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Infectious Diseases Society of America

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October 14, 2024

Chairman Jason Smith
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Ranking Member Richard Neal
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Chairwoman Cathy McMorris Rodgers
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Frank Pallone Jr.
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

RE: Medicare Physician Payment Reform Outline

Dear Chairman Smith, Ranking Member Neal, Chairwoman McMorris Rodgers and Ranking Member Pallone Jr.,

On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 13,000 physicians, scientists, public health practitioners and other clinicians specializing in infectious diseases (ID) prevention, care, research and education, thank you for your focus on reforming physician payment. IDSA is encouraged to see Congress examining potential solutions to improve beneficiary access to care and reduce health care costs.

Thank you for the opportunity to comment on your recent outline on Medicare physician payment reform suggesting changes to the Proposed Medicare Physician Fee Schedule (MPFS). IDSA represents cognitive specialists who provide complex disease prevention, diagnosis and management; develop treatment plans; and offer patients complicated therapeutic regimens in both inpatient and outpatient settings, services that benefit patients treated in primary care settings. **IDSA asks that your future efforts recognize the critical need to reform Medicare physician**

payment policies for all physicians, including cognitive specialists such as ID physicians. IDSA also asks that Congress support equitable access to ID prevention, diagnosis and treatment.

Value of Infectious Diseases Care

ID care is unique because it touches so many aspects of health care and core hospital functions. For example, ID care is essential for patients of any age undergoing cancer treatment and organ transplantation, given their high risk of serious infection. ID physicians prevent, diagnose and treat serious infections associated with surgeries, including hip and knee replacements, repairs of congenital heart defects, repairs of congenital diaphragmatic hernias, repairs of congenital orthopedic defects and cesarean sections. Additionally, sepsis is the second leading cause of maternal mortality in the United States, making ID specialists critical to help reduce the alarming rise in maternal mortality. ID physicians lead health care facility efforts to prevent infections, including health care-associated infections; guide optimal antimicrobial use to combat resistance; and respond to outbreaks. ID physicians make communities more resilient in the face of public health emergencies, often providing expertise and guidance in rural and low-resource communities where public health expertise is lacking. ID physicians' care for hospitalized patients with serious infections has been shown to reduce mortality and readmission, shorten hospital and ICU length of stay, and lower Medicare costs.[1] ID care is also critical for patients struggling with opioid addiction, as injection drug use is fueling spikes in serious infections that often require hospitalization. ID physicians frequently function as primary care providers for patients living with HIV, providing holistic care that incorporates both specialty and primary care services.

Additionally, a 2021 study found that the number of immunocompromised adults in the United States more than doubled since 2013 and is now over 6%, with an increased risk of infection in these patients.[2] In recent years, the numbers of immunocompromised infants and children have also increased, and pediatric ID physicians provide care to a significant number of these patients, who are at a much higher risk for developing serious infections.[3] Over the past four years, the medical community has seen an increase in hospitalizations and deaths due to COVID-19 in patients with chronic conditions, such as heart disease, diabetes and more.

Current Medicare Reimbursement Concerns

Currently, nearly 80% of counties in the United States do not have a single ID physician, and this poses significant patient access problems.[4] Recruitment within the specialty continues to decline. In the 2023 fellowship match, only 50.8% of ID training programs filled (down from 56% the year before), whereas

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[1] Steven Schmitt, Daniel P. McQuillen, Ronald Nahass, Lawrence Martinelli, Michael Rubin, Kay Schwebke, Russell Petrak, J. Trees Ritter, David Chansolme, Thomas Slama, Edward M. Drozd, Shamonda F. Braithwaite, Michael Johnsrud, Eric Hammelman, Infectious Diseases Specialty Intervention Is Associated With Decreased Mortality and Lower Healthcare Costs, *Clinical Infectious Diseases*, vol. 58, issue 1, 1 January 2014, p. 22–28, https://doi.org/10.1093/cid/cit610

[2] Martinson, Melissa L., and Lapham, J. "Prevalence of immunosuppression among U.S. adults." JAMA, vol. 331, no. 10, 12 Mar. 2024, p. 880, https://doi.org/10.1001/jama.2023.28019

