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IDSAs Headquarters

1300 Wilson Boulevard
Suite 300
Arlington, VA 22209
TEL: (703) 299-0200
FAX: (703) 299-0204
EMAIL ADDRESS:
info@idsociety.org
WEBSITE:
www.idsociety.org

December 28, 2018

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

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

Dear Administrator Verma:

The Infectious Diseases Society of America (IDSAs) appreciates the opportunity to provide comments on the Final Rule for the 2019 Medicare Physician Fee Schedule (MPFS). IDSAs represents more than 11,000 infectious diseases (ID) physicians, scientists and other healthcare professionals devoted to patient care, prevention, public health, education, and research in infectious diseases. Our members care for patients of all ages with serious infections, including treating meningitis, pneumonia, tuberculosis, HIV/AIDS, health care-associated infections, antibiotic resistant bacterial infections, as well infectious disease outbreaks and emerging infections such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus. Below, we provide comments on specific finalized plans related to Evaluation & Management coding as well as aspects of the Quality Payment Program.

Changes to Evaluation & Management Services

In an effort to reduce physician burden through the “Patients Over Paperwork” campaign, the Centers for Medicare & Medicaid Services (CMS) proposed changes for 2019 Evaluation and Management (E/M) coding that would have collapsed the five codes used to describe an encounter with a new patient to two codes and the same for established patient encounters (again, from five codes to two codes). During the comment period for the proposed rule, CMS engaged the physician community in several learning sessions. IDSAs also appreciated the opportunity to provide input via the in-person meetings with CMS officials and staff.

The proposed rule catalyzed medical specialties to engage in discussions of the current structure of the E/M code set as well as issues related to the current valuation of these services. IDSAs has been an active participant in many of these discussions, whether convened by the AMA CPT/RUC Workgroup, the American College of Physicians (ACP), or the Cognitive Care Alliance. The resultant effect of the proposed rule was evident in the overwhelming amount of public comments that CMS received. We appreciate the Agency’s actions prompting attention to E/M documentation, but we recognize that efforts to

reduce administrative burden must be pursued carefully, particularly for codes that describe physician services which are used by nearly all health care providers. We are keenly aware that the documentation requirement changes also force consideration of the related valuation of these services.

CMS issued a final rule that revised the code collapse concept to preserve level 1, while collapsing levels 2, 3, 4 into one level, and preserving level 5 codes, for both new and established outpatient encounters. CMS also proposed two add-on codes for use with the combined level 2-4 code, one to capture work associated with primary care services and the other to capture work associated with specialty care. While CMS delayed implementation of the new E/M code structure until 2021, IDSA and other stakeholders remain concerned about the impact these changes will have. CMS also finalized policies to reduce E/M documentation requirements with those documentation changes becoming effective January 1, 2019.

ID physicians provide primarily cognitive care and report their patient care services using E/M codes almost exclusively. Out of all physician services billed by ID physicians, E/M codes represent the overwhelming majority. Approximately 93% of ID physicians' 2016 Medicare utilization was comprised of E/M codes, totaling \$626 million of the approximately \$670 million in Medicare utilization for all services reported by ID physicians.^{1,2} Changes to the values, descriptors and the documentation requirements of E/M codes would have a profound effect on the specialty of ID. According to an impact analysis prepared by the American Medical Association (AMA), the specialty of ID will see a decrease of 4% in Medicare payments when collapsing the E/M levels 2-4 into one combined code, as finalized by CMS for implementation in 2021. Per the impact analysis as outlined by CMS in the final rule, the impact to ID is estimated to decrease payments by 1%.³ The difference in these two estimates may be due to the level of analysis, where the AMA attests that its analysis is a more granular depiction of the impact the code changes will have on specialties.⁴

In either case, the negative impact of the finalized payment policy is of great concern to IDSA, as we note a six-year trend of attracting fewer fellowship applicants compared to the total number of fellowship spots available, (ID fellowship programs attract 0.9 applicants per available spot; Other cognitive specialties such as nephrology with 0.6 applicants per available spot.).^{5,6} This negative trend in the interest in the sub-specialty of infectious diseases is linked to the low salary garnered by ID physicians compared to other medical practitioners, as reported

¹ CMS-1676-P 2016 Utilization Data Cross-walked to 2018 extracted from the files released with Medicare Physician Fee Schedule 2018 Purposed Rule.

² E/M codes include the entire CPT® E/M code range from 99201-99498.

³ Federal Register, Vol. 83, No. 226, pg. 60030.

