

May 28, 2026

Dr. Mehmet Oz, Administrator  
Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services  
Attention: CMS-2453-NC  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

**RE: Medicaid Program; 2028 Medicaid Home and Community-Based Services Quality Measure Set**

Dear Administrator Oz,

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide input on the proposed 2028 Medicaid Home and Community-Based Services Quality Measure Set notice (referred to in this document as “the proposed Measure Set”).

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.<sup>1</sup> Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service (FFS) system with a particular focus on ensuring beneficiaries’ quality of life and ability to live as independently as possible. Many MLTSS Association member plans are also leaders in integrated care for dually eligible individuals, offering Dual Eligible Special Needs Plans (D-SNPs) across the full spectrum of integration.

The Association appreciates CMS’s continued efforts to promote greater consistency and comparability in Home and Community Based Services (HCBS) quality measurement across states. Standardized, nationally comparable quality data is essential to understanding whether HCBS programs are effectively meeting the needs of members and ensuring responsible use of taxpayer funds. The Association also supports and shares in CMS's broader goal of driving meaningful quality improvement across HCBS delivery systems. At the same time, we urge CMS to consider the practical implications of the proposed Measure Set for managed care plans operating MLTSS programs.

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<sup>1</sup> Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, Lakeland Care, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices.

## **Implementation and Operational Considerations**

### **Reporting Burden and Feasibility**

The MLTSS Association appreciates CMS's stated intent to reduce state reporting burden by leveraging existing data sources, including the HCBS CAHPS database, NCI-AD and NCI-IDD survey data collection pipelines, and T-MSIS Analytic Files. However, we are concerned that the proposed Measure Set may still impose reporting burdens on MCOs which will need to provide significant data to their state partners. CMS estimates that states would report between 9 and 19 mandatory measures depending on the populations served and surveys used, a range that reflects the significant burden that multi-state plans serving diverse populations will particularly face.

CMS is soliciting comments on whether it should require states to conduct one or more of four experience of care surveys to assess the experience of care for each major population group served in the state's HCBS programs. The MLTSS Association supports the use of these surveys and sees the value in having input from members to understand program outcomes and quality of life. However, we also note that the administration of these surveys may require states to coordinate with MLTSS plans. Requiring states and plans to coordinate across multiple survey instruments may place a strain on plan resources and create inconsistencies in survey administration.

### **Survey Deduplication**

CMS is soliciting comments on whether States should be required to deduplicate survey samples when individuals may be included in the sample for multiple experience of care surveys. The MLTSS Association supports deduplication and encourages CMS to take meaningful steps in that direction, while recognizing the administrative complexity CMS has identified as a barrier.

Duplicate survey responses from the same member could meaningfully distort plan and program-level quality data, skewing results in ways that affect plan performance. At the same time, we recognize that requiring deduplication across multiple survey instruments and entities may not be immediately feasible for all states.

We therefore urge CMS to provide technical assistance and standardized guidance to states and MCOs that choose to deduplicate survey samples, and to encourage deduplication as a best practice. We also encourage CMS to assess, through the initial reporting cycle, the extent to which duplicative survey responses are occurring and the degree to which they are affecting data quality.

### **Stratification Requirements and Phase-In Schedule**

The MLTSS Association appreciates and agrees with CMS’s phased approach to stratified reporting, which requires states to provide stratified data for 25 percent of measures by July 9, 2028, 50 percent by July 9, 2030, and 100 percent by July 9, 2032.

We also encourage CMS to take the below additional steps to ensure stratified reporting is implemented in a way that produces meaningful, actionable data without imposing burden on managed care plans.

- First, CMS could consider requiring stratification by dual eligibility status. Stratification by dual eligibility status would enable CMS, states, and MCOs to identify disparities and target quality improvement efforts for this population.
- Second, CMS should clarify the unit of analysis for stratified reporting in managed care contexts. Currently, it is not clear whether stratification requirements will apply at the state aggregate level, the delivery system level, or the managed care plan level. CMS should specify how plans and states are expected to coordinate on data collection and reporting, particularly for experience of care survey measures where survey administration may be handled by the plan, the state, or a third-party vendor.
- Third, to the extent possible, CMS should disaggregate MLTSS and FFS populations within experience of care surveys.

### **Populations for Reporting and Attribution Rules**

The MLTSS Association encourages CMS to provide clear attribution guidance for members who qualify under more than one HCBS population category, for example, an older adult who also has an intellectual or developmental disability. Without clear attribution rules, plans and states risk inconsistent reporting that limits the comparability and utility of the data.

