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IDSA
Infectious Diseases Society of America

October 5, 2023

The Honorable Jason Smith
Chair
Ways and Means Committee
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Ways and Means Committee
Washington, DC 20515

RE: Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith and Representative Neal:

Thank you for the opportunity to comment on the Request for Information: Improving Access to Health Care in Rural and Underserved Areas. Sixty million people, an estimated 19% of the U.S. population, live in rural areas that face unique challenges in accessing health care. Within these rural communities, 80% of the population are designated as medically underserved. The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide input on solutions to reshape our nation's health care system and bring new access to care in rural and underserved areas. Because so many procedures (cancer chemotherapy, organ transplants, surgeries, use of certain biologics, etc.) carry a risk of infection, and so many chronic conditions (diabetes, heart disease, etc.) increase the risk and severity of infections, improved access to infectious diseases (ID) physicians is critical to improve health outcomes in rural communities.

Overview of Recommendations

As the committee crafts legislation to improve access to health care in rural and underserved areas, IDSA recommends the following, which is explained in greater detail below:

- Direct the Centers for Medicare and Medicaid Services (CMS) to increase the valuation of inpatient evaluation and management (E/M) codes;
- Provide a temporary 10% payment increase for ID physicians, similar to policies used previously for primary care and general surgery;
- Urge CMS to collaborate with professional societies and invest in the development of specialty-specific quality measures; and
- Make permanent the telehealth originating site, audio-only, and hospital inpatient E/M services flexibilities.

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 influenza, pneumonia, HIV/AIDS, viral hepatitis, antimicrobial-resistant infections and infections associated with opioid use, as well as prepare for and respond to pandemics and outbreaks including COVID-19, mpox, Ebola and Zika. 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.

Health Care Workforce

ID specialty care is especially limited in many rural areas. More than three-quarters (80%) of U.S. counties did not have a single ID doctor in 2017, including many rural and underserved areas. In addition to 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, cancer care and growing use of certain biologics carry significant risks of complicated infections.

For patients with serious infections, early intervention by ID physicians improves patient outcomes, reduces mortality, shortens hospital lengths of stay and lowers Medicare costs. Expanding access to ID care in rural areas is a vital goal.

As antimicrobial resistance increases, making infections more difficult to treat, the role of ID physicians becomes even more critical to prevent, diagnose and treat these infections. A recent study found that roughly one-third of deaths caused by multidrug-resistant (MDR) bacteria were in newborns. This may be exacerbated in rural and underserved settings where pediatric care, specifically pediatric ID care, is already limited. On the other end of the lifespan, another study found drug-resistant infections led to nearly 450,000 inpatient days and nearly 12,000 deaths among Medicare beneficiaries annually, with resistant infections costing Medicare about $1.9 billion per year. This is especially concerning with disproportionate numbers of elderly people in rural America. According to the U.S. Census Bureau, 17.5% of the rural population was 65 years and older compared to 13.8% in urban areas. It is with this background in mind that we submit our comments for your consideration.

Infectious diseases clinicians, and the services they deliver, are unacceptably undervalued in Medicare's physician fee schedule. IDSA has repeatedly asked CMS to establish adequate relative values for inpatient E/M codes, which account for the vast majority of services delivered by ID physicians. Thus far, CMS has failed in this regard. While CMS appropriately increased the valuation of outpatient E/M codes in CY 2021, CMS has not made corresponding updates to inpatient E/M codes, thus abandoning the historic relativity between the inpatient and outpatient E/M codes, which used to account for the inherently more complex nature of inpatient care.

As a country, we are wholly unprepared to manage another large-scale outbreak – let alone multiple, concurrent outbreaks – given the inadequate ID physician workforce. Experts widely agree that outbreaks will become increasingly frequent and multifaceted. We further lack the ID experts necessary to care for and prevent infections in the growing population of immunocompromised individuals, including patients with cancer, patients receiving organ transplants and patients taking biologics that impact the immune system.

Flawed payment policies that grossly devalue ID physician expertise and care are a significant contributing factor to the ID recruitment crisis. Last year, only 56% of ID physician training programs filled, while most other specialties filled all or nearly all their programs. In pediatric ID, only 43% of ID physician training programs were filled. ID remains the fifth lowest paid medical specialty, below even general internal medicine despite an additional 2-3 years of training. In order to provide the care that is needed in rural and underserved areas, IDSA calls on your Committee and Congress to appropriately address these concerns by improving ID physician reimbursement before the next outbreak(s) meets our doors.

