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IDSA
Infectious Diseases Society of America

January 2, 2018

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

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

Submitted electronically via Regulations.gov

Dear Ms. Verma,

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the 2018 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 11,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education, and research in infectious diseases. The Society's members focus on the epidemiology, diagnosis, investigation, prevention, and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, treating meningitis, pneumonia, tuberculosis, HIV/AIDS, health care-associated infections, antibiotic resistant bacterial infections, as well as emerging infections such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus diseases.

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

Facility-Based Measurement:

IDSA thanks the Agency for finalizing the option to use facility-based measurement as a proxy for MIPS quality and cost measurement for facility-based physicians. IDSA believes making this a voluntary option will allow for flexibility, allowing physicians more control over how they participate in MIPS. We understand that the Agency has delayed this option until the 2019 performance period. Hence, we remain concern that our facility-based physicians will have difficulty participating in MIPS in a meaningful way until the facility-based scoring is finalized.

As the Agency moves forward with program details of facility-based reporting, we reiterate our comments from the proposed rule:

- CMS should be willing to refine this policy option as it matures and provide details as to how it will engage providers to gain feedback.
- CMS should ensure this proposal does not run in conflict with goals of a Qualified Clinical Data Registry or other registry.
- CMS should explore a "weighted average" approach for physicians providing services in multiple facilities.

Finally, IDSA is willing to work with the Agency as this MIPS measurement option is developed and refined in the coming years.

Complex Patient Bonus:

We thank the Agency for finalizing a five-point complex patient bonus as ID physicians often treat the "sickest of the sick" on a regular basis. IDSA supports the final provisions of the complex patient bonus which include using a combination of Hierarchical Condition Category (HCC) risk scores and socio-demographic status factors. As per our proposed rule comment letter we suggested this option and appreciate CMS' implementation of this method for calculating the complex patient bonus.

Small Practice Bonus:

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

Performance Threshold:

CMS has proposed an increase in the performance threshold from three points to fifteen points. In keeping with our previous comments, we support the modest increase to allow our members

time to become more familiar with MIPS and to allow for their successful participation. Given that we support the additional bonus point proposals, we believe that many of our members, especially those who qualify for the complex patient bonus, will be successful in reaching the fifteen-point threshold. We also believe that striving for the fifteen-point threshold will better prepare clinicians for future increases in performance thresholds.

MIPS Eligible Clinicians - Low Volume Threshold:

IDSA supports the final low volume threshold of $90,000 in Part B-allowed charges and 200 Medicare Part B beneficiaries. We understand that the current administration is focusing on lowering the administrative burden for physicians and, thus, we concur that raising the threshold for required participation in MIPS is a step in the right direction. Many small practices, often in rural and underserved areas, may not able to meet the administrative burden of participating in Medicare quality programs. Hence, their exclusion from the QPP will allow these small practices to focus their limited resources on their patients.

MIPS Adjustment to Part B Drugs:

As we noted in our proposed rule comment letter, IDSA strongly disagrees with CMS' policy to include Part B drugs in the calculation of MIPS payment adjustments and eligibility determinations. Historically, Part B drugs have been excluded from payment adjustments under CMS quality reporting programs, such as the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VM) and Electronic Health Record (EHR) Incentive Program. MIPS payment adjustment provisions are included in Section 1848 of the Social Security Act (the Act), which is entitled "payment for physician services" and pertains to payment under the physician fee schedule (PFS). We believe if Congress meant for MIPS adjustments to apply to items and services outside the PFS, it would have stated that *explicitly*, or placed the MIPS adjustment provisions in a different section of the Act to make clear that they apply to items and services going beyond those paid under the PFS. In addition, we note that under the Advanced APM track of the QPP, Part B drugs are not included in the incentive payment.

Virtual Groups:

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. We thank CMS for providing contract templates for virtual groups, providing webinars, and listening sessions on virtual groups; however, small practices and solo practitioners may still struggle to find physicians to participate in a virtual group. If CMS is committed to relieving administrative burden, then we believe CMS should assist physicians in forming their virtual groups. IDSA continues to believe that CMS should develop a mechanism, platform, or some other type of resource or tool that would promote the formation of virtual groups. The platform would ideally provide practitioners who wish to join a virtual group with the means to connect with one another.

Improvement Activities:

Implementation of an Antimicrobial Stewardship Program

It is within this component of MIPS where we believe ID physicians will be particularly able to participate in a meaningful way within MIPS. IDSA is pleased to see the changes incorporated into the improvement activity titled "Implementation of an Antibiotic Stewardship Program (ASP) (IA_PSPA_15)." IDSA supports the replacement of the term hospital with the term facility as we believe that antimicrobial stewardship programs may be established at any site of service.

IDSA continues to believe that the listed example conditions in this improvement activity (IA) should either be removed entirely or revised to note that antimicrobial stewardship is applicable 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. Our previous comments on this are still applicable and we ask CMS to refer to that letter for more detail; IDSA QPP Proposed Rule Comment Letter

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 (IA). Antimicrobial resistance is an area of focus for our society, as we have many programs geared toward educating our members and the public about antimicrobial resistance and its impact on the healthcare system. To that end, IDSA is dedicated to the promotion of excellence in antimicrobial stewardship. To identify exemplary ASPs, IDSA has created a program to designate Antimicrobial Stewardship Centers of Excellence (CoE) across the U.S. health care system. The IDSA Antimicrobial Stewardship Centers of Excellence Program builds upon the criteria set forth in the CDC Core Elements with additional aspects of meaningful differentiation. The Core Criteria for the IDSA Antimicrobial Stewardship Centers of Excellence were developed by a work-group of ID physicians and ID-trained pharmacists.

