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U.S. House of Representatives

October 31, 2022

Dear Representatives:

On behalf of the Infectious Diseases Society of America (IDSAs), we thank you for your leadership in identifying challenges with Medicare health care provider reimbursement and seeking input from the health care community to develop sustainable solutions to incentivize high-quality care. Despite good intentions, MACRA has failed to deliver reimbursement that adequately reflects the value and complexity of care provided by infectious diseases (ID) clinicians. Persistent undervaluing of ID physician services has decimated our ability to recruit new physicians to our specialty and left the majority of Americans with limited or no access to ID care:

- In 2021, only 70% of ID physician training programs were able to fill their slots, while most other internal medicine subspecialties were able to fill all or nearly all of their training programs.¹
- Nearly 80% of U.S. counties do not have a single ID physician.²

Infectious diseases physicians are essential for modern medicine and emergency preparedness. Medicare physician payment reform is essential to ensure the availability of a future ID workforce that will be necessary to enable modern medicine, protect patient safety and build community resiliency:

- Patients with serious infections have better outcomes and lower Medicare costs when seen early by an ID physician.^{3,4}
- Cancer chemotherapy, organ transplantation and complex surgeries all require ID interventions.
- As medical advances expand the population of immunocompromised patients, the need for ID care will continue to grow.

¹<https://www.nrmp.org/wp-content/uploads/2022/03/2022-SMS-Results-Data-FINAL.pdf>

²<https://www.acpiournals.org/doi/10.7326/m20-2684>

³ https://academic.oup.com/jid/article/216/suppl_5/S588/4160394

⁴ <https://academic.oup.com/cid/article/58/1/22/372657>

For MACRA to fulfill its purpose of increasing value in the U.S. health care system, reforms are needed to ensure that physician reimbursement adequately reflects the value and complexity of care provided, that resources are available to clinicians to support the intense work associated with outbreak response, that all specialties are able to participate meaningfully in the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs), and that quality measures are available that are appropriate to all specialties. IDSA agrees with several MACRA implementation challenges expressed across medicine, including a lack of inflation adjustments and budget neutrality challenges. Our comments below are focused on the unique issues facing the infectious diseases specialty.

Summary of Recommendations

- Adequately value care provided by infectious diseases physicians by increasing the valuation of inpatient evaluation and management (E/M) codes commensurate with the increases provided for outpatient E/M codes in 2021.
- Ensure resources are available to enable surge capacity during public health emergencies (PHEs) by establishing an outbreak activation payment modifier that can be appended to existing codes to reimburse front-line clinicians for the significant extra work performed during a response to a PHE related to an infectious disease.
- Incentivize the development and adoption of relevant quality measures for infectious diseases physicians.
- Expand quality reporting programs to allow facility-based clinicians opportunities to get credit for outcomes they contribute to significantly within their institutions.

Reimbursement for Evaluation and Management Services

Background 2018-2022

Despite the intentions of MACRA, the Medicare payment system continues to inappropriately undervalue cognitive (non-procedure based) care, which includes care provided by ID physicians, particularly in the inpatient setting. Current and proposed values for inpatient E/M codes fail to accurately reflect the value and complexity of care provided, and this drives enormous payment disparities across medical specialties. According to data reported by Medscape in 2022, ID is the fifth lowest paid medical specialty, even below general internal medicine, despite an additional two to three years of training. High levels of medical school debt understandably drive many physicians to more lucrative specialties.

CMS began an effort in 2018 to ensure accuracy in the valuation of E/M services. As a result, Relative Value Units (RVUs) for office and outpatient E/M services were increased in CY 2021. Similarly, RVUs for certain inpatient, observation and other E/M services are proposed to be updated in the Medicare Physician Fee Schedule proposed rule for CY 2023.

