IDSA Headquarters
1300 Wilson Boulevard
Suite 300
Arlington, VA 22209
TEL: (703) 299-0200
FAX: (703) 299-0204
EMAIL ADDRESS:
info@idsociety.org
WEBSITE:
www.idsociety.org

IDSA
Infectious Diseases Society of America

April 15, 2016

The Honorable Joe Pitts
Chairman
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
420 Cannon House Office Building
Washington, DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
2470 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Green:

On behalf of the Infectious Diseases Society of America (IDSA), I write to thank you for scheduling the hearing, "Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms," for April 19. IDSA greatly appreciates the Subcommittee's leadership in repealing the Medicare Sustainable Growth Rate (SGR) formula and in overseeing efforts to implement MACRA. IDSA continues to provide input to the Centers for Medicare and Medicaid Services (CMS) on key implementation issues and to work with our members to prepare for payment reforms.

We are pleased to share with the Subcommittee some of our concerns regarding the impact of MACRA implementation and physician reimbursement on the future of the Infectious Diseases (ID) specialty, our ongoing efforts in this area, and our policy recommendations. Specifically, we request the following:

- **Direct CMS to adopt a broad interpretation of the Clinical Practice Improvement Activities (CPIA) within the Merit-Based Incentives Payment System (MIPS);**
- **Direct CMS to allocate MACRA funding for infectious diseases quality measure development; and**
- **Direct CMS to conduct the research needed to appropriately revalue current evaluation and management (E&M) billing codes.**

We hope this information will be of use to the Subcommittee as you continue your oversight activities, and we look forward to continuing to engage with you on these important issues.

The Value of ID Physicians

ID physicians make significant contributions to patient care, biomedical research, and public health. Their leadership saves lives, prevents costly and debilitating diseases, and drives biomedical innovation. ID physician involvement in patient care is associated with significantly lower rates of mortality and 30-day readmission rates in hospitalized patients, shorter lengths of hospital stay, fewer intensive care unit (ICU) days, and lower Medicare charges and payments. Unfortunately, a

decline in the number of physicians pursuing ID as a career is jeopardizing the future of this specialty and putting patients at risk of losing access to these cost-saving ID physician services, including:

- Providing life-saving care to patients with serious infections (such as HIV, sepsis, infections caused by antibiotic resistant bacteria, *Clostridium difficile*, and hepatitis C);
- Leading public health activities to prevent, control, and respond to outbreaks in healthcare settings and the community and emerging infections such as Ebola and Zika virus infections;
- Leading antibiotic stewardship programs to optimize the use of antibiotics to achieve the best clinical outcomes while minimizing adverse events, limiting the development of antibiotic resistance and reducing costs associated with suboptimal antibiotic use;
- Monitoring and managing highly complex patients with or at risk of serious infections (including organ and bone marrow transplant patients, chemotherapy patients, and others); and
- Conducting research leading to breakthroughs in the origin and transmission of emerging and re-emerging diseases, factors that make these virulent, and the development of urgently needed new antimicrobial drugs and other therapies, diagnostics, and vaccines.

Steep Decline in Physicians Entering ID

Data from the National Residency Match Program (NRMP) indicate a disturbing decline in the number of individuals applying for ID fellowship training, with 342 applicants in the 2010 – 2011 academic year and only 254 in 2014 – 2015. For 2016 – 2017, **only 65% (or 218 out of 335) of available ID fellowship positions filled**. In many specialty areas, all, or nearly all, available fellowship positions are typically filled. These data indicate a broader problem—the undervaluation of ID.

ID Reimbursement Concerns

In 2014, IDSA surveyed nearly 600 Internal Medicine residents about their career choices. While results have not yet been published, we can share that very few residents self-identified as planning to go into ID. A far higher number reported that they were interested in ID but chose another field instead. Among that group, **salary was the most often cited reason for not choosing ID.**

Average salaries for ID physicians are significantly lower than those for most other specialties and only slightly higher than the average salary of general Internal Medicine physicians, even though ID training and certification requires an additional 2 – 3 years. Young physicians' significant debt burden ($200,000 average for the class of 2014) is understandably driving many individuals toward more lucrative specialties, often with faster paths to practice.

