# IDSA
Infectious Diseases Society of America

2016-2017
BOARD OF DIRECTORS

President
William G. Powderly, MD, FIDSA
Washington University School of Medicine
St. Louis, MO

President-Elect
Paul G. Auwaerter, MD, MBA, FIDSA
Johns Hopkins University School of Medicine
Baltimore, MD

Vice President
Cynthia L. Sears, MD, FIDSA
Johns Hopkins University School of Medicine
Baltimore, MD

Secretary
Larry K. Pickering, MD, FIDSA
Emory University School of Medicine
Atlanta, GA

Treasurer
Helen W. Boucher, MD, FIDSA
Tufts Medical Center
Boston, MA

Immediate Past President
Johan S. Bakken, MD, PhD, FIDSA
St. Luke's ID Associates
Duluth, MN

Angela M. Caliendo, MD, PhD, FIDSA
Brown University/Rhode Island Hospital
Providence, RI

Henry F. Chambers, MD, FIDSA
University of California, San Francisco
San Francisco, CA

Janet A. Englund, MD, FIDSA
Seattle Children's Hospital
Seattle, WA

Thomas Fekete, MD, FIDSA
Temple University Medical School
Philadelphia, PA

Joel E. Gallant, MD, MPH, FIDSA
Southwest CARE Center
Santa Fe, NM

Lawrence P. Martinelli, MD, FIDSA
Covenant Health
Lubbock, TX

Daniel P. McQuillen, MD, FIDSA
Lahey Hospital & Medical Center
Burlington, MA

Thomas A. Moore, MD, FIDSA
IDC of Kansas
Wichita, KS

Trish M. Perl, MD, MSc, FIDSA
UT Southwestern Medical Center
Dallas, TX

Chief Executive Officer
Christopher D. Busky, CAE

IDSA 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 16, 2016

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

RE: 42 CFR Parts 414 and 495, Medicare Program; Merit Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Final Rule

Submitted Electronically via Regulations.gov

Dear Mr. Slavitt:

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the 2017 final rule of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Programs, collectively known as the Quality Payment Program, (QPP). IDSA represents more than 10,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education and research in the area of infectious diseases. The Society's members focus on the epidemiology, diagnosis, investigation, prevention, and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, serious health care acquired infections, antibiotic resistant bacterial infections, as well as emerging infections such as Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus diseases.

IDSA members are committed to improving the quality and safety of patient care in hospitals and health systems across the nation. A significant portion of our members in clinical practice are hospital-based, and many lead the "on-the-ground" efforts to combat healthcare associated infections and antimicrobial resistance. The specialty of infectious diseases (ID) is unique in that it is the only specialty whose training emphasizes the linkage between individual patient care and the impact on the larger patient population. This "bedside-to-population" system-based awareness is what distinguishes the critical role of the ID physician within the healthcare system, especially as it applies to quality improvement that is related to healthcare associated infections and antimicrobial stewardship.

**Improvement Activities (IAs):**

In our comment letter on the proposed rule, IDSA provided CMS with a list of improvement activities. Below, we provide additional detail to further describe how those activities might qualify within MIPS.

| CMS Improvement Activity Description | ID – Specific Improvement Activity |
|---|---|
| ***Population Management*: *Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or conduct periodic, structured medication reviews.*** | Many ID physicians provide Outpatient Parenteral Antimicrobial Therapy (OPAT) to patients with severe infections which often require powerful antimicrobial therapy that may be administered intravenously, over an extended period of time. We believe that the administration of OPAT qualifies under this Population Management Improvement Activity. Administering OPAT requires reconciliation and coordination of medications across transitions of care settings (from inpatient to outpatient, inpatient to home, and emergency department to home) as well as requiring the involvement of other members of the care team such as a pharmacist, primary care physician, and the emergency department physician. Finally, the use of OPAT requires periodic and structured review and follow-up care as well as complete oversight of the administration of the drug.<br><br>The use of OPAT has been shown to provide patient convenience, ensure patient safety, reduced costs and reduced average-lengths-of-stay.[1] |
| ***Patient Safety and Practice Assessment: Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics*** | Under this improvement activity subcategory is where IDSA believes we can make an impact on combating antibiotic resistance.<br><br>Antimicrobial Stewardship Programs (ASPs) are an important component in the effort to combat antimicrobial resistance. Since ASPs require clinical experience and judgment to determine the appropriate antibiotic for care of individual patients, ASPs are best led by a physician trained and experienced in the subspecialty of infectious diseases and who is prepared to hold accountability |

