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The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS—1832—P
Sent electronically via http://www.regulations.gov.

SUBJECT: Virtual Supervision of Residents

Thank you for the opportunity to comment on the CY 2026 Physician Fee Schedule and Quality Payment Program Proposed Rule (file code CMS—1832—P). To facilitate continued access to care and provide training opportunities for residents, University of California Health (UC Health) urges 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.

UC Health's mission is to improve the health and well-being of all people living in California now and in the future by educating and training the workforce of tomorrow, delivering exceptional care, and discovering life-changing treatments and cures. UC Health is an integral part of the state's health care delivery system, operating the nation's largest health sciences education program which includes six academic health centers and 21 health professional schools. All of UC's hospitals are ranked among the best in California and its medical schools and health professional schools are nationally ranked in their respective areas. UC Health is committed to providing high quality educational experiences for the next generation of health professionals and leaders to ensure an adequately trained workforce. More than 5,800 medical residents and fellows receive training in UC residency programs each year.

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 rural areas to enable patient access and resident training opportunities in rural areas. We also appreciate CMS's actions to extend the virtual supervision of residents in metropolitan areas through the end of 2025. However, CMS now proposes to revert back to the policy that existed prior to the public health emergency (PHE), which would maintain virtual supervision in rural areas but require physicians in metropolitan areas to have a physical presence during critical portions of all resident-furnished services in order to qualify for Medicare payment. Virtual supervision of

residents is 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 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. We urge CMS to withdraw this proposal and permanently allow for virtual supervision of residents in both rural and metropolitan areas for services that may be safely and effectively provided under virtual supervision.

Residents have been virtually supervised safely and effectively for several years, including when the resident provides telehealth services to patients. The attending physician is present virtually during key and critical portions of the service, available 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 crucial portion 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 urban areas. According to data from the Health Resources and Services Administration (HRSA), as of September 2, 2025, 125 million people currently reside in a Mental Health Professional Shortage Area (HPSA) and there are about 6,300 fewer practitioners than needed.[1] Similarly, 84 million people reside in a Primary Care Shortage Area and about 14,300 primary care practitioners are needed.[2] Roughly 30 percent of mental health and primary medical HPSAs are located in urban areas.[3] Additionally, a March 2024 report from the American Association of Medical Colleges (AAMC) predicts a shortage of up to 86,000 physicians by 2036.[4] These shortages have a real impact on access to care for patients, and virtual supervision is an important tool that can help address them.

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. 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. 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 these telehealth services allows the same safe and high-quality oversight as physically co-locating the attending

[1] HRSA data on health professional shortage areas by discipline can be found here: https://data.hrsa.gov/topics/health-workforce/shortage-areas
[2] Id.
[3] Designated Health professional shortage areas statistics, Bureau of Health Workforce, HRSA (March 31, 2023) https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[4] AAMC, The Complexities of Physician Supply and Demand: Projections From 2021-2036 (March 2024) can be found here: https://www.aamc.org/media/75236/download?attachment

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 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 versus two boxes on the screen.

Telehealth care by residents has been demonstrated to be a safe and effective strategy for maintaining, and in many cases increasing, access to care. The teaching physician is ultimately responsible for the clinical outcomes of the care provided by residents. Guardrails through the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting organizations ensure patient safety and oversight of residents under virtual supervision. ACGME recognizes that supervision may be exercised through a variety of methods, as appropriate to the situation, including through telecommunication technology. ACGME recognizes virtual supervision as a form of *direct* supervision, the highest level of supervision in ACGME's Common Program Requirements. Decreasing the ability for physicians to provide or supervise high-quality care virtually is harmful to Medicare beneficiaries and may negatively impact the number of physicians entering the health care workforce due to fewer physicians choosing to serve in a supervisory role.

It is imperative that the progress in improving access that has been made since the start of the PHE continue. 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 Kent Springfield at (202) 993-8810 or kent.springfield@ucdc.edu.

Sincerely,

Tam Ma
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