Technical Assistance Webinar: Core Sets Reporting and the Foundations of Digital Quality Measures (dQMs)

April 30, 2026

Sara Snowden

[Slide 1]

Welcome, and thank you for joining today's session on Core Sets Reporting and Digital Quality Measures, or dQMs. My name is Sara Snowden, and I am a researcher on the Mathematica Technical Assistance Team. I am joined today by colleagues from the Center for Medicaid and CHIP Services and the Core Sets TA team, and we appreciate your participation.

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[Slide 2]

Before we begin, a few quick logistics. All participants are muted. Closed captioning is available via the CC icon in the lower left corner of your screen. A recording of today's session and the slides will be posted on Medicaid.gov, and we will have time for questions at the end of the webinar. Lastly, if you experience any technical issues, please use the Slido Q&A feature on the bottom right of your screen, and we will assist you.

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[Slide 3]

Next, I will pass it over to Gigi Raney from the CMS team to give some welcoming remarks. Gigi?

Gigi Raney

[Slide 3]

Thank you, Sara. Good afternoon, everyone. My name is Gigi Raney, and I want to welcome you to our webinar on digital quality measurement and the transition to new data sources. I'm truly delighted to see so many dedicated state Medicaid quality staff joining us today. We've almost got 150 people already. Your commitment to improving health outcomes, often within tight budgets and evolving systems, is admirable and absolutely vital to the communities that you serve. We know that change can be challenging, especially when every state has unique resources, different starting points, and its own journey with digital transformation.

Please know how much we appreciate your willingness to embrace new approaches and to share your experiences. Today's session is designed to support you, answer your questions, and spark ideas for collaboration as we all navigate this transition together. Thank you so much for your hard work and leadership. We're driving the future of Medicaid quality, and we're honored to be part of this conversation with you. Back to you, Sara.

Sara Snowden

[Slide 3]

Thank you, Gigi.

Next slide, please.

[Slide 4]

Today's webinar provides foundational information on digital quality measures, or dQMs, including CMS expectations, how dQMs relate to Core Sets reporting, and we'll feature two states' experiences transitioning to digital reporting. Our objectives are to enhance understanding of dQMs in the context of

Core Sets reporting, support state planning for the transition to dQM reporting, and to inform future technical assistance offerings.

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Here is an overview of today's agenda. We'll start with foundational information about dQMs, followed by an overview of electronic clinical data sources, or ECDS, and how this methodology fits into Core Sets reporting. And then we'll get to hear from two states, Arizona and Connecticut, about their experiences transitioning to digital reporting. And then we will conclude with questions and a review of related TA resources.

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Let's begin with some foundational concepts related to dQMs.

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CMS defines dQMs as organized as self-contained measure specifications and code packages that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. Interoperability refers to the ability of different healthcare information technologies to securely exchange data. And in practice, this means dQMs enable automated calculation using standardized machine-readable specifications rather than requiring manual interpretation of narrative specifications.

So dQMs move us away from static human-readable specs towards automated standards-based measurement. On the right here, you'll see examples of the types of electronic data sources dQMs use, which include immunization registries, electronic health records, health information exchanges, and claims data.

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CMS's Digital Quality Measurement Strategic Roadmap outlines four domains that guide the transition to dQMs, improving data quality, advancing technology, optimizing data aggregation, and enabling alignment across measures, data, and systems. Together, these domains reflect a broad strategy to advancing digital quality measurement.

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Now, let's discuss CMS's expectations around how this all fits within the current state of Core Set reporting. Across the agency, CMS is transitioning quality programs toward dQMs to reduce administrative burden, minimize manual data entry and interpretation errors, and provide more timely quality assessments by enabling automated standardized data analysis directly from electronic data sources. The Child, Adult, and 1945 Health Home Core Set resource manuals reflect an initial step in this transition for Medicaid and CHIP quality measurement.

