NATIONAL HEALTH LAW PROGRAM

May 28, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health & Human Services
200 Independence Ave. SW
Washington, DC 20201

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

Dear Administrator Oz:

The National Health Law Program (NHeLP) is a public interest law firm that works to advance equitable access to health care and protect the health rights of people with low incomes and underserved populations. For over fifty years, we have litigated, advocated, and educated at the federal and state levels to advance health and civil rights in the United States.

We appreciate the opportunity to comment on the proposed 2028 Home and Community-Based Services (HCBS) Quality Measure Set.[1] Generally, we support the proposal to require mandatory reporting of HCBS core measures with state options for additional measures. We also supported the stakeholder engagement process that includes an advisory group to make recommendations on adding, retaining, and retiring measures through periodic updates, and on choosing which measures to stratify.[2] We continue to believe that sample sizes for experience of care surveys like the National Core Indicators (NCI) family of surveys would be far more useful to identify actionable quality improvement initiatives if the sample size were larger and better stratified to allow a more granular analysis of problems.

We are disappointed that the updated set appears to have diverged substantially from the recommendations of the stakeholder advisory committee. We encourage CMS to reconsider two of the measures proposed for retirement and also to bolster requirements to have states stratify HCBS core measures by multiple key demographic criteria beyond geography. Specifically, while other factors should be phased in later, the 2028 set should at least include some stratification by race and ethnicity, consistent with current practice for other Medicaid core measure sets, as discussed below.

Key Recommendations for the HCBS Core Measure Set

We have five key recommendations for this update to the HCBS Core Measure Set, which we will describe in more detail below:

1. Do not retire the two composite quality measures related to community integration.
2. Stratify more measures and require states to include race/ethnicity for key metrics.
3. Establish clearer guidelines for CMS to explain decisions that differ from the recommendations of the HCBS Quality Measure Set Review Workgroup.
4. Reduce the data lag for reporting HCBS quality measures by shortening the window for conducting survey research.
5. Do not increase the minimum value for suppressing reported data for any cells above 10 individuals.

1) Do not retire the composite quality measures related to measuring the degree of community integration provided for Medicaid beneficiaries.[3] Social isolation and loneliness correlate with negative health outcomes, including higher mortality.[4] Community integration and inclusion is one of the four domains CMS used to evaluate which measures to select for mandatory reporting, and is a central goal of effective delivery of HCBS.[5] The justification provided for removing these composite measures is that some of the questions

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[1] Centers for Medicare & Medicaid Services, *Medicaid Program; 2028 Medicaid Home and Community-Based Services Quality Measure Set*, CMS-2453-NC (Apr. 28, 2026), https://www.federalregister.gov/documents/2026/04/28/2026-08190/medicaid-program-2028-medicaid-home-and-community-based-services-quality-measure-set.

[2] Jennifer Lav et al., National Health Law Program, *Comments on Proposed Medicaid Access Rule* (June 30, 2023), https://healthlaw.org/resource/comments-on-proposed-medicaid-access-rule/.

[3] The two composite measures are HCBS CAHPS: Planning Your Time and Activities and POM: People Live in Integrated Environments. 91 Fed. Reg. 22827.

[4] *See, e.g.,* New Jersey Dept. Human Servs. Off. Res. & Eval., *New Jersey Social Isolation Study*, 5-7 (Apr. 2023), https://www.nj.gov/humanservices/news/reports/DHS%20Social%20Isolation%20Report.pdf/

[5] 91 Fed. Reg. 22830.

focus on social and community interactions instead of their experience with HCBS, and therefore the measure is beyond the control of the provider to influence.[6] Since the measure is taken across an average of all the respondents across a demographic group or provider type (depending on how the measure is stratified), it is completely reasonable to expect that providers can implement policies and practices to improve survey scores on these questions. A provider that offers effective individualized planning, adequate transportation, and opportunities to engage outside of the setting can most certainly influence the amount and quality of social and community interactions that its clients enjoy.[7] Indeed, the Social Isolation in Older Adults Taskforce, convened by South Carolina's Department on Aging, has recommended to include "programs to promote social connection" to the state's list of allowable expenditures for HCBS.[8]

Effective community integration can improve health outcomes for Medicaid beneficiaries and should remain a core domain in HCBS quality measurement.[9] The two metrics proposed for removal may not be perfect, but stepping away from these measures after just one reporting cycle (2026) is a step in the wrong direction.[10] We recommend retaining these mandatory measures at least through 2028 when we will have a cycle of data to review.

