



## Massachusetts Executive Office of Health and Human Services Quality Measure Alignment Taskforce

### Massachusetts Aligned Measure Set for Global Budget-Based Risk Contracts 2026 Implementation Parameters June 16, 2025

#### **I. Introduction**

In 2017, the Executive Office of Health and Human Services (EOHHS) convened a Quality Alignment Taskforce (Taskforce) to recommend to the Secretary an aligned measure set for use in global budget-based risk contracts.

Global budget-based risk contracts are defined as follows:

*Contracts between payers (commercial and Medicaid) and provider organization where budgets for health care spending are set either prospectively or retrospectively, according to a prospectively known formula, for a comprehensive set of services<sup>1</sup> 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. Global budget-based risk contracts should be amended annually to reflect modifications to the Aligned Measure Set that reflect changes to underlying national clinical guidelines.*

At the outset of its work, EOHHS' objectives were to a) reduce the administrative burden on provider organizations associated with operating under multiple, non-aligned contractual measure sets, including the burden associated with resources dedicated to varied quality improvement initiatives and to measure reporting, and b) focus provider quality improvement efforts on state health and health care improvement opportunities and priorities.

The Taskforce developed an aligned measure set for voluntary adoption by private and public payers and by providers in global budget-based risk contracts. By doing so, the Taskforce strives to advance progress on state health priorities and reduce use of measures that don't add value. This document puts forth guidance for 2026 implementation of the Massachusetts Aligned Measure Set as recommended by the Taskforce and endorsed by EOHHS.

#### **II. Implementation Parameters**

- **Commercial implementation timeframe.** Commercial insurers choosing to adopt the Massachusetts Aligned Measure Set and that have not yet done so should do so for implementation beginning 1/1/26 as contracts are renewed.

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<sup>1</sup> Contracts must include, at a minimum, physician services and inpatient and outpatient hospital services. Contracts could also include services that are not traditionally billed for, such as care management, addressing social determinants of health, behavioral health integration, etc.

- MassHealth implementation timeframe: MassHealth’s contractual measure set aligns with the Massachusetts Aligned Measure Set. MassHealth has included additional measures that are not found in the Massachusetts Aligned Core or Menu Measure Sets:
  1. *Metabolic Monitoring for Children and Adolescents on Antipsychotics*
  2. *Follow-Up After Emergency Department Visit for Mental Illness (7-day)*
  3. *Follow-Up After Hospitalization for Mental Illness (7-day)*
  4. *Follow-Up After Emergency Department Visit for Substance Use*
  5. *Topical Fluoride for Children*
  6. *Quality Performance Disparities Reduction*

The Taskforce agreed that MassHealth’s adoption of the Aligned Measure Set should allow for these deviations to meet Medicaid-specific program needs.

- Annual review process and timeframe. The Taskforce will conduct an annual review of the Massachusetts Aligned Measure Set (see details in Section III) and finalize any recommended modifications to the measure set by 5/31 each year for the next calendar year.
- Automatic incorporation of annual measure set modifications. If language is not already included in contracts, payers and providers should amend contracts by 1/1/26 to state that annual changes to the Massachusetts Aligned Measure Set shall be automatically incorporated into contracts effective the next contract performance year.
- Voluntary adoption in full and not in part. Those choosing to adopt the Massachusetts Aligned Measure Set should adopt the set in its entirety.
- Guiding principles for use of the Aligned Measure Set in contracts. While the focus of the Taskforce is on aligning contractual quality measures and not on the broader terms of global budget-based risk contracts, the Taskforce has developed a set of guiding principles for those seeking to implement the Aligned Measure Set. These principles can be found in the Appendix.
- Meaningful financial implications: It is considered outside of the scope of the Taskforce to specify monetary value attached to the measures; however, an insurer adopting the Aligned Measure Set may not attach a de minimis amount to a Core Measure such that performance on the Core Measure lacks meaningful financial implication for the provider.
- Measuring inequity reduction: Payers and providers may add a race, ethnicity, or language inequity reduction complement to any Core or Menu measure. Such measure(s) will be considered a separate measure and will be regarded as in fidelity with the Aligned Measure Set. The measure should be implemented and assessed in a manner consistent with the Taskforce-published guidance for implementation of inequity reduction measures found in the [Health Equity Measure Accountability Framework](#) under “Measure Category 2.”
- Transitioning to electronic measurement: When HEDIS measures are moved to Electronic Clinical Data Systems (ECDS) reporting by NCQA, payers and providers may retain flexibility in how the measures are used in contracts.

