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Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule. IDSA is a community of 13,000-plus physicians, scientists and public health experts working together to solve humanity's smallest and greatest challenges, from tiny microbes to major outbreaks. Infectious diseases remain among the most pressing challenges facing health care systems, frequently causing and complicating chronic disease in patients of all ages. Infectious diseases (ID) physician care has been proven to improve patient outcomes, reduce hospital length of stay and reduce costs.

ID physicians are predominantly facility-based cognitive specialists whose Medicare billing is overwhelmingly concentrated in evaluation and management (E/M) services rather than procedures. As a result, ID physicians are especially sensitive to the payment and practice expense (PE) policies advanced in this proposed rule. We offer the following comments on the CY 2027 conversion factor, practice expense methodology, coding and quality provisions, and other proposals of particular importance to the infectious diseases workforce and the patients we serve, and we welcome the opportunity to work with CMS to strengthen these policies as detailed below.

While this letter addresses the full range of proposals affecting infectious diseases physicians and their patients, IDSA wishes to highlight at the outset the provisions of greatest consequence to our specialty:

- Conversion factor: IDSA is concerned that the proposed CY 2027 conversion factor reductions further erode payment for a cognitive specialty already operating under significant financial strain, and we urge CMS to mitigate the impact of these reductions on E/M-dependent physicians.
- Practice expense methodology: IDSA urges CMS to ensure that its proposed revisions to the PE methodology, including the elimination of the indirect practice cost index and the new PE stabilization mechanism, do not further disadvantage cognitive specialties, and urges CMS to provide the code-level transparency necessary to evaluate their effects.
- Facility PE RVU cut (site-of-service): IDSA urges CMS to exempt non-procedure-based, cognitive E/M services from the facility PE relative value unit (RVU) reduction, particularly the inpatient and observation E/M services that have no non-facility counterpart and on which our facility-based members overwhelmingly depend.
- Nursing facility visits: IDSA supports CMS' proposal to correct the payment anomaly affecting nursing facility visits and urges the agency to finalize this needed correction.

- Vaccine adverse effects code (HCPCS GADV1): IDSA opposes the establishment of Health Care Common Procedure Coding System (HCPCS) code GADV1, which is clinically unnecessary given existing coding mechanisms and risks generating misleading data that could be used to overstate vaccine-related harm and undermine public confidence in immunization.
- Visit complexity add-on: IDSA does not oppose the proposed transition from HCPCS code G2211 to the new MOD1 modifier and urges CMS to preserve HCPCS code G0545 as the appropriate mechanism for recognizing the complexity of inpatient infectious disease care.

IDSA's detailed comments on these proposals and additional provisions are addressed below.

Conversion factor

Consistent with requirements established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS proposes two separate conversion factors (CFs) for CY 2027: $33.1693 for items and services furnished by Qualifying Alternative Payment Model (APM) Participants, reflecting a 1.19% decrease relative to the CY 2026 CF, and $32.8409 for all other items and services, reflecting a 1.68% decrease relative to the CY 2026 CF. MACRA provides for a 0.75% base payment update for items and services furnished by Qualifying APM Participants and a 0.25% base payment update for other items and services. The proposed conversion factors also reflect a budget neutrality adjustment of +0.53% and the loss of the temporary 2.5% payment increase for CY 2026 provided under the One Big Beautiful Bill Act.

IDSA is deeply concerned that, notwithstanding the statutory updates and the positive budget neutrality adjustment, both proposed conversion factors represent net reductions relative to CY 2026. The expiration of the temporary 2.5% increase is the principal driver of these decreases, and the result is that the vast majority of infectious diseases physicians, who are not Qualifying APM Participants and would therefore be paid under the $32.8409 conversion factor, face a 1.68% reduction in the base rate applied to their services beginning Jan. 1, 2027. This continues a longstanding and untenable pattern in which physician payment fails to keep pace with the cost of furnishing care, in contrast to the annual inflationary updates provided under other Medicare payment systems. We note that this reduction compounds year over year and is particularly damaging to cognitive, facility-based specialties such as infectious diseases, which have limited ability to offset declining rates through procedural volume or ancillary revenue.

