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January 27, 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-1600-FC

Submitted via: <http://www.regulations.gov>

Re: Comments on Medicare Program Revisions to Payment Policies under the Physician Fee Schedule for CY 2014 [CMS-1600-FC]

Dear Administrator Tavenner,

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the FY 2014 Physician Fee Schedule (PFS) final 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, 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.

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 final rule establishes changes to the code valuation process, 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 changes, as delineated in the final rule.

## **IDSA Comments – CMS CY2014 PFS Final Rule**

### **Misvalued PFS Codes**

With regards to the two agreements with the RAND Corporation and Urban Institute, we appreciate the effort that CMS has put forth to possibly validate current valuation methods and develop additional methodologies. Specifically, we have learned that the Urban Institute study will examine the work relative value units (RVUs) for approximately 120 services and validate the RVUs used in the Medicare Physician Fee Schedule for both new and existing services. The project aims to provide CMS with a process for reviewing proposed work RVUs relative to external data and assuring that the relativities within the overall RBRVS fee schedule are internally consistent within as well as across families of services and specialties. IDSA is concerned that the 120 services selected for review by the Urban Institute are too heavily skewed toward surgical procedures and do not assess codes for cognitive services, (i.e. Evaluation & Management).<sup>1</sup> As we have previously stated, 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. We therefore continue to 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. The work that the Urban Institute will perform should be expanded to include E/M services in order to inform efforts to improve the valuation of physician services that involve complex medical decision-making, services that are key to establishing the correct diagnosis and ensuring that higher cost procedures, imaging and laboratory services are used most cost-effectively.

### **Chronic Care Management Services**

As we have previously stated, we are encouraged by CMS's 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. IDSA appreciates CMS's ongoing recognition of the value of primary care services, including the non-face-to-face time expended by physicians and their staff to improve patient care and outcomes. This work has been recognized with the creation of the Transitional Care Management (TCM) codes and appears to be accounted for in CMS's proposal for chronic care management (CCM) services. IDSA views this as continued progress towards appropriately accounting for the non-face-to-face, comprehensive, coordinated care management work related to providing quality care for patients. We look forward to learning more about what practice requirements (i.e. staffing, EHR specifications) may be associated with the provision of CCM services that CMS may propose in future rule making.

As we move forward, we ask that CMS consider that there are other situations involving patients with complex clinical circumstances that often involve multiple co-morbidities where there is extensive non-face-to-face, comprehensive, coordinated care management involved. These patient cases require similar additional resources as described in the proposed rule for the CCM services, (i.e., regular physician development and/or revision of care plans; subsequent reports of

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<sup>1</sup> CMS Physician Center Communication "Medicare Physician Fee Schedule (PFS): Development of a Validation Model for Work Relative Value Units (RVUs)." Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/RVUs-Validation-Model.pdf>

## **IDSA Comments – CMS CY2014 PFS Final Rule**

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). We seek to raise awareness of other categories of beneficiaries so that CMS can look to address additional areas to appropriately value care management.

### **Physician Compare & Physician Quality Reporting System (PQRS)**

IDSA recognizes CMS's efforts towards making the Physician Compare website a constructive tool to assist Medicare beneficiaries with making health care decisions. We had expressed our concern over the 30-day preview period as being too narrow a window to effectively allow a physician to review, and if necessary, collect data to support a claim of inaccurate information and submit to CMS for consideration. In the final rule, we see that CMS will hold firm to the 30-day period and has specified no formal appeals process, therefore we will monitor CMS's handling of requests from providers to correct errors during the preview period. Given the importance of accurate physician measure display as viewed by beneficiaries making choices in selecting providers, we expect that CMS will provide sufficient resources to handle what may be a considerable volume of interest from providers and expand the length of the preview period in the future if it proves to be insufficient. Furthermore, we reiterate our concerns about the maturity of current risk adjustment and attribution methodologies that underlie the measures displayed on Physician Compare. Ensuring the accuracy of these methodologies is especially critical before posting individual physician data.

CMS has finalized the requirements for an eligible professional (EP) to earn a 2014 incentive payment as indicated in the proposed rule. Therefore, an EP must report on at least 9 measures covering at least 3 of the National Quality Strategy Domains. Each measure would have to be reported for at least 50% of the Medicare Part B fee-for-service (FFS) patients seen during the reporting period to which the measure applies. If less than 9 measures apply to the eligible professional, s/he may report 1–8 measures, and report each measure for at least 50 % of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. However, CMS will subject these EPs to the MAV process to determine whether s/he could have reported other quality data codes for additional measures and/or domains.

In previous letters, we have indicated the low participation level among EPs that are ID specialists. This is partly due to a paucity of quality measures that are directly relevant to ID physicians, their patient populations, and the settings in which they practice. We reiterate our concern for CMS's drastic expansion of reporting requirements as it could result in either a high failure rate under the MAV process and/or reporting of measures of little relevance.

IDSA is working to develop measures to comprise a robust portfolio across the measure domains upon which ID specialists can report quality care. We view favorably the additional PQRS reporting option via qualified clinical data registries, once established. We see 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.

## IDSA Comments – CMS CY2014 PFS Final Rule

Furthermore, we are optimistic that CMS will continue to explore the inclusion of hospital IQR measures, overcoming the operational issues with implementation of as many of these measures within PQRS as appropriate. As well, IDSA supports CMS's continued efforts to provide hospital-based physicians with the option to tie their performance metric assessment to that of their institutions as this may be a viable option for the short-term.

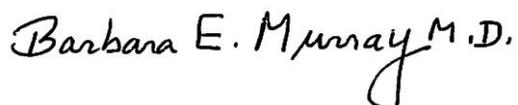
### **Value-Based Payment Modifier and Physician Feedback Program**

CMS has finalized its proposal to double the number of physicians subject to penalties under the value-based modifier (VBM) payment formula in 2016 and to increase the penalty from 1% to 2% for groups that fall into Category 2 and do not satisfy PQRS. As well, CMS finalized its proposal to make the quality-tiering approach mandatory for all eligible group practices in 2016. With respect to the Total-Per-Capita and the Medicare Spending Per Beneficiary cost measures, CMS has decided to proceed with its proposal to apply these measures, despite widespread concern. In our comment letter on the proposed rule, we expressed concern for all of these plans and we will now monitor the implementation of these measures with particular attention to the impact of risk adjustment and attribution methodologies. IDSA agrees with CMS in its selection of the "specialty benchmarking method" for attribution as it creates one national benchmark for each cost measure by which all groups of physicians can be measured in a standardized manner.

### **Conclusion**

IDSA appreciates the Agency's consideration of our comments on the CY 2014 Physician Fee Schedule Final Rule. If you have any questions or comments, please feel free to contact Andres Rodriguez, IDSA's Director for Practice & Payment Policy, at (703) 299- 5146 or via email at [arodriguez@idsociety.org](mailto:arodriguez@idsociety.org).

Respectfully,



Barbara E. Murray, MD, FIDSA  
President