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IDSAs Headquarters

1300 Wilson Boulevard
Suite 300

Arlington, VA 22209

TEL: (703) 299-0200

FAX: (703) 299-0204

EMAIL ADDRESS:

info@idsociety.org

WEBSITE:

www.idsociety.org

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Dr. Kate Goodrich, M.D.

Director and CMS Chief Medical Officer, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244-1850

Submitted via Email: macra-episode-based-cost-measures-info@acumenllc.com

Re: Episode-based Cost Measure Development for the Quality Payment Program

Dear Dr. Goodrich,

The Infectious Diseases Society of America (IDSAs) appreciates the opportunity to provide comments on the development of Episode Groups for use in cost measurement as required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. IDSAs represents over 10,000 infectious diseases physicians and scientists devoted to patient care, disease prevention, public health, education, and research in the area of infectious diseases. 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 disease and Zika virus disease.

IDSAs members are committed to improving the quality and safety of patient care in a manner that accurately values the benefits of cognitive care that ID physicians provide to patients with severe infections. Under section 101(f) of MACRA, the Centers for Medicare & Medicaid (CMS) is required to establish episode groups, patient condition codes, and other classification codes that will be used to measure resource use in the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs). When CMS is developing episode groups, the agency will "consider the patient's clinical problems at the time that items and services are furnished during an episode of care, such as the clinical conditions and diagnoses, whether or not hospitalization occurs, and the principal procedures or services furnished." IDSAs provides the following comments related to the development and implementation of episode groups with the aim of ensuring that these episodes appropriately account for the valuable care provided by infectious disease (ID) physicians.

As CMS has noted with the release of the draft set of episode groups, there are no specifications outlined that could be used for subgroup development; however, it is our understanding that CMS may develop episode subgroups in the future. We note that

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CMS has stated that it does not want to disadvantage physicians who assume care of complex patients. ID physicians often treat the most complex of patients on a regular basis. The treatment an ID physician provides does not fall into discreet episodes based on organ systems or procedures, or even acute episodes of care as currently defined. An infection can occur within any organ, after any procedure, or during any acute inpatient stay. We believe that ID physicians are unique and therefore will require careful consideration during the creation of episode groups.

Per documents released by CMS, episode groups will be developed from claims data that identifies typical cases for various types of medical conditions. Many episodes of care that involve an inpatient stay may also involve infection that may lead to significant resource use.

This is especially true for infections such as carbapenem-resistant Enterobacteriaceae (CRE), methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant Enterococci (VRE). IDSA is concerned with the episode group development process that is focused on items and services furnished during an episode of care (those that are easily accounted for by their respective billing or procedure codes), and that may not recognize the provision of more system-based services such as infection prevention and antimicrobial stewardship. It appears that the episode group development process resembles a direct cost-based accounting methodology and does not account for underlying services that would be captured in indirect costs. We raise this point here as we believe it is relevant context as the episode groups are defined and subsequently applied in the cost performance category of MIPS, and potentially adopted for use in alternative payment models (APMs), such as bundled payments. IDSA believes that when CMS is creating episode groups, system-level activities such as infection prevention and antimicrobial stewardship should be considered, given that episodes of care with low total resource use may be due to these underlying activities. The ID physician plays a vital role in leading these programs that contribute to low infection rates within healthcare settings, yet there is no way to appropriately attribute that effort.

As CMS moves forward with the development of the episode groups, IDSA would also like to raise concern about physician attribution within the episodes. We understand that CMS will issue future postings and have additional stakeholder outreach to solicit feedback on attribution as well as other aspects of cost measure development, but the issues we raise may inform how the episodes are defined. Within the inpatient setting, ID physician involvement in the care of patients with severe infections has been well-documented to lead to decreased mortality, reduced length-of-stay, fewer readmissions, and lower costs.¹ ID physicians are called to provide consultations by a patient's attending physician, but it should be noted that the timing of this consult is out of the control of the ID physician. This is important because, despite evidence which shows that earlier ID consultation leads to improved outcomes, some ID consults are ordered "late", which may lead in turn to increased resource utilization due to the "rescue care" that ID physicians must then provide. In addition, given the consultative relationship between ID physicians and attending physicians, it is possible that treatment recommendations provided by the ID physician may not be followed by the attending physician in a timely manner, if those recommendations are followed at all. In these instances, the patient's condition may worsen and the episode may show higher resource utilization relative to the baseline case. These factors are outside the control of the ID physician and can place him/her at a disadvantage when episode attribution occurs, resulting in ID

¹ Schmitt et al, *Infectious Diseases Specialty Intervention is Associated with Decreased Mortality and Lower Healthcare Costs*, Clinical Infectious Diseases 2014; 58(1):22-8.

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physicians having higher resource utilization cases attributed to them. CMS's work on patient relationship categories and codes is expected to mitigate some concerns about attribution; however this work has yet to be completed.

Finally, risk adjustment that incorporates socio-economic status will be an important component of the resource attribution, as there are patients with social risk factors that could predispose them to high resource utilization for their care. Patients' pre-existing conditions may also lead to poor outcomes, and this is where risk-adjustment could mitigate the attribution of high resource utilization to the ID physician. For instance, an ID physician may provide treatment to a diabetic, alcoholic, injection-drug using patient who presents to the hospital in florid septic shock from staphylococcal endocarditis with septic emboli to brain, epidural abscess, and multiple septic joints. The treatment of this patient would most likely result in high resource utilization, which is out of the control of the ID physician due to the patient's pre-existing conditions.

Thank you for the opportunity to comment on this important topic. IDSA looks forward to working with CMS as it develops and implements Episode Groups for use in cost measurement. If you have questions or need additional information, please feel free to contact me via email or phone, (arodriguez@idsociety.org , 703-299-5146).

Respectfully,



Andrés Rodríguez

VP, Clinical Affairs - IDSA