National Consensus Development and Strategic Planning for Health Care Quality Measurement

Core Quality Measures Collaborative (CQMC) Proprietary Measures Toolkit: Tips for Payers Working with Measure Owners and Registries

January 15, 2026

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Overview

Purpose and Audience

The Core Quality Measures Collaborative (CQMC) is a broad-based coalition of health care leaders working to facilitate cross-payer measure alignment through the development of core sets of measures to assess the quality of health care in the United States. CQMC aims to reduce the burden of measurement through voluntary adoption of high-value measures in its core sets.

The goal of this toolkit is to inform payers about the proprietary measures contained in the CQMC core sets and to offer actionable guidance so that payers can implement them. This toolkit provides:

- An overview of the CQMC, explaining its value proposition for payers.
- Information and strategies on how payers can engage with proprietary measures, specifically, registry measures, in the core sets.
- An overview of tools and efforts that are currently advancing interoperability, the keystone to quality measure alignment between private and public payers.

This toolkit was developed with input from CQMC members—including specialty societies, measure owners/stewards, and payers—based on information collected through key informant interviews, written feedback from CQMC members, and verbal feedback from the CQMC Steering Committee.

Who is part of the CQMC?

The CQMC is a diverse coalition of health care leaders including consumer groups, medical associations, health insurance providers, purchasers, and other quality stakeholders. CQMC is a public-private partnership that encourages cross-payer measure coordination through the development of core sets of measures to assess the quality of health care in the United States. The CQMC is a membership-driven and -funded effort, with additional funding provided by AHIP. Battelle, which serves as the CQMC operational home through its Partnership for Quality Measurement.

The CQMC aims to:

Identify high-value, high-impact, evidence-based measures promoting better health outcomes.

Align measures across public and private payers to achieve congruence in the use of measures for quality improvement, transparency, and payment purposes.

Reduce the burden of measurement by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and reporting requirements across payers.

Figure 1: Aims of the CQMC

What are the CQMC Core Sets? Why Should Payers Use Them?

The CQMC core measure sets are groups of **scientifically sound measures focused on the ambulatory setting. These measures promote a patient-centered assessment of quality.**

The CQMC uses a **consensus-based approach** and established measure-selection principles for developing and maintaining the core sets in 10 clinical areas. When public and private payers use the same sets of high-priority measures, reporting burden is reduced and quality improvement becomes more consistent and more impactful (Figure 1). The CQMC's overarching objective is to align public and private payers around shared sets of quality measures (Figure 2).

