2025 Quality Measure Catalog

Executive Summary

INTRODUCTION

Background

Health care quality measurement serves an important role in ensuring that patients receive high-quality care, identifying areas for improvement, and facilitating accountability. The role of quality measurement will continue to expand, in part as a result of the health care system's shift from fee-for-service (FFS) reimbursement to alternative payment models (APMs), value-based payment approaches that provide added incentive payments to provide high-quality and cost-efficient care.[1,2] Global budgets are the most common form of APMs used in the Commonwealth and typically include incentives based on provider organizations' performance on a set of health care quality measures.[3] While quality measurement continues to be valuable for patient care and payment, a lack of alignment in the specific measures used in global budget-based risk contracts has been a major source of administrative burden in the health care system, contributing to clinician burnout and dilution of quality improvement efforts.[4]

To address these challenges, the Executive Office of Health and Human Services (EOHHS), in collaboration with the Massachusetts Center for Health Information and Analysis (CHIA) and the

Massachusetts Health Policy Commission (HPC), convened the Quality Measure Alignment Taskforce ("Taskforce") in 2017. Members of the Taskforce include individuals with quality measurement expertise from provider organizations, commercial and Medicaid managed care plans, academic institutions, state agencies, and consumer advocacy organizations.

The primary goal of the Taskforce has been to maintain an aligned set of quality measures ("Aligned Measure Set") for voluntary adoption by private and public payers and providers in global budget-based risk contracts. Adoption of a single, expert-informed set of quality measures would simplify administration for both providers and payers, advance the state's quality improvement priorities, and enable state agencies to better monitor health system performance overall. Through a consensus process, the Taskforce developed and maintains the Massachusetts Aligned Measure Set, a standard set of quality measures and specifications that is reviewed and updated annually. The Commonwealth currently relies on voluntary adoption of this Aligned Measure Set by providers and commercial payers; however, legislation signed earlier this year requires CHIA to establish a measure set for mandatory adoption (Chapter 343: An Act Enhancing the Market Review Process), which is policy under development. CHIA will continue to report on voluntary adoption of the Aligned Measure Set until new requirements are effective.

To track adoption of and adherence to the Aligned Measure Set by Massachusetts payers, CHIA and the HPC annually administer a voluntary survey—the Quality Measure Catalog—to learn which quality measures payers have included in their global budget-based risk contracts for the upcoming year. This publication, prepared in collaboration with the HPC, is CHIA's annual report on the Aligned Measure Set and includes details about the adoption of Taskforce-endorsed measures in global budget-based risk contracts, the stratification of measures by race, ethnicity, and/or language, and identification of measures not endorsed by the Taskforce that continue to be used in contracts.

For additional background and previous analysis of the Aligned Measure Set, please visit the following resources:

- EOHHS Quality Measure Alignment Taskforce website
- EOHHS Quality Alignment Taskforce: Report on Work Through July 2018 (October 2018)
- Massachusetts Health Policy Commission DataPoints, Issue 21: The Quality Measure Alignment Taskforce's Evaluation of Payer Adherence to the Massachusetts Aligned Measure Set (February 2022)

Statewide performance results for a subset of the Aligned Measure Set referenced in this report, including Patient Experience Survey results and some clinical quality measures from the Healthcare Effectiveness Data and Information Set (HEDIS), were recently published in CHIA's Annual Report on the Performance of the Massachusetts Health Care System (March 2025). Provider performance results at the parent provider group and medical group levels are also available in the Select Clinical Quality and Patient Experience Survey interactive dashboard.

In addition, CHIA applied a health equity lens to quality measurement by stratifying these performance results by race and ethnicity in the inaugural Equity in Quality of Care report, which will be published later this summer.

Estimating Covered Lives Under Global Budget-Based Risk Contracts

Chapter 224 of the Acts of 2012 set goals to increase the adoption of APMs in the Commonwealth, and CHIA annually collects information from payers about APM adoption. While the Quality Measure Catalog dashboard

includes information on use of quality measures in contracts for years 2022-2025, the most current APM data CHIA has available is for 2023, so representation of covered lives under global budget arrangements should be interpreted as contextual estimates.