These manuals include links to Electronic Clinical Quality Measure, or eCQM, specifications that are similar to Core Set specifications, and ECDS specifications for Core Set reporting. We'll talk more about how states can use ECDS specifications for Core Set reporting in just a moment. But CMS recognizes that states are at different stages of readiness to report dQMs, and as a result, timelines for adopting dQMs will vary. At this stage, CMS encourages states to begin incorporating additional digital data sources into Core Set's reporting, and while states work to incorporate additional data sources, they may

continue using administrative data, either alone or in conjunction with digital data sources, to calculate Core Set measures that include ECDS reporting specifications.

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[Slide 10]

Next, we'll discuss how ECDS fits into Core Sets reporting and supports the transition to dQMs.

Next slide.

[Slide 11]

ECDS is a reporting methodology that expands the use of electronic data sources to provide a more complete view of care. It can serve as a transitional step toward fully digital quality measurement. ECDS measures can be reported using the human-readable specifications developed for Core Sets or be digitally reported as dQMs. In contrast, dQMs are fully digital and use machine-readable, standard-based specifications, such as Fast Healthcare Interoperability Resources, or FHIR, and Clinical Quality Language to enable automated calculation. Both ECDS and dQMs support interoperability, that is, the exchange and use of various electronic data sources and systems, by enabling standardized use of electronic data across systems. With these distinctions in mind, let's discuss the current state of ECDS reporting for Core Set measures.

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Several 2026 Core Set measures include ECDS reporting specifications. States may use one or multiple electronic data sources in the specifications for ECDS reporting. However, states are not required to use all of the allowable ECDS data sources in the specifications in order to report a measure. This flexibility allows states to begin with administrative data while they expand access to additional electronic data sources over time. Next, we'll discuss key differences between traditional quality measures that use administrative claims and encounter data and ECDS and how dQMs differ.

Next slide.

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Traditional quality measurement relies on administrative data and, in the case of the hybrid methodology, sample manual chart review. These measures use human-readable specifications that require manual review and interpretation. ECDS expands available data sources to include EHRs, IHEs, registries, and more.

ECDS can support digital formats such as FHIR and clinical quality language for measures to be fully automated and reported as dQMs. However, for Core Sets reporting, ECDS specifications are currently available in human-readable formats, similar to traditional quality measures to support states' current capabilities along the transition to dQMs. dQMs differ in that they use fully machine-readable, standards-based specifications to enable automated calculation and reporting. So this progression reflects a shift from manual processes towards automated, interoperable measurements.

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So this slide illustrates the phased transition from current reporting approaches to fully digital measurement. Today, states use a combination of traditional quality measures and ECDS specifications. In the next phase, states will expand the use of multiple electronic data sources and adopt standardized data formats. And in the future, dQMs will enable fully automated, standards-based reporting using interoperable systems.

In this future state, Core Set dQM specifications will consist of self-contained packages of files that include technical specifications with both human-readable documentation and computable specifications. dQMs will rely on one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. And again, CMS recognizes that states will move along this continuum at different paces.

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[Slide 15]

So this table lists the measures in the 2026 Child, Adult, and 1945 Health Home Core Sets that include ECDS and/or electronic health record specifications, which links to the eCQM specifications we mentioned earlier in this presentation. The box to the right of the table has links to the Core Set resource manuals and the dQM TA brief, which provides a step-by-step example of how to calculate the APM-CH measure using the ECDS specifications. As a note, the CIS-CH and IMA-CH measures are specified for ECDS reporting. However, ECDS specifications are not currently available for the 1945-A Health Home Core Set. Next, we'll take a look at preliminary information from what states reported for 2025 Core Sets using the ECDS methodology.

Next slide.

[Slide 16]

States and territories reported for 2025 Core Set data to CMS through QMR. Thank you all who helped prepare and submit data and respond to questions from the technical assistance team. We wanted to share some preliminary data on 2025 reporting for the 13 measures with ECDS specifications. As you can see, 51 states and health home programs reported at least one measure using the ECDS methodology.

Across these measures, administrative data remained the most commonly used data source. Notably, many states reported using administrative data alone, even when using the ECDS methodology. For example, 39 states and programs reported at least one measure with administrative listed as the only data source. Of these measures, two were reported by over 30 states as administrative only. And these measures include metabolic monitoring for children and adolescents on antipsychotics, which was reported by 31 states. Follow-up care for children prescribed attention deficit or hyperactivity disorder medication, which was reported by 30 states.