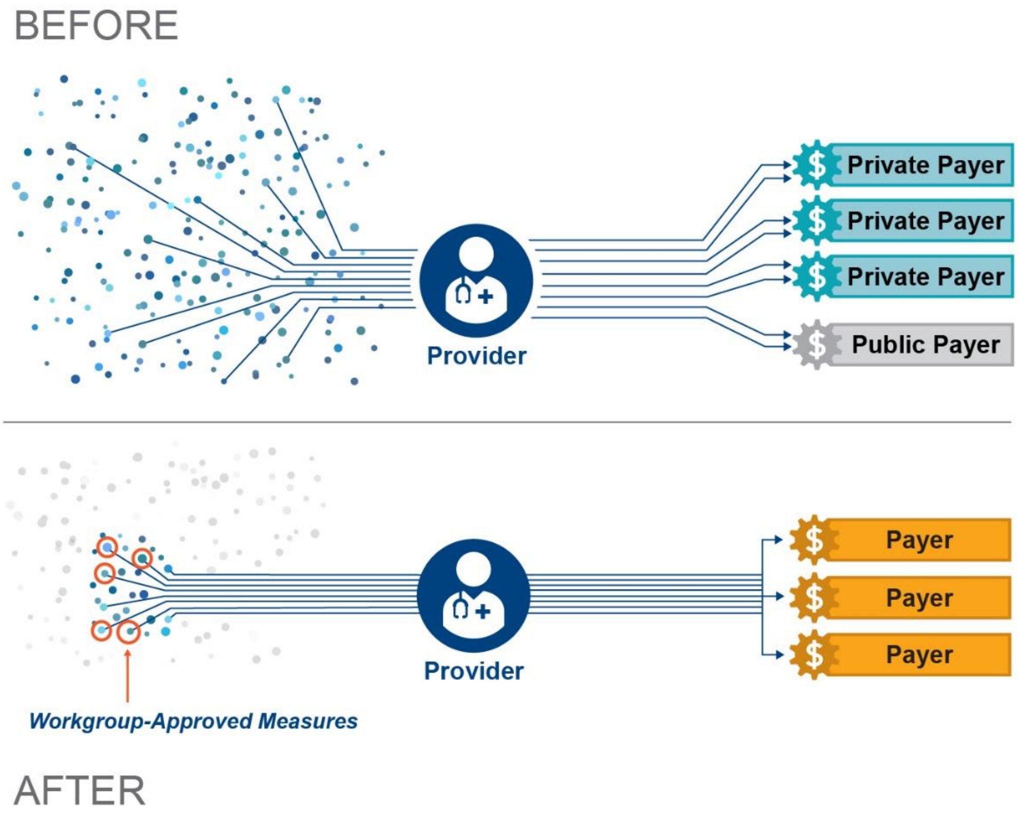

Figure 2: The Ideal State of How CQMC Core Sets Can Reduce Reporting Burden

Proprietary Measures and the CQMC Core Sets

What are Proprietary Measures?

Private entities such as accreditation bodies, regional quality collaboratives, and specialty societies develop and own proprietary measures. As such, these measures are not freely or publicly accessible. Their full specifications (i.e., the detailed instructions needed to calculate, report, and interpret the measure) are typically behind a paywall or require a licensing agreement. Users must pay for access or obtain permission to use the measures in reporting or analysis. Some quality measures require the use of proprietary analytics, such as Solventum™ Grouper Plus Content Services (GPCS) and the Johns Hopkins Adjusted Clinical Group (ACG)® System.

Examples of proprietary measures include some of the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) measures and measures developed by specialty societies for use in registries and internal and external quality reporting programs. These measures often play a critical role in quality improvement, but their use in value-based payment programs may be limited by access restrictions. In contrast, government-stewarded measures are not proprietary.

The shift toward digital measures has caused some measures that once had publicly available specifications to become proprietary. For example, the conversion of HEDIS® measures to electronic clinical data system (ECDS) measures necessitated use of clinical quality language (CQL), prompting many HEDIS® measures to return to proprietary status after being available for public use.

Why do CQMC Core Sets Include Proprietary Measures?

Public Availability of Measure Specifications for CMS Reporting

While CMS makes measure specifications publicly available for CMS program reporting, measures are often subject to a measure steward's intellectual property rights and licensing requirements for outside use. Public accessibility of specifications does not equate to public availability for all uses, and proposed uses of proprietary measures are subject to approval by measure owners/stewards.

For example, the specifications of a measure might be publicly accessible for reporting in the Merit-based Incentive Payment System (MIPS), but other uses may require a standard or commercial license.

Although the CQMC's mission indicates that core sets should be composed solely of measures with publicly accessible specifications, such as those used in Centers for Medicare and Medicaid Services (CMS) federal quality reporting programs, the collaborative workgroups may include proprietary measures when they determine such a measure adds high value and captures important aspects of care not well assessed by publicly available measures. In such cases, including proprietary measures ensures the core set is meaningful for improving care and aligned with current practice, particularly where these measures are widely used by private health plans or required for outside certifications.

Proprietary Measures in the CQMC Core Sets: Registry-Based

What are Registries?