[3] Harpaz, R., Dahl, R., & Dooling, K. (2016). "Prevalence of immunosuppression among U.S. adults," 2013. JAMA, 316(23), 2547. https://doi.org/10.1001/jama.2016.16477

[4] Walensky, Rochelle P., et al. "Where is the ID in COVID-19?" Annals of Internal Medicine, vol. 173, no. 7, 6 Oct. 2020, pp. 587–589, https://doi.org/10.7326/m20-2684.

most specialties filled 90% to 100% of their training programs. These shortages are driven in large part by reimbursement disparities that negatively impact ID physicians. Many medical students and residents are very interested in this field but cite financial reasons for pursuing specialties that have much higher reimbursement rates. Only two other medical specialties fall below ID in terms of compensation, according to Medscape. One of those specialties, pediatrics, is primarily paid outside of the Medicare system. Changes to the way ID care is reimbursed, as outlined below, are critical to improve recruitment into the field and, subsequently, provide benefits for patient care and outcomes.

Bucket 1: Payment Updates

Baseline Update

The proposal to eliminate the statutory positive updates and replace them with an updated percentage of the Medicare Economic Index (MEI) every five years must consider the unique cost structures associated with ID practices. The complexity and variability in patient cases, particularly those involving multidrug-resistant organisms, necessitate comprehensive care approaches that are often resource-intensive. For instance, patients with multidrug-resistant organisms require extended treatment protocols, which demand both time and specialized resources. As another example, responding to emerging or reemerging , such as COVID-19 or mpox, can require significant time and specialized resources to prevent spread, conduct investigations and access novel therapies, often in coordination with the Centers for Disease Control and Prevention (CDC) and state and local public health. Adjustments to the MEI should reflect these realities to ensure the sustainability of ID practices, which are crucial for managing conditions that can lead to serious public health threats, such as sepsis and outbreaks of infectious diseases.

Additionally, IDSA is deeply concerned about the implications of the proposed changes to physician payment updates. **The shift from regular positive updates to a one-time adjustment of only a fraction of the MEI every five years is troubling. Even if this adjustment were to match 100% of the MEI, it fails to account for the reality that inflation and practice costs rise annually.** This gap means that ID reimbursement rates will effectively diminish over time, undermining the ability to provide high-quality care. The proposed structure not only jeopardizes the financial viability of ID practices but also threatens to compromise the resources necessary for patient care in an evolving health care landscape.

Bucket 2: Budget Neutrality

The Provider Reimbursement Stability Act Introduced by Rep. Greg Murphy, MD

The updated lookback provision must specifically address the reimbursement patterns unique to ID specialists. Many ID interventions currently lack adequate compensation under prevailing Medicare models, which can lead to financial instability and impede access to necessary services. **The reimbursement structure should recognize the substantial contributions of ID physicians to patient care, particularly in the domains of antimicrobial stewardship and infection control, which are essential in mitigating the impact of health care-associated infections (HAIs).**

Bucket 3: Alternative Payment Models (APMs)

APM Bonus

A one-year clean extension of the APM bonus should be extended in order to further incentivize participation in payment models and should include measures specifically relevant to infectious disease management, such as reductions in hospital-acquired infections and successful treatment outcomes for complex cases. The one-year extension under consideration is at the current 1.88% rate and not the full 5% incentive that was available during the first six years of the Medicare Access and CHIP Reauthorization Act (MACRA), which would be more beneficial to ID physicians. CDC reports that over 1.7 million hospital-associated infections occur annually in the U.S., underscoring the need for effective APMs that incentivize ID specialists' critical work in preventing and managing these infections.[5] Furthermore, the CY 2025 MPFS highlights the importance of value-based care initiatives, promoting alternative payment models that reward improved patient outcomes and cost efficiency. **As part of these initiatives, APMs should emphasize the integration of comprehensive care strategies, including interdisciplinary collaboration and patient engagement, which are essential for effectively managing infectious diseases**. It is crucial to ensure that the performance metrics within APMs align with national quality improvement goals, thereby fostering accountability and enhancing the overall quality of care delivered by ID specialists.