⁴ American Medical Association, Summary; 2019 Medicare Physician Fee Schedule and Quality Payment Program Final Rule, pg. 15.

⁵ National Resident Matching Program, Charting Outcomes in the Match, Specialties Matching Service, Appointment Year 2018. National Resident Matching Program, Washington, DC. 2018.

⁶ National Resident Matching Program, Results and Data: Specialties Matching Service 2018 Appointment Year. National Resident Matching Program, Washington, DC. 2018.

in national surveys.^{7,8} Fewer internal medicine and pediatric residents enter in ID fellowships will eventually reduce access to ID specialty care for Medicare beneficiaries. During a recent, panel discussion on Medicare physician payment highlighted, the disparity seen between the geographic distribution of ID physicians and other cognitive physicians relative to the distribution of Medicare patients who died from diseases treated by those cognitive specialists. This discrepancy was cited as evidence of insufficient access to care for Medicare beneficiaries.⁹

Changes to E/M that result in even a 1% decline in reimbursement for ID physicians may exacerbate patient access to ID specialty care and threaten the career viability for an ID physician. We believe it is imperative that our Society continues to work with the Agency and other stakeholders to develop solutions that will ensure accessible care to Medicare beneficiaries, while alleviating administrative burden and appropriately value the cognitive care involved in E/M services.

Cognitive care is the very essence of the E/M services. Such clinical care involves applying intellectual curiosity and critical thinking to gather relevant information about a patient's history of present illness, performing an assessment of overall health (mental and physical) surrounding the chief complaint, considering family history and socio-demographic factors and then in communication with the patient and referring provider, making informed recommendations as to the appropriate evaluation, diagnosis and treatment for the patient. Within cognitive care, medical decision-making (MDM) has always been a fundamental core component upon which the real value of the service is based. The inability to quantify the complexity of the MDM in a consistent and reliable manner has likely made this less important and less valued compared to easily quantifiable procedure-based services.

In discussions that relate to the valuation of physician services, the term “work” is used often and generally refers to the activities health care providers perform. “Work,” as it is used in this context refers to the array of activities (such as physical examination, MDM and counseling) but does not refer to the complexity of the work. In other words, “work” describes the breadth of activities but not “depth.” It is easy to describe the array of activities involved as well as the time spent in the performance of these activities, but it is difficult to describe the complexity within each activity, unless one considers certain characteristics unique to the patient.

We believe that to appropriately value the work performed, one must account for the array of activities and the complexity within and across activities. It is important to recognize that CPT/HCPCS codes describe the activities of the work, stratified into levels of increasing activity, (i.e. the counseling activity for a level 4 should be more than that for a level 2). Absent consideration of specific patient characteristics, efforts to value the activities will fall short because there is currently no measure (or proxy) that relates to complexity at the individual

⁷ Bonura EM, Lee ES, Ramsey K, Armstrong WS. Factors influencing internal medicine resident choice of infectious diseases or other specialties: a national cross-sectional study. *Clin Infect Dis* 2016; 63:155–63.

⁸ Medscape. Physician compensation report 2017. <https://www.medscape.com/sites/public/physician-comp/2017>. Accessed 16 December 2018.

⁹ Berenson R, Goodson J, Miller M, Eyles M. “Medicare Physician Payment Rules.” Panel Discussion. American Enterprise Institute. Washington, DC. 2018.

patient level. One should consider how the “counseling” activity for a level 2 E/M service might be more “complex” for a patient with a hearing disability or mild cognitive impairment. As well, the physical examination involved in a level 2 E/M might be more “complex” for a patient who is morbidly obese, Parkinson’s disease or is quadriplegic. Therefore, we take this opportunity to introduce to the broader discussion of E/M services the importance of considering complexity at the patient level, as well as re-emphasizing the inadequacy of the current valuation process to measure complex MDM.

We recognize that there are methodologies employed that attempt to quantify MDM (e.g. Marshfield Clinic Scoring Tool) by counting diagnostic and management options. Such tools might be considered useful as they reinforce documentation requirements needed to select the appropriate level of E/M service, but these tools do not address the complexity of the individual patient. Furthermore, the consideration of time as an explicit factor in selecting the level of E/M service is problematic in that it leads the determination of service level in a direction that does not appreciate the clinical experience of the provider. As such, the more seasoned clinician who can distill a complex patient’s case with more efficient MDM (honed by years of clinical experience) is neither recognized nor rewarded. In addition, such tools re-introduce documentation burden at time when CMS is striving to reduce the same.

