



IDSAs

Infectious Diseases Society of America

2010-2011 BOARD OF DIRECTORS

President
James M. Hughes, MD, FIDSA
EMORY UNIVERSITY
ATLANTA, GA

President-Elect
Thomas G. Slama, MD, FIDSA
INDIANA UNIVERSITY SCHOOL OF MEDICINE
INDIANAPOLIS, IN

Vice President
David A. Relman, MD, FIDSA
STANFORD UNIVERSITY SCHOOL OF MEDICINE
PALO ALTO, CA

Secretary
Kathryn M. Edwards, MD, FIDSA
VANDERBILT UNIVERSITY MEDICAL CENTER
NASHVILLE, TN

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

Immediate Past President
Richard J. Whitley, MD, FIDSA
UNIVERSITY OF ALABAMA AT BIRMINGHAM
BIRMINGHAM, AL

Paul G. Auwaerter, MD, FIDSA
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
BALTIMORE, MD

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

Michael L. Butera, MD
PULMONARY MEDICINE AND INFECTIOUS DISEASES
MEDICAL GROUP
SAN DIEGO, CA

Carlos del Rio, MD, FIDSA
EMORY UNIVERSITY
ATLANTA, GA

Thomas M. File, Jr., MD, FIDSA
SUMMA HEALTH SYSTEM
AKRON, OH

Carol A. Kauffman, MD, FIDSA
UNIVERSITY OF MICHIGAN MEDICAL SCHOOL
ANN ARBOR, MI

Andrew T. Pavia, MD, FIDSA
UNIVERSITY OF UTAH
SALT LAKE CITY, UT

William G. Powderly, MD, FIDSA
UNIVERSITY COLLEGE DUBLIN
DUBLIN, IRELAND

**Wesley C. Van Voorhis, MD,
PhD, FIDSA**
UNIVERSITY OF WASHINGTON
SEATTLE, WA

Chief Executive Officer
Mark A. Leasure

IDSAs Headquarters

1300 Wilson Boulevard
Suite 300
Arlington, VA 22209

TEL: (703) 299-0200

FAX: (703) 299-0204

E-MAIL ADDRESS:

info@idsociety.org

WEBSITE:

www.idsociety.org

October 5, 2011

Glen Hackbarth, Esq., Chairman
Robert Berenson, MD, FACP, Vice Chairman
Medicare Payment Advisory Commission (MedPAC)
601 New Jersey Ave NW
Suite 9000
Washington, D.C., 20001
Submitted via email:
Submitted online:

RE: Draft Recommendation for SGR "Fix" Ignores Cognitive Specialties that Perform Similar Services and Face the Same Challenges as Primary Care

Dear Chairman Hackbarth and Vice Chairman Berenson,

The Infectious Diseases Society of America (IDSAs) is writing to voice serious concerns about the draft recommendation to Congress under consideration by MedPAC to repeal the SGR by instituting unilateral cuts for three years and then a seven year payment freeze for non-"primary care" physicians as was discussed during the Commission's September 14-15 meeting. IDSAs believes these cuts will have a serious adverse effect on beneficiary access to care.

IDSAs represents more than 9,300 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, surgical infections, those with cancer or transplants who have life-threatening infections caused by unusual or drug-resistant microorganisms, people living with HIV and AIDS, and new and emerging infections, such as severe acute respiratory syndrome (SARS) and H1N1 influenza.

The draft recommendation calls for 5.9% cuts for each of three consecutive years to physicians in all specialties other than those classified as "primary care physicians" under the Affordable Care Act (ACA) definition. While we are sympathetic to efforts to assist primary care physicians, this recommendation ignores the fact that other cognitive specialties face similar problems. The broader issue is that Evaluation & Management (E/M) services in general are undervalued relative to procedural services. Any cuts or prolonged freezes for E/M services will make it difficult for cognitive specialists to survive economically. At the very least, many will have little choice but to limit their participation in the Medicare program.

ID is almost a purely cognitive specialty. On average, ID specialists bill 94% percent of charges using E/M codes, a higher proportion of E/M services than general internists (85%) and family practitioners (87%). Most ID practices provide primary care for people living with HIV/AIDS as well as longitudinal care for patients with serious infections such as osteomyelitis and endocarditis. In June, MedPAC acknowledged that Congress must act to protect access to the small number of physician specialties that look much more like “primary care” in terms of their billings, practices, and income than they look like procedural specialties. Indeed, ID practices are similar to primary care practices in terms of their billings and income but also in the challenges they face in maintaining their economic viability.

A small number of non-procedural specialties provide care to patients with chronic and complex illnesses that often require considerable time managing the coordination of care, especially the transition from inpatient to outpatient care. For instance, ID specialists often evaluate patients prior to hospital discharge for appropriateness of outpatient parenteral antibiotic therapy, order the appropriate treatment, schedule coordinated follow-up visits, monitor for adverse effects through laboratory testing and outpatient evaluation, and sometimes administer the drugs themselves. Such services are critically important to ensuring quality outcomes and avoiding unnecessary costs. Better care coordination of patients with chronic and complex illnesses is an area where significant system efficiencies can be achieved and an important activity that is aligned with Centers for Medicare and Medicaid Services’ stated goals for healthcare reform. Freezing already undervalued cognitive services will only undermine current efforts and make future reforms more difficult.

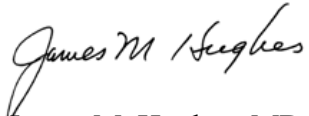
Conclusion

IDSAs agree that the SGR is a flawed formula that must be permanently fixed. However, it is overly simplistic to consider all non-“primary care” specialties as a single category. In fact, the continuing practice of lumping cognitive specialties that perform predominantly E/M services and face the same challenges as “primary care” physicians together with more highly paid procedural specialties will lead to shortages of and diminished access to cognitive physicians with *additional specialized* training who provide care and coordinate care for the most complex, most vulnerable Medicare beneficiaries.

IDSAs are concerned that MedPAC’s draft recommendation for the SGR “fix” does little to incentivize the kind of care coordination and time spent with patients that “primary care” and other specialists provide. A successful fix of this system must include recognition of specialists who coordinate and manage care for patients with chronic and complex conditions. Indeed, it is this additional training and expertise upon which primary care physicians currently rely in constructing diagnostic and therapeutic algorithms for many older patients. Failure to recognize this will result in less appropriate care and more adverse outcomes for some of the highest need, highest cost Medicare beneficiaries.

If you have any questions, please feel free to contact Andres Rodriguez, IDSA's Senior Program Officer for Practice & Payment Policy, at 703-299-5146 or arodriguez@idsociety.org.

Sincerely,

A handwritten signature in cursive script that reads "James M. Hughes".

James M. Hughes, MD, FIDSA
President, IDSA