Among the 7 commercial payers that submitted a 2025 Quality Measure Catalog, 49.0 percent of Massachusetts residents who were enrolled in a private commercial health insurance plan had their care covered under a global budget arrangement in 2023. The 2 largest Massachusetts-based commercial payers, Blue Cross Blue Shield of Massachusetts (BCBSMA) and Harvard Pilgrim Health Care (HPHC), reported that nearly two-thirds of their commercial member months are enrolled in a global budget arrangement (61.1 percent and 62.2 percent, respectively), indicating that adoption by these largest payers drives overall commercial membership in this type of APM. Among those enrolled in a Medicaid Managed Care Organization (MCO)/Accountable Care Organization (ACO), 91.2 percent were covered under this arrangement.

METHODOLOGY

The Quality Measure Catalog survey request is sent annually to all Massachusetts commercial payers and MassHealth.[5] Commercial payers are asked to report quality measures that are in only their private commercial global budget-based risk contracts for the upcoming year.[6] MassHealth submits a survey for Medicaid MCOs and ACOs, which includes contracts that may be administered by a commercial payer.

Quality Measure Catalog submissions are used to track adoption of endorsed measures in contracts, to calculate payer adherence rates to the Aligned Measure Set, and to track stratification of measures by race, ethnicity, and/or language for either internal or contractual purposes. Additionally, the submissions allow the Taskforce to track modifications to defined measure specifications and/or homegrown measures used to identify potential innovations in quality measurement.

Payer adherence to the Aligned Measure Set is calculated as the sum of instances endorsed measures were used by a given payer in their global budget contracts divided by the total instances of all measures used by a given payer in their global budget contracts. Endorsed measures reflect all measures that are designated as Core, Menu, Developmental, Innovation, and On Deck measures in the Aligned Measure Set.[7] Please refer to the interactive dashboard for definitions of each of these measure categories. The Taskforce determined that hospital domain measures are out of scope for global budget-based risk contracts and have therefore excluded them from consideration for the Aligned Measure Set and from the adherence calculation.

$$\frac{\sum \textit{Number of payer global budget-based risk contracts that include endorsed measures}}{\sum \textit{Number of payer global budget-based risk contracts that include any measures (endorsed or not endorsed/monitoring)}}$$

While the rate described above monitors adherence to the requirement that contracts include only endorsed measures, true adherence to the Aligned Measure Set requires payers and providers to use ***all*** Core measures in ***every*** contract. New this year, CHIA is presenting the Core Set adherence rate in the accompanying interactive dashboard, which tracks how frequently Core measures are used in contracts. The Core Set adherence rate is calculated by taking the sum of instances of Core measures being used in a given payer's global budget-based risk contracts and dividing it by the expected number of instances that Core measures would be used if all Core measures were used in all contracts.

$$\frac{\sum \text{Number of payer global budget-based risk contracts in which Core measures are used}}{(\Sigma \text{ Number of global budget-based risk contracts}) * (\Sigma \text{ Number of Core measures in the Aligned Measure Set})}$$

This report focuses on contract years 2022-2025 and is an updated and expanded analysis of the February 2022 HPC *DataPoints* issue, which examines data from 2019-2021.

OVERVIEW OF THE MASSACHUSETTS ALIGNED MEASURE SET

The Taskforce has defined 6 categories of measures, 5 of which make up the Massachusetts Aligned Measure Set—Core, Menu, Developmental, Innovation, and On Deck. Payers and providers are expected to adopt all Core measures; they can choose measures from the Menu Set and/or choose to pilot Developmental, Innovation, or On Deck measures. While the Taskforce tracks Monitoring measures, use of Monitoring measures in contracts is not considered in adherence with the Aligned Measure Set because performance on these measures is already high and there is limited opportunity for improvement. Should performance for these measures decline, the Taskforce may consider moving them into the Core or Menu Sets.

The Taskforce annually reviews and makes minor modifications to the Aligned Measure Set as measures are added or retired. Detailed descriptions of each Aligned Measure Set category, as well as the full Aligned Measure Sets for years 2022-2025, can be found in the interactive dashboard.

KEY FINDINGS

Fidelity to the Aligned Measure Set

Fidelity to the Aligned Measure Set requires 2 conditions to be met, and each condition is discussed separately:

1. Contracts include only measures that are endorsed in the Aligned Measure Set (a score of 100% means that a payer is not using any non-endorsed measures in any contracts). To monitor fidelity to this condition, CHIA calculates the **overall adherence rate**, which reflects the proportion of endorsed measures used in contracts.
2. Contracts include all Core Set measures (a score of 100% means that each contract a payer reports includes all 6 Core Set measures). The calculated **Core Set adherence** rate reflects the completeness of appropriate Core Set adoption.

