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September 9, 2025

Mehmet Oz, MD

Administrator

Centers for Medicare and Medicaid Services

U.S. Department of Health and Human Services

200 Independence Avenue SW

Washington, DC 20201

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') Calendar Year (CY) 2026 Medicare Physician Fee Schedule (MPFS) Proposed Rule. IDSA is a global community of 13,000-plus clinicians, scientists and public health experts working together to solve humanity's smallest and greatest challenges, from tiny microbes to major outbreaks. Infectious diseases remain among the most pressing challenges facing health care systems, frequently causing and complicating chronic disease in patients of all ages. ID physician care has been proven to significantly improve patient outcomes, reduce hospital length of stay and reduce costs.

We are pleased to support several components of the CY 2026 Medicare Physician Fee Schedule Proposed Rule as well as offer suggestions to strengthen some provisions, as detailed below.

Payment provisions

Practice expense proposals

Proposal to maintain current PE/HR data and cost shares for CY 2026

IDSA acknowledges CMS' intention to modernize practice expense (PE) allocations to better capture current clinical practice realities and practice setting shifts. We note the agency's appropriate recognition of methodological shortcomings in the 2022 Physician Practice Information (PPI) and Clinician Practice Information (CPI) survey data, namely, issues related to low specialty-specific response rates, limited granularity for subspecialties such as infectious diseases (ID) and concern regarding the representativeness of surveyed practices. We also understand why these data are not ready to serve as a comprehensive replacement for current practice expense per hour (PE/HR) values across the physician fee schedule.

However, we must also underscore that, under CMS' proposed approach, maintaining current PE/HR data and imposing the 50% reduction to facility PE relative value unit (RVU) allocation, ID faces an overall 6% cut, and a 9% cut for facility-based services, which constitutes most of the care delivered by ID

physicians. The alternate cost share models reflected in data from the American Medical Association (AMA) PPI and CPI surveys, detailed in Impact Table 108, demonstrates that ID continues to experience disproportionately negative impacts under multiple methodologies. These impacts, while still significant, would affect the ID specialty to a lesser extent than the CMS proposal. If CMS moves forward with the facility PE allocation reduction and does not adopt a targeted mitigation strategy for disproportionately impacted specialties, such as ID, we strongly recommend that CMS use the AMA PPI/CPI data for the ID specialty as an interim measure to reduce the excessive harm to our specialty while more accurate, specialty-specific data are developed. Further, we support continued refinement of the AMA PPI and CPI surveys and the exploration of alternative PE data sources and would welcome the opportunity to partner with CMS on an ID-specific data collection effort to better capture the true costs of ID practice.

Proposal to reduce facility PE RVU allocation based on work RVUs

IDSA strongly opposes CMS' proposal to reduce the portion of facility PE RVUs allocated based on work RVUs to 50% of the non-facility allocation beginning in CY 2026 based on the assumption that facility-based physicians generally incur lower indirect costs because they are less likely to maintain an office-based practice. **IDSA's member data and recent surveys reveal a much more diverse practice landscape.**

A significant portion of inpatient ID work for both hospital-employed and independent physicians involves transitions in the care of patients that receive intravenous antibiotics from the hospital to outpatient home-based or infusion center therapy. This transition requires significant resources, including dedicated outpatient parenteral antimicrobial therapy (OPAT) nurses, pharmacists, medical assistants, case managers, social workers, vascular access teams, computer equipment, communication devices and other technology. The cost of this staffing and equipment is not covered by common inpatient or outpatient evaluation and management (E/M) visit codes. ID physicians who use telemedicine for inpatient rounding also incur costs from audio-video and computer equipment, carts and staffing tele-presenters in remote hospitals, which constitute additional expenses that are not covered by E/M codes. Office space within facilities is also needed to conduct these sessions to protect patient privacy.

Many facility-based infectious diseases specialists are not hospital employees but rather operate as independent practitioners or members of small groups who contract to provide consultative services to hospitals. Many of these ID physicians maintain independent office space, incur rent and utility expenses, employ administrative and clinical support staff, and shoulder ongoing costs for equipment, information technology and compliance infrastructure, costs typically associated with office-based practice.

For example, preliminary IDSA data indicate that a meaningful proportion of ID physicians performing inpatient consultations, especially in small and mid-sized communities, **are structured as independent practices or professional corporations, not directly salaried by the hospital.** These physicians continue to bear substantial indirect and direct overhead, including office lease and maintenance, payroll and benefits for support staff, liability and regulatory compliance, and capital investments in diagnostic and infection prevention technology. The practice expense profile for these facility-based ID physicians is therefore not analogous to a hospital-employee model.

Moreover, irrespective of employment status, the nature of ID practice requires significant ongoing investment in infection prevention, advanced diagnostic stewardship programs, data analytics for antimicrobial stewardship, biosafety training, pandemic preparedness, multidisciplinary care coordination and compliance with evolving local and federal mandates. These resource-intensive obligations **are often uncompensated** or only partially supported by institutional contracts and are not limited to office-based care.

Therefore, IDSA urges CMS to recognize the full spectrum of ID physician practice models and avoid blanket assumptions of minimal or absent overhead for facility-based ID services. Specialty-specific data demonstrate that many facility-based ID physicians retain significant independent practice expenses. Failing to account for these realities in PE allocation risks exacerbating chronic undercompensation, threatening the sustainability of the specialty and diminishing patient access, particularly in underserved or community hospital settings where independent or contracted ID physician models remain prevalent.

To ensure accurate and equitable reimbursement, **IDSA recommends that CMS:**

- Utilize specialty data and stakeholder input to identify and better quantify the proportion of facility-based ID specialists who continue to incur traditional office- and practice-related overhead, including those under independent contractor or group arrangements
- Consider the full continuum of indirect costs, including infection prevention infrastructure, stewardship programs, ongoing staff training and compliance requirements, as integral to the practice expenses borne by both office-based and facility-based ID physicians
- Allow for the submission and review of supplemental specialty-led data (such as from the Value of ID study¹ or targeted rapid audits) to provide detailed documentation of actual overhead among facility-based ID practitioners
- Ensure final PE policy development and any redistribution proposals are accompanied by robust specialty impact analysis and stakeholder engagement, with safeguards against harmful distortions in reimbursement for ID care

Only through a realistic assessment of the modern infectious diseases practice environment can CMS ensure the PE component of the fee schedule accurately and fairly supports all ID physicians, regardless of practice setting or employment arrangement. **No changes to PE should be finalized until these recommendations have been completed.**

Overarching challenges in ID service valuation

ID physicians face persistent undervaluation in Medicare as current valuation methodologies prioritize procedure-based productivity, leaving the consultative, diagnostic and care coordination services central to ID practice inadequately recognized and reimbursed. ID specialists are instrumental in value-based care through their leadership in infection prevention, population health surveillance and collaborative multidisciplinary approaches that improve care effectiveness and efficiency, core pillars of CMS' value-based purchasing programs. As we have shared before, ID practice is characterized by high-complexity patient populations, care management for resistant organisms, epidemic response, public health leadership and antimicrobial and diagnostic testing stewardship initiatives, services that are integral to health care system function but are inadequately captured by the current RVU paradigm.

