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June 27th, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: 42 CFR Parts 414 and 495, Medicare Program; Merit Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule

Submitted Electronically via Regulations.gov

Dear Mr. Slavitt:

The Infectious Diseases Society of America (IDSAs) appreciates the opportunity to provide comments on the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive as proposed under the Physician Fee Schedule (PFS). IDSAs represents more than 10,000 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, HIV/AIDS, serious health care acquired infections, antibiotic resistant bacterial infections, as well as emerging infections such as Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus diseases.

IDSAs members are committed to improving the quality and safety of patient care in hospitals and health systems across the nation. A significant portion of our members in clinical practice are hospital-based, and many lead the "on-the-ground" efforts to combat healthcare associated infections and antimicrobial resistance. The specialty of infectious diseases is unique in that it is the only specialty whose training emphasizes the linkage between individual patient care and the impact on the larger patient population. This "bedside-to-population" system-based awareness is what distinguishes the critical role of the ID physician within the healthcare system, especially as it applies to quality improvement that is related to healthcare associated infections and antimicrobial stewardship.

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It is with this perspective that we offer our comments on the proposed rule related to MIPS and APMs.

Impact of the Quality Payment Program (QPP) on the Specialty of Infectious Diseases:

IDSA is optimistic with some of the proposals outlined in the MIPS and APM proposed rule. We are hopeful that the new Quality Payment Program (QPP), which incorporates both the MIPS and APM options, can evolve to offer some improvement over the other quality programs that it will replace (PQRS, EHR, and VB modifier). However, we remain concerned that the MIPS program is really just an amalgamation of the previous stand-alone programs now imperfectly combined under one label with a composite scoring methodology. Furthermore, whereas we commend CMS for offering real incentives under the APM option, it appears that these incentives will only be realized by larger physician groups, leaving physicians in small to mid-sized practices confined to the MIPS program. We believe that the QPP, if implemented as proposed, will be complex and increase the administrative burden on physicians. As such we have provided alternatives that we hope will ease this burden and allow infectious diseases physicians to obtain proficiency in the program.

The implementation of the new QPP will have a profound impact on ID physicians. CMS estimates that approximately 5,544 ID physicians will be participating in the MIPS program. Approximately 43% (2,300) of those physicians will experience a negative payment adjustment, equaling a \$12 million loss in Medicare allowed charges across the specialty.¹ Given this projection, IDSA seeks to mitigate that loss and improve ID physician participation by proposing what we believe to be viable options within the current MIPS program. It is our hope that under the improved QPP, ID physicians will have a greater opportunity for participation and will have more meaningful and appropriate opportunities to show high quality care across the specialty of infectious diseases.

Quality Measurement Under MIPS:

Since the implementation of the Physician Quality Reporting System (PQRS), the percent of ID specialists participating in PQRS has been slowly increasing from 18% in 2011 to 66% in 2014, as indicated in the recent PQRS 2014 Reporting Experience, (CMS, April 2016). Despite this gradual increase in participation, our members continue to have very few meaningful reportable measures available to the specialty of infectious diseases. Current PQRS measures are not well-aligned with infectious disease practices. This is due in part to the overwhelming proportion of clinical services being delivered in the inpatient setting while most of the PQRS measures developed apply to face-to-face encounters in the outpatient setting. Aside from HIV and HCV, there are no truly ID-specific measures on which ID specialists can report. Based on CMS' 2014

¹ Federal Register, Vol. 81, No. 89, page 28373

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PQRS experience report, the five most frequently reported individual measures by ID specialists are as follows:

#130 – Documentation of Current Medications in the Medical Record

#226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

#128 – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up

#111 – Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older

#110 – Preventive Care and Screening: Influenza Immunization

These measures are not directly applicable to ID specialty practice, yet our members report them only to avoid financial penalties due to a lack of other options. IDSA continues to propose relevant and meaningful ID measures for CMS to consider within the QPP. For example, we are pleased that CMS is proposing to retain measure #407: Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia set as a high priority measure in the MIPS quality performance category. Earlier this year, we submitted two additional measure concepts (Appropriate Use of anti-MRSA Antibiotics and 72-hour Review of Antibiotic Therapy for Sepsis) into the CMS Measures Under Consideration (MUC) process, both related to advancing quality measurement of antimicrobial stewardship at the physician-level. We look forward to further discussions with CMS to advance these into inclusion with the list of applicable measures under the quality component of MIPS.

