May 28, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

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

Dear Administrator Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,500 family physicians and medical students across the country, we appreciate the opportunity to comment on the notice published in the Federal Register on April 28, 2026, regarding the proposed 2028 Home and Community-Based Services (HCBS) Quality Measure Set. The proposed measure set would require states to report on 23 mandatory measures, with three additional voluntary measures, as part of CMS's implementation of the 2024 Medicaid Access Rule.

Family physicians routinely care for Medicaid beneficiaries across the care continuum, including many patients who rely on HCBS to safely remain in their homes and communities. These patients frequently present with multiple chronic conditions, functional limitations, behavioral health needs, and significant social risk factors that require continuous and coordinated management spanning medical and community-based systems. The AAFP believes that the primary care physician should be directly involved in the initial decision to initiate home health services and remain engaged in the planning, delivery and ongoing care management. Thus, we appreciate CMS's goal of advancing a consistent, state-level HCBS quality framework to improve outcomes for Medicaid beneficiaries. However, we urge CMS to account for the central role of primary care in coordinating care for high-need patients utilizing HCBS.

We recommend CMS:

- Retain and revise LTSS-3 to capture vital, system-wide care coordination;
- Explicitly frame the proposed NCI-AD measure as a system-level indicator to prevent provider-level attribution or downstream punitive uses; and

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- Advance operational infrastructure that enables closed-loop communication, point-of-care visibility, and effective coordination between HCBS systems and primary care.

Measure suggested for removal: "LTSS-3: Shared Person-Centered Plan with Primary Care Provider."

LTSS-3 is a CMS-stewarded measure assessing the percentage of Medicaid LTSS participants whose person-centered care plan is shared with their identified primary care provider within 30 days of development. CMS has proposed removing this measure based on recommendations from the HCBS Quality Measure Set Review Workgroup, which cited administrative burden, reliance on manual record review, and limited utility due to consistently high performance scores.

The AAFP appreciates CMS's efforts to reduce administrative burden and strengthen the overall effectiveness of HCBS quality measurement. We agree that the reporting requirements for many HCBS quality measures, including LTSS-3, may place undue emphasis on burdensome documentation processes that do not consistently and directly translate into meaningful care coordination.

However, the complete removal of LTSS-3 raises significant concerns. As currently structured, it is the only measure in the proposed set that explicitly captures the connection between HCBS care planning and primary care. Eliminating this measure risks weakening accountability for coordination across care settings at a time when Medicaid beneficiaries with complex and chronic conditions require greater integration between medical care and community-based services. For primary care providers, timely access to HCBS information is essential to delivering effective care. The ability to manage chronic conditions, reconcile medications, monitor functional status, and coordinate across settings depends on having visibility into the services a patient is receiving and any changes in their care plan. When this information is not accessible, care becomes fragmented, increasing the likelihood of avoidable emergency department visits and hospitalizations. And evidence demonstrates that coordinated and accessible HCBS services are associated with reduced avoidable hospitalizations and improved patient outcomes.[i,ii]

Instead of removing LTSS-3, we strongly recommend CMS retain and revise the mandatory measure to better reflect meaningful care coordination between HCBS and primary care. In collaboration with the HCBS Quality Measure Set Review Workgroup, we recommend CMS update LTSS-3 to assess whether primary care providers have timely, interoperable, and workflow-integrated access to key elements of the HCBS care plan. The measure should emphasize the usability of shared information rather than the mere act of data transmission, remain at the state or program level, and avoid introducing provider reporting requirements or additional administrative burden for states and programs. CMS should also consider aligning the measure to critical care coordination points, such as hospital discharge or

significant changes in patient condition, where coordination between HCBS and primary care is most consequential.

Further, we encourage CMS to view the Workgroup's finding of high performance as evidence that the measure reflects a standard coordination practice that still warrants ongoing accountability, rather than an indication of limited utility.

We also note that CMS has appropriately recognized the foundational importance of person-centered planning in its decision to retain LTSS-1 ("Long-Term Services and Supports Comprehensive Assessment and Update") and LTSS-2 ("Long-Term Services and Supports Comprehensive Person-Centered Plan and Update") in the 2028 HCBS Quality Measure set, despite similar concerns and recommendation for removal raised by the Workgroup. CMS acknowledged that removing or replacing these measures could be disruptive to states and could undermine the core element of person-centered planning in HCBS. We support this approach and urge CMS to apply the same principle to LTSS-3. While LTSS-1 and LTSS-2 ensure that a person-centered care plan is developed, LTSS-3 ensures that plan actually reaches the primary care provider responsible for managing the patient's ongoing care. Without that connection, even well-developed care plans may not inform clinical decision-making. Eliminating LTSS-3 would therefore risk creating a parallel gap in accountability and further fragmenting care for Medicaid beneficiaries with complex needs.

