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# IDSAs

Infectious Diseases Society of America

July 12, 2016

The Honorable Orrin Hatch  
Chairman  
Committee on Finance  
United States Senate  
104 Hart Senate Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate  
221 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

Thank you for scheduling the hearing entitled, "Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: Ensuring Successful Implementation of Physician Payment Reforms." IDSAs greatly appreciates the Committee's leadership in repealing the Medicare Sustainable Growth Rate (SGR) formula and in overseeing MACRA implementation. IDSAs 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 Committee some of our recommendations for MACRA implementation and hope you will raise some of these issues with CMS Administrator Slavitt during the upcoming hearing. We provided detailed comments to CMS and below highlight some specific issues that we believe will be of interest to the Committee—such as the need for new infectious diseases (ID) quality measures and ways to better align new physician quality improvement programs with antibiotic stewardship and public health emergency preparedness. Given the Committee's interest in physician reimbursement issues, we also want to highlight a related concern regarding the current undervaluation of the infectious diseases (ID) specialty, which is leading to a steep decline in the number of physicians pursuing ID specialization, at a time when our nation urgently needs ID physician expertise.

## The Value of ID Physicians

ID physicians make significant contributions to patient care, biomedical research, and public health. Their leadership and services save lives, prevent costly and debilitating diseases, and drive 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. Some of the specific important contributions of ID physicians include:

- 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.

### **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. We are hopeful that the new Quality Payment Program (QPP), which incorporates both the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) options, will offer significant improvements over the existing quality programs that it will replace. However, we are concerned that the APM option, which offers significant incentives, will not be accessible to physicians in small or mid-sized practices; and that the MIPS program, as currently structured, misses many opportunities to provide quality-based incentives.

The implementation of the new QPP will have a profound impact on ID physicians. CMS estimates that approximately 5,544 ID physicians will be participating in the MIPS program. Approximately 43% (2,300) of those physicians will experience a negative payment adjustment, equaling a \$12 million loss in Medicare allowed charges across the specialty. Given this projection, IDSA has offered CMS a series of recommendations to strengthen the MIPS program geared toward providing the highest quality ID physician services.

### *Additional ID Quality Measures*

Current Physician Quality Reporting System (PQRS) measures are not well-aligned with infectious disease practices. This is due in part to the overwhelming proportion of ID clinical services being delivered in the inpatient setting while most of the PQRS measures developed apply to face-to-face encounters in the outpatient setting. Aside from HIV, HCV, pneumonia vaccination and influenza immunization, there are no truly ID-specific measures on which ID specialists can report.

IDSA continues to propose relevant and meaningful ID measures for CMS to consider within the QPP. Earlier this year, we submitted two additional measure concepts (Appropriate Use of anti-MRSA Antibiotics and 72-hour Review of Antibiotic Therapy for Sepsis) into the CMS Measures Under Consideration (MUC) process, both related to advancing quality measurement of antimicrobial stewardship at the physician-level. We hope the Committee will encourage CMS to advance these into inclusion on the list of applicable measures under

the quality component of MIPS. Antibiotic stewardship is critical to prevent the misuse and overuse of antibiotics that drive the development of antibiotic resistance—a serious and growing public health crisis that claims at least 23,000 lives in the US a year according to the Centers for Disease Control and Prevention (CDC) and complicates a host of other medical services that rely upon safe and effective antibiotics, including the care of preterm infants and immunocompromised patients, solid organ and bone marrow transplants, cancer chemotherapy and many surgeries.

IDSA is also pleased that MACRA provides CMS with additional funding for measure development. We believe the lack of relevant ID measures within the MIPS is partly due to the time and cost of measure development, and the additional funding from the MACRA offers an invaluable opportunity for CMS to assist in the development of measures where gaps exist. We urge the Committee to encourage CMS to use part of this funding towards the development of ID measures.

#### Clinical Practice Improvement Activities (CPIAs) under MIPS

It is within this component of the MIPS where we believe ID physicians will have the most impact and will be able to participate in a meaningful way within the QPP. However, we offer several recommendations to help ensure that the robust array of appropriate ID activities is reflected in the available CPIAs.

IDSA is pleased that CMS is proposing the implementation of an antibiotic stewardship program (ASP) as a CPIA, and we recommend that CMS strengthen this approach by establishing leadership of an ASP as a high weight CPIA while maintaining participation in an ASP as a medium weight CPIA. The CDC has recommended that all ASP have a single leader who will be responsible for the program's outcomes and have noted that physicians—particularly those with formal training in infectious diseases—have been highly effective in this role. Further, the Joint Commission's Prepublication Standards for Antimicrobial Stewardship specifically cites the involvement of an infectious diseases physician in ASPs. CMS has issued two proposed rules to require ASPs in acute care hospitals and long term care facilities, aligned with the goals and objectives of the National Action Plan for Combating Antibiotic Resistant Bacteria (CARB). The growing need for stewardship activities and expert leaders to ensure their success underscores the importance of making leadership of ASP a high weight CPIA.

IDSA is also pleased that CMS has included some emergency preparedness and response activities in the CPIA list. However, we strongly believe preparedness should go beyond volunteering for domestic and international humanitarian work and emergency response and disaster assistance. It is critical that our hospitals and health systems prepare and build the capacity to respond to public health emergencies, including outbreaks such as Ebola Virus Disease, Zika, MERS-CoV, pandemic influenza and others. ID physicians are heavily involved in these intensive efforts, which often involve coordination across multiple departments in a hospital or health system and with public health entities, needs assessments, development of protocols, communications plans and other activities. IDSA recommends that CMS add additional CPIAs to encompass leadership and participation in a wide array of health care facility preparedness and response activities.

CMS has appropriately recognized the need to develop and include additional CPIAs, allowing for greater participation in MIPS. IDSA has recommended that CMS consider the following CIA concepts: development, implementation, and oversight of infection prevention and control programs; development, implementation and oversight of infectious diseases protocols for solid organ and stem cell transplant procedures; implementation and on-going leadership of a hospital avoidance and timely discharge program enabled through outpatient parenteral antibiotic therapy; leadership of activities related to hospital or health system engagement with local, state or federal public health entities (such as surveillance, immunization programs, or outbreak response).

### **Undervaluing ID: Jeopardizing the Next Generation of ID Physicians**

It is important for policymakers to understand that MACRA implementation is occurring against a complex backdrop for physicians and our healthcare system in which compensation issues are driving young physicians away from the field of infectious diseases. 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 221 in 2016-2017. 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.

In 2014, IDSA surveyed nearly 600 Internal Medicine residents about their career choices. 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.

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.

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 Committee 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.

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,

A handwritten signature in black ink that reads "Johan S. Bakken MD, PhD". The signature is written in a cursive, slightly slanted style.

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