A registry is a system that collects, stores, and shares information about people who have a certain disease, a health condition that increases their risk for morbidity or mortality, or who have been exposed to something that might harm their health.[1]

A single registry can include data from multiple sources, including data collected expressly for use in the registry or data originally collected for other purposes. Examples of data that may appear in a registry include:

- Demographic information from hospital admission or discharge forms
- Medication use

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[1] National Committee on Vital and Health Statistics. (2022, November). *Frequently asked questions about medical and public health registries*. Department of Health and Human Services. https://ncvhs.hhs.gov/wp-content/uploads/2022/11/FAQ-on-Public-Health-Registries.pdf

- Diagnoses or treatment plans
- Electronic health records (EHRs)
- Claims

These data can be collected directly from patients and clinicians or from secondary data sources, via medical charts, EHRs, other clinical information systems, data warehouses, claims datasets, birth and death records, non-patient-level databases, distributed research networks, and even other registries.[2]

Registries are available on a variety of different topics—but not all can be used to support quality measurement activities. Generally, clinical data registries (CDRs) and qualified clinical data registries (QCDRs) are types of clinician registries used for quality reporting. CMS certifies QCDRs, which collect medical or clinical data on behalf of a MIPS-eligible clinician.

Measures included in QCDRs are subject to the same rigorous testing requirements as measures whose specifications are publicly accessible (via pre-rulemaking or consensus-based entity [CBE] endorsement, for example). Each QCDR measure undergoes a formal approval process to ensure reliability and validity. Registries must demonstrate that their measures perform as intended and are valid at the level for which they are specified.[3]

QCDRs and CDRs can operate at national and regional scales for purposes other than value-based payment, including population health, benchmarking, performance comparisons, risk stratification, contract negotiation, and more.[4]

Advantages of using registry measures in payer programs

- ✓ Registry data offers a more complete clinical detail than claims data
    - Because claims data are generated for billing purposes, they do not reflect the full clinical record.
    - Registries provide comprehensive medical data collected over time and across multiple data sources.
    - Registry data tends to provide more *information on outcomes.*
- ✓ Data are available for a wider variety of care settings, tracked over time, and collected from different care sites.
- ✓ Registry measures may make some specialties more willing to enter into value-based care arrangements as they can more easily demonstrate value to payers.
- ✓ With registry measures, payers and providers can create cross-cutting performance outcome benchmarks.

Figure 3: Advantages of Using Registry Measures in Payer Programs

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[2] Gliklich, R.E., Leavy, M.B., & Dreyer, N.A. (2020, September). Data sources for registries. In *Registries for evaluating patient outcomes: A user's guide* (pp. 132-158). Agency for Healthcare Research and Quality.

[3] Centers for Medicare & Medicaid Services. (2025). 2025 QCDR Measure Development Workshop: Deck [PDF slides]. Quality Payment Program. Available from: Resource - QPP

[4] Pogones, S., Mullins, A., & Guerrero Tucker, G. (2021). Put your clinical data to work with a registry. *Family Practice Management.* Retrieved December 18, 2025, from https://www.aafp.org/pubs/fpm/issues/2021/1100/p21.html

Registry measures provide strong return on investment for payers. These measures allow payers to more clearly identify gaps in care and determine which treatments are most effective. Information from registries can also be helpful when making coverage or other policy decisions.

Tips for Working with Registries

Relationship Building

Building trust between registries, measure owners/stewards, and health plans is critical to advancing adoption of registry measures within the CQMC. In conversations with registries, payers should engage early, share their goals, and describe how they plan to use registry measures or data. Registries and measure owners/stewards want to avoid the unintended consequence of data being used unfairly against registry members and would benefit from knowing payers' intentions for data usage and the level at which data will be analyzed. A data use agreement can ensure payers, measure owners/stewards, and registries have similar expectations for how the data will be used.

