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September 6, 2013

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-P

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

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

Dear Administrator Tavenner,

The Infectious Diseases Society of America (IDSAs) appreciates the opportunity to provide comments on the FY 2014 Physician Fee Schedule (PFS) proposed rule. 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.

IDSAs 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, the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, 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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Misvalued PFS Codes

CMS has used the Medicare physician payment rulemaking process to carry out its statutory requirement to periodically identify potentially misvalued services. CMS establishes practice expense (PE) relative value units (RVUs) for procedures that can be furnished in either a non-facility setting or facility setting. The agency has also collaborated with the American Medical Association's Relative Value System Update Committee (AMA RUC) and the medical specialty societies to accomplish much of this task. The AMA RUC has an established process for identifying potentially misvalued codes and making recommendations for adjusting relative value units (RVUs), which takes into consideration the federal government's mandate to improve the valuation of services paid under the PFS. As an active participant, IDSA believes that the RUC process makes valuable contributions to improving the valuation of services but we also believe that it is appropriate to explore other valuation methodologies and to consider other sources of resource utilization data.

CMS has entered into two agreements with the RAND Corporation and Urban Institute to develop additional methods of valuation. We look forward to learning more about these time estimation projects through future rulemaking and other public notices (i.e., Open Door Forum Updates). We also note CMS' openness to considering time data from sources such as the Department of Veteran Affairs (VA), the National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS) National Database, and the Physician Quality Reporting System (PQRS) databases inasmuch as these may provide more accurate estimations of physician time spent across the range of services. Whereas these projects and pursuits may yield useful results towards improving the valuation of physician services, **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 include direct involvement of physicians and other healthcare providers who are the purveyors of the very medical services that are to be valued. Therefore, we are hopeful that the project team assembled for the Urban Institute project will be the result of a thorough, transparent process that attracts physicians knowledgeable in work valuation that appropriately accounts for complex medical-decision making.

Furthermore, we are aware of efforts to establish separate, higher valued evaluation and management (E/M) codes that would be specific to primary care physicians (PCPs)¹. These efforts come on top of existing higher payments for PCPs that already exist in the Medicare program. We view this concept as flawed and counter-productive to broader efforts aimed at addressing the inadequate valuation of E/M services for all physicians. In its March 2013 report, the National Commission on Physician Payment Reform noted,

¹ AAFP Letter to CMS Recommending the Creation of Separate E/M Codes – Available at <http://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-CMS-PrimaryCareCodes-032713.pdf>

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“While the discussion about reimbursement has generally focused on services performed by primary care physicians, the commission believes that the real issue is not one of relative payment of specialists versus primary care physicians but, rather, of payment for E/M services as contrasted with procedural services. These include E/M services provided by, among others, cardiologists, endocrinologists, hematologists, infectious disease specialists, neurologists, psychiatrists, and rheumatologists.”

IDSA agrees, and urges CMS to focus on improving the valuation of physician services, accounting for the complexity of medical decision-making.

Services with Higher Total Medicare Payments in the Office vs. Facility

We support CMS’ efforts to achieve cost transparency and standardize payment for services across settings. When services, such as E/M, are provided in one setting vs. another, we agree that it is unlikely that resource use varies with significance or that costs are considerably different. For other services, that may not be the case, which requires a better understanding of the costs, including why and how they are different in each setting. Nonetheless, we have some fundamental concerns with CMS’ proposal as stated, which would limit the non-facility PE RVUs for individual codes so that the total non-facility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. Again, we are generally supportive of efforts to improve transparency in costs and ensure financial incentives for shifting services are eliminated.

We would disagree with CMS’ reliance upon the identification of codes through the new “screen” to automatically adjust the non-facility PE RVUs. We are concerned because CMS has not provided a mechanism for validating that both the facility and non-facility resource use data upon which CMS is relying may otherwise be accurate. CMS also fails to cite the statutory authority allowing it to establish “upper payment limits for office-based procedures” by relying solely upon data used to calculate payments under the Hospital Outpatient Prospective Payment System (OPPS). Given our understanding, the agency should only use OPPS payment rates to establish a guideline for determining potential payment limits under the PFS, as well as reasonable criteria for the presumption to be rebutted.