Three measures, the CCS, CIS, and IMA measures, had all states and programs reporting more than just administrative data. And some states were able to include multiple data sources for all ECDS measures. So the key takeaway is that while adoption of ECDS is widespread, most states and programs are still early in the process of incorporating additional electronic data sources. On the next few slides, we'll look more closely at the data sources states reported using with the ECDS methodology and how they vary by measure.

Next slide.

[Slide 17]

This slide shows combinations of ECDS data sources used in 2025 reporting for three example measures, the ADD-CH, AIS-AD, and BCS-AD. Administrative data alone was the most common approach, followed by administrative data combined with EHR and/or HIE data, and combinations of administrative and case management data with EHR and/or HIE. The least frequently used data source combination was EHR and personal health record data alone.

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[Slide 18]

In this slide, we further break out the data sources states used for 2025 reporting of Child Core Set measures with ECDS specifications. Since states can use multiple data sources to calculate each

measure, the number using each data source won't necessarily sum to the total number of states reporting. Note, ECDS was the only available methodology in the Core Set specifications for four measures listed on this slide, the APM, ADD, PRS, and PDS measures. These had administrative data as the most commonly selected data source, with some states also selecting EHR/PHR, or HIE and registry data.

For two measures, the CIS and IMA measure, administrative and hybrid specifications were available for Core Set reporting in addition to ECDS specifications. Fewer states used the ECDS methodology to report these measures. Notably, among the states that opted to use the ECDS methodology had a higher percentage reported using both EHR/PHR, and administrative data for their calculations. Next, we'll take a look at the Adult Core Set.

Next slide, please.

[Slide 19]

This slide shows the breakdown of data sources used by states that reported six adult Core Set measures using the ECDS methodology. Across these measures, administrative data and EHR, PHR were the most frequently cited sources, while case management system data was the least frequently cited data source. Note, ECDS was the only available methodology in the Core Set specifications for three measures listed on this slide, the AIS, PRS, and PDS measures.

For the other three measures, the BCS, COL, and CCS, other specifications were also available. The PDS-AD measure had a more even distribution across data sources among the 17 states that reported using the ECDS methodology. And this may be because some of the codes needed to calculate this measure, including identifying positive depression screening results, are not available in claims data for many states.

Next, we will hear from states about their experiences transitioning to digital quality measurement. First, Arizona will share their experiences, and then we will hear from Connecticut and their administrative service organization partner, Community Health Network of Connecticut.

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[Slide 20]

Great. At this point, I will turn it over to the Arizona team, Georgette Chukwuemeka, Strategic Performance Administrator, and Lindsay Irelan, Quality Improvement Supervisor, is here to share their experiences. I'll turn it over to you.

Georgette Chukwuemeka

[Slide 20]

Thanks, Sara. Good morning, everybody. My name is Georgette Chukwuemeka, and I'm a member of the Quality Improvement Team with the Arizona Healthcare Cost Containment System, or AHCCCS for short, the state's Medicaid agency. And I'm joined here, as Sara mentioned, by my colleague, Lindsay Irelan, as well. Thank you all for the opportunity to be here and to share some information about Arizona's experience with ECDS reporting and digital quality measurement. So, we'll go ahead and get started.

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[Slide 22]

All right. So first, we wanted to provide a very brief overview of AHCCCS and share some information about our agency.

Next slide.

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AHCCCS is the largest insurer in Arizona and has 11 contracts with eight8 managed care organizations, or MCOs, to ensure the healthcare needs of more than 1.8 million members are met. We use federal, state, and county funds to provide services, covering more than 50% of births in Arizona, as well as 60% of nursing facility days, among other things. It's also the single state agency for behavioral health services and is considered the state mental health authority and state opioid response authority as well.

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As mentioned, we have 11 contracts with eight 8 unique managed care organizations, and those MCOs provide services for five distinct programs. That includes AHCCCS Complete Care, also known as ACC, which serves qualifying adults and children. We have AHCCCS Complete Care Regional Behavioral Health Agreements, also known as ACC-RBHAs, which serves qualifying members diagnosed with a serious mental illness, or SMI.

