



Centers for Medicare & Medicaid Services

Evaluation and Management Services

As a cognitive specialty, infectious diseases (ID) physicians use evaluation and management (E/M) CPT® codes to bill for the services they provide. For many years, E/M codes have been in significant need of revision to better reflect the services physicians provide while also decreasing documentation burden. Recently the Centers for Medicare and Medicaid Services (CMS) revised the office and outpatient E/M code descriptors, documentation and associated payment values. This was an important first step in recognizing the complex, non-procedural care and treatment delivered by cognitive-focused physicians. However, ID physicians primarily deliver care in the hospital setting and receive payment based on inpatient E/M codes, which have yet to be revalued.

Beginning Jan. 1, 2021, CMS will implement its previously finalized revisions to office/outpatient E/M services. The sum of this policy change, along with other changes outlined in the 2021 Medicare Fee Schedule final rule, will result in a 4 percent reduction in payments to ID physicians, in order for the agency to meet its statutory budget neutrality requirements.

IDSAs continues to advocate for improvements in the inpatient E/M codes. We believe this action will help address the significant ID workforce shortage and resultant gap in patient access to ID care by ensuring fair and appropriate payment for the cognitive work of ID physicians. At this time, the ID specialty workforce is at risk, as increasing numbers of physicians with significant medical student debt find the lower paying specialties financially infeasible. In fact, a [recent study published in the *Annals of Internal Medicine*](#) found that 208 million Americans live in areas with little or no access to an ID physician, a frightening statistic during a national public health emergency.

We recommend:

- **CMS continue to review, revise and revalue inpatient E/M services using an evidence-based approach, while working in conjunction with the American Medical Association (AMA) CPT Editorial Panel;**
- **CMS to work with Congress to mitigate the reduction in Medicare payments to ID physicians due to budget neutrality requirements concurrent with its implementation of the revised office/outpatient E/M service values.**

Physician Payment Enhancement for Activities Associated with the Treatment of COVID-19

IDSA members are on the front lines of the pandemic, taking on increased direct and indirect work to effectively treat patients with COVID-19 and performing additional, critical activities associated with managing a pandemic. We believe a long-term policy that ensures additional resources can be made quickly available when future epidemics arise will be crucial to improving our collective response to infectious disease outbreaks. In the meantime, however, short-term solutions are warranted to address current needs.

In July 2020, IDSA met with CMS to propose a model for a professional services claims-based payment enhancement that would quickly channel resources to health care practitioners on the front lines of the COVID-19 pandemic. Funded through a portion of the remaining Provider Relief Fund General Distribution, the payment would help recognize the enhanced, non-separately reimbursable work performed by physicians during the COVID-19 Public Health Emergency. IDSA has continued to dialogue with CMS about this proposal. The proposal is supported by several additional specialty organizations, including the Society of Hospital Medicine and the American College of Emergency Physicians and has been adopted as a resolution by the American Medical Association House of Delegates.

We recommend:

- **CMS take action to implement IDSA’s proposed professional services claims-based payment enhancement — funded through The CARES Act Provider Relief Fund General Distribution, or deemed a change in regulation — to help recognize the enhanced, non-separately reimbursable work performed by physicians during the COVID-19 Public Health Emergency.**

Telehealth and Telemedicine Services

The COVID-19 pandemic has fueled the need for the use of telehealth and telemedicine to treat patients, provide peer-to-peer guidance and assist with other aspects of caring for patients with COVID-19. During the early months of COVID-19 pandemic, telemedicine visits increased 154% based on [encounter data](#) from four of the largest telemedicine providers in the country. This coupled with the dramatic increase [in the use of telemedicine visits](#) by Medicare beneficiaries underscores the need to maintain the flexibilities within the Medicare program in the payment and provision of telehealth services covered under the public health emergency declaration. It is particularly crucial to provide equal payment for audio-only/telephone visits, as many Medicare beneficiaries lack broadband access or video capability. The physician service rendered is the same as a video visit, and undervaluing payment for audio-only/telephone visits could restrict patient access to care. As the COVID-19 pandemic continues, patients covered by the Medicare and Medicaid programs will continue to need access to telehealth services.