We are also concerned with CMS’ assertion that OPPS data are better and more reliable than data used to develop PE RVUs under the PFS, and therefore that the hospital OPPS data should be relied upon in adjusting payments under the PFS. We are not convinced that data collected through hospital cost reports will always be comparable to the office-based resource inputs collected under the PFS PE methodology. In fact, we believe that information from non-facility data resources is more accurate than the facility data that CMS has published. CMS should have a mechanism for excluding codes from the proposal if CMS is presented with data that are more reliable than the hospital OPPS data.

Ultimately, we are concerned that CMS’ proposed policy may lead to access problems for beneficiaries, particularly if certain services can no longer be provided in a physician’s office, which would force seniors to hospital outpatient departments (HOPD) or ambulatory surgical

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centers (ASC). Beneficiaries, particularly those on a fixed income, may face higher copayments and cost sharing when the same service is provided in the HOPD or ASC, possibly making the service cost prohibitive.

Should CMS have the authority to make such a policy change, we suggest a minimum of a one-year delay in implementation so that the public can better understand the policy. If a delay is not possible, we request that CMS' proposal be transitioned-in over multiple years to minimize disruptions for those providers who will be significantly impacted by this proposal, as well as beneficiary access to care.

Site of Service Data Collection

New data have shown that services once provided in the physician office setting are shifting back to HOPDs primarily due to increasing hospital employment of physicians. Recently, the Medicare Payment Advisory Commission (MedPAC) recommended equalization of payment for evaluation and management (E/M) services across settings, and it has considered additional recommendations to equalize payment for other services. Hospitals are also purchasing physician practices and redesignating them as off campus provider-based OPDs, which allows the same "practice" to bill for the same service at a significantly higher rate. The result appears to be higher program spending and beneficiary cost sharing without a notable change in patient care or quality.

CMS is considering collecting information that would allow it to analyze the frequency, type, and payment for services furnished in off campus provider-based hospital departments, in order to understand this trend. CMS discusses means by which the data could be collected. Under option one, CMS would create a new place of service (POS) for use on claim forms when these departments bill Medicare. Under option two, CMS would require hospitals to break out charges for services in these departments in their usual cost reports.

IDSA supports the development of a new place of service (POS) code to identify off-campus provider-based outpatient departments, which we believe will help CMS and others identify when physician offices, for example, have been re-designated as OPDs. We are also not convinced that newly designated OPDs that were once physician practices should be paid at OPPS rates. It is more appropriate that these practices should continue to be designated and paid as physician offices.

Complex Chronic Care Management Services

We appreciate CMS' 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. To that end, we welcome CMS' proposal that would refine PFS 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

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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.

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 comorbidities 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). Our objective here is to raise awareness of other categories of beneficiaries so that CMS can look to address additional areas to appropriately value care management. Recognizing that the recently established Transitional Care Management (TCM) codes and the proposed CCCM codes are "building blocks" towards better-valued care management services, we provide comments on the specific points that define the scope of CCCM services.

We believe it is unnecessary to require use of a certified, practice-integrated EHR that meets current HHS meaningful use criteria. We think it is reasonable to allow for the possibility that a practice may provide for full access to a patient's electronic medical record without meeting the most current HHS meaningful use criteria. It is more important that a practice provide 24/7 access for patients, enable full access to a patient's electronic medical record, and an ability to demonstrate the use of written protocols than to require that an APN or PA be dedicated to providing CCCM services. For many practices, it may be cost prohibitive to employ an APN or PA and we believe that other staff/non-physician providers may adequately provide the level of service and care as called for in CCCM. We believe that meeting these requirements, as well as the requirement that the patient opt-in to receive these services, should suffice and provide assurance to provide high quality, safe CCCM services. Furthermore, 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 through the previously specified requirements.

Chiropractors Billing of E/M Services

CMS seeks comment on several questions related to the billing of E/M services by chiropractors. CMS had previously established policy that limits payment to chiropractors for the services described by CPT codes 94980-94983. Furthermore, the AMA RUC HCPAC recently reviewed the services reported by chiropractors, which appear to have adequately captured the pre-, intra-, and post-service work for which chiropractors may be reimbursed under current law. Therefore, IDSA does not see any benefit, clinical or otherwise, to allowing chiropractors to bill for E/M services.