2) Require stratification for more measures and include stratification by major racial and ethnic groups. HCBS quality measure development and deployment have lagged behind acute care for years. These delays are especially serious because HCBS are used by people with substantial support needs and because they constitute a large share of Medicaid's annual expenditures. For this reason, CMS should dedicate more attention and resources to closing the development gap between acute care and HCBS quality measurement and oversight. Unfortunately, this proposed rule falls short of that needed urgency.

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[6] Id. at 22828.

[7] *See* Darren McCausland et al., *The Potential for Person-Centred Planning to Support the Community Participation of Adults with an Intellectual Disability*, 26 J. INTELLECTUAL DISABIL. 603 (July 5, 2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC9442779/; Carli Friedman, *Increasing the Social Capital of People with Disabilities* (Apr. 21, 2022), https://www.c-q-l.org/resources/newsletters/increasing-the-social-capital-of-people-with-disabilities/.

[8] S.C. Instit. Of Medicine & Public Health and S.C. Dept. on Aging, *Addressing Social Isolation in Older Adults as a Determinant of Health: Executive Summary*, 1 (June 2023), https://imph.org/wp-content/uploads/imph-social-isolation-2023-exec-summary-accessible.pdf.

[9] Rebecca Kasey, The Council on Quality and Leadership, *Moving from Community Participation to Inclusion and Integration* (Feb. 21, 2024), https://www.c-q-l.org/resources/newsletters/moving-from-community-participation-to-inclusion-and-integration/.

[10] The 2026 reporting cycle has not even finished, so removing this measure now goes against CMS's own intention of keeping valid measures in the HCBS Quality Measure set for at least five years. 91 Fed. Reg. 22827.

For example, the proposal requires states to stratify 5 mandatory measures by geography, with no discussion of race and ethnicity. The reporting of data stratified by race/ethnicity has been recognized as a priority for tracking and driving health care quality improvement for other Medicaid populations. The 2026 and 2027 Child Core Set Measures require that states report 12 separate measures stratified by race/ethnicity.[11] The Adult Core Set for Behavioral Health similarly requires 5 measures reported by race/ethnicity in 2026. NCQA now supports stratified reporting of outcomes by race/ethnicity for 22 HEDIS measures.[12] Racial disparities have also been documented in HCBS, but Medicaid does not yet collect or report on racial/ethnic disparities in access to and quality of the HCBS.[13] The decision to ignore race/ethnicity in required stratification represents a lost opportunity to learn more about a recognized problem and tailor HCBS delivery to match the needs of these different communities.

More generally, we urge CMS to encourage a more rapid shift toward stratified quality measure reporting. Not only does this allow for better illumination of health disparities, but it increases state's ability to identify specific areas of concern within data sets and then develop targeted response. We are concerned that the 2028 proposal relies too heavily on aggregate state-level reporting, which is typically less actionable – to "reduce reporting burden" – in lieu of requiring more granular reporting that can illuminate disparities across groups, programs, delivery systems, or other factors.[14]

In sum, we strongly recommend that CMS add requirements for states to begin to stratify some HCBS measures by race/ethnicity as part of this first stratification requirement, and to increase requirements to stratify reporting by additional demographic categories to close the gaps with acute care. In addition, CMS should support states and the major experience of care survey developers to implement best practices for successful collections of race/ethnicity data even when it is voluntary.

3) Establish clearer guidelines for CMS to explain decisions that differ from the recommendations of the HCBS Quality Measure Set Review Workgroup. Under this proposed rule, the Review Workgroup recommended removing 3 measures (LTSS-1, LTSS-2, and LTSS-3) from mandatory reporting and recommended adding four measures to the HCBS Quality Measure Set. CMS only proposes to follow one of these seven recommended

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[11] Dan Brillman, Centers for Medicaid & CHIP Services, *2027 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance* (Dec. 30, 2025), https://www.medicaid.gov/federal-policy-guidance/downloads/sho25005.pdf.

[12] NCQA, *Data, Measurement and Equity*, https://www.ncqa.org/health-equity/data-and-measurement/, (last visited May 26, 2026).

