



IDS A

Infectious Diseases Society of America

2014-2015 BOARD OF DIRECTORS

President
Stephen B. Calderwood, MD, FIDSA
MASSACHUSETTS GENERAL HOSPITAL
BOSTON, MA

President-Elect
Johan S. Bakken, MD, PhD, FIDSA
ST. LUKE'S ID ASSOCIATES
DULUTH, MN

Vice President
William G. Powderly, MD, FIDSA
WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
ST. LOUIS, MO

Secretary
Penelope H. Dennehy, MD, FIDSA
HASBRO CHILDREN'S HOSPITAL
PROVIDENCE, RI

Treasurer
Cynthia L. Sears, MD, FIDSA
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
BALTIMORE, MD

Immediate Past President
Barbara E. Murray, MD, FIDSA
THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER
HOUSTON, TX

Judith A. Aberg, MD, FIDSA
ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI
NEW YORK, NY

Barbara D. Alexander, MD, MHS, FIDSA
DUKE UNIVERSITY MEDICAL CENTER
DURHAM, NC

R. Michael Buckley, MD, FIDSA
UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
PHILADELPHIA, PA

Deborah Cotton, MD, MPH, FIDSA
BOSTON UNIVERSITY SCHOOL OF MEDICINE
BOSTON, MA

Janet A. Englund, MD, FIDSA
SEATTLE CHILDREN'S HOSPITAL
SEATTLE, WA

Thomas Fekete, MD, FIDSA
TEMPLE UNIVERSITY MEDICAL SCHOOL
PHILADELPHIA, PA

Lawrence P. Martinelli, MD, FIDSA
COVENANT HEALTH
LUBBOCK, TX

Louis B. Rice, MD, FIDSA
WARREN ALPERT MEDICAL SCHOOL
OF BROWN UNIVERSITY
PROVIDENCE, RI

Steven K. Schmitt, MD, FIDSA
CLEVELAND CLINIC
CLEVELAND, OH

Chief Executive Officer
Mark A. Leasure

IDS A 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

July 7, 2015

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 holding tomorrow's hearing, "Medicaid at 50: Strengthening and Sustaining the Program." The Medicaid program is a critical source of coverage for preventive and health care services for some of our most vulnerable patients. With the Affordable Care Act's (ACA) Medicaid expansion, the program has taken on an even greater role in providing comprehensive and reliable coverage to our patients living with HIV and many others who previously were uninsured. We urge strong and ongoing federal support for this vital program.

I write to offer information and recommendations to strengthen Medicaid reimbursement of infectious diseases (ID) physicians and the impact of ID physician reimbursement on patient care, public health, and research. We hope you will find our perspectives useful as you review this important program and consider improvements.

The Value of the Infectious Diseases (ID) Physician

ID physicians provide expert life-saving care for a wide variety of medically complex patients, including many who rely upon Medicaid for their health coverage. For example, in inpatient hospital settings, ID physicians often consult with the primary treating physician on the care of patients who may have serious infections that require intensive monitoring to accurately diagnose and appropriately manage. ID specialists provide cost-saving stewardship of diagnostic testing. ID specialists optimize treatment by recommending appropriate antibiotics or other antimicrobial drugs, duration of therapy, and route of delivery, and by monitoring clinical and laboratory progress to minimize adverse drug reactions.^{1,2} Furthermore, ID specialists facilitate care transitions from the inpatient setting through provision and

¹ Petrak RM, et. al. The value of an infectious diseases specialist. *Clin Infect Dis* 2003;36:1013-17.

² McQuillen DP, et. al. The value of infectious diseases specialists: non-patient care activities. *Clin Infect Dis* 2008;47:1051-63.

oversight of outpatient antibiotic therapy. Such programs are themselves a form of antimicrobial stewardship; infectious diseases consultation reduced use of parenteral antibiotics by 28% in one study.³ In outpatient settings, ID physicians routinely provide follow up care to recently hospitalized patients as well as extensive ongoing care to patients with chronic infections such as HIV/AIDS. Of particular note, ID specialists play an important role in the treatment of chronic hepatitis caused by Hepatitis C virus (HCV), which is a disease of high incidence within the Medicaid population and comes with significant treatment costs. Access to ID specialists for patients infected with HCV is critical to ensure that the most appropriate and most cost-effective treatment is provided.