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As you know, the E/M codes are under increased scrutiny by OIG and other federal agencies². Recovery auditors and other program integrity contractors have expanded their efforts to audit E/M services. CMS and the Office of the National Coordinator (ONC) are exploring whether use of health information technology (HIT) inadvertently increases vulnerability of the Medicare program to “upcoding” in E/M services. Finally, as we move away from “fee-for-service” models of care and into integrated, team-based approaches to delivery, it seems counter-productive to “unbundle” E/M aspects of chiropractic care from the codes currently billed by those professionals. As well, we are concerned with the potential negative impact that expanding E/M services to chiropractors may have with respect to budget neutrality adjustments applied to the overall fee schedule. Therefore, we do not see any compelling reason, clinical or otherwise, for expanding the billing of E/M services by chiropractors.

Proposals Regarding the Clinical Laboratory Fee Schedule

IDSA is committed to the highest standards of care for patients with infectious diseases. To this end, patients and their treating physicians need access to pertinent diagnostic testing to guide safe management. Precise diagnosis leads to more efficacious care while empiricism often results in higher levels of patient morbidity and mortality, as well as unnecessary costs. Unfortunately, because of current reimbursement policies, access to needed and appropriate diagnostics is often substantively delayed, or, in some instances, simply not available.

Due to the rapid pace of innovation in diagnostics, such reimbursement barriers to clinical integration are increasingly a major issue. Reimbursement sometimes does not even cover the actual expense of testing. In particular, inadequate reimbursement for new or expensive diagnostic tests may hamper innovation, limit access to testing for physicians and patients, and may paradoxically increase the cost of care. Obtaining new Current Procedural Terminology (CPT) codes or revising existing ones to accommodate emerging diagnostic tests is a complex process that can take up to two years. Furthermore, once codes are obtained, coverage of these tests may vary by insurer, and current coding and payment mechanisms often do not reflect the true cost or the clinical value of the assay.

IDSA applauds CMS for proposing to embark on a review of codes and associated payment levels on the Clinical Laboratory Fee Schedule (CLFS). We believe that the goal of the proposed review should be to set payment levels in a transparent way that more accurately reflects current circumstances. Initial payment levels are often not accurate, and, as CMS acknowledges, there is little opportunity to update or correct levels once they are established. Importantly, we note that although technology has indeed progressed rapidly in the last few decades, and that the cost of technology often falls with time, advances such as automation and high-throughput testing do not necessarily lead to reductions in cost. We urge CMS not to make assumptions about cost reduction, but instead endeavor to identify the true costs of testing and the cost savings afforded by proper use of testing.

IDSA recommends that CMS re-evaluate the proposed process for prioritizing and reviewing codes on the CLFS. The knowledge and expertise of clinicians and clinical microbiologists are

² OIG report- “Coding Trends of Medicare Evaluation and Management Services” - <https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf>

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crucial to the CMS review process. It seems inefficient to wait until the public comment stage to access such resources. Instead of beginning with the oldest codes, we suggest that CMS review the codes in sections, e.g., codes for microbiology tests. This will allow the agency to convene appropriate expert groups to review a related set of codes. Additionally, there is a great need for payment-setting methodology that is transparent and reflects the true cost of testing. For example, gap filling (the use of local payment data to assign a new test code payment) may be a more accurate method than cross walking (comparing a new test to an existing clinical test). However, collection of gap filling data is time-consuming and therefore most new test code prices are assigned using cross walked codes, which frequently receive lower payment rates. **We urge CMS to use or develop methodology that better reflects testing costs.** The CLFS has a direct impact on quality patient care and should not be a barrier to the highest standards of care for patients with infectious diseases.