Much of the complex MDM involved in E/M services provided by ID physicians as well as physicians in other cognitive specialties happens outside of the face-to-face encounter. Over the past five years, IDSA has been supportive of the Agency’s efforts to recognize non-face-to-face care provided such Chronic Care Management (CCM) and Transitional Care Management (TCM). Most recently, CMS finalized policy to cover non-face-to-face work conducted in Virtual Check-in visits and Interprofessional Consultation services. However, the basis for valuation of these codes is largely dependent on time and fails to account for the complexity of the patient.

There are no reasonable, reliable metrics identified that accurately capture complex MDM consistently across all providers who bill E/M services, at least within the current payment system. As part of the Cognitive Care Alliance, IDSA has advocated for CMS to lead research into this area to resolve the underlying inadequacies of the current valuation system. We recognize that the work involved to identify more appropriate inputs to measuring MDM would be extensive and involve an understanding of Decision-Making Capacity Assessment (DMCA) Models. Such research requires the leadership of CMS to convene other important stakeholders (AMA, ACP, etc.) and ensure a comprehensive approach. We recognize that this research would require years to design and carry-out and would require significant funding. Therefore, we believe it may be unrealistic to call for this to be done in time to meet the 2021 implementation date of the outpatient E/M code revisions as indicated in the final rule.

While we believe the work that CMS has done to prompt activity for revising E/M services and reducing documentation requirements is important, we think that patient complexity should be a factor that is included in the broader effort to appropriately value cognitive care (E/M services). It is with this premise that IDSA is exploring solutions that apply fairly across all health care providers that bill E/M services and that attempt to correct the inequities in the compensation of

cognitive services through a patient-centered approach. Given the current inadequacies to value cognitive care and until a research project is launched by key stakeholders to identify better metrics, we look within the current payment system to find reasonable proxies to advance toward an improved alternative to recognize complex MDM across all providers who bill E/M services. ***In pursuit of alternatives, we propose adapting the Hierarchical Condition Category (HCC) Coding to factor into payment for services under the Physician Fee Schedule. Specifically, we propose that CMS establish a threshold HCC baseline above which an add-on payment would be triggered when physicians provide Level 5 E/M services to complex patients, (with complexity determined by the HCC score).***

We submit this proposal based on the following considerations and provide additional details below:

- The HCC coding allows for the diagnoses (as captured by ICD-10 coding) that apply to a patient to be translated into a risk adjustment factor (RAF) score, which is used in risk-adjusted modeling.
- CMS incorporates HCC coding in a variety of programs for purposes of risk-adjustment, (e.g., Medicare Advantage, Quality Payment Program with the value-based payment modifier, the calculation of the complex patient bonus under the Merit-based Incentive Payment System, and in Alternative Payment Models). In fact, in response to comments regarding the use of the HCC risk score as a component for calculating the complex patient bonus under MIPS, the Agency stated that it “continues to believe HCC risk scores are a valid complex patient indicator”.¹⁰
- Medicare calculates the average HCC score for the Medicare population. As noted in the Methodological Overview of Utilization & Payment Data Public Use File, the average HCC risk score is set at 1.08.¹¹
- An HCC threshold baseline could be established by CMS (for example 2 x Average HCC).
- When a provider performs a Level 5 E/M visit for a complex patient (one with an HCC above the threshold baseline set by CMS), an add-on payment would be triggered to recognize the work involved in treating the complex patient.

In summary, we propose the HCC score (a cumulative measure of complexity as determined by patient-specific ICD-10 codes) that is used by CMS in several programs as a proxy for patient complexity. This should be applied only to the highest level of E/M services, for patients whose HCC score is significantly above the Medicare average, to trigger an add-on payment to the physician in recognition of greater MDM required by treating a complex patient. We are intentionally proposing that the High HCC Score Add-on (HHSA) payment applies to treating complex patients that meet the level of activity involved for a Level 5 E/M Service. We are mindful that the detailed documentation requirements needed to meet that level are still in place

¹⁰ Federal Register, Vol. 82, No. 220, pg. 53773.

¹¹ Centers for Medicare & Medicaid Services, Medicare Fee-For-Service Provider Utilization & Payment Data Physician and Other Supplier Public Use File: A Methodological Overview, April 7, 2014; Last Updated May 3, 2018.

and that a narrow application of the add-on payment will have to be modeled for purposes of budget impact analysis.