In addition, ID physicians are essential for the success of value-based care models, including accountable care organizations and hospital quality improvement efforts, as their expertise reduces hospital-acquired infections, minimizes readmissions due to infectious complications and leads targeted interventions that lower overall costs while improving patient outcomes. While IDSA greatly appreciates the implementation of Healthcare Common Procedure Coding System (HCPCS) code G0545 as part of the CY 2025 PFS rulemaking, the lack of recognition and continued undervaluation for

¹ "Infectious Diseases Society of America. 'Value of ID.' IDSA, www.idsociety.org/value-of-id/.

time-intensive, non-face-to-face care coordination activities that are foundational to optimal outcomes in infectious diseases result in inadequate compensation.

This, in turn, undermines ID physician recruitment and retention, accelerates existing workforce shortages and restricts patient access to expert infection care at a time when antimicrobial resistance, emerging pathogens and health care-associated infections pose ongoing threats to public health and safety. ID physicians already face a severe and growing workforce shortage, with recruitment challenges worsening each year. This shortage is directly tied to the persistent undervaluation of ID services in Medicare and the broader reimbursement gaps for time-intensive, nonprocedural care. As demand for expert infectious diseases care rises due to antimicrobial resistance, emerging pathogens and health care-associated infections, the current lack of adequate compensation further discourages new trainees from pursuing ID and jeopardizes the sustainability of the specialty. If these trends continue, Americans will face greater risks from widespread infectious threats, undermining both individual patient outcomes and the nation's public health response capabilities.

In addition to the above, IDSA also urges CMS to explore ways it could better recognize and account for the following ID activities that continue to be undervalued:

- **Infection prevention and control leadership and oversight:**
ID physicians serve as institutional leaders for infection prevention that is essential to successfully executing patient safety and improved quality of care to prevent health care-associated infections by developing policies, implementing and auditing protocols, conducting surveillance and ensuring compliance with federal/state mandates. These roles require significant non-billable administrative and staff oversight time to ensure patient, visitor and staff safety and prevent spread of multidrug-resistant organisms (MDROs) and extensively drug-resistant organisms (XDROs). These infection prevention activities align directly with value-based care principles, as they reduce adverse events, hospital-acquired infections and unnecessary utilization, leading to improved patient safety and substantial cost savings for health systems and payers.
- **OPAT:**
OPAT management remains a significant clinical activity that reduces costs by allowing patients to continue care outside of the acute care hospital setting but poses ongoing challenges regarding reimbursement under the current Medicare coding framework. Despite the complex, high-acuity nature of OPAT, often involving daily review of laboratory results, adjustment of antimicrobial regimens, coordination with infusion services and direct communication with both patients and on-site care teams, there is still no dedicated E/M code for these services. Yet, OPAT exemplifies value-based care in ID by enabling safe outpatient management of complex infections, reducing inpatient length of stay, lowering costs and improving patient satisfaction, all central metrics in quality-based payment programs.

The lack of an appropriate billing mechanism is particularly problematic given that many OPAT management tasks, such as addressing side effects, overseeing lab abnormalities or mitigating line complications, are frequently performed remotely and are not face-to-face encounters. As a result, ID physicians orchestrating comprehensive OPAT care for patients at home or in skilled nursing facilities are unable to bill for a substantial amount of their clinical work, despite the intensive monitoring and decision-making required to maintain patient safety and drive positive outcomes. This coding gap does not align with the level of responsibility, time and expertise these activities demand, highlighting a growing disconnect between the evolution of care delivery and available reimbursement pathways.

- **Antimicrobial stewardship program administration:**

CMS has prioritized stewardship nationally, and ID physicians lead and maintain active, data-driven antimicrobial stewardship programs. This includes direct provider interventions, education, prescriber guideline development, reporting on use and resistance, regulatory documentation and multidisciplinary reviews, which are all resource heavy, rarely reimbursed and essential for public safety. Effective stewardship efforts constitute high-impact value-based care interventions that reduce unnecessary antibiotic use, prevent complications such as *Clostridioides difficile* infection and curb health care expenditures tied to antimicrobial resistance, all major goals in CMS' alternative payment models and pay-for-performance programs. These activities, in collaboration with infection prevention, help decrease development of MDROs and XDRs and thereby decrease health care costs and sustain the usefulness of antimicrobial agents.

- **Diagnostic and clinical stewardship initiatives:**

ID physicians are at the forefront of high-value diagnostics, designing and reviewing testing protocols, minimizing unnecessary utilization, interpreting complex results, leading quality improvement initiatives and integrating advances in laboratory medicine. These efforts support hospital and system-wide cost savings and patient safety. The diagnostic stewardship expertise that ID physicians bring enhances value-based outcomes through targeted testing strategies, minimization of waste and faster, more accurate treatment, directly supporting CMS' quality metrics and bundled payment initiatives.

- **Biosafety and regulatory compliance:**

Maintaining regulatory readiness, including adherence to standards set by The Joint Commission, the Centers for Disease Control and Prevention (CDC), the Clinical Laboratory Improvement Amendments, and the Occupational Safety and Health Administration, demands ongoing staff training, timely incident response, regular policy updates, infrastructure investments and frequent compliance reporting. ID physicians frequently serve as designated biosafety officers or compliance leads, often without dedicated resource support. In addition to their expertise in zoonosis and emerging or reemerging infections, ID physicians have played pivotal roles in the early recognition of pathogens such as West Nile virus and mpox in the United States. Consequently, ID physicians lead many of the nation's special pathogens treatment units, contributing vital leadership and clinical expertise to biosafety and biosecurity efforts.

