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4040 Wilson Blvd.
Suite 300
Arlington, VA 22203

info@idsociety.org
703.299.0200
IDSOCIETY.ORG

May 5, 2026

The Honorable John Joyce, MD
Co-Chair, Congressional Doctors Caucus
U.S. House of Representatives
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Murphy, MD
Co-Chair, Congressional Doctors Caucus
U.S. House of Representatives
407 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
U.S. House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

RE: Medicare Physician Payment Legislation Draft — IDSA Comments and Recommendations

Dear Dr. Joyce, Dr. Murphy and Dr. Schrier,

On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 13,000 infectious diseases physicians and other ID specialists, we write regarding the discussion draft of legislation to reform the Medicare Access and CHIP Reauthorization Act. IDSA appreciates the opportunity to comment on this important proposal. While we support several provisions in your draft bill, we strongly urge you to strengthen the legislation to better address the urgent reimbursement and workforce challenges facing infectious diseases physicians and we are pleased to offer specific recommendations below.

Infectious diseases remain one of the lowest-compensated specialties in medicine, despite the essential role ID physicians play in caring for medically complex patients, leading antimicrobial stewardship efforts, responding to public health threats and improving outcomes across inpatient and outpatient settings. Low reimbursement, combined with high educational debt and longstanding payment inequities under Medicare, has contributed to significant recruitment challenges and workforce shortages that threaten patient access to essential infectious diseases care. In last year's annual Match, only 45% of ID physician fellowship training programs filled, whereas most specialties fill 90% or more of their programs. Nearly 80% of U.S. counties do not have a single infectious diseases physician, underscoring the extent to which payment and workforce challenges are already affecting access to care.[1]

For these reasons, IDSA encourages you to incorporate the following recommendations in the draft bill to better support the sustainability of the infectious diseases workforce and the Medicare patients who rely on ID expertise. In particular, IDSA recommends:

- Revise the proposed conversion factor update to provide a full Medicare Economic Index (MEI) increase; clarify that increases in payments for primary care services explicitly include those delivered by internal medicine subspecialties, such as infectious diseases, and extend the add-on payments to hospital inpatient evaluation and management services.

[1] Infectious Diseases Society of America. State of ID: Assessing ID Workforce Shortages in the United States. Infectious Diseases Society of America, 2024, https://www.idsociety.org/globalassets/idsa/id-workforce/idsa-state-of-id-brief.pdf.

- Ensure that Merit-Based Incentive Payment System (MIPS) reforms protect specialties that lack adequate measures, incorporate meaningful specialty society input and prioritize clinically relevant, outcomes-based metrics that reflect the value of infectious diseases care.
- Preserve viable pathways for ID physicians to participate in alternative payment models (APMs) by freezing APM thresholds and improving transparency and accountability in Center for Medicare and Medicaid Innovation (CMMI) model design and implementation.
- Modernize budget neutrality and practice expense policies in ways that reduce payment volatility and improve the accuracy and fairness of Medicare physician reimbursement.
- Exempt nonprocedural services (including those provided by ID, hospital medicine and emergency medicine) from cuts to practice expense reimbursement.

IDSA supports several important elements of the discussion draft, including efforts to improve payment stability, reform quality measurement and update budget neutrality policies. However, because infectious diseases physicians face uniquely severe reimbursement and workforce pressures, the legislation should do more to ensure that Medicare payment reform meaningfully improves the viability of ID practice and patient access to ID care.

Title I — Conversion Factor Update and Primary Care Investment

IDSA strongly supports the discussion draft's move to an MEI-based update for the Medicare Physician Fee Schedule (PFS) conversion factor, which represents a significant improvement over the current framework and better reflects the need for a stable, inflation-linked update for physicians' services. The current PFS update mechanism has not kept pace with inflation nor the cost of furnishing physician services and has contributed to ongoing reimbursement instability and stagnation for physicians. However, IDSA is concerned that permanently setting the update at MEI minus one percentage point, and further constraining it with a cap, would continue to erode physician payment, especially for cognitive specialties like infectious diseases that are chronically under-reimbursed. **IDSA urges Congress to provide annual Medicare physician payment updates that reflect the full MEI.**

