May 28, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2453-NC
P.O. Box 8016
Baltimore, MD 21244-1850

[CMS-2453-NC] Medicaid Program; 2028 Medicaid Home and Community-Based Services Quality Measure Set

Submitted Electronically via: https://www.regulations.gov/commenton/CMS-2026-0332-0001

Dear Administrator Oz,

LeadingAge appreciates the Centers for Medicare & Medicaid Services' (CMS) goals of improved quality and transparency in the administration of Medicaid home and community-based services (HCBS) programs. We are grateful for the opportunity to comment on CMS notice [CMS-2453-NC] Medicaid Program; 2028 Medicaid Home and Community-Based Services Quality Measure (QM) Set.

We, along with our state partners, represent more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

Home and community-based services are the backbone of our care economy, with Medicaid providing payment for the largest subset of these services—delivering care and services to more than 2.5 million individuals. With states designing and implementing their Medicaid programs to meet their own program goals, each state has flexibility in service type, scope, duration, and availability, as well as population targeting and eligibility criteria. In short, each state program is unique. CMS's effort to establish consistent standards for comparing service quality, access, timeliness, and participant satisfaction across HCBS programs is laudable, though CMS and states will face significant implementation hurdles.

The burden of collecting HCBS QM data must fall on states, not providers.
LeadingAge supports the adoption of quality and participant satisfaction measures and more transparency in service availability but has some concerns about the operational logistics of the new requirements. Existing quality reporting in other programs relies on providers to either administer participant surveys or contract with third parties to administer surveys. Both arrangements are burdensome for providers, administratively and fiscally. The administration of surveys by providers is costly and introduces inconsistencies in participant responses. Individuals may feel obligated to provide positive marks for fear of retribution, yielding falsely

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positive responses or be experiencing depression and trauma recovery causing their assessments to be skewed overly negative.

Providers may also feel uncomfortable asking their participants to answer surveys, which could prompt them to hire a third party to eliminate conflicts of interest — an added cost for already cost-burdened providers. Small, rural providers would feel this pinch especially acutely, adding yet another Providers should not be part of the data collection process for HCBS QMs.

Additionally, use of multiple organizations with inconsistent training for survey administrators will reduce the consistency and reliability of results. For this reason, CMS should instruct states to execute a contract and pay for a single evaluation entity, such as a college or university, that can establish rigorous guidelines for statistically valid sampling, encompassing geographic and population density diversity as well as waiver program, service utilization, and intensity diversity. CMS should also define required standards for surveyor training, including consistent curricula covering participant introductions, framing of questions, appropriate use of collected data, and how participants can access additional follow-up contacts. By establishing these standards at the federal level, results across states will be more consistent and comparable, regardless of which measures states elect to include in their reporting.

The general population, including Medicaid enrollees, is inundated with phishing schemes and requests for survey completion. To optimize participant response, states should be urged to develop standardized information and websites for providers to reference and participants to access, with easily digestible information about the process, what questions will be asked, how a participant can verify a solicitation, and how collected information will be used. Supporting providers in speaking with participants about upcoming surveys will promote survey uptake and bolster participant confidence in the process.

Older adults are particularly targeted by fraudsters; concerns about technology literacy and social isolation make them especially susceptible to repeated solicitation attempts. Assuring older adults that survey requests are legitimate, and providing clear assurances about Medicaid program enrollment verification, will improve participation rates and yield more reliable data.

The burden of paying for federally mandated QM collection and reporting should fall on CMS, not states.
LeadingAge supports CMS in the establishment of HCBS quality measure programs and agrees with the value in comparing programs across state lines. Many states have already undertaken contracts for quality measure assessments through NCI-AD or others. These states should be celebrated, and more support offered to promote their learning and continuous program improvement. As CMS implements the provisions of the Medicaid Access Rule that reference the quality measures out for comment, CMS should consider ways to financially support states with the new costs. Without significant federal investment above standard administrative matching arrangements, states are ill-positioned to expend additional funds to establish contracts for participant outcome surveys and additional quality reporting requirements.

Stratified reporting will generate more actionable and comparable data than aggregate data.
LeadingAge is supportive of CMS's requirement for states to submit measure data stratified by age to demonstrate differences in population experience by age. We feel CMS could benefit from additional data on population-specific reporting depending upon the duration of services enrollment, program, authority, and managed care plan. Though this requirement comes with significant state-level burden in reporting, many states administer distinct programs for distinct populations in unique offices with little or no overlap in quality measurement or operational objectives. For example, states operating distinct waivers in separate offices within a state Medicaid agency for older adults receiving services and individuals with intellectual

and developmental disabilities will benefit from stratified rather than aggregated data. Similarly, cross-state comparisons are unreliable when scores appear consistent within a given program but diverge significantly when measured against other programs and populations.