- **Multidisciplinary care coordination and complex patient management:**

ID physicians manage patients with highly complex needs and frequently those who are severely immunocompromised, have undergone solid organ or stem cell transplants, receive intensive cancer chemotherapy or live with advanced HIV infection. ID physicians also coordinate extensively with ICU teams and surgical teams about patients undergoing complex surgeries that are complicated by ID problems, often involving prosthetic devices, such as heart surgery, orthopedic surgery and neurosurgery. This responsibility involves:

- Peer-to-peer facilitation with oncology, nephrology, transplant and pharmacy teams
- Regular adjustment of regimens in response to evolving resistance and patient-specific factors



- Strict infection prevention beyond routine hospital practices
- Diagnostic stewardship to rapidly identify new threats and limit the spread of multidrug-resistant organisms

Care coordination provided by ID specialists is foundational to value-based care, realizing lower rates of complications, reduced readmissions and improved outcomes in high-risk patient populations, all targeted outcomes in value-based contracts and CMS payment reforms.

- **Education, staff training and quality assurance:**

Ongoing education for providers and front-line staff on novel pathogens, emerging infection control practices and updated regulatory requirements is routinely planned and delivered by ID physicians as a core expectation in most health care organizations, which benefits many different departments within their institution.

RVU determination and impacts

IDSA concurs with CMS' iterative approach to RVU valuation, which synthesizes input from the AMA RUC, independent reviews, professional society recommendations, empirical medical literature and Medicare claims experience. **However, IDSA strongly cautions against any downward adjustment of work or practice expense RVUs that does not explicitly and methodically account for the distinctive, resource-intensive character of infectious diseases care, particularly given the specialty's structurally low compensation baseline.**

The proposal to implement multiyear phase-ins for material RVU reductions is appreciated but must be explicitly extended to encompass negative impacts arising from cumulative PE methodology and site-of-service changes, not just individual code revaluations.

Malpractice RVU methodology

IDSA acknowledges the update of malpractice RVUs through refreshed premium data and risk index recalibration and supports continued refinements in specialty classification and risk indexing to ensure accurate representation for infectious diseases practice.

Conversion factors

CMS proposes two distinct conversion factors (CFs) recognizing the differing policy frameworks for Qualifying Alternative Payment Model (APM) Participants and other items and services. Specifically, CMS proposes a CF of \$33.5875 for services furnished by Qualifying APM Participants, reflecting an aggregate increase of 3.84% relative to the 2025 CF. For other items and services, CMS proposes a CF of \$33.4209, representing a 3.32% increase relative to 2025. These adjustments derive from a confluence of factors, including base payment updates mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) (+0.75% for Qualifying APM Participants and +0.25% for others), a budget neutrality adjustment of +0.55% and a temporary 2.5% increase authorized under the One Big Beautiful Bill Act (OBBBA) for CY 2026.

While IDSA welcomes these overall increases in the CF, which support incremental improvements in Medicare reimbursement rates, we note that the projected payment impact across specialties, detailed in Table 92 and attendant analyses, does not yet incorporate the MACRA base updates or the OBBBA temporary increase. Furthermore, IDSA recognizes that actual payments to infectious diseases practitioners will vary considerably based on practice size, service mix and site of service.



Given our specialty's persistent challenges with historically low Medicare reimbursement rates, **IDSA strongly urges CMS to prioritize policies that translate these nominal CF gains into meaningful payment stability and growth for infectious diseases physicians. This includes robust adjustment mechanisms to counterbalance the disproportionate influence of practice expense reallocations and indirect cost changes that our specialty faces.**

Additionally, IDSA respectfully strongly encourages CMS to maintain transparency in its CF calculation methodologies and continue engaging with specialty societies to ensure that conversion factor changes, implementation timing and reconciliation with the broader practice expense and RVU adjustments are equitable and cognizant of the unique resource intensiveness of infectious diseases care.

Efficiency adjustment

IDSA appreciates the sentiment behind CMS' proposal to introduce an efficiency adjustment in the Proposed Rule as a means to better reflect gains in efficiency for non-time-based services, while holding time-based services, such as E/M, harmless. Under this proposal, CMS would reduce the work RVUs and the corresponding intraservice physician time for procedures and other non-time-based services by -2.5%, based on a five-year lookback of the Medicare Economic Index productivity adjustment. We agree that, over time, advances in technology, practitioner experience and process improvements may systematically reduce the resources required to furnish certain services.

CMS' own impact analysis anticipates that specialties with predominantly time-based billing (such as family practice, psychiatry and geriatrics) will generally see a small increase in RVUs due to the redistributive effects of the policy, while procedural specialties are more likely to experience modest decreases. **IDSA appreciates CMS' efforts to modernize the valuation of physician work to maintain relativity and accuracy across the PFS, provided that time-based services remain excluded from this policy so that ID physicians are protected from unintended negative consequences.**

Valuation of specific services

Combination COVID-19 vaccine administration (CPT codes 90480 and 9X16X)

IDSA appreciates CMS' initiative to propose new values for combination COVID-19 vaccine administration codes in the Proposed Rule. Streamlined coding for combination vaccines, especially those anticipated to contain updated strains or combined with other respiratory virus components, will be critical to the evolving public health strategy for COVID-19 prevention.

We support CMS' efforts to establish appropriate payment for CPT codes 90480 and 9X16X, which are intended to reflect the complexity associated with the counseling, storage, handling and documentation requirements for these new combination vaccines. IDSA encourages CMS to ensure these rates adequately account for the additional time and expertise required of infectious diseases physicians and other clinicians to address patient concerns, navigate evolving guidance and promote vaccine uptake in populations at risk. We also emphasize the importance of periodic payment rate review as product characteristics, public health recommendations and workflow burdens continue to evolve for combination vaccines.

RSV monoclonal antibody administration (CPT codes 96380 and 96381)





IDSA welcomes CMS' proposal to introduce and value new codes for the administration of respiratory syncytial virus (RSV) monoclonal antibodies. Given the emergence of preventive mAbs like nirsevimab for infants and other high-risk groups, clear coding and appropriate reimbursement are essential to support their integration into clinical practice so that these patients can be protected against serious infection.

We support the use of resource-based RVU assignments that adequately capture the provider time required for obtaining informed consent, clinical assessment and post-administration observation. Consistent and sufficiently valued codes are vital to ensuring equitable access to these lifesaving therapies. IDSA requests ongoing monitoring of payment adequacy as clinical indications expand and as more data become available on administration requirements in various care settings. IDSA advocates for simplified administrative requirements and maximum flexibility in reporting and payment processes for these codes so that clinicians can focus on patient care and outbreak management.