There is also the Arizona Long-Term Care System, or ALTCS, the elderly and physical disabilities program, which serves our elderly members and members diagnosed with a physical disability, as well as our ALTCS developmental disabilities program, which serves our members diagnosed with specific developmental disabilities. And then we have the Arizona Department of Child Safety Comprehensive Health Plan, which serves our children and youth in foster care, and we do have a fee-for-service program, mainly for our tribal population.

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All right. This chart reflects the current care delivery system outlining the programs just mentioned on the previous slide, as well as the associated health plans, or MCOs, for each program. Of note, there are some health plans that serve multiple populations as either direct contractors with AHCCCS or subcontracted health plans for an AHCCCS contractor.

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And lastly, we wanted to share some information about our population trajectory from approximately March-April 2020 through present-day April 2026. In March 2020, the PHE allowed members to keep Medicaid coverage, regardless of current eligibility status, which contributed to the growth in enrollment numbers. And then you can see around April 2023, even though the chart makes it a little difficult to see that, the small text there. But around April 2023, you can see that the member population begins to decline due to the end of the PHE and eligibility determinations. As of April 1st, 2026, AHCCCS serves about 1.8 million members, as mentioned earlier.

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[Slide 27]

So next, we wanted to share a little bit about the AHCCCS Quality Improvement Team in lead-up to information about our performance measures and ECDS dQMs.

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As part of the Medical Services Team within the Office of the Director, the Quality Improvement Team oversees contractor activities meant to improve clinical and non-clinical performance. That includes projects such as performance measures, and that includes the annual reporting of the CMS Core Set results, performance improvement projects, member satisfaction surveys, and other QI-associated efforts, including but not limited to quality components of value-based purchasing payment reform initiatives.

The QI team works closely with QI staff from each of our MCOs, as well as different units and teams within our Division of Managed Care, which is primarily responsible for the oversight of MCO clinical operations and related compliance efforts.

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As part of the MCO oversight activities, the QI team annually reviews and updates managed care contract and policy requirements related to QI activities. Specific to performance measures, some of the MCO requirements include calculating and reporting performance measures using methodologies specified by AHCCCS, participating in performance measure validation or PMV activities conducted by an AHCCCS external quality review organization, or EQRO. And meeting performance measure standards set by AHCCCS and developing quality improvement plans to improve measure performance as needed.

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The QI team also facilitates monthly collaborative meetings with the QI staff of its MCOs to discuss QI-related topics and activities. And as part of these meetings, MCOs were initially surveyed in April 2022 to determine their ECDS dQM reporting readiness. A similar survey was conducted more recently in March 2026 to assess changes in their capabilities. And the next several slides really outline some of those survey results in a comparison of then and now.

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All right. First, I wanted to go over some of the results from the April 2022 survey of our MCOs, where 75% of our MCOs indicated that they were utilizing EHRs as an ECDS data source. All of our MCOs were using clinical registries at the time. 25% indicated they were using case management systems and records. And 50% indicated they were using health information exchange HIE data. In that same survey, the MCOs shared some general challenges with incorporating ECDS data sources, including things such as technology and system limitations, data issues such as validation, completeness, and consistency, and provider barriers such as education, staff, and costs for data acquisition.

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[Slide 33]

In the more recent survey conducted last month, 100% of our MCOs reported using EHR and clinical data registries. 88% of them reported using case management systems and data, as well as social needs assessment data. 75% reported using HIE data. 38% reported using patient-generated report or patient-reported data, as well as other data feeds for services such as dental or labs. And 25% reported using patient portal data. Some of the challenges that MCOs noted with integrating ECDS data sources included data layouts and integration, system connectivity, some of the same data issues that we saw before, validation completeness, as well as some similar provider barriers, education, staff, and cost. And as well as evolving requirements and resources required to validate new data feeds.

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As a summary from April 2022 to March 2026, we saw an increased utilization of data sources, such as with EHR data, case management, and HIE. We also saw additional data sources being leveraged, such as the social needs assessment, patient portal, patient-generated or patient-reported data, and then other data feeds as well.

Next slide.

