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September 2, 2014

Marilyn B. Tavenner, RN, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013
Attention: CMS-1612-P
Submitted via: <http://www.regulations.gov>

Re: Comments on Medicare Program Revisions to Proposed Payment Policies
under the Physician Fee Schedule for CY 2015 [CMS-1612-P]

Dear Administrator Tavenner:

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the FY 2015 Physician Fee Schedule (PFS) proposed rule. IDSA 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, pandemic influenza, 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 Middle East Respiratory Syndrome (MERS), and Ebola.

IDSA members are committed to improving the quality and safety of patient care in a manner that aligns reimbursement with value-based principles. This PFS proposed rule outlines changes to the code valuation process, Medicare Telehealth Services, Chronic Care Management, the Physician Quality Reporting System (PQRS), the Physician Resource-Use Feedback Program and the Value-Based Payment Modifier (VBM), the Medicare Shared Savings Program (MSSP) and the Physician Compare Website, among other Part B related issues. Below, we submit our specific comments on these proposed changes.

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Improving the Valuation of the Global Service Package

CMS proposes to transition all 010-day and 090-day global codes to 000-day global codes by 2017 and 2018, respectively, and to call for all medically reasonable and necessary visits to be billed separately during the pre- and post-operative periods outside the day of the surgical procedure. This proposal is based on past challenges to obtain accurate data to verify the number, level, and relative costs of post-operative visits included in global packages as well as general concern over the reliability that the post-operative care is being provided to the typical patient.

IDSA supports increasing the accuracy of physician payment and commends CMS for investigating methods to more accurately pay Medicare providers for the services they provide. As well, IDSA encourages CMS and other stakeholders to increase efforts to identify more accurate sources of utilization data on which to base the valuation of physician services. Current options being considered for the transition to 000-day global codes should ensure the accurate accounting of physician work (PW), practice expense (PE), and malpractice risk for services being performed. Transitioning the 000- and 090-day global codes would “unbundle” post-operative care and the discrete episodes of care provided would need to be individually reported. IDSA recommends working within the existing framework of CPT® Codes to describe these services if this proposal is finalized. The existing CPT® E&M code families have been used to value (directly or indirectly) post-operative care to this point and there does not appear to be a compelling reason to change.

IDSA has long been an active participant in the AMA RUC and believes that the established process makes significant contributions to improving the valuation of services. Therefore, we echo the AMA RUC’s call for collaboration with CMS over a reasonable period of time to ensure accurate valuation and avoid unintended consequences in this endeavor.

Chronic Care Management

We commend CMS for the ongoing recognition of the value of non-face-to-face time expended by physicians and their staff to improve patient care and outcomes. This recognition was captured in the establishment of the Transitional Care Management (TCM) codes (CPT 99495 and CPT 99496) and is now also recognized in the Chronic Care Management (CCM) codes. CMS proposes to finalize payment policy for the CCM code, 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 Medicare beneficiaries 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 subsets of beneficiaries. We view the TCM and CCM codes as “building blocks” towards more appropriately valued care management services.

To elaborate, infectious diseases specialists often treat patients with complex, severe infections that require strict adherence to antimicrobial treatment protocols that may last several weeks to months. Moreover, it is not uncommon that patients with severe infections have multiple co-morbidities that bring added complexity to their management and treatment. ID specialist-managed patients with HIV and HCV require ongoing care coordination as well as patients who are on Outpatient Parenteral Antibiotic Therapy (OPAT). These patients require similar additional resources as described in previous rule-making for the CCM 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

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the care plan; and/or adjustment of medical therapy). Our objective here is to raise awareness of other subsets of beneficiaries and to highlight that complex care coordination takes place both in primary care and specialist settings so that CMS can consider additional areas to appropriately value complex care management.

With respect to the specifications related to scope of services and the requirements for services furnished incident to a physician's service under general physician supervision, we are supportive of what CMS has proposed. However, with respect to the valuation of the CCM services, we hope CMS will take into account the RUC process that involved a review of robust survey results from relevant stakeholders, many of which were the same that CMS actively engaged to provide input. This process led to a RUC recommendation, based on a rationale supported by the data, as to how the CCM services should be valued. We ask CMS to give careful consideration to the RUC recommendation as it finalizes the payment policy for CCM services.