While this publication primarily focuses on changes from 2022 to 2025, it is worth highlighting that since the first Aligned Measure Set was endorsed by EOHHS for 2019 contracts, overall adherence to the Aligned Measure Set across all respondents increased from 65 percent in 2019 to 94 percent in 2025, driven by a notable decline in the use of non-endorsed measures in contracts.

The overall adherence rate across all participating payers remains high in 2025 at 94 percent. UnitedHealthcare (UHC) is the only commercial payer that has not achieved the Taskforce goal of at least 70 percent adherence to the overall measure set, and its adherence rate declined from 63 percent in 2024 to 53 percent in 2025. MassHealth reports 100 percent overall adherence for all years, though MassHealth does include some population-specific measures that are not part of the Aligned Measure Set but that have been endorsed by the Taskforce for use in MassHealth ACO

contracts. Therefore, this report also includes a commercial-only adherence rate, which aggregates across only private commercial lines of business; this rate has improved from 54 percent in 2019 to 92 percent in 2025.

Despite dramatic improvement in ***overall*** adherence to the Aligned Measure Set since 2019, the **Core Set** itself is not being properly utilized. New for 2025, the Taskforce established a 70 percent Core Set adherence rate goal. The Core Set adherence rate across all payers was 74 percent in 2025, an improvement from 2024 (66 percent adherence); however, adherence varied considerably among individual payers. BCBSMA had the highest Core Set adherence rate at 95 percent in 2025, followed by 83 percent for MassHealth. The remaining 5 of the 7 reporting payers did not meet the goal: HPHC was close at 65 percent; Health New England (HNE) and Mass General Brigham Health Plan (MGBHP) had similar Core Set adherence rates (38 percent and 37 percent, respectively); WellSense reported 17 percent adherence; and UHC reported 0 percent (meaning none of the Core measures are in use in any of its contracts). Improving adoption of the Core Set as recommended is necessary to support provider organizations in focusing quality improvement efforts on state priorities.

In interviews that Taskforce staff conducted with payers to better understand fidelity to the Aligned Measure Set, payers cited some potential barriers to adoption, including:

- multi-year contracts that do not adjust to annual changes in the Aligned Measure Set during the contract period;
- provider requests to use non-endorsed measures;
- payer interest in use of non-aligned HEDIS measures that the National Committee for Quality Assurance (NCQA) considers for plan accreditation;
- insufficient denominators for certain measures; and
- the burden of collecting outcome measures that rely on clinical data.

National payers have also noted challenges with implementing Massachusetts-specific requirements that do not align with their contracting in other states.

Race, Ethnicity, and Language Stratification

Starting in the 2022 Quality Measure Catalog, payers indicated which measures used in contracts are stratified by race, ethnicity, and/or language (REL) for **internal use** (meaning that stratified results are informative but not a component of the payer/provider global budget arrangement). Payers also reported whether measures were stratified for **contractual use** (meaning that stratified results were incorporated into provider contracts for accountability). This publication provides broad information about the number of payers stratifying measures for either purpose, but a future publication may specify measures stratified for contractual use. It is worth recognizing, however, that in 2025 contracts, several payers stratified at least one measure by race, ethnicity, and/or language: BCBSMA, HNE, HPHC, MassHealth, and MGBHP. This is a notable improvement from the prior year, when only MassHealth and BCBSMA stratified at least one measure.

Understanding which measures are most commonly stratified may help inform policies to focus efforts toward broader, system-wide REL stratification and identify opportunities to reduce health inequities. Within the Core Set, 1 measure was stratified by 6 of the 7 reporting payers in 2025: NCQA HEDIS Controlling High Blood Pressure. Additionally, 5 of the reporting payers stratified the Glycemic Status Assessment for Patients with Diabetes (formerly the NCQA HEDIS measure HbA1c Control for Patients with Diabetes: Poor Control [>9.0%]) by REL.

Among the Menu Set, 4 reporting payers each stratified 4 measures, all NCQA HEDIS measures related to cancer screening as well as child and adolescent well-care visits.

Use of Measures Designated "Not Endorsed"

Despite significant improvements in adherence to the Aligned Measure Set, some measures that are not endorsed—meaning that the Taskforce reviewed the measure and did not include it in any category of the Aligned Measure Set—continue to be used in 2025 contracts. Tracking use of non-endorsed measures is valuable to ensure that the Aligned Measure Set includes metrics representing health care system priorities, and it may present opportunities to reevaluate non-endorsed measures that are consistently in use.