We present this proposal based on a preliminary analysis. IDSA commissioned The Moran Company to conduct an analysis using the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF) to determine the average Hierarchical Condition Categories (HCC) risk score for Medicare beneficiaries that are treated by Medicare providers who identify as infectious diseases physicians. For comparison, the data analysis also tabulated the average HCC scores for the specialties of endocrinology, rheumatology and neurology. As noted in the Methodological Overview, the average risk score is set at 1.08.¹² The preliminary analysis revealed that the average HCC for each of the indicated specialties was well above the average risk score for the Medicare population dataset. IDSA would welcome the opportunity to discuss this concept further with CMS and other interested stakeholders, where we could review the preliminary data in more detail and further discuss the concept.

IDSA has long believed that infectious diseases physicians treat “the sickest of the sick” patients. According to CMS, the specialty of infectious diseases is ranked 2nd out of 67 specialties when assessing average Hierarchical Condition Category (HCC) risk score and 7th when assessing Medicare-Medicaid Dual Eligible Patient Ratios, (both HCC and Dual eligibility are measures of patient complexity that CMS uses in the Merit-based Incentive Payment System).¹³ IDSA has commissioned claims-based research to assess the impact of ID physician intervention in patients with severe infections compared to patients with the same infections that do not have an ID physician involved in their care, (“ID vs No ID”). This research has employed the Propensity-Scoring Match (PSM) Methodology which creates matched pairs of risk-adjusted ID vs No ID patients. Patients with large PSM scores are more complex patients. In an analysis of a Medicare claims dataset, it was noted that “40% of the pre-match ID cohort was dropped for having very large propensity scores that could not be matched, and approximately 55% of the pre-match no-ID cohort was dropped for having very small propensity scores.”¹⁴ Research employing the same methodology on a commercial claims dataset indicated similar findings.¹⁵

Infectious diseases physicians are not the only specialists that treat medically complex patients. A recent study comparing the complexity of patients as seen by different medical specialties found that those patients treated by ID physicians, nephrologists and neurologists “consistently tended to be more complex than others, whereas patients seen by other types of physicians, such

¹² Centers for Medicare & Medicaid Services, Medicare Fee-For-Service Provider Utilization & Payment Data Physician and Other Supplier Public Use File: A Methodological Overview, April 7, 2014; Last Updated May 3, 2018.

¹³ Medicare Program; CY 2018 Updates to the Quality Payment Program, Proposed Rule. Federal Register / Vol. 82, No. 125, p.30137. Available at <https://www.federalregister.gov/documents/2017/06/30/2017-13010/medicare-program-cy-2018-updates-to-the-quality-payment-program>

¹⁴ Schmitt et al. Infectious Diseases Specialty Intervention Is Associated With Decreased Mortality and Lower Healthcare Costs. *Clinical Infectious Diseases*, Volume 58, Issue 1, 1 January 2014, Pages 22–28, <https://doi.org/10.1093/cid/cit610>

¹⁵ Schmitt et al. Early Infectious Diseases Specialty Intervention Is Associated With Shorter Hospital Stays and Lower Readmission Rates: A Retrospective Cohort Study. *Clinical Infectious Diseases*, ciy494, <https://doi.org/10.1093/cid/ciy494>

as clinical allergists, dermatologists and family physicians consistently tended to be less complex.”¹⁶ We share the above information to provide further context to our proposal and to highlight that cognitive specialists I treat complex patient populations. However, it should be noted that our proposal as presented here would apply to all physicians who treat complex patients. We look forward to exploring this concept with the Agency and other stakeholders.

Quality Payment Program:

MIPS Claims Submission Types for Small Practices

We recognize that CMS wants to move away from claims-based reporting given its belief that most quality measures reported under this mechanism are “topped out.” While we have concerns with the Agency’s policy associated with topped out measures, we do understand and appreciate the desire to move toward electronic reporting. However, some MIPS eligible clinicians face challenges with electronic reporting through other mechanisms. For this reason, IDSA appreciates that CMS has finalized its proposal to make the Medicare Part B claims collection type available to MIPS eligible clinicians in small practices with fifteen or fewer clinicians, beginning with the 2021 MIPS payment year. We urge CMS to continue seeking opportunities to make the program flexible for as many MIPS eligible clinicians as possible.

Topped Out Measures

The previous policy, which included a 4-year timeline to identify and potentially remove topped out measures, was revised so that once a measure has reached an extremely topped out status (e.g., a measure with an average mean performance within the 98th to 100th percentile range), it may propose the measure for removal in the next rulemaking cycle. CMS indicated that it would consider retaining the measure if there are compelling reasons as to why it should not be removed (e.g., if the removal would impact the number of measures available to a specialist type or if the measure addressed an area of importance to CMS).