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As a result of using ECDS data sources, our MCOs reported that performance measure rates for several measures have generally improved. This includes measures such as Breast Cancer Screening, Controlling High Blood Pressure, Childhood Immunization Status, Immunizations for Adolescents, Colorectal Cancer Screening, Glycemic Status Assessment, and Prenatal Depression Screening and Follow-Up.

As an example, one of our MCOs reported that by utilizing case management data in particular, on average, they noted a 13-plus percentage increase in impact for screening measures, such as Prenatal Depression Screening and Follow-Up, among others. The MCOs also noted there have been some improvements in data standardization and completeness over time, although as noted earlier, that's still considered a challenge as well.

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[Slide 36]

So next, we just wanted to go over how this impacted our quality measure reporting for federal fiscal year 2025.

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For federal fiscal year 2025, reflective of calendar year 2024, QMR for the CMS Core Sets, AHCCCS required its MCOs to calculate and report several performance measures using ECDS data sources. MCO-level performance measure results were aggregated by an AHCCCS EQRO to develop statewide results that could be reported to CMS through the QMR system.

As a result, we were able to report several of the Core Set measures using the ECDS methodology. I won't list them all, but they are noted here for reference. One note, however, is that there are particular populations within Arizona's Core Set reporting, such as its fee-for-service population, as well as its transient members, those members who switch health plans or delivery systems within continuous enrollment periods, that did not incorporate ECDS data sources due to varying challenges and therefore reflect administrative data only.

Next slide.

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With that, we wanted to conclude with lessons learned as well as looking forward.

In terms of lessons learned, on the next slide

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Arizona noted that ECDS data specific to the fee-for-service population and transient members are not readily available. Capturing LOINC and SNOMED codes has been an ongoing challenge for both AHCCCS and the MCOs. And then collaboration with MCOs is really critical in being able to leverage those ECDS data sources for performance measure reporting.

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Looking forward, to further improve in measure rates and data capture, MCOs are planning to develop strategies for collecting those LOINC and SNOMED codes from provider systems, as those codes are not readily and currently available in claims data. They're also planning to implement processes to obtain

remote monitoring data, continue engaging with providers and integrating EHR data sources, and also incorporate those FHIR standards into their current processes.

In addition, on our end, we are intending to continue collaborating with our MCOs to report performance measures using ECDS data sources at the statewide level, but then also explore strategies for incorporating ECDS data sources, such as our statewide HIE, for the fee-for-service population. And I believe that is it.

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[Slide 41]

Yep. We have our email address here (ahcccsqi@azahcccs.gov) if anybody has any questions for us after the presentation, but I'll turn it back over to Sara at this time. Thank you.

Sara Snowden

[Slide 42]

Thank you so much, Georgette. Next, I'll hand it over to Caroline Anyzeski, Health Program Assistant from the Connecticut team, and their administrative service organization partner, Karen Dubois, who is the Director of Quality Management at Community Health Network of Connecticut. Over to you all.

Caroline Anyzeski

[Slide 43]

Good afternoon, everyone. I am Caroline Anyzeski, a Health Program Assistant, as stated, in the Division of Health Services at Connecticut Department of Social Services, which is the state's Medicaid agency.

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And then if we could go to the next slide.

[Slide 45]

All right. I'm going to give a little overview of the Husky Health program.

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Medicaid, which is also called Husky Health in Connecticut, covers a little over 1 million people, which is about one in three children and one in six adults. We have Husky A, which covers children and families. Husky B, which is CHIP. Husky C, coverage for those with disabilities. And Husky D, which is Medicaid for low-income adults.

Connecticut Husky Health is 100% fee-for-service. Because of that, we have an administrative service model and we have ASOs for medical, behavioral, dental health, and non-emergency transportation. The ASO model focuses on the member, has lower administrative costs, and helps improve quality and program experience.

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All right. I'm going to pass this over to Karen Dubois, who will go into more detail about the dQMs.

Karen Dubois

[Slide 47]

Thank you, Caroline. And hello, everybody. Today, we're going to be looking at four Connecticut Medicaid rates on four of the Core Set measures, two adult and two children. And within each of the Core Sets, we'll explore the impact on the rates by ECDS reported data sources for an established ECDS measure and for one that will be transitioning in the near future. And we thought this would be a good way to look at the data sources that are currently used as we transition to a digital quality measure reporting system in 2030.