Reducing Fraud

Allowing accountable care organizations to flag adherent billing behavior without imposing risk is vital for ID practices, where billing complexities can arise from prolonged and intricate treatments. Given the intricate nature of infectious disease management, ID specialists frequently encounter challenges in accurately coding for services rendered, particularly in cases involving multiple consultations, prolonged hospital stays and extensive follow-up care for conditions such as sepsis and complicated infections. This flexibility in identifying adherence without penalty can encourage ID physicians to focus on delivering quality patient care rather than navigating the burdensome administrative challenges of billing compliance. **Furthermore, by advocating for an environment where ID specialists can report adherence without fear of financial repercussions, Congress can enhance the overall integrity of billing practices while ensuring that necessary care, such as comprehensive evaluations and extended therapies for resistant infections, is appropriately documented and reimbursed. Streamlined billing processes and clear guidelines can lead to better resource allocation and ultimately improve patient outcomes in infectious disease treatment.**

Reforming CMMI and PTAC

The overarching goal of enhancing the transparency and accountability of the Center for Medicare and Medicaid Innovation (CMMI) must include mechanisms that enable ID specialists to contribute meaningfully to the development of innovative care models. The recent legislative efforts, particularly the bill from Rep. Michael C. Burgess, MD, to amend the Social Security Act regarding the Physician-

[5] Centers for Disease Control and Prevention. Antibiotic Resistance Threats in the United States, 2019. U.S. Department of Health and Human Services, 2019, www.cdc.gov/drugresistance/biggest-threats.html.

Focused Payment Model Technical Advisory Committee (PTAC), aim to ensure that the committee operates with a more defined and independent mission.

Key provisions of this bill include a reset of committee members, which would require the Comptroller General to appoint new members within a specified timeframe, ensuring that the committee composition reflects diverse medical perspectives. **IDSA recommends that Congress consider the inclusion of cognitive specialists, such as ID physicians, as PTAC members.**

Additionally, the bill mandates the establishment of bylaws to govern the committee's work and outlines its duties, including providing technical assistance to stakeholders planning to submit physician-focused payment models. This technical support can be invaluable for ID specialists, allowing them to navigate the complexities of payment model submissions and ensuring that models are informed by the latest clinical insights. Furthermore, the PTAC would be required to submit annual reports to Congress detailing the proposals received, the actions taken and the status of implementation or testing, thereby increasing accountability and promoting transparency in the development of payment models that directly impact infectious disease management. These reforms are vital for ensuring that CMMI is accountable for testing the payment modes that PTAC has recommended and that the payment models tested under CMMI are not only innovative, but also clinically relevant and applicable to a broader range of specialty types, ultimately leading to improved patient outcomes in the field of infectious diseases.

Bucket 4: Merit-Based Incentive Payment System (MIPS)

Late Submission

While we appreciate and support extended deadlines, we would like to further discuss with members of Congress specific strategies for extending these accommodations. Allowing eligible clinicians to submit their data late with scaled penalties is imperative, particularly for ID specialists who often manage urgent and unpredictable cases. The flexibility in reporting timelines will ensure that quality metrics accurately capture the realities of infectious disease management, which necessitates immediate action and ongoing patient monitoring. **Given the often complex nature of treatment protocols in infectious diseases – such as coordinating multidisciplinary care for patients with multidrug-resistant infections – this provision will help ID physicians avoid penalties that may arise from unforeseen delays in data submission due to clinical demands.** Furthermore, extending the late submission grace period will encourage greater participation in quality reporting among ID specialists, ultimately leading to a more comprehensive understanding of the effectiveness of interventions and improving the quality of care provided to patients.

