

**Infectious Diseases Society of America**  
**Statement in Response to Senate Finance Committee Hearing: Bolstering Chronic Care**  
**Through Medicare Physician Payment on April 11, 2024**

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On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 13,000 physicians, scientists, public health practitioners and other clinicians specializing in infectious diseases prevention, care, research and education, I thank the Committee for its focus on physician payment issues, highlighting the needs of patients with chronic conditions. **IDSA asks the Committee to recognize the link between chronic diseases and infectious diseases and the critical need to reform Medicare physician payment policies to support access to infectious diseases prevention, diagnosis and treatment that can especially impact patients with chronic diseases.**

**The Connection Between Chronic Disease and Infectious Disease**

Chronic diseases and infectious diseases are inextricably linked. Some chronic diseases are caused by infections. Patients with chronic conditions are often at greater risk of contracting infectious diseases and suffering more serious illness from infections, as we saw with COVID-19. These issues demonstrate that infectious diseases (ID) physicians play a key role in caring for patients with chronic diseases. As the percentage of the U.S. population that is immunosuppressed (due to transplants, use of certain biologics, cancers, etc.) continues to grow, so will the need for a robust ID workforce and a payment system that enables ID recruitment and access to ID care.

Recent research has shown that many chronic illnesses result from infectious agents and can be exacerbated by infectious pathogens.<sup>1</sup> For example, infectious agents such as viruses, bacteria and parasites can cause cancer or increase the risks of developing cancer. Certain viruses can also disturb the signals in the body that moderate cell growth and can lead to cancer developing. Cancer patients also have a much weaker immune system due to the spread of cancer to the bone marrow, thereby stopping the production of blood cells that can help in fighting infections. Furthermore, cancer treatments such as chemotherapy, steroids and radiation can weaken the immune system, making cancer patients more susceptible to infections.

The human immunodeficiency virus (HIV) is now regarded as a chronic disease that patients live with for multiple decades due to the use of antiretroviral therapy (ART).<sup>2</sup> Health care systems

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<sup>1</sup> Knobler, S. L., O'Connor, S., Lemon, S. M., & Najafi, M. (2018). *OVERVIEW*. The Infectious Etiology of Chronic Diseases - NCBI Bookshelf. <https://www.ncbi.nlm.nih.gov/books/NBK83680/>

<sup>2</sup> Deeks, S.G., Lewin, S.R., and Havlir, D.V. (2013). "The end of AIDS: HIV infection as a chronic disease," *The Lancet*, 382(9903), pp. 1525–1533. doi:10.1016/s0140-6736(13)61809-7.

across the country now treat HIV patients with chronic care management models. However, ART can cause multiple complications over time. Cumulative exposure over time to antiretroviral drugs has demonstrated that HIV-infected adults are at a much higher risk for the development of cardiovascular disease, kidney disease, osteoporosis and neurocognitive disease. Patients that have been diagnosed with viruses such as HIV have weaker immune systems and are less able to fight infections that may cause cancer. HIV patients are at a higher risk for many different forms of cancer, including Kaposi sarcoma, Hodgkin's lymphoma and liver and lung cancer.<sup>3</sup>

The number of immunosuppressed adults in the United States has been increasing over time due to wider use of new immunosuppressive treatments for a broad range of conditions that are immunocompromising, including cancer, organ transplants, autoimmune disorders, rheumatoid arthritis, psoriasis and more. Immunosuppression greatly increases the risks and severity of infections. A review of 2021 data found that 6.6% of U.S. adults are immunosuppressed, a significant increase from the 2.7% reported in 2013.<sup>4 5</sup> Additionally, the numbers of immunocompromised infants and children have also increased, and pediatric ID physicians provide care to a significant number of these patients who are at a much higher risk for developing serious infections.

Over the past four years, the medical community has seen an increase in hospitalizations and deaths due to COVID-19 in patients with chronic conditions, such as heart disease, diabetes and more.

### **Antimicrobial Resistance and Risk of Complications**

The prevalence of antimicrobial resistance (AMR) is a growing threat to patients, including those with chronic diseases. Millions of Americans per year develop hospital-acquired infections due to antibiotic-resistant pathogens.<sup>6</sup> The inappropriate use of antibiotics over decades has resulted in antibiotic resistance rates that continue to rise, with recent progress hampered by the COVID-19 pandemic.

To address the threat of AMR, IDSA greatly appreciates the leadership of Sens. Michael Bennet (D-CO) and Todd Young (R-IN) in sponsoring the bipartisan PASTEUR Act, which would strengthen the antibiotic and antifungal pipeline by changing the way the federal government pays for novel antibiotics and antifungals that address unmet needs – paying for value instead of volume used. Under PASTEUR, the federal government would enter into contracts with novel antibiotic/antifungal developers to pay a set fee for a supply of new drugs regardless of the

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<sup>3</sup> Risk factors: infectious agents. (2019, March 4). National Cancer Institute. <https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents>

<sup>4</sup> Martinson, Melissa L., and Lapham, J. "Prevalence of immunosuppression among U.S. adults." JAMA, vol. 331, no. 10, 12 Mar. 2024, p. 880, <https://doi.org/10.1001/jama.2023.28019>.

<sup>5</sup> Harpaz, R., Dahl, R., & Dooling, K. (2016). Prevalence of immunosuppression among U.S. adults, 2013. JAMA, 316(23), 2547. <https://doi.org/10.1001/jama.2016.16477>

<sup>6</sup> Clinical Infectious Diseases, ciad428. "AMR Guidance." IDSA Home, [www.idsociety.org/practice-guideline/amr-guidance/](http://www.idsociety.org/practice-guideline/amr-guidance/).

quantity used. PASTEUR would also provide grants to hospitals to support antimicrobial stewardship programs, with priority given to rural, critical access and safety net hospitals (which may partner with academic institutions for stewardship). Successful implementation of PASTEUR would require more ID physicians to ensure patients with resistant infections receive optimal treatment, lead clinical trials for novel antimicrobials and ensure that new antimicrobials are used appropriately.