Registries generally welcome substantive, collaborative discussions, and payers can expect some level of partnership. Registries vary in their partnership models: some offer standard licensing agreements, while others may require access to data for testing or reserve the right to audit measure data. Furthermore, measure stewards/owners may request to review proposed methodologies for analysis of the data. Registries will likely not share clinician-level raw data, as these data are intended for use by participating clinicians, specialty societies, and registries for quality improvement and reporting purposes. Any access to clinician-level data must be clearly scoped.

Payers should expect negotiation and ongoing discussion. Specialty societies are deeply invested in the measures they develop and will seek to ensure appropriate use.

Data Use Agreements

Establishing a data use agreement can ensure payers and registries have similar expectations for how clinical data will be used. Any facility-level data access request may require each unique facility to sign a data release consent form prior to the registry releasing any data. Additionally, payers may need to discuss and amend agreements with registry participants before data is shared.

Registries and payers can negotiate data use agreements via a neutral third party, or a third party can serve as a transparent intermediary that documents data flow and usage. A health information exchange (HIE), which aggregates clinical data from EHRs for standardized delivery to the payer, could serve as this third party. A HIE can also be used on top of a registry to expand data sources and enable better population health management by tracking trends across communities.

There may be data interoperability challenges when sharing data between registries and payers. Different data formats and unstructured data may create challenges for data transfer. Data may be missing or inaccurate. Some data may not be sharable due to Health Insurance Portability and Accountability Act (HIPAA) guidelines or other privacy laws.

As such, registries and payers should define data interoperability and transport considerations up front. Parties should agree on exchange methods (e.g., Health Level 7 Fast Healthcare

Interoperability Resources Application Programming Interfaces (HL7 FHIR APIs) using Data Exchange for Quality Measures (DEQM) Measure Report and, where applicable, Bulk FHIR/Da Vinci profiles) or alternate formats (e.g., the Consolidated Clinical Document Architecture (C-CDA),Quality Reporting Document Architecture (QRDA) I/III, or delimited flat files) delivered over secure channels (HTTPS with OAuth 2.0/SMART Backend Services or Secure file Transfer Protocol (SFTP)). Specify whether the registry will return patient-level clinical data or only calculated measure results, along with mapping to the United States Core Data for Interoperability (USCDI)/US Core, value set and measure-specification versioning, member matching and provider attribution rules, data quality/provenance requirements, cadence and latency, and audit/logging expectations. Defining these parameters early reduces rework and ensures data are usable for the payer's approved purposes.

> Successful payer–registry partnerships share technical specifications and align methodology upfront—especially attribution, risk adjustment, and benchmarks—so registries' clinical depth can support quality improvement and value-based contracting without duplicative reporting. Cardiovascular registries like the National Cardiovascular Data Registry (NCDR®) show that clear data-use agreements and joint technical workgroups can align attribution and benchmarking, producing fairer comparisons and more actionable feedback.

Measure Licensing Agreements

To gain access to measure specifications, payers can work with registries to enter into a licensing agreement detailing licensing, fees, and appropriate use. Because not all measure owners/stewards operate registries, and some registries implement measures they do not own, collaboration among measure owners/stewards, registries, and payers is essential to ensure clear alignment on measure use and outputs.

A measure licensing agreement grants the payer the legal right to use the proprietary measure specifications for purposes outside of CMS programs (e.g., in their own contracts or internal quality programs). In addition to proper application of measure specifications, these agreements may ensure compliance with intellectual property rights or restrictions on measure modification or redistribution. Commercial and non-CMS payers must negotiate a measure license agreement with measure owners/stewards before gaining access to detailed specifications. Once this agreement is in place, payers can begin formal discussions with registries on measure usage.

Payers should clearly communicate their intended use cases—such as quality improvement, incentive design, or contract performance. Payers should provide measure owners/stewards the opportunity to review and provide input on proposed methodologies, as they establish the intellectual property guidelines and usage rights for their measures, even when implemented through a third-party registry.

