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The Honorable Daniel Brillman
Director
Centers for Medicaid & CHIP Services
7500 Security Boulevard
Baltimore, MD 21244

Recommendations for Implementing the Medical Frailty Exclusion of the Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC)

Dear Director Brillman,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,500 family physicians and medical students across the country, we respectfully request an opportunity to meet with you and your team to discuss the medical frailty exclusion under the Medicaid community engagement, or work, requirements and the [interim final rule](#) (IFR), *Medicaid Program; Community Engagement Requirement for Certain Individuals* (CMS-2454-IFC).

Medicaid remains indispensable to the nation's health care infrastructure, providing more than 75 million Americans with a stable pathway to affordable, continuous care, particularly in rural and underserved communities. Family physicians are central to Medicaid access, serving as the primary point of entry for many beneficiaries, and regularly providing longitudinal care for Medicaid patients with serious and complex medical conditions, substance use disorders, behavioral health conditions, disabilities, and chronic illnesses.ⁱ

In our previous [comments](#) responding to the IFR, the AAFP shared concerns regarding CMS's interpretation of the medical frailty exclusion, including the requirement that an individual with a serious or complex medical condition demonstrate that the condition significantly impairs their ability to satisfy the community engagement requirement. We continue to believe that this additional functional inquiry narrows a condition-based statutory exclusion, and risks introducing administrative burdens for physicians and gaps in coverage for eligible patients. We are particularly concerned that, without clear federal guardrails, state implementation of the medical frailty exclusion may shift a significant portion of the responsibility for eligibility determinations from state Medicaid agencies to physicians and their care teams.

We appreciate CMS's recent [guidance](#) to states on verifying medical frailty ex parte to the extent possible before requesting additional information from beneficiaries or clinicians.

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When available claims, pharmacy, disability, utilization, or other reliable data are insufficient, we agree that treating physicians may appropriately provide, as a final measure, the clinical information necessary to inform the determination. **Physician involvement, however, should be explicitly limited to matters requiring clinical expertise and should not become a routine substitute for state eligibility determinations.**

Thus, the AAFP would welcome the opportunity to meet with CMCS to discuss the following four areas where federal clarification could promote consistent state implementation of the medical frailty exclusion, preserve appropriate state eligibility responsibilities, and limit unnecessary reliance on treating clinicians:

1. Ambiguity between Clinical Assessment and Eligibility Determination

We are concerned that the IFR's functional-impairment standard creates ambiguity regarding the appropriate role of treating clinicians in medical frailty determinations. Our concern is particularly pronounced for patients with serious or complex medical conditions, where the IFR provides that an individual whose condition is well-managed and does not significantly impair the ability to satisfy the community engagement requirement should not be considered medically frail.

Family physicians routinely assess and document patient histories, diagnosis, prognosis, and long-term treatment planning. However, whether those clinical findings constitute significant impairment for purposes of qualifying for the medical frailty exclusion requires application of Medicaid eligibility criteria and is not itself a clinical diagnosis or independently established medical standard. The Social Security Administration provides a useful model of clarity in its disability adjudication process in 20 C.F.R. §§ 404.1545–404.1546 and associated [guidance](#) where treating clinicians provide evidence regarding the nature and severity of an impairment, and may describe the claimant's ability to perform work, but they are explicitly "neither asked nor expected to make a decision whether the claimant is disabled." We believe CMCS has the opportunity to establish a similarly clear allocation of responsibility for medical frailty determinations.

While we appreciate CMS's [recent efforts](#) to provide states with guidance and implementation resources addressing medical frailty determinations, the cases that cannot be resolved through existing data are likely to include the most clinically nuanced circumstances in which states seek additional information from treating physicians. In those cases, we are concerned that, without clear guidance, physicians will be expected to determine whether a patient's condition meets Medicaid eligibility criteria, rather than simply providing information to support the state's determination. We therefore urge CMCS to consider how the functional-impairment standard for medical frailty is intended to operate in practice, the scope of clinical information treating

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physicians should reasonably be expected to provide, and where responsibility should transition from clinical assessment to state eligibility determination. CMCS should issue additional guidance clarifying the respective responsibilities of state Medicaid agencies and treating clinicians, specifically, that physicians are responsible for providing relevant clinical information while Medicaid agencies retain responsibility for applying medical frailty eligibility criteria to those records. CMCS should also provide examples illustrating how states should evaluate clinical information against the functional impairment standard, particularly for patients with serious or complex medical conditions. Such guidance would help prevent inconsistent state practices and ensure that physicians are not expected to make Medicaid eligibility determinations.