Additionally, dually eligible individuals represent a disproportionate share of HCBS enrollment and expenditures, yet the proposed Measure Set does not explicitly address the unique needs, care patterns, or data challenges associated with this population. The MLTSS Association encourages CMS to ensure that the proposed Measure Set captures the experience of dually eligible individuals and supports the integration of Medicare and Medicaid services for this population. Specifically, we note that while CMS has identified dually eligible individuals as a required reporting population under § 441.312, the proposed 2028 Measure Set provides little guidance on how states and plans should report on this population.<sup>2</sup> We urge CMS to issue specific attribution and reporting guidance for dually eligible individuals as part of its

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<sup>2</sup> [https://www.ecfr.gov/current/title-42/part-441/section-441.312#p-441.312\(d\)\(5\)\(ii\)](https://www.ecfr.gov/current/title-42/part-441/section-441.312#p-441.312(d)(5)(ii))

implementation guidance including specifying whether dually eligible individuals are included or not for all required measures. Also, as we note above, we urge CMS to consider requiring stratification by dual eligibility status as a first step toward capturing this population's unique experiences with care.

The MLTSS Association appreciates the release of quality measures for [children, youth, and young adults \(CYYA\) receiving Medicaid HCBS](#). The MLTSS Association would be happy to convene the appropriate managed care Subject Matter Experts (SMEs) to support CMS as they engage on future measures for more specialized populations and other domains, including employment and self-direction.

### **Proposed Reporting Schedule**

The MLTSS Association supports a biennial reporting cycle to balance the administrative burdens of data collection with the need for timely, actionable data. However, we are concerned that the July 2028 reporting deadline may not allow sufficient time for states to report accurately and consistently for measures where plans will need to conduct file reviews and analyze their own assessment and case management data, and states will need to aggregate such data across many plans and other case management entities in order to meet reporting requirements. MLTSS plans have been working to prepare for the required data reporting, including renegotiating data sharing agreements with state Medicaid agencies, updating their case management and encounter data systems, and coordinating with survey vendors. However, given the updates included in the proposed measure set, we recommend that CMS continue to build on its existing implementation guidance and technical assistance efforts by providing targeted, ongoing support specifically for MLTSS plans and their state partners ahead of the first reporting cycle and beyond. While we first raised these concerns during the Medicaid Access rulemaking,<sup>3</sup> the MLTSS Association continues to believe that states and plans will face significant challenges meeting the July 2028 deadline, and we urge CMS to take meaningful steps to mitigate those barriers.

We also encourage CMS to consider whether the current reporting deadline provides sufficient time for managed care plans and states to build the necessary data infrastructure, renegotiate contracts, and coordinate with survey vendors, and whether an extension to the deadline may be needed to ensure the integrity of the first reporting cycle. To inform that assessment, we urge CMS to engage directly with managed care plans and states on their operational readiness, as they are best positioned to provide insight into the feasibility of the current timeline. The MLTSS Association stands ready to support that engagement, including by convening member plans, co-hosting roundtables, or participating in listening sessions with CMS to facilitate that dialogue.

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<sup>3</sup> [https://16805b35-3b53-4bc9-880a-c0b207d6cc71.usrfiles.com/ugd/16805b\\_23df0a776e924c2aa8f23840ba0b8e58.pdf](https://16805b35-3b53-4bc9-880a-c0b207d6cc71.usrfiles.com/ugd/16805b_23df0a776e924c2aa8f23840ba0b8e58.pdf)

### **CMS Reporting of Administrative Measures on States' Behalf**

CMS is soliciting comments 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 in an effort to reduce reporting burden. The MLTSS Association supports CMS's proposal to allow states the option of having CMS report on the three administrative data measures, LTSS-6, LTSS-7, and LTSS-8, on their behalf using data from the T-MSIS Analytic Files. This option could meaningfully reduce duplicative reporting obligations for both states and plans. We encourage CMS to make this option as accessible as possible, and to clearly communicate to states and plans which T-MSIS data elements are required to support CMS's calculations.