### **Current Medicare Reimbursement Concerns**

Currently, nearly 80% of counties in the United States do not have a single ID physician, and this poses significant patient access problems.<sup>7</sup> Recruitment within the specialty continues to decline. In last year's fellowship match, only about 51% of ID training programs filled (down from 56% the year before), whereas most specialties filled 90%-100% of their training programs. These shortages are driven in part by reimbursement disparities that negatively impact infectious disease physicians.

Many medical students and residents are very interested in this field but cite financial reasons for pursuing specialties that have much higher reimbursement rates. Only three other medical specialties fall below ID in terms of compensation, according to Medscape. Two of those – pediatrics and public health – are primarily paid outside of the Medicare system. The shortage of ID physicians is very worrisome from a patient care and public health perspective, given the unique roles ID physicians play. ID is uniquely part of the foundation of modern health care. Cancer chemotherapy, organ transplants and other surgeries carry significant risk of infection and require ID expertise. Many hospital quality measures, conditions of participation (antimicrobial stewardship, infection prevention and control) and other metrics upon which hospital payments hinge (hospital readmissions, health care-associated infections) all fundamentally require ID physicians. ID physicians are at the forefront of leading preparedness and responses to outbreaks and pandemics. Patients with serious infections have better outcomes, shorter hospital stays and lower health care costs when cared for by an ID physician.<sup>8</sup>

### **IDSA's Proposals to Improve ID Capacity and Reimbursement**

As the Finance Committee considers Medicare Physician Fee Schedule reforms, we strongly urge you to include provisions that target specialties, like ID, that are at the bottom of the payment scale and are experiencing recruitment challenges and workforce shortages directly linked to inadequate reimbursement. IDSA recommends a provision that would provide a temporary 10% incentive payment to ID physicians, modeled after similar previous efforts for primary care and general surgery. This approach would provide a critical, rapid boost that would impact the specialty decisions of current medical students and residents. It would also serve as a bridge to provide time to develop and implement longer-term solutions.

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<sup>7</sup> Walensky, Rochelle P., et al. "Where is the ID in Covid-19?" *Annals of Internal Medicine*, vol. 173, no. 7, 6 Oct. 2020, pp. 587–589, <https://doi.org/10.7326/m20-2684>.

<sup>8</sup> McQuillen, Daniel P., and MacIntyre, Ann T. "The value that infectious diseases physicians bring to the healthcare system." *The Journal of Infectious Diseases*, vol. 216, no. suppl\_5, 15 Sept. 2017, <https://doi.org/10.1093/infdis/jix326>.

Over the last several years, IDSA has repeatedly engaged with the Centers for Medicare & Medicaid Services (CMS) to ask for assistance in addressing the reimbursement challenges that are impeding recruitment of ID physicians. Initially, we focused on urging CMS to improve the values of inpatient evaluation and management (E/M) codes, the codes mainly used by ID physicians, to maintain their historic relativity with outpatient E/M codes (whose values were increased in 2021). The historic relativity was based upon the fact that inpatient care is inherently more complex than outpatient care. Patients with serious infections often have underlying chronic illnesses, require more complex medical decision making and are at greater risk of adverse outcomes. CMS has not accepted this recommendation.

In January 2024, IDSA provided a list of services performed by ID physicians that are not adequately captured by existing E/M codes, in response to a request from CMS. At the end of February 2024, IDSA [submitted to CMS draft code descriptors](#) for infectious diseases complex prevention, infectious diseases, complex investigation/diagnosis, complex antimicrobial therapy and infectious diseases complex care management. IDSA also shared two draft code descriptors that refer more generally to complex care, to provide CMS with options that are not ID-specific: complex medication management and inpatient complex care management. The six code descriptors align with the six categories of activities routinely performed by ID physicians not adequately captured by current E/M codes. IDSA encouraged CMS to include these new codes and/or add-on codes in the upcoming CY 2025 Medicare Physician Fee Schedule rulemaking.

Several members of Congress are increasingly concerned about the ID physician workforce shortage and ID reimbursement issues. Last fall, a bipartisan group of representatives sent a [letter](#) to CMS asking for the agency to incentivize more medical students to enter the infectious diseases field by modifying its reimbursement policy.

Like many medical specialties, IDSA is supportive of broad reforms to the Medicare physician payment system, including tying payment updates to a measure of inflation, such as the Medicare Economic Index; revising budget neutrality requirements, including raising the budget neutrality threshold; and requiring ongoing updates to the practice expense inputs that inform the value of services. These reforms are essential to addressing some of the foundational challenges that persist in the physician payment mechanism. However, these reforms alone are not sufficient to address the significant payment disparities facing ID that are driving ID recruitment challenges.

## **Conclusion**

Thank you for your attention to physician payment issues and for considering our requests regarding the need to bolster access to ID treatment and prevention of infectious diseases through Medicare reimbursement reforms. While Medicare primarily covers adults, pediatric ID physicians face similar reimbursement and recruitment challenges that we hope to discuss in the future. We look forward to working with the Committee on these critical topics.

Should you have any questions or wish to discuss our requests further, please contact Amanda Jezek, IDSA's senior vice president for public policy & government relations, at [ajezek@idsociety.org](mailto:ajezek@idsociety.org).