Measure suggested for addition: "NCI-AD: Percentage of People Who Can Get an Appointment to See or Talk to Their Primary Care Doctor When They Need to."

The AAFP appreciates CMS's intention to assess system-level access challenges to primary care experienced by individuals receiving HCBS through this proposed addition. Timely access is essential for managing chronic conditions, addressing emerging clinical needs before they escalate, and reducing avoidable emergency department visits and hospitalizations. For HCBS beneficiaries who often have complex, ongoing medical and functional needs, delays in primary care access can quickly result in destabilization and higher-cost downstream care.[iii]

To achieve this objective, the measure must be clearly established and maintained as a system-level indicator of access, rather than an implicit metric of individual provider performance. In many communities, particularly rural, underserved, and Medicaid-dominant areas, appointment availability is constrained by structural and systemic barriers such as workforce shortages, Medicaid payment rates, care team capacity, and patient complexity. Thus, clear guardrails will be important to ensure this measure is applied consistently with this intent. If interpreted as a provider-level performance metric, it could introduce incentives within managed care contracting or network design that inadvertently constrain participation or capacity, particularly in already under-resourced settings. In that context, the measure could risk reinforcing, rather than alleviating, access challenges.

Thus, we encourage CMS to clearly state that this measure is intended to inform state- and program-level policy, network adequacy, workforce planning, and payment strategy, and not to drive provider-level accountability. It should not be used, directly or indirectly, for provider attribution, performance penalties, or additional administrative requirements. Instead, the measure should function as a tool to identify capacity gaps and guide targeted system-level investments, including in workforce, transportation, reimbursement, and team-based care models.

Properly framed and implemented, this measure holds the potential to provide valuable insight into primary care access barriers and support meaningful improvements in care for HCBS beneficiaries. Without these guardrails, however, it risks reinforcing the very access constraints it is intended to address.

Call for greater continuity of care through HCBS and Primary Care

While we support CMS's focus on access through the 2028 HCBS Quality Measures, improving outcomes for HCBS beneficiaries will also require broader integration and care coordination between HCBS and primary care. Primary care physicians frequently lack timely visibility into HCBS services, including what supports are available, how to initiate them, and whether authorized services are ultimately delivered.[iv] Even when providers recommend or order services, they often receive no confirmation regarding approval, implementation, or delays. This absence of closed-loop communication limits effective care coordination, complicates clinical decision-making, and increases risk for patients whose health and stability depend on reliable support in the home and community.

To meaningfully improve HCBS quality and patient outcomes, we recommend CMS prioritize strengthening the operational infrastructure necessary for effective integration between HCBS and primary care. The AAFP believes public- and private-sector models can exemplify the type of social care data infrastructure needed to achieve integration, particularly community care hubs and certain bidirectional data exchange intermediaries, including health data utility models.[v] We encourage CMS to further align with and strengthen these approaches by prioritizing the following actions:

- Require clear and standardized pathways for initiating HCBS services;
- Promote interoperable, real-time access to HCBS care plans within clinical workflows;
- Ensure timely notification of service changes, reassessments, and care disruptions; and
- Establish expectations for bidirectional communication between HCBS providers, health plans, and providers.

We thank you for the opportunity to provide comments on this important issue. Should you have any questions, please contact Sahana Chakravartti, Regulatory Specialist, at schakravartti@aafp.org.

Sincerely,

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

[i] Keesee, E., Fabius, C. D., Kim, J., Stevenson, D., & Keohane, L. M. (2026). Medicaid Home and Community-Based Services initiation and acute services use. JAMA Health Forum, 7(3), e260206. https://doi.org/10.1001/jamahealthforum.2026.0206

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[iv] Norman, G. J., Wade, A. J., Morris, A. M., & Slaboda, J. C. (2018). Home and community-based services coordination for homebound older adults in home-based primary care. *BMC geriatrics*, *18*(1), 241. https://doi.org/10.1186/s12877-018-0931-z

[v] American Academy of Family Physicians. (2024). *Primary care information blueprint*. https://www.aafp.org/assets/image/upload/v1763156270/j7siqedeynnqfpscidca.pdf