November 4, 2022

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

PO Box 8016 Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

Re: Request for information on accessing healthcare, provider experiences, and advancing health equity.

We write on behalf of the members of the Council of Academic Family Medicine (CAFM) which collectively includes organizations representing family medicine medical school and residency faculty, community preceptors, residency program directors, medical school department chairs, research scientists, and others involved in family medicine education. We have submitted this information through the on-line form, but it doesn’t allow for some of the links and formatting so we are sending a separate formal letter in response to you. CAFM offers the following specific suggestions:

1. **Accessing Healthcare and Related Challenges:** public comment on personal perspectives and experiences, including narrative anecdotes, including challenges individuals face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication.)

There are several areas where we have comments that relate to challenges with access that also fall into one or more of the other categories. Due to the character count limitations of the form, we will only include them in one section; not all they apply to.

We are grateful for the quick actions CMS took to include waivers in many areas of provision of care, most especially concerning telehealth during the COVID-19 Public Health Emergency (PHE.) However, we believe there are areas where CMS should use the experience of the PHE to identify further issues that can continue once the PHE ends. For example, the use of audio-only telehealth in

CMS, in their final rule for the CY2023 physician fee schedule, did not respond to comments regarding concerns over access due to lack of broadband, or cellular data, or lack of access to technology supporting video, disparities in digital literacy, mobility issues of elderly or other patients, lack of time off from work, age of patient and competency with digital technology, etc. Instead, it reiterated that audio-visual communication is the appropriate standard. We continue to request that CMS re-examine this issue and include changes that allow for the continuation of telehealth care beyond the PHE.

Several articles have shown the importance of telehealth, including audio-only telehealth in addressing cancer screening (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8530237/>), prenatal care, <https://pubmed.ncbi.nlm.nih.gov/33038898/>, <https://pubmed.ncbi.nlm.nih.gov/34767317/>, and generally showing comparable patient outcomes (both mortality and satisfaction) when compared to video conference, even if videoconference was superior generally from a provider perspective <https://pubmed.ncbi.nlm.nih.gov/30153920/>. Another study of telephone vs. video visits during the pandemic from safety-net providers showed that while video visits might be the gold standard, by requiring them over phone visits, the digital divide is widened, and equity issues arise by requiring such. The study concluded that “despite challenges, providers reported positive experiences delivering care remotely using both telephone and video during the COVID-19 pandemic and believe both modalities are critical for enabling access to care in the safety net.” <https://www.jabfm.org/content/34/6/1103>

Workforce and Training Implications: In addition to the question of access to care, we have concerns about the impacts of restrictions on telehealth and the use of audio-only telehealth in the primary care workforce and on training.

There are also implications on training from removing much of the progress we have seen in telehealth during the pandemic. Physicians and trainees scaled up telehealth efforts and developed curricula rapidly early in the pandemic. However, suppose it is not a modality that continues to be paid for at reasonable reimbursement rates or is only available in limited areas (audio-only in rural areas). In that case, most programs will be unable to train resident physicians in this care modality, causing a patchwork of training across the country and a lack of standardized training.

Reimbursement also has significant ramifications from a national workforce perspective. As our patients go back to work in person, telehealth allows for much less loss of work days/hours, and elderly patients and others with mobility issues do not have to run through the difficulty and expense of getting to an in-person visit. Often, these patients need other family members to help them as well, causing a loss of work hours for family members when a telehealth visit would be appropriate.

**Recommendations for how CMS can address these challenges through our policies and Programs:**

By requiring only video access for telehealth for most of the country, CMS is exacerbating access issues and promoting concerns regarding a digital divide that has substantial health equity implications and needs to be addressed. If CMS is not comfortable permanently expanding the ability to use audio-only telehealth, it should continue it temporarily and spend the funding on research into this issue. A joint research effort with CMS funding and AHRQ’s Center for Primary Care Research would be one way to address this issue. Another would be for CMMI to conduct a demonstration project to help address this question and a related question regarding what reimbursement rate is needed to support this care. We are concerned that CMS is letting the perfect be the enemy of the good – and that while video telehealth might be a gold standard, it is clear, even from CMS’s perspective, that audio-only telehealth has its place. CMS has agreed to continue to allow this for rural situations, but as we have shown, there are other types of patients for whom this can be an essential care modality. Patients who can’t take much time away from work or childcare, patients who have mobility issues, and patients without the economic resources to have adequate digital coverage (either in terms of hardware, broadband, etc.) are all categories of patients who can benefit from audio-only telehealth services. CMS should make every effort to try to support this care.