IDSA urges CMS to use all available administrative authority to mitigate these reductions and to work with Congress to secure a permanent, adequate and predictable annual payment update tied to the cost of providing care, such as an update linked to the Medicare Economic Index. Sustained real-dollar reductions in physician payment threaten access to specialized infectious diseases care, exacerbate existing workforce shortages in a specialty already facing significant recruitment and retention challenges, and undermine the financial viability of the facility-based practices on which Medicare beneficiaries with complex infections depend. We further urge CMS to be transparent regarding the interaction between the conversion factor update and the specialty-level impacts presented in Table D-B5. As CMS explains, Table D-B5 shows "the estimated payment impact on allowed charges by specialty, including the estimated payment impact by site of service," and CMS separately instructs stakeholders that CY 2027 national payment rates are calculated by applying the RVUs in Addendum B to the applicable conversion factor. Because the specialty-level impacts in Table D-B5 reflect the redistributive effects of the proposed RVU and budget-neutrality changes rather than the separate reduction in the conversion factor, the estimated impacts shown do not, on their face, convey the full payment reduction infectious diseases physicians will experience. IDSA therefore requests that CMS clarify, for the benefit of all commenters, whether the impacts displayed in Table D-B5 incorporate the proposed conversion factor reductions and, if they do not, that CMS make available estimates reflecting the combined effect of both the RVU changes and the conversion factor reductions, so that specialties can accurately assess the true payment impact of this rule.

Payment provisions

Practice expense

IDSA notes that, in the CY 2027 proposed rule, CMS advances several major structural changes to its PE methodology, rather than confining its efforts to the input refinements that have characterized recent rulemaking. While we share CMS' stated goal of better aligning payment policy with contemporary physician practice patterns and of reducing overreliance on outdated survey data, we have significant concerns with the specific proposals advanced in this rule and their impact

on infectious diseases physicians, as detailed below. At the same time, we must emphasize at the outset that ID physicians cannot absorb another payment reduction. As IDSA underscored in its comments on the CY 2026 proposed rule, the practice expense policies finalized last year, specifically, the decision to maintain current practice expense per hour (PE/HR) data while imposing the 50% reduction to facility PE RVU allocation, imposed an overall 6% cut on ID and a 9% cut on facility-based services, which constitute most of the care delivered by ID physicians. **Any further redistribution that compounds these reductions would threaten the sustainability of the specialty and diminish patient access, particularly in the rural and community hospital settings where independent and contracted ID physician models remain prevalent.**

General practice expense methodology changes

CMS proposes several interrelated modifications to its indirect PE methodology. First, CMS proposes to revise its indirect PE allocation to avoid what it views as an inappropriate advantage conferred on codes that can be billed with professional-component-only or technical-component-only billing, so-called "triplet services," which are primarily diagnostic and imaging services. Accordingly, except for 10- and 90-day global codes, CMS proposes to allocate indirect PE using both the work RVU and the clinical labor RVU for all services, rather than applying that approach only to services reportable using technical, professional and global components. Second, CMS proposes to eliminate the indirect practice cost index (IPCI) from the calculation of PE RVUs — that is, to remove steps 12 through 17 of the current PE methodology — in order to de-emphasize the historic 2007-era PE/HR survey data and to reduce the extent to which aggregate specialty-level survey data override more current code-level inputs and allocators. Third, to avoid the large annual fluctuations in PE RVUs that would otherwise result from eliminating the IPCI, CMS proposes to apply a new "PE stabilization factor" that would cap most year-over-year swings in a code's PE RVU at 5%, with certain exceptions for new, revised, revalued and formerly contractor-priced codes.