Despite the significant and vital contributions ID physicians make to patient care, research, and public health, their work continues to be undervalued. Over 90% of the care provided by ID physicians is accounted for by evaluation and management (E&M) services. These face-to-face, cognitive encounters are undervalued by the current payment systems compared to procedural practices (e.g., surgery, cardiology, and gastroenterology). This accounts for the significant compensation disparity between ID physicians and specialists who provide more procedure-

based care, as well as primary care physicians who provide similar E&M services but who have received payment increases simply because of their specialty enrollment designations as "primary care physicians." Cognitive E&M services comprise a higher percentage of services provided by ID specialists than those provided by primary practice specialists such as Internal Medicine, Family Medicine or Pediatrics, based on CMS data.

MACRA Implementation: Opportunities and Challenges

IDSA is excited for the opportunities that MACRA implementation presents to realign physician payment to truly incentivize high quality care. In order for the promise of MACRA to be realized, **we urge the Subcommittee to direct CMS to recognize a wide variety of activities and payment models that are relevant to physicians in different specialties and a wide variety of practice settings and avoid a one-size-fits-all approach that limits meaningful participation by many specialists in federal quality reporting and improvement programs** (as is currently the case for ID physicians with the Physician Quality Reporting System (PQRS)).

Clinical Practice Improvement Activities (CPIA) under the Merit-based Incentive Payment System (MIPS)

This component of MIPS offers a great opportunity for physicians to be recognized for innovative quality improvement activities that significantly impact patient outcomes but may not necessarily easily fall into a "quality metric box." **Given the diverse array of activities that we believe should qualify as CPIAs, we urge the Subcommittee to support a broad interpretation of CPIAs. In order to appropriately capture the many activities needed in order to meaningfully improve patient care, CPIAs should be based upon completion or ongoing participation in activities measured by a specified number of activities rather than hours.** Below are a few potential CPIA examples that could be utilized by ID physicians and would greatly benefit our patients and public health:

- Implementation and/or on-going leadership of an antimicrobial stewardship program
- Implementation and/or on-going leadership of an infection prevention program
- Development of disaster preparedness-related protocols (i.e. facility/system-level Ebola response programs)
- Leadership of health care worker and/or population-based immunization programs
- Implementation and/or on-going leadership of a hospital-avoidance and timely discharge program enabled through outpatient parenteral antimicrobial therapy (OPAT)
- Development of treatment protocols for solid organ transplant cases
- Liaison activity related to hospital/health system engagement with local public health entities

The goal of the CPIA component of the MIPS is to reward eligible professionals who keep up-to-date on best practices and are actively engaged in clinical improvement. As CPIAs can differ across specialties, we urge the Subcommittee to encourage CMS to defer to specialties' interpretations of the CPIA component.

Support for Quality Measure Development Relevant to ID

The current paucity of quality measures relevant to ID have made it extremely difficult and often impossible for ID physicians to participate in current federal quality programs. Existing

HIV/AIDS and Hepatitis C measures are useful, but to only a select portion of ID physicians who focus on treating these patients. For ID physicians who are mainly inpatient-based, the paucity of measures is magnified. We remain concerned that the current lack of ID-relevant measures will result in the public's inability to make clear and meaningful comparisons across our specialty and potentially result in inaccurate conclusions about the quality of ID specialists in general. It also has resulted in little actionable data on which our own members can target quality improvement efforts.

IDSA continues to dedicate efforts to developing clinical quality measures relevant to the treatment of infectious diseases. Our efforts include:

- Development of measure concepts for *Staphylococcus aureus* and submission of these measure concepts to CMS in response to the ongoing CMS Call for Measures.
- Development of measures for Appropriate Treatment of MSSA Bacteremia, which were included in the list of new individual quality measures for CY 2016 PQRS.
- Submission of measure concepts to the National Quality Forum's (NQF) Measure Inventory Pipeline in hopes that we may engage other stakeholders in an effort to further develop these and other measures.
- Involvement in a multi-pronged strategy to promote better antibiotic stewardship.

