IDSA
Infectious Diseases Society of America

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June 12, 2024

The Honorable Ron Wyden
Chair
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

RE: Bolstering Chronic Care Through Physician Payment: Current Challenges and Policy Options in Medicare Part B

Dear Chair Wyden and Ranking Member Crapo,

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, I thank the Committee for its focus on physician payment issues. IDSA is encouraged to see the Senate Finance Committee examining potential solutions to protect beneficiary access to care. IDSA thanks the Committee for the opportunity to comment on the recent white paper entitled "Bolstering Chronic Care Through Physician Payment: Current Challenges and Policy Options in Medicare Part B." **IDSA asks the Committee to recognize the link between chronic diseases and infectious diseases and the critical need to reform Medicare physician payment policies to support access to ID prevention, diagnosis and treatment that can especially impact patients with chronic diseases.**

Recommendations

<u>Targeted Payment Incentives for ID</u>: IDSA advises the Senate Finance Committee to consider the need for targeted reforms aimed at the most chronically undervalued specialties that are facing the biggest recruitment shortfalls and workforce shortages. Specifically, cognitive specialties have long been undervalued as compared to procedural specialties. Recent CMS efforts to boost payment for outpatient evaluation and management (E/M) services are a step in the right direction, but more must be done — especially for inpatient E/M services, which account for the vast majority of ID physician services. Developing

and implementing new payment models that allow for greater participation for specialties like ID that have thus far had little opportunity to participate is critical but will take time. **We urge Congress to also advance short-term incentives to help expand access to ID expertise while larger reforms are developed. To further this aim, IDSA proposes a temporary 10% incentive payment for ID physicians, outside of budget neutrality, similar to what has been done for general surgery and primary care, both of which now have higher annual compensation than ID.**

Resources for Measure Development: We also strongly urge Congress to fund measure development, targeting specialties with the greatest lack of meaningful measures, to ensure that all specialties can participate in quality programs.

New Codes for Complex ID Services: Finally, it is critical that codes accurately reflect the complexity of work being performed by ID physicians. Much of ID care is not adequately accounted for by current codes, and because most of our services are inpatient, the new G2211 code is of limited utility**. IDSA has proposed to CMS new codes to more accurately capture complex infection prevention, complex ID diagnosis and investigation, complex antimicrobial management and complex ID care. We ask that you urge CMS to please include these codes in the upcoming FY 2025 Medicare Physician Fee Schedule Proposed Rule.**

Value of Infectious Diseases Care

ID care is unique because it touches so many aspects of health care and core hospital functions. ID care is essential for patients 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 and cesarean sections. Additionally, sepsis is the second leading cause of maternal mortality in the United States, making ID specialists critical to help reduce maternal mortality. ID physicians lead health care facility efforts to prevent infections, including health care associated infections (HAIs); 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 physician care for hospitalized patients with serious infections can reduce mortality and readmission, shorten hospital and ICU length of stay and lower Medicare costs.[1]

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] 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. 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

[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.

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 most specialties filled 90% to 100% of their training programs. These shortages are driven in 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.

Conversion Factor Considerations

Adjusting physician reimbursement rates to better reflect inflation is helpful for all but does not address specific concerns for specialties that have been the most chronically undervalued, like ID and other cognitive specialties. ID physicians have not had sufficient opportunities to participate in alternative payment models thus far, despite being involved in all aspects of patient care. **IDSA recommends that Congress consider the development of policies that can account for cost savings from ID physician services, such as individual patient services and programmatic services such as infection prevention and control. These cost-saving measures can be utilized to help boost ID physician reimbursement. As a result of ID physician interventions, such as avoiding HAI penalties, health care systems save on patient care costs and apply that revenue toward ID physician reimbursement.**

Budget Neutrality

Currently, the Medicare Physician Fee Schedule statute requires CMS to make budget neutrality adjustments for policy updates projected to result in outlay changes over $20 million per year. IDSA and many other medical societies support Congress raising the threshold to allow for greater flexibility in determining pricing and policy changes for services without triggering across-the-board cuts. However, updating the budget neutrality threshold on its own will not increase access to ID expertise. Oftentimes, Medicare physician payment is overestimated by CMS, which results in physician payment cuts due to redistribution in the conversion factors. **To counter the potential of utilization assumptions, IDSA recommends the establishment of a period of time where CMS can reconcile overestimates of pricing adjustments for individual services.** This reconciliation period would allow for the Medicare conversion factor to be calculated with more accuracy based on utilization data and claims.