In 2025, non-endorsed measures were used in 51 contracts, an increase from the prior year when they were used in only 37 contracts. Despite this one-year increase, overall usage of non-endorsed measures has declined since 2022, when a total of 101 contracts contained non-endorsed measures.

Measures in the Overuse domain, which includes measures related to avoiding potentially unnecessary interventions, account for the highest use of non-endorsed measures in contracts—the 3 unique measures in this domain were used in 21 contracts in 2025, and measures in this domain are in use by 3 of the 7 reporting payers. Visit the interactive dashboard to review the full list of non-endorsed measures in contracts in 2022-2025 by measure domain, including details about how many payers used the measures in each year and the number of contracts.

DATA NOTES

- Mass General Brigham Health Plan (MGBHP) was formerly AllWays Health Partners.
- WellSense was formerly BMC HealthNet.
- UniCare confirmed that they do not have global budget-based risk contracts with quality measures.
- CHIA historically requested catalog surveys from Commonwealth Care Alliance (CCA) and Fallon, but Taskforce staff have determined that neither payer serves commercial members in global budget-based risk contracts, so surveys are no longer requested from these payers.
- Aetna has not responded to any Quality Measure Catalog survey requests since CHIA and the HPC began issuing requests in 2018, but based on review of the Registered Provider Organizations and the HPC ACO certification programs, Taskforce staff have determined that Aetna most likely does not hold global budget-based risk contracts in Massachusetts.
- HPHC and THP are Point32Health companies. CHIA no longer collects and reports results from THP because its global budget contracts have migrated to HPHC according to Point32Health.

NOTES

1. Massachusetts Executive Office of Health and Human Services Quality Alignment Taskforce, *Report on Work Through July 2018* (Boston, October 2018), **https://www.mass.gov/doc/eohhs-quality-alignment-taskforce-report-on-work-through-july-2018-october-2018/download**.
2. Centers for Medicare and Medicaid Services, "Quality Payment Program APMs Overview," accessed July 11, 2025, **https://qpp.cms.gov/apms/overview**.
3. Center for Health Information and Analysis, *Annual Report on the Performance of the Massachusetts Health Care System (Boston*, March 2025), **https://www.chiamass.gov/assets/2025-annual-report/2025-Annual-Report.pdf**.
4. Health Policy Commission, "2016 Annual Cost Trends Hearing Testimony," accessed July 11, 2025, **https://masshpc.gov/meetings/annual-cost-trends-hearings/2016-cth/testimony**.
5. Since the Taskforce began tracking adherence to the Aligned Measure Set in 2019, the Quality Measure Catalog has seen the following completion: MGBHP (formerly AllWays Health Partners) began reporting for 2022 contracts, Blue Cross Blue Shield of Massachusetts (all years), Harvard Pilgrim Health Care (all years), Health New England (all years), Tufts Health Plan (reported 2019-2023; as of 2024, Point32Health is migrating global budget contracts from THP to HPHC, to be completed by 2025. THP will no longer submit a survey), UnitedHealthcare (began reporting for 2022 contracts), WellSense (formerly BMCHP, all years). Surveys were also sent to Aetna (no response) and Cigna (no response).
6. The Taskforce has defined global budget-based risk contracts as follows: "Contracts between payers (commercial and Medicaid) and provider organizations where budgets for health care spending are set either prospectively or retrospectively, according to a prospectively known formula, for a comprehensive set of services for a broadly defined population, and for which there is a financial incentive for achieving a budget. The contract includes incentives based on a provider organization's performance on a set of measures of health care quality or there is a standalone quality incentive applied to the same patient population."
7. The Set also designates Monitoring measures, but these are not endorsed for contractual use. The adherence calculation uses instances, or the number of contracts a measure is used in, to account for frequency of measure use across contracts. If a non-endorsed measure is in use in only 1 contract and an endorsed measure is in use in several contracts, the adherence rate accounts for this.

For more information, please contact:

CENTER FOR HEALTH INFORMATION AND ANALYSIS
501 Boylston Street
Boston, MA 02116
(617) 701-8100
www.chiamass.gov

MASSACHUSETTS HEALTH POLICY COMMISSION
50 Milk Street
Boston, MA 02109

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