IDSA also appreciates the discussion draft's proposed non-budget-neutral investment in primary care. Strengthening primary care is important to improving prevention, chronic disease management and care coordination across Medicare. Consistent with the broader primary care physician community, IDSA supports targeted investments in primary care services and believes they are critical to improving outcomes and reducing avoidable downstream costs. **However, Congress should clarify that any increase in payment for primary care services under the legislation is applied based on the services furnished, identified through CPT or HCPCS codes, rather than physician specialty designation, enrollment category, or taxonomy.** This service-based approach would appropriately recognize that infectious diseases physicians and other internal medicine subspecialists provide nonprocedural, cognitive care that is similar in nature to primary care and play a central role in managing medically complex patients and coordinating care. For example, infectious diseases specialists frequently partner with primary care clinicians in the longitudinal management of patients with HIV, hepatitis, recurrent and drug-resistant infections, post-acute antimicrobial therapy needs, and immunocompromising conditions, making it especially important that Medicare payment policy support both primary care and specialty collaboration rather than advancing one at the expense of the others. **IDSA therefore recommends that the "Increase in Payment for Primary Care Services" provision apply the add-on to primary care E/M visit codes and related evaluation and management codes when furnished by clinicians whose practices are predominantly E/M-based, including internal medicine subspecialists such as infectious diseases.**

Congress should also advance payment adequacy for physicians whose services generate substantial clinical and system value but remain undervalued under the current fee schedule. Consistent with IDSA's recent comments on the Medicare Physician Fee Schedule, this should include specialties like infectious diseases, where physicians provide predominantly cognitive, evaluation and management services that improve outcomes, reduce complications, and support stewardship and infection prevention, yet continue to lag behind most other specialties in Medicare reimbursement and overall compensation.

Title II — MIPS Reform

Section I — Rebranding

IDSA

IDSA appreciates the draft's recognition that the current MIPS has become associated with a program structure that is often administratively burdensome, clinically misaligned and insufficiently responsive to specialty practice. For infectious diseases physicians, whose work is frequently consultative, cognitively intense, and delivered across inpatient and outpatient settings, the current MIPS framework has too often failed to capture the true value of specialty care.

The elimination of the Improvement Activities category is particularly significant for infectious diseases physicians, as many of the most feasible and high-value MIPS activities for ID have been recognized through that category, including antimicrobial stewardship programs, infection prevention and control initiatives, HIV care coordination, and other structured quality improvement efforts. **IDSA urges Congress to ensure that these activities are not lost in the transition, but rather are explicitly incorporated into the revised framework's quality, resource use or cost containment components so that stewardship, infection prevention and other ID-led initiatives continue to be recognized and rewarded.**

The draft bill's restructuring of the underlying scoring framework by eliminating Improvement Activities and Promoting Interoperability as scored performance categories and establishing a new Cost Containment category would materially alter how physicians are evaluated. It is imperative that any revised payment system remains fair to specialties whose contributions are often reflected through complex cognitive care, prevention of downstream complications and reduced avoidable utilization rather than through easily quantifiable procedural volume.

IDSA is particularly concerned that the legislation does not define "Cost Containment," creating uncertainty about how the category would be operationalized and whether it could inadvertently disadvantage specialists who treat medically complex, high-risk patients. To avoid penalizing clinicians who care for immunocompromised patients, transplant recipients, individuals with multidrug-resistant organisms and other high-severity populations, **IDSA recommends that any cost and cost containment metrics incorporate robust, specialty-appropriate risk adjustment and transparent attribution methodologies that clearly delineate which costs are assigned to consulting specialists versus primary or facility-based teams.**

IDSA further urges Congress to require that any cost containment methodology be defined through notice-and-comment rulemaking, include specialty-specific risk adjustment and be subject to independent evaluation before being used for payment purposes. Independent evaluation and public comment are critical to ensure that new measures and scoring rules promote genuine efficiency and quality improvement rather than blunt cost cutting that could undermine access to necessary specialty care for high-risk patients.

Section II — Temporary Reduction in MIPS Penalties During Transition

IDSA strongly supports the proposal to reduce MIPS payment penalties during the transition period while the program is being reworked. Under the legislative text, the reduced maximum MIPS payment adjustment of 2% would apply to payment years 2029 through 2033, which are tied to performance years beginning with 2027, rather than reducing penalties immediately. A temporary reduction in penalties from 9% to 2% would provide important protection for physicians who are currently subject to a scoring system that does not consistently offer adequate, specialty-relevant or operationally feasible metrics. This transition policy is particularly important for infectious diseases physicians and other specialties that have faced persistent difficulty identifying attributable measures that reflect their clinical work.