ID physicians — unlike primary care physicians and other cognitive specialists whose work is dominated by the delivery of outpatient E/M services (e.g., rheumatology, endocrinology) — primarily deliver care in the inpatient setting. Therefore, when CMS improved the office and outpatient E/M services in CY 2021 (resulting in payment increases of 12%-15% for specialties that heavily use these codes), and subsequently applied a statutory budget neutrality adjustment, the ID specialty absorbed a 4% cut on top of already low compensation relative to other physician specialties. Because ID physicians viewed the overarching effort as incredibly important to cognitive care and delivery, and a precursor for improvements in the E/M services ID physicians deliver in the inpatient setting, we lauded CMS' proposals and urged CMS to finalize the increases. The expectation was that the inpatient E/M services would improve commensurate to the outpatient E/M services, allowing ID physicians to finally realize — similar to their cognitive specialty colleagues in CY 2021 — a meaningful increase in value for the services they deliver most.

Medicare Physician Fee Schedule Proposed Rule CY 2023

Unfortunately, CMS' proposed revisions to the values for inpatient and observation E/M visits in the CY 2023 MPFS Proposed Rule are woefully inadequate relative to the increases provided for office and outpatient E/M services and contravene IDSA's request that CMS apply an equitable approach that maintains the longstanding relativity across the inpatient and office and outpatient E/M codes (see attached table).

As part of its proposed justification for the stagnant increases to the inpatient E/M services, the proposed rule contained some faulty assumptions about the nature of outpatient and inpatient E/M care, seemingly rejecting the reality that inpatient care is inherently more complex than outpatient care:

- 1) **Assumption:** Physicians providing E/M services in the outpatient setting face greater uncertainty in estimates of illness and treatment courses. **Reality:** The level of uncertainty in the inpatient setting is often greater, given the predominance of more seriously ill, extraordinarily complex patients with multiple comorbidities that can frequently lead to multiple complications that change the trajectory of a patient's care.
- 2) **Assumption:** Hospital support staff translates to lower physician effort in inpatient settings. **Reality:** Hospitals are facing serious staffing shortages. Further, additional hospital staff cannot replace or duplicate the unique expertise and higher-level medical decision-making provided by physicians and necessary for the inherently more complex, more severely ill patients in inpatient settings.
- 3) **Assumption:** Outpatient physicians spend more time coordinating care with other providers. **Reality:** The far more complex nature of inpatient care — including the higher number of comorbidities — typically results in far greater necessary coordination in the inpatient setting. Because infectious diseases impact so many other areas of inpatient care, ID physicians are routinely coordinating with surgery teams, transplant teams, oncology, critical care and others to review and evaluate patient histories, develop infection prevention plans, coordinate treatment, educate patients and family members and facilitate transitions of care.

In addition, not all institutions have the full and extensive on-site diagnostic testing services necessary to meet the full needs of their patients. Depending on specific patient needs, ID physicians must coordinate with their hospital laboratories, commercial reference laboratories or public health laboratories (sometimes all of the above for a single patient, as multiple tests are often necessary to rule out certain infections and make conclusive diagnoses). During an outbreak, an ID physician may be required to spend multiple hours per patient collaborating with the state health department and public health laboratory in order to access diagnostic testing and treatment for a single patient — as is the case with the current monkeypox PHE and for which there is no compensation. The severity of illness in the inpatient setting can require more extensive diagnostic testing, monitoring of treatment and coordination between medical teams, including physician coordination between medical and interdisciplinary teams.

The MPFS Proposed Rule for CY 2023 demonstrates that CMS failed to adequately consider or value the higher degree of medical complexity and severity that is routinely encountered in an inpatient setting compared to an outpatient setting. In fact, the severity of a patient's illness or condition and the complexity of care they require are among the most typical triggers of a hospital admission. In other words, inpatient care is inherently more complex than outpatient care.

Inpatient care is characterized by a high number of very complex patients. For example, from 2007 to 2013, total hospital discharges in Florida increased by approximately 115,000, according to Florida Hospital Association data. Moderate-complexity and basic-complexity discharges accounted for 22% and 5% of this growth, respectively. High-complexity discharges, on the other hand, accounted for about 73% of overall discharge

growth. If we look at this on a patient-day (instead of a patient-discharge) basis, high-complexity admissions represented more than 95% of all incremental patient days over that six-year time frame.⁵

