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July 15, 2024

The Honorable Sheldon Whitehouse
United States Senate
Hart Senate Office Building, Room 530
Washington, DC 20510

The Honorable Bill Cassidy, MD
United States Senate
Dirksen Senate Office Building, Room 455
Washington, DC 20510

RE: Whitehouse/Cassidy Medicare Primary Care Request for Information and Pay PCPs Act

Dear Senator Whitehouse and Senator Cassidy,

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 request for information (RFI) on Medicare primary care reform and the proposed Pay PCPs Act. While the RFI is focused on primary care, the improper definition and valuation of physician services, primarily evaluation and management (E/M) services, affect cognitive specialists beyond primary care who predominantly bill E/M codes. 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 legislation recognize the critical need to reform Medicare physician payment policies not only for primary care, but for cognitive specialists including ID physicians, and to support 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 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 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 can 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 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.

Hybrid Payments for Providers

The RFI describes hybrid payments as a way to give primary care providers "*steady, upfront and value-based payments for under-reimbursed activities, while maintaining some traditional FFS payments for certain services*," in order to facilitate innovation and "*more easily integrate diverse care activities to*

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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.

improve care quality and reduce costs." Recent literature, on which the legislative text appears to rely, refers to hybrid payments as a mix of fee-for-service (FFS) and population-based payments.[5] IDSA appreciates the goals of the draft legislation and believes ID physicians would benefit from a similar approach. Multiple activities performed by ID physicians are either under-reimbursed or not reimbursed *at all*. Similarly, there are few meaningful CMS quality measures that make a direct connection to ID physician services. These gaps must be addressed to provide a foundation for ID physicians to move toward value-based models.

For the aforementioned reasons, IDSA offers the following recommendations to establish a value-framework for ID care that will address similar challenges facing our specialty and enable the development of alternative and hybrid models of payment. Further below, we offer proposed legislative language that would incorporate our recommendations into the *Pay PCPs Act of 2024*.

Recommendation – Establishment of a new HCPCS Add-on Code and Relative Value for Infectious Diseases Services: ID physicians primarily bill inpatient E/M service codes. These codes are not robust enough to capture the complexity and value of ID physician work and expertise, and they leave many activities performed by ID physicians under- or un-compensated. In its CY2025 Medicare Physician Fee Schedule proposed rule, CMS includes a proposed new Hospital Inpatient or Observation Evaluation and Management (E/M) Add-on for Infectious Diseases (HCPCS code GIDXX) to describe the complexity inherent to hospital inpatient to hospital inpatient or observation care associated with a confirmed or suspected infectious disease performed by a physician with specialized training in infectious diseases.

The establishment of this new add-on code and relative value for ID care is essential. The availability of this billing code, along with appropriate valuation, will provide both a foundation for ID physicians to begin to receive more accurate reimbursement and important data that can be used to improve "benchmarks" in current population-based models to inform the development of new value-based care models for ID care.

The new add-on code, as proposed by CMS, appears to include three main elements: 1) disease transmission risk assessment and mitigation; 2) public health investigation, analysis and testing; and 3) Complex antimicrobial therapy counseling and treatment. IDSA agrees that these should be the major categories of activities, and we want to clarify with CMS that an ID physician may bill this add-on code when doing any one or any combination of these activities. It would be infeasible to require that an ID physician perform all three in a single instance.

We request that you include a provision in your bill to establish this add-on code to provide it with statutory foundation and to indicate congressional support to CMS. We are currently reviewing the proposed rule's specific language regarding the add-on code to determine if we want to recommend any modifications to help ensure that the new add-on code can achieve its goals. We would be happy to share our feedback with you, along with specific proposed legislative language on this issue.

[5] Berenson, R. A., Shartzer, A., & Pham, H. H. (2023). Beyond demonstrations: implementing a primary care hybrid payment model in Medicare. Health Affairs Scholar, 1(2). https://doi.org/10.1093/haschl/qxad024

Recommendation – Resources for ID Measure Development: Measures that meaningfully connect ID physician activities to care improvements and cost savings in current CMS quality programs are limited. Ensuring the contributions of ID physicians are accurately reflected in value-based models is critical. To address this challenge, IDSA recommends the development of additional quality and resource use measures, including measures that address outpatient antibiotic therapy, antimicrobial resistance and infection prevention and control, that are attributable to ID physicians in outpatient and inpatient settings. Such measures will both facilitate broader engagement of ID physicians in quality programs and value-based payment models and incentivize the types of health care services provided by ID physicians that improve patient care and reduce patient complications and health care costs.