However, IDSA is concerned that, as drafted, the temporary reduction in penalties would not provide sufficient time for recommendations from the Quality Reform Task Force to take effect. The bill directs the task force to begin issuing recommendations for performance periods on or after Jan. 1, 2027, and contemplates a five-year performance period process under which specialties with inadequate measures would be prioritized, but the reduced 2% maximum adjustment would apply only from 2029 through 2033. **As a result, the legislation could allow penalties to return to the full 9% adjustment before the measure-development and implementation process is sufficiently mature for all affected specialties.**

In addition, IDSA recommends that any return from the temporary 2% framework to the full adjustment structure occur only after CMS demonstrates that affected specialties have access to a sufficient set of validated, attributable and implementable measures and that those measures have been operationalized through a fair reporting pathway. At a minimum, Congress should consider conditioning reinstatement of the full adjustment on clear benchmarks, such as completion of the task force's specialty-specific recommendations, availability of an adequate number of applicable measures for the specialty, and a reasonable period for testing and implementation before full penalties resume. **Alternatively, we urge you to consider a phased increase in the maximum adjustment, rather than an immediate reversion to 9%, to provide a more measured transition as the revised MIPS framework is implemented.** Absent

such a safeguard, specialists could again be exposed to penalties under a system that remains structurally incomplete for their field.

Section III — Establish New Quality Care Reform Task Force at CMS to Develop and Implement New Quality Reporting Metrics

IDSA strongly supports the establishment of a new task force dedicated to the development of quality reporting metrics that are focused on outcomes, simplification and automated data extraction from EHR and billing systems. This policy appropriately recognizes that the long-term credibility of Medicare quality policy depends on measures that reflect actual clinical practice, align with evidence-based care and reduce unnecessary reporting burden. **IDSA is particularly encouraged that the draft legislation includes representation for each medical specialty over a five-year performance period cycle, ensuring that all specialties have an opportunity to be included in the task force's work, and that the draft bill directs the task force to prioritize specialties with an inadequate set of quality measures during the initial years of implementation.** Specialty society engagement is essential for infectious diseases because meaningful measures in this field must account for antimicrobial stewardship, infection prevention, outbreak preparedness and response, prevention of transmission of high-consequence pathogens and pathogens of risk to public health, management of serious and drug-resistant infections, diagnostic accuracy, and the coordination of care for medically complex patients across settings.

IDSA also supports the stated goal of requiring that measures recommended by the task force conform with applicable clinical guidelines and be designed to promote quality of care or reduce costs. At the same time, the legislative text may be more prescriptive than intended, and **IDSA encourages you to ensure that this standard does not unduly constrain the task force's flexibility to consider measures that could help inform future clinical guidelines or reflect evolving evidence and standards of care.** For this reason, the bill should ensure that the task force is directed to prioritize scientific validity, appropriate risk adjustment, specialty attribution and feasibility across diverse practice settings, including hospital-based and consultative environments where many infectious diseases physicians practice. IDSA further recommends that you broaden the statutory language to recognize measures that promote quality of care while reducing or responsibly maintaining costs, as some high-value interventions may preserve appropriate resource use and prevent downstream harm even where further near-term cost reductions are limited.

In addition**, IDSA strongly supports the bill's provisions expanding access to Medicare claims data for qualified clinical data registries and clinician-led registries and the related emphasis on registry-based reporting pathways.** Qualified clinical data registries and specialty-led registries are especially important in infectious diseases because they can capture clinically meaningful data elements and outcomes that are often not reflected in generic MIPS measures, thereby improving both quality measurement and quality improvement efforts. IDSA also encourages Congress to ensure that registry-based reporting pathways remain practical and accessible for specialty societies and clinicians, including those practicing in hospital-based, multisite and resource-constrained environments. Implementation of the new claims-data access process should be accompanied by clear guidance, reasonable fees and technical support so that registries representing smaller or resource-constrained specialties, such as infectious diseases, can realistically use these data for quality assessment, quality improvement and research.