E/M visit add-on code G2211

IDSA is strongly supportive of CMS' proposal to expand the scope of G2211 to include home and residence E/M visits, in addition to office and outpatient E/M visits. ID physicians often care for patients with very complex, serious and chronic conditions that require prolonged longitudinal management, frequently outside the traditional office setting. Many ID patients, such as those receiving home infusion therapies for prolonged and serious infections, immunocompromised individuals or patients undergoing complex outpatient antibiotic management, may be homebound, residing in skilled nursing or assisted living facilities, or unable to access typical outpatient clinics.

CMS' recognition that "building trust as part of a longitudinal practitioner-patient relationship may be particularly significant in the context of home and residence E/M visits" significantly highlights the vital role of continuity and relationship-based care, a hallmark of ID practice, in improving patient outcomes. We agree that the complexity inherent in these encounters, including coordination with other providers and caregivers, addressing social determinants of health, medication management, infection prevention and transitions of care, mirrors or may even exceed the complexity seen in office-based visits.

IDSA therefore supports the proposal to revise the descriptor for G2211 as follows: "Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established.)"

We appreciate CMS' responsiveness to stakeholder input and its commitment to ensuring that Medicare payment policy accurately reflects the complexity and resource demands of contemporary practice, regardless of site of service. **We urge CMS to finalize this proposal as written, clarifying in the rule's preamble and guidance that infectious diseases physicians and other longitudinal specialties may appropriately utilize G2211 when managing complex or serious conditions in all approved E/M settings, including home and residence visits.**

The expanded applicability of G2211 will support true appropriate reimbursement and encourage the delivery of high-value, relationship-based care for Medicare beneficiaries living with complex infectious diseases.



Chronic illness and behavioral health

Prevention and management of chronic disease

IDSA strongly supports the focus on prevention and management of chronic disease as outlined in the Proposed Rule. Infectious diseases and chronic conditions are linked in multiple ways and ID research, public health interventions and access to care by ID physicians are crucial to efforts to address chronic disease. Infectious diseases can cause or contribute to the development of chronic conditions, including type 1 diabetes, asthma, heart disease, cancer, kidney disease, gastrointestinal disease, and bone and joint disease in patients of all ages. Chronic conditions make individuals more susceptible to infections and worse outcomes. ID physician care and ID research are critical to preventing and managing chronic conditions.

Infectious diseases physicians play a critical role in disease prevention through antimicrobial stewardship programs, infection prevention and control measures, vaccination advocacy and public health surveillance activities, all of which represent proactive, upstream interventions that can significantly prevent costly hospitalizations and complications, especially after lifesaving surgeries and organ transplants, and joint replacements.

We encourage CMS to recognize the vital preventive services that infectious diseases physicians provide beyond traditional treatment models. These include: pre-exposure prophylaxis counseling and management for high-risk populations; travel medicine consultations that prevent imported infectious diseases; outbreak investigation and containment services; antimicrobial stewardship programs that prevent antimicrobial resistance development and *C. difficile* infections; and comprehensive vaccination services for immunocompromised patients. Additionally, the integration of motivational interviewing (MI) techniques in infectious diseases care, particularly for patients with chronic infections like HIV, hepatitis B, hepatitis C or tuberculosis, has demonstrated significant success in improving medication adherence, reducing transmission risks and enhancing long-term health outcomes. MI is widely accepted as an evidence-based, patient-centered counseling method that helps increase medication adherence, encourage healthy behavior changes and improve long-term outcomes by drawing out patients' intrinsic motivation for change. Studies supported by the HIV Medicine Association and related infectious diseases organizations have shown that the use of MI techniques by care teams can significantly enhance antiretroviral therapy adherence, reduce the risk of HIV transmission and help address common barriers such as stigma, substance use and psychosocial challenges. Digital health tools and therapeutic applications specifically designed for infectious disease prevention and management, including medication adherence platforms and patient education applications, represent innovative approaches that align with CMS' vision for modernized, prevention-focused health care delivery.

Telehealth

Requests to add services to the Medicare Telehealth Services List for CY 2026: Infectious disease add-on code

IDSA greatly appreciates the proposal to add CPT add-on code G0545 to the inpatient Medicare Telehealth Services List. IDSA is strongly supportive of this proposal. As detailed in the Proposed Rule, G0545 encompasses a critical suite of services, such as risk assessment for disease transmission, public health investigation and analysis, and sophisticated antimicrobial therapy counseling, that are essential to the management of complex infectious disease patients. The thoughtful review by CMS, as



articulated in steps 1–3 of the review process, correctly affirms that all service elements of G0545 are amenable to delivery via interactive telecommunications and therefore suitable for telehealth coverage under section 1834(m) of the Social Security Act.

IDSA believes that enabling infectious diseases physicians to provide this add-on complexity service via telehealth will significantly enhance timely access to specialist expertise, particularly in areas with limited in-person infectious diseases resources. The COVID-19 pandemic underscored the vital role of infectious diseases telemedicine in broadening access to expert care while maintaining rigorous standards of clinical management.

However, while we commend this proposal, IDSA urges CMS to also allow G0545 to be billed in conjunction with outpatient/office E/M services. Many infectious diseases consultations, including those with substantial complexity such as newly diagnosed or suspected serious infection cases, antimicrobial management and public health coordination, frequently arise in outpatient settings, including clinics, ambulatory facilities and home health care arrangements. Allowing the add-on code to be billed with outpatient services would reflect the continuum of infectious diseases care and ensure Medicare beneficiaries receive the same standard of complex infectious diseases expertise regardless of care setting. Allowing the add-on code to be billed in outpatient settings also recognizes that ID physicians performing office-based care often are in service of preventing hospital admissions or shifting services that were historically performed in a hospital setting to an outpatient one, such as OPAT. Certain ID services are tantamount to the care provided within a hospital setting and therefore should be billed similarly. This expansion would align with CMS’ intention to maximize beneficiary access and address evolving models of telehealth delivery.

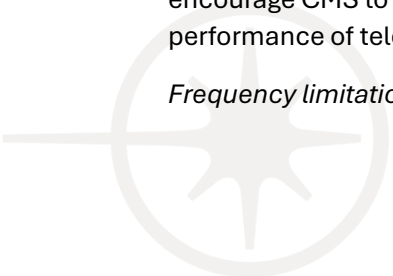
Changes to the Medicare Telehealth Services List review process and status designation

IDSA appreciates the intent to streamline and clarify the process for adding services to the Medicare Telehealth Services List, particularly through the proposal to revise the review process by reducing it from a five-step to a three-step approach. The removal of Step 4 (mapping to a service’s permanent status) and Step 5 (requirement for evidence of analogous clinical benefit) appropriately centers the review on whether the service is separately payable under the PFS, subject to Section 1834(m) of the Social Security Act, and compatible with delivery via interactive telecommunications technology.