[1] Petrak, R., Skorodin, N., Fliegelman, et al. Value and Clinical Impact of an Infectious Disease-Supervised Outpatient Parenteral Antibiotic Therapy Program, Open Forum Infectious Diseases, Fall 2016, 3(4).

| | |
|---|---|
| | for effective performance of an ASP. Stewardship involves a multi-disciplinary, team-based approach, also involving ID-trained pharmacists, clinical microbiologists, and other providers and leveraging health care information technology systems.<br><br>IDSA believes the participation in and use of antimicrobial stewardship at any level, for any infectious disease or condition (such as sepsis) and not just those listed in the final rule, should meet the intention of this improvement activity. In addition, IDSA continues to believe that infectious diseases physicians are best suited to lead ASPs, and therefore we reiterate our previous comments that if an ID physician implements and/or administers an ASP that this activity should be weighted high under the QPP. If the physician does not attest to participating in a leadership role of the ASP and is merely attesting to participation in the ASP, then the weight of the CPIA should remain medium. |
| ***Expanded Practice Access: Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients.*** | IDSA promotes the adoption of telemedicine within the clinical practice of infectious diseases as a key strategy to extend access to specialty care. We believe this improvement activity can be easily tracked with the addition of the new place of service (POS) code under the Medicare Physician Fee Schedule, coupled with the specialty designation, (in this case 44 for the specialty of infectious diseases) to indicate that the service was delivered via telehealth. |
| ***Emergency Response and Preparedness: Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response*** | IDSA supports the development of broader bio-preparedness programs to include emergency response to natural disasters as well as such as the spread of deadly disease outbreaks (e.g. Ebola and Zika virus epidemics) Bio-preparedness focuses on activities directed toward system-wide hazards preparedness for public health emergencies and provides coordination at the local level that aligns |

| | |
|---|---|
| | with preparedness planning on regional and national levels. In an age where emerging infectious diseases from one part of the world can be rapidly transferred to another part of the world due to international air travel, the need for bio-preparedness will be critical for many health care systems. We suggest that CMS include bio-preparedness as an improvement activity under the QPP which would include ID physicians' leadership of bio-preparedness training and implementation of bio-preparedness programs within hospitals or hospital systems. |

**Virtual Groups:**

IDSA supports the Agency's development and implementation of virtual groups. The implementation and development of virtual groups will give smaller, independent practices more opportunities to more meaningfully participate in the Quality Payment Program, whether it is through group reporting under MIPS or participating in advanced APMs. As it stands now, the design of the Advanced APM track makes it nearly impossible for individuals and small group practices to participate. Forming virtual groups may provide smaller practices with more leverage and resources to help them move into the advanced APM track of the QPP.

IDSA recommends that CMS develop a mechanism, platform, or other type of resource that would promote the formation of virtual groups. This platform would provide practitioners who wish to join a virtual group with a means to connect with each other, and could be housed within the Physician Compare website. Alternatively, given that CMS has physician performance data and beneficiary claims data, CMS could potentially design virtual groups of high quality/low cost providers, as opposed to providers trying to form their own virtual groups.

**Hospital-Based Physicians:**

As we have stated in past comment letters and in ongoing meetings with CMS, the majority of ID physicians practice in the inpatient setting. Section 1848(q)(2)(C)(ii) of MACRA allows for physicians to report quality measures that are used in other payment systems, such as those measures used for inpatient hospital reporting. Therefore, IDSA has advocated for allowing hospital-based physicians to have the option of choosing whether they would like to use hospital performance measures under Medicare quality incentive programs. In addition to our support for this reporting option, the American Hospital Association also advocates for this as well, and suggests that CMS "develop a quality and resource use measure reporting option in which hospital-based physicians can use CMS hospital quality program measure performance in

MIPS."[2] IDSA supports this provision as long as the physician maintains the autonomy to choose whether or not to be held accountable for facility-level measures and performance. While CMS did not finalize any provisions for this reporting option in this final rule, we look forward to working with Agency to implement this reporting option under the QPP.

IDSA points out that there is a subset of measures within the Inpatient Quality Reporting (IQR) program (e.g. CLABSI, CAUTI, *C. difficile* and, MRSA infections) that pertains to the clinical practice of infectious diseases as well as the work done within Infection Control & Prevention Programs and Antimicrobial Stewardship Programs. For some of our members, linking their quality performance to the performance of their facility on these measures could prove reasonable and beneficial to the physician as well as the facilities and patients by aligning quality objectives. We look forward to continued discussions with CMS on this matter.