IDSA supports CMS' proposal to have MIPS eligible clinicians report only six measures, as this is a lower threshold than the current PQRS, which requires that an eligible clinician or group report on at least nine measures covering three NQS domains. IDSA also supports CMS's decision to remove the NQS domain requirement and instead use these domains as a guide for selecting measures and to guide measuring national quality goals.

Hospital-Based Physicians:

Section 1848(q)(2)(C)(ii) of the Act allows for physicians to report quality measures that are used in other payment systems, such as those measures used for inpatient hospital reporting. As we have stated in [past comment letters](#) and in ongoing meetings with CMS, the majority of ID physicians practice in the inpatient setting. Therefore, IDSA has advocated for letting hospital-based physicians have the option to choose whether they would like to use hospital performance measures under Medicare quality incentive programs. We are pleased to see this option incorporated into the new Quality Payment Program, and look forward to working with CMS as this reporting option is incorporated into the MIPS program. We understand that CMS has not proposed any specific options at this time; however, IDSA would like CMS to note that IDSA supports this provision as long as the physician maintains the autonomy to choose whether or not to be held accountable for facility-level measures and performance.

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There exists a subset of measures within the Inpatient Quality Reporting (IQR) program (e.g. CLABSI, CAUTI, *C. difficile*, MRSA) that pertains to the clinical practice of infectious diseases as well as the work done within Infection Control & Prevention Programs and Antimicrobial Stewardship Programs. For some of our members, linking their quality performance to the performance of their facility on these measures could prove reasonable and beneficial to the physician as well as the facilities and patients by aligning quality objectives. We look forward to continued discussions with CMS on this matter.

Development and Implementation of Quality Measures:

Section 1848(q)(2)(D)(viii) of the Act provides that the pre-rulemaking process under section 1890A of the Act (requiring recommendations from NQF's Measure Application Partnership's (MAP)) is not required to apply to the selection of MIPS quality measures. We support the elimination of this requirement, as we believe this could potentially speed the process for implementing measures into the MIPS. We note that the development of quality measures has traditionally been a long and time-consuming process, and we support any change that could streamline the process to bring new measures into the MIPS.

In addition, we note that the MACRA provides CMS with additional funding for measure development. We believe the lack of relevant ID measures within the MIPS is partly due to the time and cost of measure development, and we believe the additional funding from the MACRA offers an invaluable opportunity for CMS to assist in the development of measures where gaps exist. To that end, we request that CMS consider using part of this funding towards the development of ID measures.

Submission Mechanisms:

IDSA supports CMS' proposal to retain the reporting mechanisms currently available in the PQRS, particularly the QCDR and claims-based reporting mechanisms. In general, IDSA supports offering physicians the widest range of reporting mechanisms in order to alleviate reporting burden. However, we oppose CMS' proposal to only allow use of one submission mechanism per category. We note that there may be a need for a clinician to report independent measures through multiple reporting mechanisms. For example, an eligible clinician might identify a handful of clinically relevant e-specified measures that can be reported through an EHR, but also might identify a few other relevant measures that are not yet e-specified and can only be reported through a registry or via claims. If not enough e-specified measures exist that are relevant to an eligible clinician's practice, the eligible clinician should be able to report on a combination of e-specified measures and non e-specified measures, particularly since reporting on e-specified measures will allow the eligible clinician to earn bonus points under the quality performance category. As well, we note that there are certain measures that are only able to be reported via registry (i.e. the HCV measures) and ask that CMS consider not restricting measures to only one reporting option.