We support this proposed revision, as it recognizes the complexity and variability of clinical practice and rightfully emphasizes professional judgment in determining telehealth suitability. By eliminating the categorical “permanent” or “provisional” designations and instead considering all included services as permanent, CMS acknowledges the evolving evidence base and clinical experience with telehealth services without unnecessarily impeding timely access to innovative care models. **However, we respectfully urge CMS to monitor the impact of this change, particularly for services newly added under the revised criteria, to ensure ongoing safety, quality and beneficiary access to essential infectious diseases services.**

Moreover, IDSA supports CMS’ continued reservation of authority to remove services from the list based on internal review or stakeholder feedback, providing important safeguards for patient safety. We encourage CMS to maintain transparent communication and a data-driven approach in reviewing the performance of telehealth services, including ongoing stakeholder engagement.

Frequency limitations





IDSA supports the proposal to permanently remove the frequency limitations for subsequent care services in inpatient and nursing facility settings (CPT codes 99231-99233 and 99307-99310) and critical care consultations (HCPCS codes G0508 and G0509) furnished via telehealth. As we have consistently advocated in previous comment letters, these frequency limitations represent arbitrary administrative barriers that inappropriately restrict physician clinical judgment and may compromise patient care. For infectious diseases specialists, the ability to provide subsequent inpatient consultations and critical care consultations without artificial frequency restrictions is particularly crucial given the complex, rapidly evolving nature of infectious disease conditions that often require frequent reassessment and adjustment of antimicrobial therapy. Patients with complicated infections or multidrug-resistant organisms, or those receiving specialized treatments, may require more frequent specialist input than these arbitrary limitations would allow. The removal of these restrictions will enable ID physicians to make care decisions based on clinical needs rather than administrative rules, ultimately improving patient outcomes and access to specialized infectious diseases expertise. **We urge CMS to finalize this proposal as it represents a significant step toward eliminating unnecessary barriers to medically necessary care while preserving appropriate clinical decision-making authority for specialists.**

Virtual direct supervision

IDSA supports the proposal to permanently adopt a definition of direct supervision that includes immediate availability of the supervising practitioner via audio/video real-time communications technology (excluding audio-only) for all incident to services, except those with a global surgery indicator of 010 or 090. This proposal rightly recognizes the advancements in telehealth and care delivery models by allowing practitioners greater flexibility to supervise clinical care virtually, which can improve access to expertise, particularly critical in infectious diseases where consultation may be needed across sites and geography. IDSA agrees with the rationale that this approach maintains patient safety by excluding high-risk surgical procedures requiring closer oversight, while enabling efficient, patient-centered care for lower-risk services. IDSA encourages CMS to foster innovations that maintain quality and safety, yet expand practitioner availability and patient care options, especially for practices stretched by workforce shortages or serving rural or underserved areas. This permanent policy will help modernize health care delivery while retaining appropriate protections for more complex procedures.

Quality provisions

Merit-Based Incentive Payment System performance threshold

We appreciate CMS' continued commitment to refining quality measurement under the Quality Payment Program. As detailed in the Proposed Rule, we support the proposal to update the Merit-Based Incentive Payment System (MIPS) performance thresholds in a manner consistent with statutory requirements and based on prior year data and keep the threshold at 75 points from 2026 to 2028. We encourage continued stakeholder engagement as CMS pursues its goal of aligning MIPS with broader value-based care objectives.

RFI on future MIPS performance thresholds

In response to the request for information on whether future performance thresholds should be determined based on single-year data or over multiple years, and on the prospect of increasing the threshold in the future, **IDSA urges CMS to prioritize approaches that balance fairness, predictability and clinical reality.** Setting the threshold using a multiyear average can reduce volatility year-over-year



and account for external factors that disproportionately impact specialties caring for complex, high-risk or underserved patient populations. However, IDSA also recognizes the value in periodically reassessing the threshold to ensure it remains meaningful and aligned with improvements in care delivery and outcome measurement.

We encourage CMS to avoid abrupt or substantial increases in the threshold, as this could inadvertently penalize specialties, such as infectious diseases, that may have limited opportunities to impact certain MIPS performance categories or face unique patient care challenges. Instead, IDSA recommends a gradual, transparent and well-communicated approach to any potential threshold changes, ensuring that all clinicians have the information and lead time necessary to engage constructively in the Quality Payment Program and to deliver high-value care to Medicare beneficiaries.

MIPS quality measures

Quality Measure 508: Adult COVID-19 Vaccination Status

IDSA strongly opposes the proposal to remove Quality Measure 508: Adult COVID-19 Vaccination Status (MIPS CQM) from MIPS beginning in the 2026 performance year. The ongoing burden of COVID-19 on adult populations, especially those with comorbidities or immunocompromised states, makes continued surveillance, measurement and improvement of vaccination rates critically important. Retaining this measure provides an essential mechanism to encourage clinicians to assess, recommend and document COVID-19 vaccination among adult patients, a fundamental step in preventing severe disease, reducing transmission and safeguarding public health. With the persistence of COVID-19 circulation, episodic surges and the emergence of new variants, the removal of this measure is premature. **Elimination of Quality Measure 508 risks diminishing provider accountability and could signal to clinicians and the public that COVID-19 vaccination is no longer a high priority, despite ongoing evidence to the contrary. We urge CMS to reconsider and maintain this measure, ensuring continued focus on monitoring and improving adult COVID-19 vaccination as an integral component of quality patient care.**

Overall, maintaining this measure helps track and address disparities in vaccination rates, ensuring vulnerable and underserved populations are not left behind. Additionally, this measure supports rapid response to future surges or variant-driven waves by keeping vaccination infrastructure and documentation practices active. Retaining COVID-19 vaccination measurement keeps consistent with other adult immunization quality measures (e.g., influenza, pneumococcal), reinforcing its importance as standard preventive care. Specifically, hospitalizations, long COVID prevalence and associated health care costs remain significant, justifying the continued prioritization of vaccination, especially in vulnerable populations. Removing the measure now would disrupt ongoing trend analyses, making it harder to evaluate the long-term impact of vaccination programs and identify gaps. Regular vaccination assessment is a low-cost, high-impact intervention that strengthens a health care system's ability to manage respiratory disease burden throughout the year.