IDSA has significant concerns regarding CMS' proposal to eliminate the IPCI from the PE methodology by removing calculation steps 12 through 17, and to revise the step 8 indirect cost allocator so that indirect PE is allocated using both the work RVU and the clinical labor RVU for all services, rather than only for the diagnostic and imaging services to which that approach currently applies. While CMS characterizes these changes as budget-neutral in the aggregate, and Table D-B5 shows a near-zero aggregate impact for infectious disease, this aggregate figure obscures the effect of the proposal on our specialty. It reflects a redistribution of practice expense relative value units away from facility-based services and toward office-based services, and a near-zero specialty average can mask substantial code-level losses for the inpatient and facility-based services that constitute the overwhelming majority of the care ID physicians furnish.

More than 80% of the Medicare evaluation and management services furnished by infectious diseases physicians are delivered in the inpatient setting, and the specialty is among the most cognitive and least procedural in medicine. As a result, infectious diseases is not insulated by the aggregate; it is disproportionately exposed to every reduction CMS applies to facility-side practice expense. This exposure is not theoretical. Independent modeling by McDermott+ projects that the indirect PE index for infectious disease would fall from 1.95 to 1.51 under the proposal, a decline of approximately 22%, among the largest of any specialty.

The proposal's effect on our members is most visible at the code level. The subsequent hospital care codes (CPT 99231–99233) represent the daily backbone of inpatient infectious diseases practice. CMS' own "Fully Implemented PE RVUs" file demonstrates that, once fully implemented, the facility practice expense RVUs for these codes would fall further still: from 0.24 to 0.21 for CPT 99231, from 0.40 to 0.34 for CPT 99232, and from 0.62 to 0.51 for CPT 99233, reductions of roughly 13% to 18% in the practice expense component alone. Critically, these cuts come on top of the reductions our members already absorbed in CY 2026, when the facility indirect PE reduction cut infectious disease payment by approximately 6% overall and 9% in the facility setting, the steepest facility impact of any medical specialty. In combination with the PE reductions in CY 2026, this change would seriously impede the ability of Medicare patients to receive appropriate inpatient care and could negatively impact length of stay and rehospitalization numbers.

We therefore urge CMS to recognize that "budget neutrality" at the specialty-aggregate level does not describe the experience of a facility-based ID physician. Because ID physicians furnish the overwhelming majority of their E/M services in the facility setting, they are concentrated on the losing side of the site-of-service redistribution that CMS' own impact tables display: The facility-side reductions fall squarely on ID, with little or no offsetting benefit from the office-based increases that cushion specialties with a more balanced site-of-service mix. For our members, these proposals represent a second consecutive year of compounding facility practice expense reductions to the E/M services that make

up the core of their Medicare practice. ID physicians cannot absorb another cut without reductions in necessary care for Medicare patients.

CY 2026 indirect PE site-of-service differential

IDSA appreciates that CMS acknowledges the concerns raised by IDSA and others regarding the CY 2026 policy that allocated only half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting relative to the non-facility setting. As CMS now recognizes, limiting the PE options to "facility" or "non-facility" fails to account for the range of employment models that drive significant differences in actual practice expenses, and the facility PE reduction has had a disparate effect on independent physicians and small groups, accelerating the insolvency of independent practices and contributing to further hospital consolidation. IDSA welcomes CMS' solicitation of comment on how it might refine this policy in the future, including the potential use of a modifier to identify "employed" physicians and the question of how much indirect PE hospital-employed physicians incur when furnishing care within a facility.

IDSA continues to strongly oppose the 50% reduction to facility PE RVU allocation as applied to ID services and reiterates our longstanding position that this policy rests on the flawed assumption that facility-based physicians generally incur lower indirect costs because they are less likely to maintain an office-based practice. IDSA's member data reveal a far more diverse practice landscape. Many facility-based ID specialists are not hospital employees but rather operate as independent practitioners or members of small groups that contract to provide consultative services to hospitals; these physicians maintain independent office space, incur rent and utility expenses, employ administrative and clinical support staff, and shoulder ongoing costs for equipment, information technology and compliance infrastructure.