Administrative structures within states contribute to differing program administration, and assessing Medicaid HCBS in the aggregate may not provide any benefit if some programs are disproportionately responsive to the QMs selected by the state while other programs fall short. CMS specifically seeks comment on whether states should be required to deduplicate results for experience of care surveys if individuals are served in multiple programs or authorities in a survey period. While requiring states to deduplicate responses would improve results aggregated within programs, determining the program to which a respondent should be attributed brings additional policy decisions and burden to states. This population is likely to be limited and unlikely to have a material effect on reportable scores. As an alternative, CMS could require states to include in their reporting the number of individuals who appear in duplicative responses.

For example, if a state reports 10,000 surveys across 5 programs, with 100 being duplicative responses representing double or more counting of 40 individuals in multiple programs, then CMS, the public, and researchers are better positioned to analyze data and make comparative assessments. The impact of participant duplication in multiple programs will be determined by participant sampling parameters outlined in contracts between states and selected entities. If these duplications are anticipated to create a statistical difference in reporting and distribution, CMS should establish recommendations and best practices for states to consider in population sampling and de-duping survey participants. Regardless of the avenue, without CMS parameters states will take different courses effecting data utility and comparability.

We believe the burden associated with stratified reporting is warranted as states and CMS consider how to assess Medicaid HCBS program quality. Millions of people across the country rely on Medicaid HCBS, with millions more needing similar services. These unserved individuals are either on waiting lists because of caps on participant totals or their incomes fall outside of eligibility for services. If CMS were to impose program-stratified reporting, acquired data could be used to better assess program growth and the need for additional authorities or policy changes in other programs such as offering a limited Medicare-funded service plan to support older adults in their homes or other options for comprehensive reform of long-term care financing.

Increased transparency in HCBS program administration provides data for continuous program accountability.

Services delivered in peoples' homes are complex to monitor and their quality is difficult to assess. The establishment of quality measures and the use of participant experience of care surveys provide another tool for states and CMS to assess internal controls in Medicaid HCBS. States have a vested interest in strong program integrity and oversight because of shared spending arrangements between states and the federal government. Additional windows into program administration and participant experience will provide valuable data for states and CMS to assess service delivery and availability, as well as whether participants view available services as meeting their needs. Collecting data to understand how available and delivered HCBS advance Medicaid program goals of economy, efficiency, quality, and access will promote participant accountability and buy-in while providing key data for states and the federal government.

Collected data will allow states to seek best practices from other state programs and identify opportunities to streamline program administration, change workflows, or increase oversight where needed. Policy

changes to improve Medicaid HCBS outcomes and participant experience build confidence in the program, promote integrity and efficiency, and preserve access for those most in need.

Burden on states is significant, particularly with many concurrent directives from CMS.
The importance of states' accurate and timely reporting of quality measures should be balanced against the considerable current competing demands on state Medicaid agencies. As states partner with CMS to promote quality in their Medicaid programs, states are facing increased urgency to amend policies and practices for provider credentialing and revalidation along with increased information technology (IT) infrastructure demands for participant enrollment and redetermination. State Medicaid workloads are being triaged based on high-risk vulnerabilities and exceedingly tight timelines.

From CMS' April 23 letter to states seeking response on states' intended actions to revalidate 'high-risk providers' to operationalizing IT infrastructure changes to comply with increased frequencies of eligibility verifications and work reporting requirements, parallel work on HCBS quality measure reporting could take a back seat. Though work on quality measures supports program integrity and CMS' current focus on maintaining the program for people who need it most, many other priorities are competing for limited state-staff time and states should be supported in operationalizing a well-thought-out and functional QM reporting infrastructure not simply a compliant one, despite a lack of penalties.

Additionally, we understand that our recommendation for CMS to direct states to contract out for the participant satisfaction survey components imposes a cost to states at a time when their Medicaid financing is being restructured by state-directed payment and provider tax changes in HR 1. The complexities in state Medicaid financing cannot be overstated, and time must be allotted for development and collection of procurements and responses. Compounding these challenges with IT change requests and restructuring of financing mechanisms is creating a never-ending list of immediate policy changes for states to manage simultaneously.

Though we appreciate the importance and support the implementation of HCBS QMs, we urge CMS to provide states with technical assistance and leniency in the timing of their adoption of federal QM reporting.

We thank CMS for seeking comments on the proposed HCBS quality measures and support CMS' efforts to maintain Medicaid as a viable and vibrant program to support older adults, wherever they call home. Please contact Georgia Goodman (ggoodman@leadingage.org) with questions.

Sincerely,

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