2. Open-Ended and Burdensome Clinician Documentation

Where physician documentation is deemed necessary, the AAFP is concerned that an open-ended documentation process could require practices to devote substantial time to determining what information a state needs, how much documentation is sufficient, and how to respond within Medicaid eligibility timeframes. That burden is particularly consequential in primary care, where documentation requests compete directly with limited physician and staff capacity for patient care. In 2025, HRSA reported that 92 million Americans lived in designated primary care shortage areas and that 15,628 additional physicians are needed merely to eliminate existing shortage designations.ⁱⁱ **A medical frailty process that routinely depends on new physician documentation could therefore both divert scarce clinical capacity from patient care and impede access to the exclusion in communities where primary care is often least available.**

We believe this risk reveals an opportunity for CMCS to provide states and practices with clear federal standards that preserve reasonable state flexibility while limiting unnecessary variation in the information physicians are expected to supply. We would welcome discussion of a short, standardized federal medical frailty form or, at minimum, a uniform federal set of clinical data elements for cases in which treating-clinician documentation is necessary. A uniform and standardized framework would give physicians clear parameters regarding the information they are expected to provide and reduce uncertainty about the scope of their role in the verification process. Further, CMCS can complement these standards by expanding its [existing](#) resources on community engagement to include provider-facing instructions, examples, review expectations, and technical assistance on specifically navigating the medical frailty exclusion.

3. Data Limitations Defaulting to Clinician Documentation

As mentioned above, we appreciate CMS's continued guidance to states to utilize *ex parte* verification, including its recent tiered [framework](#) designed to use available data to

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establish medical frailty before resorting to individualized review. While we strongly support the prioritization of ex parte verification, we are concerned regarding the instances when available data does not resolve the determination. **An inconclusive administrative record should not presumptively result in a broad request for physician certification.** Particularly in clinically complex cases, the absence of sufficient data may reflect limitations in the underlying data rather than uncertainty about the patient's medical condition.

Thus, we urge CMCS to issue guidance on how states should proceed when available information is incomplete or inconclusive. Specifically, states should narrowly tailor their requests to the specific clinical question that remains unresolved. Further, as states increasingly consider technological tools to support implementation, these safeguards become even more important.ⁱⁱⁱ Such tools may help identify potentially qualifying beneficiaries and reduce manual review, but they should support, not replace, appropriate adjudication. CMCS should clarify that a data gap, an inconclusive algorithmic result, or an automated process's failure to identify medical frailty should not, without further review, support an adverse determination or automatically shift the evidentiary burden to the treating physician.

For the same reason, AAFP continues to encourage CMCS to preserve self-attestation beyond 2027 when reliable information is unavailable or insufficient to establish or subsequently verify medical frailty. Maintaining this pathway would reduce unnecessary reliance on new physician documentation while ensuring that limitations in the available evidence do not prevent otherwise qualified beneficiaries from establishing or maintaining the medical frailty exclusion.

4. Repetitive Verification of Conditions Unlikely to Materially Change

Finally, we are concerned that the IFR's reverification framework could require beneficiaries and treating clinicians to repeatedly establish medical frailty even where the underlying clinical circumstances are chronic, progressive, or otherwise unlikely to change materially. Repeated verifications may create additional administrative burden and recurring opportunities for coverage disruption without necessarily producing information that improves the accuracy of the determination. We urge CMCS to establish streamlined verification pathways for individuals with chronic, progressive, or otherwise unlikely-to-improve conditions. Specifically, **CMCS should encourage states to rely on previously verified clinical information when there is no indication of a material change in the individual's condition and only request new clinical documentation where that information is necessary to reassess eligibility.**

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We recognize the substantial implementation responsibilities facing CMCS and the states. Our immediate concern is that implementation of the medical frailty exclusion should not unnecessarily shift eligibility functions or administrative responsibilities into physician practices. There remains an important opportunity to address these risks before provider-facing processes become established across state programs.

We would therefore appreciate the opportunity to meet with you and appropriate members of the CMCS team to discuss these implementation concerns, share the perspective of family physicians caring for patients who may qualify for the medical frailty exclusion, and explore practical approaches that support accurate and consistent state implementation while preserving the appropriate role of treating clinicians.

Thank you for your consideration. For additional questions, please contact David Tully, Vice President of Government Relations, AAFP at dtully@aafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Nosal", with a large, stylized initial "S" and a trailing flourish.

Sarah C. Nosal, MD, FAAFP
American Academy of Family Physicians, Board Chair

ⁱ Medicaid and CHIP Payment and Access Commission. (2021, June). *Physician acceptance of new Medicaid patients: Findings from the National Electronic Health Records Survey*. <https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf>

ⁱⁱ Health Resources and Services Administration. (2025, December). *State of the primary care workforce, 2025*. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf>

ⁱⁱⁱ Mello MM, Nagireddy H. Roles for AI in Implementation of Medicaid Work Requirements. *JAMA Health Forum*. 2026;7(9):e264102. doi:10.1001/jamahealthforum.2026.4102