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We stress that NQS domains should continue to be used only as a guide for choosing quality measures and not used as part of a reporting requirement. We also note that measures may sometimes be classified under multiple NQS domains, leading to the complexity of using NQS domains to base part of a reporting requirement.

Reporting on Outcomes and High Priority Measures:

IDSA opposes the requirement to report on outcome and high priority measures. While we believe in the importance of collecting data based on these measures, the availability of these measures is highly dependent on the nature of a clinician's practice, so the clinician or group should be free to determine which measures they report. While we recognize that outcome measures will more meaningfully reflect the quality of care provided to patients, flexibility needs to be in place to ensure specialties that still do not have access to outcome measures data are not unfairly penalized. The availability of outcome measures is dependent on many things including the depth of the medical literature on specific diseases and conditions. Availability of these measures is beyond the control of the average eligible clinician. Outcomes measures at the physician level can also be particularly challenging to construct for two primary reasons— small sample sizes and the difficulty of identifying outcomes for which the physician can and should be held accountable.

Moreover, we reiterate our concern for the application of these requirements to report on measures that have not been vetted in terms of appropriate risk adjustment. As we have stated in previous comment letters, we request CMS push for the appropriate application of sociodemographic status (SDS) adjustments to quality measures. A large body of evidence demonstrates that SDS factors such as income and insurance status affect many patient outcomes, including readmissions and costs. For purposes of accountability (e.g., public reporting, pay-for-performance), SDS factors should be included in risk adjustment of the performance score as soon as possible. Failing to adjust measures for these factors can lead to substantial unintended consequences, including harm to patients and heightened health care disparities by diverting resources away from providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to worse outcomes.

Data Completeness Threshold:

IDSA opposes CMS' proposed thresholds for data completeness, requiring that a MIPS eligible clinician or group would be required to report quality measures data on at least 80% of its Medicare Part B patients (if using the claims-based submission mechanism) or, 90% of all patients (if using a qualified registry, QCDR, or EHR submission mechanism). This is a significantly higher bar than the 50% data completeness threshold that is currently required under the PQRS. IDSA is concerned this threshold may cause a large number of ID clinicians to

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fail the reporting requirements under the quality performance category. We also believe that 50% provides an adequate sample of quality measures data.

With respect to proposing an 80% data completeness threshold for the qualified claims-based submission mechanism, we note that this is a significant departure from what is currently required for claims under the PQRS, as CMS has maintained a data completeness threshold of 50%. We are concerned that this proposal will result in a significantly increased burden for clinicians, diverting resources away from patient care. Unlike the other data submission mechanisms, the clinician is responsible for entering QDCs onto the claim form for each reported patient. There are no third party intermediaries that perform this task for these clinicians.

With respect to proposing a 90% threshold for the qualified registry submission mechanism, IDSA notes that, in the past, CMS required that an EP report measures data for at least 80% of his/her patients using the qualified registry option in PQRS. However, we note that the proposed 90% threshold is higher and would require registries to report on ALL patients, not just Medicare patients, which is currently the requirement under the PQRS.

We also note that when CMS had finalized increasing the number of measures that would be reported in PQRS from three to nine in the 2014 PFS final rule (78 FR 74459-74461), CMS lowered the reporting threshold for data completeness to 50% of patients to compensate for the increase in the reporting threshold. While CMS is proposing to lower the number of measures required to be reported under the MIPS from nine to six measures, we note that the reporting burden is still significantly higher than when the 80% threshold was used for PQRS.

IDSA is particularly concerned with CMS's proposal to require that clinicians and groups using the QCDR option to report on 90% of ALL their patients. CMS has consistently maintained a data completeness threshold of 50% for QCDRs, so an increase of the data completeness threshold by almost twofold was not foreseeable. The QCDR option is still a relatively new option under the PQRS. In fact, there are approximately 18 new QCDRs on the 2016 PQRS QCDR list (50 QCDRs in 2015 vs. 68 QCDRs in 2016). Both existing and new QCDRs will find the 90% reporting threshold difficult to obtain in addition to other requirements and aspects that CMS intends the QCDR to be able to handle either starting in 2017 or in future years. For example, in addition to being able to submit data on quality measures for the quality performance category, CMS is also requesting, if feasible, that a QCDR be able to submit data for the ACI and CPIA performance categories.

