May 27, 2026

Dr. Mehmet Oz
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is pleased to offer comments on the 2028 Medicaid Home and Community-Based Services Quality Measure Set.

NAMD is a nonpartisan, professional community of leaders who provide health insurance to almost 80 million people through Medicaid and CHIP in the states, D.C., and the U.S. territories. NAMD elevates thought leadership on policy matters, amplifies the experience and expertise of state and territory leaders, supports programs in continuous improvement and innovation, and optimizes partnerships to help millions live their healthiest lives.

First and foremost, Medicaid agencies continue to support the development and iteration of a nationally standardized set of quality measures for Medicaid-funded home- and community-based services (HCBS). Medicaid agencies recognize the importance of standardization and the role these measures play in promoting more consistent use of quality measures across states and territories, enabling CMS and states and territories to compare data across HCBS programs, and improving the quality of care and outcomes for individuals receiving HCBS.

However, as our members undertake significant systems, operational, and programmatic changes driven by recent federal rulemaking, federal legislation, and individual state priorities, **we urge CMS to provide greater technical assistance and consider a phased approach to the public reporting of HCBS measures commensurate with available implementation assistance provided to states and territories.** NAMD's membership stands ready to engage with our peers to maximize the impact of CMS-provided assistance to ensure HCBS measures are as robust as possible to inform future policymaking. Given the importance of HCBS services for some of the nation's most vulnerable individuals, states and territories need sufficient time to strengthen core data collection, reporting infrastructure, and measure implementation processes to ensure reported data is accurate, meaningful, and useful for quality improvement efforts.

States and territories are facing budget constraints at a time when they are simultaneously undertaking major system transformations and implementing policies with an already overextended Medicaid workforce. Right now, Medicaid agencies are managing substantial programmatic and operational changes driven by federal rulemaking, federal legislation, and from their state legislatures. CMS' own Medicaid and CHIP Policy Implementation Roadmap

demonstrates the volume of Medicaid enterprise system changes that agencies have been undertaking and will continue to implement over the coming years. Importantly, these efforts require not only system changes, but also significant staff capacity to operationalize, oversee, and maintain implementation activities at a time when states and territories are experiencing staff shortages and budget shortfalls.[1]

In order for states and territories to fully advance implementation of CMS' HCBS Quality Measure Set reporting requirements, CMS should recognize the significant operational and infrastructure investments needed to support biennial reporting on mandatory measures beginning July 9, 2028. For states and territories participating in the Money Follows the Person (MFP) program, these reporting requirements begin even earlier, on September 9, 2026. **Therefore, we urge CMS to provide robust technical assistance and consider a phased approach that would allow for states and territories to continue strengthening core data collection and reporting infrastructure, while maintaining flexibility to implement requirements in a way that reflects their unique systems, capacity, and readiness. Additionally, CMS should consider further supporting states and territories by:**

1. **Providing additional technical assistance and implementation guidance.** CMS should offer additional technical assistance, including operational guidance, examples of successful reporting approaches, reporting templates, enhanced Federal Financial Participation (FFP), and opportunities for peer-to-peer learning across states and territories. Some of the MFP states and territories have indicated that they are still investing in the infrastructure needed to report these measures accurately, and additional federal support is necessary to ensure meaningful implementation.

2. **Allowing flexibility in aggregation and reporting approaches.** CMS should allow states and territories to report or stratify measures by waiver, population, or delivery system. According to a 2025 survey by Kaiser Family Foundation, all states (including the District of Columbia) offer HCBS services through at least one program and many offer it across multiple programs – 1915 (c) waivers (47 states), 1115 demonstration waivers (15 states), personal care state plan (33 states), or community first choice (10 states). Aggregating data across these programs creates a significant administrative burden on the Medicaid agency and will make it less clear which areas need a targeted focus on strengthening quality improvement.

3. **Reevaluating the reliance on T-MSIS data for reporting administrative measures.** If CMS intends to calculate administrative measures using T-MSIS data, CMS should first address any existing T-MSIS data quality concerns and verify whether the data is complete and standardized to support accurate reporting. States and territories expressed concern that current data limitations may produce inaccurate or misleading results. We acknowledge and appreciate the significant collaboration between CMS and our members to improve T-MSIS data quality overall.

[1] In a 2022 survey by NAMD, Medicaid agencies reported that 1 in 6 positions were vacant within the agency.

4. **Clarifying expectations for mixed delivery systems.** CMS should clarify their reporting expectations on administrative measures for states that operate both fee-for-services and managed care delivery systems. Aggregating data across multiple systems and vendors is operationally difficult and would require significant coordination across systems, vendors, and program areas.

5. **Implementing an embargoed review period and allowing states and territories to review their measure results and provide context before the information is publicly reported.** If data is reported too early and before systems and data collection processes are fully developed, this could create inaccurate or misleading impressions about HCBS program performance for states and territories. Similar to the Medicaid and CHIP Scorecard, CMS should provide states and territories with an opportunity to review data prior to public release. This allows for early detection of potential measurement discrepancies, additional context for state-specific program design that supports measure interpretation, and gives states and territories an opportunity to prepare messages for key stakeholders in advance of public data release.

6. **Making LTSS Measure 1 and 2 voluntary.** CMS should make both of these measures voluntary to begin with, and especially in fee-for-service (FFS) delivery systems. States and territories have indicated that these measures are not designed for FFS and that they would benefit from technical assistance to operationalize them consistently and accurately.

7. **Incorporating the measure-specific feedback submitted by ADvancing States and National Association of State Directors of Developmental Disabilities Services (NASDDDS).** As the associations representing state agencies responsible for day-to-day operations of Medicaid-funded HCBS waiver programs for older adults, people with physical disabilities, and people with intellectual and developmental disabilities, ADvancing States and NASDDDS members have specific expertise that is important for CMS to consider. Notably, these organizations serve as measure stewards of the NCI and NCI-AD measure sets. Therefore, NAMD supports approaches that promote state and territory flexibility, demonstrated measure feasibility, data-quality safeguards, privacy protections, and avoidance of new mandatory reporting burdens before states have sufficient infrastructure and guidance.

8. **Aligning the HCBS Quality Measure Set, where feasible, with long-term services and supports quality frameworks developed by the National Committee for Quality Assurance (NCQA).** This includes harmonizing measure concepts, definitions, and specifications; aligning data sources and reporting methodologies where feasible; and minimizing duplicative or closely overlapping measures across frameworks. Greater alignment would promote consistency and reduce administrative burden.

9. **Aligning with existing federal data reporting cycles and measurement periods, along with flexible reporting windows.** By aligning reporting deadlines with existing state and territory reporting cycles for federal requirements, this would reduce

administrative burden and staff time by allowing agencies to leverage established reporting processes and workflows.

Thank you for the opportunity to provide comments on this proposed rule. We look forward to the continued partnership between CMS and state and territory Medicaid agencies in furtherance of our mutual aims around improved access, experience, and outcomes in Medicaid-funded HCBS.

Sincerely,

Stuart Portman
NAMD Board President
Georgia Medicaid Director

Lee Grossman
NAMD Board President Elect
Iowa Medicaid Director