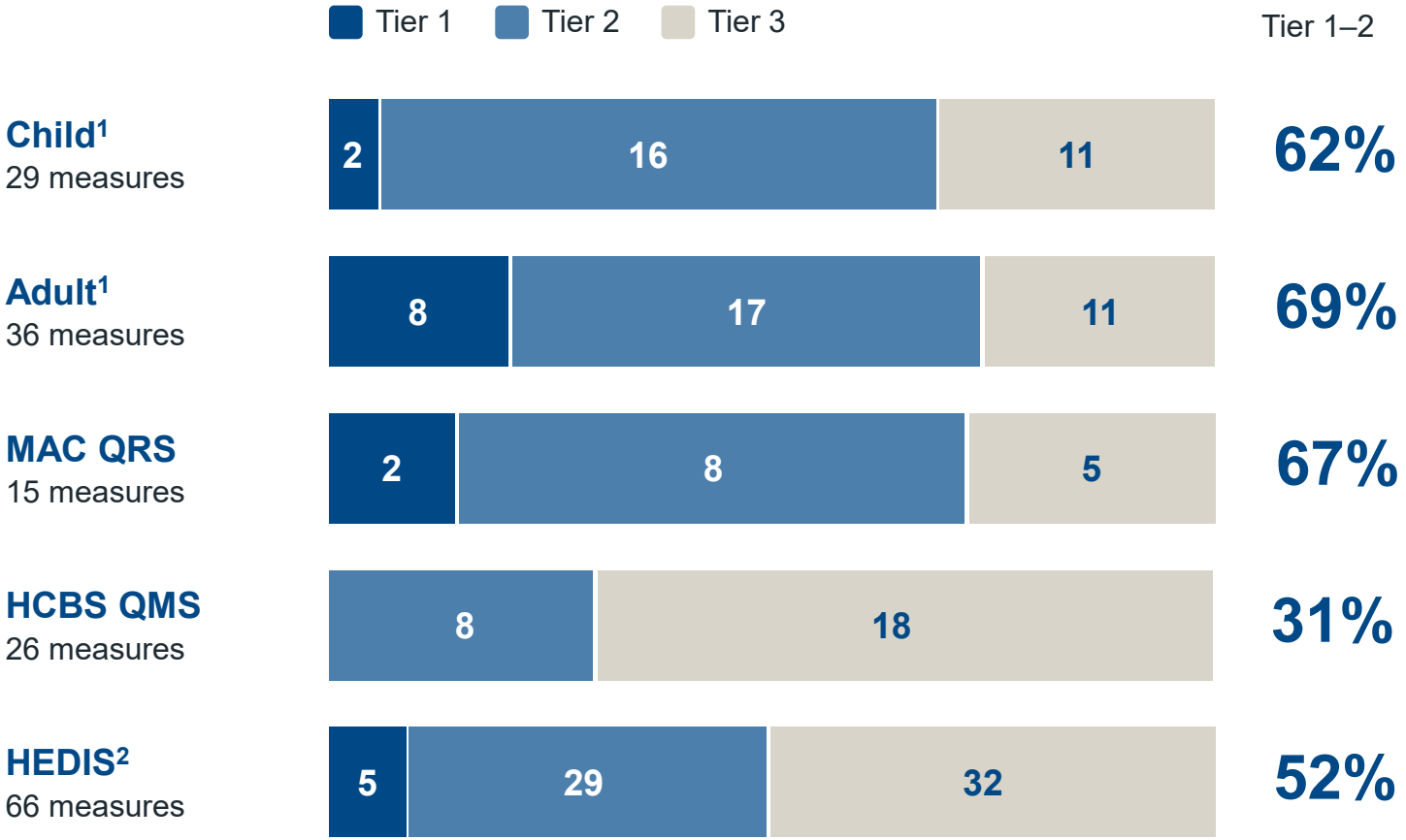
Measure	Tier	Child	Adult	MAC QRS	HCBS QMS	HEDIS
Prenatal and Postpartum Care (PPC)	Tier 2	●	●	●	–	●
Follow-Up After Hosp. for Mental Illness (FUH)	Tier 3	○	○	○	–	○
Controlling High Blood Pressure (CBP)	Tier 1	–	●	●	–	●
Glycemic Status Assessment (GSD)	Tier 1	–	●	●	–	●
Pharmacotherapy for Opioid Use Disorder (POD)	Tier 2	–	–	–	–	●
Breast Cancer Screening (BCS)	Tier 2	–	●	●	–	●
Contraceptive Care – Postpartum (CCP)	Tier 2	●	●	●	–	–
First-Line Psychosocial Care, Antipsychotics (APP)	Tier 3	○	–	○	–	○
Depression Remission or Response (DRR-E)	Tier 1	–			–	●
LTSS-8: Successful Transition after Facility Stay	Tier 2	–	–	–	●	–