Should CMS maintain a percentage-based threshold, IDSA recommends keeping the 50% performance threshold for eligible clinicians and groups reporting quality data via claims, qualified registry, QCDR, and EHRs. As an alternative, IDSA requests that CMS consider an alternative to a percentage-based threshold, such as requiring a MIPS eligible clinician or group to report data on a consecutive number of patients, similar to what has been required for groups

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using the CMS web interface. We believe reporting on a consecutive number of patients eliminates the possibility of gaming, as an eligible clinician would not be able to skip patients. It also eliminates the stress for eligible clinicians to begin reporting at the very start of the performance period for fear that the clinician would not be able to meet the required data threshold otherwise.

For example, similar to what is required for measures groups under the PQRS, CMS could establish a data threshold of 20 consecutive patients. Therefore, an individual MIPS eligible clinician (or each eligible clinician in a group for groups of 2-24 eligible clinicians) would report a measure for at least 20 consecutive patients during the performance period if reporting via claims, qualified registry, QCDR, or EHR. For groups of 25 or more, CMS could establish a threshold similar to what is proposed for the CMS web interface.

Request for Clarification:

IDSA seeks clarification as to how the quality measurement component under MIPS would be scored if a MIPS eligible clinician or group fails to report measures data for the required 80% or 90% threshold. For example, how would a MIPS eligible clinician be scored if the clinician only reports quality measures for 50% of their patients using a qualified registry? CMS proposes not to count measures with a zero percent performance rate, but it is unclear how a MIPS eligible clinician would be scored if he/she reports on less than 80% or 90% of his/her patients. IDSA requests that CMS provide clarification for this scenario in the final rule.

Specialty-Specific Measures:

IDSA supports CMS' proposal to allow the reporting of specialty-specific measure sets to meet the submission criteria for the quality performance category, even if it would mean an eligible clinician or group would report on fewer than six measures. We believe this is critical in order not to disadvantage eligible clinicians and groups for which few applicable measures would exist under MIPS.

QCDRs:

In general, we note the potential heavy burden CMS is proposing to place on QCDRs as the MIPS is implemented – e.g., updating their systems to account for new criteria under the quality performance category, allowing for the ability to submit data for the ACI and CPIA performance categories, and requiring the QCDRs to provide feedback reports to its users at least six times a year. We request that CMS exercise caution when making such significant changes and consider a more gradual approach to changing requirements for QCDRs. As a specialty that is carefully assessing the feasibility of establishing a QCDR, we view such proposed changes as posing additional challenges towards that end.

Clinical Practice Improvement Activities (CPIAs) under MIPS:

It is within this component of the MIPS where we believe ID physicians will have the most impact and will be able to participate in a meaningful way within the QPP. CMS proposes a total of 94 CPIAs, and only 11 of the proposed CPIAs are classified as “high-weight.” We support CMS developing a broad range of CPIAs, specifically more high-weight CPIAs, and reiterate our previous comments outlined in the MACRA RFI that the choice of activities should be optional and choices within established subcategories should not be mandatory (i.e. there is no requirement to choose a CIA within each subcategory). We also believe that for physicians to demonstrate performance of a CIA that attestation be required one time, on an annual basis.

We also ask CMS to consider that if a physician performs in the leadership role of a CIA, then the CIA should be considered “high weight” whereas simple attestation of participating in a CIA should be considered “medium weight” activity. Whereas CMS has proposed that a 90-day performance period would be required for CPIAs, IDSA asks that CMS consider allowing that no specific time periods apply to the performance of CPIAs. Many of the proposed CPIAs are ongoing activities which are not limited by a performance period per se. For example, if a physician chooses to attest on the CIA of “Expanded Practice Access,” he or she would not expand the access to the practice to a finite number of days just to meet the CIA performance period. Additionally, implementation and leadership of an antimicrobial stewardship program is not an activity that would be performed for only a 90 day time period, but would be an ongoing activity. IDSA believes that not requiring a specified performance period for CPIAs would simplify the reporting and be more appropriately aligned with the nature of these activities.