1. **Understanding Provider Experiences:** factors impacting provider well-being and the supply and distribution of the healthcare workforce.

Several areas below might fit into other categories. Still, we are putting them in here because they relate to the supply and distribution of the healthcare workforce – whether it relates to provider experience or not. Much of this relates to the education and training experience and barriers that generally impact the supply and distribution of the primary care physician workforce and family medicine.

* + Rural GME issues:

Medicare accounts for two-thirds of public funding for residency training and program requirements influencing physician workforce distribution. Many rural areas lack access to primary care physicians and other specialties compared to urban and suburban areas. At the same time, 20% of the U.S. population lives in rural communities and only an estimated 10% of physicians practice in those communities. Physician distribution is influenced by training, and most work within one hundred miles of their residency program. Unfortunately, rural hospitals typically cannot afford to create residency programs because they operate on narrow margins and require a predictable funding source. Moreover, caps on the number of Medicare-funded GME residents created by the Balanced Budget Act of 1997 have limited the growth of GME in rural areas and have not kept pace with the 27% rise in residents since enactment.

These limitations, even with recent efforts to support more residency training slots in rural America through the Consolidated Appropriations Act of 2021 (CAA 2021) and previously through the redistribution of residency slots in other legislation, have not had a significant impact in producing more physicians who will practice in rural communities. Targeted rural GME solutions are needed. Please see below for our recommendations for CMS to address these concerns.

In addition, there are three non-legislative problems that CMS could adjust to help rural training. Currently, CMS does not allow existing rural track programs (separately accredited programs established before the CAA 2021) to grow their cap limitation in sites they are now training in, where they can grow their cap if they develop new training sites. This policy has an unbalanced burden on family medicine training programs which are the bulk of programs with previously existing rural track programs (formerly called Rural Training Tracks.) Please refer to our comments on the Proposed and Final Rules implementing the CAA 2021 (<https://bit.ly/3SZPDuJ>

and <https://bit.ly/3NyEpMo>) that discuss the authority we believe CMS has to accomplish this change.

Our other concern is that we request that CMS make changes to how it sets the FTE limits for residents training in rural track programs. Currently, CMS counts the time residents spend training at the rural site across five years and the time spent in the urban setting and then measures the highest number (in any program year) during the fifth year of the cap-setting window across all participating hospitals. That number is multiplied by the program accredited length, and then for each hospital, a ratio of that hospital’s FTE’s training over the entire five years over the total training time of training for both sites (rural hospital and rural non-hospital site counted together.) Because a rural track program typically has its residents train in the urban hospital in year one, rather than in the rural setting, the urban hospital gets more than its fair share of the cap, and the rural site gets less than the actual number of FTE’s training in that site. When apportioned this way, rural sites are disadvantaged compared to urban hospital sites. Please refer (again to our previous comments referenced above regarding the CAA 2021) for examples explaining this problem and how it can be resolved.

Lastly, in another provision of the CAA 2021, Section 126, relating to the distribution of 1000 new GME slots, CMS has the opportunity to add an impact factor described in our comments, for which we provided more information to CMS, to ensure that places would go to institutions/programs that actually produce more physicians who practice in rural and underserved areas, rather than just ones who train in HPSAs.

* + Teaching Health Center Graduate Medical Education (THCGME) and the primary care exception:

A technical problem exists regarding allowing payments under the Teaching Physician primary care exception to be made for residents training in THCs. These regulations allow for independent practice by residents and subsequent billing for specific non-complex codes in ambulatory practice settings. Because the laws were written in 1995, before THCs came into existence, they are limited to situations where residents are funded under Medicare graduate medical education (GME), while THC residents are financed from HRSA. Please see the section below for our recommended solution.

**Recommendations for how CMS can address these challenges through our policies and Programs:**

*Rural GME Solutions Needed:*

While much of the changes would require legislation to provide CMS the authority to make the change, CMS should be able to request that the Administration, in its annual budget proposal, request that Congress make these legislative changes to support rural physician training. Two companion bills in Congress right now (S. 1893/HR 8508) would provide changes in Medicare statute that would support such training, including 1) establishing a separate payment for rural training, not based on current Medicare GME formulas, and not defrayed by Medicare’s share, 2) allowing Critical Access Hospitals and Sole Community Hospitals access to this new/different payment amount, 3) expanding the definition of rural beyond the current non-CBSA definition that Medicare uses for GME purposes, and 4) remove the caps on rural training.