Addition of hepatitis C virus quality measure

IDSA strongly supports the addition of the Hepatitis C Virus (HCV): Sustained Virological Response (SVR) Quality Measure to the MIPS Clinical Quality Measures inventory. This outcome-focused measure directly aligns with IDSA's commitment to evidence-based care and the joint American Association for the Study of Liver Diseases (AASLD)-IDSA hepatitis C guidance recommendations, which

emphasize universal treatment for all adults with chronic HCV infection. SVR represents the gold standard for determining virologic cure of HCV, defined as undetectable HCV RNA levels 12 weeks after treatment completion, and serves as a meaningful indicator of successful patient outcomes. Given that current direct-acting antiviral therapies can achieve cure rates exceeding 95% in properly treated patients, measuring SVR rates will help identify gaps in the care continuum and drive quality improvement initiatives.² This measure fills a critical need in infectious diseases quality measurement, as highlighted by IDSA's ongoing efforts to develop specialty-specific quality measures that demonstrate the value and impact of infectious diseases physicians on patient outcomes. By tracking SVR rates, clinicians can better assess treatment effectiveness, identify opportunities for improvement and ultimately work toward the public health goal of hepatitis C elimination. The measure will also provide valuable data to support evidence-based practice improvements and help demonstrate the clinical and economic value of hepatitis C care delivery by infectious diseases specialists.

MIPS cost

IDSA acknowledges the proposal to refine the attribution methodology for the total per capita cost (TPCC) measure starting with the 2026 performance period. Specifically, we agree that limiting attribution within a defined period to beneficiaries who have received at least two qualifying services from the same clinician group, where both services are provided by a clinician not excluded based on specialty, will better identify true ongoing care relationships and help ensure that cost accountability aligns more closely with clinicians genuinely managing patient care. We appreciate the proposed exclusion of advanced care practitioners in specialist-only groups from measure attribution, as this will prevent inappropriate attribution of costs for specialty care that may not reflect longitudinal primary care relationships. These changes align with our longstanding concerns about attribution misalignment in cost measurement and will help foster fairer and more clinically relevant performance assessment.

IDSA also supports the proposal to establish a two-year informational-only feedback period for new MIPS cost measures. Providing clinicians with confidential feedback before incorporating new cost measures into performance scoring will allow time for practitioners and organizations to understand measure specifications, interpret potential cost drivers and adapt practice workflows without the risk of immediate payment adjustments. We believe this phased approach is critical for successful measure adoption and will help mitigate potential unintended consequences that could arise from lack of familiarity or insufficiently tested measurement strategies. We encourage CMS to engage in transparent communication and provide actionable feedback during this period to ensure that all specialties, including infectious diseases practitioners who may have unique cost profiles, can use this period for meaningful quality improvement.

MIPS promoting interoperability

Electronic case reporting measure

IDSA understands and supports the proposed suppression of the electronic case reporting (eCR) measure due to CDC's temporary pause in onboarding new health care organizations for eCR production and new local public health agencies for eCR data receipt. This pause, undertaken to

² Ghany, Marc G., et al. "Hepatitis C Guidance 2019 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection." *Hepatology*, vol. 71, no. 2, 2020, pp. 686-721. National Institutes of Health, <https://pmc.ncbi.nlm.nih.gov/articles/PMC9710295/>.



improve and automate onboarding processes and ensure long-term sustainability, would likely make it infeasible for many otherwise compliant clinicians and health care organizations to meet the requirements for validated data production within the allotted time frame.

IDSA believes that this approach is both pragmatic and equitable, given the current technical and operational barriers beyond the control of clinicians. Suppressing the eCR measure ensures that clinicians will not be penalized during this transition, maintaining fairness in the MIPS scoring process. We encourage CMS to provide clear communication regarding this policy and ensure that stakeholders are given timely updates about the resumption of eCR onboarding. IDSA also urges CMS to continue investments in strengthening the nation's digital public health infrastructure and to coordinate closely with CDC and other stakeholders as eCR capabilities are restored, ensuring a seamless future transition that supports quality reporting and infectious disease surveillance efforts.

MIPS improvement activities

Removal of improvement activities

IDSA opposes the proposed removal of the following improvement activities (IAs): “Vaccine Achievement for Practice Staff: COVID-19, Influenza and Hepatitis B,” “Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities” and “COVID-19 Clinical Data Reporting With or Without Clinical Trial.”

“Vaccine Achievement for Practice Staff: COVID-19, Influenza and Hepatitis B”

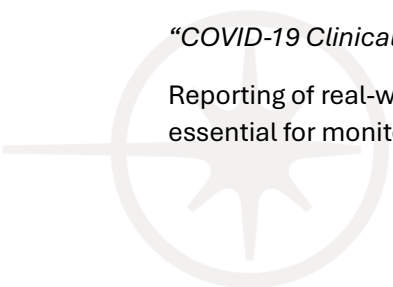
This IA supports vaccination as a cornerstone of infectious disease prevention for health care personnel, both for their safety and for the protection of vulnerable patient populations. Removing this activity seriously undermines ongoing efforts to combat vaccine-preventable disease transmission within health care settings. Especially with the continued risk of COVID-19 and persistent threats from influenza and hepatitis B, practice-level vaccination achievements should remain a recognized quality improvement focus. Retaining this IA reinforces public health and aligns with CDC and infection prevention priorities, setting clear expectations for immunization standards across practices. High vaccination coverage among health care personnel helps reduce absenteeism and maintain staffing capacity during outbreaks and maintains readiness for emerging infectious threats.

“Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities”

The removal of activities specifically focused on closing gaps in care delivery to marginalized communities is very premature and would send the wrong signal at a time when inequities remain stark and persistent. Health disparities continue to drive poor outcomes in infectious diseases, including disproportionate burdens for communities of color, rural areas and individuals with limited access to preventive care. If diseases of high prevalence in these communities are not addressed early, they often progress to advanced stages that require far more expensive tertiary care, thereby increasing global health care costs. Early intervention in these communities is thus not only an ethical imperative but also a cost-effective strategy. Recognizing quality improvement activities that directly address social determinants and inequities is vital for progress toward more equitable health outcomes.

“COVID-19 Clinical Data Reporting With or Without Clinical Trial Participation”

Reporting of real-world clinical data relating to COVID-19, including outside of clinical trials, remains essential for monitoring trends, informing best practices and rapidly responding to outbreaks or





emerging threats. Removing this improvement activity diminishes incentives for providers to contribute to important data-driven pandemic response efforts. Ongoing COVID-19 data collection from front-line clinicians is critical not only for current management, but also for preparing for future public health emergencies. This IA supports both evidence-based care and national preparedness goals.