Clinical Data Registries and MIPS Value Pathways (MVPs)

Incorporating clinical data registries focused on infectious diseases as valid MIPS participation pathways will enhance the collection of critical data regarding treatment efficacy, patient outcomes and best practices. By allowing ID specialists to utilize registries that track metrics specific to infectious disease management – such as rates of antibiotic prescribing, adherence to treatment protocols and outcomes of various interventions – the program can better reflect the unique challenges faced by these

practitioners. Additionally, IDSA encourages Congress to advise CMS that by better incentivizing the use of registries in MIPS, the agency will promote collaboration among ID physicians, allowing them to share insights and benchmarks that can drive quality improvement across the field. **IDSA recommends this approach as it aligns with broader public health goals, since effective data collection and analysis can lead to enhanced strategies for combating antibiotic resistance and improving infection control practices.** Additionally, as health care continues to evolve toward value-based care, recognizing the contributions of clinical data registries will ensure that ID specialists are adequately supported in their efforts to deliver high-quality care.

Furthermore, allowing clinician participation in clinical data registries to count fully toward satisfying the requirements of the four categories of MIPS would drastically reduce reporting burden; minimize duplicative data submissions, as most ID physicians are already contributing in one way or another to national registries; and recognize more meaningful efforts to ensure high-quality care.

IDSA continues to have reservations about the way MVPs are being implemented, and we question whether the framework goes far enough in terms of fundamentally fixing aspects of the program that have long prevented meaningful participation by our specialty. For example, the MVP framework does little to resolve the ongoing lack of relevant measures available to largely hospital-based cognitive specialists, such as ID physicians. Aside from the HIV and hepatitis C virus quality measures, which are meaningful to only a small proportion of ID physicians in the outpatient setting who focus on these disease areas (as opposed to general ID), there are very few ID-specific measures on which ID physicians can report to avoid payment penalties. We remind Congress that ID physicians are not "proceduralists," but rather nonproceduralists/cognitive physicians who provide most of their services using evaluation and management (E/M) codes, many of which are billed in the inpatient setting. Our specialty's unique billing and practice patterns have made it challenging to develop additional quality measures that are feasible to report under a program like MIPS. Since 2013, IDSA has dedicated efforts to developing ID-relevant clinical quality measures, such as the 72-Hour Review of Antibiotic Therapy for Sepsis, Appropriate Use of Anti-Methicillin Resistant *Staphylococcus aureus* Antibiotics and Appropriate Treatment of Initial *Clostridium difficile* Infection, to help fill this gap, but these measures have consistently been rejected by CMS when submitted for the Annual Call for Measures.

Unfortunately, the MVP framework is limited to the current inventory of MIPS quality measures and does little to incentivize the development or use of more innovative and meaningful measures. IDSA encourages Congress to urge CMS to adopt policies to address these shortcomings and to work with professional societies to increase the number and use of relevant clinical quality measures. **IDSA would greatly appreciate an opportunity to partner with Congress and CMS to explore the development of new MIPS measures for infectious diseases conditions that are reportable by multiple specialties within the hospital setting.**

Paperwork Reduction

The elimination of unnecessary clinical practice improvement activities and the redistribution of the scoring weight among other MIPS categories will benefit ID specialists, who face substantial

administrative burdens. However, eliminating this category and nothing else would shift the weight to other MIPS categories that are more difficult to comply with and score well on. **Streamlining the reporting requirements is essential for allowing ID physicians to focus on delivering patient care rather than additional administrative burden associated with paperwork, which can detract from the time and resources available for managing complex infections and ensuring optimal patient outcomes.** Reducing administrative hurdles can also enhance participation in quality reporting initiatives, as physicians will be more likely to engage with systems that are straightforward and less time-consuming. **Additionally, by simplifying MIPS requirements, the program can foster an environment of continuous quality improvement, where ID specialists can dedicate more time to implementing evidence-based practices and engaging with patients, ultimately leading to better health outcomes.** Most MIPS participants find this category easier to score well on, and simplifying this program should not place more scoring weight on some of the more complicated MIPS categories.

