

July 2, 2020

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS–5531–IFC
P.O. Box 8013
Baltimore, MD 21244–1850

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Dear Administrator Verma,

On behalf of the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, the North American Primary Care Research Group, we are pleased to submit comments in response to the Interim Final Rule with comment, published May 8, 2020, *Federal Register*, titled Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program.

We are extremely appreciative of the information you included in the prior interim rule Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and the clarifications of some of these provisions in the current interim final rule. The multiple waivers and changes to rules to accommodate changes in healthcare practice needed to respond to the COVID-19 public health emergency (PHE) are exceptionally helpful and we greatly appreciate your work that addresses questions relating to teaching physicians' supervision of residents and allows remote precepting.

Our comments focus mainly on issues regarding the “Exception: Evaluation and management services furnished in certain centers”, commonly called the primary care exception (42 CFR § 415.174). In addition, we comment also on telehealth provisions and additional provisions relating to Medicare graduate medical education (GME).

G. Medical Education

Holding Hospitals Harmless from Reductions in IME Payments Due to Increases in Bed Counts Due to COVID-19

We support the change included in this section, for the duration of the COVID-19 PHE, for purposes of determining a hospital's IME payment amount, the hospital's available bed count is considered to be the same as it was on the day before the COVID-19 PHE was declared. The proposal revises § 412.105(d)(1), “to state that beds temporarily added during the timeframe of the COVID-19 PHE, as defined in § 400.200, is in effect, are excluded from the calculations to determine IME payment amounts.”

We appreciate and support the purpose of this change – to prevent hospitals from any undue reductions in DGME and IME payments due to changes in bed numbers related to an increase of emergency beds due to COVID-19 patient loads.

1. Time Spent by Residents at Another Hospital during the COVID-19 PHE

In addition, CMS makes a further change to prevent further financial losses by allowing a hospital to claim time spent by residents training at other hospitals. Normally, under regulations in place prior to the PHE, a hospital cannot claim time spent by residents training at other hospitals for GME payment purposes. During the Public Health Emergency (PHE), hospitals will be allowed to claim “their” residents’ time spent at other hospitals to allow hospitals to send residents to where they are needed without financial considerations.

We support this change and appreciate CMS’s flexibility in this area. In addition, related to this change, CMS has stipulated that, “During the COVID-19 PHE, the presence of residents in non-teaching hospitals will not trigger establishment of per resident amounts or FTE resident caps at those non-teaching hospitals.”

This is a critically important provision, both during the PHE, and in general. We have submitted comments before to CMS in response to its June 11, 2019 Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork, asking that the agency change its regulations so that a rotation of a resident to a GME-naive hospital would not trigger either the establishment of a per resident amount or FTE caps at those non-teaching hospitals.

Specifically, we stated that that two major limitations in funding rural graduate medical education exist based on current rules, or CMS interpretation of current rules, regarding the establishment of caps and per resident amounts. Transient, partial training of residents in rural hospitals has resulted in artificially low caps on resident training for these hospitals, and artificially low per resident amounts (PRAs) associated with that hospital. While the rural hospital may expand its cap by establishing a new program, once the cap is reset, the program cannot expand in the future. Of even more concern, the PRA is set forever, even though the hospital has never sponsored a training program, making it unlikely that a hospital will ever be able to start a new training program.

We recommended the following solution: Exempt hospitals from having a cap on resident positions (and the associated PRA) set if they are only training rotators from other institutions for brief periods of time. Hospitals that sponsor residency programs have a Designated Institutional Official (DIO,) so all hospitals with a DIO would be excluded from this request. For those hospitals where there is no DIO because another organization is the sponsor of the residency, the rubric should be “no claim, no trigger.” In other words, if the hospital isn’t claiming, or hasn’t claimed, costs for the training of those residents CMS should not establish a PRA, and the cap clock should not be started. This is in keeping with the sentiment expressed in current statute that discusses the limits “with respect to a hospital’s approved medical residency training program.” (§1886 DGME(h)(2) and (§1886 DGME(h)(2)(F)(i). The solution should be applied both prospectively AND retroactively. We recognize that this will not affect (help) hospitals whose cap was set due to residents rotating through in 1996 due to the statutory language of the BBA, and we are working on legislation to help I those instances, but CMS can make changes to its interpretation of its own regulations to help current and future situations.

