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August 21, 2017

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

RE: CMS-5522-P, Medicare Program, CY 2018 Updates to the Quality Payment Program, 42 CFR Part 414

Submitted electronically via Regulations.gov

Dear Ms. Verma,

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the 2018 proposed rule of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Programs, collectively known as the Quality Payment Program (QPP). IDSA represents more than 10,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases. 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, treating meningitis, pneumonia, tuberculosis, HIV/AIDS, serious health care acquired 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 hospitals 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 (ID) 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. "Bedside-to-population" system-based awareness is what distinguishes the critical role of the ID physician within the healthcare system. This especially applies to quality improvement related to healthcare associated infections and antimicrobial stewardship.

Facility-Based Measurement:

IDSA supports the option to use facility-based measurement as a proxy for MIPS quality, and cost measurement for facility-based physicians. IDSA believes making this a voluntary option will allow for flexibility, allowing physicians more control over how they participate in MIPS. As we have stated in past comment letters and in ongoing meetings with the Agency, the majority of infectious diseases (ID) physicians practice in the inpatient setting and they find it difficult to report on sufficient relevant measures from the provider measure sets offered under the legacy PQRS and the new MIPS.

IDSA has continually advocated for allowing hospital-based physicians to have the option of choosing whether they would like to use hospital performance measures to apply to physician-focused Medicare quality incentive programs. IDSA points out that there is a subset of measures within the Hospital Value-based Purchasing program such as the CLABSI, CAUTI, C. difficile, and MRSA infections measures which directly pertain to the clinical practice of infectious diseases physicians. For some of our members, linking their physician-level quality performance to the performance of their facility on these measures could prove reasonable and beneficial to the physician as well as to facilities and patients by aligning quality objectives. We also note that ID physicians are consultative physicians who participate in the care of inpatients, and therefore even ID-centric performance measures may be decided upon by others rather than by ID physicians.

We suggest other ideas for the Agency to consider related to this proposal:

- Bonus points for participating in this option using the value based purchasing program (VBP) as this would help align quality programs across payment systems and providers.
- CMS should have a willingness to refine this policy option as it matures and provide details as to how it will engage providers to gain feedback.
- CMS should ensure this proposal does not run in conflict with goals of a QCDR or a registry.
- CMS should explore a “weighted average” approach for physicians providing services in multiple facilities.

Complex Patient Bonus:

We thank the Agency for proposing a complex patient bonus as ID physicians often treat the “sickest of the sick” on a regular basis. Per the average Hierarchical Condition Category (HCC) risk score calculation found in Table 36 of the proposed rule, ID physicians have the second highest risk score at 2.35, only behind the specialty of nephrology. We also recognize that the HCC is an assessment that does take into account socio-demographic status (SDS) factors. We note that 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 as it relates to “complex patients.” While we appreciate the proposed implementation of the complex patient bonus, IDSA believes that a bonus ranging from one to three points is not meaningful, especially once the total performance scores

increase as the QPP program matures. We also note that as currently proposed, the complex patient bonus may end up significantly lower than the proposed small practice bonus of five points. While we support small practices, the bonus for treating complex patients should be higher than the bonus of owning a small practice.

We suggest CMS develop a multiplier that would also take into account the societal risks to which patients may fall. We read with great interest CMS' alternative proposal to use dual eligible status as an indicator of complexity. ID physicians also rank quite high on this scale and they have an average dual eligible ratio of 31.6%. IDSA proposes combining the two approaches to appropriately reward physicians who treat very complex patients with high societal risks.

Small Practice Bonus:

We continue to support small practices in our work; therefore, we are grateful to the Agency for proposing a small practice bonus. The proposed five point small practice bonus added to a proposed threshold of fifteen points for 2018 will most certainly help many solo practitioners and small practices achieve the fifteen point threshold. We look forward to working with the Agency on additional policies that will help small practices that participate in the MIPS.