### **III. Annual Review Process**

The Taskforce will conduct an annual review process to maintain the Massachusetts Aligned Measure Set. Taskforce staff will prepare information on the following topics for review by the Taskforce:

1. substantive HEDIS changes to the measures in the current Massachusetts Aligned Measure Set;
2. CMS-driven changes to the MassHealth ACO measure set and Medicare ACO measure set;
3. adoption of Core, Menu and Innovation measures in global budget-based risk contracts;
4. alignment of the measure set with statewide health priorities;
5. opportunities for improvement in performance for Core and Menu measures;
6. most recent state performance on measures in the Monitoring Set;
7. possible transition of Developmental and On Deck measures into the Core or Menu Set, and
8. any other Taskforce recommended changes.

Following the Taskforce's annual review, the Taskforce will submit its recommendations for annual changes to the Secretary of the Executive Office of Health and Human Services for review and acceptance.

## **Appendix: Guiding Principles for Use of the Aligned Measure Set in Contracts**

While the focus of the Taskforce is on aligning contractual quality measures and not on the broader terms of global budget-based risk contracts, the Taskforce has developed a set of guiding principles for those seeking to implement the Aligned Measure Set. These guiding principles apply to all Aligned Measure Set measure categories used in contracts.

### **Selection of Menu Measures**

For those providers and payers who choose to adopt the Aligned Measure Set, the Core Set should be adopted in full as these measures represent high priority areas for the State. The Menu Set allows providers and payers to supplement the Core Set, but the Taskforce recommends that contracts limit use of Menu measures to allow providers to focus on key opportunities for improvement. The Taskforce further recommends that Menu measures selected for contract use should target identified opportunities to improve care specific to the contracted population.

### **Reasonable Benchmarks**

The Taskforce recommends that provider organizations and payers negotiate benchmarks that:

- are not below current provider performance;
- are achievable by the provider organization (achievement benchmarks should not be so far above provider performance as to discourage improvement efforts), and
- reflect a reasonable understanding of high performance.

Furthermore, the quality incentive program should not be structured in a way that penalizes providers for caring for populations with higher clinical and/or social risk.

### **Adequate Denominators**

Provider organizations and payers should not use measures in contracts if denominators are too small to report a reliable measurement<sup>2,3</sup>. Minimum denominator sizes to achieve reliable measurement may differ based on measure type.<sup>4</sup> To the extent that any Core Measure does not

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<sup>2</sup> For this purpose, the NQF definition of reliability of the measure score is used: “Reliability of the measure score refers to the proportion of variation in the performance scores due to systematic differences across the measured entities (or signal) in relation to random error (or noise).” [https://www.qualityforum.org/Measuring\\_Performance/Improving\\_NQF\\_Process/Measure\\_Testing\\_Task\\_Force\\_Final\\_Report.aspx#:~:text=Reliability%20and%20Validity,-A%20quality%20measure&text=Reliability%20refers%20to%20the%20repeatability,in%20the%20same%20time%20period](https://www.qualityforum.org/Measuring_Performance/Improving_NQF_Process/Measure_Testing_Task_Force_Final_Report.aspx#:~:text=Reliability%20and%20Validity,-A%20quality%20measure&text=Reliability%20refers%20to%20the%20repeatability,in%20the%20same%20time%20period) (Accessed June 16, 2025). Taskforce staff will update this language, as necessary, to reflect any modifications to NQF’s definition of reliability of the measure score.

<sup>3</sup> For further guidance on how to calculate reliability, please see RAND Health’s publication, “The Reliability of Provider Profiling: A Tutorial” (2009). Available at: [https://www.rand.org/content/dam/rand/pubs/technical\\_reports/2009/RAND\\_TR653.pdf](https://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR653.pdf) (Accessed June 16, 2025).

<sup>4</sup> Sequist, T, Schneider E, Li A, et al. Reliability of Medical Group and Physician Performance Measurement in the Primary Care Setting. *Medical Care* 2011; 49(2):126-131. Available at: <https://journals.lww.com/lww->

meet minimum denominator size, the insurer may elect to not include the measure when applying a performance incentive and/or disincentive provision in the contract.

**Total Number of Measures for Use in a Contract**

The Taskforce aims to align the use of quality measures across contracts and to reduce administrative burden on providers. In pursuit of those aims, the Taskforce recommends that payers and providers limit the number of measures used in any given contract to 15 or fewer (this number excludes hospital measures).

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[medicalcare/Abstract/2011/02000/Reliability\\_of\\_Medical\\_Group\\_and\\_Physician.4.aspx](#) (Accessed June 16, 2025).