Revise the rules implementing the CAA 2021 GME provisions. Please refer to our comments on the Proposed and Final Rules implementing the CAA 2021(<https://bit.ly/3SZPDuJ>

and <https://bit.ly/3NyEpMo>) that discuss the authority we believe CMS has to accomplish these changes and the specific solutions needed. The changes we request would allow for:

1. Expansion of existing rural training sites for programs established before the CAA 2021
2. Revision of the way that the cap is set for rural track programs to alleviate the inaccurate benefit accruing to the urban hospital at the expense of the rural training site.
3. Implementing an impact factor related to the distribution of new slots through Section 126 of the CAA 2021.

*THCGME and the Primary Care Exception:*

Allow Teaching Health Center residents/teaching physicians to utilize the primary care exception: Apply the Teaching Physician Primary Care Exception rules for payments for services furnished by residents in patient care activities in determining payments made under Section 340H of the Public Health Service Act in addition to those furnished by residents under Medicare GME. (See §415.174 (a)(1))

**§415.174 Exception: Evaluation and management services furnished in specific centers.**

(a) In the case of specific evaluation and management codes of lower and mid-level complexity (as specified by CMS in program instructions), carriers may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply, all of the following conditions must be met:

(1) The services must be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under §§413.75 through 413.83, or for which payments made under Section 340H of the Public Health Service Act to Teaching Health Center Graduate Medical Education programs.

1. **Advancing Health Equity**: individual and community-level burdens, health-related social needs, and strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

There are many areas within the purview of the Department of Health and Human Services that can bring to bear changes that would support individual and community burdens with an effort to achieve health equity. Many of these areas relate to programs and policies, not within CMS’s purview. For example, increased funding of primary care research within the Agency of Healthcare Research and Quality could help address the best practices and identify areas ripe for change that would support advancing health equity. Several HRSA programs under Title VII and VIII of the Public Health Service Act, especially the Primary Care training and enhancement program, would also help advance this goal.

Within CMS, though, we think that the Centers for Medicare and Medicaid Innovation (CMMI) can best help address these concerns by supporting demonstrations of new ways to care for patients. We would hope that the CMMI would look more wholistically regarding payment to identify what changes might be supported to address health inequalities, social determinants of health, and burdens impairing comprehensive care. Current Medicare rules and reimbursement are still set up to pay for specific healthcare services rather than looking at populations and expanding the kind or type of services provided.

Research has shown that to provide appropriate guideline-based care, primary care physicians would need to spend over 24 hours per day. In a 2022 study,[[1]](#footnote-1) PCPs estimated a need of 26.7 h/day, comprising 14.1 h/day for preventive care, 7.2 h/day for chronic disease care, 2.2 h/day for acute care, and 3.2 h/day for documentation and inbox management. With team-based care, PCPs need 9.3 h per day (2.0 h/day for preventive care and 3.6 h/day for chronic disease care, 1.1 h/day for acute care, and 2.6 h/day for documentation and inbox management).

PCPs do not have enough time to provide the guideline-recommended primary care. With team-based care, the time requirements would decrease by over half but still be excessive. We must find ways to alleviate these pressures and ensure that primary care physicians have the right tools to reduce this time even further to make it more manageable and provide needed care to all patients.

Chronic disease care requires the primary care enterprise coordinating care between providers and systems. However, there are typically disparate pieces of information coming at them. It can’t be called integrated care because specialists are frequently not involved in the care teams; information is directed at primary care but is not bi-directional, and information is not coordinated. For example, one key issue is that systems have different ways of handling this. Research is in small pieces, such as how to integrate chronic care into the EHR, but there is typically not a broader look at the need to get all parties involved.

