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November 12, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Dave Camp
Chairman
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairmen:

The Infectious Diseases Society of America (IDSAs) appreciates the opportunity to provide comments on the discussion draft of the SGR legislation emerging from the joint efforts of the House Ways and Means and Senate Finance Committees. IDSAs represents more than 10,000 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases (ID). 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, surgical infections, those with cancer or transplants who have life threatening infections caused by unusual or drug-resistant microorganisms, people living with HIV and AIDS, and new and emerging infections, such as severe acute respiratory syndrome (SARS) and pandemic influenza.

We view this legislation as a unique opportunity to repeal the Sustainable Growth Rate (SGR) formula and simplify current value-based payment programs. For too long, the SGR has served as a barrier to sound financial planning by physicians to effectively manage their practices, due to unreliable or unstable Medicare reimbursement. Moreover, the current health care quality improvement programs such as PQRS, VBM, and EHR MU could benefit from simplification and a more gradual implementation. Therefore, we provide comments on the draft legislation with renewed optimism. Our specific feedback on the proposed draft legislation appears below.

We thank the committees' joint effort and for continuing to engage the physician community in seeking to reform the current physician reimbursement system and streamline value-based payment for Medicare. Please contact Jonathan Nurse with any questions at 703-299-0202 or jnurse@idsociety.org.

Sincerely,

Barbara E. Murray, MD, FIDSA
President

SGR Repeal and Annual Updates

We are pleased that this proposal would permanently repeal the SGR update mechanism but we implore the committees to consider allowing for an annual increase, perhaps triggered by an excessive increase in the Medicare Economic Index (MIE) or an adjustment that is applied at least every other year during the 10 year period. Many physicians will be unprepared to transition to an advanced Alternative Payment Model (APM) in the near-term and even modest annual increases to their PFS payment rates will help ensure financial viability. As well, it should be recognized that physician payments have trailed inflation for over a decade and that imposing a freeze in payments as physicians transition to new APMs could be taken as unfunded mandate.

Value-Based Performance (VBP) Payment Program

IDSA favors a more streamlined approach to quality and resource utilization reporting. Under this proposal, the VBP payment program will assess eligible providers based on four categories: Quality, Resource Use, Clinical Practice Improvement Activities, and adoption/meaningful use of Electronic Health Records (EHR) Systems. These categorical assessments will combine to form a composite score, by which the eligible provider will be evaluated against his/her peers and incentive payments will occur in a budget neutral manner.

Quality

With respect to how Quality will be assessed, we are pleased to see recognition of the need for funding to develop additional measures. As we noted in our comment letter to the CMS CY2014 Physician Fee Schedule Proposed Rule¹, only 16.1% of eligible ID specialists have participated in the PQRS program, with the overall program participation rate for all eligible professionals being only 26%. One reason for this low participation rate is that there are few measures that are reasonably relevant to the practice of general Infectious Diseases. Even the measure sets related to HIV and Hepatitis C Virus (HCV) are applicable only to a select portion of our members who treat these patient groups. IDSA has engaged CMS in discussion on the development of ID-specific measures, having developed measure concepts for the treatment of Staphylococcus aureus and measure concepts for Antimicrobial Stewardship. With more funding being made available through the proposed legislation, we are hopeful that we can advance these concepts through to become endorsed measures.

Resource Use

Resource Use is another assessment category that will factor into the composite score under the VBP program. As described in the draft legislation outline, the metrics and methodology that exist under the current Value-Based Modifier (VBM) program, would be “enhanced” for use under this new, streamlined program. Again in our comment letter on the PFS proposed rule, IDSA expressed serious concern over the use of these metrics and the application of the measures that hold physicians responsible for factors outside of their direct control. The “total per capita cost” measures, for example, hold physicians accountable for the total annual costs related to the care of a patient, which incorrectly assumes that physicians have control over the care plan and treatment decisions of other physicians who also treated the patient over the reporting year. Furthermore, the newly proposed Medicare Spending Per Beneficiary (MSPB) measure is equally concerning since it evaluates costs related to the totality of services furnished to a patient surrounding an inpatient hospitalization. This includes all Medicare Part A and Part B payments during the episode, which spans from 3 days prior to an index admission through 30 days post