Moreover, a significant portion of inpatient ID work, for both hospital-employed and independent physicians, involves transitioning patients receiving intravenous antibiotics from the hospital to outpatient home-based or infusion-center therapy, which requires substantial resources, including dedicated outpatient parenteral antimicrobial therapy (OPAT) nurses, pharmacists, medical assistants, case managers, social workers, vascular access teams, and associated equipment and technology, none of which is covered by common inpatient or outpatient E/M visit codes.

For these reasons, IDSA urges CMS to exempt non-procedure-based, cognitive E/M services, including those furnished by ID physicians, from the facility PE RVU reduction. These services represent primary care delivered in hospital settings and have been persistently undervalued in Medicare reimbursement. **Critically, the inpatient and observation E/M services on which ID physicians depend are facility-only codes that have no non-facility counterpart.** Unlike specialties whose facility PE RVU reductions are at least partially offset by corresponding increases to the office-based version of the same service, ID physicians have no such offset available to them: The facility reduction is a total, uncushioned loss to the specialty. This structural feature of the code set means the redistribution CMS characterizes as budget-neutral operates, for ID, as a one-directional cut. An exemption for these non-procedure-based codes would carry minimal fiscal impact given the small proportion of total fee schedule spending they represent, making this both a clinically sound and fiscally responsible policy. We appreciate that last year CMS exempted maternity care services from PE RVU reductions, recognizing the critical importance of preserving access to maternity care across the country. We assert that ID care should similarly be exempt, as it is central to hospital functions, including efforts to prevent readmissions and health care-associated infections; necessary to many areas of health care, including cancer chemotherapy, organ transplants and other complex surgeries; and facing catastrophic workforce shortages.

As CMS considers refinements to the site-of-service differential, **IDSA further recommends that the agency utilize specialty data and stakeholder input to better quantify the proportion of facility-based ID specialists who continue to incur traditional office- and practice-related overhead, and that it recognize the full continuum of indirect costs integral to ID practice, including infection prevention infrastructure, antimicrobial stewardship and diagnostic stewardship programs, ongoing staff training, and compliance obligations, as borne by both office-based and facility-based ID physicians.**

Nursing facility visits

IDSA supports CMS' proposal to correct the unintended payment anomaly affecting nursing facility visits. As CMS acknowledges, similarly situated patients in the nursing facility setting are treated as "facility" when the service is covered as a skilled nursing facility service under Part A but as "non-facility" when covered as a nursing facility service under Part B, even though the distinction is driven by the beneficiary's coverage status rather than by any difference in the setting or resources of care. IDSA agrees that this is an unintended anomaly and supports CMS' proposal to increase the facility PE

RVUs to match the non-facility PE RVUs for the affected nursing facility E/M codes (CPT codes 99304-99310, 99315 and 99316). This correction appropriately recognizes that the practice costs of furnishing these visits do not vary with the beneficiary's Part A or Part B status. The principle CMS applies here is precisely the one IDSA urges CMS to extend to the inpatient and facility-based E/M services furnished by ID physicians: Where the resources required to furnish a cognitive E/M service do not differ, payment should not be artificially depressed by the site-of-service or coverage classification attached to it. Just as CMS proposes to raise the facility PE RVUs for these nursing facility codes to eliminate a distinction untethered from any real difference in the cost of care, CMS should similarly protect the facility-based E/M services on which ID physicians and their patients depend from reductions that bear no relationship to the resources those services actually require.