Source: Review of federal Medicaid quality reporting programs (2027 Child and Adult Core Sets and proposed 2028 HCBS Quality Measure Set) and MY2026 HEDIS measures

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Initial results from the CMS measure crosswalk demonstrate that a majority of federal reporting and HEDIS measures are Tier 1 and / or Tier 2



Potential consideration for Medicaid programs

1. Determine which measures are required, and for which program
2. Find measures in the crosswalk by CMIT # or name that have been tiered for federal reporting programs
3. Determine which measures are State-specific, and their purpose
4. Apply the framework to State-specific measures to inform prioritization

1. Including mandatory Child Core Set measures as well as non-mandatory measures that are not part of the Core Set
2. Including 10 measures that NCQA has proposed retiring in MY2027 that were classified as Tier 3 measures

Source: Review of federal Medicaid quality reporting programs (2027 Child and Adult Core Sets and proposed 2028 HCBS Quality Measure Set) and MY2026 HEDIS measures

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Recap: The Investing in Health Outcomes Pledge focuses on a framework of prevention, chronic disease management, and behavioral health

Prioritize prevention, chronic disease management, and behavioral health care where appropriate for each of the populations that States serve – with a focus on clear outcomes over time

Populations	Prevention	Chronic disease management	Behavioral health
Children and youth	• **Increase early intervention**: Increase delivery of well-child visits and EPSDT screenings	• **Reduce obesity**: Support healthy weight through improved nutrition and physical activity	• **Decrease lifetime prevalence of chronic conditions**: Ensure universal developmental and behavioral health screening and timely referral
Pregnant and postpartum women	• **Improve birth outcomes**: Ensure access and timely follow up to prenatal care	• **Decrease maternal morbidity and mortality**: Deliver evidence-based treatment for hypertension and diabetes	• **Prevent maternal mental health deaths**: Expand access to screening and treatment for perinatal mental health conditions
Working age adults	• **Reduce cancer deaths**: Ensure age-appropriate cancer screenings for colon cancer, breast cancer, and cervical cancer	• **Reduce obesity**: Promote physical activity, nutrition • **Decrease the impact of chronic disease**: Deliver evidence-based treatment to manage cardio-vascular disease, diabetes, and HIV	• **Decrease substance use disorder (SUD) deaths**: Initiate and sustain treatment for SUD through behavioral and medication-assisted approaches
Individuals receiving long-term services and supports (LTSS)	• **Ensure reliable access to routine care:** Reduce gaps in access to primary and preventive care	• **Reduce unplanned acute care utilization and hospital readmissions:** Provide proactive care coordination and medication management	• **Decrease functional decline and increase days at home:** Address behavioral health needs, including depression, anxiety and cognitive decline, as integrated components of whole-person LTSS care

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States can first anchor the appropriate outcomes to then select measures and link them to financial incentives

1. **Name the population**
   Children, pregnant/postpartum, adults, LTSS users
2. **Name the priority outcome**
   A plain-language sentence a Governor could say
3. **Size the potential impact**
   Members affected, cost, variation, movable in 3 years
4. **Find and tier the relevant measures**
   Start with measures in the crosswalk; test feasibility
5. **Determine financial incentives for measures**
   3–5 outcomes, each carried by a Tier 1 or 2 measure

Questions for selecting measures for payment

1. Is the measure being reported and harmonized across multiple programs?
2. Are plans and / or providers already achieving the outcome with meaningful variation?
3. If a measure is Tier 3, what is the path to evolve and build data around such a measure?

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States can progress to develop increasing financial accountability for measures that are linked to improved health outcomes



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States can consider five design decisions for assigning financial accountability to priority measures

Distinguish between reporting and accountability	Define what good performance looks like	Size the incentive to change behavior	Publish the rules before measurement begins	Guard against unintended consequences
Prioritize which measures must be explicitly linked to payment versus a reporting function for transparency	Set the target (e.g., national percentiles, in-State peers, improvement over baseline) and decide whether plans are financially rewarded for reaching a target, improving, or both	Set the payment large enough that plans act on it, weighed against what it would cost a plan to move the measure	Set clear expectations on how measures will be calculated and how payment functions will work prior to the measurement year, not after plans or provider see results	Determine and put in place guardrails if a payment incentive could lead to potential gaming or avoidance of select patient populations