Proposals Regarding the Clinical Laboratory Fee Schedule

Physicians require access to pertinent diagnostic laboratory tests to provide the most effective care for patients with infectious diseases. The pace of innovation of these tests has accelerated in recent years, but there are still barriers to their integration into clinical care. Access to novel, innovative tests that could significantly improve patient care is particularly hindered when the reimbursement for the test does not cover the actual cost to perform the test.

IDSA applauds the efforts of CMS to implement provisions updating diagnostic test reimbursement as required by the Protecting Access to Medicare Act of 2014 (PAMA). These provisions have the potential to significantly reduce the reimbursement barriers hampering optimal medical care. We also look forward to PAMA's establishment of an expert advisory panel that will provide input on the development, validation, performance, and application of clinical laboratory tests. Infectious diseases diagnostics face unique issues and have tremendous potential to significantly improve not only individual patient care, but also public health by identifying patients for whom infection control measures must be taken and by guiding appropriate antibiotic use to limit the development of antibiotic resistance. IDSA urges you to include infectious diseases experts in the upcoming advisory panel.

Physician Compare Website

In previous rulemaking, CMS finalized its plans to report in 2015 a sub-set of twenty PQRS measures from the 2014 reporting year. CMS indicates that these data will be made publicly available in early 2015. CMS proposes to make available for public reporting all 2015 reporting year individual EP-level PQRS measures collected via registry, EHR, or claims via Physician Compare website for public display in late 2016. As we consider the rapid expansion of data to be made publicly available, we become increasingly concerned with the potential misinterpretation of these data, resulting in inaccurate conclusions being formed by consumers as an unintended consequence.

As CMS has stated, the primary goal of Physician Compare is to help consumers make informed health care decisions. IDSA supports CMS in this endeavor and encourages CMS to provide more detail as to how it plans to carry out concept testing with consumers to ensure appropriate interpretation of the quality measure performance data provided via Physician Compare. 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 a lack of reportable data (i.e., lack of applicable measures for the specific specialty). This will

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help ensure that consumers do not come away with a negative impression of providers who have no quality data displayed.

The underlying assumption is that consumers will utilize Physician Compare not to inform decisions as to whether or not they should seek care for their condition(s) but rather which provider should they seek out to complete their care, from the available pool of providers. As we have previously mentioned in response to prior rulemaking, many ID specialists have been unable to participate fully in PQRS, due to a dearth in applicable quality measures. While IDSA continues to invest resources in the development of more meaningful measures (e.g., *Staphylococcus aureus* measure concepts), we remain concerned that the current lack of ID-relevant measures approved for PQRS may result in the public drawing inaccurate conclusions about the quality of ID specialists in general as well as specific ID specialists.

Based on what CMS has proposed, a patient will be able to search on Physician Compare for an infectious diseases specialist and see that some ID specialists have participated in PQRS and others have not. Those that have participated may show reporting on a limited number of measures, for example, conditions such as hepatitis C virus (HCV) or activities such as Medication Reconciliation, with associated performance bench-marking information. On the other hand, a search for osteomyelitis, limited by a lack of useful measures, may yield less usable information. Worse, the lack of measures applicable to ID may leave the consumer with the mistaken impression that ID specialists lack the quality outcomes to justify participation in their care. If there are no applicable measures for a given clinical condition, then this should be explained and further guidance should be provided to aid the patient-consumer as to how to use Physician Compare or other resources to find an appropriate provider.

Given the current functionality of Physician Compare, we feel significant enhancements are needed to allow for appropriate comparisons to be made across providers, once CMS makes detailed quality measure data available. We ask CMS to provide more detail as to how it plans to display bench-marked physician performance data and reiterate our concern for the use of "star" ratings (as used to indicate quality performance for accountable care organizations on Physician Compare) or other arbitrary thresholds since they often exaggerate minor performance differences on measures and result in inappropriate distinctions between physicians whose performance is not statistically different.

Given these challenges, we support CMS' proposal to consider including specialty society measures on Physician Compare or, more desirably, simply linking Physician Compare to specialty society websites that publish non-PQRS measures of quality. This would give specialties greater flexibility to promote measures, standards, and other activities that are most relevant and meaningful to their physician members and the patients they treat. We agree with CMS that measures reported through this alternative mechanism would still have to be supported by scientific evidence, comprehensively vetted and tested, and trusted by the physician community.