When specialists were ranked according to patient complexity across all nine markers for complexity (rate of a mental health condition, number of physician types, number of physicians, mean days in hospital, mean emergency department visits, mean number of comorbidities, highest mean number of prescribed medications, highest rate of death and highest rate of placement in a long-term care facility), the order, from most to least complex, was nephrologist, infectious diseases specialist, neurologist, respirologist, hematologist, rheumatologist, gastroenterologist, cardiologist, general internist, endocrinologist, allergist/immunologist, dermatologist and family physician.⁶

To stabilize, and potentially increase, the ID workforce, **IDSAs have requested that CMS restore relativity across its outpatient and inpatient E/M codes sets by finalizing the IDSA-requested RVUs as outlined in Table 1 attached to provide increases to the values of inpatient E/M codes commensurate with the increases provided to outpatient E/M code values in 2021. We ask that you communicate congressional support for this request to CMS.** Going forward, we encourage Congress to work with medical specialty societies to develop approaches that will accurately value the complexity and value of care provided to ensure that our health care system has the diverse array of specialists needed to provide high-quality care to an increasingly complex Medicare population.

Clinician Resources to Support Outbreak Response

The COVID-19 pandemic and subsequent monkeypox outbreak highlighted another shortcoming of our existing Medicare reimbursement system. There is currently no mechanism to reimburse clinicians for much of the heightened services associated with treating patients in an outbreak who are not captured in the fee schedule. In 2020, IDSA and its partnering organizations highlighted this concern to CMS and urged CMS to consider establishing a modifier so ID physicians and other eligible clinicians could identify, and be compensated for, heightened work during an outbreak. We referred to this proposed policy as “outbreak activation” coding and payment.

Two years later, CMS has yet to take action on this proposal, although it has acknowledged the impact of infectious diseases on codes and rate setting. Failure to direct resources to individual clinicians, particularly those on the front lines of infectious diseases outbreaks such as COVID-19 and monkeypox, is a dangerous precedent. Inpatient hospitals receive a 20% payment enhancement for COVID-19 related care, but under this approach, resources fail to reach the clinicians providing the care.


MIPS Medicare Value Pathways (MVPs)

IDSAs continue to support the overarching goals of the MVP framework, namely to streamline MIPS reporting, reduce clinician burden and provide a glidepath to APM participation. However, we continue to have reservations about the manner in which MVPs are being implemented and 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.

As IDSA has repeatedly expressed to CMS, 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 human immunodeficiency virus (HIV) and hepatitis C virus (HCV) 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. Since 2013, IDSA has dedicated efforts to develop ID-relevant clinical quality measures such as the 72-

⁵ <https://www.ecgmc.com/thought-leadership/articles/its-complicated-why-patient-complexity-is-reshaping-care-delivery-and-what-it-means-for-hospitals>

⁶ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2716991>


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 relies on 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 direct CMS to address this shortcoming by working with professional societies to increase the number of relevant clinical quality measures and expand MIPS to allow facility-based clinicians opportunities to get credit for outcomes they contribute to significantly within their institutions, which might be measured under a separate CMS facility-level quality program. This would not only provide ID physicians with a more meaningful participation pathway but would also promote team-based approaches to care and minimize duplicative reporting.

We deeply appreciate your review of MACRA and your commitment to improving the physician workforce and access to high-quality care. We greatly appreciate this opportunity to provide comments, and we hope to work closely with you to reform the Medicare physician payment system. If you have any questions, or if we can assist you in your efforts, please contact Amanda Jezek, IDSA senior vice president for public policy and government relations, at ajezek@idsociety.org.

Sincerely,



Carlos del Rio, MD FIDSA
President, Infectious Diseases Society of America

Attachments

- Essential Role of ID Physicians
- Table: CY 2023 Proposed Inpatient and Outpatient Work RVUs
- Clinical Vignettes Demonstrating Inpatient E/M Patient Complexity

Attachment 1: Essential Role of ID Physicians

IDSA represents more than 12,000 infectious diseases (ID) physicians, scientists and other health care professionals devoted to patient care, prevention, public health, education and research in infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, viral hepatitis, health care-associated infections, antibiotic-resistant infections, infections associated with the opioid epidemic and emerging and re-emerging infectious diseases.