We continue to be proactive in attempting to address the measures gap for ID physicians. However, considerable financial investment is required to see measure development through the full process. In fact, the cost of developing a measure or set of measures can range from $250,000 to $500,000 or even higher depending on the complexity of the measure, the intended use of the measure (internal quality improvement, pay for performance, public reporting, etc.), and the rigor and extent of testing and consensus-based endorsement. We are currently trying to engage other entities that may be willing to assist in further developing ID measures. **However, we urge the Subcommittee to direct CMS to expeditiously allocate funding authorized under MACRA to address current measurement gaps such as for ID.** IDSA has already made this request to CMS, and specifically encouraged CMS to prioritize funding allocation to the development of quality measures for antibiotic stewardship. Given this Subcommittee's longstanding commitment to combating antibiotic resistance, we hope you will help advance this important effort.

Promoting Appropriate Valuation of Evaluation and Management Codes

While not explicitly addressed in MACRA, current E&M codes fail to reflect the increasing complexity of E&M work, which covers the vast majority of ID as discussed above. Without updated, accurate E&M codes, the payment reform activities included in MACRA will have only a limited impact on improving ID patient care and will fail to address the underlying problem of undervaluing ID that is driving fewer young physicians to enter the specialty. ID physicians often care for more chronic illnesses, including HIV, hepatitis C, and recurrent infections. Such care involves preventing complications and exploring complicated diagnostic and therapeutic pathways. ID physicians also conduct significant post-visit work, such as care coordination, patient counseling and other necessary follow up.

IDSA urges the Subcommittee to direct CMS to undertake the research needed to better identify and quantify the inputs that accurately capture the elements of complex medical decision-making. Such studies should take into account the evolving health care delivery models with growing reliance on team-based care, and should consider patient risk-adjustment as a component to determining complexity. Research activities should include the direct involvement of physicians who primarily provide cognitive care. Specifically, this research should:

1) Describe in detail the full range of intensity for E/M services, placing a premium on the assessment of data and resulting medical decision making;
2) Define discrete levels of service intensity based on observational and electronically stored data combined with expert opinion;
3) Develop documentation expectations for each service level;
4) Provide efficient and meaningful guidance for documentation and auditing; and
5) Ensure accurate relative valuation as part of the Physician Fee Schedule.

IDSA remains committed to ensuring a robust ID physician workforce for current and future generations to provide high quality patient care, protect public health and drive biomedical innovation. In addition to developing federal policy recommendations, we are also engaging in numerous other activities, including:

- Sponsoring a study that will evaluate current and existing ID Workforce needs;
- Increasing mentorship and scholarship opportunities at our annual scientific meeting (IDWeek) and throughout the year (including establishing additional ID interest groups at medical schools and strengthening ID curriculum);
- Launching a campaign to educate key audiences, including medical students and residents, on the value of ID physicians; and
- Continuing research to document the value that ID specialists bring to the healthcare system, public health and biomedical research, as well as efforts to share those findings.

Once again, we thank the Subcommittee for its attention to physician payment and health care quality, and we look forward to continuing to work with you in order to meet the evolving needs of our patients.

Sincerely,

Johan S. Bakken MD, PhD

Johan S. Bakken, MD, PhD, FIDSA
IDSA President

About IDSA

IDSA represents over 10,000 infectious diseases physicians and scientists devoted to patient care, disease prevention, public health, education, and research in the area of infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, antibiotic-resistant bacterial infections such as those caused by methicillin-resistant *Staphylococcus aureus* (MRSA) vancomycin-resistant enterococci (VRE), and Gram-negative bacterial infections such as *Acinetobacter baumannii*, *Klebsiella pneumoni*ae, and *Pseudomonas aeruginosa*, and, finally, emerging infectious syndromes such as Ebola virus fever, enterovirus D68 infection, Zika virus disease, Middle East Respiratory Syndrome Coronavirus (MERS-CoV), and infections caused by bacteria containing the New Delhi metallo-beta-lactamase (NDM) enzyme that makes them resistant to a broad range of antibacterial drugs.