In general, CMS should share any findings derived from the concept testing it intends to conduct with patient-consumers with specialty societies who could provide additional resources on quality measurements. Furthermore, we believe it is important for CMS to include a disclaimer on the Physician Compare website informing the public of the limitations of the PQRS measure set and noting that if a specialty does not have applicable PQRS measures, this is not a negative reflection on the specialty or the quality of its physicians.

In terms of CMS' proposal to publicly report CG-CAHPS data starting in 2014, IDSA recognizes the importance of patient experience measures, but has concerns about their subjectivity and the inability of some of the CG-CAHPS measures, such as "Getting Timely Care, Appointments and Information" and "Access to Specialists," to accurately capture aspects of care over which an individual physician has direct control. Until CMS can refine these measures and ensure accuracy at the individual physician

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level, we urge the agency to either only provide these data to physicians via confidential feedback reports or to only publicly report these measures on an aggregate, large group practice level. Additional concerns about the CAHPS measures are discussed below.

Furthermore, IDSA would like to reiterate its concerns about the 20 patient minimum threshold for reporting performance information on Physician Compare. A sample size this small will compromise the validity of the data, provide little information of value for patient decisions-making, and result in inaccurate judgments that could harm the reputation of physicians.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (PQRS)

Requesting Informal Review

CMS finalized its policy to impose a two-percent reimbursement penalty on claims filed in 2017 for those eligible providers (EP) who do not satisfy reporting requirements in 2015. As this increased penalty period looms, CMS is moving to finalize the policy by which an EP can request an informal review of submitted data that result in a payment penalty. In this PFS proposed rule, CMS proposes to set the period during which an EP can request an informal review to be within 30-days of the date that physician feedback reports are released. IDSA welcomes this proposal as linking the review request to a physician's receipt of the feedback report seems reasonable and should allow for an opportunity for corrections to be made that may improve the calculations of the value modifier. IDSA again asks that CMS consider allowing for a longer period to submit the request for informal review. With this current proposal to allow 30-days from the release of the feedback reports to request an informal review, some practices may be caught unprepared to react to the feedback report with sufficient time to verify their data to confirm grounds for an informal review, prior to actually submitting the request for review.

Proposed changes to PQRS Measures

CMS proposes to add 28 new individual measures and two measures groups to the PQRS for 2015. Of particular interest to infectious diseases specialists are the measures for HCV, an infectious disease that can now be treated with advanced therapies prescribed by ID specialists. This addition will help to increase the number of ID-related measures. From the [PQRS Experience Report](#), based on 2012 data, there were 6,116 ID eligible providers, of which 35.3% participated in PQRS. The top five most commonly reported measures from ID eligible provider are as follows:

- #124: Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR) – retired as of January 2013
- #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older
- #110: Preventive Care and Screening: Influenza Immunization
- #130: Documentation of Current Medications in the Medical Record
- #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measures to confirm vaccinations as well as the other popularly reported measures above do not really reflect quality care in infectious diseases. As previously mentioned, IDSA continues to dedicate efforts to developing clinical quality measures relevant to the treatment of infectious diseases. We have developed measure concepts for *Staphylococcus aureus* and have submitted these measure concepts to CMS, in response to the ongoing CMS Call for Measures. They were not considered for inclusion in 2015, due to a need for validation and testing. We have also submitted these measure concepts to the National Quality Forum's Measure Inventory Pipeline in hopes that we may engage other stakeholders in efforts to further

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develop these and other measures. The challenge that we face is that to see measure development through the full process requires considerable financial investment. As well, we have developed concept process measures for which we feel would be useful to advance quality measurement in infectious diseases care (i.e., Antimicrobial Stewardship, Outpatient Parenteral Antimicrobial Therapy) but these were not welcomed by the NQF. We are hopeful to engage other entities that may be willing to assist in further developing these measures as well as patient outcome measures related to infectious diseases.