Our members continue to work vigorously to manage, treat and oversee the response to the COVID-19 public health emergency (PHE), while also leading response efforts for the monkeypox PHE and preparing for potential U.S. cases of Ebola from the current outbreak in Uganda. They are on the front lines of these crises: caring for patients; designing and updating infection prevention and control programs; developing new and innovative diagnostic testing and patient management protocols; collaborating with state and local health departments on communications and mitigation efforts such as vaccination campaigns; leading health care facility responses; and conducting research to develop new tools for the prevention, diagnosis and treatment of COVID-19, monkeypox, Ebola and other emerging and re-emerging infectious diseases. This work enhances patient safety and provides essential expertise and partnership to public health, primary care and other medical specialties, allowing a wide array of medical services to be provided safely. In addition to these emergency responses, ID physicians exercise constant vigilance to recognize clinical presentations of emerging infectious diseases and manage increasingly complex patient populations, as medical advances like transplantation and cancer care carry significant risks of complicated infections and increase the percentage of the population that is immunocompromised.

Attachment 2: CY 2023 Proposed Inpatient and Outpatient Work RVUs

Table 1. CY 2023 Proposed Inpatient & Observation Work RVUs			
CPT Code	2023 wRVU Proposed Rule	Change from 2022	IDSA Request
<i>Initial Visits</i>			
CPT 99221	1.63	-15.1% (1.92)	1.92
CPT 99222	2.60	0% (2.61)	2.79
CPT 99223	3.50	-9.3% (3.86)	4.25
<i>Same Day Discharge</i>			
CPT 99234	2.00	-21.9% (2.56)	2.00
CPT 99235	3.24	0% (3.24)	3.24
CPT 99236	4.30	+2.4% (4.20)	4.30

Attachment 3: Clinical Vignettes Demonstrating Inpatient E/M Patient Complexity

To demonstrate the complex realities of inpatient E/M care provided by ID physicians, we provide the following clinical vignettes that are representative of the types of patient cases typically handled by ID physicians:

- A patient with recent bilateral total knee arthroplasties, cardiovascular disease and diabetes presents with fever and pain in his lower back, right knee and right hip. An ID consultation is requested to review the case, conduct a thorough history and physical examination and interpret the significance of positive blood cultures. The ID physician consultant must choose appropriate diagnostic testing and surgical intervention, assess antimicrobial susceptibility, make a therapeutic decision and facilitate transition from inpatient to outpatient parenteral antibiotic therapy (OPAT). Coordination is required with orthopedic surgery, hospital medicine, pharmacy, physical therapy and case management. Extensive patient and family education are required during hospitalization and post discharge to appropriately monitor antimicrobial therapy, prevent spread or worsening of infection, promote wound care and identify potential emerging complications of both the infection and the treatment (intravenous line complications and antimicrobial adverse effects). The ID physician is often the first and only physician to interact with and care for the patient post discharge.
- A recent lung transplant recipient with a history of serious infections presents with tachycardia and hypotension. Urinalysis shows pyuria; CT imaging shows bilateral pulmonary nodules and hepatic nodules. An ID consultation is requested. The ID physician consultant orders further diagnostic evaluation to determine antibiotic choice and duration of therapy. Extensive testing required includes blood and respiratory cultures, blood chemistries, serologies, acute phase reactants and potentially a biopsy — all of which will require the expertise of an ID physician to interpret and manage. Given the need for immunosuppression to prevent organ rejection, extremely close monitoring is required to rapidly identify potential additional infections. The patient's history of serious infections may limit antimicrobial therapy options, heightening the need for complex clinical decision-making, including combination therapy approaches. Coordination is required with the pulmonary transplantation team. Extensive patient and family education are required during hospitalization and post discharge.
- A patient with prostate cancer, diabetes and chronic obstructive pulmonary disease (COPD) is admitted for a severe urinary tract infection. He is treated with antibiotics and initially improves but develops fever and abdominal pain. An ID consultation is requested. The patient requires interpretation of microbiologic studies of stool, urine and blood, as well as imaging findings. Pre-existing comorbidities need to be factored into interpretation and clinical decision-making, potentially increasing risks and limiting treatment options. Coordination is required with urology, general surgery, pathology, radiology, pharmacy and case management. Extensive patient and family education are required during hospitalization and post discharge.