Physician Compare

IDSA commends CMS on its commitment to making the Physician Compare website a constructive tool to assist Medicare beneficiaries with making healthcare decisions. The enhancements brought about with the redesign make it easier to search for Medicare physicians and other healthcare professionals. As finalized in previous rulemaking, CMS will provide a 30-day preview period prior to publication of quality data on Physician Compare so that group practices and Accountable Care Organizations (ACOs) can view their data before it is publicly reported. We look forward to learning more about the preview process and we are hopeful that it will allow for prompt resolution of erroneous data, as necessary. However, we take this opportunity to express our concern that the 30-day preview period is 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. **We urge CMS to reconsider and extend the duration of this preview period.**

The IDSA cautions against CMS reporting individual physician performance data as early as 2015, based on 2014 data. We do not believe that the current challenges related to risk adjustment and attribution can be overcome in that short of a time period. We urge CMS to take a gradual approach to public reporting by first carefully testing it at the large group practice level and then at the smaller practice level. Only after CMS closely evaluates the accuracy of these data and the value they serve to the public should CMS consider moving on to public reporting of individual-level data. **IDSA urges CMS not to expand the information reported on Physician Compare until CMS can ensure the accuracy of the underlying database and performance calculations.**

IDSA encourages CMS to disclose further how it plans to educate consumers as to the appropriate interpretation of 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 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. For example, in proposing to publicly report CY 2014 CG-CAHPS data for any group practice (regardless of size), we hope that the consumer will be made aware that such data are made available on a voluntary basis, at the expense of the physician group reporting the data. We expect that the reporting of CMS funded CG-CAHPS data, collected for GPRO group practices of 100 or more EPs who report via the web interface, will be accompanied by an explanation of the distinction of these group practices from others.

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In terms of CMS' proposal to publicly report CG-CAHPS data in 2014 for ACOs and group practices with 100 or more EPs, the 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 level, we urge the agency to only publicly report these measures on an aggregate, large group practice level.

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

Physician Quality Reporting System (PQRS)

Proposed Reporting Requirements

CMS is proposing that in order for an eligible professional (EP) to earn a 2014 incentive payment, s/he must report on at least nine 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. This is in contrast to the current requirement to report 3 measures for 80% of applicable patients.

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. From the 2010 PQRS Experience Report, we note that 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%. From the 2011 PQRS Experience Report, we note that the top five most commonly reported measures by ID Specialists are as follows:

- 124 – Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR) (Since retired as of 1/1/2013)
- 110 – Preventive Care and Screening: Influenza Immunization
- 111 – Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older
- 130 – Documentation of Current Medications in the Medical Record
- 114 – Preventive Care and Screening: Inquiry Regarding Tobacco Use – (Retired 1/1/2011)

Beyond these top five, there are few measures that are reasonably relevant to the practice of general Infectious Diseases. Even the measure sets related to HIV and HCV are applicable only to a select portion of our members who treat these patient groups.

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Given these circumstances, we oppose CMS' proposal to triple the reporting requirement to 9 measures. Many infectious disease physicians currently find it challenging to report on 3 measures that are specific enough to be truly relevant and meaningful to their practice. We fear this proposed expansion will result in either a high failure rate or reporting of measures of little relevance simply for the sake of reporting. With penalties beginning in 2015 and plans to publicly report PQRS performance data and link it to the value modifier that same year, **it is critical that CMS focus on the quality of the measures reported rather than the quantity.**

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.). According to the 2011 PQRS Experience Report, the claims-based reporting mechanism for individual measures is still the most popular across all the reporting options. While the new qualified clinical data registry reporting option expands opportunities for physicians, we suspect that few entities will qualify during the first year due to stringent requirements and the need for the entity to have been in existence for one year prior to the start of the reporting period. Given upcoming penalties, public reporting, and more stringent reporting requirements overall, **CMS should not be taking away reporting options at this time, but instead giving physicians a broader choice of options to encourage participation.**

Core Measures

In this rule, CMS also proposes to expand the number of recommended core measures for 2014 and beyond. As was voiced during the 2013 rulemaking process, there is concern about the use of the term "core" since in the EHR Incentive Program the term refers to "mandatory" measures. While we believe it is CMS' intent to promote measures that target priority conditions that affect a large number of patients, we would like to remind CMS of the importance of giving physicians the flexibility to choose measures that are most relevant to their practice and patient population.

Patient Experience Measures

IDSA also would like to express its concern with the proposal to require the use of a certified survey vendor for groups choosing to report CG-CAHPS measures. We are concerned about the cost this would impose on practices and we encourage CMS to assist with administration of the survey, as it currently does for group practices with 100 or more EPs, who do not have to take any additional action to provide these data to CMS.