Performance Threshold:

CMS has proposed an increase in the performance threshold from three points to fifteen points. In keeping with our previous comments, we support the modest increase to allow our members time to become more familiar with the MIPS and to allow for their successful participation. Given that we support the additional bonus point proposals, we believe that many of our members, especially those who may qualify for the complex patient bonus, will be successful in reaching the fifteen point threshold. We also believe that striving for the fifteen point threshold will better prepare clinicians for future increases in performance thresholds.

MIPS Eligible Clinicians - Low Volume Threshold:

IDSA supports increasing the low volume threshold, from \$30,000 to \$90,000 and from 100 Medicare patients to 200. We understand that the current administration is focusing on lowering the administrative burden for physicians. Many small practices, often in rural and underserved areas, are often not able to meet the administrative burden of participating in Medicare quality programs. Hence, their exclusion from the QPP will allow these small practices to focus their limited resources on their patients.

We strongly disagree with CMS' policy to include Part B drugs in the calculation of MIPS payment adjustments and eligibility determinations. Historically, Part B drugs have been excluded from payment adjustments under CMS quality reporting programs, such as the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VM) and Electronic Health Record (EHR) Incentive Program. In the 2017 QPP final rule, CMS deferred commenter questions as to whether Part B drugs would be included in the MIPS program, stating it would "consider this issue and provide clarification" in the future. In this proposed rule, CMS has not offered a clear proposal; rather it appears to be "clarifying" what it believes to be existing policy but still does not provide the clarity necessary to make meaningful comments.

MIPS payment adjustment provisions are included in Section 1848 of the Social Security Act (the Act), which is entitled “payment for physician services” and pertains to payment under the physician fee schedule (PFS). We believe if Congress meant for MIPS adjustments to apply to items and services outside the PFS, it would have stated that *explicitly*, or placed the MIPS adjustment provisions in a different section of the Act to make clear that they apply to items and services going beyond those paid under the PFS. In addition, we note that under the Advanced APM track of the QPP, Part B drugs are not included in the incentive payment. CMS should exclude Part B drugs from MIPS eligibility determinations and payment adjustments. MIPS payment adjustments should only apply to covered PFS services.

Virtual Groups:

IDSA continues to support the development of virtual groups, but we also struggle with the logistics of how virtual groups will actually be constructed. If CMS is committed to relieving administrative burden, then we believe CMS should assist physicians in forming their virtual groups. It is our understanding that the Agency will provide contract templates for virtual groups; however, small practices and solo practitioners may still struggle to actually find physicians to participate in a virtual group. As we stated in our [previous comment letter](#), IDSA believes that CMS should develop a mechanism, platform, or some other type of resource or tool that would promote the formation of virtual groups. The platform would ideally provide practitioners who wish to join a virtual group with the means to connect with one another. Finally, as we stated in our previous comments, we believe CMS could assist in the formation of virtual groups by using claims data to design groups of high quality/low cost providers.

Cost:

For payment year 2020, CMS has proposed to hold the cost performance score at zero. As it stands now, the cost score in 2020 would be 10% of the total performance score. At face value, this seems to be a reasonable proposal, but we caution CMS that in payment year 2021, the cost category will jump to 30% of the total performance score. We understand the increase in payment year 2020 is mandated by law; however a jump from 0% to 30% could have a substantial impact on many practices. We also note that the episode-based cost measures have not yet been developed and may not be ready in time for implementation in performance year 2019, affecting payment year 2021.

IDSA believes that CMS should provide sufficient time for the development of the cost measures, allow for testing through a voluntary pilot program, and allow time for education of clinicians on how to use the new episode cost measures. We urge CMS to work with stakeholders to develop policies that will ease the transition to the mandated cost percentage of 30% for payment year 2021.

We continue to be concerned about the application of the “Value Modifier” measures on ID physicians in the cost performance category of MIPS. Specifically, the risk-adjustment methodology that underlies the Total Per Capita Cost and Medicare Spending Per Beneficiary (MSPB) measures does not fairly capture the socio-demographic status (SDS) factors of Medicare beneficiaries and therefore leads to inappropriate comparisons. As we have noted above, CMS should consider improving the risk-adjustment methodology to include additional SDS factors.