Helping Small and Rural Practices

Reviving technical assistance for small practices, particularly those located in Health Professional Shortage Areas, is essential for ID specialists who frequently serve underserved populations. An investment of $20 million for fiscal years 2026-2030 will provide necessary support for these practices to implement effective infection management strategies and enhance access to specialized care. Additionally, targeted resources for training and education can empower small and rural practices to adopt best practices in infectious disease management, such as antibiotic stewardship programs, which are crucial for combating antibiotic resistance in communities. By fostering partnerships with local health departments and academic institutions, small practices can leverage resources and knowledge to improve patient care. This support is particularly vital for ID specialists, who often work on the front lines of public health and need the infrastructure to effectively respond to infectious disease outbreaks and manage chronic infections in rural settings.

Outside of MIPS, we have previously shared the value of audio-only technology in management of ID conditions, as it is often the only means by which some Medicare beneficiaries will be able to access ID care, even absent the pandemic. Broadband internet remains limited or nonexistent in many areas of the country, making access to audio-visual technology nearly impossible. Moreover, in our experience, some Medicare beneficiaries find audio-visual technologies difficult to use, while others feel uncomfortable using them altogether. This is particularly true for those with certain health conditions, including those managed by ID clinicians, who prefer the increased privacy afforded via audio-only care. **We encourage Congress to urge CMS to improve reimbursement for telephone E/M services so that reimbursement reflects the care provided, not the device used. We urge Congress to work with CMS to extend flexibility on originating site requirements and geographic restrictions, as well as allow the use of audio-only telehealth.**

Bucket 5: Quality Measures

Digital Quality Measures

Emphasizing digital quality measures under the quality performance category is crucial for enhancing the efficiency and accuracy of care delivery, particularly in the field of infectious diseases. The integration of digital measures can facilitate real-time data collection and analysis, enabling ID specialists to monitor patient outcomes and adherence to treatment protocols more effectively. **By allowing for voluntary demonstration projects that test new digital measures, Congress can advocate for fostering innovation and identify the most effective metrics that reflect the complexities of managing infectious diseases, such as rates of hospital-acquired infections and compliance with vaccination schedules.**

Digital measures can also help reduce administrative burdens by automating data collection processes, thereby freeing up valuable time for ID specialists to focus on patient care. The transition to digital quality measures aligns with the broader health care movement toward electronic health records (EHRs) and health information technology, which have been shown to improve care coordination and facilitate better communication among health care providers. Moreover, integrating digital measures into MIPS can promote consistency in performance evaluation, allowing for more accurate comparisons across practices and enhancing the overall quality of care.

Additionally, as infectious diseases often require rapid response and adjustments to treatment plans based on evolving clinical data, digital quality measures can provide timely feedback to clinicians. This feedback loop can enhance decision-making processes, ensuring that ID specialists are equipped with the latest information on best practices and emerging health threats. By leveraging technology in this way, ID physicians can also ensure that quality measures are aligned with the specific needs of patients facing infectious diseases, thus improving health outcomes and patient satisfaction.

The development and validation of these digital measures should involve input from a diverse range of stakeholders, including ID specialists, public health officials and patient advocacy groups. This collaborative approach will ensure that the measures are relevant, actionable and tailored to the unique challenges posed by infectious diseases. By focusing on digital quality measures, Congress can drive improvements in care delivery, enhance patient engagement and ultimately create a more responsive health care system that effectively addresses the complexities of infectious disease management.

While IDSA appreciates the benefits of moving toward digital measurement and appreciates all of the recent policies coming out of the Department of Health & Human Services to support interoperability and exchange of electronic health information, the infrastructure is not yet universally available, and ID physicians continue to face challenges related to EHR selection and use. **IDSA opposes any mandates regarding the use of digital quality measures until the landscape is more fully evolved and all clinicians have access to affordable, interoperable EHRs or other data systems.**

Conclusion

Thank you for your attention to physician payment issues and for considering our requests regarding the need to bolster access to ID treatment and prevention through Medicare physician payment reform. We look forward to working with Congress on these critical topics.

Should you have any questions or wish to discuss our requests further, please contact Amanda Jezek, IDSA's senior vice president for public policy and government relations, at ajezek@idosciety.org.

Sincerely,

Steven K. Schmitt, MD, FIDSA, FACP
IDSA President