### **Specific Measure Recommendations**

#### **Measures the Association Recommends for Removal or Exclusion**

- 1. LTSS-1: Long-Term Services and Supports Comprehensive Assessment and Update;***
- 2. LTSS-2: Long-Term Services and Supports Comprehensive Person-Centered Plan and Update;***
- 3. LTSS-4: Reassessment and Person-Centered Plan Update after Inpatient Discharge; and***
- 4. MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls.***

We appreciate CMS's ongoing commitment to strengthening quality oversight, advancing accountability, and promoting person-centered care across HCBS programs. CMS's continued efforts to improve care coordination, outcomes measurement, and beneficiary experience reflect important priorities that support the delivery of high-quality LTSS services. We value the agency's collaborative approach to enhancing program integrity and driving meaningful improvements for members and providers alike. We appreciate the opportunity for public comment and appreciate CMS's engagement in these important issues. At this time, we seek to highlight concerns regarding the operational burden, usability, and future uncertainty associated with hybrid/case management review measures.

#### *Measure Feasibility*

These measures require detailed review of case management documentation to validate the presence of numerous core and supplemental elements within specified timelines. These measures function operationally as hybrid review measures and require extensive manual chart abstraction. As a result, implementation and reporting create substantial administrative complexity and cost for states and managed care organizations. The burden associated with these measures includes:

- Manual review of case management records

- Lack of standardized data capture fields across HCBS programs and care management platforms
- Significant staffing burden associated with record retrieval, abstraction, quality review, and validation
- Challenges integrating data across fee-for-service and managed care delivery systems

### *Measure Usability*

As currently structured, LTSS-1, LTSS-2, LTSS-4, and MLTSS-5 may unintentionally emphasize documentation completeness over the actual quality and effectiveness of person-centered supports. Applying traditional medical-management documentation standards to HCBS environments may not fully account for the operational realities and philosophical foundations of LTSS programs. In practice, this can result in significant administrative burden without a commensurate increase in meaningful quality insight or beneficiary outcomes improvement. Another limitation is that the measures assume that completeness equals quality. A fully completed assessment may still fail to capture the lived experience of highly complex LTSS members. Conversely, a highly effective care manager who meaningfully improves a member's stability and independence could perform poorly if documentation is incomplete. This creates a disconnect between measured quality and actual care quality.

The measures also place heavy operational emphasis on standardized tools and discrete data capture. While standardization improves audit reliability and comparability across organizations, it risks reducing person-centered care into structured fields and predefined elements. In populations with significant social, cognitive, and functional complexity, the most important aspects of care are often relational, adaptive, and difficult to quantify. Those dimensions are largely invisible within these measures.

Ultimately, the critique is not that assessments and care plans are unimportant. Comprehensive assessment and coordinated planning are essential in LTSS. Fundamentally, LTSS-1, LTSS-2, LTSS-4, and MLTSS-5 measure whether organizations completed and recorded required activities, but they do not adequately measure whether members became safer, healthier, more independent, more satisfied, or better able to remain in their homes and communities.

### *Future Uncertainty of Hybrid Measures*

We are aware of the collaboration and partnership with NCQA in developing measures LTSS-1, LTSS-2 and LTSS-4. NCQA's LTSS HEDIS measures CAU, CPU, and RAC are almost identical and share the same burdens in reporting. NCQA has publicly stated its intent to transition HEDIS reporting to a fully digital model by Measurement Year 2030 and retire hybrid

methodologies by MY 2029 in order to reduce administrative burden and improve interoperability and scalability.

NCQA has released modernization plans for several traditional hybrid HEDIS measures, including transitions toward administrative-only or Electronic Clinical Data Systems (ECDS) methodologies. However, no comparable roadmap currently exists for LTSS HEDIS measures corresponding to LTSS-1, LTSS-2, LTSS-3, and LTSS-4.

As a result, there is significant uncertainty regarding:

- Whether LTSS measures will transition to digital/ECDS methodologies
- Whether hybrid review methodologies will eventually be retired
- Whether interoperable HCBS data standards exist to support digital implementation

This uncertainty creates substantial implementation risk for states and managed care organizations. States may be required to invest heavily in continuing to operationalize labor-intensive hybrid abstraction processes without clarity regarding the long-term future of the measures or whether those investments will soon become obsolete as NCQA transitions toward digital quality measurement.

We therefore encourage CMS to:

- Coordinate closely with NCQA regarding the future direction of LTSS measures
- Provide transparency regarding modernization and digital transition plans
- Avoid establishing long-term mandatory reporting requirements absent a clear modernization roadmap
- Consider whether hybrid LTSS measures remain an appropriate long-term measurement approach given the industry-wide movement away from manual chart abstraction
- Consider delaying long-term mandatory reporting requirements until greater alignment exists between CMS requirements and NCQA's digital quality strategy

#### *General Recommendations*

Given the cumulative burden associated with hybrid and case management review measures, we encourage CMS to:

- Minimize reliance on manual chart abstraction wherever possible
- Consider optional rather than mandatory reporting for measures requiring intensive record review
- Conduct additional burden analysis with states and managed care organizations prior to finalizing mandatory reporting requirements

We support CMS's goals of improving HCBS quality measurement and accountability; however, successful implementation will require balancing meaningful quality oversight with operational feasibility and administrative sustainability. Additionally, sustained reliance on hybrid LTSS measures without a clear digital transition strategy may significantly increase administrative burden while creating uncertainty for states, managed care organizations, and providers responsible for implementation.