In addition, IDSA suggests that CMS lower the reporting threshold for CPIAs. According to the proposed rule, physicians will have to report up to six CIA activities which may become overly burdensome; therefore IDSA suggests that CMS lower this threshold, perhaps reporting on a maximum of three CPIAs (or 30 points) as opposed to six (or 60 points) such that the administrative burden is lessened, allowing more attention to be given towards the most relevant activities in order to have a more meaningful and sustained quality impact.

Antimicrobial Stewardship Programs (ASPs) as a CIA:

We are pleased that CMS is proposing the following activity under the Patient Safety and Practice Assessment subcategory:

- Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics

We recommend, however, that CMS finalize a high-weighted option for this activity depending on whether a physician has taken a leadership role in the activity. **Specifically, we request that**

CMS finalize a high-weighted activity under the Patient Safety and Practice Assessment subcategory for leadership in implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to published clinical guidelines for diagnostics and therapeutics. If the physician cannot attest to participating in a leadership role of the ASP and is merely attesting to participation in the ASP, then the weight of the CPIA should remain a medium as currently proposed.

The current Administration has noted the importance of combating antimicrobial resistance by releasing a National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB). This action plan highlights the growing need and urgency to combat antimicrobial resistance. The Centers for Disease Control and Infection estimates that every year in the United States, more than two million illnesses and 23,000 deaths are caused by drug-resistance bacteria.² One of the primary goals of the President's initiative to fight antibiotic-resistance is to establish ASPs in all acute care hospitals and improved antimicrobial stewardship within all healthcare settings.³ Finally, we note the Action Plan has set a goal that within three years, all hospitals that wish to participate in the Medicare and Medicaid programs will have to comply with Conditions of Participation which will "advance compliance with recommendations in CDC's Core Elements of Hospital Antibiotic Stewardship Programs".⁴

Recently, CMS issued its NPRM related to the Medicare Program's Conditions of Participation (CoP) where it is proposing that all acute care and critical access hospitals (CAHs) have formalized antimicrobial stewardship programs. On the assumption that this proposed rule will be finalized in such a way that ASPs become mandated, there will be much needed activity to establish and enhance ASPs, not only in acute care and critical access hospitals but also in long-term care facilities. Given that The Joint Commission's [Prepublication Standards for Antimicrobial Stewardship](#) specifically cites the involvement of an infectious diseases physician in ASPs, we anticipate that many ID physicians will take leadership roles in these efforts and therefore **encourage CMS to make the leadership of an ASP a high-weight activity within the CPIA component of the QPP in order to highlight the pressing need for these programs and to support the National Action Plan for Combating Antibiotic-Resistant Bacteria.**

Emergency Response and Preparedness as a CPIA:

IDSA is pleased that CMS has included activities of emergency response and preparedness in the CPIA list. However, we strongly believe preparedness should go beyond volunteering for domestic and international humanitarian work and emergency response and disaster assistance. **IDSA recommends that CMS also allow for other CPIAs that encompass the development, implementation, and leadership of bio-preparedness programs that will provide system-**

² The White House, *National Action Plan for Combating Antibiotic-Resistance Bacteria*, March, 2015, page 5.

³ *Ibid*, page. 12.

⁴ *Ibid*, page. 13.