Recommendations

The proposed removals would severely erode essential infrastructure supporting vaccination, health equity initiatives and infectious diseases data reporting. Each of these IAs, “Vaccine Achievement for Practice Staff: COVID-19, Influenza and Hepatitis B,” “Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities” and “COVID-19 Clinical Data Reporting With or Without Clinical Trial,” has demonstrated significant value in routine clinical operations and in emergency public health response. Far from being outside CMS’ current focus, these activities intrinsically promote prevention, patient well-being and equitable access to care for all patient communities to address the causes of chronic disease and enhance the collaboration for the primary prevention of illness.

Ensuring that health care personnel are immunized against COVID-19, influenza and hepatitis B is one of the most effective primary prevention strategies for protecting both vulnerable patients and the clinical workforce against serious infectious diseases. Using structured toolsets and resources to close health and health care inequities translates directly into earlier diagnosis, prevention of disease progression and improved management of chronic and infectious illnesses in underserved communities. Continued COVID-19 clinical data reporting supports timely surveillance, informs evidence-based prevention strategies and enables rapid intervention to protect population health, which are functions that are fundamental to patient well-being and public health preparedness. **IDSA urges CMS to consider the negative ramifications of discontinuing these measures in preventing or controlling future outbreaks. We anticipate repeated potentially disastrous outbreaks without these safeguards.**

Their continued inclusion encourages best practices, aligns squarely with CMS’ stated priorities around prevention, nutrition and well-being, and sustains momentum on issues of national importance. **IDSA urges CMS to retain these improvement activities for the CY 2026 performance period and beyond, ensuring that the Quality Payment Program continues to incentivize these critical, prevention-focused and equity-driven improvements in infectious diseases care and public health.**

MIPS Value Pathways

IDSA continues to have reservations about the way MIPS Value Pathways (MVPs) are being implemented, and we question whether the framework goes far enough in terms of fundamentally fixing aspects of the program that have long prevented meaningful participation by our specialty. **For example, the MVP framework does little to resolve the ongoing lack of relevant measures available to largely hospital-based cognitive specialists, such as ID physicians.** Aside from the HIV and hepatitis C virus quality measures, which are meaningful to only a small proportion of ID physicians in the outpatient setting who focus on these disease areas (as opposed to general ID), there are very few ID-specific measures on which ID physicians can report to avoid payment penalties. We remind CMS that ID physicians are not “proceduralists” but rather non-proceduralists/cognitive physicians who provide most of their services using E/M codes, many of which are billed in the inpatient setting. Our specialty’s unique billing and practice patterns have made it challenging to develop additional quality measures that are feasible to report under a program like MIPS.



Since 2013, IDSA has dedicated efforts to developing ID-relevant clinical quality measures, such as the 72-Hour Review of Antibiotic Therapy for Sepsis, Appropriate Use of Anti-Methicillin Resistant *Staphylococcus aureus* Antibiotics, and Appropriate Treatment of Initial *Clostridium difficile* Infection, to help fill this gap, but these measures have consistently been rejected by CMS when submitted for the Annual Call for Measures. A clear example reinforcing the value of specialty cognitive input is seen in the management of *Staphylococcus aureus* bacteremia, where multiple studies have demonstrated that formal ID consultation is strongly associated with reduced mortality, improved adherence to evidence-based care and lower rates of complications and relapse. The presence of an ID physician's expertise in the chart leads directly to hospital-wide practice improvements, such as more thorough source control evaluation, correct antibiotic selection and appropriate follow-up that translates to better patient-centered outcomes. **Rewarding and incentivizing these cognitive contributions through meaningful, ID specialty-relevant quality measures would not only advance care quality but also recognize the essential, complex decision-making that ID specialists provide in managing serious infections.**

Unfortunately, the MVP framework is limited to the current inventory of MIPS quality measures and does little to incentivize the development or use of more innovative and meaningful measures. **IDSA encourages CMS to adopt policies to address these shortcomings and to work with professional societies to increase the number and use of relevant clinical quality measures. IDSA would greatly appreciate an opportunity to partner with CMS to explore the development of new measures to populate future MVPs for infectious diseases conditions that are reportable by multiple specialties within the hospital setting.**

We also encourage CMS to expand opportunities for facility-based clinicians to get MIPS credit for outcomes they contribute to within their institutions, which might be measured under a separate CMS quality program. The number of clinicians who have qualified for facility-based scoring under MIPS to date has been lower than expected, which might signal a need to reevaluate and update this policy. Doing so would not only provide ID physicians with a more meaningful participation pathway but would also promote team-based approaches to care and minimize duplicative reporting.

Given these ongoing challenges, IDSA strongly urges CMS not to mandate MVPs starting in 2029, but to instead preserve choice in the program and to work with stakeholders, including IDSA, to address some of the underlying limitations of the program that make it challenging for ID physicians to participate meaningfully and successfully.

Modifying existing MVPs for CY 2026

IDSA also notes the proposal to modify all 21 existing MVPs for CY 2026, addressing both quality measure and improvement activity inventories. It is essential that any modifications to MVPs and their measure inventories continue to preserve strong, relevant infectious disease content to ensure accurate capture of the value ID clinicians provide, particularly in antimicrobial stewardship, infection prevention and management of complex infections.

In addition to the modifications to all existing MVPs for CY 2026, IDSA recognizes and appreciates the proposed addition of several clinically relevant measures to the Prevention and Treatment of Infectious Disorders MVP. **Notably, CMS proposes adding a hepatitis C virus quality measure, which aligns with core infectious diseases priorities and supports national elimination goals. IDSA strongly supports the inclusion of this evidence-based quality measure, as sustained virological response remains the gold standard of curative treatment in HCV management and its use in performance measurement will incentivize best practices and improved patient outcomes.**



Additionally, the proposed addition of three new cost measures warrants close attention from the infectious diseases community. The Respiratory Infection Hospitalization (COST_RIH_1) episode-based cost measure will assess resource utilization and cost effectiveness for clinicians managing acute respiratory infections requiring inpatient care — a domain frequently managed by ID physicians, particularly during influenza, COVID-19 and RSV seasons. The Sepsis (COST_S_1) episode-based cost measure similarly aims to evaluate clinician-attributed costs for inpatient sepsis care, an area of major clinical and socioeconomic impact where ID expertise is critical in driving both quality and stewardship. The Medicare Spending Per Beneficiary Clinician (MSPB_1) cost measure will attribute broader per-episode spending for acute inpatient care, expanding cost accountability for clinicians involved in complex infections and multidisciplinary care teams. **IDSA supports inclusion of clinically relevant episode-based cost measures that appropriately risk-adjust for patient complexity and care setting and urges CMS to ensure transparency in measure methodology and attribution criteria.**

