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Attention: CMS-1693-P
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September 10, 2018

Submitted electronically via <http://www.regulations.gov>

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P)

Dear Administrator Verma:

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the Proposed Rule for the 2019 Physician Fee Schedule. IDSA represents more than 11,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education, and research in infectious diseases. Our members care for patients of all ages with serious infections, treating meningitis, pneumonia, tuberculosis, HIV/AIDS, health care-associated infections, antibiotic resistant bacterial infections, as well as emerging infections such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus diseases.

IDSA members are committed to improving the quality and the safety of patient care in all healthcare settings and in 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 routinely emphasizes the linkage between individual patient care and the impact on the larger patient population. It is with this background that we provide our comments on the proposals for the 2019 Medicare Physician Fee Schedule (MPFS) and the Quality Payment Program (QPP).

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Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services:

After a review of the statutory specifications that define when and how Medicare can pay for “telehealth” services, the Agency has taken a thoughtful approach to mitigate these concerns while recognizing physician services can be delivered via “remote communication technology.” In so doing, the Agency proposes to pay for services that are “routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.”

IDSA values the use of telehealth and telemedicine in extending infectious diseases expertise to patients in both rural and urban settings as well as within underserved populations. To promote the adoption of telehealth technology within the clinical practice of infectious diseases, IDSA has been conducting a pilot project that uses a telemedicine platform to connect long-term care facilities with ID physicians who then provide antimicrobial stewardship training and guidance to the facility’s staff. As we see great potential for the use of telehealth technology, IDSA is pleased to see that CMS has been thinking creatively about approaches to increase the use of communication technology within the healthcare system. We appreciate the regulatory limitations that CMS must overcome in creating these novel concepts and look forward to working with the Agency to promote the use of telehealth, telemedicine and other technologies for use in treating Medicare beneficiaries.

Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCII):

To promote the recognition of communication technology in the care of patients, CMS proposes the creation of a “Virtual Check-in” code. This code could be billed when a physician or other health care professional “has a brief non-face-to-face check-in with a patient via communication technology to assess whether the patient’s condition necessitates an office visit” and when it does not result in a follow-up visit. CMS proposes that this “triage-like” activity code could not be billed if the patient had an office visit within the previous 7 days, as it is assumed that the service is considered bundled in the office visit.

IDSA supports the creation of this virtual check-in code because it demonstrates the Agency’s continued recognition of non-face-to-face patient care that ID physicians provide when caring for complex patients with infections. IDSA had supported past efforts by the Agency to recognize non-face-to-face patient care when the Transitional Care Management (TCM) Services code and the Chronic Care Management (CCM) Services code were recognized by CMS. IDSA believes the virtual check-ins apply to the care of infectious diseases patients as often patients who are receiving outpatient parenteral antibiotic therapy (OPAT), or who have just started HIV treatment therapy may need to follow-up with an ID physician on a matter that is suitable to be addressed employing communication technology. However, we are concerned about the 7-day time constraint may limit the appropriate use of the code. that has been proposed because we feel many patients may need a quick check-in within that timeframe but may not need to schedule a visit. For example, within a few days of starting anew treatment regimen a patient may have a question about a side effect which can be answered virtually, negating the need for

an office visit. We ask that the Agency consider a 3-day timeframe instead. If CMS chooses to expand the codes to allow for diagnosis and treatment using communication technology as well as triage, there would be a greater value to patients and their providers if the proposed codes could be used for follow-up care at a minimum.

Remote Evaluation of Pre-Recorded Patient Information (HCPCS code GRAS1):

CMS indicates that the Agency has received requests for separate payments for physician use of recorded video and/or images captured by a patient to evaluate a patient's condition. By distinguishing "remote communication technology" as distinct from "telehealth services," the Agency is then able to propose a specific code (GRAS1) that describes remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology. CMS clarifies that the work described by this proposed code could not originate from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. The Agency seeks comment on the use of this code for only established patients or the use of this code for certain services where it might be appropriate for new patients.

As with the virtual check-in code, IDSA believes that a code that describes the evaluation of pre-recorded patient information could be applicable to the care of established patients with infectious diseases. Evaluation of rash or a visual assessment of a vascular access device could be evaluated remotely. However, as with the virtual check-in code, we believe that the proposed time limits applied to this code should be changed from 7 days to 3 days.