Proprietary Measures in the CQMC Core Sets: NCQA HEDIS®

HEDIS® is a tool used by more than 90% of U.S. health plans to measure performance on important dimensions of care and service. To ensure that HEDIS® stays current, the NCQA has established a process to evolve the measurement set each year through its Committee on Performance Measurement.

Why are HEDIS® Measures in the Core sets?

Many of the HEDIS® measures included in the core sets are used in federal programs (e.g., MIPS, CMS Medicaid Core Set, CMS Innovation Center [CMMI] models, the CMS Universal Foundation). For the measures adopted by the federal government, NCQA specifies them at the appropriate level of accountability for the program and as electronic clinical quality measures (eCQMs).[5] Specifications for measures adopted by the government are publicly available for entities reporting them to these federal programs.

Including HEDIS® measures in core sets promotes alignment and reduces reporting burden across plans and providers because the HEDIS® measures are commonly used. Most health plans already use HEDIS® measures because they are a requirement of the NCQA Health Plan Accreditation program, and many states require plans to be NCQA accredited. NCQA also uses HEDIS® measures for their physician recognition programs such as the Patient-Centered Medical Home (PCMH) program.

Health plans often suggest that clinicians use aligned measures to foster shared accountability and align plan and provider incentives. Because many HEDIS® measures were developed for plan-level reporting, plans should assess their suitability for clinician-level use.

NCQA and Registries

NCQA specifies some of their HEDIS® measures for ECDS reporting. The ECDS reporting standard provides health plans with a structured approach for gathering and submitting standardized electronic clinical data to support HEDIS® quality measurement and improvement. ECDS-reported measures generate the denominator from claims data but allow organizations to supplement the measure's numerator with supplemental data sources such as clinical registries, HIEs, immunization information systems, disease/case management systems, and EHRs. NCQA recognizes the importance of registry data as a supplemental data source for the HEDIS ECDS measures.

Initial Steps to Using Proprietary Measures

Activities that could increase uptake of proprietary measures while decreasing barriers to their use include:

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[5] Agency for Healthcare Research and Quality. (n.d.). Measurement sets for physician quality reporting programs. https://www.ahrq.gov/talkingquality/measures/setting/physician/measurement-sets.html

1. Create a roadmap, checklist, or implementation guide for payers who would like to engage with registries.
2. Start discussions around how payers, measure owners/stewards, and registries could better collaborate.
   a. Build consensus around acceptable use of registry data to enhance trust between measure owners/stewards, payers, and registries.
   b. Develop frameworks that describe the shared benefits of increased collaboration (e.g., joint quality improvement studies, transparency protocols).
   c. Compile case studies of payer, measure owner/steward, and registry collaboration.
3. Develop application programming interfaces (APIs) to pass registry data to payers after agreements are put in place.
4. Develop data use agreement and measure licensing agreement templates.
5. Develop a decision tree to help payers determine when to seek registry-based measures versus other measures.
6. Assemble a spreadsheet of licensing fees for proprietary measures so payers can access cost information in one place. Consider adding registry contact information and general information about registries.
7. Quantify the return on investment, develop a cost-impact analysis, or delineate the value proposition for use of proprietary and registry measures.
8. In the long term, consider consolidating registry measures under third-party organizations for easier payer access and communications. Ensure data are protected against inappropriate use by having strong safeguards in place that protect registries, measure owners/stewards, clinicians, and patients.

Looking Ahead – Technology

Interoperability

Interoperability is essential for using registry-based measures effectively because it ensures that data from diverse sources can be exchanged and integrated seamlessly. When integrated through interoperable standards, these registry-based measures not only enhance alignment across programs but also streamline data exchange, creating a foundation for scalable, high-quality reporting that supports value-based care. To improve data interoperability and scale measure alignment, multiple groups are evolving standards-based APIs and national frameworks to reduce reporting burden and improve data quality for measurement. Here is a brief overview of ongoing interoperability efforts.

