



VIA ELECTRONIC TRANSMISSION

May 28, 2026

Dr. Mehmet Oz
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-2453-NC, Medicaid Program; 2028 Medicaid Home and Community-Based Services Quality Measure Set

Dear Dr. Oz:

On behalf of ADvancing States and the National Association of State Directors of Developmental Disabilities Services (NASDDDS), we are pleased to offer comments on the 2028 Medicaid Home and Community-Based Services Quality Measure Set (CMS-2453-NC).

ADvancing States is a nonpartisan association of state government agencies that represents the nation's 56 state and territorial agencies on aging and disabilities and long term services and supports directors. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services (HCBS). Our members administer services and supports focused on older adults and people with physical disabilities, and their caregivers. They manage a wide range of Medicaid HCBS programs and are largely responsible for implementing the HCBS Quality Measure Set. Together with our members, we work to design, improve, and sustain state systems delivering long-term-services and supports (LTSS) for people who are older or have a disability and their caregivers.

NASDDDS represents the nation's state agencies, and the District of Columbia and Puerto Rico, providing services to children and adults with intellectual and developmental disabilities (I/DD) and their families. NASDDDS promotes visionary leadership, systems



innovation, and the development of national policies that support HCBS for individuals with disabilities and their families. The NASDDDS mission is to assist member state agencies in building effective, efficient person-centered systems of services and supports. NASDDDS members administer a significant portion of the Medicaid program, have responsibility for implementing the HCBS Quality Measure Set, and manage approximately one third of Medicaid LTSS spending and within that, three quarters of Medicaid HCBS spending.

Thank you for your continuing work to strengthen the critical HCBS services that over 5 million Medicaid beneficiaries receive. This notice follows over a decade of efforts to finalize and publish a reliable, transparent, and meaningful HCBS Quality Measure Set. The goals of the measure set continue to reflect important priorities for Medicaid:

- promoting more common and consistent use within and across states of nationally standardized quality measures in HCBS programs;
- enabling access for states and CMS and states to comparative quality data on HCBS programs;
- driving improvement in the quality of and outcomes for people receiving HCBS; and
- supporting states' efforts to ensure equitable access to services and supports in their HCBS programs.

In FY 2023 alone, HCBS accounted for \$145.9 billion in Medicaid expenditures. As HCBS programs and service delivery systems continue to grow, it is imperative to ensure beneficiaries have access to high-quality service delivery that supports them to live and thrive in their communities.

At the same time, states face unprecedented budget constraints and competing regulatory priorities. In order for states to successfully implement the HCBS Quality Measure Set, resources will be required. While we acknowledge and thank CMS for providing Money Follows the Person grantee states the opportunity to use MFP funds to implement the HCBS Quality Measure Set, it remains an unfunded mandate. We ask for consideration in delaying implementation, cutting back requirements on mandatory measure reporting – including removal of the administrative measures – and provide opportunities to fund states with operating needed reporting infrastructure.

Mandatory Measures

CMS Request for Comment: CMS requests comment on whether there are additional measures that should be mandatory and whether any of the proposed mandatory measures should instead be voluntary or removed from the 2028 HCBS Quality Measure Set.

We appreciate CMS's efforts to solicit stakeholder feedback and engage the HCBS QMS Workgroup in identifying appropriate mandatory measures for the 2028 Quality Measure Set. We recognize that MFP grantee states already have experience with the recommended mandatory measures.

At this state of implementation, we recommend maintaining the currently proposed mandatory measures without expansion for at least the 2028 HCBS QMS. Allowing states time to establish baseline data and benchmarks will provide them and CMS with a stronger foundation for evaluating feasibility, consistency, and long-term measure utility before additional mandatory measures are introduced.

CMS Request for Comment: CMS requests comment on whether to include a total of 23 mandatory measures in the 2028 HCBS Quality Measure Set.

Given the significant number of existing experience of care and administrative measures already included in the proposed set, we do not recommend adding further mandatory measures at this time.

CMS Request for Comment: CMS requests comment on whether States should be required to report participant-reported experience of care survey measures from one or more of the four experience of care surveys proposed for inclusion in the HCBS Quality Measure Set. Because States serve different HCBS populations and may use one or more of the four proposed experience of care surveys, the total number of measures a State would report would be expected to range from 9 to 19.

States need to retain flexibility to utilize as many surveys as needed to cover all populations. States use varying surveys currently (such as NCI-IDD, NCI-AD, or HCBS CAHPS) and requiring a single survey would create administrative and financial burdens for states to shift operations. States currently have quality strategies built around their current

experience of care survey administration and requiring additional shift or adoption of additional tools would create undue burden for participating states.