Improvement Activities:

Implementation of an Antimicrobial Stewardship Program

It is within this component of the MIPS where we believe ID physicians will be able to participate in a meaningful way within the MIPS. IDSA is pleased to see the proposed changes to the improvement activity titled “Implementation of an Antibiotic Stewardship Program (ASP) (IA_PSPA_15).” IDSA submitted the proposed recommendations during CMS’ Call for Improvement Activities and we are thankful to the agency for including our changes in this proposed rule. Given IDSA and the Centers for Disease Control and Prevention (CDC) high priority stance for combating antimicrobial resistance, we believe that antimicrobial stewardship should be appropriately recognized as an important improvement activity.

However, IDSA suggests that CMS make changes to IA_PSPA_15, Implementation of an ASP. We believe that an ASP does not only address the specific conditions listed in the current activity description and the proposed change, (i.e. upper respiratory infections in children, diagnosis of pharyngitis, and bronchitis treatment in adults) but is also applicable to any infectious disease. IDSA defines antimicrobial stewardship as “coordinated interventions designed 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.” Antimicrobial stewards seek to achieve optimal clinical outcomes related to antimicrobial use, minimize toxicity and other adverse events, reduce the costs of health care for infections, and limit the selection for antimicrobial resistant strains.”¹ Fighting antimicrobial resistance is an all-encompassing activity and not related to specific infectious conditions. We propose that CMS remove the disease examples listed in the activity. We believe the listed conditions may be interpreted as the only conditions for which this improvement activity is applicable, therefore making this improvement activity overly prescriptive and subject to misinterpretation.

Finally, as further evidence that ASPs are not geared to one specific infectious disease, we provide the Centers for Disease Control and Prevention (CDC) ideal of what an ASP should accomplish: “ASP’s can both optimize the treatment of infections and reduce adverse events associated with antibiotic use. These programs help clinicians improve the quality of patient care and improve patient safety through increased infection cure rates, reduced treatment failures, and increased frequency of correct prescribing for therapy and prophylaxis.”²

In addition to removing the specific conditions listed, IDSA suggests that CMS replace the term hospital which is used throughout the proposed language, and insert the term “facility.” We acknowledge that IDSA submitted the improvement activity using the term hospital, but believe that ASPs may be implemented at many different sites of service, and therefore the term facility may be more appropriate

¹ Promoting Antimicrobial Stewardship in Human Medicine, Infectious Diseases Society of America, http://www.idsociety.org/stewardship_policy/. Accessed August 1, 2017.

² Core Elements of Hospital Antibiotic Stewardship Programs, Centers for Disease Control and Prevention, <https://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html>. Accessed August 1, 2017.

and less prescriptive. If the Agency has any questions or concerns about this improvement activity, we would welcome a dialogue and the opportunity to work with the Agency.

As we stated in a previous [comment letter](#), IDSA continues to recommend the implementation and continued supervision of an ASP be a high weighted improvement activity. Given the societal impact of using antimicrobials appropriately, the work involved in the implementation of an ASP, and the work involved in continually supporting and administering an ASP, we believe that this should be a high weighted activity.

CDC Training on Antibiotic Stewardship

IDSA would like to thank for the Agency for addressing the urgent societal impact of antimicrobial resistance. IDSA is generally supportive of improvement activities that promote better antimicrobial stewardship. As you are likely aware, antimicrobial resistance is an area of focus for our society, as we have many programs geared toward educating our members and the public about antimicrobial resistance and its impact on the healthcare system. As such, we support the proposed inclusion of two new improvement activities that would encourage physicians to learn and to understand the importance of antimicrobial resistance. Completion of the CDC's training modules is one of many ways physicians can learn about antimicrobial resistance. We support the use of CDC's materials for this purpose. We also agree with the proposed weights of the two improvement activities *Completion of CDC Training on Antibiotic Stewardship* (high weight), and *Initiate CDC Training of Antibiotic Stewardship* (medium weight). However, while we lend our support for these improvement activities, we ask for clarification as to the exact CDC modules the Agency is referencing in these proposed improvement activities.