Next slide, please.

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What you're looking at here is the Connecticut rates for Breast Cancer Screening. NCQA transitioned the Breast Cancer Screening measure from an administrative-only reported measure to ECDS reported measure in measurement year 2023. The 2026 rate is not yet finalized, and benchmark rates for 2025 are not yet available. But as you can see, the rates for 2023 and 2024 were above the gold line, which is the Core Set median, and the top quartile, which is the gray line on the two bars for 2023 and 2024.

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This slide displays the ECDS data sources specifically contributing to the 2025 rate. And we're looking at the pie graph. The green part of the pie is the majority. 99.71% of our data is coming from administrative claims data, with a small fraction coming from EHR/PHR categories that we have data sources for.

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[Slide 50]

The next measure is the Hemoglobin A1c Control for Patients with Diabetes less than 8% rate. And for this voluntary Adult Core Set measure, it is currently reported administratively and hybrid. It's slated to become an NCQA HEDIS-ECDS reported measure in measurement year 2027. The bars on the graph demonstrate the components of the administrative versus the hybrid. As you can see, the hybrid component of the measure does have an impact on the final rate that we submit. Over the four years, the rate has made some slight improvements. However, it is expected to decline. We are expecting for it to decline as the hybrid component is completely removed from the measure in 2029 as NCQA and CMS transition from ECDS reporting to digital quality measure reporting.

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This information is valuable. What you're seeing here gives us an idea of where those data sources are coming from with our administrative rate. And this is valuable to us to understand what additional sources we need to get ourselves ready and strategies to get ourselves ready in order to sustain the rate before the hybrid component goes away. What we're seeing here is that the majority of our data for this measure came from our EHR/PHR data sources, followed by administrative sources, which is our claims data, and then our HIE, or clinical registry data.

Next slide.

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The first measure for the Child Core Set that we'll be talking about is the Metabolic Monitoring for Children and Adolescents on Antipsychotics. This measure has two rates. As you can see, Cholesterol Testing is on the left, Blood Glucose Testing is on the right. This particular measure was transitioned as an administrative only to ECDS reported in measurement year 2024. And Connecticut's rates were below the Core Set median and the top quartile for Blood Glucose Testing and below the top quartile for Cholesterol

Testing. I've included this measure because it is important to share on the next slide where our data is coming from.

You can go to the next slide. Thank you.

[Slide 53]

Most of our data, as you can see, the green is from our administrative claim sources. We do get HIE data from our state HIE on labs. And when we looked at our HIE data sources, specifically, independently, we saw that those sources did contribute to this measure quite a bit. However, we had a lot of that data already through claims. And so, what you're seeing with the purple slivers of the pie are 2% for the Blood Glucose Testing and 4% for the Cholesterol Testing were lab values that we obtained from the HIE that were not in our claims data. And then we also had a little bit come in from our EHR/PHR sources.

Next slide.

[Slide 54]

The Childhood Immunization Status rate, again, this one is transitioned from an administrative and hybrid measure to an ECDS measure in 2026. So, the green bars and the blue indicate the impact that administrative and hybrid has on this rate for these measures. And like the HbA1c adult measure, we are expecting to see a decline in this rate with the hybrid component being removed.

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[Slide 55]

When we look at the administrative rate only for 2025 and dig into the data sources that were contributing to that, we're seeing that the majority of that was through claims data, with a little bit of that EHR/PHR data contributing to the administrative rate. And all of this is important. Again, as I said earlier, it's valuable information so that we can position ourselves in order to sustain our rates and hopefully improve.

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Transitioning to getting our digital quality readiness. Connecticut is at the very beginning of that journey. The ECDS data sources do provide additional data sources to help with our rates, but ECDS is really that stepping stone to get to the digital quality measure reporting that's going to be required by CMS and NCQA. And what we did is looked at a couple of different things.

And you can go to the next slide, please. Thank you.

