Outbreak Activation Reimbursement for Providers on the Frontlines of the COVID-19 Response

REQUEST

IDSA asks that Congress establish an enhanced payment and authority for a Medicare coding pathway for outbreak activation activities of health care providers, similar to Medicare's existing trauma activation coding and payment policies.

BACKGROUND

While there are a variety of mechanisms which may achieve this goal, one potential option would be to provide a section 1135 waiver. Under section 1135 of the Social Security Act (SSA), which requires both a public health emergency determination as well as a Presidential declaration of a major disaster or emergency pursuant to the Stafford Act, the Secretary has the authority to temporarily waive or modify certain Medicare, Medicaid, CHIP, and HIPAA Privacy rule requirements. Waivers or modifications under section 1135 of the SSA may be retroactive to the beginning of the emergency period (or to any subsequent date). The waiver or modification terminates either upon termination of the emergency period or 60 days after the waiver or modification is first published (subject to 60-day renewal periods until termination of the emergency). These current law declarations could provide an appropriate trigger for enhanced payment for outbreak activation activities.

Alternatively, CMS could be directed to establish coding and payment for "outbreak activation" modeled after CMS' current mechanism for trauma activation payment[1]. Specifically, CMS could establish a new "outbreak activation" HCPCS code and provide payment for the increased costs associated with:

1. maintaining specialized equipment and other supplies necessary for managing an influx of patients that may be impacted by transmission of a community-wide disease or other qualifying outbreak;[2]
2. assembling the necessary clinical professionals (e.g., infectious diseases, critical care medicine, and emergency medicine physicians, among others) to immediately diagnose, treat, and manage the care of such patients; and
3. repurposing areas of the facility to manage a growing influx of outbreak patients.
4. coordinating preparation and response activities with state and local public health authorities
5. providing updates and guidance to the community
6. coordinating with human resources to ensure well-being of healthcare facility staff

CMS could also be directed to establish a physician-level payment modifier that would allow the clinical professionals to receive enhanced Medicare reimbursement associated with the delivery of professional services associated with the outbreak.

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1139CP.pdf

[2] Through rulemaking, CMS could establish parameters to define a qualifying outbreak

RATIONALE

Recognizing the intense and sustained work of many providers who are on the front lines of the current COVID-19 pandemic, an outbreak activation payment would allow the Secretary to designate existing codes as well as create new codes or modifiers for certain activities that are relevant to a particular outbreak situation. In addition, the Secretary could designate a specific "bump up" of the reimbursement of such codes during the declared emergency period in a local area or on a national level if warranted. This approach would help address current COVID-19 response needs for those already on the front lines, but also could impact the specialty decisions of current residents, helping to boost the number of residents applying for specialties essential to responding to the current COVID-19 pandemic and future pandemics, including infectious diseases, thereby strengthening our workforce very soon. In the longer term, this mechanism could help make the field of infectious diseases more financially feasible for more physicians, helping to ensure the workforce necessary to respond to future public health emergencies.

Capacity in the field of infectious diseases was already stretched before COVID-19. There has been a 21.6% decline in the number of applicants to infectious diseases fellowship training programs from 2011-2016. The last few years saw only modest improvements that have plateaued. IDSA surveyed internal medicine residents in 2014 and found financial concerns were the chief barrier to pursuing ID. Data published by Medscape in 2019 indicate that average annual salaries for infectious diseases physicians are below all other medical specialties except pediatrics, family medicine, endocrinology and public health, and even below the average salary for general internal medicine, even though ID training and certification requires an additional 2-3 years of study. Salaries for the highest-paying specialties are nearly double the salaries for infectious diseases. Given that the average medical student debt is $200,000, the infectious diseases specialty is a financially infeasible choice for many.

DRAFT LEGISLATIVE LANGUAGE

If the Section 1135 waiver was deemed as the most appropriate process, then Section 1135 of the SSA [42 U.S.C. 1320b–5] could be amended by adding a new paragraph (8) to read as follows:

(b) Secretarial authority. -- To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to –

> (8) certain payment parameters with respect to certain health care items or services, including providing enhanced payment for certain items or services, to compensate health care providers (or a class of health care providers) for additional resource-intensive activities related to paragraph (1) of subsection (a)[i].

[i] Sec. 1135(a)(1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under titles XVIII, XIX, and XXI;