We continue to be concerned that the topped-out measures policy will have a negative impact on the measures used by ID physicians. Specifically, two of the top five measures ID physicians typically report *could* be removed by year 2021, (i.e., #130: Documentation of Current Medications in the Medical Record and #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention). Also, aside from HIV and hepatitis-C virus (HCV) quality measures, which are only meaningful to a sub-set of ID physicians, there are very few ID-specific measures upon which ID physicians can report. We also note that Measure #130 and #226 are among the highest reported measures for several other medical specialties.

¹⁶ Tonelli, M., Wiebe, N., Manns, B.J., et al. Comparison of the Complexity of Patients Seen by Different Medical Subspecialists in a Universal Health Care System, JAMA Network Open. 2018.1(7):e184852.doi:10.1001/jamanetworkopen. 2018.4852.

Given the above, IDSA urges CMS to carefully evaluate its topped-out measures policy #130 and #226 to ensure ID physicians and other medical specialties have enough quality measures to sufficiently participate in the Quality performance category of MIPS.

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

CMS finalized its proposal to include eight new episode-based measures, including “Simple Pneumonia with Hospitalization” as an acute inpatient medical condition, and attribute an episode of care to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines under a TIN that renders at least 30 percent of the inpatient E&M claim lines for that patient’s hospitalization.

As we stated in our comments on the episode-based measures proposal, IDSA recognizes the value in team-based patient care and shared accountability; however, we continue to have concerns with the attribution approach for episode-based measures for acute inpatient medical conditions. Again, for appropriate and fair cost attribution, consideration must be given as to the *timing of the consult* provided by the ID physician within the full episode of care. To validate this point, we shared a collection of peer-reviewed articles in our comment letter to the proposed rule that pointed to the impact of early ID physician intervention on total healthcare spending and mortality, as well as outlined a clinical scenario for ID unique to the pneumonia episode.¹⁷ Unfortunately, CMS did not modify its proposal, nor did it meaningfully respond to our concerns.

We remain concerned about the impact of the Cost Performance category, and particularly the “Simple Pneumonia with Hospitalization” episode-based measure on ID physicians. We urge CMS to reconsider its attribution methodology considering the issues we have previously raised. We welcome the opportunity to discuss this issue further with agency officials.

Improvement Activities Performance Category

Despite clarification in its proposed rule that Improvement Activities (IAs) requiring “significant investment of time and resources should be high-weighted,” CMS failed to increase the weight for “Implementation of an Antibiotic Stewardship Program (ASP) (IA_PSPA_15)” as requested by IDSA. We continue to believe this IA should be designated as “high-weight” due to the extensive amount of effort and cross-disciplinary resources that are required to implement an ASP, not to mention the enormous importance of this activity on public health. Ironically, CMS previously deemed “Completion of CDC Training on Antibiotic Stewardship (IA_PSPA_23)” which is only *one component* of implementing an ASP (IA_PSPA_15) a high-weighted IA. As previously noted, this discrepancy promotes a confusing and inconsistent message to participating clinicians and beneficiaries about the significance of efforts to combat antimicrobial

¹⁷ IDSA Comment Letter to 2019 PFS QPP Proposed Rule. Available at https://www.idsociety.org/globalassets/idsa/policy--advocacy/current_topics_and_issues/access_and_reimbursement/2018/091018-idsa-comment-letter-cy2019_qpp-and-pfs_final.pdf

resistance, which has been identified as a national strategic priority.¹⁸ We again urge CMS to revise the weighting of “Implementation of an Antibiotic Stewardship Program (ASP) (IA_PSPA_15)” to a high-weight activity.

Facility-Based Measurement by Individual Clinicians

Facility-based measurement continues to be of interest to ID physicians, having the potential to significantly reduce the administrative burden of MIPS participation aligning with the Agency’s Patients Over Paperwork and Meaningful Measures initiatives.

As CMS implements facility-based measurement, we urge the agency to work closely with IDSA as tools and resources are developed for clinicians to identify which facilities they may be attributed to, how to view and understand the Hospital Value-Based Purchasing (VBP) score of attributable facilities, how the Hospital VBP score is converted to MIPS scoring, special consideration and requirements for group reporting, and exclusion criteria for facility-based measurement, (e.g., virtual group participants). This collaboration will be essential as ID physicians predominantly work in the inpatient hospital setting and are likely to be deemed facility-based. We again encourage CMS to provide a “mock report” based on past years data allowing facility-based clinicians to gain a sense of how the individual clinician or group performed when attributed to the facility in which they attended to the most Medicare beneficiaries.