[13] *See, e.g.,* Chanee D. Fabius et al. *Racial Disparities in Medicaid Home and Community-Based Service Utilization among White, Black, and Hispanic Adults with Multiple Sclerosis: Implications of State Policy* 6 J. RACIAL AND ETHNIC HEALTH DISPARITIES 1200 (2019), https://link.springer.com/article/10.1007/s40615-019-00621-9?fromPaywallRec=false;

[14] 91 Fed. Reg. 22838.

changes (LTSS-3).[15] It also seeks to remove the two important 2026 mandatory measures mentioned above. Notably, the Review Workgroup did not recommend removing those two measures from the mandatory set.

CMS's low take-up of the Workgroup's recommendations in its first iteration is noteworthy. Departing from those thoughtfully balanced perspectives requires transparent, well-supported explanation to provide a context for the disagreement. CMS's justification for some of its decisions, such as for dropping the community inclusion measures, does not meet that threshold. While CMS is not required to take every recommendation from the Review Workgroup, repeated divergence from Workgroup recommendations suggests a misalignment. For example, CMS's stated reason for not adding the four measures is that they have no "conceptually similar measures" across all four surveys. If CMS requires commonality across all experience of care surveys to adopt new mandatory measures, it should have communicated that to the Review Workgroup in advance. In the future, when CMS proposes to depart from a Workgroup recommendation, it could provide the Workgroup an opportunity to respond to its stated concerns before finalizing its decision. This would make the process genuinely iterative and could strengthen the reasoning set out in the proposed rule. It would also reinforce CMS's commitment to broad stakeholder engagement. CMS should also assess whether the Workgroup needs more training and support to ensure members have the tools to understand the kind of feedback that CMS needs.

4) Reduce reporting lag for HCBS quality measures. In prior comments on HCBS quality metrics we have called for CMS to shift to annual reporting of this measure set.[16] This would align with the reporting cycle for the other Medicaid quality measure sets. Annual reporting would reduce the lag between when problems are identified and when states can act to address those problems. The current proposal requests stakeholder comment on a proposal to allow states a full two-year window to collect data for the 2028 Quality Measure Set. That proposed timeline would allow a survey fielded in the summer of 2026 to not be reported to CMS until Fall 2028 – over two years after the data was collected. Timeliness of results is a key factor in determining actionable information.

While states should have some flexibility with when to field different experience of care surveys for different populations, the data lag created by CMS's proposed approach will undermine one of the key goals of the HCBS Quality Measure Set – to provide actionable data for program improvement. We recommend that CMS require states to post publicly results from each experience of care survey within a year of data collection, even if that data

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[15] It is true that a state can report the Review Workgroup's recommended measures as a voluntary measure under CMS's proposal, but the CMS HCBS Quality Measure Set would not identify these measures as specifically helpful, as the workgroup recommended.

[16] Jennifer Lav et al., National Health Law Program, *Comments on Proposed Medicaid Access Rule*, 34-5 (June 30, 2023), https://healthlaw.org/resource/comments-on-proposed-medicaid-access-rule/.

may later be submitted to CMS as part of the 2028 HCBS measure cycle. This will at least ensure that data is posted while relatively fresh despite being reported only every other year.

5) Finally, CMS should not increase the minimum value for suppressing reported data for any cells above 10 individuals.[17] The concern about potential retro-identification of survey participants is real and important, but the risk diminishes quickly as cell size increases. The proposed rule does not provide clear examples when a privacy concern might justify increasing the suppression threshold from 10 to 25, 50, or even 100. Experience of care surveys often have samples of only a few hundred individuals. Allowing suppression at higher values reduces data transparency and will likely create major barriers to the increased reporting of data stratified by key demographic factors like race/ethnicity where smaller cell values are much more likely due to relatively small overall sample sizes.

Where privacy is not a specifically justified concern, we oppose increasing the value for cell size suppression. The value of data transparency should supersede any reduction in reporting burden that stems from cell suppression.

Conclusion

Thank you for the opportunity to share our comments on the 2028 HCBS Quality Measure Set. If you have any questions, please contact David Machledt (machledt@healthlaw.org).

Sincerely,

David Machledt
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[17] 91 Fed. Reg. 22840.