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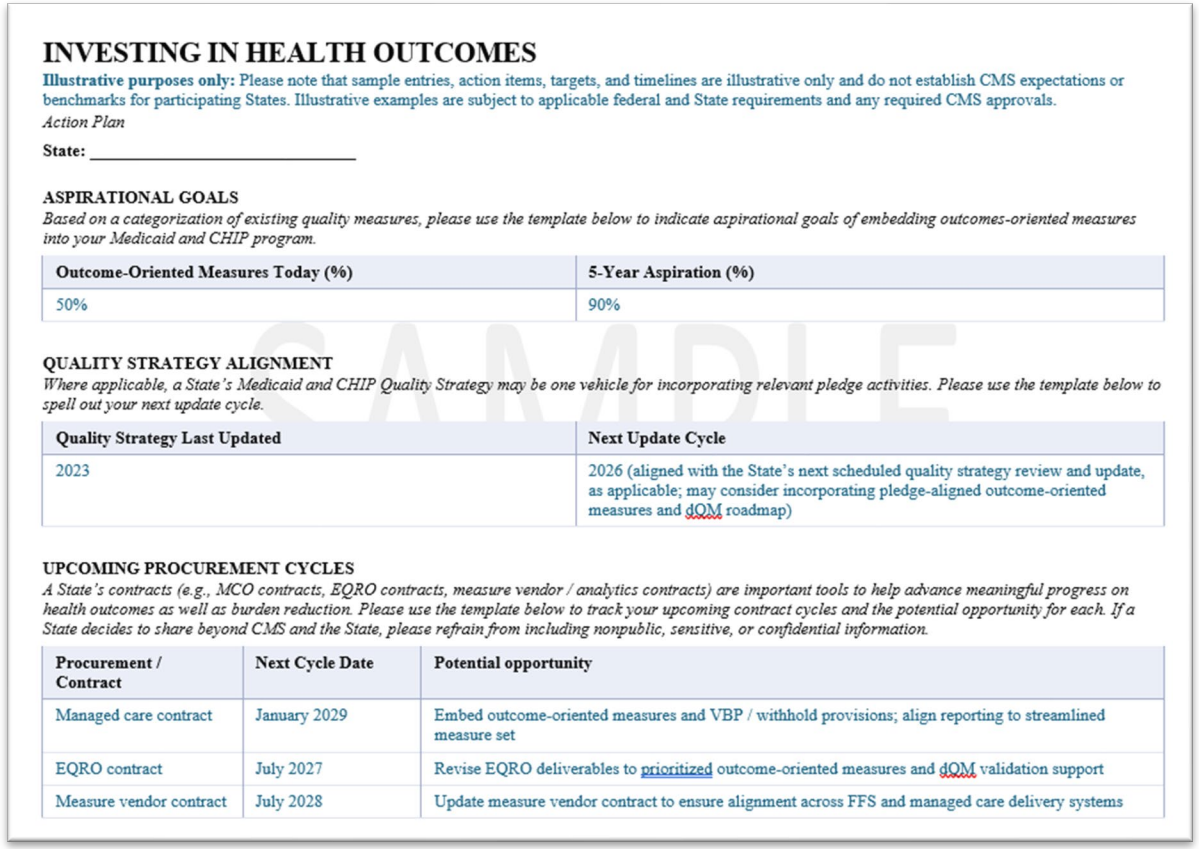
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Next steps

1. **CMCS will follow-up 1:1 with states and share data on their % of outcome-oriented measures, informed by CMS measure crosswalk**

2. **Participating states may evaluate their current quality measure programs in relationship to the three-tier framework to inform prioritization**

3. **Participating states may continue working on their Action Plans**



INVESTING IN HEALTH OUTCOMES

Illustrative purposes only: Please note that sample entries, action items, targets, and timelines are illustrative only and do not establish CMS expectations or benchmarks for participating States. Illustrative examples are subject to applicable federal and State requirements and any required CMS approvals.

Action Plan

State: _____

ASPIRATIONAL GOALS

Based on a categorization of existing quality measures, please use the template below to indicate aspirational goals of embedding outcomes-oriented measures into your Medicaid and CHIP program.

Outcome-Oriented Measures Today (%)	5-Year Aspiration (%)
50%	90%

QUALITY STRATEGY ALIGNMENT

Where applicable, a State's Medicaid and CHIP Quality Strategy may be one vehicle for incorporating relevant pledge activities. Please use the template below to spell out your next update cycle.

Quality Strategy Last Updated	Next Update Cycle
2023	2026 (aligned with the State's next scheduled quality strategy review and update, as applicable; may consider incorporating pledge-aligned outcome-oriented measures and dQM roadmap)

UPCOMING PROCUREMENT CYCLES

A State's contracts (e.g., MCO contracts, EQRO contracts, measure vendor / analytics contracts) are important tools to help advance meaningful progress on health outcomes as well as burden reduction. Please use the template below to track your upcoming contract cycles and the potential opportunity for each. If a State decides to share beyond CMS and the State, please refrain from including nonpublic, sensitive, or confidential information.

Procurement / Contract	Next Cycle Date	Potential opportunity
Managed care contract	January 2029	Embed outcome-oriented measures and VBP / withhold provisions; align reporting to streamlined measure set
EQRO contract	July 2027	Revise EQRO deliverables to prioritized outcome-oriented measures and dQM validation support
Measure vendor contract	July 2028	Update measure vendor contract to ensure alignment across FFS and managed care delivery systems

SAMPLE

Email InvestingInHealthOutcomes@cms.hhs.gov with questions

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