Quality

Cross-cutting Measures:

IDSA appreciates CMS' decision to delay the implementation of cross-cutting measures for future MIPS years as well as the opportunity to provide further comments on this matter. As stated in this proposed rule, a cross-cutting measure is "broadly applicable across multiple clinical settings and individual MIPS eligible clinicians or groups with a variety of specialties" and CMS seeks comments on how to "construct a cross-cutting measure requirement that would be most meaningful to MIPS eligible clinicians from different specialties and that would have the greatest impact on improving the health of populations." Additionally, CMS proposes to implement the following cross-cutting measures in future MIPS program years,

- MIPS #47: Advance Care Plan
- MIPS #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- MIPS #130: Documentation of Current Medications in the Medical Record
- MIPS #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- MIPS #236: Controlling High Blood Pressure
- MIPS #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

IDSA aligns with the commenters requesting CMS not require the reporting of cross-cutting measures for future MIPS program years. For our members, the requirement of reporting cross-cutting measures is an added administrative burden that increasingly complicates reporting efforts that may lead to a negative payment adjustments. As CMS promotes high-value patient care, cross-cutting measures do not promote the like. Requiring all MIPS eligible clinicians to report one or more cross-cutting measures promotes overutilization and does not leverage the expertise and of a specialist when treating a patient.

Topped Out Measures:

Based on CMS' 2015 PQRS Experience Report, the five most frequently reported individual measures by ID physicians are as follows:³

1. #130: Documentation of Current Medications in the Medical Record
2. #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
3. #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
4. #110: Preventive Care and Screening: Influenza Immunization
5. #111: Pneumonia Vaccination Status for Older Adults

As stated in the CY 2017 Quality Payment Program final rule, a topped out process measure is one with a median performance rate of 95 percent or higher. According to the QPP's 2017 Quality Benchmarks, measures #130 and #226 would be topped out process measures, which are the top two individual process measures most frequently reported by ID physicians as well as two of the six proposed cross-cutting claims-based measures (#47, #128, #130, #226, #236, #317). With these circumstances, the prospective removal of topped out claims-based process measures coupled with a dearth of appropriate, applicable quality performance measures reportable by ID physicians, [highlighted in IDSA's previous comment letter](#), would be detrimental to the successful QPP reporting for ID physicians. In conjunction with the rationale stated in our comments regarding the MIPS specialty measure set below, we respectfully recommend that CMS does not adopt the proposal to remove topped out claims-based process measures to provide ID physicians additional opportunities to report quality measures.

Specialty Measure Set:

IDSA appreciates CMS' proposal of a specialty measure set for ID physicians as outlined in Table B.29, Infectious Disease. We believe that with the identification of appropriate quality measures, specialty measure sets have the potential to provide ID physicians with a mechanism to fully participate in the QPP. As the proposal of the ID specialty measure set is an encouraging initial step, Table B.29 Infectious Disease requires revisions as it offers very few meaningful reportable measures to the specialty of ID.

IDSA believes it is important to describe the clinical practice of our members to provide context to the issues they face in the QPP. Infectious diseases (ID) physicians are not "proceduralists" but rather cognitive specialists, providing most of their services using Evaluation & Management (E/M) codes. According to the CY2015 Utilization Released with the CY2017 Medicare Physician Fee Schedule Final Rule, 93 percent of all total allowed charges by Medicare for ID physicians were for E/M codes (99201-99499). Highlighting the predominate inpatient practice pattern of an ID physician, of the 93 percent of

³ CMS 2015 Reporting Experience Including Trends (2007-2015) for the Physician Quality Reporting System. 2017.

the E/M Medicare claims submitted by ID physicians, 88 percent of those claims were delivered in the inpatient setting. Also, it is important to note that in the inpatient setting, ID physicians are called on to provide services by the attending physician in cases where patients are thought to be suffering from an infection.