CMS proposes to remove 73 measures from the PQRS for 2015, some of which are being proposed for removal because they are entirely clinical process measures that do not meaningfully contribute to improved patient outcomes or because performance rates are close to 100%, suggesting no gap in care. We note that the perioperative measures group and its components (Perioperative Care: Timing of Prophylactic Parenteral Antibiotic/ Selection of Prophylactic Antibiotic/Discontinuation of Prophylactic Parenteral Antibiotics) is among these proposed for removal. We believe these component measures should not be retired despite their “topped out” status. Specifically, we request that CMS consider maintaining these measures for reporting due to their alignment with antimicrobial stewardship principles. IDSA has been a leader in advocacy for antimicrobial stewardship (AS) and we seek to maintain adherence to stewardship across all health care settings. Although performance on these measures is currently high, if they are completely retired, efforts to track adherence to stewardship via a consistent mechanism will be hindered. Performance deterioration is a well-documented occurrence when attention to, and measurement of, a particular issue is de-emphasized or ceased. Given the national concern related to antibiotic resistance, we ask CMS to consider retaining these measures within the PQRS.

Patient Experience Measures

In late 2014, CMS proposes to publicly report on CAHPS performance reported by groups of 100 or more, but by 2015, it would report on CAHPS performance for groups of 25 or more and, in 2016, it would report on performance for groups of 2 or more. While reporting the CAHPS measures would be optional for groups with 2-99 EPs for the 2017 payment adjustment, CMS proposes that beginning with the reporting period for the 2018 PQRS payment adjustment (i.e., 2016), group practices with 25+ EPs participating in GPRO would be required to not only report on, but to also bear the cost of using a certified vendor to collect the CAHPS survey measures. This strategy is concerning as it seems to indicate the agency’s desire to make patient experience measures a required component of federal quality initiatives in the future, including the VM and Physician Compare.

While it is important to understand patient experience in the care setting, patient experience/satisfaction should not be a required element of reporting for providers since these are often subjective in nature and not directly under the control of the physician (e.g., patient wait times in a hospital setting). In many specialties, there is no direct correlation between higher patient experience scores and better clinical outcomes. Furthermore, holding physicians accountable for patient satisfaction measures may result in perverse incentives that actually lead to lower quality care (e.g., antibiotic and pain medication overuse to satisfy patient requests). We urge CMS to instead focus on evidence-based, physician-driven clinical quality measures for accountability purposes and to retain patient experience measures for internal quality improvement purposes only.

We also reiterate our concerns about requiring the use of certified survey vendors for CAHPS reporting, especially as this reporting option becomes a requirement that applies to an increasingly large number of physicians. The cost of working with a certified vendor may be prohibitive for many smaller practices. We encourage CMS either to assist with administration of the survey or to maintain this as an *optional* reporting mechanism.

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Reporting Requirements

While IDSA appreciates the many positive improvements CMS has made to the PQRS over the years and the need to continually raise the bar on measurement, participation rates remain low within most specialties. In many cases for ID specialists, this is due to a lack of meaningful and relevant measures. Therefore, we continue to object to the 9 measure reporting requirement. Many infectious diseases physicians currently find it challenging to report on 3 measures that are specific enough to be truly relevant and meaningful to their practice. We expect that the 9 measure requirement will result in either a high failure rate or the reporting of measures of little relevance simply for the sake of reporting. With the PQRS transitioning to an all-penalty program in 2015, CMS' rapid release of publicly reported data, and the increasing penalties associated with the value-modifier (VM), it is critical that CMS focus on the quality of the measures reported rather than the quantity.

While we continue to support giving physicians the flexibility to choose measures that are most relevant to their practice and patient population, we do see value in targeting priority conditions and care processes that affect a large number of patients. As such, IDSA accepts CMS' proposal to require that 2 of the 9 PQRS measures reported by physicians come from a set of 18 "cross-cutting" measures. This proposed set of measures includes some commonly reported on by our members, including Documentation of Current Medications in the Medical Record; Preventive Care and Screening: Influenza Immunization; and Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older. Going forward, we encourage CMS to take advantage of the crosscutting measure set to target additional ID-related topics that are relevant across specialties and settings. One in particular is the promotion of better antimicrobial stewardship. There is a substantial body of literature that links stewardship to reductions in *C. difficile* infections and health care costs, specifically, and, more broadly, to reductions in antimicrobial resistance overall, which is a huge concern at the national level. We would be happy to discuss with CMS some measure concepts and other strategies we have considered to promote stewardship.