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A couple of components were considered when we're looking at our readiness strategy. And these components can occur simultaneously. So the first one is raising awareness and education. Some of the questions to ask are: are all supporting departments aware of the transition to dQM reporting? Is there knowledge of the magnitude of the journey? This is something that is going to take years. It's not something that is going to happen overnight. A lot of the education has been on understanding that the term ECDS is different from digital quality measures, as Sara pointed out earlier in the webinar. The other important component or the other important piece in this component is having executive sponsorship.

Secondly, the next component is identifying applicable data sources. Take an inventory of existing internal and external data sources that are available to the organization. Identify if there's any additional data sources that could be used that are currently not being tapped into. And then, be sure to have a clinical team involved in those data sources. They can help identify additional relevant data sources that may not have been used traditionally.

And then, our third component, research vendor solutions and resources. So just like states and plans are all in different spaces in terms of readiness, vendors are as well. And having talked to a couple of

vendors, understanding what their solutions are, if they're requiring internal resources that have to be acknowledged to support those solutions or the vendor solution, if it's feasible and adaptable to existing processes or future needs of the organization.

And then, finally, the last component of the initial piece of this is project plan development. You want to include short-term and long-term objectives, identify timelines and have as detailed timelines as possible. And then, organization-wide execution with communication on the project status throughout. This is a big undertaking and affects all areas of the organization.

And you can go to the next slide.

[Slide 58]

And that is it. I will hand it back over to Sara.

Sara Snowden

[Slide 58]

Thank you so much, Karen and Caroline. We really appreciate you all sharing. So now we will be able to move into questions.

Next slide, please.

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So please submit your questions using the Slido panel on the lower right corner of your screen. When the Slido panel is selected, you will see a Q&A box where you can type your questions and then click Send. You can also use that if you need any technical assistance. So we will go ahead and open that up.

Okay. It looks like we already have a question in. Somebody asked, is an ECDS measure that's reported using only administrative data the same thing as a standard or non-ECDS measure? Thank you for your question. For Core Set, ECDS measures can be calculated using either the human readable narrative specifications that are provided in the resource manuals, or digital packages that are developed by NCQA. So if a state uses the human readable specifications and calculates using administrative data alone, this would be a similar process as calculating and reporting a traditional administrative measure, although there are some differences in the measurement terms used in the specifications compared to traditional administrative specifications.

Okay. Looks like we have another question.

What measures would CMS recommend targeting as states expand digital data sources, particularly as an effort to improve data quality? So we encourage states to review their current quality reporting to identify measures that may not accurately reflect quality of care when relying on administrative data alone, especially for ECDS measures. CMS encourages states to identify health information exchanges that may be data sources. Additionally, data from labs using LOINC codes. These could also be an option. States may also consider potential holders of lab data as partners to engage with. Some states that we know of have reported promising results by beginning their dQM efforts with measures for which services are not fully captured in claims data. So for example, one state focused on the depression screening and follow-up measure, and they saw that using administrative data alone, they observed very low performance. However, performance improved substantially after they incorporated electronic health record data into the measure calculation. So other states have similarly gained some more comprehensive insight into care delivery by integrating additional data sources, such as state immunization registries as well. Thank you for that question.

Another question we had: will CMS's dQM specifications align with NCQA's HEDIS dQM specifications? Currently, in the Core Set resource manuals, only human readable versions of the ECDS specifications are included. These specifications align with the HEDIS digital package specifications with some minor differences such as age breakouts. Thank you for that question as well.

Okay. It looks like we have a question for the state speakers, if anyone would like to answer. When a patient portal was mentioned as a data source, were you actually pulling data directly from individual patient portals?

Georgette Chukwuemeka

Hi, Sara, this is Georgette. That's something we'll probably have to follow up with our MCOs on, to get a little bit more detail about how they are pulling data from the patient portal systems.

Karen Dubois

And I could speak for Connecticut. We are not using patient portals at this time.

Sara Snowden

Thank you. Another question, potentially for Arizona, do your current MCO contracts fully reflect reporting requirements for ECDS and dQM measurement to inform potential reporting standards for other states that are using managed care?

Georgette Chukwuemeka

So within our contracts and policies, we do specify that our MCOs must adhere to performance measure methodologies that are indicated by AHCCCS or selected by AHCCCS. Within that, within that, I don't believe we go into too much further detail about, you know, for example, some of the data sources required under the ECDS methodology, but we do specify that the methodologies could be ECDS, could be admin, could be hybrid. But the additional details of the data sources are not included in contractor policy at this time.