IDSA is concerned, however, that the bill would also require MIPS-eligible professionals to report applicable quality measures through certified EHR technology or clinical data registries, with those who do not do so treated as achieving the lowest potential score for the measure. While IDSA supports a long-term shift toward more automated, digital reporting, this requirement could be particularly challenging for small, rural and resource-constrained practices that have historically relied on claims-based reporting and may have limited access to CEHRT or specialty registries. IDSA therefore urges Congress to pair the new reporting requirement with a realistic transition period, technical assistance and alternative reporting pathways, and to ensure that clinicians are not penalized solely because they lack the infrastructure or institutional control needed to meet CEHRT or registry reporting standards.

IDSA recommends that this subsection ultimately provide clear statutory protections ensuring that specialties are not penalized if adequate measures have not yet been developed, tested and operationalized. The task force should therefore be paired with a transition framework that recognizes measure gaps and explicitly protects physicians from adverse consequences while those gaps are being addressed.

Section IV — Technology Modernization

IDSA supports the outline's focus on improving CMS technology infrastructure to support implementation of the Act and to facilitate more efficient data sharing and interoperability. If thoughtfully designed, technology modernization could help reduce

physician burden, improve the integrity of quality reporting and make it easier for clinicians to participate in Medicare quality programs without diverting excessive resources away from patient care. At the same time, IDSA urges caution in assuming that automated extraction or interoperability solutions are uniformly available across all physicians, practices and care settings. Infectious diseases physicians practice in a wide range of environments, including hospitals, academic centers, independent groups and resource-constrained settings, and many continue to face substantial variation in EHR functionality, registry integration and reporting capacity.

Accordingly, IDSA recommends that any technology modernization provisions be implemented with flexibility, phased timelines and adequate support for adoption. Congress and CMS should ensure that modernization efforts expand participation rather than create new inequities for small, hospital-based, rural or specialty practices that may lack the resources to rapidly meet new technical requirements. IDSA also urges policymakers to recognize that technology modernization must be accompanied by strong cybersecurity protections and sufficient resources to support compliance with those protections. In many practice settings, particularly smaller, rural, safety-net and resource-constrained environments, the financial and operational resources needed to implement secure, interoperable systems may be inadequate. As a result, modernization policies should account not only for technical capability, but also for the cybersecurity infrastructure, workforce capacity and ongoing support necessary to protect patient data and avoid placing disproportionate burdens on under-resourced providers.

Title III — APM/CMMI Reform

Section I — Threshold Reform

IDSA supports the bill's extension of the current Qualifying APM participant thresholds through payment year 2029, as this change would help preserve a viable pathway for physician participation in advanced payment models while CMS and stakeholders continue to refine the model landscape. For infectious diseases physicians, threshold policy is not an abstract technical issue; it directly affects whether clinicians who meaningfully contribute to value-based care can realistically qualify for available incentives in a system where specialty-focused APM options remain limited. Infectious diseases physicians frequently generate value through activities that are difficult to capture under conventional fee-for-service payment but are central to successful alternative payment arrangements, including antimicrobial stewardship, outpatient parenteral antimicrobial therapy oversight, infection prevention, diagnostic optimization and coordination of care across inpatient and outpatient settings. Even where these services produce measurable savings and better outcomes, ID specialists may still face difficulty meeting Qualifying APM participant thresholds because they are often participants in broader organizational care models rather than the primary holders of attributed patient panels or episode accountability.

In practice, the substantial cost savings generated by timely ID consultation, stewardship and infection prevention are often diffuse and attributed to hospitals or health systems rather than to individual ID physicians, while Medicare's payment and threshold structures more readily recognize direct revenue generation from procedures than the downstream savings associated with complex cognitive care. As a result, ID physicians' contributions to value-based care are systematically undervalued in both traditional fee-for-service and current APM threshold methodologies.