We recommend:

- **CMS maintain flexibilities in the payment and provision of telehealth services within the Medicare program until such time that there is no longer a public health emergency, or the policy changes have been made permanent. These flexibilities include:**

- **Payment – Payment for telemedicine services (including audio-only/telephone visits) is the same as what otherwise would have been paid if the service were provided in-person.**
- **Patient Eligibility – Prior doctor/patient relationship is waived; new and established patients are eligible for telehealth services.**
- **Site of Service – All originating site requirements are waived; beneficiaries may receive telehealth services from any location, including their home, inpatient setting and nursing facilities.**
- **Geography – Geographic restrictions are waived; beneficiary does not have to live in a rural area to use telemedicine services.**

Laboratory Services Payment Reduction

IDSA is concerned that recent cuts to independent laboratory services limit the ability of clinical laboratories to develop, innovate and offer critical diagnostic tests. From 2018-2020, most infectious diseases diagnostic tests received successive 10% reductions (for a 30% or greater reduction overall), with another 5% cut proposed for 2021. These rates do not reflect market-based payments as intended by Congress and will derail critical advances in point-of-care (POC) testing. High quality POC testing is a critical component of addressing the COVID-19 pandemic, in addition to the role it plays in helping to ensure appropriate antibiotic use (or withholding antibiotics if a viral infection is diagnosed). Alleviating payment reductions to vital laboratory services is a requisite to ensuring high quality diagnostic testing during the pandemic and beyond.

We recommend:

- **CMS work with Congress to develop a comprehensive solution to ensure that Medicare reimbursement truly reflects the market;**
- **CMS address the flawed methodology for calculating fees within the Clinical Laboratory Fee Schedule. The current method reduces patient access to rapid and accurate testing due to fewer laboratories offering these tests, which may be particularly detrimental to patients in rural and underserved areas;**
- **CMS expand Medicare’s determination of “medically necessary” services to include multiplex tests that are essential to rapid diagnosis for infectious diseases patient care. This will ultimately reduce test turnaround time, length of hospital stays, disease transmission and health care costs while enhancing the appropriate use of antibiotics, which will also enhance patient outcomes and reduce antimicrobial resistance;**
- **CMS survey for variance within market segments to better understand utilization in different regions of the country and within laboratory types, including reference laboratories, physician office–based laboratories and independent laboratories;**
- **CMS utilize existing program integrity and program administration authorities to improve data accuracy through a statistical survey method that is less burdensome on providers and reflects the full range of health care sites and their associated services and relative costs.**

Quality Payment Program

As the Quality Payment Program enters its fifth year, IDSA remains committed to ensuring meaningful participation of our members. We support continued efforts by CMS to reduce clinician quality reporting burden as well as to develop more meaningful measures focused on patient-important health outcomes. As well, we appreciate the agency's flexibility in delaying new program requirements and components during COVID-19, as well as the agency's efforts to quickly implement the COVID-19 Clinical Trials (IA_ERP_3) Improvement Activity (IA) during this pandemic. To ensure the Quality Payment Program is relevant to our members and the patient populations they serve, it is critical that additional ID-specific quality measures become available for Merit-based Incentive Payment System (MIPS) reporting. In addition, work is needed to ensure the availability of ID-relevant improvement activities and ensure existing activities are adequately weighted.

We recommend:

- **CMS work with IDSA to develop more relevant ID quality measures focused on meaningful health outcomes;**
- **CMS increase the weight of "Implementation of an Antibiotic Stewardship Program (ASP) (IA_PSPA_15)" to a "high-weight" activity, as it requires significant investment of time and resources.**

Center for Medicaid and CHIP Services

Section 1115 Medicaid Waivers

The Medicaid program is a critical source of health care coverage for people with HIV, covering more than 40% of people with HIV. See *IDSA/HIVMA/Pediatric Infectious Diseases Society [Policy Statement on the Medicaid Program, Public Health and Access to HIV Care](#)*. Guidance issued during the Trump Administration encouraged states to submit waivers allowing them to impose work requirements and other barriers to maintaining Medicaid eligibility that run counter to the intent of the program. These policies threatened access to health care coverage and care for people with HIV and millions of other low-income Americans who counted on the program before the pandemic. Given the magnitude of job and health insurance losses since March 2020, these policies have become even more harmful to our nation's public health.

We recommend:

- **Immediately rescinding the [January 2018 letter](#) on "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries" to state Medicaid directors and the [January 2020 letter](#) on "Healthy Adult Opportunity" encouraging states to submit waivers to receive a capped amount of federal support rather than the Federal Medicaid Matching rate that allows financing to grow depending on demand for services and increases in service costs.**

For questions regarding our recommendations, please contact Amanda Jezek, IDSA Senior Vice President for Public Policy and Government Relations at ajezek@idsociety.org or Andrea Weddle, HIVMA Executive Director at aweddle@hivma.org.