CMS Request for Comment: CMS requests comment on whether we should exclude any of the surveys from the 2028 HCBS Quality Measure Set. Individuals receiving HCBS under more than one HCBS program or delivery system during the same reporting period could potentially be included in the survey sample for more than one experience of care survey.

We do not recommend exclusion of any experience of care surveys currently contemplated.

CMS Request for Comment: CMS requests comment on whether we should require States to deduplicate survey samples when individuals may be included in the sample for multiple experience of care surveys.

If states are using multiple surveys, we would recommend that they select one survey tool for each unique population.

CMS Request for Comment: CMS requests comment on our proposal to include LTSS–1 and LTSS–2 as mandatory measures in the 2028 HCBS Quality Measure Set.

Person-centered assessment and planning are a core component of strong HCBS services, and therefore critical to measure. We do not believe that LTSS-1 and LTSS-2 are the correct measures, as currently specified, to achieve that goal.

As required by the *Ensuring Access to Medicaid Rule*, an independent HCBS Quality Measure Set (QMS) Review Workgroup comprising representatives from State agencies, managed care plans, beneficiary advocates, providers and provider associations, researchers, measure developers, and other subject matter experts was established in fall 2024. The purpose of the workgroup was to review and identify gap areas in the HCBS QMS and recommend changes for improvement. The HCBS QMS Review Workgroup reiterated the value of and importance of the concept of measuring person-centered planning yet recommended removing these measures from the measure set.

In particular, the workgroup reviewed each of the measures suggested for addition or removal through a public call for measures and, in spring 2025, voted on the

recommendations. The workgroup by a 2/3 vote recommended removal of LTSS-1 and LTSS-2 from the measure set. However, CMS proposes to require them as mandatory measures. We believe this represents a missed opportunity to align the measure set with workgroup member expertise and to prioritize measures that more directly assess person-centered outcomes and system performance.

It is important to note that these measures were originally built for MLTSS programs and reflect the activities that are undertaken by a managed care plan when delivering HCBS. While CMS states that they have been respecified for fee-for-service (FFS) systems, as constructed, they do not fit those systems. Regarding LTSS-1, a FFS system often uses multiple assessment tools – one to determine eligibility and one to advise service plan development, and in many cases do not obtain the information required to meet measure specifications. For LTSS-2, FFS states may have a decentralized system of case managers/support coordinators developing person-centered service plans. For both measures, states without a managed care delivery system will encounter significant administrative burden to collect the required data.

Finally, LTSS-1 and LTSS-2, as currently specified, primarily measure the completion of documentation and administrative processes rather than the quality, effectiveness, or person-centered nature of the planning itself.

While documentation and timeliness are important operation components, the presence of completed forms or required fields does not necessarily demonstrate that a meaningful person-centered assessment or planning process occurred or that services were truly shaped by an individual's goals, preferences, and desired outcomes.

Person-centered planning should focus on what is important *to* and *for* the person receiving services, including the individual's goals, preferences, relationships, strengths, desired outcomes, and definition of a meaningful life in the community. Likewise, person-centered assessment processes should incorporate strength-based approaches that identify an individual's capabilities, interests, natural supports, and opportunities for community inclusion — not solely deficits, diagnoses, or service needs.

While we strongly support the importance of measuring person-centered planning and assessment, we do not believe LTSS-1 and LTSS-2, as currently specified, adequately capture these foundational principles of person-centered practice.

Although CMS notes that states have begun building infrastructure to support these measures, many states remain in the early stages of assessing the substantial operational, systems, staffing, and reporting changes that would be required to implement LTSS-1 and LTSS-2.

States continue to seek additional clarity regarding measure specifications, reporting methodologies, operational expectations, and the reporting infrastructure CMS intends to use. Further, because these measures were originally developed within managed care environments, many fee-for-service HCBS systems would require significant modifications to assessment tools, workflows, documentation practices, and data systems before reliable reporting could occur.

As a result, many states have not yet begun the full scope of systems redesign and infrastructure development necessary to operationalize these measures effectively.

While we fully support the importance of person-centered planning and assessment, we remain concerned that LTSS-1 and LTSS-2:

- primarily assess documentation completion rather than meaningful person-centered practices or outcomes;
- may incentivize compliance-focused administrative activity rather than high-quality planning processes;
- impose significant administrative and systems burden on states, particularly in fee-for-service delivery systems;
- do not align well with how many modern HCBS systems operationalize assessment and service planning; and
- may provide limited value for quality improvement relative to the operational burden required for implementation

At the same time, CMS is clearly signaling a shift toward experience, outcomes, and standardized national reporting, with measures heavily grounded in tools like NCI™ and CAHPS®.

