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IDSA
Infectious Diseases Society of America

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The Honorable Michael Burgess, MD
Chairman
Subcommittee on Health Committee on Energy & Commerce
United States House of Representatives
2336 Rayburn House Office Building
Washington, DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health Committee on Energy & Commerce
United States House of Representatives
2470 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Burgess and Ranking Member Green,

The Infectious Diseases Society of America thanks you for scheduling the hearing, "MACRA and MIPS: An Update on the Merit-Based Incentive Payment System." IDSA represents more than 11,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education, and research in infectious diseases. Our members care for patients with serious infections, including HIV/AIDS, viral hepatitis, healthcare-associated infections, antibiotic-resistant infections, as well as emerging infections such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus diseases. IDSA provided detailed comments to the Centers for Medicare and Medicaid Services on the 2018 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).

Outlined below, we are pleased to describe the important roles of ID physicians. Please note several provisions of the 2018 final rule that we support. We also strongly recommend important changes to MIPS related to antibiotic resistance and antibiotic stewardship and highlight an underlying ID physician compensation issue that is hampering our ability to meaningfully participate in new payment models and indeed may threaten the future of our subspecialty.

The Value of ID Physicians

IDSA members are committed to improving the quality and the safety of patient care in hospitals and health systems across the nation. Many lead the "on-the-ground" efforts to address healthcare-associated infections, antimicrobial resistance, and bio-emergencies. The specialty of infectious diseases is unique in that it is the only specialty that routinely emphasizes the linkage between individual patient care and the impact on the larger patient population. ID

physician involvement in patient care is associated with significantly lower rates of mortality and 30-day readmission rates in hospitalized patients, shorter lengths of hospital stay, fewer intensive care unit (ICU) days, and lower Medicare charges and payments. ID physicians care for some of the most complex patients and are essential to the safety and effectiveness of many life-saving medical interventions, including organ and bone marrow transplants, complex surgeries and cancer chemotherapy. ID physicians also conduct research leading to breakthroughs in the origin and transmission of emerging and re-emerging diseases, factors that make these diseases virulent, and the development of urgently needed new antimicrobial drugs and other therapies, diagnostics, and vaccines.

2018 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 appreciates that the 2018 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) included many improvements and recommendations we made in response to the proposed rule. We also reiterate some concerns and recommendations below.

- IDSA appreciates that the final rule includes the facility-based measurement option as a proxy for MIPS quality and cost measurement for facility-based physicians. We remain concerned that many ID physicians who are facility-based will have difficulty participating in MIPS in a meaningful way until the facility-based scoring is finalized.
- IDSA is pleased that the final rule includes a five-point complex patient bonus (as ID physicians often treat the "sickest of the sick" on a regular basis) and includes a small practice bonus.
- IDSA supports the final low volume threshold of $90,000 in Part B-allowed charges and 200 Medicare Part B beneficiaries, which we believe will lower administrative burden, particularly for small practices and practices in rural and underserved areas, allowing them to focus their limited resources on patient care.
- IDSA supports the finalized options for the implementation of virtual groups for participation in MIPS, but we await further details as to how virtual groups will be constructed. If CMS is committed to relieving administrative burden, then we believe CMS should assist physicians in forming their virtual groups.
- IDSA appreciates the CMS decision not to finalize the requirement for eligible clinicians to report cross-cutting measures. We encourage CMS to remove the requirement entirely, as it would intensify administrative burden and increase the likelihood that our members would not be able to report to MIPS satisfactorily.
- IDSA appreciates the inclusion of an infectious disease specialty measure set for MIPS. Nonetheless, we continue to have strong reservations regarding the clinical relevance of the majority of the measures to the practice scope for many ID physicians. Of the proposed measures, IDSA recommends that only those that align with the practice of an ID physician be included. Specifically, we support the inclusion of measures regarding influenza immunization, pneumococcal vaccination, documentation of current medications, and appropriate treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteremia.
- Recognizing that there are significant financial incentives participation in an Alternative Payment Model (APMs), we call attention to the challenges that exist for ID physician participation. Unlike procedure-based care, ID and other cognitive care typically does not

have easily identifiable episodes of care that result in easily measured patient outcomes. Even when there is an easily identifiable episode of care, (i.e. patient with cellulitis within the Bundled Payment Care Improvement – Advanced Program), the program design has made it impossible for ID physicians to design a value-based care plan for the episode, (i.e. the BPCI-Advanced program required that a patient with cellulitis be admitted to the hospital to "trigger" the episode). ID physicians would like to be able to demonstrate their value by designing episode bundles that avoid having a patient admitted to the hospital.