Interprofessional Internet Consultations:

CMS is proposing the addition of six codes the MPFS for "interprofessional consultations" that involve telephone/internet usage and may result in verbal and written reports to the requesting physician, for various ranges in time. Specifically, these codes describe assessment and management services conducted through telephone, internet, or electronic health record consultations. Furnished when a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician or qualified healthcare professional with specific specialty expertise without the need for the patient's face-to-face contact with the consulting physician or qualified healthcare professional. Five of the codes are used to indicate work of the consultative physician and one of the codes is used to report the work of the referring physician or another qualified provider.

We envision the use of these codes to be concentrated in integrated health systems where providers (both treating/requesting and consultative) have unencumbered access to the patient's electronic health record to enable an informed discussion that could mitigate potential liability to the consultative physician that provides these types of services. Currently, it is common for ID physicians to be spontaneously engaged by other physicians in an informal manner related to the care of a patient with which the ID physicians do not have an established relationship. These encounters may range from a situation where specific clinical questions may be posed (e.g. related to appropriate antimicrobial selection) to instances where a few symptomatic details are provided, and the ID physician is asked to suggest possible diagnostic courses of action. It is

important to note are that these encounters occur (1) often, (2) are driven by the recognition of an ID physician's unique clinical expertise, and (3) are currently non-reimbursable services. Given this reality, IDSA supports the Agency's proposal to introduce these codes as the codes would allow for a mechanism to capture the contributions of care to a patient that ID physicians as well as other cognitive specialists provide daily. As written, the proposed rule mentions that the interprofessional internet consultations describe "services conducted through telephone, internet, or electronic health record consultations." IDSA urges CMS to include secure messaging platforms in its definition of internet communication, since some providers may face interoperability barriers when attempting to communicate via messaging systems embedded in electronic health record platforms.

Evaluation & Management (E/M) Visits

IDSA previously submitted comments in response to the specific proposals contained in the rule related to outpatient evaluation and management services, (IDSA Comments – Regulations.gov Document ID: CMS-2018-0076-0621).¹ We reiterate our appreciation of the Agency's efforts to alleviate physicians of the administrative burden related to documentation requirements for outpatient E/M visits. However, the proposed payment policy associated with the changes to outpatient E/M codes for new and existing patients are of great concern to us and, therefore, we again ask that CMS postpone the implementation timeline of this payment policy as indicated in the proposed rule to work with the physician community to explore better alternatives.

We arrived at this position after a careful financial analysis of the proposed blended payment rates for new and established E/M patient visits specifically focused on ID physicians, conducted by The Moran Company (TMC). Using the 2016 Medicare Physician and Other Supplier Public Use File (PUF), the 2018 RVU File (Q4) and the 2019 Proposed Physician Fee Schedule Addendum B, TMC was able to derive an impact of the blended E/M payment rate to the specialty of ID overall as well as assess the impact at the individual's NPI level. Our analysis finds that the proposal would result in significant financial losses to ID physicians who typically report level 4 and level 5 E/M codes because of the complexity of cases ID physicians treat daily. Whereas CMS indicates in the proposed rule that the impact of the proposed changes would result in a modest increase in overall payments to the specialty of infectious diseases, our analysis of the data indicates the impact to be -5.1% of total payments for ID physicians who see patients in the office setting. In a separate analysis conducted by the AMA, the estimated financial impact on ID of the CMS proposed E/M changes and including the impact of the MPPR proposal is -9%.²

Upon further reflection of the financial impact and with a broader perspective of the challenges that the specialty of infectious diseases already faces, we are compelled to emphatically re-state

¹ IDSA Comments on CY2019 Proposed Rule – Outpatient E/M changes - <https://www.regulations.gov/document?D=CMS-2018-0076-6937>

² American Medical Association. Estimated Impact of CY2019 Evaluation and Management Proposed Policy by Medicare Specialty. Analysis uses Estimated CY2017 Medicare Utilization and CY2019 Medicare CF for both "Current Method" and "Proposed Method"; E/M MPPR Estimate based on 2016 Medicare Carrier 5% Standard Analytic File. August 2018.

our concern for the proposed changes that CMS has put forth. Below we provide a few facts that characterize the current state of ID:

- ID consistently ranks in the bottom quartile of annually published physician compensation survey reports.^{3,4,5}
- Previous to 2016, the specialty of infectious diseases had seen a continual decline in the number of applicants to ID fellowship programs, where the number of applicants dipped below the number of positions available for several consecutive years.⁶ In 2017, IDSA launched several activities to promote the specialty of infectious diseases primarily through mentorship of residents who showed interest, increasing applications, yet still below the number of positions available.
- IDSA supported research into this trend and identified that compensation was a significant driver of specialty selection among internal medicine residents.⁷
- There are numerous studies, some supported through IDSA, which prove the value that ID physicians provide when involved in the care of patients with severe infections, as compared to patients with severe infections whose care does not involve an ID physician.^{8,9,10,11,12,13} This “value” is reported in outcome measures such as decreased mortality, decreased length-of-stay, and lower costs.
- Despite this established value, there are hospitals and other health care facilities that do not have access to infectious diseases physicians.

Informed by the financial analysis described above, we see the proposed changes that CMS has set forth in the rule to have the potential to counter-act our efforts to promote infectious diseases as a specialty and improve access to ID care for those Medicare recipients suffering from severe infections thereby decreasing beneficiary access to to expertise clearly shown to impact positive outcomes. We ask that the Agency take into consideration this potential unintended consequence, postpone the implementation timeline and work with IDSA and others to find better alternatives.

³ Medscape Physician Compensation Report 2016. Accessed 9/6/18 at <https://www.medscape.com/features/slideshow/compensation/2016/public/overview#page=1>

⁴ Medscape Physician Compensation Report 2017. Accessed 9/6/18 at <https://www.medscape.com/slideshow/compensation-2017-overview-6008547>

⁵ Medscape Physician Compensation Report 2018. Accessed 9/6/18 at <https://www.medscape.com/slideshow/2018-compensation-overview-6009667>

⁶ National Resident Matching Program. Results and Data- Specialties Matching Service. 2018 Appointment Year. Accessed on 9/7/18 at <http://www.nrmp.org/wp-content/uploads/2018/02/Results-and-Data-SMS-2018.pdf>

⁷ Bonura EM, Lee ES, Ramsey K, Armstrong WS. “Factors Influencing Internal Medicine Resident Choice of Infectious Diseases or Other Specialties: A National Cross-sectional Study.” *Clinical Infectious Diseases*, Volume 63, Issue 2, 15 July 2016, Pages 155–163, <https://doi.org/10.1093/cid/ciw263>

⁸ Schmitt et al. Infectious Diseases Specialty Intervention Is Associated With Decreased Mortality and Lower Healthcare Costs. *Clinical Infectious Diseases*, Volume 58, Issue 1, 1 January 2014, Pages 22–28, <https://doi.org/10.1093/cid/cit610>

⁹ Schmitt et al. Early Infectious Diseases Specialty Intervention Is Associated With Shorter Hospital Stays and Lower Readmission Rates: A Retrospective Cohort Study. *Clinical Infectious Diseases*, ciy494, <https://doi.org/10.1093/cid/ciy494>

¹⁰ Bai AD, Showler A, Burry L, et al. Impact of infectious disease consultation on quality of care, mortality, and length of stay in *Staphylococcus aureus* bacteremia: results from a large multicenter cohort study. *Clinical Infectious Diseases* 2015; 60:1451–61

¹¹ Hamandi B, Husain S, Humar A, Papadimitropoulis EA. Impact of Infectious Disease Consultation on the Clinical and Economic Outcomes of Solid Organ Transplant Recipients Admitted for Infectious Complications. *Clinical Infectious Diseases* 2014; 59: 1074-1082

¹² Spec A, Olsen MA, Raval K, Powderly WG. Impact of Infectious Diseases Consultation on Mortality of Cryptococcal Infection in Patients Without HIV. *Clinical Infectious Diseases*, Volume 64, Issue 5, 1 March 2017, Pages 558–564, <https://doi.org/10.1093/cid/ciw786>

¹³ Burnham JP et al. Infectious Diseases Consultation Reduces 30-Day and 1-Year All-Cause Mortality for Multidrug-Resistant Organism Infections. *Open Forum Infectious Diseases*, Volume 5, Issue 3, 1 March 2018, ofy026, <https://doi.org/10.1093/ofid/ofy026>

Part B Drugs; Application of an Add-on Percentage for Certain Wholesale Acquisition Cost (WAC)-based Payments:

Current Medicare Fee for Service payments for separately payable drugs and biologicals furnished by providers and suppliers include an add-on of 6 percent of the volume-weighted average sales price (ASP) or wholesale acquisition cost (WAC) for the drug or biological (the “6 percent add-on”). CMS has proposed to cut the 6% add-on to just a 3% add-on due to the belief that “more revenue can be generated from percentage-based add-on payments for expensive drugs, and an opportunity to generate more revenue may create an incentive for the use of more expensive drugs”.