Freezing the thresholds is therefore important not only because it avoids narrowing eligibility but because it acknowledges that Medicare's current APM portfolio has not yet matured to the point where many specialists can participate on equitable terms. Raising or allowing thresholds to tighten in the absence of more robust specialty-relevant opportunities would risk excluding physicians whose work advances value-based goals but whose practice structure does not align neatly with existing attribution methodologies. This issue is particularly significant in infectious diseases because the specialty often exerts a high downstream impact through consultative intervention rather than high procedural volume or direct longitudinal attribution. ID physicians can reduce complications, avoid unnecessary admissions or prolonged hospitalizations, improve antimicrobial use and lower readmissions, yet those benefits are frequently realized across multiple settings and providers, making them harder to assign within traditional APM threshold frameworks. As a result, the present threshold architecture systematically undervalues the specialty's contribution to cost savings and containment and outcome improvement, even when that contribution is substantial.

Accordingly, IDSA supports freezing current thresholds while encouraging Congress and CMS to use this period to expand and refine specialty-relevant APM opportunities. Threshold relief should function as a bridge to a more inclusive model environment in which the value created by specialty physicians is measured more accurately and in which participation standards reflect the realities of multidisciplinary care delivery rather than only primary attribution mechanics. Freezing current thresholds is critical for infectious diseases physicians, whose contributions to lower-cost, higher-quality care are often realized through consultation, stewardship and care redesign activities that improve performance across the broader delivery system.

Section II — CMMI Guardrails

IDSA strongly supports the proposal to establish stronger guardrails around the development, modification and termination of CMMI models, including formal notice-and-comment requirements for terminating or modifying models and enhanced reporting to Congress that explicitly addresses model savings and performance. These guardrails are especially important for specialty physicians because innovation models can substantially reshape care delivery, referral patterns and financial risk exposure, yet specialty input has not always been sufficiently incorporated at the earliest stages of model design. IDSA also supports the bill's requirement for the Government Accounting Office, in consultation with MedPAC, to report on barriers to specialty participation in value-based models and to recommend policies to reduce those barriers, as this analysis will be critical to ensuring that future models are designed to support, rather than sideline, specialties such as infectious diseases.

For infectious diseases physicians, model transparency is not simply a procedural concern; it is essential to ensuring that payment innovation does not unintentionally undermine clinically necessary specialty care. Without sufficient visibility into model methodology, attribution rules, benchmark construction and specialty roles, CMMI models may create incentives that reward short-term cost minimization without adequately accounting for the long-term value of appropriate infectious diseases intervention, especially in medically complex populations. **IDSA therefore urges Congress to include explicit transparency provisions for model development, such as requiring CMS to provide advance notice of models under development and to offer meaningful opportunities for engagement with relevant specialty societies and other stakeholders before models are finalized.**

Notice-and-comment rulemaking would improve model legitimacy by giving specialty societies and front-line clinicians a meaningful opportunity to identify design flaws for models that CMS intends to test at scale or expand, or when CMS is proposing material changes to existing models. In the context of infectious diseases, this could help surface issues such as inadequate recognition of stewardship activities, failure to account for the complexity of severe infections, insufficient risk adjustment for immunocompromised patients or the omission of specialty consultation as a model-supported intervention that improves outcomes and reduces downstream spending. IDSA is not recommending full notice-and-comment rulemaking for every small or voluntary demonstration, but believes that models that are expanded, significantly modified or used to inform broad payment policy should be subject to formal rulemaking and robust stakeholder input.

IDSA also supports guardrails requiring transparency when a model is terminated early or changed substantially. Sudden model termination or mid-course redesign can disrupt care transformation efforts, strand investments in staffing and analytics, and create uncertainty for clinicians who have reorganized practice operations in reliance on the model's continuation. This instability is especially problematic for specialties, which often require longer lead times to build workable participation strategies and may already be operating at the margins of model eligibility. **IDSA therefore believes congressional reporting should be interpreted broadly to include not only aggregate savings figures, but also meaningful information about model performance across patient populations, specialties and care settings.** Reports are most useful when they illuminate which design choices improved outcomes, where specialty participation was feasible or infeasible, whether financial risk was distributed fairly, and how quality safeguards operated in practice.

Title IV — Budget Neutrality Reform

Section I — Threshold

IDSA supports the proposal to increase the budget neutrality threshold from $20 million to $54.3 million and to index that amount to the MEI every five years. The current threshold has remained unchanged for decades and no longer reflects the scale of the Medicare Physician Fee Schedule or the magnitude of routine coding, valuation and policy updates, with the result that relatively modest changes can trigger disproportionate, across-the-board payment adjustments. For infectious diseases physicians, this issue is especially important because across-the-board conversion factor reductions can occur even when the underlying policy change has little relationship to ID services themselves. Raising and indexing the threshold would better calibrate budget neutrality to the contemporary Medicare payment environment and reduce the likelihood that technical updates elsewhere in the fee schedule generate destabilizing consequences for specialties that are not the drivers of the change.