¹ IDSA Comments to the CMS CY2014 PFS Proposed Rule, available at http://www.idsociety.org/uploadedFiles/IDSA/Policy_and_Advocacy/Current_Topics_and_Issues/Access_and_Reimbursement/2013/IDSA%20Comment%20PFS%20CY2014_final.pdf

discharge, with certain exclusions. Any “enhancements” to these metrics and their underlying methodology should significantly improve their application at the eligible provider level, to include improvements in currently employed risk-adjustment methodologies. Requiring physicians to indicate their role (primary care or specialist) and the type of treatment (chronic condition, acute episode) in individual episodes of care may be part of the solution to appropriate attribution and accurate accounting of resource use. We look forward to learning more details as to how Resource Use will be accounted for within the VBP Payment Program.

Clinical Practice Improvement Activities

The draft outline calls for a Clinical Practice Improvement Activities to be established through a collaborative process with physicians and other stakeholders, as a component of the VBP Payment Program. These activities fall under five sub-categories:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Participation in any Medicare APM

We believe this component of the VBP Payment Program might help providers transition from “volume to value” but further details are required. It is our hope that this category of the VBP Payment Program can allow for inclusion of other activities that promote improvements in the delivery of quality care. We have previously indicated our support for inclusion of “board-sponsored quality improvement initiatives” such as the American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) Program.² The self-evaluation component of the ABIM’s MOC program provides an opportunity for infectious disease physicians to maintain a commitment to lifelong learning. The self-evaluation requirement includes two components: 1) Self-Evaluation of Medical Knowledge, which includes open-book modules testing clinical and practical knowledge in a particular field; and 2) Self-Evaluation of Practice Performance, which includes the completion of one of the ABIM’s Practice Improvement Modules (PIMs) or one of the ABIM Approved Quality Improvement (AQI) pathway programs of other organizations. Specifically, PIMs could be included under this component if they are linked to one of the sub-categories above. For example, there is a PIM for the treatment of Hepatitis C Virus (HCV), which requires a minimum of 25 chart reviews and includes 41 measures related to diagnostic testing for HCV, antiviral treatment, preventive care, and counseling. This PIM could qualify under this component of the VBP Payment Program, provided it addressed some aspect of “beneficiary engagement” or “care coordination.” The ABIM PIMs and AQIs are web-based tools that guide physicians through a review of patient data and support the implementation of practice-based quality improvement plans. IDSA believes activities such as these should be considered as relevant Clinical Practice Improvement Activities.

EHR Meaningful Use

We understand that the current EHR-MU requirements would remain in place under the proposed legislation. We respectfully ask that this opportunity be taken to allow for a more gradual implementation timeline of the current program requirements to be established. Furthermore, we ask that some consideration be given for the practical reality that physician practices face, when few EHR vendors have updated systems to be fully MU 2 compliant, leaving many still trying to catch up with current requirements and facing risks of not being able to fully certify in 2014. Finally, we also ask that the committees consider allowing certain physicians who, due to their particular sub-specialty and/or mode of

² IDSA’s response to CMS Request for Information on the Use of Clinical Quality Measures Reported under the PQRS, the EHR Incentive Program, and Other Reporting Programs available at http://www.idsociety.org/uploadedFiles/IDSA/Policy_and_Advocacy/Current_Topics_and_Issues/Access_and_Reimbursement/2013/IDSA%20CMS%20RFI%20Response_FINAL.pdf

practice (i.e. multi-hospital-based, contracted by hospital but not “hospital-employed”), be allowed to exempt themselves from the EHR category of the VBP Payment Program. Under the current program, those physicians who can demonstrate “Lack of control over availability of CEHRT for more than 50% of patient encounters,” are eligible for a hardship exemption. We assume that this allowance will carry over to the new, streamlined program.

Performance Assessment and Weights for Performance Categories

We understand that professionals would be assessed and receive payment adjustments based on a composite score, derived from performance in each of the categories discussed above. These scores would reflect the differences in professionals’ performance and would be tied to VBP incentive payments or penalties. Given the budget neutrality requirement of the VBP Payment Program, payment increases provided to professionals with high performance scores would be offset by payment reductions to poor performing professionals. In contrast, the current VBM program divides providers into three tiers of low-average-high for both the quality composite score and the cost composite score, and rewards the outliers on the high-end with penalties imposed on outliers on the low-end.