An alternative approach that CMS could consider is to add specific measures from the experience of care surveys to address person-centered planning (in lieu of LTSS-2). We believe they would more effectively measure that concept. For example, the NCI surveys

include both process and outcome-oriented indicators regarding person-centered planning and outcomes. The following measures are included below for your consideration:

NCI-IDD

- The percentage of people who report that they helped make their service plan
- The percentage of people who report that the service planning meeting included people they wanted to be there
- The percentage of people who report that their service plan includes things that are important to them
- The percentage of people who report their case manager/service coordinator reviews their service plan with them throughout the year, when needed

NCI-AD

- Percentage of people who are involved in making decisions about their service plan
- Percentage of people whose service planning meeting included the people they wanted to be there
- Percentage of people whose service plan reflects what was discussed in the service plan meeting
- Percentage of people whose service plan includes their preferences and choices

CMS Request for Comment: CMS requests comment on whether the measures recommended for addition by the HCBS Quality Measure Set Workgroup should be included as mandatory measures in the 2028 HCBS Quality Measure Set.

Given the significant number of existing experience of care and administrative measures already included in the proposed 2028 HCBS QMS, we do not recommend adding further mandatory measures at this time.

CMS Request for Comment: CMS requests comment on whether to allow States to report on the HEDIS equivalent of LTSS–1 and LTSS–2 (FASI–1 and FASI–2 in place of LTSS–1 and LTSS–2, respectively) to meet the proposed mandatory reporting requirement for those measures. We request comment on these proposed options for States.

As further detailed above, we do not agree that these should be mandatory measures.

CMS Request for Comment: CMS requests comment on collecting the data on the proposed mandatory measures through several different methods, depending on the measure. Specifically, comments are requested on whether to provide States the option to elect, for each of the three administrative data measures, to either self-report using a standardized form in MDCT or have CMS conduct analyses and report on the State’s behalf using T-MSIS Analytic Files, consistent with § 441.312(d)(1)(iii).

We appreciate that CMS has offered this option but remain concerned about the accuracy and validity of T-MSIS data. We are hopeful that the data quality will improve over the next year or two, but would prefer that states have the opportunity to make the decision about whether to have CMS calculate those measures after seeing the measure data. State would like the opportunity to report data directly to CMS if the T-MSIS data does not match state data.

CMS Request for Comment: CMS proposes to require States that conduct the HCBS CAHPS survey to report the results to the HCBS CAHPS survey database managed by the Agency for Healthcare Research and Quality (AHRQ) and for CMS to work with AHRQ to obtain the survey results from the HCBS CAHPS database rather than through State reporting directly to CMS. For States that conduct NCI-AD and NCI-IDD, CMS requests comment on States reporting the data through the existing processes for those surveys and for CMS to obtain the survey results directly from the measure stewards (ADVancing States and Human Services Research Institute (HSRI) for NCI-AD; and the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and HSRI for NCI-IDD), rather than through State reporting directly to CMS.

As measure stewards, we note that the costs associated with data reporting to CMS on behalf of the state is not – as yet - funded. If CMS does not intend to provide funding for the measure stewards, states may experience increased costs.

Voluntary Measures

CMS Request for Comment: CMS requests comment on the CMS proposals to include LTSS-4 and MLTSS-5 as voluntary measures in the 2028 HCBS Quality Measure Set.

As reporting to CMS is new, we do not support adding any voluntary measures to the 2028 HCBS Measure Set. We want to focus on meeting the requirements for the mandatory measures for the first year of reporting. Moreover, CMS will not have a standard and uniform set of measures to report; states that choose not to report the voluntary measures could appear less invested in HCBS quality outcomes. This presents a risk that would instead demonstrate an inaccurate portrayal of HCBS systems and state investment in quality service delivery.

CMS Request for Comment: CMS requests comment or additional evidence that could inform future selection decisions.

We suggest that if CMS is to include additional measures, that measures are selected that work across both FFS and managed care delivery systems.

CMS Request for Comment: CMS requests comment on whether FASI–1, FASI–2, HCBS–10, Plan All-Cause Readmission, or LTSS– 3 should be included as voluntary measures in the 2028 HCBS Quality Measure Set.