Section II — Budget Neutrality Corrections on Utilization

IDSA appreciates the inclusion of a mechanism to reconcile budget neutrality adjustments when CMS relies on estimated utilization that later proves inaccurate. A retrospective correction process would improve the accuracy of payment policy by

recognizing that projection errors can materially distort the conversion factor and can embed unwarranted reductions into future payment rates if they are left unaddressed. This reform is particularly relevant for infectious diseases and other specialties that may be affected by payment shifts resulting from assumptions about newly unbundled or separately payable services, even where actual utilization ultimately diverges from CMS estimates. By requiring CMS to compare estimated and actual utilization and to reconcile meaningful differences, the draft would introduce a more analytically sound approach to budget neutrality and help reduce the cumulative effects of forecast error on physician reimbursement.

Section III — Timely Updates to Direct Cost Inputs

IDSA supports the requirement that CMS update direct cost inputs on a regular, category-wide basis at least once every five years and do so in consultation with relevant stakeholders, including physician specialty societies. Timely updating of clinical labor, equipment, supplies and other direct cost assumptions is essential to maintaining the integrity of practice expense valuation, particularly in an environment where input costs can change materially over time. Regular and simultaneous updates across categories would also promote methodological consistency and reduce the risk that outdated assumptions persist in ways that distort payment relativity across specialties and practice settings. For infectious diseases physicians, accurate input valuation matters not only for individual services, but also for preserving confidence that Medicare payment policy reflects actual resource use rather than stale data or uneven update cycles.

IDSA also recommends that the bill be strengthened to exempt nonprocedural services from practice expense reductions that can result from methodology changes or other technical adjustments unrelated to the actual resources required to furnish those services. Because infectious diseases physicians primarily provide nonprocedural, cognitive services, such an exemption would help ensure that updates to direct cost inputs do not inadvertently exacerbate longstanding payment inequities for specialties that already face chronic under-reimbursement under the Medicare Physician Fee Schedule and that provide services akin to primary care in inpatient settings, including ID, hospital medicine and emergency medicine. **IDSA has developed legislative language to address these practice expense cuts and would welcome the opportunity to work with you to incorporate that approach into the discussion draft.**

Section IV — Limitation on Year-to-Year Variance

IDSA supports the proposal to limit year-to-year conversion factor variance associated with budget neutrality adjustments to 2.5%. Greater stability in the annual conversion factor is important because abrupt swings in physician payment make it more difficult for practices, hospitals and physician groups to plan staffing, invest in care delivery infrastructure and sustain access in specialties that already face workforce and reimbursement challenges. For infectious diseases physicians, who often practice in settings shaped by hospital contracting, consultative demand and public health needs, payment volatility can have effects that extend beyond individual physician compensation and influence the broader availability of specialty expertise. A reasonable limit on annual variance would not resolve all structural payment concerns, but it would introduce a more stable framework that is better suited to supporting continuity of care and longer-term practice planning.

Conclusion

IDSA appreciates the considerable work reflected in this discussion draft and your commitment to advancing a more stable, rational and clinically grounded Medicare physician payment system. Across Titles I through IV, the draft takes important steps to improve conversion factor updates, reform MIPS, strengthen pathways into alternative payment models and modernize budget neutrality policies that have too often produced misaligned and destabilizing payment outcomes for physicians. For infectious diseases physicians, these reforms matter not only from the standpoint of payment policy, but also because they affect the health system's capacity to support high-quality care for medically complex patients, respond to infectious threats and sustain access to specialty expertise across care settings. IDSA welcomes the opportunity to provide these comments and looks forward to continued engagement with you as the legislation is refined. Thank you for your leadership and for the opportunity to comment on this important proposal. Should you have any questions or wish to discuss these recommendations further, please contact Amanda Jezek, IDSA's senior vice president for public policy and government relations, at ajezek@idsociety.org.

Sincerely,

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