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level responses for outbreaks such as Ebola and Zika. Recently, the CDC has requested information from stakeholders regarding the *Monitoring and Coordinating Personal Protective Equipment (PPE) in Healthcare to Enhance Domestic Preparedness for Ebola Response*. We recommend that CMS finalize two CPIAs related to leadership and participation in this program:

- High-weighted activity: Leadership in the CDC’s Monitoring and Coordinating Personal Protective Equipment (PPE) in Healthcare to Enhance Domestic Preparedness for Ebola Response project
- Medium-weighted activity: Participation in the CDC’s Monitoring and Coordinating Personal Protective Equipment (PPE) in Healthcare to Enhance Domestic Preparedness for Ebola Response project

We believe that this CPIA should reflect a much broader scope than just Ebola virus disease. We recommend that CMS add additional activities related to preparedness for serious, highly infectious diseases that have significant morbidity, mortality, and/or transmissibility. Finally, as we have mentioned throughout, IDSA believes that CPIAs that involve leadership and implementation should be weighted as high and simple attestation to participation in a CPIA should be weighted medium.

Telehealth Services as a CPIA:

IDSA is pleased with the proposals that CMS has put forth regarding the provision of telehealth services. We support the inclusion of CPIAs that use telehealth as a means of providing population management activities. We also support the inclusion of the use of telehealth technologies under the Expanded Practice Access CPIA as IDSA believes telehealth is one option by which a practice will be able to provide expanded hours to patients. IDSA has long been a proponent of the use of telehealth technologies to provide care as appropriate to those who are geographically challenged. In addition, IDSA supports the use of telehealth technologies to consult with other physicians regarding the care of patients, or to provide antimicrobial stewardship programs (“tele-stewardship) with the expertise that ID physicians can provide. Finally, recognizing that ID specialists are not physically present in all health care facilities, tele-stewardship is a model that may be used to achieve ASP implementation especially in critical access hospitals, long-term care, and sub-acute care facilities. IDSA suggests that CMS consider the activity relating to establishing and leading a tele-stewardship program count as two CPIAs, to reflect recognition of the separate activity of adapting telehealth services and leading ASP. We look forward to working with CMS on expanding these concepts.

CME as a CPIA:

IDSA requests that CMS explicitly recognize selected qualifying CME as a “medium-weight” clinical practice improvement activity within the Merit-Based Incentive Payment System (MIPS). CME has been long recognized as an effective means by which physicians demonstrate engagement in continued professional development and it is critical for the early development,

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implementation and enhancement of the individual physician within health care system based quality improvement. IDSA is an ACCME-accredited provider with over 8,000 members in the practice of Infectious Diseases, many of them hospital-based and actively participating in healthcare system quality and performance improvement. The IDSA is well positioned to provide CME activities that teach the principles of quality improvement and support physicians attempting to decrease the role of infection in patient morbidity and mortality, in addition to hospital costs. IDSA's accredited CME programs, which focus on infectious disease issues on a national level, play a significant role in improving the competence of infectious diseases physicians in implementing performance and practice changes. IDSA also takes the lead in the development of clinical practice guidelines for infections. These guidelines are integrated into IDSA's and other professional CME activities and influence clinical practice improvement.

Future Development of CPIAs:

IDSA commends CMS for its call for comments on future development and inclusion of CPIAs within this portion of the MIPS. ID physicians perform a broad range of activities that we believe could be incorporated into the CPIA list. By providing a broader range of CPIAs, CMS stands a better chance of having even greater participation in the program. More specifically, IDSA would like to recommend the following CPIA concepts for consideration.

- **Development, implementation, and oversight of infection prevention programs in acute care or long-term care facilities. Many of our members currently hold medical directorships of infection control at acute care facilities. In this role, they lead efforts to promote hand hygiene and manage and prevent transmission of multi-drug resistant organisms.**
- **Development, implementation and oversight of infectious diseases protocols that apply to solid organ transplant (SOT) procedures at facilities with SOT programs, typically academic medical centers.**
- **Development, implementation and oversight of infectious disease protocols that apply to stem cell transplant procedures at facilities with stem cell transplant programs**
- **Implementation or on-going leadership of a hospital-avoidance and timely discharge (HATD) program enabled through outpatient parenteral antibiotic therapy (OPAT). Under this CPIA, the ID physician would oversee a HATD team that would include a pharmacist, infusion nurse, and home health representative in order to enable the patient to safely complete their antibiotic course of therapy in the outpatient/home setting. In addition to overseeing the entire team, the ID physician may also be the treating physician or the consultant physician for OPAT treatment.**
- **Development, implementation, and oversight of system-level bio-preparedness protocols and other bio-preparedness activities. This CPIA would focus on activities**

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that are directed toward system-wide, all hazard preparedness for public health emergencies, which would include coordination at the local level.