***2. LTSS-3: Shared Person-Centered Plan with Primary Care Provider***

The MLTSS Association supports CMS's decision not to include LTSS-3 in the proposed 2028 Measure Set and encourages CMS to finalize this exclusion in the final Measure Set. This measure presents a particular challenge for managed care plans serving dually eligible members who are not enrolled in an aligned Medicare Advantage plan. Because primary care is covered by Medicare for these members, the Medicaid plan may not have the information needed to identify the member's primary care provider and therefore cannot share the person-centered plan with that provider. While this underlying data gap remains unresolved, retaining this measure would unfairly penalize plans serving high proportions of unaligned dually eligible members. We do not believe its exclusion would create a gap in the Measure Set.

***3. HCBS CAHPS: Transportation to Medical Appointments Composite Measure***

The MLTSS Association urges CMS to remove the CAHPS Transportation to Medical Appointments Composite from the mandatory Measure Set. Transportation is an important benefit in many HCBS programs. MLTSS plans participating in those programs have a critical role in ensuring their members have adequate transportation access through their care coordination activities. However, in some states, transportation benefits are carved out or are provided through Medicare and other programs, outside of the MCO's oversight. The HCBS Measure Set includes several other measures related to transportation access, so we do not believe that removing this measure would result in a gap.

***4. Plan All-Cause Readmission (HEDIS)***

The MLTSS Association supports CMS's decision not to include the Plan All-Cause Readmission measure in the proposed 2028 Measure Set. CMS annually adjusts the rate and desired values for this measure, while plans' intervention strategies often require several years before demonstrating measurable outcomes, creating a structural disconnect between plans' improvement efforts and how they are assessed. Additionally, the complexity of the weighting methodology makes it difficult for the general public to use this measure to meaningfully evaluate plan or program quality, and there is no parallel measure for fee-for-service LTSS programs, limiting comparability. We encourage CMS to confirm this measure's exclusion in the final Measure Set.

### **Measures the Association Recommends for Addition**

The MLTSS Association urges CMS to reconsider the following measures for inclusion as either mandatory or voluntary measures for the 2030 of future measure sets.

#### ***1. Employment Measures***

We recommend adding the NCI-AD measure assessing the percentage of people who have or want a paying job in the community. Community employment is a core goal of HCBS programs and a critical indicator of community integration and self-direction. The absence of employment-related measures from the mandatory Measure Set represents a meaningful gap, particularly given CMS's longstanding emphasis on competitive integrated employment as an outcome for individuals with disabilities receiving HCBS.

#### ***2. Caregiver Assessment***

We recommend adding a measure assessing the percentage of Medicaid LTSS participants who have documentation of a caregiver assessment that includes core elements within a specified timeframe. Family caregivers are essential partners in HCBS and their needs and capacity directly affect the sustainability of care. The absence of a caregiver assessment measure from the Measure Set represents a notable gap in the framework's ability to assess the comprehensiveness and person-centeredness of HCBS planning.

#### ***3. Choice, Control, and Self-Direction Measures***

Self-determination and choice are foundational principles of HCBS policy. While we understand the reporting burden associated with collecting data on self-direction related quality measures, their absence from the mandatory Measure Set is a significant gap. We therefore recommend that CMS add at least one self-direction measure to the Measure Set in future years.

### **Conclusion**

The MLTSS Association supports CMS's efforts to establish a nationally consistent HCBS Quality Measure Set and recognizes the importance of quality measurement in driving improvement in care and outcomes for Medicaid beneficiaries receiving HCBS. We appreciate the opportunity to comment on the ongoing development of HCBS quality measures and welcome opportunities to continue discussing these comments and recommendations with CMS further. If CMS has any questions, please contact me at [mkaschak@mltss.org](mailto:mkaschak@mltss.org).

Sincerely,

National  
MLTSS  
Health Plan Association

A handwritten signature in black ink, appearing to read "Mary Kaschak". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Mary Kaschak  
Chief Executive Officer  
The National MLTSS Health Plan Association