Furthermore, while we thank CMS for trying to move towards more robust and clinically relevant reporting mechanisms, such as EHRs and registries, we request that CMS preserve the claims-based reporting mechanism as an option for those who find it most convenient (e.g., newcomers, small/solo practitioners and group practices, rural providers, etc.). As indicated in the PQRS Experience Report from 2012 data, claims-based reporting is the most commonly used reporting mechanism for ID eligible providers outside of all group reporting options.

Qualified Clinical Data Registry

IDSA continues to support the flexibility provided by this new reporting mechanism, especially as we continue to work to develop a robust portfolio of ID-specific measures. We view this new reporting mechanism as an opportunity to test more innovative approaches to quality improvement than are permitted under the current system and to collect data on measure concepts that can be used to refine and finalize the development of ID-specific clinical quality measures.

Nevertheless, we feel some of the requirements associated with the QCDR reporting mechanism are overly restrictive and may pose challenges to those seeking to become a qualified entity. For example, although risk adjustment is a critical component of quality measurement, we do not believe it should be a requirement for qualified clinical data registries at this point in time since it is a resource intensive task and one for which there is no single proven model to ensure accuracy. We are also concerned about CMS' proposal to require QCDRs to report on at least 3 outcomes measures. Many specialties continue to face challenges identifying well-defined, validated and properly risk-adjusted outcomes measures and find it challenging enough to satisfy the 2014 requirement of one outcomes measure. While outcomes measures should be encouraged, they should not be a requirement in the early stages of this new reporting

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mechanism. We also believe that the requirement to collect data on 9 measures is too high of a bar for these entities. This arbitrary requirement fails to recognize the unique role of the QCDR to select measures that are most relevant and meaningful to their participants. Similarly, we believe that the “50% of *all* patients (Medicare and non-Medicare)” reporting requirement is much too high and unfair since it holds QCDR participants to a higher bar than traditional PQRS participants, who are only required to report on Medicare patients. We request that CMS permit a QCDR to instead submit a statistically valid sample of patients for each measure. Finally, we are very concerned about the newly proposed requirement that QCDRs publicly report measure performance data. Many specialties have not yet developed the analytics needed to report data to the public in an accurate and meaningful manner nor have they collected data long enough to accurately calculate performance rates and set benchmarks that are meaningful to both consumers and physicians. Registry participants should be given the opportunity to familiarize themselves with registry participation and ways to translate performance feedback into meaningful practice improvements before data is widely released. For all of these reasons, we feel that at least initially, QCDRs should not be required to publicly report on measure data.

In summary, we urge CMS to take a more phased approach to implementation of this new reporting option and to allow for more flexibility in how clinical registries meet PQRS qualification criteria over time. CMS should adopt the least stringent requirements that ensure a sufficient level of quality assurance without discouraging participation.

Value-Based Payment Modifier

Penalties

While IDSA realizes that CMS is required under statute to apply the value modifier (VM) to all physicians by 2017, we continue to have concerns about the speed at which this program would hold physicians accountable for both quality and cost. We would appreciate it if CMS would use its authority, where possible, to lessen the immediate impact of value-based penalties, especially on smaller group practices and individual providers, and to extend the time of implementation in order to better evaluate the accuracy of cost measure calculations and the overall strategy of holding physicians accountable for resource-based performance.

For 2017, CMS is proposing to apply the VM to all groups, while also doubling the non-participation penalty to 4% and maintaining the mandatory quality tiering calculation. While we appreciate that CMS is proposing to hold groups with 2-10 EPs and solo practitioners harmless from downward performance-based payment adjustments during this first year, we are still concerned about other aspects of this proposal. For one, this strategy would mean that in 2017, the first year that groups with 10-99 EPs could be subject to mandatory downward performance-based adjustment, they could be penalized up to 4%. This also would mean that during the very first year that the VM applies to the smallest of practices (2-10 EPs), they would be subject to a non-participation penalty that is two times as large as the penalty initially applied to larger practices (10-99 EPs) in 2016 and four times as large as the penalties initially applied to the largest of practices (100+ EPs) in 2015.

We strongly object to subjecting smaller practices to such a high standard during their first year of this relatively new program. Smaller practices face greater challenges participating in federal quality reporting programs. At least initially and as they become accustomed to federal reporting requirements, they should be subject to the same or lower penalties as larger practices, who have greater resources to dedicate to a program. We recommend that, in addition to holding smaller groups harmless from performance-based downward adjustments during the initial year, CMS also subject them to a lower penalty for non-participation. In the second year, when these groups are no longer held harmless from

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downward adjustments, they should also be subject to a lower initial penalty, preferably -1% or -2% at the most.