In 2014, several IDSA leaders published, “[Infectious Diseases Specialty Intervention Is Associated with Decreased Mortality and Lower Healthcare Costs](#),” in *Clinical Infectious Diseases*.⁴ The study reviewed Medicare data from 2008-2009 for over 270,000 hospital stays of patients with at least 1 of 11 targeted serious infections to compare stays that involved ID physician intervention with those that did not, as well as early versus late ID physician intervention. The sample included 101,991 stays with ID physician involvement and 170,366 stays without. Risk adjusted, stays with ID physician involvement were associated with significantly lower rates of mortality and 30-day readmission rates. Patients receiving care from an ID physician also had significantly lower risk-adjusted lengths of hospital stay, far fewer intensive care unit (ICU) days, and much lower Medicare charges and payments than those who did not receive any ID physician care. Patients receiving early intervention from an ID physician (within 2 days of admission) had even better outcomes as compared to those with no ID physician involvement: 3.8% shorter overall hospital stays, 5.1% shorter ICU stays, 3.4% lower costs for the hospital stay, and 6.2% lower costs for the 30 days post-discharge. Although these findings are based solely upon Medicare data, we believe the impact of care from an ID physician is applicable across patient populations and payers, including Medicaid.

ID physicians provide tremendous value beyond direct patient care as well. For example, ID physicians contribute significantly to our national security, leading public health responses to natural and manmade ID threats such as bioterrorism attacks, Middle East Respiratory Syndrome Coronavirus (MERS-CoV), Ebola virus disease, antibiotic resistance, foodborne illnesses, and other emerging threats. ID physicians provide critical expertise and leadership for infection control programs and activities at healthcare facilities across the nation. ID physicians are also leading antibiotic stewardship programs at institutions throughout the country, which are critically needed to optimize patient care and outcomes and curtail the overuse and misuse of antibiotics that is driving the development of resistance. As the federal government pursues the establishment of stewardship programs in all hospitals and long-term care facilities (as indicated in the National Action Plan for Combating Antibiotic Resistant Bacteria), we will rely upon a well-trained cadre of ID physicians to direct this important effort at the local and institutional level. Further, ID physicians are critical for the conduct of clinical trials to evaluate and

³ Shrestha, NK et. al. Antimicrobial stewardship at transition of care from hospital to community. *Infect Control Hosp Epidemiol*. 2012 Apr;33(4):401-4. doi: 10.1086/664758.

⁴ Schmitt, Steven et. al. Infectious Diseases Specialty Intervention Is Associated With Decreased Mortality and Lower Healthcare Costs. *Clin Infect Dis*. (2014) 58 (1): 22-28.

validate greatly needed new vaccines, diagnostics, and antibiotics and other antimicrobial drugs. We greatly appreciate this Subcommittee's leadership in advancing the 21st Century Cures Act (H.R. 6), which IDSA is proud to support. And we underscore that the success of provisions in this bill seeking to stimulate urgently needed antibiotic research and development will hinge upon the availability of ID physicians to conduct the necessary clinical trials.

The Future of ID Patient Care, Public Health, and Research in Peril

Unfortunately, despite the vital role of ID physicians in caring for patients, protecting public health and driving research, the future of this specialty is in jeopardy as fewer and fewer young physicians are choosing to enter this field. Data from the National Residency Match Program (NRMP) indicate a disturbing decline in the number of individuals entering into ID fellowship training. In the 2010-2011 academic year, there were 342 NRMP applicants matching nationwide in ID. This number has consistently declined every year since, with only 276 applicants matching via the NRMP in 2014-2015. Interestingly, ID and nephrology are the only two internal medicine subspecialties experiencing this decline. In 2014, IDSA leaders 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.

Reimbursement for ID Physicians

Relatively low compensation for ID physicians as compared to other medical specialties is an important concern for IDSA, and one that we hope the Subcommittee will examine closely. Over 90% of the care provided by ID physicians is considered evaluation and management (E&M), as opposed to procedures. The face-to-face encounters that ID physicians have with patients suffering from serious infections continue to be undervalued by current payment systems that much more generously reward procedures. To elaborate, infectious diseases specialists often treat patients with complex, severe infections that require strict adherence to antimicrobial treatment protocols that may last several weeks to months. Moreover, it is not uncommon that patients with severe infections have multiple co-morbidities that bring added complexity to their management and treatment. ID specialist-managed patients infected with HIV and HCV require ongoing care coordination. The provision of these E&M services requires a high level of expertise and complex medical decision-making that is inappropriately undervalued under current payment systems, including Medicaid.