We commend CMS for recognizing the hardships that hospital-based physicians face when trying to participate in quality programs and are supportive of CMS's decision to finalize the re-weighting of the Advancing Care Information (ACI) to zero for those hospital-based clinicians that choose to not report quality measures under the ACI category. This will most certainly alleviate some of issues that hospital-based physicians face.

**Quality and Cost Measurement in the Medicare Incentive Payment Program:**

Medicare incentive payment programs continue to offer very few meaningful reportable measures to the specialty of ID. The PQRS measures were not well-aligned with ID clinical practice and did not change with the implementation of the Quality Payment Program. This is due in part to the overwhelming proportion of ID physician's clinical services being delivered in the inpatient setting while most of the quality measures currently available apply to encounters in the outpatient setting. Aside from HIV and HCV quality measures, which are only meaningful to ID physicians in the outpatient setting who have a focus in HIV care (as opposed to General ID), there are very few ID-specific measures upon which ID physicians can report to avoid payment penalties. Adding to the difficulties in satisfactorily reporting, the current Value-based Payment Modifier (VM) program design and underlying attribution methodology is problematic.

We have heard from many members how, despite their efforts to report on available measures, they are penalized due to program design flaws. For example, a single-specialty ID physician group satisfactorily reported on HIV measures (#160, #381, and #368) which were subsequently not accepted due to the lack of a national benchmark.[3] This resulted in the practice being assessed a lower overall score on quality.

We continue to hear from our members who express concern and frustration about the lack of quality measures available for ID physicians, and while one of the goals of the new QPP is to

[2] American Hospital Association Issue Brief: Physician Payment Reform Under the MACRA, July 15, 2016.
[3] Centers for Medicare & Medicaid Services; Benchmarks for Measures Included in the Performance Year 2015 Quality and Resource Use Reports.

alleviate administrative burden and to create more effective quality programs, IDSA remains concerned that our members continue to have very few relevant quality measures from which to choose. IDSA continues to propose relevant and meaningful ID measures for CMS to consider within the QPP. For example, we are pleased that CMS is proposing to retain measure #407: Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia set as a high priority measure in the MIPS quality performance category. Earlier this year, we submitted two additional measure concepts (Appropriate Use of anti-MRSA Antibiotics and 72-hour Review of Antibiotic Therapy for Sepsis) into the CMS Measures Under Consideration (MUC) process, both related to advancing quality measurement of antimicrobial stewardship at the physician-level. Neither were adopted to the MUC list due lack of evidence related to measure feasibility, reliability, and validity testing.

Based on CMS' 2014 PQRS experience report, the five most frequently reported individual measures by ID physicians are as follows:[4]

#130 – Documentation of Current Medications in the Medical Record

#226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

#128 – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow- up

#111 – Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older

#110 – Preventive Care and Screening: Influenza Immunization

These measures are neither directly applicable nor are they are a valid quality evaluator of the practice of ID, yet our members report them only to avoid financial penalties due to a lack of other options. However, ID physicians have few other options and therefore we encourage CMS to not eliminate these measures in the future as this would significantly affect our physician members.

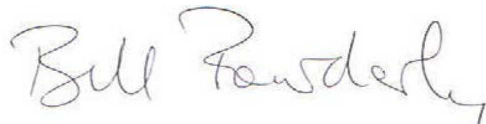
While the Cost Category of MIPS will not factor into performance in program year 2017, IDSA continues to have concerns regarding the methodology of attribution used to assign patients' cost of care to physicians. Specifically, under step two of the current attribution process for the total per capita costs measure, a beneficiary is attributed to a specialist that provided the plurality of primary care services in a given year when such services were not provided by traditional primary care providers, including certain non-physician practitioners. We believe this attribution process is flawed in that our ID physicians have little control over the costs of other types of care a patient might incur during the course of a given year. We look forward to working with the Agency in developing attribution methods that better represent specialty providers, such as ID physicians.

---

[4] CMS 2014 Reporting Experience Including Trends (2007-2015) for the Physician Quality Reporting System April 15, 2016.

IDSA appreciates the efforts of CMS to promote improved patient safety and better quality of care as set forth in this proposed rule for MIPS and APMs. We look forward to further engagement with CMS and other stakeholders as we transition to the QPP. If you have any questions, please feel free to contact Andrés Rodríguez, Vice President Clinical Affairs, at 703-299-5146 or arodriguez@idsociety.org.

Respectfully,



William G. Powderly, MD, FIDSA
President, Infectious Diseases Society of America