One issue of concern is the concept of the development of a care plan. Much is made of the need for a care plan, but little attention is targeted to the actual planning, not the plan. For example, what is communication planning? How do you create relationships with specialists who need to be involved, rather than a plan just stating that they should be involved? Much of the need for a patient care plan devolves into concentrating on the medical disease, not the patient. There needs to be robust evaluation and intervention of social determinants of health. For example, it’s not helpful to put things into a care plan relating to social determinants of health that a patient can’t execute, such as housing, food insecurity, etc. Research to date has focused on the tool (care plan) rather than on making the connections needed to provide communication and care. The document isn’t the intervention. One of our members stated, “If we ignore that they can’t eat or get medicine, then even the best care plan won’t work right.”

The current payment structures with fee-for-service payments don’t help provide holistic patient care. There is a need for more global payment structures to ensure that a robust team is in place to provide care so that things are not handled piecemeal but are integrated into the totality of care. See below for examples of successful models that need to be scaled up to help address some of these equity concerns.

**Recommendations for how CMS can address these challenges through our policies and Programs:**

*Successful models of integrated care that CMS can use to help address questions of health equity and social determinants of health:*

One solution that helps is using community health workers. Information for developing care plans needs to be collected where the patient lives rather than in the doctor’s office. Filling out a form in the office would create gaps. There is a need to have a process and program for those with multiple chronic conditions where health workers go to where they live to help focus on what the patient feels is necessary.

Another successful model of going to where the patient is, can be found in Houston, TX. Shreela V. Sharma, Ph.D., RD, is leading an effort to address the mounting health and social needs of families throughout our communities by facilitating the development of a Community Information Exchange as part of her leadership role in the Health Equity Collective. She serves as co-lead of the Health Equity Collective, a community-wide coalition in the Greater Houston area with more than 120 local organizations. The Community Information Exchange is one of the Health Equity Collective’s primary efforts to establish an impactful and sustainable data-driven system to promote health equity in the Houston community. <https://www.uth.edu/out-in-front/story.htm?id=5deab805-7556-432c-af2c-07536c32d65c>

Another model, also from the Houston, TX area, is the Patient Care Intervention Center (PCIC) <https://pcictx.org/> which provides innovative approaches to Care Coordination, Population Health, and Health Information Technology.

Lastly, the work of Rushika Fernandopulle, MD, a practicing physician and co-founder and CEO of Iora Health, which is a venture-backed, national de-novo primary care group based in Boston, MA (currently part of One Medical.), is an example of the provision of integrated, comprehensive primary care.<https://ioraprimarycare.com/what-is-primary-care/>

Bottom Line: there is a need for changes to the payment structure, the development of better team care, and acknowledgment of the care planning process, not just the care plan itself.

**Additional areas of research to help fill gaps:**

One additional perspective for introducing new interventions in comprehensive primary care is the concern that many of these interventions might work in highly resourced areas or systems. Still, it may be challenging to adapt to other communities. One avenue for needed research is using community health centers or FQHCs to address some of these innovations or models of care. Highly integrated systems have the tools, but there is a need to test and develop for less resourced systems. Historically, these innovations have started or been imposed on highly resourced systems and are supposed to trickle down; it needs to be the other way around – starting at the community center level.

1. **Impact of the COVID-19 Public Health Emergency Waivers and Flexibilities**: CMS wants to understand the impact of waivers and flexibilities to identify areas for improvement, including opportunities to decrease further the burden and address health disparities that the PHE may have exacerbated.

We have addressed the question of audio-only telehealth earlier in an earlier section. In this section, we would like to raise the need for expanding codes allowed under the PHE, which will not be continued after the end of the PHE. In particular, we are concerned about what codes are authorized to be used under the primary care exception.

* We request the inclusion of 99204 and 99214 E&M codes in the primary care exception.

The primary care exception was included in regulation in the mid-1990s in acknowledgment by CMS that primary care residents need autonomous experience without being hampered by the insertion of a faculty member into patient care visits to develop the self-reliance necessary for independent ambulatory continuity practice as well as an independent, trusting relationship with a panel of patients. CMS implemented this concept by limiting the circumstances in which residents could see patients without the teaching physician’s presence. One of the limitations related to the complexity of the visits. Only less complex visit codes were allowed to be part of the exception.