Sara Snowden

Thank you. Another question we got was, following up on the first question, if a state follows the ECDS specifications using the human readables, but only has access to administrative data for a particular measure, is the state considered to be compliant with the ECDS reporting method or not? Yes, a state that adheres to the human readable ECDS specifications in the resource manuals is complying with ECDS reporting methodology, even if they are just using administrative data alone at this time. Thank you for that question.

Okay, so we've received a few questions around the use of FHIR APIs and HIEs. And we know states are interested in learning more about other states' experiences, just confirming that CMS is looking for opportunities for states to share directly with each other, such as in small group learning sessions. So more information will be coming on that. And if we did not get to your question, we will definitely follow up with you after the webinar. So thank you all for your participation and your questions.

Okay, next slide, please.

[Slide 60]

So now we'll launch a brief set of polls to better understand your current priorities and inform future technical assistance.

Next slide, please.

[Slide 61]

Okay, the first slide -- or sorry, the first poll is what is the biggest barrier that your state faces in obtaining digital data for Core Set reporting? Please select one of the below and don't forget to click Send. And if you select other, feel free to add any details or clarification in the Q&A panel. Okay, we can close this poll and see what folks said. Okay, it looks like the most popular response was access to outside sources of clinical data, such as EHRs. Thank you for your responses. Next slide, please.

[Slide 62]

The next poll is what dQM-related technical assistance content would be most beneficial to your state. You can select all that apply here. And again, if you select other, please feel free to add any details or clarification in the Q&A panel. Okay, folks, a couple of seconds. Don't forget to click Send. Okay, we can close this poll. Thank you for participating. It looks like templates such as roadmaps for moving to dQM reporting was the most popular response. So thank you all.

Next slide, please.

[Slide 63]

Poll number three, what is your preferred TA format? And here you can select all that apply. Okay, we can close this one as well. Webinars followed by written resources were the most popular responses.

Thank you.

[Poll 64]

And lastly, which of the following topics would you be most interested in exploring through small group learning opportunities? Please rank the below options by your preference. You can click in. When you hover, you should see numbers appear as one being the most interested. You can also drag the responses in order of how you prefer them in the poll.

Okay, we'll give folks a couple more seconds to rank your preferred options, and don't forget to click Send. Final call, last 10 seconds, and then we will close this one out. Okay, we can go ahead and close and see what folks said. Great, thank you for your responses.

We can go ahead and move on to the next slide.

[Slide 65]

So lastly, we wanted to highlight some of the new and upcoming dQM-related TA resources.

Next slide.

[Slide 66]

CMS has developed several resources to support states, including a dQM TA brief that includes a step-by-step measure, calculation example, a dQM fact sheet, which is a new resource that addresses common questions about dQMs and Core Sets, and the dQM readiness resource, which we'll discuss in more detail on the next slide.

The new readiness resource was shared with states on March 12th. Please email CMS at the address shown here if you did not receive a copy and are interested. CMS also plans to host a small group learning session for states to share their experiences and lessons learned on incorporating digital data sources, like HIEs and/or clinical registries, intercourse sets reporting, and improving interoperability. So stay tuned for more information on that.

Next slide, please.

[Slide 67]

So as we mentioned, there is a new dQM-TA readiness resource designed to help states assess their current capabilities, identify barriers, and plan next steps for transitioning to dQM reporting. It is intended to support internal discussions and inform future technical assistance. States are encouraged, but they are not required, to share their completed assessments with CMS to inform ongoing support.

Next slide, please.

[Slide 68]

Additional resources are also available to support your dQM efforts, and a glossary of key terms is included at the end of this slide deck.

Next slide, please.

[Slide 69]

Thank you so much for your time and participation. We really appreciate your partnership and all that you do to improve quality of care for Medicaid and CHIP beneficiaries. We encourage you to explore the resources shared today and to reach out for any technical assistance as you continue your transition to digital quality measurement. Thank you to our speakers, and thank you all for attending today.