As reporting to CMS is new, we do not support adding any voluntary measures to the 2028 HCBS Measure Set. We want to focus on meeting the requirements for the mandatory measures for the first year of reporting. Moreover, CMS will not have a standard and uniform set of measures to report; states that choose not to report the voluntary measures could appear less invested in HCBS quality outcomes. This presents a risk that would instead demonstrate an inaccurate portrayal of HCBS systems and state investment in quality service delivery.

CMS Request for Comment: CMS requests comment on whether to collect the data on voluntary measures through several different methods, depending on the measure. These methods include CMS analyses using T– MSIS Analytic Files; 43 the HCBS CAHPS database; the MDCT; 44 NCI–AD survey data collection; and NCI–IDD survey data collection.

As reporting to CMS is new, we do not support adding any voluntary measures to the 2028 HCBS Measure Set. We want to focus on meeting the requirements for the mandatory measures for the first year of reporting. Moreover, CMS will not have a standard and uniform set of measures to report; states that choose not to report the voluntary measures

could appear less invested in HCBS quality outcomes. This presents a risk that would instead demonstrate an inaccurate portrayal of HCBS systems and state investment in quality service delivery.

CMS Request for Comment: For States that conduct NCI-AD and NCI-ID, CMS requests comments on whether data should be reported through the existing processes for those surveys, with CMS obtaining results directly from the measure stewards (ADvancing States and HSRI for NCI-AD; and NASDDDS and HSRI for NCI-ID), rather than through State reporting directly to CMS.

As measure stewards, we will report data on measures from these surveys on behalf of the state. However, we note that the costs associated with this reporting is not funded. If CMS does not intend to provide funding for the measure stewards, states may experience increased costs.

CMS Request for Comment: CMS requests comment on these proposals, particularly related to whether there are existing data sources for measures for which States would need to self-report the measures using a standardized form in MDCT.

As noted above, we do not recommend reporting of the voluntary measures in the early implementation years of the HCBS Quality Measure Set.

Proposed Stratification Requirements

CMS Request for Comment: CMS requests comment on whether to require States to report stratified data for five of the mandatory measures: LTSS-1, LTSS-2, LTSS-6, LTSS-7, and LTSS-8, and to stratify by geography only for the first reporting period.

We appreciate the effort to reduce the administrative and cost burden associated with stratification of the experience of care survey derived mandatory measures and agree that delaying the stratification of the survey measures is appropriate. As noted earlier in this comment letter, we oppose the inclusion of LTSS-1 and LTSS-2 as mandatory measures. For the other measures, we agree that reporting by geography is reasonable.

We appreciate CMS's efforts to balance meaningful stratification with administrative feasibility and beneficiary privacy protections. However, we remain concerned that



additional stratification requirements, particularly for experience of care survey measures, could increase the risk of indirectly identifying individuals receiving HCBS services.

HCBS programs frequently serve smaller and more specialized populations than other healthcare delivery systems, particularly within rural areas, specific waiver populations, or narrowly defined demographic groups. As additional stratification variables are layered into reporting requirements, cell sizes may become sufficiently small that individuals could potentially be identifiable even absent direct personal identifiers.

This concern is especially important given the highly individualized nature of HCBS services and the smaller provider networks and communities in which many people receive supports. We therefore encourage CMS to approach future stratification requirements cautiously and to maintain robust suppression standards and flexibility for states in order to appropriately protect individual privacy.

CMS Request for Comment: CMS requests comment on whether to determine the number of proposed mandatory measures that would require stratification using the likely maximum number of measures that States would need to report, rather than the total number of proposed mandatory measures in the 2028 HCBS Quality Measure Set. Specifically, CMS asks whether to require States to report stratified data for five of the mandatory measures. We believe this approach more effectively recognizes the practical implications of the design of the 2028 HCBS Quality Measure Set than an approach based on the total number of proposed measures.

We appreciate the effort to reduce the administrative and cost burden associated with stratification of the experience of care survey derived mandatory measures and agree that delaying the stratification of the survey measures is appropriate. As noted earlier in this comment letter, we oppose the inclusion of LTSS-1 and LTSS-2 as mandatory measures. For the other measures, we agree that reporting by geography is reasonable.

We appreciate CMS's efforts to balance meaningful stratification with administrative feasibility and beneficiary privacy protections. However, we remain concerned that additional stratification requirements, particularly for experience of care survey measures, could increase the risk of indirectly identifying individuals receiving HCBS services.