Qualified Clinical Data Registry

The IDSA supports the new mechanism through which EPs could report non-traditional PQRS measures to a "qualified clinical data registry" since this gives specialties and other representative entities, such as certifying boards, the ability to select measures that are most relevant to its members. As we have previously mentioned, there are a select few measures that apply to the practice of general infectious disease medicine. IDSA is working to develop measures to comprise a robust portfolio across the measure domains upon which ID specialists can report quality care. 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.

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Nevertheless, we feel some of the requirements associated with this new 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 also do not believe registries should be required to report on at least one outcome measure. Many specialties continue to face challenges identifying well-defined, validated and properly risk-adjusted outcomes measures. While outcomes measures should be encouraged, they should not be a requirement in the early stages of this new reporting mechanism. We also believe that the requirement to collect data on 9 measures is too high of a bar, as mentioned earlier in regards to the other PQRS reporting mechanisms. Despite the flexibility afforded under this new reporting option, qualified registries should not face such a large responsibility during their first year of participating in the program.

In summary, we urge CMS to take a more phased approach to implement this new reporting option that allows 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.

Use of Hospital IQR Measures for PQRS

CMS also proposes to include measures available under the Hospital Inpatient Quality Reporting (IQR) Program that have been retooled for physician-level reporting under the PQRS. The following two measures on this proposed list are relevant to our specialty:

- PN-6: Initial Antibiotic Selection for CAP in Immunocompetent Patient (CMS)
- IMM-1c: Pneumococcal Immunization (PPV23) – High Risk Populations (Age 5 through 64 years) (CMS)

As an alternative, the agency seeks comment on whether it should attribute the performance results from the Hospital IQR Program to individual physicians that elect to have their hospital's performance scores attributed to them.

IDSA supports efforts to identify ways to streamline reporting programs to avoid duplication and minimize unnecessary burdens on physicians. As such, IDSA appreciates CMS' efforts to provide hospital-based physicians with the option to tie their performance metric assessment to that of their institution as this may be a viable option for the short-term. IDSA is hopeful that this effort will succeed and allow for other measures to be considered.

However, several issues must be addressed at the onset to establish the parameters for such an option to materialize. For example, a verifiable linkage must exist between an eligible provider and a facility/facilities to accurately attribute the inpatient/outpatient measures for each facility to the individual EPs. Furthermore, for physicians who see patients at more than one facility, there should be a way to assign performance measures from across the facilities, weighted proportionately by the volume of services provided by the individual physician at each facility. Recognizing that this is proposed as an option for individual physicians to consider, we believe the program also would have to entice sufficient participation of a large segment of a facility's medical staff in order to have a chance at reasonable uptake. It will be essential for a facility to establish a critical mass to ensure "buy-in" and shared responsibility to achieve high quality care across the Inpatient Quality Reporting measures in order for physicians to opt to tie their individual performance assessment to that of their

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institution. An individual physician may have exemplary performance, however if the hospital does not have the same level of performance, an individual physician would be unfairly and negatively impacted. Typically, an individual physician has a limited impact on the overall performance of a facility. IDSA welcomes the opportunity to discuss the feasibility and further development of this concept with CMS and other stakeholders.

Value-Based Payment Modifier and Physician Feedback Program

Eligible Professionals

The IDSA has serious concerns about CMS' proposal to double the number of physicians subject to penalties under the value-based modifier (VBM) payment formula in 2016. While we understand that CMS is required to phase in this program and apply it to all physicians by 2017, we feel this proposed expansion is too aggressive when so many methodological issues remain unresolved. Implementing the program at such a rapid pace leaves CMS with very little time to evaluate the results of the first year and to modify it accordingly. The VBM is one of multiple regulatory requirements interfering with physician practice and implementing the program too rapidly will only further erode the patient-physician relationship. CMS notes that this proposed expansion would affect nearly 500,000 physicians working in groups (or nearly 60% of physicians). As of last count, nearly 700,000 physicians and other EPs had not even successfully taken part in the PQRS. **CMS should not apply the modifier to so many physicians when pay-for-reporting rates remain so low.**

VBM Adjustments

Similarly, we also oppose CMS' proposal to increase the penalty from 1% to 2% for groups that fall into Category 2 and do not satisfy PQRS. It seems unfair to hold smaller practices to this higher penalty during their first year of being subject to the modifier when large practices were only subject to a 1% penalty during their first year (2015). Small practices face greater challenges in terms of participating in federal quality reporting programs and should not be subject to an even greater penalty than large group practices during their first year of the VBM. We also have concerns about CMS' proposal to make the quality tiering approach mandatory for all eligible group practices in 2016. While we appreciate that smaller groups (10-99 EPs) would only be subject to an upward or neutral adjustment, we again object to smaller group practices being held to a higher standard than larger group practices during their first year of participation in the program.