IDSA opposes this proposal. Unlike chemotherapeutics, most antimicrobials that are administered in the outpatient setting are low cost drugs that do not have significant profit margins and this cut would eliminate what little profit margin exists. Reducing Part B drug payment methodology from WAC plus 6 percent to WAC plus 3 percent would undermine the ability of most ID practices to offer outpatient parenteral antimicrobials thereby forcing many Medicare patients to endure prolonged and costly extended or acute care facility stays. Not only do antibiotic therapies provided in the facility setting cost more, but hospitalized patients are at increased risk of complications. Further reducing payments for Part B drugs would undermine initiatives, such as the Partnership for Patients, that are focused on providing high quality and cost-effective care transitions to the outpatient setting that avoid facility-based complications.

Quality Payment Program:**MIPS Claims Submission Types for Small Practices**

CMS proposes to make the Medicare Part B claims collection type available to MIPS eligible clinicians only in small practices, 15 or fewer clinicians, beginning with the 2021 MIPS payment year. IDSA appreciates the policies that CMS has put forth to support small practices within the Medicare program. IDSA does recognize the importance of promoting the utilization of electronic quality reporting as part of broader efforts to enhance interoperability, while also supporting the need for smaller practices to have options like claims-based reporting to ease their administrative burden.

Topped Out Measures

CMS previously finalized a 4-year timeline to identify and potentially remove topped out measures. Per this policy, after a measure has been identified as topped out for three consecutive years through the benchmarks, CMS may propose to remove the measure through notice and comment rulemaking. CMS proposes to change its existing policy so that once a measure has reached an extremely topped out status (e.g., a measure with an average mean performance within the 98th to 100th percentile range), it may propose the measure for removal in the next rulemaking cycle. The removal would be regardless of whether it is in the midst of the topped-out measure lifecycle, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made, after taking into account

any other relevant factors. CMS is concerned that topped out non-high priority process measures require data collection burden without added value for eligible clinicians and groups participating in MIPS. CMS indicates it would consider retaining the measure if there are compelling reasons as to why it should not be removed (e.g., if the removal would impact the number of measures available to a specialist type or if the measure addressed an area of importance to CMS).

IDSA would like to reiterate our concerns as presented in our previous [comment letter for the CY2018 QPP Final Rule](#) with regards to the proposed topped out measures policy as it will remove two of the top five measures reported by ID physicians by year 2021. This would be detrimental for successful reporting for ID physicians as measures #130: Documentation of Current Medications in the Medical Record and #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention were the top two of the top five measures reported by ID physicians according to the [2016 Physician Quality Reporting System Experience Report](#). Additionally, the 2016 PQRS Experience Report also states that for ID physicians who participated in PQRS, the main submission mechanism was claims-based for the PQRS program during the years 2013-2016. With the CMS goals of increasing clinician electronic reporting by limiting the number of eligible clinicians who can utilize the claims collection type and retiring topped out claims quality measures, ID physicians will have fewer opportunities to report quality data satisfactorily in upcoming QPP program years.

Additionally, aside from HIV and hepatitis-C virus (HCV) quality measures, which are only meaningful to a small proportion of ID physicians in the outpatient setting who have a focus in HIV care (as opposed to General ID), there are very few ID-specific measures upon which ID physicians can report avoiding payment penalties due to the heterogenous nature of the reason for ID consultations and practice. Additionally, as HIV screening and testing can occur in multiple healthcare settings, the treatment and management of HIV patients is outpatient-dominant, as HIV patients require frequent, long-term follow up to monitor how they respond to the prescribe treatment.

The negative impact removal of measures #130 and #226 would have on quality reporting across all eligible medical specialties., According to the 2016 PQRS Experience Report the 41 MD/DO specialties listed in Table 14: Top Reported Individual Measures by Specialty or Provider Type (2016) in the 2016 PQRS Experience Report, #130 was the top measure reported by 29 specialties (70 percent) and #226 was reported the second most by 21 specialties (51 percent). In addition, across all medical specialties claims-based reporting was the most utilized method of reporting for the 2016 PQRS program.