Historically, before the PHE, CMS only allowed E&M codes 99201-99203 and 99211-99213 to be included in the primary care exception to the teaching physician rule. This rule made sense at the time of the establishment of the exception, back in the mid-90s, as the 99204s and 99214s were considered complex visits, often involving patients with acute or unstable chronic conditions requiring the teaching physician to personally examine and assess the patient to assure a high standard of care. However, within the Medicare population, it is not unusual to find patients with three or more chronic conditions presenting for new and follow-up visits that require a level of time and decision-making consistent with a level 4 code for the management of multiple chronic diseases but do not involve a level of diagnostic complexity that is beyond the resident physician’s ability to provide quality care with indirect supervision. In addition, in recent years, medical training has moved further toward competency-based assessment and rigorous supervision standards have been put in place.

In fact, the ACGME has moved toward competency-based education through the development of common program requirements. ([https://www.acgme.org/What-We-Do/Accreditation/Common-](https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements) [Program-Requirements](https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements) ) These requirements were developed specifically to produce independent, well-trained physicians in the context of patient safety. This revision is a concept CMS recognized when it developed regulations in the mid-90s that created the primary care exception. ACGME notes that “combined with gradually increasing authority and independence, supervision, and feedback allow resident physicians to transition from novice learner to proficient practitioner after residency training. At the same time, excessive supervision without progressive independence, as resident physicians acquire knowledge and skills, may hamper their progression from learner to competent practitioner in their discipline.”([https://www.acgme.org/What-We-Do/Accreditation/Clinical-Experience-and-](https://www.acgme.org/What-We-Do/Accreditation/Clinical-Experience-and-Education-formerly-Duty-Hours/Research-and-Testimony) [Education-formerly-Duty-Hours/Research-and-Testimony](https://www.acgme.org/What-We-Do/Accreditation/Clinical-Experience-and-Education-formerly-Duty-Hours/Research-and-Testimony) (Chapter 6 New Supervision Standards: Discussion And Justification))

These Common Program Requirements compel the establishment of a Clinical Competency Committee (CCC) in each accredited residency and fellowship. The committee reviews all resident physicians twice a year, evaluating the resident physician’s progress. As part of those evaluations, the committee determines whether (and for what purposes) the resident physician is ready for direct vs. indirect supervision. Below is our solution to this problem.

* Medicare Supervision Flexibilities:

During the COVID-19 PHE, CMS adopted a policy on an interim basis allowing supervision of a resident by a teaching physician either in person or virtually through audio/video real-time communication technology during the critical portion of the service. The goal was to ensure beneficiary access to necessary services and maintain sufficient workforce capacity to furnish patient services safely. This policy generally requires real-time observation by the teaching physician through audio-video technology (not mere availability) and omits audio-only (e.g., telephone without video). CMS recently finalized regulations to permanently allow Medicare payment for virtual supervision of residents by teaching physicians only when the patient and resident are located in a rural area. When residents provide telehealth services, virtual supervision by the teaching physician will only be allowed in rural areas. We strongly urge that remote supervision of residents in teaching settings through audio/video real-time communications technology be made a permanent policy, regardless of the location of the patient or resident and teaching physician, especially for low-risk services such as evaluation and management visits.

**Recommendations for how CMS can address these challenges through our policies and Programs:**

*Add E&M codes 99204 and 99214 permanently to the primary care exception*

With the internal processes mentioned above in place, we believe it is safe and advantageous for CMS to include the 99204 and 99214 E&M codes in the primary care exception. Our goal is to reduce unnecessary bureaucracy, not appropriate supervision. This change would free preceptors to spend more time with resident physicians on complex and unstable patients, no matter the code billed.

CMS has had more than enough experience through the PHE when it allowed all E&M codes to be included in the exception, to see how these have been an essential addition to the ability of resident physicians to train appropriately, without harm to the patient. Our program directors, the academic physicians most closely aligned with the training of residents, are not asking for the next level of codes to be included (99205 and 99215) as they agree that the level of complexity requires direct supervision. We ask CMS to permanently include 99204/99214 codes in the primary care exception.

*Make permanent the remote supervision requirements included in the PHE waivers for telehealth services provided by a resident for evaluation and management visits.*

Remote virtual supervision has been shown to be safe and effective. We recommend that CMS continue to allow such supervision for services when a patient is located in a rural area and for all evaluation and management services regardless of the place of care.

1. Porter, J., Boyd, C., Skandari, M.R. *et al.* Revisiting the Time Needed to Provide Adult Primary Care. *J GEN INTERN MED* (2022). https://doi.org/10.1007/s11606-022-07707-x [↑](#footnote-ref-1)