Cost Measures

The IDSA would like to reiterate its concerns about the cost measures CMS proposes to use in 2016. 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. 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.

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

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episode, which spans from 3 days prior to an index admission through 30 days post discharge, with certain exclusions. We appreciate that the MSPB measure excludes certain variables, such as episodes during which the index admission contained a transfer, and that groups of physicians would have to be attributed a minimum of 20 episodes during the performance period to have their performance on this measure included in the value-based payment modifier. However, we still have concerns about holding physicians accountable for costs outside of their control, such as Part A claims and spending that occurs prior to or after the index hospitalization that triggers attribution. If anything, this measure is more appropriate for the Hospital Inpatient Quality Reporting Program since it encourages care coordination at the facility-level, yet even hospital stakeholders have expressed concern about the accuracy and value of this measure in the past. It also should be noted that last year, the Measures Application Partnership (MAP) encouraged additional study and piloting of this measure before adoption and implementation, noting that there are insufficient data to support it at the individual clinician level and that it needs further testing. Furthermore, this measure is still under consideration by the National Quality Forum (NQF). Due to these ongoing issues, we caution CMS against adopting this measure for physician-level accountability at this time.

If CMS does proceed with the use of this measure, it is critical that it employ an attribution method that most accurately reflects the contribution of the physician group being held accountable. CMS proposes multiple methods for attributing the MSPB episode to groups of physicians. Its preferred proposal would be to attribute an MSPB episode to a group of physicians subject to the value modifier when any EP in the group submits a Part B Medicare claim under the group's TIN for a service rendered during an inpatient hospitalization that is an index admission for the MSPB measure. Thus, the same index admission and MSPB episode could be attributed to more than one group of physicians. As an alternative, CMS proposes to attribute the MSPB episode to physician groups from which an EP in the group billed a part B claim for a service rendered at any time during the MSPB episode (i.e., from 3 days prior to an index admission through 30 days post-discharge). CMS also considered attributing an MSPB episode to the group of physicians that provided the plurality of Part B services billed either during the entire MSPB episode or during the index hospitalization only. However, it felt the other alternatives would better incentivize more coordinated, team-based care and hold a higher number of TINs accountable under this measure.

The IDSA believes it is important for each physician caring for a patient to understand how he/she contributes to the patient's total cost of care. However, it is not necessarily appropriate to hold each of these physicians *accountable* for the patient's *total* cost of care. We fear not only physicians being held responsible for decisions outside of their control, but unintended consequences such as physicians not ordering labs prior to prescribing antibiotics in order to minimize costs, which could lead to inappropriate antibiotic use, increased drug resistance, and harm to the patient, as well as the general public. For these reasons, **we support CMS' continued 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 understand that CMS has been

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working hard to develop specialty-specific episode-based cost measures, and we remind CMS of our support for and interest in assisting with that task.

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. IDSA believes it is critical that cost measures have a more direct link to the quality measures used to assess value. 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 urge CMS to incorporate cost measures into the modifier gradually, testing them on specific populations with clearly inappropriate spending patterns before widespread implementation. For example, CMS cites in this rule the IOM finding that Medicare spending post-hospital discharge is a major source of unexplained variation in Medicare spending. We encourage CMS to focus on areas that require the greatest attention rather than apply broad cost measures to groups of physicians holding them accountable for factors outside their control.