With the above rationale, IDSA asks CMS to consider retaining measure #130 and #226 as they would not only affect the opportunities to report for ID physicians but most of medical specialties.

Cost Performance Category, Episode-Based Measures Proposed for the 2019 and Future Performance Period

For the 2019 MIPS performance-period cost performance category, in addition to the Total Per Capita Cost measure, CMS is proposing to include eight new episode-based measures that include “Simple Pneumonia with Hospitalization” as an acute inpatient medical condition. CMS proposes to attribute an episode of care to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines under a TIN that renders at least 30 percent of the inpatient E&M claim lines for that patient’s hospitalization. The 30 percent threshold is said to emphasize team-based care as it is inclusive of more clinicians, patients, and cost.

IDSA recognizes the value in team-based patient care and shared accountability but have concerns with the attribution methodology, namely with the “Simple Pneumonia with Hospitalization” cost measure as it may be attributed to our physician members. We believe that for appropriate and fair cost attribution, consideration must be given as to the timing of the consult provided by the ID physician within the full episode of care. In recent research that analyzed private insurance claims data to assess the impact of ID physician inpatient intervention on patient outcomes, , early ID physician intervention was associated with lower total healthcare spending, lower mortality rate, lower readmission rates, and shorter length of stay.¹⁴ Complementing this research, a study analyzing Medicare claims data found similar associations with early ID physician intervention and lower costs and mortality.¹⁵ Furthermore, Reig et al. demonstrated lower treatment costs and decreased antimicrobial resistance development with ID physician consultation for patients with pneumonia and infective endocarditis.¹⁶ Collectively, these studies highlight the importance of the timing of the ID consult within an episode of care, which occurs at the discretion of the primary providers attending to the care of the patient.

As an example, consider the clinical scenario of a patient admitted to the hospital for simple pneumonia administered inappropriate empiric antibiotics and without appropriate respiratory cultures to assess the efficacy of the empiric antibiotic on the causative pathogen; as a consequence of this inadequate care, the patient deteriorates and is admitted to the ICU. This scenario, not infrequently, is the trigger for an ID physician consultation resulting in, medical decisions and institution of appropriate therapy to effectively treat the patient. This episode of care, with delay in ID consultation leading to increased costs and utilization of resources, may nonetheless be attributed to the ID physician under the current episode-based attribution methodology because the ID physician’s claims amount to 30 percent of the patient’s hospitalization. This scenario would likely not occur in the other two acute inpatient medical condition episode of care measures of “Intracranial Hemorrhage or Cerebral Infarction” and “ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)” as hospitalists would be the primary caregiver at admission then referred to neurologists and cardiologists, respectively.

¹⁴ Schmitt S. et al. Early Infectious Diseases Specialty Intervention Is Associated with Shorter Hospital Stays and Lower Readmission Rates: A Retrospective Cohort Study. *Clin Infect Dis*. 2018 Jun 13. doi: 10.1093/cid/ciy494

¹⁵ Schmitt S, McQuillen DP, Nahass R, et al. Infectious diseases specialty intervention is associated with decreased mortality and lower healthcare costs. *Clin Infect Dis* 2014; 58:22–8.

¹⁶ Reig S, Küpper MF. Infectious diseases consultations can make the difference: a brief review and a plea for more infectious diseases specialists in Germany. *Infection*. 2016 Apr;44(2):159-66. doi: 10.1007/s15010-016-0883-1. Epub 2016 Feb 23.

IDSA respectfully recommends that CMS reevaluate the attribution methodology for the episode of care measures to account for when a physician may be consulted in the timeline of an episode of care and incorporate appropriate adjustments to attribute the cost of care. IDSA would welcome the opportunity to discuss this important factor within physician attribution methodology with the Agency.

Improvement Activities Performance Category

CMS clarifies in the 2019 QPP Proposed Rule that Improvement Activities (IAs) that require “significant investment of time and resources should be high-weighted.” IDSA continues to believe that “Implementation of an Antibiotic Stewardship Program (ASP) (IA_PSPA_15)” is deserving of a high-weight designation due to the extensive amount of effort and resources that are required to implement an ASP. Cosgrove et al. define antimicrobial (antibiotic) stewardship as “a set of coordinated interventions to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy and route of administration.”¹⁷ In short, an ASP assists clinicians in prescribing the right drug, at the right dose, at the right time, for the right duration. According to the CDC Core Elements of Hospital Antibiotic Stewardship Programs, an effective ASP is composed of policies and interventions that include leadership commitment, action, accountability, tracking and reporting, drug expertise, and education.