- **Leadership of activities related to hospital/health system engagement with local public health entities (such as assisting with an outbreak response or healthcare worker immunization programs).**

We believe the activities described above fall under the definition of a CPIA within the MACRA legislation as an activity that will improve clinical practice or care delivery and when effectively executed, are likely to result in improved outcomes. **When CMS issues a call for additional CPIA activities, IDSA will provide more detailed comments and concepts regarding the development of these CPIA and others we have mentioned.**

Virtual Groups:

IDSA supports the use of virtual groups, and is optimistic for the development of this concept. Below, IDSA reiterates our comments on the creation of virtual groups and we look forward to working with the Agency in the coming years to assist with the development and implementation of virtual groups.

The virtual group concept could be of high value to ID physicians as they currently have few opportunities to demonstrate their unique contributions to high quality, high value care. **We urge CMS not to limit the number or size of a virtual group, not to adopt prescriptive geographic standards, -and not to limit the reporting mechanisms that might be available to virtual groups. We support the development of virtual groups that will give smaller, independent practices more negotiating power, along with a greater influence over more comprehensive care decisions that larger groups practices and health system have.** We also believe the ever-increasing health care system consolidation does not allow for CMS to assess the performance of individual practitioners practicing in larger multi-specialty groups. The formation of a virtual group might allow for physicians working in larger healthcare systems to report on appropriate quality measures and be held accountable for care that is attributable to them. **IDSA suggests that CMS hold a listening session to convene specialties and other interested parties to determine how best to establish the virtual group option in the MIPS.**

Quality Performance Period:

IDSA opposes the proposed performance period of January 1, 2017 to December 31, 2017 for the 2019 MIPS payment adjustment, particularly for the first year of MIPS. The breadth of the MIPS program is large, and given the publication of the final MACRA rule expected in November 2016, it will be difficult for us to adequately educate our members in time for the start of the proposed performance period for the 2019 MIPS payment adjustment. **IDSA requests that CMS shorten the performance period for the 2019 MIPS payment adjustment to be the last six months of 2017 (that is, July 1, 2017 through December 31, 2017).** We note that there is past precedent for establishing a shortened performance period. When the Physician

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Quality Reporting Initiative (PQRI) was first established, the first reporting period for the PQRI was a shortened 6-month period from July 1, 2007 through December 31, 2007. We believe a shortened period is necessary in this situation.

General Comments regarding Alternative Payment Models (APMs):

IDSA is concerned with the limited number of APMs that CMS is proposing to be defined as Advanced APMs. With only six current APMs proposed as Advanced APMs, many physicians will find it difficult, if not impossible, to transition to the APM side of the QPP. IDSA is also concerned that our physicians, who are solo practitioners or are a part of small physician practices, in that these physicians will have little opportunity to become part of an APM. We urge CMS to keep these practitioners in mind when developing policies regarding APM participation. We look forward to working with CMS in this regard and are willing to provide input as needed. **We suggest that CMS hold a listening session with all relative stakeholders to describe the activities that physicians need to pursue in order to become part of an APM in the future.**

IDSA appreciates the efforts of CMS to promote improved patient safety and better quality of care as set forth in this proposed rule for MIPS and APMs. We look forward to further engagement with CMS and other stakeholders as we transition to the QPP. If you have any questions, please feel free to contact Andrés Rodríguez, Director for Practice & Payment Policy, at 703-299-5146 or arodriguez@idsociety.org.

Respectfully,



Johan S. Bakken, MD, PhD, FIDSA
President