The inappropriate undervaluing of E&M services has created a significant compensation disparity between ID physicians and specialists who provide more procedure-based care, as well as primary care physicians who provide similar or identical E&M services but who receive payment increases simply because they are called "primary care physicians." This disparity is a key driver of the waning interest in ID among young physicians. For example, a 2015 review by Medscape of 26 medical specialties found that ID was 6th from the bottom.⁵ Average annual

⁵ Peckham, Carol. Medscape Infectious Disease Physician Compensation Report 2015.

salaries for ID physicians are only 8.7% higher than the average salary of general internal medicine physicians, even though ID certification requires an additional 2-3 years of training. While we recognize that physician compensation is still significantly higher than what most Americans earn, we are nonetheless tremendously concerned about the future of the ID specialty, the patients who will need access to care for serious or life-threatening infections, and public health activities that will continue to rely upon ID physician expertise and leadership. Far too few young physicians are pursuing ID careers, instead seeking the higher compensation associated with other specialties whose annual salaries are 1 2/3 to twice that of ID specialists. The significant debt burden facing young physicians (\$200,000 on average for the class of 2014) is understandably driving many individuals toward more profitable specialties.

Recommendations

Medicaid policy is one area in which the federal government can help address the payment disparity facing ID physicians. For example, the ACA currently provides for increased reimbursement for physicians who perform primary care services to Medicare beneficiaries and who are of a specific designation, (e.g., family medicine, internal medicine, geriatric medicine, or pediatric medicine). It is important to understand there is no code in the physician fee schedule for “primary care services.” Primary care physicians (PCPs) and infectious diseases specialists bill identical E&M codes, and both coordinate care for individual patients. However, because of how the legislation was drafted, an ID specialist will be reimbursed less than other physicians for providing the same or usually substantially more complex E&M services. IDSA continues to advocate for appropriate reimbursement for these face-to-face patient encounters provided by ID physicians within the Medicare program. As the Subcommittee examines broad issues regarding the Medicaid program, we are hopeful that you can consider opportunities to provide adequate reimbursement for E&M services, including those provided by ID physicians.

The ACA also included a provision that provided Medicare-level reimbursement rates under Medicaid to physicians practicing in the specialties of family medicine, pediatrics, and internal medicine as well as related pediatric and internal medicine subspecialists, including ID physicians. While not a comprehensive solution to ID physician reimbursement concerns, this policy was helpful, particularly in allowing ID physicians to maintain or expand their Medicaid patient populations. We understand that Congress opted to allow this provision to expire at the end of 2014 and that a variety of complex factors led to that decision. However, we urge the Subcommittee to consider ways to address ID physician reimbursement as you consider broader Medicaid policies. We also recognize that Medicaid policy alone cannot thoroughly and sufficiently address concerns regarding ID physician compensation and the decreasing numbers of people entering this important field. We look forward to other opportunities to engage with the subcommittee on these issues and offer additional policy recommendations for your consideration.

Once again, we thank the Subcommittee for holding this important hearing, and look forward to continuing to work with you on issues of importance to patients and public health. Should you have any questions, please feel free to contact Amanda Jezek, IDSA's Vice President for Public Policy and Government Relations at ajezek@idsociety.org or 703-740-4790.

Sincerely,

A handwritten signature in cursive script that reads "Stephen B. Calderwood".

Stephen B. Calderwood, MD, FIDSA
President, 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 pneumoniae, and Pseudomonas aeruginosa, emerging infections such as Middle East respiratory syndrome coronavirus (MERS-CoV), Enterovirus D68, and Ebola virus disease, and bacteria containing novel resistance mechanisms such as the New Delhi metallo-beta-lactamase (NDM) enzymes and others that make them resistant to a broad range of antibacterial drugs, including one of our most powerful classes of antibiotics, the carbapenems (carbapenem-resistant Enterobacteriaceae, or CRE).