HL7 FHIR®

HL7 is the standards-developing organization that stewards the FHIR standard for exchanging health care data. FHIR will enable faster and easier transfer of health information between different systems. FHIR will also facilitate electronic communication of data across different EHR platforms, which will reduce reporting burden.

Registries are working toward specifying their measures using FHIR standards. NCQA has specified HEDIS® measures as digital quality measures to allow health plans to collect and report standard electronic clinical data for HEDIS® quality measurement and improvement, with FHIR standards supporting this interoperability.

Clinical Quality Language (CQL)

HL7 also developed the CQL standard. CQL is a standardized human-readable and machine-executable authoring language for expressing clinical quality measures and clinical decision support (CDS) logic. By providing a common, computable expression language, CQL supports consistency, interoperability, and quality measurement.

Trusted Exchange Framework and Common Agreement (TEFCA)

The TEFCA, created under the 21st Century Cures Act, established a framework for health care information technology interoperability across the country. TEFCA will make accessing and appropriately using health records easier. TEFCA created a roadmap to support a FHIR exchange in TEFCA to accelerate FHIR adoption. Features of TEFCA may include nationwide patient and payer lookup and registry connections to analyze EHR data. Via TEFCA and FHIR, registry data could flow directly into HEDIS® or eCQMs, reducing reporting burden.

Artificial Intelligence (AI)

As use of AI continues to proliferate across health care, opportunities will arise for efficiencies in data extraction, mapping, and quality measure abstraction. Artificial intelligence can significantly ease the challenges of working with clinical registries by automating schema mapping, translating proprietary measure specifications into executable logic, and validating data for accuracy and completeness. In the long term, AI-driven solutions could enable federated analytics, allowing payers to derive insights from registry data without requiring direct data transfers.

Together, standards-based APIs, FHIR/CQL, TEFCA, and emerging AI capabilities provide a practical path to interoperable, lower-burden quality measurement and stronger alignment across public and private programs.

Conclusion

By fostering collaboration among payers, measure owners/stewards, and registries, and by leveraging interoperability standards, payers can move toward greater alignment, reduced reporting burden, and improved quality measurement. Proprietary measures often provide critical insights into specialty care that cannot be captured through measures available for unrestricted public use alone.

Moving forward, success will depend on building trust, establishing clear data use and licensing agreements, and investing in infrastructure that supports seamless data exchange. These efforts will not only enhance adoption of proprietary measures in the CQMC core sets but also strengthen value-based care initiatives across public and private sectors. For additional resources and updates, visit the Partnership for Quality Measure’s website and CQMC page.

Appendix A. Contacts for Registry Measures in the CQMC Core Sets

Measure Steward	Registry	Contact
American Academy of Hospice and Palliative Medicine	Palliative Care Quality Collaborative (PCQC)	info@aahpm.org
The American Board of Family Medicine	PRIME Registry	primeteam@primeregistry.org
American College of Cardiology	National Cardiovascular Data Registry (NCDR)	Contact Us
American College of Radiology	ACR National Radiology Data Registry (NRDR)	Submit a ticket : NRDR - National Radiology Data Registry Support
American Heart Association	Outpace CVD Registry™	AQ Contact Us
American Psychiatric Association	PsychPRO	qualityandpayment@psych.org
American Society of Clinical Oncology	ASCO Quality Measures	measurement@asco.org
American Society for Gastrointestinal Endoscopy	GI Quality Improvement Consortium, Ltd (GIQuIC)	info@giquic.org
College of American Pathologists	College of American Pathologists' (CAP) Pathologists Quality Registry	mips@cap.org
Minnesota Community Measurement	Minnesota Community Measurement	support@mncm.org
The Society for Thoracic Surgeons	STS National Database™	Contact Us | STS
Wisconsin Collaborative for Healthcare Quality (WCHQ)	Data | Healthcare Reporting | WCHQ | Madison	info@wchq.org

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