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October 9, 2023

The Honorable Michael Burgess, MD, Chair
The Honorable A. Drew Ferguson, D.M.D
The Honorable Buddy Carter, BSPharm
The Honorable Lloyd Smucker
The Honorable Blake Moore
The Honorable Rudy Yakym
Health Care Task Force
House Committee on the Budget Committee
U.S. House of Representatives

Dear Chair Burgess, Representatives Ferguson, Carter, Smucker, Moore and Yakym,

On behalf of the Infectious Diseases Society of America (IDSA), thank you for the opportunity to respond to the Task Force's request for information regarding ideas that will help reduce the cost of health care and improve quality. IDSA represents more than 12,000 infectious diseases physicians, scientists and other health care and public health professionals specializing in infectious diseases, including those in your states and districts. Our members care for patients with serious infections, including infections that are resistant to available antimicrobials, influenza, HIV/AIDS, tuberculosis, viral hepatitis, infections associated with opioid use and infections associated with cancer and transplantation. Our members are leaders in the readiness and responses to pandemics, outbreaks and emerging infectious diseases.

ID physicians bring value to our nation's health care system, delivering high-quality care that lowers health care costs and improves patient outcomes.[1] Similarly, antimicrobial drugs are essential to the provision of modern medicine. Unfortunately, shortages of ID physicians and a dearth of novel antimicrobials limit patients' ability to access care that would improve outcomes and lower costs.

We appreciate the opportunity to discuss these challenges and recommended solutions that will help to achieve a more cost-effective, high-quality system of care. **Specifically, IDSA recommends:**

- **Passage of the bipartisan PASTEUR Act (H.R. 2940) to deliver novel antimicrobials and guide optimal antimicrobial use, which will impact hospital lengths of stay and associated costs by enabling the availability of effective antibiotics to treat unmet needs and rapid cures.**

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[1] https://academic.oup.com/jid/article/216/suppl_5/S588/4160394

- **Investment in the ID workforce through improved reimbursement and targeted loan repayment, which will allow more patients to access ID physician care that has been found to improve outcomes and reduce hospital lengths of stay and health care costs.**

In response to the specific questions that you seek feedback on, we offer the following actions, which Congress could take to improve outcomes while lowering health care spending.

Efforts to Promote and Incorporate Innovation Into Medicare and Other Programs
ID physicians make significant contributions to patient care, biomedical research and public health. Their leadership and services save lives, prevent costly and debilitating diseases and drive biomedical innovation. **ID physician interventions are associated with significantly lower rates of mortality and 30-day readmission rates in hospitalized patients, shorter lengths of hospital stay, fewer intensive care unit days, and lower Medicare charges and payments.[2]**

Unfortunately, despite the demonstrated value of ID physicians, **nearly 80% of U.S. counties lack an ID physician.[3]** The U.S. is wholly unprepared to manage another large-scale outbreak – let alone multiple outbreaks – given the inadequate ID physician workforce. We lack the ID experts necessary to care for and prevent infections in the growing population of immunocompromised individuals, including patients with cancer, patients receiving organ transplants and patients taking biologics that impact the immune system. **Last year, only 56% of ID physician training programs filled, while most other specialties filled all or nearly all of their programs.[4] ID remains the fourth lowest paid medical specialty, below even general internal medicine despite an additional 2-3 years of training.[5] These factors threaten to further impair access to life and cost-saving ID care for a broad swath of Americans.**

This is due in large part to CMS' flawed payment policies that grossly devalue ID physician expertise and care are a significant contributing factor to the ID recruitment crisis. Inpatient evaluation and management (E/M) codes account for the majority of ID physician services, and these codes do not accurately reflect the value of the care provided.

IDSA proposes three ways that CMS and Congress can act to improve ID reimbursement and fill in the gaps in the ID workforce:

- Congress should establish an ID Incentive Payment Program to provide a temporary 10% payment increase for all services provided by an ID clinician. This proposal is modeled after similar approaches used previously for primary care and general surgery and would provide an urgently needed bridge to support ID recruitment immediately while longer-term payment models are established.
- Congress should urge CMS to increase the values of inpatient E/M codes to reinstate the historic relativity between inpatient and office/outpatient E/M RVUs, the latter of which received updates in 2021.

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[2] https://academic.oup.com/cid/article/58/1/22/372657
[3] https://www.acpjournals.org/doi/10.7326/m20-2684
[4] https://www.nrmp.org/wp-content/uploads/2023/04/2023-SMS-Results-and-Data-Book.pdf (page 61)
[5] https://www.medscape.com/slideshow/2023-compensation-overview-6016341?icd=login_success_email_match_norm#3

- Congress should urge CMS to convene an expert panel to review research and recommend 1) improved methodologies for reviewing E/M codes and 2) data-driven updates to E/M codes; such a panel would work with the American Medical Association RVS Update Committee to address the inability of current methodologies to accurately determine intensity and value of cognitive services.

CBO's Modeling Capabilities on Health Care Policies: Limitations or Improvements

IDSA believes that the Congressional Budget Office (CBO) is often limited in scoring cost savings from innovative health interventions that have an initial upfront cost but are likely to yield significant savings over time. One potential example is the bipartisan PASTEUR Act, which would expand the availability of novel antimicrobials to treat the most serious, life-threatening drug-resistant infections. Under PASTEUR, the federal government would enter into subscription agreements with innovators to pay for novel antimicrobials, rather than paying for the volume of antimicrobials used. This federal investment would spur private support to speed new antimicrobials to physicians, enabling better treatment and quicker hospital discharges, thus decreasing the high costs associated with lengthy hospital stays that are currently typical for individuals with multidrug-resistant infections.