We are grateful that CMS has understood the need to not harm non-teaching hospitals that take in residents during the PHE. We hope that CMS will give consideration of the need for hospitals

to send residents to other non-teaching hospitals for training purposes as well, not just the COVID-19 emergency and hope that CMS will see the value of making this change permanent.

M. Additional Flexibility under the Teaching Physician Regulations

There are two provisions under this section that have been critically important to provision of primary care services under the teaching physician regulations. First, we appreciate greatly the change CMS has allowed regarding remote precepting, or supervision, of residents by the teaching physician. Without this change, access to care would have been deeply affected as the pandemic necessitated restrictions on physical presence, both between patients and physicians, and residents and their supervisors.

We especially appreciated the correction, included in this interim rule, that the primary care exception can be used for telehealth visits and specifically that CMS has clarified in this rule, “the supervision of primary care residents under the primary care exception can be performed through communications technology immediately following telehealth visits performed by residents.”

We were very gratified to see the expansion of services allowed to be paid for under the primary care exception. Many of these services were included in our request of CMS as part of our response to the June 11, 2019 Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork, and we appreciate the inclusion of those plus other services such as audio-only evaluation and management codes. Although not included in this rule, we appreciated clarification that CMS promulgated on June 17th, the “COVID- 19 FAQs on Medicare Fee-for Service Billing” that CMS “expanded the primary care exception to include all five levels of an office/outpatient E/M service (CPT codes 99201–99205 and CPT codes 99211–99215).”

We ask that CMS use the experience under the PHE to review its position on what services should be allowed under the primary care exception and expand the list accordingly for services provided once the PHE expires.

In addition, a technical problem exists regarding allowing payments under the Teaching Physician primary care exception to be made for residents training in THCs. Because the regulations 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 funded through HRSA. As CMS continues to examine its use of the primary care exception, we ask that CMS revise its regulation under §415.174 (a)(1)) to allow 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.

N. Payment for Audio-Only Telephone Evaluation and Management Services

The rule greatly expanded the ability of primary care physicians and residents to use audio-only telephone E/M codes with reimbursement equivalent to typical E/M visit codes. Understanding that these services were replacements of typical office/outpatient services and cross walking the reimbursement commensurately has been a tremendous boost to access to care for patients. Including these codes in the list of services that residents can provide was also a critical decision which we support. However, we ask that CMS clarify the technology necessary for supervision using these codes. In the FAQs referenced above, in question #4 under the heading *S. Additional Flexibility under the Teaching Physician Regulations* CMS states, “This means that

the resident can conduct a phone visit with a patient while being **supervised virtually** by the teaching physician.”

We would like additional clarification regarding use of the term “supervised virtually.” CMS has used various terms when expressing technology requirements for remote supervision. In the rule, CMS has stated supervision can be done “remotely through virtual means via audio/video real time communications technology,” and at other times, especially in the FAQs, CMS has used the term “interactive telecommunications technology,” and “supervised virtually.” The question becomes key when considering supervision of audio-only visits. One of our members posed a scenario that makes it difficult to understand the need for an audio-visual supervision for an audio E/M visit. He asked, “What about when I precept a resident who is at a remote location from me and doing an audio only telephone visit with a patient, and I join the conversation in a three way call to review the history, assessment and plan with the resident and patient. Do I still need to get the resident on an audiovisual link to bill?” In this scenario, it seems like in order to bill, the preceptor would have to call the resident afterward using audio/visual means to confirm what he said/directed on the phone, even though he participated in the visit, in order to bill for the phone visit. That seems like an undue administrative burden. We hope CMS will revise the requirement for supervision of residents providing audio-only visits to allow for audio-only technology.

As you continue to work to address the concerns of the provider community to help provide needed care to patients during this emergency, we would appreciate your consideration of our requests regarding clarification and support for future changes beyond the public health emergency. If you have any questions, please contact Hope Wittenberg, Director, Government Relations, at 202-986-3309 or hwittenberg@stfm.org.

Sincerely,



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