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Deputy Administrator and Director of Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Seshamani:

The Association of American Medical Colleges (AAMC) applauds the significant actions CMS has taken during the COVID-19 pandemic to support hospitals and physicians by providing regulatory relief and flexibility throughout the health care system. These changes have increased the ability of the nation's teaching hospitals and health systems and faculty physicians to expand vital care to patients. While some of the waivers and flexibilities have been extended for additional time after the public health emergency (PHE), others will expire when the PHE ends on May 11, including the policy that has allowed virtual supervision of residents in metropolitan statistical areas. To facilitate continued access to care and provide training opportunities for residents, we urge CMS to continue to allow virtual supervision of residents in all geographic regions for services that may be safely and effectively provided under virtual supervision, especially primary care and mental health services, which may be furnished using telehealth.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers. Learn more at aamc.org.

We appreciate CMS's decision in its 2021 physician fee schedule rule to permanently allow virtual supervision of residents for certain types of services in non-metropolitan areas to enable patient access and resident training opportunities in rural areas. We urge CMS to extend this policy to all regions of the country. Virtual supervision of residents has been critical in enabling expanded access to health care services. At a minimum, continuing to allow virtual supervision of residents for certain types of services in all geographic regions will increase the

workforce capacity of teaching institutions, increase access to care for patients, and allow important experience and training for the future physician workforce under appropriate supervision.

Residents have been virtually supervised safely and effectively during the PHE, including when the resident provides telehealth services to patients. The attending physician is present virtually during key and critical portions of the service, available real-time immediately, and both the attending physician and resident have access to the electronic health record. Teaching physicians render personal and identifiable physician services during the care and exercise full personal control over the management of the care for which payment is sought. CMS requires that the documentation in the patient's medical record must clearly reflect how and when the teaching physician was present during the key and critical portion of the service, along with a notation describing the specific portions of the service for which the teaching physician was virtually present.

While we commend CMS for recognizing the importance of access to care in rural areas, it is important to recognize that significant workforce shortages are also impacting access to care in other regions of the country. According to data from the Health Resources and Services Administration (HRSA), as of April 24, 2023, 160 million people currently reside in a Mental Health Professional Shortage Area (HPSA) and there are 8,200 fewer practitioners than are needed.[1] Approximately 25% of mental health HPSAs are located in urban areas and 24% span both rural and non-rural areas.[2] Currently, 99 million people reside in a Primary Care Shortage Area and there are 17,199 primary care practitioners that are needed.[3] Additionally, a June 2021 report from the AAMC predicts a shortage of up to 124,000 physicians by 2034.[4] These shortages have a real impact on access to care for patients.

The AAMC supports the current exclusion from direct supervision by interactive telecommunications technology of surgical, high risk, interventional and other complex procedures, endoscopies, and anesthesia services. For these services, we believe that the requirement for the physical presence of the teaching physician for the entire procedure or the key portion of the service with immediate availability throughout the procedure, is necessary for patient safety given the risks associated with these services. When providing these types of services, a patient's clinical status can quickly change and there is a need for the rapid onsite decision-making of the supervising physician.

Continuing to allow virtual supervision is critical, particularly for the type of services that are safely and effectively provided by telehealth. As an example, there is a significant shortage of psychiatrists in all regions of the country. During the PHE, psychiatrists have been providing a large portion of their care to patients through telehealth, and residents in psychiatry have been providing telehealth services that are virtually supervised by the attending psychiatrist. Data from the Clinical Practice Solutions Center (CPSC) which contains claims data from faculty practices shows that psychiatrists are currently furnishing over 50% of their services by telehealth.[5] When these services are provided, the patient, resident, and attending physician join virtually on the same platform, which has been safe and effective. The virtual supervision of residents providing

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[1] HRSA data on health professional shortage areas by discipline can be found here: https://data.hrsa.gov/topics/health-workforce/shortage-areas

[2] Designated Health professional shortage areas statistics, Bureau of health Workforce, HRSA (March 31, 2023) https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport

[3] Id.

[4] AAMC, The complexities of physician supply and demand: projections from 2019-2034 (June 2021) can be found here https://www.aamc.org/media/54681/download

[5] The Clinical Practice Solutions Center (CPSC) developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance.

these telehealth services allows the same safe and high-quality oversight as physically co-locating the attending physician with the additional benefit of ensuring access to care. The attending and resident both interact with the patient virtually and receive the same information from the patient whether they are co-located or in different locations. This allows the supervising physician to play an active role in patient evaluation and treatment. Video platforms allow the resident and attending physician to communicate seamlessly with each other through sending real-time private messages to one another and/or to meeting virtually face-to-face in a private breakout room separated from the patient. From the patient's vantage point, the only difference between virtual supervision and in-person supervision during a service provided via telehealth is one verses two boxes on the screen.

Guardrails exist through the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting organizations that have standards and systems that will ensure patient safety and oversight of residents when virtual supervision of residents occurs. ACGME sets forth extensive program requirements, including requirements related to supervision. ACGME recognizes that supervision may be exercised through a variety of methods, as appropriate to the situation, including through telecommunication technology. The program must demonstrate that the appropriate level of supervision is in place for all residents and is based on each resident's level of training and ability guided by milestones, as well as patient complexity and acuity. The faculty must assess the knowledge and skills of each resident and delegate to the resident the appropriate level of patient care authority and responsibility, and each resident must also know the limits of their scope of authority. Teaching physicians are ultimately responsible for determining the level of supervision required and any adverse events that occur. ACGME, other accrediting organizations, and the medical education community work hard to monitor, report, and address any issues related to workload, patient safety, medical error, resident well- being and burn-out, professionalism, and resident learning and outcomes.[6]

It is imperative that the progress in improving access that has been made during the PHE continue when the PHE ends. Therefore, we urge CMS to amend its regulations to allow virtual supervision of residents in all geographic regions for services that may be safely and effectively furnished under virtual supervision. Thank you for your consideration. If you have any questions, please contact Gayle Lee at galee@aamc.org.

Sincerely,

Jonathan Jaffery, MD, MS, MMM
Chief Health Care Officer

cc: David Skorton, MD, AAMC President and CEO

[6] *See* ACGME program requirements (common program requirements residency)