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[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.

Alternative Payment Models

ID physicians have not had sufficient opportunities to participate in alternative payment models. ID physicians provide expertise that makes Alternative Payment Models (APMs) and Advanced Alternative Payment Models (A-APMs) more successful and that helps save hospitals and health systems money – for example, by preventing infections and longer hospital stays and/or readmissions. Thus far, it has been challenging for CMS to find a way for ID physicians to share in the cost savings that their work generates, in part because of the great heterogeneity of health system structures and employment arrangements. **Congress should direct CMS to ensure that alternative payment model participants allocate a portion of the shared savings payment within the model to ID physicians to account for their leadership and management of infection prevention and control and antimicrobial stewardship activities. Additionally, Congress should direct CMS to adopt a mechanism to ensure that clinically relevant physicians have the option to be integrated into leadership and governance roles within an A-APM and to share in the savings generated by the model, which would ensure the provision of clinically appropriate care and ensure fair mechanisms for distributing payments to specialists.**

In order to incentivize increased participation in alternative payment models, **IDSA recommends lowering participation thresholds under the Quality Payment Program (QPP) that a physician must meet to become a Qualifying Participant in an A-APM so that physicians can qualify for the APM track of the QPP.** Currently, participation thresholds are too high for many clinicians to achieve.

Merit-Based Incentive Payment System

Congress needs to fund the development of measures and models that can accurately quantify ID work. **The current lack of quality measures that are relevant to ID care severely limits the ability of the Merit-Based Incentive Payment System to effectively measure performance on meaningful outcomes, accurately predict care quality and deliver value.**

Chronic Care in the Primary Care Setting

Chronic diseases and infectious diseases are inextricably linked. Some chronic diseases, including some cancers, are caused by infections (cervical cancer, long COVID, other post-infectious syndromes, etc.). Patients with chronic conditions like diabetes or heart disease are often at greater risk of contracting infectious diseases and suffering more serious illness from infections, as we saw with COVID-19. **These issues demonstrate that ID physicians play a key role in caring for patients with chronic diseases and thus should be included in payment models focused on chronic disease.**

Additionally, hybrid payment models within a primary care setting should be focused on person and family-centered care, high-value care, team-based and collaborative care, accessible care and integrated care. Currently, many hybrid models can contribute to ID physician burnout, ID physician shortages and disincentives to spending on ID care. To ease the financial burden for ACO-attributed beneficiaries who require high-quality infectious disease chronic care management, **IDSA recommends incorporating co-pay assistance for beneficiaries, timely access to patient data and claims data so that funding is easily granted for long-term care, telehealth services to reduce downstream healthcare utilization, and a focus on population health management.**

Relative Value Units

The resource-based relative value structure does not include a mechanism to value physician training and expertise, even though physician expertise significantly benefits patients and improves outcomes. This particularly limits reimbursement for cognitive specialties like ID, given their use of inpatient E/M codes. While we appreciate that CMS increased the value of outpatient E/M services in 2021, due to budget neutrality requirements, this resulted in an overall 4% decrease for ID. Worse yet, CMS failed to subsequently **increase the value of inpatient E/M codes proportionate to the newly improved outpatient E/M services to maintain the historic relativity between inpatient and outpatient E/M, further dampening payment to ID physicians.** CMS' rationale for this policy change was that physicians in the inpatient setting have greater access to other facility-based resources. This rationale is flawed for two reasons: First, physicians in the outpatient hospital setting have the same access to these resources, yet this was not factored in when improvements were made to the outpatient E/M services, and second, **inpatient care is inherently more complex than outpatient, particularly given that these patients often have multiple chronic, comorbid conditions and require a higher degree of medical decision-making. IDSA urges Congress to direct CMS to restore the historic relativity between inpatient and outpatient E/M services.**

In addition, we note that many ID services (such as infection prevention and control, antimicrobial stewardship, employee health and safety) are foundational for patients, hospitals and health systems, yet this work is not explicitly captured by available coding systems. As a result, these services are difficult to quantify and reimburse, leaving ID physicians without fair compensation for their efforts. We urge Congress to direct CMS to establish coding that would account for this work, consistent with our recommendations above (see New Codes for Complex ID Services).

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 reimbursement reforms. While Medicare primarily covers adults, pediatric ID physicians face similar reimbursement and recruitment challenges that we hope to discuss in the future. We look forward to working with the Committee 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 & government relations, at ajezek@idsociety.org.

Sincerely,

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