Recommendation – ID Inclusion in Current or New Payment Models: ID physicians have not had sufficient opportunities to participate in alternative or other value-based payment models. ID physicians provide essential expertise that makes these payment models more successful, improves patient outcomes and saves hospitals and health systems money – for example, by preventing infections and readmissions and shortening hospital stays. 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 heterogeneity of health system structures and employment arrangements. To help address these challenges and to facilitate the participation of ID physicians in value-based care arrangements, IDSA encourages you to include the following provisions in your bill:

- Direct HHS to prioritize and share "shadow bundles" data specific to ID care and management with total cost of care models (e.g., accountable care organizations);
- Permit ID physicians to elect facility-based scoring when they provide more than 50% of covered professional services in a hospital setting;
- Direct HHS to adopt a mechanism to ensure that clinically relevant physicians, including ID physicians, are meaningfully integrated into leadership and governance roles within alternative payment models and provided opportunities to receive a portion of the savings generated by the model.

Recommendation – Targeted Payment Incentives for ID: IDSA urges you to consider the need for targeted reforms aimed at the most chronically undervalued specialties that are facing the biggest recruitment shortfalls and workforce shortages. ID physicians, in particular, have long been undervalued compared to other specialties – including primary care and internal medical specialties. Efforts by the Centers for Medicare and Medicaid Services (CMS) to boost payment for outpatient E/M services were a step in the right direction, but subsequent efforts to value inpatient E/M services still do not account for the complexity of care for patients who are hospitalized. Compared with other specialists who provide complex cognitive care, ID physicians are uniquely disadvantaged by the current valuation for inpatient E/M services because ID physicians spend proportionately more – indeed, a large majority of – effort providing care for patients who are hospitalized. **ID physicians need policymakers to provide interim relief while the aforementioned efforts – establishing new codes and valuation, developing new quality and resource use measures, and implementing new or revising existing value-based models – are underway. For this reason, we urge you to include in your bill a short-term incentive to help expand access to ID expertise while broader reforms are developed. Specifically, 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.**

Recommendation – Restore Codes for Non-Face-to-Face Care and Improve Valuation for Interprofessional Consultations: ID physicians provide complex cognitive care, which often means reviewing lengthy records before visits and acting upon results and adjusting treatment after visits. These non-face-to-face visits occur across ID care, including and especially when providing outpatient parenteral antimicrobial therapy and care for mpox patients.[6] CMS established codes for non-face-to-face care but declared them invalid (meaning they are no longer paid by CMS) in 2023. CMS has established codes for interprofessional consultations, which are physician-to-physician consultations that do not require a patient visit. Because ID physicians provide nonprocedural care, they are often asked to provide interprofessional consultations. IDSA believes that interprofessional consultations are an improvement over informal "curbside" requests for assistance and acknowledges that they increase efficiency of care. Nonetheless, IDSA is concerned that interprofessional consultation codes are undervalued for the amount of time, expertise and risk for the consulting physician.

Technical Advisory Committee

IDSA supports the proposed Pay PCPs Act's establishment of a new Technical Advisory Committee within CMS to determine relative value unit rates and correct existing distortions that lead to the under-reimbursement for high-value activities and services. IDSA also recommends that this new advisory committee should develop methods to address health disparities, quality of care and Medicare beneficiary access to services. Proper valuation of these services is of paramount importance to IDSA's members and to ensure that payment reflects the complex work that ID physicians perform.
IDSA recommends that your bill target the Technical Advisory Committee's focus on evaluating and improving E/M and other nonprocedural services exclusively, rather than attempting to evaluate all service codes. By limiting the committee's charge in this manner, CMS can address the portion of the Medicare physician fee schedule that is most urgently in need of reform. Additionally, IDSA recommends that the Technical Advisory Committee be composed of individuals with expertise in health care policy, including physicians, patients, health economists, coders, health informaticists and potentially other stakeholders with expertise in payment policy; with this expertise, the committee will be well-positioned to address the challenges faced across cognitive specialties.

The committee should be focused on implementing an evidence-based, data-driven approach to assess the E/M and nonprocedural service code definitions and ensure that their valuations are accurate, reliable and reflective of the value of the specialty expertise and longitudinal care delivered to Medicare beneficiaries. Following an analysis of data, research, methodologies and knowledge gaps, a Technical Advisory Committee would be well-suited to develop a set of recommended changes to address inadequacies in the E/M service code definitions and valuations.