A more gradual roll out of the penalties is also critical in terms of giving CMS more time to evaluate and make improvements to the program. CMS and the public still have much to learn about the validity of cost measures, the accuracy of patient attribution and risk adjustment methodologies, the reliability of composite scores, the significance of benchmarks, and the overall value of performance data to both physicians and patients.

Quality Measures

Our concerns about the pace at which CMS proposes to apply the VM are heightened by the program's continued reliance on PQRS measures, including acute and chronic care prevention measures, many of which are not relevant to our specialty, for quality calculations. We also reiterate our opposition to including patient satisfaction measures in any value-based payment modifier calculations.

In regards to QCDR reporting, CMS claims it does not currently have the technical capacity to use QCDR quality measure data to calculate the quality portion of the VM. As an alternative, it would automatically consider physicians who satisfy PQRS requirements using a QCDR to be "average quality" for purposes of the VM calculation. While we support an initial one or two year period during which QCDRs can collect baseline data, develop benchmarks, and improve or remove measures before they are used for accountability purposes, the "average quality" designation should not be used long term since it may unfairly penalize those whose high performance should be rewarded. CMS should work with QCDRs to develop a mechanism by which quality performance data, as well as cost and resource data (if collected), can be used to determine the VM calculation since these are measures that specialties find most important and that most accurately reflect the scope of their members' care.

Cost Measures

IDSA also would like to reiterate its concerns about the cost measures CMS proposes to continue to use in 2017. While we appreciate CMS' effort to encourage more care coordination among healthcare providers and across settings, we continue to have reservations about measures that hold physicians responsible for factors outside of their direct control. Both the total per capita cost measures and the Medicare Spending Per Beneficiary measure hold physicians accountable for the totality of costs associated with 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.

As we have stated previously, it is important for each physician caring for a patient to understand how he/she contributed to the patient's total cost of care, but it is not necessarily appropriate to hold each of these physicians *accountable* for the patient's *total* cost of care. In our specialty and others, accountability for cost could result in unintended consequences, such as physicians not ordering laboratory tests or diagnostics prior to prescribing antibiotics in order to minimize costs, which we see on a daily basis leads to inappropriate antibiotic use, increased drug resistance, and harm to the patient, as well as the general public. For these reasons, we support CMS' use of the proposed set of cost measures for educational purposes only (i.e., via confidential feedback reports), but request that CMS not hold physicians accountable for cost measures until it has developed and carefully tested more focused episode-based cost measures that more accurately reflect care over which a physician has control and allow for more equal comparisons of patient populations. We are encouraged by discussions in this rule about the work CMS has been doing to develop specialty-specific episode-based cost measures, and we remind CMS of our support for and interest in assisting with that task.

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Furthermore, it is critical that cost measures have a more direct link to the quality measures used to assess value. Another major flaw of the current proposed set of cost measures is that they have little relevancy to the more condition/procedure-specific quality measures used to calculate the value modifier.

Conclusions about the value of medical care will have little significance if the cost and quality measures on which they are based focus on different elements of care.

Finally, we oppose CMS' decision to not apply socioeconomic status adjustments to cost measures under the VM. A large body of evidence demonstrates that patients' socio-demographic factors such as income and insurance status can affect outcomes, including readmissions and cost. Failing to adjust measures for these factors can lead to inaccurate data and conclusions, and thus substantial unintended consequences, including harm to patients and heightened health care disparities by diverting resources away from providers treating large proportions of disadvantaged patients; in turn, such providers may decide to reduce the numbers of low income or non-insured patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to worse outcomes.

Informal Inquiry Process

IDSA supports CMS' efforts to expand the informal inquiry process in regards to performance calculations. Under current policy, a group of physicians is simply given the option to contact CMS after receiving its annual Physician Feedback report to inquire about the report and the calculation of the VM. CMS now proposes a more formal process for groups to request a correction of a perceived error. CMS would recompute the group's cost composite and readjust its tier accordingly if the agency determines it made an error in the cost calculation for 2015. However, CMS claims it is not technically feasible to do the same for quality composite errors in 2015 and would instead classify a TIN as "average quality" in those cases (by 2016, CMS claims it would be able to recompute a TIN's quality composite). IDSA cautions CMS against holding practices accountable for performance without a mechanism in place to ensure corrections to the data. While CMS' intent may be to hold a group harmless by deeming it "average quality," this characterization may not accurately reflect the performance of the group and can actually result in the inappropriate application of penalties or the loss of an earned incentive. Physicians should not be at risk for penalties or fail to earn a deserved incentive simply because CMS does not have the capacity to correct inaccurate data. We also encourage CMS to give groups at least until February 2015 to request a correction for the 2015 payment adjustment.