Improvement Activities: Implementation of an Antibiotic Stewardship Program

IDSA would like to highlight for the Subcommittee the improvement activity entitled "Implementation of an Antibiotic Stewardship Program (ASP)," for three key reasons: First, we greatly appreciate this subcommittee's strong attention to the national and global crisis of antibiotic resistance and the subcommittee's leadership in driving solutions. Second, we believe this component of MIPS represents a key area where ID physicians will be particularly able to participate in a meaningful way. Third, we believe changes to CMS policy are necessary to maximize the impact of this component of MIPS.

IDSA believes that the listed example conditions in this improvement activity (IA) should either be removed entirely or revised to note that antibiotic stewardship applies to any infectious disease condition, and not just those listed in the improvement activity. We remain concerned that the listed conditions may be interpreted as the only conditions for which this improvement activity is applicable, therefore making this improvement activity overly prescriptive and subject to misinterpretation.

High Weight for implementation of an Antimicrobial Stewardship Program

We continue to urge the Agency to make the Implementation of an ASP a high weighted improvement activity. IDSA believes that implementation of an ASP would meet the parameters set by the Agency when determining if an IA should be of high weight. In the QPP Final Rule for 2017, CMS stated, "we believe that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being." Antibiotic stewardship directly provides an impact on beneficiary care, safety, health, and well-being by assisting providers and facilities in prescribing the correct antibiotic, using the correct dose, and for the correct amount of time. Antibiotic stewardship programs have been demonstrated to reduce inappropriate antibiotic use that drives the development of resistance and to reduce adverse events associated with antibiotic use, such as *C. difficile* infection.

Finally, as this Subcommittee is well aware, antibiotic stewardship programs play a central role in combating antibiotic resistance nationally and globally. Expert national and international bodies including CMS, the Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, the President's Council of Advisors on Science and Technology and the World Health Organization have all emphasized ASP as a priority recommendation. Given the societal and population health impact of using antibiotics appropriately, the work involved in the implementation of an ASP, and the work involved in continually supporting and administering an ASP, we believe that this should be a high weighted IA.

Undervaluing ID: Jeopardizing the Next Generation of ID Physicians

We want to highlight for the Subcommittee that MACRA implementation is occurring against a complex backdrop in which compensation issues are driving young physicians away from the field of infectious diseases. Data from the National Residency Match Program (NRMP) indicate a disturbing 21.6% decline in the number of applicants to infectious disease fellowship training programs over a 5-year period ending in 2016. These data indicate a broader problem—the undervaluation of ID.

In 2014, an IDSA survey of nearly 600 Internal Medicine residents revealed that salary was the most often cited reason for not choosing ID. Average salaries for ID physicians are significantly lower than those for most other specialties. Young physicians' significant debt burden ($200,000 average for the class of 2014) is understandably driving many individuals toward more lucrative specialties.

Over 90% of the care provided by ID physicians is accounted for by evaluation and management (E/M) services. These face-to-face, cognitive encounters are undervalued by current payment systems compared to procedural patient encounters (e.g., surgery, cardiology, and gastroenterology), as current E/M codes fail to reflect the increasing complexity of E/M services. This accounts for the significant compensation disparity between ID physicians and physicians that provide a greater proportion of procedure-based care.

Without updated, accurate E/M codes, the payment reform activities included in MACRA will have only a limited impact on improving ID patient care and will fail to address the underlying problem of undervaluing ID patient care that is driving fewer young physicians to enter the specialty. ID physicians often care for more chronic illnesses, including HIV, hepatitis C, and recurrent infections. ID care often involves reviewing ill patients with many days of hospitalization or complex outpatient case management that are both time intensive to do well. Such care involves preventing complications and exploring complicated diagnostic and therapeutic pathways. ID physicians also conduct significant post-visit work, such as care coordination, patient counseling and other necessary follow up. IDSA urges the Subcommittee to direct CMS to undertake the research needed to better identify and quantify the inputs that accurately capture the elements of complex medical decision making.

Reimbursement for Telemedicine

ID physicians are increasingly seeking opportunities to utilize telemedicine to expand access to care, particularly in rural and other underserved communities, and to conduct clinical research and provide continuing medical education. The Extension for Community Health Outcomes (ECHO) program has demonstrated success in treatment of hepatitis C virus. Evidence also supports the use of telemedicine for HIV management, for which subspecialty care can be critical. Compared to in-person management by generalists, subspecialty care using telemedicine has been shown to improve virologic suppression and result in a greater rise in CD4+ T-cell counts in a large prison population and may prove beneficial for HIV care in other resource-limited settings. Telemedicine can also be used to expand ID physician-led services, including antibiotic stewardship programs and infection prevention and control programs, to a wide variety of healthcare settings. We appreciate this Subcommittee's ongoing attention to telemedicine and encourage additional efforts to promote use of telemedicine to allow reimbursement for care delivered remotely.

Once again, we thank the Subcommittee for its attention to physician payment and health care quality, and we look forward to continuing to work with you to meet the evolving needs of our patients.

Sincerely,

Paul G. Auwaerter, MD, MBA, FIDSA
President, IDSA