IDSA currently participates in the American Medical Association's Current Procedural Terminology (CPT) Editorial Panel and Relative Value Scale Update Committee (RUC) processes and views a Technical Advisory Committee as complementary to, not a replacement for, their work. We recognize the commitment specialty societies, their CPT and RUC advisors, and panel members make to

[6] Clin Infect Dis. 2024 May 14: ciae262. doi: 10.1093/cid/ciae262. Online ahead of print. *Quantifying the Time to Administer Outpatient Parenteral Antimicrobial Therapy: A Missed Opportunity to Compensate for the Value of Infectious Diseases* Asher J Schranz, Michael Swartwood, Madison Ponder , Renae Boerneke, Teresa Oosterwyk, Angela Perhac, Claire E Farel, Alan C Kinlaw

participate in these processes. However, most of these panel members come from procedural specialties and lack expertise in complex E/M care delivery, which limits their ability to appropriately describe and value cognitive work. Specifically, the RUC may be best suited for valuing procedural services, and **IDSA suggests that an expert panel focus on valuing E/M and nonprocedural services, like the transitional care management and principal care management services.** Additionally, we urge Congress to recognize that primary care specialties are not alone in suffering from the consequences of the prolonged misvaluation of E/M care and to consider any provisions to authorize a Technical Advisory Committee separately from those that may address primary care payment models.

Pay PCPs Act – IDSA Revisions

The recommendations discussed above are intended to provide the foundation that will allow ID physicians to participate in value-based care as currently the lack of ID codes and ID quality measures does not allow for the design of a hybrid payment model for ID. Below is suggested legislative language that we encourage you to include in the proposed Pay PCP Act in order to provide the opportunity for ID physicians to participate in hybrid payment models under Medicare.

Section 1. Short Title. This Act may be cited as the ‘‘Pay PCPs and ID Act of 2024’’.

Section 2. Findings.

[Insert into the existing list]

(10) Infectious diseases (ID) physicians play a crucial role in preventing, diagnosing, and treating infectious diseases, including antimicrobial-resistant infections, emerging infectious diseases, HIV, viral hepatitis, and infections associated with opioid use. They also manage infectious complications from procedures such as cancer chemotherapy and organ transplantation. Patients treated by ID physicians experience better health outcomes, shorter hospital stays, and lower healthcare costs.

(11) There is a critical shortage of ID physicians in the United States. Nearly 80% of counties do not have a single ID physician, and according to the Association of American Medical Colleges (AAMC), there were just over 9,900 active ID physicians in the U.S. in 2021. In 2023, only 50.8% of ID physician training programs filled, compared to other specialties that filled all or nearly all their programs.

(12) High numbers of medical students and residents report interest in ID, but financial barriers prevent many from entering the field. ID physicians are among the lowest compensated in medicine, earning less than general internal medicine physicians despite additional years of training. The primary codes billed by ID physicians, evaluation and management (E/M) codes, are significantly undervalued, contributing to financial disincentives.

(13) The shortage of ID physicians and the low fill rates for training programs are exacerbated by low reimbursement rates. Improved reimbursement is crucial to boost recruitment and ensure that all patients have access to ID care. Addressing these financial barriers is essential for strengthening the ID workforce needed to meet current and future healthcare demands.

(14) Ensuring access to ID physicians is vital for pandemic preparedness and for managing infectious diseases that pose significant public health risks. ID physicians contribute to building resilience against outbreaks and pandemics, which is increasingly important given the aging population and the growing complexity of healthcare.

(15) Congress has previously recognized national physician workforce needs and promoted certain specialties through enhanced Medicare reimbursements. Given the severe ID workforce

shortages and recruitment barriers, similar legislative measures are warranted to support the ID workforce and ensure adequate access to care.

[Insert new section 4 and renumber accordingly]

Section 4: Establishing a Value-Framework for Infectious Diseases Care and Management in Medicare

(a) **Establishment**. The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may establish within the Medicare physician fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) a value-framework for infectious diseases services provided by infectious diseases physicians.

''(1) **Definitions**.—In this subsection:

''(A) **Infectious Diseases Physician**.—The term 'infectious diseases physician' and 'ID physician' means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 44 – Infectious Disease as their primary specialty code in the physician's enrollment under section 1866(j).