We await further detail in the draft legislation as to how the Secretary will be able to determine the “winners” (high performers) and “losers” (low performers). We have concerns as to how this may play out as it promotes a heightened sense of competition between physicians, in an environment that is already challenging with heavy penalties and program compliance regulations.

With respect to the proposed weights for the performance categories, we note that the EHR-Meaningful Use and Resource Use categories are weighted more heavily than the Quality and Clinical Practice Improvement Activities. As we have discussed above, the EHR-MU program and the Resource Use category (with the currently inadequate metrics and methodology) are the two main problematic categories under the new, streamlined VBP Payment Program. For this reason, we ask that the committees reconsider the proposed weighting and allow for more emphasis to be placed on Quality and Clinical Practice Improvement Activities.

Encouraging Alternative Payment Model Participation

IDSA appreciates the intent of the proposed legislation to provide strong incentives (+5% bonus) for providers to participate in an advanced alternative payment models (APM) that hold two-sided financial risk tied to quality measurement. Exempting those who participate in these advanced APM from the VBP Payment Program is also a strong incentive to participate in these shared-risk models. Furthermore, we commend the committees for proposing several options across Medicare and non-Medicare revenue, as there are many private payer ACOs emerging. We await further details as to how this program would allow for good-faith effort in attempting to comply with threshold requirements that are assessed retrospectively. Providers who agree to participate yet fail to achieve the target threshold, (i.e. at least 50% of all-payer revenue through an advanced APM), due to external circumstances, should not be penalized. Moreover, the physician exclusivity requirement for participation in ACOs and receiving any portion of shared savings is problematic. Physicians should be able to participate for purposes of shared savings in as many ACOs or other APMs that are financially viable.

Encouraging Care Coordination for Individuals with Complex Chronic Care Needs

We were pleased with the adoption of the Transitional Care Management (TCM) Codes in CY 2013 and we are encouraged by CMS' proposal in the NPRM for CY2014 Medicare Physician Fee Schedule that would refine payment for complex chronic care management (CCCM) services, recognizing that current E/M codes do not appropriately account for the work involved in non-face-to-face, comprehensive, coordinated care management for beneficiaries with multiple co-morbidities. IDSA views this as continued progress towards promoting accountable care for patients but believes there is much work to be done with respect to adequately capturing the work performed and promoting care coordination between physicians. We are encouraged by CMS' acknowledgement that E/M codes do not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries. Likewise, we are pleased to see that the proposed legislation would establish payment for CCCM codes.

As infectious disease specialists, we often treat patients with complex, severe infections that require strict adherence to antimicrobial treatment protocols that can last several weeks to several months. Moreover, it is not uncommon that patients with severe infections have multiple co-morbidities (chronic conditions) that bring added complexity to the management and treatment of such patients. These patient cases require similar additional resources as described in the proposed rule for the CCCM services, (i.e., regular physician development and/or revision of care plans; subsequent reports of patient status; review of laboratory and other studies; communication with other health professionals not employed in the same practice who are involved in the patient's care; integration of new information into the care plan; and/or adjustment of medical therapy). Infectious Diseases Specialists effectively lead Outpatient Parenteral Antimicrobial Therapy (OPAT) programs in many forms, which enable the timely transition of patients from the inpatient setting to the outpatient/home setting, providing the care coordination services as described above. As we conveyed in our comments on the CY2014 PFS Proposed Rule, the proposed legislation should call for CCCM codes that apply to all categories of patients with complex needs who have chronic conditions. We ask the committees to allow the Secretary flexibility in setting certification standards of practices who are providing care management services, as we believe requiring that a practice obtain certification from a national organization such as NCQA would prove burdensome and lead to no enhancements to the quality of care achieved.

Ensuring Accurate Valuation of Services under the PFS

The discussion draft indicates a plan to commission the Government Accountability Office (GAO) to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC). We note here that CMS has entered into two agreements with the RAND Corporation and Urban Institute to develop additional methods of valuation. It is our hope that any work the GAO be tasked to perform will not be duplicative of the work currently underway by outside entities. Moreover, it is our hope that the collective work be complementary such that it may yield useful results towards improving the valuation of physician services. Across all these efforts, we reiterate the need for consideration of the complexity of medical decision-making, on the part of many cognitive specialists and primary care physicians, involved in the treatment of acute and chronic conditions. As we have previously asserted, the current Medicare fee schedule is flawed in large part due to inherent biases in the valuation process that favor procedures, imaging, and laboratory services over cognitive services. IDSA supports exploration of alternative valuation models with the aim of improving the valuation of physician services that involve complex medical decision-making. Furthermore, we believe it is imperative that any alternative valuation process includes direct involvement of physicians and other healthcare providers who are the purveyors of the very medical services that are to be valued.