For the 2016 and 2017 payment adjustments, CMS proposes to establish a 30-day period that would start after the release of the QRURs for the applicable reporting period for a group or individual to request a correction of a perceived error related to the VM calculation. We urge CMS to adopt a longer period, such as 60 days, for physicians to request a correction. Physicians have reported difficulty accessing the Feedback Reports and since many are still unfamiliar with both the reports and the VM, they will need more time to sift through this complex set of data and to really understand what they are looking at, let alone identify potential errors.

Hospital-based Physicians

In past rule-making, CMS has indicated an interest in providing hospital-based physicians (or solo practitioners who are hospital-based) the option of electing the inclusion of Hospital Value-Based Purchasing (VBP) Program performance in their VM calculation in future years of the program. If CMS were to establish a voluntary policy in which groups could elect to include hospital performance, they could make the election to have that performance included in their VM for a payment adjustment period based on the hospital's historic VBP Program performance which would be known to the TIN at the time of election. Since a significant number of ID specialists practice primarily in the hospital, IDSA is

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pleased to see more details emerge as to how CMS might implement this option.

CMS has proposed two methodologies by which to identify those eligible professionals who should have this option. The first methodology proposed involves self-attestations by the group or solo provider to being “hospital-based.” The other proposed methodology would have CMS set specific criteria. CMS also proposes two possible methodologies to determine which hospital or hospitals’ performance would apply to a given tax identification number (TIN). The first proposed methodology would base the determination on the plurality of services provided by a TIN (the TIN would be attributed to the Hospital VBP Program performance of the hospital at which the eligible professional billed the most professional services during a given performance period). The second possible methodology would base the determination on some threshold of the TINs hospital-based services at a hospital (i.e., require that a TIN have performed at least 30 percent of its hospital-based services at a given hospital to have that hospital’s performance included in the TIN’s VM; a weighted average across all hospitals that meet the threshold would be applied as the VBP Performance tied to the TIN).

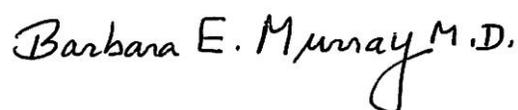
IDSA is encouraged by these proposals and welcomes the opportunity to discuss these proposed methodologies with CMS. Based on our initial impression of what appears in the proposed rule, we favor the option that allows hospital-based physicians to self-attest and we prefer the second methodology for tying multiple hospitals’ VBP Program performance to the provider at the TIN-level. It is not uncommon to have an ID specialist providing consults at multiple hospitals; therefore, we feel this option is most appropriate.

Physician Feedback Program

As the information presented in the feedback reports takes on more significance due to the application of the VM and public reporting, it is absolutely critical that CMS continue to work to improve the Physician Feedback reports. The format of the reports remains confusing to most providers, the underlying data are difficult to interpret, and providers have reported difficulty accessing the reports. We encourage CMS to continue to evaluate and refine the reports in consultation with medical specialty societies. An important part of this process will be to further tailor the reports to each specialty by highlighting the measures/conditions of the recipient of the report, providing additional details on the physicians’ patient population and other providers whose data may have influenced the report, and providing recommendations or action items. We also encourage CMS to continue to provide educational resources and other guiding tools to assist physicians with accessing and navigating the reports.

IDSA appreciates the efforts of CMS to promote improved patient safety and better quality of care as set forth in this PFS proposed rule. We welcome further discussion with CMS and other stakeholders on how quality measurement in the PQRS program can include measures more relevant to quality care within infectious diseases. If you have any questions, please feel free to contact Andrés Rodríguez, Director for Practice & Payment Policy, at 703-299-5146 or arodriguez@idsociety.org.

Respectfully,



Barbara E. Murray, MD, FIDSA
President