Cost Measure Benchmarks

In prior rulemaking, CMS finalized its decision to calculate the benchmark for each cost measure used to determine the value modifier as the national mean of the performance rates among *all* groups of physicians subject to value modifier (i.e., the peer group). In this rule, CMS acknowledges that comparisons at the group level could have varied impacts on groups of physicians that are comprised of different physician specialties, especially as CMS begins to apply the value modifier to smaller groups of physicians and solo practitioners. As such, CMS proposes to update its methodology to adjust measure scores for differences in physician group specialty mix using a “specialty adjustment” methodology beginning with the 2016 modifier. First, CMS would calculate national specialty-specific expected costs for each cost measure. Next, the agency would determine the specialty mix of each group, and calculate a “specialty-adjusted expected cost.” This cost is a weighted average of the national specialty-specific costs, where the weights are each specialty’s proportion of Part B payments within the group. Finally, CMS divides the total per capita cost of each group by the “specialty-adjusted expected cost,” multiplying the resulting ratio by the national average per capita cost. This final result is a “specialty-adjusted total per capita cost” that CMS would use to determine whether a practice is high, average or low cost. This method would be applied to each of the cost measures used to calculate the value modifier.

CMS also discusses an alternative adjustment methodology called “comparability peer grouping.” Instead of directly adjusting each group practice’s scores, CMS would segment physician practices into cohorts based on their specialty mix. CMS would then assign benchmarks to each cohort, and individual groups within the cohort would have their measure performance compared to their cohort, and not to an adjusted national average.

IDSA very much appreciates CMS’ recognition of the fact that certain specialties have patient populations that require services that may result in higher (or lower) than average costs. While we continue to have concerns about broad-based cost measures that evaluate total per capita costs and overall costs related to an inpatient episode, we feel this proposed adjustment is a step in the right direction.

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The two methodologies under consideration both have a mix of strengths and weaknesses. We agree with CMS that the “specialty adjustment” method is more suitable for evaluating smaller groups of physicians who often have fewer or single specialty composition. This method would minimize confusion since it creates a single national benchmark for each cost measure against which all groups, regardless of size, would be assessed.

On the other hand, the “comparability peer grouping” method would create a different benchmark for each cohort. While this may result in more accurate comparisons, it is a much more complex task. For one, it would require the construction of peer groups by identifying group practices with the “nearest comparable specialty mix.” The task of defining which groups of physicians are similar enough to be included in a peer group is not only complicated, but potentially subjective and prone to variability. Furthermore, while we appreciate that a group practice’s peer group would have to include a minimum number of peers to ensure a reliable comparison, we are concerned about CMS’ proposal to add to the peer group the next level of comparability in cases where the minimum number of other group practices with the same specialty mix cannot be met. Again, this could significantly affect the accuracy of this method. The variability of this method would also make it difficult for groups of physicians to understand how their costs are benchmarked. We appreciate that the comparability peer grouping method treats each group of physicians as a whole, rather than as a sum of its parts as in the specialty benchmarking method, which encourages care coordination through shared accountability. However, this could also disguise the impact of higher cost specialties practicing in a multi-specialty group, which may not be a reflection of inappropriate resource use, but simply the more resource intense care associated with certain specialties and patient populations.

Given the aforementioned concerns, **we support the “specialty adjustment” method**, but urge CMS to carefully evaluate the accuracy of this method and to make changes and/or test other methods as necessary. We also remind CMS of the importance of accurately identifying specialists and sub-specialists under either method. Specialty designations identified through claims often mask very important differences in sub-specialist care. For example, within the specialty of infectious disease medicine, there are certain ID physicians who focus on much more specific, complex and costly patient populations, such as those with HIV/AIDS or solid organ or bone marrow transplantation. **Regardless of which method is adopted, CMS should consider ways to better account for subspecialty care than is permitted via claims-based specialty designations since differences within a single specialty are sometimes as distinct as differences between specialties.**

Feedback Reports

Finally, we urge CMS to continue to work to improve the Quality and Resource Use feedback reports. This task is critical since reports will now serve as the basis for the modifier. We appreciate CMS’ efforts to conduct educational outreach regarding the reports. However, the format of the reports is still confusing and the underlying data remain difficult to interpret. We continue to encourage CMS to 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.

IDSA Comments – CMS CY2014 PFS Proposed Rule**Conclusion**

IDSA appreciates the Agency's consideration of our comments on the CY 2014 Physician Fee Schedule Proposed 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. We look forward to working with CMS as it finalizes this regulation.

Respectfully,



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President