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April 20, 2026

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RE: IDSA Follow-Up from April 15, 2026 Meeting

Dear Alec, Joe and Jacob,

Thank you for meeting with representatives from the Infectious Diseases Society of America (IDSA) on April 15 to discuss opportunities to improve infectious diseases (ID) physician reimbursement following reductions in practice expense payments that negatively impacted our specialty, including patient access to ID care and recruitment efforts. We greatly appreciate your recognition of the valuable role ID physicians play in our health care systems, and we look forward to working with you on short- and long-term solutions.

As we discussed, we understand and share CMS's underlying goal of better aligning payment with resource use and encouraging office-based care where appropriate. However, for infectious diseases — where the majority of care occurs in the inpatient setting due to the severity and complexity of illness — the recent reductions in practice expense payments have had significant unintended consequences. It is critical to address these consequences and ensure patients have access to ID care, as **patients with serious infections are discharged sooner from hospitals and have lower overall costs of care when they have access to an ID physician.**

We have continued to reflect on the various levers available to CMS to improve the financial viability of our field. **Ultimately, we need rapid relief this year or at least in 2027 from the cuts to practice expense that were recently implemented to mitigate our immediate loss of capacity to provide patient care. We are pleased to offer a proposed rapid solution, as well as longer-term solutions on which we would very much like to collaborate. We welcome your feedback and ongoing dialogue.**

Value of ID and workforce gaps

As you know, ID physicians are integral to diagnosing and treating the serious infections that frequently complicate complex care such as cancer chemotherapy, organ transplants, hip and knee replacements, cesarean sections and other surgeries. **Approximately 80% of ID physician care is in the inpatient setting because the patients we care for are extremely sick and complex.**

Unfortunately, despite significant interest in our specialty among medical students and residents, we face significant shortfalls in recruitment; high medical student debt leads many physicians to more lucrative specialties. **In last year's annual Match, only 45% of ID physician fellowship programs filled nationwide, down from 50% the previous two years.** Most other specialties fill 90% or more of their programs. As Dr. Thomas A. Moore, MD, FACP, FIDSA, of Kansas noted during our meeting, his practice had to reduce its staffing as a result of the practice expense cuts — a phenomenon that is occurring across the country, particularly in rural communities where some of the greatest unmet need for access to ID care exists.

Request for a near-term solution

While CMS' practice expense policy was intended to better align payment with the costs it believes physicians actually incur, particularly in facility settings where they may not bear the same level of overhead, its application raises unique concerns for ID physicians. In hospital-employed settings, these payments often support ID physician compensation and related system-level activities (e.g., antibiotic stewardship, antimicrobial resistance, infection control and prevention), so reductions undermine hospital-based ID programs. For independent ID physicians, these reductions cut payment for costs ID physicians actually incur.

The cuts to physician reimbursement for practice expense are directly harming ID physicians and restricting our ability to provide patient care. These reductions strain practice capacity and limit timely access to infectious diseases specialists, resulting in delays in care delivery and patients presenting with more advanced illness that requires more intensive and costly treatment. By contrast, when ID physicians can reach patients in a timely manner, infectious diseases services have been shown to reduce Medicare costs by shortening hospitalizations and ICU stays.

While we pursue longer term solutions to promote the financial sustainability of our field, we urgently request that CMS provide rapid relief in the coming months or by January 1, 2027, at the latest, from the cuts to practice expense. Specifically, we propose that CMS exclude the services listed below from the application of the methodology that reduces indirect practice expense RVUs for services delivered in the facility setting as finalized in the CY 2026 Medicare Physician Fee Schedule final rule:

1. Hospital inpatient or observational care evaluation and management services
2. Emergency department evaluation and management services
3. Nursing facility evaluation and management services
4. Critical care evaluation and management services
5. Other evaluation and management services determined appropriate by the Secretary

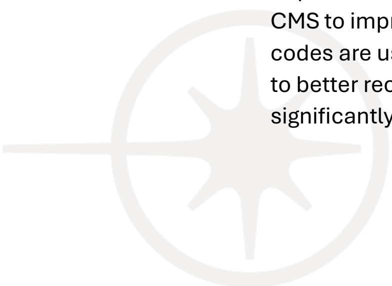
We would also welcome other ideas from CMS that would similarly provide timely relief to ID physicians from the most recent reimbursement cuts.

During our meeting, you noted the agency's reluctance to "double pay" for services for which health care facilities are already being paid, and we support the good stewardship of taxpayer resources. But, as we noted, the reality is that facility payments for practice expenses do not reach ID physicians. You also highlighted the infectious diseases add-on code (G0545), which CMS implemented in CY 2025 PFS rulemaking. We remain deeply grateful for this code, and it was beginning to make a meaningful difference for our specialty. However, the subsequent reductions to practice expense reimbursement have effectively erased these gains.

Additional levers for CMS to improve the financial viability of infectious diseases

We are tremendously grateful for your interest in working with us to secure the longer-term financial viability of the ID specialty. Below we offer additional targeted policy approaches that better reflect the complexity and resource intensity of infectious diseases care. We would welcome the opportunity to collaborate in any of these areas.

- Improve the valuation of the inpatient evaluation and management (E/M) codes: For several years IDSA urged CMS to improve the valuation of E/M codes, but CMS made only modest improvements and noted that these codes are used by many specialties beyond ID. We appreciate that CMS has taken steps in recent rulemaking to better recognize the time and complexity involved in inpatient care; however, the current valuations still fall significantly short of capturing the intensity and cognitive effort required for complex infectious diseases



management. We would welcome the opportunity to collaborate on refining these values to ensure more accurate reimbursement for ID services.

- Value-based care: We are eager to expand value-based care opportunities for ID physicians to share in the savings that their expertise generates. We need care models that capture the full scope and value of ID services, particularly in areas such as outpatient parenteral antimicrobial therapy (OPAT), antimicrobial stewardship, hospital avoidance, early discharge, and complex care coordination. Greater support from CMS in funding and prioritizing the development and testing of such models, alongside outcome measures that are specific and meaningful for ID practice, would be instrumental in advancing this long-term effort.

- Bio-Preparedness Workforce Pilot Program: As we discussed, IDSA is actively working to directly address the high medical student debt that drives so many physicians to more lucrative specialties. Congress has authorized the Bio-Preparedness Workforce Pilot Program at the Health Resources and Services Administration (HRSA) to incentivize health care professionals to pursue careers in ID and work in communities with the greatest need by providing up to three years of student loan repayment in exchange for ID service in health professional shortages, medically underserved communities and federal facilities (e.g., VA settings, Ryan White clinics, community health centers). We would be deeply grateful if you would help prioritize implementation of this vital program with your colleagues at HRSA and HHS. Specifically, we ask that you urge HRSA to develop the loan repayment documentation and program structure, redirect $5 million in FY26 funds to initiate the loan repayment, and include the program in next year's budget request.

Thank you again for your genuine interest in working with us to help guarantee the immediate and long-term survival of the infectious diseases specialty, which is vital to the health of the nation. We look forward to continued partnership.

Sincerely,

Ronald G. Nahass, MD, MHCM, FIDSA
President
Infectious Diseases Society of America