IDSA's CoE program places emphasis on an institution's ability to implement stewardship protocols through its electronic health record (EHR) system as well as provide ongoing education to its medical staff. The goals of the program are to recognize those who have achieved high standards in their stewardship programs, and highlight the value of stewardship in preserving the effectiveness of the vulnerable supply of antibiotics.

IDSA believes that making implementation of an ASP a high weighted improvement activity 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 (*81 FR 77194)* 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."* Antimicrobial stewardship directly provides 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. We note that CMS must also share our beliefs of the importance of antimicrobial stewardship as the Agency finalized two improvement activities *Completion of CDC Training on Antibiotic Stewardship* (high weight), and *Initiate CDC Training of Antibiotic Stewardship* (medium weight), which support training on antimicrobial stewardship using CDC Training Modules. In fact, completion of the training modules, occurring just once in a four-year time frame, is regarded as high weight (which we support). We believe that the implementation and ongoing supervision of an ASP (IA_PSPA_15) requires continuing support and improvement, a process that does not end, and therefore should be high weight as well.

Finally, antimicrobial stewardship and the appropriate use of antimicrobials are national issues that have resulted in a shared concern among many federal agencies including the CDC, FDA, NIH and, of course CMS. Given the societal and population health impact of using antimicrobials appropriately, the work involved in the implementation of an ASP, and the work involved in continually supporting and administering an ASP, we believe that this should be a high weighted IA.

Quality:

Cross-cutting Measures:

IDSA appreciates CMS' decision to not finalize the requirement for eligible clinicians to report cross-cutting measures. We would like to reiterate our comments for the CY 2018 Quality Payment Program Proposed Rule and request that CMS remove the requirement all together. This potential requirement would increase the administrative burden to an already resource intensive process and increases the likelihood that our members will not satisfactorily report to MIPS, potentially resulting in negative payment adjustments. Additionally, we believe that required reporting of cross-cutting measures does not support high-value patient care. Requiring all MIPS-eligible clinicians to report one or more cross-cutting measures promotes overutilization and does not leverage the expertise of a specialist when treating a patient.

Topped-Out Measures:

As CMS has finalized the 4-year timeline to identify topped-out measures, IDSA has concerns with the prospective measures that may be would be identified as topped-out in future MIPS performance years. Applying the topped-out measure policy to currently available MIPS quality measures, #130: Documentation of Current Medications in the Medical Record and #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention would be tagged as measures with little room for improvement. Based on the assumption that these measures would perform at a median performance rate of 95 percent for 4 years, CMS will

consider removing measures #130 and #226 from the MIPS quality measure pipeline. This would be detrimental for successful reporting for ID physicians as measures #130 and #226 were two of the top five measures reported by ID physicians according to the 2015 Physician Quality Reporting System (PQRS) Experience Report.

Furthermore, CMS has reiterated their intentions to include more outcome measures that have been tested for reliability and validity within the MIPS program. IDSA recognizes the importance of measuring outcomes. However, IDSA believes that the criteria for quality measures to be included in MIPS for future program years create a higher burden to an already resource and financially intensive measure development process. This coupled with the prospective removal of measures #130 and #226 would present ID physicians with a severe lack of reportable quality measures for MIPS.

IDSA appreciates that CMS recognizes that there are certain types of high value measures and will take into consideration factors such as clinical relevance and availability of specialty measures prior to removal of a measure. However, we respectfully recommend that CMS does not adopt the proposal to remove topped-out claims-based process measures as, at present, these are key to providing ID physicians additional opportunities to report quality measures.

Infectious Disease Specialty Measure Set:

IDSA appreciates the inclusion of an infectious disease specialty measure set for MIPS. Nonetheless, we continue to have strong reservations regarding the clinical relevancy of the majority of the measures (outlined in Table B. 29 Infectious Disease Specialty Measure Set) to the practice scope for many ID physicians. In IDSA's previous comments for the CY 2018 Quality Payment Program Proposed Rule, we provided the rationale as to why the majority of the specified measures are not applicable to the day-to-day practice pattern of an ID physician.

We would like to reiterate that ID physicians are not "proceduralists" but rather cognitive specialists, providing most of their services using Evaluation & Management (E/M) codes. According to the CY2015 Inpatient Utilization and Payment Public Use File (Inpatient PUF) Released with the CY2017 Medicare Physician Fee Schedule Final Rule, 93 percent of all total allowed charges by Medicare for ID physicians were for E/M codes (99201- 99499). Highlighting the predominate inpatient practice pattern of an ID physician, of the 93 percent of the E/M Medicare claims submitted by ID physicians, 88 percent of those claims were delivered in the inpatient setting. Also, it is important to stress that in the inpatient setting, ID physicians are consultants and provide medical decision making and patient care plan information as recommendations to the attending physician who may or may not implement the recommendations.

IDSA urges CMS to reconsider the measures specified in Table B.29 Infectious Disease Specialty Measure Set and only include the following measures that better align with the practice pattern of an ID physician.

- #110: Preventive Care and Screening: Influenza Immunization
- #111: Pneumococcal Vaccination Status for Older Adults
- #130: Documentation of Current Medications in the Medical Records

- #407: Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia

IDSA appreciates that the Agency concurred with and finalized many of our suggestions. We look forward to further engagement with CMS and other stakeholders as we work toward meeting the goals of the 2018 QPP Final Rule. If you have any questions, please feel free to contact Andrés Rodríguez, Vice President, Clinical Affairs and Practice Guidelines at 703-299-5146 or arodriguez@idsociety.org.

Respectfully,

Paul G. Auwaerter, MD, MBA, FIDSA

President