''(B) **Infectious Diseases Services**.—The term 'infectious diseases services' and 'ID services' means physicians' services furnished by an infectious diseases physician and submitted for payment under the fee schedule under section 1848.

(b) **Establishment of HCPCS Codes and Relative Values for Infectious Diseases Services**.

(1) **Establishment of HCPCS Code**. Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(t) **HCPCS Codes for Infectious Diseases Management Services**.—

''(1) Not later than January 1, 2025, the Secretary shall establish a new HCPCS code for the following infectious disease management services: (Note: IDSA to follow up with specific language suggestion upon review of the proposed new infectious diseases add-on code in the CY2025 MPFS proposed rule.)

(B) **Temporary Incentive Payment**.

(i) **Incentive Payments**. Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(cc) **Temporary Incentive Payments for Infectious Diseases Services**.

''(1) **In General**. In the case of infectious diseases services furnished on or after January 1, 2025, and before January 1, 2030, by an infectious diseases physician, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

''(2) **Coordination with Other Payments**. The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection respectively.

''(3) **Application**. The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).''

(ii) **Conforming Amendment**. Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by subsection (a)(2), is

amended by striking ‘‘Subsections (x) and (y)’’ and inserting ‘‘Subsections (x),(y), and (cc)’’.

(3) **Budget Neutrality Adjustment**. In implementing the provisions of subsections (2), the Secretary shall ensure that the aggregate expenditures under the Medicare program do not exceed the amount that would have been expended if these subsections had not been enacted. The Secretary shall make appropriate adjustments to the conversion factor, relative value units, or other elements of the fee schedule to ensure that changes made under these subsections do not result in increased expenditures.

(c) **Prioritization of Value-Metrics for Infectious Diseases Care and Management.** [insert at the appropriate place in sec. 1848(q), (r) or (s)?) in title XVIII, SSA]

(1) **Development of Quality Measures.** The Secretary shall prioritize the development of quality measures for infectious diseases care and management, including measures that address outpatient antibiotic therapy, antimicrobial resistance, and infection prevention and control, that are attributable to ID physicians in outpatient and inpatient settings.

(2) **Development of Resource Use Measures**. The Secretary shall prioritize the development of resource use and episode-based cost measures for infectious diseases care and management, including measures that address outpatient antibiotic therapy, antimicrobial resistance, and infection prevention and control, that are attributable to ID physicians in outpatient and inpatient settings.

(3) **Collaboration with Total Cost of Care Models**. The Secretary shall prioritize and share ‘shadow bundles’ data specific to infectious diseases care and management with total cost of care models, including Alternative Payment Models (APMs) and Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).

(4) **Facility-based Scoring for ID Physicians**. The Secretary shall permit ID physicians to elect facility-based scoring when they provide more than 50 percent of covered professional services in a hospital setting.

(d) **Integration of ID Physicians into Alternative Payment Models and Shared Savings Programs**. The Secretary shall identify and implement a mechanism to ensure clinically relevant physicians, such as ID physicians, are meaningfully integrated into leadership and governance roles within APMs and MSSP ACOs, and provided opportunities to receive a portion of savings generated under the model for the provision of clinically appropriate care.

(e) **Outreach and Education**.

(1) The Secretary shall conduct outreach activities to inform healthcare providers, including infectious diseases physicians, and other relevant stakeholders, about the new HCPCS codes and the incentive payment program established under this section.

(2) The Secretary shall provide education and technical assistance to healthcare providers to ensure proper utilization of the new codes and to maximize participation in the incentive payment program.

(f) **Open Door Forum**.

(1) Not later than 6 months after the date of the enactment of this Act, the Secretary shall convene an open door forum to provide an opportunity for stakeholders, including healthcare providers, infectious diseases specialists, and professional societies, to provide input on the implementation of the HCPCS codes and incentive payment program.

(2) The Secretary shall use the input gathered from the open door forum to inform the final implementation and any necessary adjustments to the program.

(g) **Reporting and Evaluation**. The Secretary shall report to the Senate Finance Committee, House Ways and Means Committee, and House Energy and Commerce Committee within three years of implementation, detailing the impact of the new HCPCS codes and incentive payment policy on patient outcomes, access to care, and overall healthcare costs. The report shall include recommendations for any necessary adjustments to improve the policy's effectiveness.

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 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 & government relations, at ajezek@idosciety.org.

Sincerely,

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