As a comparator to IA_PSPA_15, “Completion of CDC Training on Antibiotic Stewardship (IA_PSPA_23)” is an IA focused on antibiotic stewardship education, which is only one component of implementing an ASP (IA_PSPA_15) and yet it has been given a high-weight designation. This discrepancy promotes a confusing and inconsistent message to participating clinicians and consumers that efforts to combat antimicrobial resistance are not “high-weight” activity and thus are not important. With this rationale, we urge the Agency to revise the weighting of “Implementation of an Antibiotic Stewardship Program (ASP) (IA_PSPA_15)” to a high-weight activity.

Facility-Based Measurement by Individual Clinicians

IDSA is appreciative of the efforts CMS has dedicated to providing detailed information for the facility-based measurement option for MIPS eligible clinicians. Through continued and frequent dialog with facility-based clinicians such as ID physicians, we believe that the facility-based measurement option has the potential to significantly reduce the administrative burden of quality reporting aligning with the Agency’s Patients Over Paperwork initiative, which in turn, can lead to increased QPP participation by ID physicians.

IDSA supports the CMS proposal to include on-campus outpatient hospitals (POS Code 22) to care settings that determine facility-based clinician status as it aligns with healthcare market trends of mergers and acquisitions. Additionally, IDSA believes the CMS proposals of a clinician having a minimum of one service billed in the inpatient hospital or emergency room

¹⁷ Cosgrove, S., Hermsen, E., Rybak, M., File, T., Parker, S., & Barlam, T. (2014). Guidance for the Knowledge and Skills Required for Antimicrobial Stewardship Leaders. *Infection Control and Hospital Epidemiology*, 35(12), 1444-1451.

and the ability to attribute a Hospital Value-Based Purchasing score to a clinician to be appropriate criteria to qualify for facility-based measurement.

No Election of Facility-Based Measurement

CMS proposes to automatically apply facility-based measurement to MIPS eligible clinicians' quality and cost performance category scores that qualify for such measurement. Additionally, in cases where MIPS-eligible clinicians actively submit quality data for the MIPS program, CMS proposes to accept the higher combined score when comparing facility-based and MIPS quality and cost measurement scores. CMS also proposes that a group of eligible clinicians must collectively submit Improvement Activities and Promoting Interoperability data to indicate that the clinicians desire to be measured as a facility-based group.

As previously stated, IDSA is heartened by the further specification of the facility-based measure option as this policy would affect many of our members, allowing a useful option to easier participation in MIPS. As with any new initiative, it will be imperative to raise awareness and provide educational resources to clinicians and their staff on how best to utilize the facility-based measurement option. IDSA recommends that CMS develop additional resources regarding matters such as but not limited to the iterative steps required for a clinician to identify which facilities they may be attributed to, how to view and understand the hospital VBP score of attributable facilities, how the hospital VBP score is converted to MIPS scoring, requirements for group reporting including options for submission type, and exclusion criteria for facility-based measurement, (e.g., virtual group participants). Lastly, we believe it would be beneficial for facility-based clinicians to able to preview a "mock report" based on past years data to gain a sense of how the individual clinician or group performed when attributed to the facility in which they attended to the most Medicare beneficiaries.

Measures in Facility-Based Scoring

Starting in the MIPS performance year 2019, CMS proposes to adopt the FY 2020 Hospital VBP Program measures, associated benchmarks, and performance periods for the purposes of facility-based measurement of MIPS-eligible clinicians. IDSA recognizes the value of adopting the Hospital VBP Program measures as it brings measure alignment across various Medicare quality reporting programs, supporting CMS' Meaningful Measures initiative. Although we are supportive of this facility-based measurement option, we do have concerns regarding the clinical relevance and appropriateness of attributing the entirety of the Hospital VBP program measure set to the care provided by ID physicians.

In the 2019 QPP Proposed Rule, Table 49: FY 2020 Hospital VBP Program Measures shows the four domains and measures a facility-based clinician will be evaluated on under the facility-based measurement option. Before expanding upon our concerns regarding these measures and domains, we believe it is important to describe the clinical practice of our members to provide context. ID physicians are not "proceduralists" but rather cognitive specialists, providing most of their services using Evaluation & Management (E/M) codes. Additionally, ID physicians are called to consult on patients with infections or suspected infections by the attending physicians

and to provide diagnostic, treatment, and/or management recommendations to the attending physician, who ultimately chooses to accept or reject the ID physician's recommendations.