However, IDSA reiterates longstanding concerns regarding the continued inclusion of the TPCC measure within the Prevention and Treatment of Infectious Disorders MVP. As previously expressed, TPCC assesses costs across the continuum of care without sufficient adjustment for specialty roles or care intensity, and it frequently holds ID physicians accountable for cost domains beyond our direct clinical influence. In its broad application, TPCC yields little actionable information to inform specialty-driven quality improvement, particularly for consultants who are typically responsible for short-term interventions designed to optimize clinical outcomes and resource use. **We urge CMS to revisit the appropriateness of TPCC for infectious diseases specialties and to prioritize cost measures that offer both accuracy and actionable insights tailored to the consultative, stewardship and acute care contributions of ID physicians.**

Group participation in MVPs

IDSA recognizes and supports the updated approach to defining group participation in MVPs for 2026. **Specifically, IDSA agrees with the proposed flexibility allowing practices to self-attest to their specialty composition during the MVP registration process, rather than having CMS make these determinations based on imperfect claims data.** The new definitions clarify that a single specialty group may consist of clinicians in one specialty type or those involved in a single clinical focus, and that multispecialty groups are comprised of multiple specialties, accommodating the wide variety of practice arrangements utilized in infectious diseases. The new definitions are important for ID practitioners involved in collaborative and multidisciplinary practices, as they more accurately reflect the structure and focus of specialty care teams that manage complex episodes of care. It is essential to recognize that transplant infections and tuberculosis (TB) each represent distinct and challenging clinical entities within infectious diseases practice, separate from, but often as involved and resource-intensive as, other major domains like sepsis and HIV.

Transplant infections require highly specialized expertise due to the interplay of immunosuppression, unique microbiologic risks and the frequent need for advanced diagnostics and individualized therapeutic regimens. Similarly, TB management in transplant patients is distinguished by its own complexities: rigorous pre-transplant screening, nuanced decision-making around latent and active TB therapy and careful adjustment for drug interactions with immunosuppressive regimens. These scenarios demand close care coordination among ID specialists, transplant teams, pharmacists and other disciplines to optimize patient safety, especially given the substantial impact that ID guidance has on reducing morbidity, mortality and resource utilization in these vulnerable populations.



Furthermore, we appreciate CMS' attention to the unique needs of small, multispecialty groups. By proposing that small multispecialty practices (15 or fewer eligible clinicians) may continue to report as a group without forming subgroups, CMS addresses transition barriers uniquely faced by smaller ID practices. This flexibility is crucial for maintaining equitable opportunities for small practices and safety net providers or those serving rural and underserved communities to continue to participate meaningfully in the Quality Payment Program and MVPs without undue administrative burden.

We urge CMS to ensure that the structure and content of MVPs, as well as subgrouping policies, support the continued participation and recognition of infectious diseases clinicians and that relevant measures remain available within MVPs as traditional MIPS sunsets.

MIPS Qualified Clinical Data Registries

IDSA strongly supports CMS' proposal to provide MIPS Qualified Clinical Data Registries (QCDRs) and Qualified Registries with up to one year after MVP finalization to fully support newly finalized MVPs, beginning with the 2026 performance period. This proposal represents a pragmatic acknowledgment of the technical implementation challenges that third-party intermediaries face when adapting their systems to support new reporting pathways. As documented in prior feedback from specialty registry coalitions, QCDRs have historically struggled with compressed timeframes between final rule publication and effective dates, which typically allow only two months for programming new measures and preparing systems for MVP reporting. This brief window is inadequate given the complexity of developing specialty-specific measures, integrating new data elements into existing platforms and conducting thorough testing to ensure data integrity. The infectious diseases community relies heavily on QCDRs to provide meaningful, specialty-relevant quality measures that better reflect the scope of ID practice compared to traditional MIPS measures. **By extending the implementation timeline to one year, CMS will enable QCDRs to provide more robust support for infectious diseases specialists participating in future ID-focused MVPs, ultimately improving the quality and reliability of specialty-specific quality reporting while reducing the administrative burden on ID practitioners.**

Advanced Alternative Payment Models

IDSA appreciates the proposal to determine Qualifying APM Participant (QP) status at the individual clinician level in addition to the APM entity level and to utilize Covered Professional Services for QP determinations, rather than limiting assessments to E/M services. **IDSA supports these changes, as they will more accurately reflect the breadth of activities provided by eligible clinicians, including infectious diseases specialists whose contributions often extend beyond traditional E/M encounters.** Infectious diseases physicians frequently lead and participate in antimicrobial stewardship initiatives, oversee health care epidemiology infection prevention programs to reduce hospital-acquired infections and prevent increased length of stay in hospitals, and provide direction for OPAT services, all of which are essential for patient safety, quality improvement and cost-effective care. Additionally, ID specialists are increasingly responsible for device stewardship activities, such as managing protocols and multidisciplinary care pathways to prevent and address device-associated infections, further demonstrating the diverse scope of high-value services they deliver. **By expanding the range of services considered for QP determination, CMS can help minimize incentives for APM entities to exclude specialists from participation lists, promoting more equitable access to Advanced APMs for all clinicians.**

Conclusion



IDSA appreciates the opportunity to provide feedback on the CY 2026 Medicare Physician Fee Schedule Proposed Rule and the proposed updates to the Quality Payment Program. The continued evolution of payment models and quality reporting requirements is critical for ensuring that the Medicare program incentivizes high-quality, efficient and patient-centered care. Above all, it remains essential that program changes promote equitable access, reduce administrative burden and enable clinicians to focus on delivering value-driven care to Medicare beneficiaries.

We look forward to ongoing collaboration with CMS to implement these policies in a manner that strengthens the Medicare program and benefits patients, providers and the broader health care system. If you have any questions or if we may be of any assistance to you, please do not hesitate to contact Yasmin Rafiq, IDSA's regulatory and reimbursement policy manager, at yrafiq@idsociety.org.

Sincerely,

A handwritten signature in black ink that reads "Tina Q. Tan MD". The signature is written in a cursive, flowing style.

Tina Tan, MD, FIDSA, FPIDS, FAAP

President

Infectious Diseases Society of America