Additionally, the bill includes resources for critical access and rural hospitals and long-term care facilities to establish or expand antimicrobial stewardship programs to guide the appropriate use of antibiotics, preserve the supply of these valuable products and further reduce costs associated with antimicrobial misuse.

When CBO reviews PASTEUR, it will be important to consider not only initial federal outlays, but also the cost savings associated with the availability and appropriate use of novel antimicrobials that PASTEUR will deliver. Congress could improve the ability of the CBO to consider the impact of novel antimicrobials on the long-term cost by advancing bipartisan legislation such as the Preventive Health Savings Act (H.R. 766).

Evidence-Based, Cost-Effective Preventive Health Measures or Interventions to Reduce Long-Term Health Costs

According to CDC, the rate of drug-resistant infections in the U.S. is skyrocketing, showing that U.S. antimicrobial-resistant infections and deaths in hospitals rose 15% in 2020. In the U.S., more than 2.8 million infections occur and at least 35,000 people die from antimicrobial-resistant infections each year, but the real burden is likely far greater. **National health care costs linked to infections from 6 of the 18 biggest antimicrobial resistance (AMR) threats are estimated to be more than $4.6 billion annually; $1.9 billion of these costs are estimated to be borne by Medicare.[6] The availability of novel antimicrobials would allow patients to be effectively treated and discharged from the hospital more quickly, significantly reducing health care costs.**

Combating AMR is central to preparedness, as resistant secondary infections complicate public health emergencies. As resistance spreads, antimicrobials lose their effectiveness, jeopardizing

[6] https://www.cdc.gov/drugresistance/solutions-initiative/stories/partnership-estimates-healthcare-cost.html

modern medicine. Advances including cancer chemotherapy, organ transplantation, surgeries such as hip and knee replacements and the use of certain biologics to treat an array of health conditions all carry serious infection risks and are made possible by the availability of safe and effective antimicrobials.

Antimicrobial development is not keeping pace with patient needs. There are fewer than 50 antibiotics in any stage of clinical development worldwide, and only a handful of them address the most urgent needs. Most large pharmaceutical companies are no longer doing antibiotic discovery and development, and the small biotech companies that have driven recent innovation struggle to stay afloat. Antibiotics are unique – they are typically used for a short duration and must be used judiciously to safeguard their effectiveness. These factors make it extremely difficult for developers to earn a return on investment in antibiotic innovation.

Additionally, antimicrobial stewardship is essential to guide the optimal use of antimicrobials and slow the development of resistance. Antimicrobial stewardship programs in health care facilities educate prescribers about optimal antimicrobial use and establish protocols to improve antimicrobial use. **Stewardship programs have demonstrated effectiveness at improving patient outcomes, reducing resistance and lowering health care costs.**[7] But many health care facilities do not have the resources necessary to adequately support antimicrobial stewardship, and additional resources are needed.

The magnitude of the AMR crisis requires an innovative approach to combating and staying ahead of drug-resistant superbugs. Passing the PASTEUR Act, as discussed above, is the single most important thing Congress can do now to address the growing AMR crisis. IDSA is deeply grateful that Rep. Ferguson is the lead sponsor of this important bill and that Reps. Burgess and Carter are co-sponsors. We recommend that the Task Force highlight PASTEUR as a priority for passage this Congress.

IDSA also urges a new approach to ensuring a fully staffed, robust ID workforce that can provide evidence-based care that improves patient outcomes and saves the health care system money. As mentioned at the beginning of our letter, the ID specialty is experiencing severe gaps in capacity. Fewer medical residents are choosing to become ID physicians due to high medical debt and low compensation relative to other medical specialties. An average medical student educational debt of more than $250,000 drives many physicians away from ID and toward more lucrative specialties. It is important to tackle this issue at both ends – ensuring ID physician reimbursement reflects the value of care provided and reducing the barrier that medical student debt poses to entering ID. Congress established the Bio-Preparedness Workforce Pilot Program as part of the Consolidated Appropriations Act, 2023, to incentivize more medical graduates to enter the ID specialty by providing loan repayment to ID health professionals working in health professional shortage and medically underserved areas. Prior to the establishment of the pilot, no federal programs offered loan repayment for providing ID care or conducting emergency preparedness activities in health care facilities. The pilot will help address urgent ID workforce shortages driven by a lack of financial incentives.

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[7] https://link.springer.com/article/10.1186/s13756-019-0471-0

This program will serve as a significant incentive to enter ID within the upcoming educational, training and recruitment processes and would ensure a more equitable distribution of ID experts across the country.

Funding this authorized program will be a strong first step toward ensuring we have the ID clinician expertise to provide patient care, protect public health and ensure readiness for future public health emergencies. IDSA is extremely grateful to Rep. Burgess for co-leading the effort to secure funding for this program. While we are disappointed that the FY24 House L-HHS appropriations bill was unable to include funding for the pilot, we look forward to working with you to secure this funding in the future.

Conclusion

IDSA appreciates the opportunity to respond to the Task Force's request for information, and we appreciate your consideration of our comments. Please let us know how we can be helpful to you and do not hesitate to reach out to Amanda Jezek, Senior Vice President for Public Policy and Government Affairs, at ajezek@idsociety.org should you have any questions or need additional information.

Sincerely,

Carlos del Rio, MD, FIDSA
President, IDSA