From IDSA's analysis of the current MIPS claims-based quality measures, there are 45 claims-based MIPS measures that are applicable to E/M codes 99201 to 99499⁴. Of the 45 measures, only one quality measure is a valid measurement of an ID physician's care, MIPS #407: Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia. When expanding the analysis to include registry-based MIPS measures, 133 measures are applicable to E/M codes 99201 to 99499⁵. Of the 133 measures, IDSA has identified 24 measures that have relevance to the field of ID, as the measure title refers to antibiotics, infectious conditions, or immunization (measure #'s 65, 66, 91, 93, 110, 111, 116, 176, 205, 275, 331, 332, 333, 334, 337, 338, 340, 387, 390, 394, 400, 401, 407, 447).

Although the 24 identified measures are relevant to the broad field of ID, 18 out of the 24 measures (measure #'s 65, 66, 91, 93, 110, 111, 116, 176, 275, 331, 333, 332, 334, 337, 387, 394, 400, and 447) are not applicable to the scope of practice for an ID physician. For example, as the majority of ID physicians consult on patients in the inpatient setting, they are not likely to encounter nor are they the attending physicians for the patient populations that are applicable to the aforementioned measures. Furthermore, ID physicians who specialize in the treatment of HIV and HCV patients in the outpatient setting are experiencing difficulties in avoiding Value-based Payment Modifier (VM) payment penalties as well as meeting specific measures due to flawed program design and reimbursement policies. For example regarding VM payment penalties, a large single-specialty ID physician group satisfactorily reported on HIV measures (#160, #381, and #368) which were subsequently not accepted due to the lack of a national benchmark.⁶ This resulted in the practice being assessed a lower overall score on quality.

Further highlighting the difficulty of MIPS reporting for ID physicians, to satisfactorily report for measure #205 HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis, a physician must document the chlamydia, gonorrhea, and syphilis screening results for an HIV infected patient.⁷ An ID physician who treats a patient infected with HIV who is eligible for inclusion in the denominator of measure #205 will not be reimbursed by Medicare for ordering a test to screen for chlamydia, gonorrhea, and syphilis as ID physicians are not categorized as "primary care physician or practitioner" and designated as "specialists."⁸ This unintended consequence of the Medicare STI test reimbursement policy further eliminates potential MIPS quality measures reportable by our members.

⁴ 2017 Quality Performance Program (QPP) Individual Claims Measures Single Source

⁵ 2017 Quality Performance Program (QPP) Individual Registry Measures Single Source

⁶ Centers for Medicare & Medicaid Services; Benchmarks for Measures Included in the Performance Year 2015 Quality and Resource Use Reports.

⁷ Centers for Medicare & Medicaid Services; Measure #205 (NQF 0409): HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis – National Quality Strategy Domain: Effective Clinical Care. QPP Quality Measure Specifications. Nov 2016. Available at:

https://qpp.cms.gov/docs/QPP_quality_measure_specifications.zip

⁸ Centers for Medicare & Medicaid Services; National Coverage Determination (NCD) for Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs (210.10). Nov 2011. Available at: [CMS Clinical Policy NCD for STIs](#).

With this rationale, we respectfully recommend that CMS revise Table B.29, Infectious Disease to include only the following measures:

- Measure #110: Preventive Care and Screening: Influenza Immunization
- Measure #111: Pneumococcal Vaccination Status for Older Adults
- Measure #130: Documentation of Current Medications in the Medical Record
- Measure #407: Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia

We look forward to working with Agency on our proposals for the quality measure set and would welcome discussions with the Agency to create more meaningful measures for use by ID physicians.

IDSA appreciates the efforts put forth by CMS to improve the participation parameters of the Quality Payment Program. We look forward to further engagement with CMS and other stakeholders as we work toward meeting the goals of this proposed rule. 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.

Respectfully,

A handwritten signature in cursive script that reads "Bill Powderly". The signature is written in black ink and is positioned above the printed name.

William G. Powderly, MD, FIDSA

President