Attempting to improve service-level payments, the proposed legislation sets a target of 1% of the estimated expenditures under the physician fee schedule for identifying misvalued codes. If the target is met (i.e. enough codes are revalued to extract the target amount of dollars), that amount would be redistributed within the fee schedule in a budget neutral manner. If the target is not met, fee schedule payments will be reduced by the difference between the target and the amount of misvalued services identified that year.

IDSA is concerned that this activity would be duplicative and even counter-productive of the AMA-led RUC Relativity Assessment Workgroup's efforts. Under this initiative, almost 1600 codes have been reviewed, resulting in \$2.5 billion in redistribution within the Medicare Physician Payment Schedule, between 2009 and 2013.³

Furthermore, we understand the need to empower the Secretary with the ability to effectively solicit information related to accurately value services under the PFS, and to have cooperation from selected professionals. We believe the most effective way to do so would be to ensure that such requests pose no uncompensated burden on the professionals that are selected and apply a more "pay-for-reporting" concept to achieve the objective. The proposed legislation suggests that the selected professionals may be compensated. Given that the selected professionals are handling the administrative burden associated with transitioning to new APMs or to the VBP Payment Program, the additional burden of compiling and submitting information would be significant. By providing for some form of compensation to offset the burden seems reasonable. Applying penalties on selected professionals who fail to report seems excessive and counter-productive.

Expanding the Use of Medicare Data for Performance Improvement and Transparency of Physician Medicare Data

The proposed legislation would allow qualified entities to provide or sell non-public data analyses to physicians or other professionals to assist in their quality improvement activities and to provide or sell similar analyses to health insurers and employers meeting certain criteria. We are eager to learn more details about this section of the proposed legislation. As mentioned above, IDSA has quality measure concepts in development and plans to generate more measure concepts for various infectious diseases but, given the high costs associated with measure development, we seek to collaborate with other stakeholders, particularly those with access to data that would enable measure validation and development of risk-adjustment methodology. We ask the committees to consider specialty societies and other entities as eligible to receive the data at no cost. We propose that commercial payers and employers be required to collaborate with medical specialty societies and patient advocacy groups in order to receive the non-public data analyses at low or no cost. The National Quality Forum (NQF) has recently embarked on a new campaign to promote collaboration across stakeholder groups (Sponsors, Data Holders, Innovators, and Experts) by developing an "incubator process."⁴ We encourage the committees to incorporate this spirit of collaboration around measure development as they finalize the legislation.

With respect to promoting transparency of physician Medicare data, the proposed legislation would require HHS to publish utilization and payment data for physicians and other practitioners on the physician compare website, along with quality and resource use information, in the hopes that it will assist beneficiaries in evaluating professionals. As we have conveyed to CMS, IDSA has concerns over

³ The RUC Relativity Assessment Workgroup Progress Report, accessed on November 8, 2013 at <http://www.ama-assn.org/resources/doc/rbrvs/five-year-progress.pdf>

⁴ QReport SPECIAL EDITION: 2013 Annual Conference Review accessed on November 8, 2013 at http://www.qualityforum.org/Events/Conferences/Annual_Conference/2013/2013_Annual_Conference.aspx

the current Physician Compare Program. We believe more work must be done to ensure the accuracy of the underlying database and performance calculations for the information currently being reported. These current issues should be addressed before the reported information is expanded, as the proposed legislation calls for.

Furthermore, we have stressed the importance of having a robust program that educates consumers as to the appropriate interpretation of quality measure performance data provided via Physician Compare. This will also apply to reported information related to utilization and payment. It is our hope that consumers will be appropriately oriented to the data provided, with explanations that include possible reasons for why there may be lack of reportable data, (i.e., lack of applicable measures for the specific specialty). This will help to ensure that consumers do not come away with a negative impression of providers who have no quality data displayed.