In reviewing the Hospital VBP Program measures to determine clinical relevance and appropriateness of measures to evaluate the clinical performance of ID physicians, we have found that ID physicians would not have direct bearing on the outcomes of the mortality measures for acute myocardial infarction and heart failure, the elective delivery measure, and the surgical site infection outcome measure. IDSA suggests that CMS should explore reweighting facility-based measure scores at the VBP measure level, rather than domain level, to more accurately evaluate our facility-based members on measures more relevant to their clinical practice. IDSA urges CMS to consider a facility-based clinician's specialty and workflow, e.g. attending vs. consulting physician, to avoid evaluating clinicians on nonrelevant quality and cost measures. For example, ID physicians' clinical performance should not be evaluated on how well they screen a patient's body mass index and develop a follow up plan when the value of ID physicians is their expertise to accurately diagnose, appropriately treat, and manage patients afflicted with infectious diseases.

Expansion of Facility-Based Measurement to Use in Other Settings

IDSA is supportive of the proposal to expand the facility-based measurement option into post-acute care settings but cautions CMS to thoughtfully develop this expansion through extensive dialog with MIPS-eligible clinicians who may be affected by this proposal. IDSA welcomes engagement with CMS to discuss this option further.

Complex Patient Bonus for the 2021 MIPS Payment Year

We thank CMS for proposing to continue the five-point complex patient bonus as ID physicians treat the "sickest of the sick" on a regular basis. IDSA supports the continuation of the complex patient bonus which include using a combination of Hierarchical Condition Category (HCC) risk scores and socio-demographic status factors. As we have advocated in our previous statements and comments, IDSA supports the use of HCC scores to assign complexity to the patient. We believe that to ensure consistency among the QPP and the MPFS, which are closely tied together, the use of an HCC score is an accurate measure to the complexity of the patient encounter.

Small Practice Bonus

IDSA supports CMS' proposal to continue the small practice bonus as applied in the quality performance category. We are appreciative of the Agency's effort to support small practices in complying with MIPS. IDSA is open to having communications with CMS to discuss additional policies that will help small practices participate in MIPS.

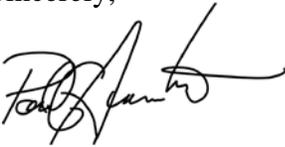
Table Group B: Proposed New and Modified MIPS Specialty Measure Sets for the 2021 MIPS Payment Year and Future Years, B.25. Infectious Disease

IDSA would like to thank CMS for reviewing our comment letter regarding the Infectious Disease specialty measure set and revising the set to include most appropriate measures according to currently available MIPS quality measures. While we are appreciative of the

change, IDSA would like to request more opportunities to collaborate with CMS to develop meaningful measures for the ID specialty collaboratively with CMS. As the Agency is aware, developing fully tested electronic clinical quality measures (eCQMs) are cost prohibitive for many societies, including IDSA. With the Agency’s proposal to remove low value measures, IDSA could face an even greater quality measurement gap. IDSA welcomes engagement with CMS to discuss and develop actionable steps to fill the ID specialty measurement gap.

IDSA recognizes the efforts put forth by CMS to address administrative burden on physicians in many aspects of the proposals as put forth in the CY2019 Physician Fee Schedule Proposed Rule. We again take this opportunity to ask CMS to postpone the implementation timeline for the changes to outpatient E/M and work with IDSA and others medical societies. We assure the Agency we stand ready with proposals as to how we might meet the goals of “Patients Over Paperwork” and improve the accuracy and valuation of evaluation and management services that physicians provide. As the QPP enters its third year, we appreciate the Agency’s work to remove barriers and facilitate easier participation in MIPS and look forward to further dialogue with CMS on how the program can evolve towards more relevant quality measurement focused on meaningful health outcomes. If you have any questions, please feel free to contact Andrés Rodríguez, Vice President, Clinical Affairs and Practice Guidelines at 703-299-5146 or arodriguez@idsociety.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul G. Auwaerter", with a long horizontal flourish extending to the right.

Paul G. Auwaerter, MD, MBA, FIDSA
President