CMS Request for Comment: For each of the measures CMS requires States to stratify, CMS requests comments on whether to require stratification by geography, using a minimum standard of core based statistical area (CBSA) with a recommendation to move towards Rural-Urban Commuting Area Codes. CMS is not proposing to require stratification for any other factors.

We do not recommend that any measures should be stratified in year one of HCBS Quality Measure Set implementation. However, if CMS decides to pursue this approach, geography is likely the easiest strata to employ.

Proposed Reporting Populations and Proposed Attribution Rules for More Than One HCBS Population

CMS Request for Comment: CMS requests comment on whether State reporting on each mandatory measure (and each voluntary measure, if applicable) should be in the aggregate across all of the applicable HCBS programs subject to the requirements at § 441.311(c).

We do not support a merged or aggregate reporting of all applicable HCBS programs subject to the requirements § 441.311(c). Aggregating data across fundamentally different HCBS programs, waiver authorities, delivery systems and populations would not provide a meaningful or accurate representation of HCBS quality within a state.

Many states administer HCBS through distinct program structures designed to serve different populations with different service models, provider networks, and oversight mechanisms. Combining these data into a single statewide aggregate could obscure meaningful variation in performance and reduce the usefulness of the data for quality improvement purposes.

In addition, requiring states to combine data across multiple systems would create significant administrative and operational burden, particularly where data systems and reporting structures were not designed for cross-program aggregation.

Proposed Reporting Schedule

CMS Request for Comment: CMS requests comment on whether to retain flexibility in the 2028 HCBS Quality Measure Set by allowing States that conduct HCBS CAHPS and/or POM to field those surveys at any time during calendar year 2026 or 2027, and States conducting NCI-AD and/or NCI-IDD to field those surveys during the July 2026–June 2027 or July 2027–June 2028 reporting cycles. CMS requests comment on proposed timeframes for States to field experience of care surveys for the 2028 HCBS Quality Measure Set, including our proposed flexibility for States to conduct experience of care surveys during a two-year time period.

We appreciate the flexibility considered by CMS and support the proposal to allow reporting in the prior two-year time period.

CMS Request for Comment: CMS requests comment on the measurement periods for each measure as to the feasibility of State reporting in 2028.

Some, but not all, states have implemented an experience of care survey. Those who implemented the surveys and have participated in the current or next data cycle should be in a situation to report required data elements in 2028. However, for states that have not yet implemented an experience of care survey, 2028 is a very aggressive timeline to select a survey, implement the survey, and complete data collection. One of the largest challenges will be for states to identify a funding source to complete this work.

Proposed Exemption for Small Numbers

CMS Request for Comment: CMS requests comment on allowing States to suppress values larger than 10, such as up to 25, up to 50, or up to 100, due to beneficiary privacy, State reporting burden, or other factors.

We support the proposal to allow States to suppress values up to 100 due to beneficiary privacy, State reported burden for a small N, and other potential factors such as cost in reporting small data sets.

General Comment

While the HCBS Quality Measure Set is a huge step forward in our field, we must note the lack of any measures addressing the direct care workforce. Workforce capacity is an



essential prerequisite for access to home and community-based services. We would offer the NCI State of the Workforce survey as a source of potential measures for future iterations of the HCBS QMS on wages, tenure, turnover and other key metrics about the direct care workforce.

Thank you again for the opportunity to provide comments on the proposed 2028 HCBS Quality Measure Set. We appreciate CMS's continued commitment to strengthening quality services, transparency, and accountability across HCBS systems with recognizing the complexity and diversity of state service delivery structures.

As CMS finalizes implementation of the 2028 HCBS QMS, we encourage continued collaboration with states, people with lived experience, providers, and other stakeholders to ensure the measure set remains feasible, meaningful, and focused on improving outcomes for people receiving HCBS.

Successful implementation will require balancing transparency and accountability with operational realities facing state HCBS systems, including administrative capacity, systems readiness, reporting burden, and the differences among HCBS delivery models across the country.

We appreciate CMS's continued stakeholder engagement throughout this process and welcome ongoing dialogue regarding implementation considerations, reporting methodologies, and future measure development efforts.

If you have any questions or would like additional information, please contact Rosa Plasencia (rplasencia@advancingstates.org) and Laura Vegas (lvegas@nasddds.org).

Sincerely,

A handwritten signature in blue ink that reads "Martha Roherty".

Martha Roherty
Executive Director
ADvancing States

A handwritten signature in blue ink that reads "Mary Sowers".

Mary Sowers
Executive Director, National Association of
State Directors of Developmental Disabilities