Measures in Facility-Based Scoring

We continue to have concerns regarding the *clinical relevance* and *appropriateness* of attributing the entirety of the Hospital VBP program measure set to the care provided by ID physicians. As a reminder, ID physicians are cognitive specialists that are frequently called to consult on patients with infections or suspected infections by the attending physicians to provide diagnostic, treatment, and/or management recommendations to the attending physician, who ultimately chooses to accept or reject the ID physician’s recommendations.

As noted in our comments on the proposed rule, ID physicians would not have a *direct* bearing on the outcomes of the mortality measures for acute myocardial infarction and heart failure, the elective delivery measure, and the surgical site infection outcome measure. As such, we suggested that CMS consider reweighting facility-based measure scores at the VBP measure level, rather than the domain level, to facilitate a more accurate evaluation of our facility-based members on measures relevant to their clinical practice.

We recognize that CMS finalized its proposal to use the facility-based score to determine the MIPS quality and cost performance category scores, unless CMS receives another submission of quality data for or on behalf of that clinician or group and the combined quality and cost performance category score for the other submission results in a higher combined quality and cost performance score. Nevertheless, we ask CMS to explore the option in a future proposal.

Expansion of Facility-Based Measurement to Use in Other Settings

¹⁸ Office of the White House; National Strategy for Combating Antibiotic-Resistant Bacteria, September 2014.

We continue to support the expansion of the facility-based measurement option into post-acute care settings, urging extensive dialog with MIPS-eligible clinicians who may be affected by such proposals. IDSA welcomes the opportunity to discuss this option further.

Development of Additional Facility-based Measures

We urge CMS to work with IDSA and similarly-situated medical societies on the development of quality and resource use measures that consider the unique role of facility-based physicians in episodes of care. While arguably more complex, composite measures associated with high-impact health conditions could allow the agency to account for individual aspects of care that facility-based physicians are engaged, including direct patient care on the floor and in the clinic, to the establishment and day-to-day management of system-wide programs that impact patient outcomes across the care continuum. We urge CMS to convene those specialties that are predominantly facility-based for a listening session and/or town hall to discuss the feasibility of developing composite measures for facility-based physicians.

Complex Patient Bonus for the 2021 MIPS Payment Year

We thank CMS for finalizing its proposal to continue the five-point complex patient bonus as ID physicians treat the “sickest of the sick” on a regular basis. IDSA supports the continuation of the complex patient bonus which include using a combination of Hierarchical Condition Category (HCC) risk scores and socio-demographic status factors. As we have advocated in our previous statements and comments, IDSA supports the use of HCC scores to assign complexity to the patient

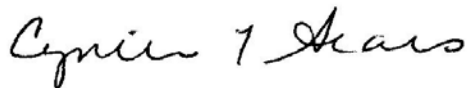
Table Group B: Proposed New and Modified MIPS Specialty Measure Sets for the 2021 MIPS Payment Year and Future Years, B.25. Infectious Disease

We appreciate the finalization of the Infectious Disease specialty measure set, which CMS revised to include the most appropriate measures according to currently available MIPS quality measures. We look forward to collaborating with CMS to develop additional measures for the ID specialty, applying principles consistent with CMS’ Meaningful Measures initiative yet filling the ID specialty measurement gap.

In closing, IDSA recognizes the efforts put forth by CMS to address the administrative burden of clinical care and we appreciate the Agency’s actions on this broad reaching issue. We assure the Agency we stand ready to meet the goals of “Patients Over Paperwork” and improve the accuracy and valuation of evaluation and management services that physicians provide.

We look forward to engaging with the Agency and other stakeholders in productive discussions that explore alternatives and additional options. As the QPP enters its third year, we appreciate the Agency's work to remove barriers and facilitate easier participation in MIPS and look forward to further dialogue with CMS on how the program can evolve towards more relevant quality measurement focused on meaningful health outcomes. If you have any questions, please contact Andrés Rodríguez, Vice President, Clinical Affairs and Practice Guidelines at 703-299-5146 or arodriguez@idsociety.org.

Sincerely,

A handwritten signature in black ink that reads "Cynthia L. Sears". The signature is written in a cursive, flowing style.

Cynthia L. Sears, MD, FIDSA
President