IDSA Proposal: Incentive Payment for ID Clinicians

IDSA recommends Congress pass legislation to **create an ID Incentive Payment Program**, which would provide a temporary 10% payment increase for all services provided by an ID clinician. This proposal is modeled after similar approaches used previously for primary care and general surgery. It would provide rapid relief to address

significant ID workforce shortfalls resulting from inadequate reimbursement and provide a bridge to longer term solutions to more appropriately value ID physician services and improve opportunities for ID participation in more innovative payment models. Urgent action is needed to improve ID reimbursement in order to strengthen ID physician recruitment and expand Medicare beneficiary access to ID physician care in rural and underserved areas.

In addition, to spur action by the Administration, Congress should encourage CMS to increase the values of inpatient E/M codes to reinstate the historic relativity between inpatient and office/outpatient E/M RVUs. Congress should also recommend that CMS convene an expert panel to review research and recommend 1) improved methodologies for reviewing E/M codes and 2) data-driven updates to E/M codes; such a panel would work with the American Medical Association RVS Update Committee to address the inability of current methodologies to accurately determine intensity and value of cognitive services.

Innovative Models and Technology

IDSA encourages the Committee to recommend that CMS collaborate with professional societies and invest in the development of specialty-specific quality measures that meaningfully apply to ID clinicians and the unique services they provide. The availability of such measures will help drive improvements in the quality of care provided and enable ID clinicians to participate in innovative payment models.

IDSA supports access for rural and underserved areas to specialty services via telemedicine. This is particularly crucial to ensure rural hospitals have access to experts to help address issues such as flu, RSV, COVID-19, mpox and antimicrobial stewardship expertise.

IDSA supports CMS' implementation of important telehealth provisions in the Consolidated Appropriations Act, 2023, namely those that would maintain many of the flexibilities provided during the COVID-19 public health emergency. In particular, **IDSA supports the expansion of the scope of telehealth originating sites for services furnished via telehealth to include any site in the U.S. where the beneficiary is located at the time of the telehealth service, including an individual's home**, and continued coverage and payment of audio-only telehealth services included on the Medicare Telehealth Services List as of March 15, 2020.

While telehealth is a critically important tool to expand access to care in rural communities, it still requires a robust workforce. The current shortage of ID physicians limits the amount of care that can be provided via any mechanism, including telehealth. It is critical that Congress address the financial drivers of workforce shortages to meaningfully expand access to care in rural communities.

Telephone Evaluation and Management Services

Audio-only technology is important in the management of ID conditions in rural and underserved areas, as it is often the only means by which some Medicare beneficiaries will be able to access ID care, even absent the pandemic. Broadband internet remains limited or nonexistent in many rural areas of the country, making access to audio-visual technology nearly impossible. Moreover, some Medicare beneficiaries find audio-visual technologies difficult to use, while others feel uncomfortable using them altogether. This can be particularly true for those with stigmatized health conditions like HIV, or patients without stable housing who may prefer the increased privacy afforded via audio-only care. We appreciate that CMS has deemed the telephone E/M services (CPT codes 99441-99443) as "telehealth services" and will remain actively priced through CY 2024, but we **urge your committee to recommend that CMS makes that status permanent.** We further note that these services are woefully undervalued regarding the cognitive effort and expertise required on the part of the provider, often managing conditions of high complexity that would be reimbursed at a higher, more appropriate rate if provided via a device with visual capability. We have encouraged CMS to improve reimbursement for telephone E/M

services so that reimbursement reflects the care provided, not the device used, and to remove limitations on telephone E/M services that only cover "patient initiated" calls.

Additions to the Medicare Telehealth List

IDSA appreciates that CMS will retain hospital inpatient E/M services on the Medicare Telehealth List through CY 2024 but is disappointed it did not propose to add these services permanently. **We request that the hospital inpatient E/M services be permanently retained on the Medicare Telehealth List.** Below, we provide examples of how this has been invaluable to beneficiaries seeking ID care.

- A hospital system in Virginia, with smaller hospitals in West Virginia, was struggling with increased transfers from the smaller hospitals to the main hospital overextending the capacity of the main hospital. The implementation of tele-ID services at the smaller hospitals reduced transfer needs by a minimum of 50%, which improved access to care and hospital capacity throughout the hospital system.
- A community hospital in New Mexico, a Level III Trauma Center and a known catchment hospital for all orthopedic-related trauma in the three neighboring communities, lost its in-person ID coverage. Availability of a tele-ID service allowed the hospital to continue services with access to ID specialists for a large population.

Access to ID care is critical to protecting the health of people who live in rural and underserved areas. In closing, thank you for the opportunity to raise these important issues. We look forward to continuing to work with you and your colleagues to expand access to health care in rural and underserved areas. For more information, please contact Amanda Jezek, IDSA senior vice president for government relations and public policy, at ajezek@idsociety.org.

Sincerely,

Carlos del Rio, MD, FIDSA
President