Payment reduction for office and outpatient E/M services furnished with a global procedure (modifier -25)

CMS revisits a proposal it advanced, but did not finalize, in the CY 2019 rulemaking, and proposes to reduce payment when a separately identifiable office or outpatient (O/O) E/M service is furnished by the same physician, or a physician in the same group practice, on the same day as a procedure with a 0-, 10- or 90-day global period. Under the proposal, the most expensive service billed (whether the surgical procedure or the E/M visit) would be paid at 100% of its total RVUs, and all other services furnished on the same day, surgical or E/M, would be paid at 50% of their total RVUs. As proposed, the policy is limited to office and outpatient E/M services; however, CMS seeks comment on whether to expand its application to all E/M services, including inpatient E/M visits.

IDSA supports this proposal. The proposed reduction would fall principally on specialties that furnish office-based procedures on the same day as a separately identifiable E/M service, and, because it operates within a budget-neutral system, the resulting redistribution would benefit cognitive, E/M-based specialties such as infectious diseases. IDSA has long urged CMS to correct the persistent undervaluation of cognitive care relative to procedural services, and we view this proposal as a constructive step toward rebalancing payment away from procedure-intensive fields and toward the primary care and cognitive specialties on which Medicare beneficiaries increasingly depend.

For the same reasons, IDSA supports extending the policy to all E/M services, including inpatient E/M. An expansion to the inpatient setting would apply to physicians furnishing procedures alongside a same-day E/M service in the hospital and, under budget neutrality, would similarly redistribute payment toward the cognitive, consultative care that infectious diseases physicians furnish. IDSA therefore urges CMS to apply the policy to all E/M services rather than limiting it to the office and outpatient setting.

IDSA does, however, urge CMS to modify one element of the proposal. As drafted, the reduction would apply when the E/M service and the procedure are furnished by the same physician or a physician in the same group practice**. IDSA recommends that CMS instead apply the reduction only when the two services are furnished by the same physician, or a physician in the same group practice and the same specialty.** A physician should not be subject to a payment reduction merely because a physician of a different specialty within the same group practice happens to furnish a procedure for the same patient on the same day. The clinical work of an infectious diseases physician furnishing a separately identifiable E/M service is distinct from, and unrelated to, a procedure performed by a colleague in another specialty, and the two should not be treated as a single same-day episode for purposes of this policy. Limiting the reduction to physicians of the same group practice and specialty would target the policy at the genuine overlap CMS seeks to address while avoiding inappropriate penalties for unrelated, medically necessary care.

Vaccine adverse effects management (HCPCS code GADV1)

CMS proposes to create a new add-on code, HCPCS code GADV1, to recognize the physician work involved in the diagnosis and management of a suspected vaccine adverse reaction when that work goes above and beyond the associated E/M visit. As proposed, GADV1 would be billed in 15-minute increments for time personally spent by the physician or qualified health care professional and would be reportable as an add-on to specified office, outpatient, and home or residence E/M base codes (CPT codes 99202-99205, 99211-99215 and 99341-99350). CMS additionally seeks comment on whether to establish a stand-alone code for encounters in which a patient is evaluated only for a vaccine-related complaint, outside the context of an E/M visit furnished for a separate concern, and whether such a code should be crosswalked to HCPCS code G2212 for purposes of its work RVU and practice expense inputs.

IDSA opposes the establishment of HCPCS code GADV1. While IDSA strongly supports fair and adequate payment for the cognitive work our members perform, we are concerned that creating a distinct, separately payable code dedicated specifically to vaccine adverse effects is neither clinically necessary nor advisable as a matter of public health policy.

Serious adverse reactions to vaccines are rare, and vaccines authorized and recommended for use in the United States have well-established safety profiles supported by rigorous pre-authorization evaluation and robust post-marketing surveillance. In the uncommon circumstances in which a patient presents with a suspected vaccine adverse reaction, the physician work involved in evaluating and managing that presentation is already appropriately recognized within the existing E/M framework, which accounts for the complexity of the history, examination and medical decision-making required. A separate add-on code is therefore duplicative of work already captured under current coding and valuation.

Beyond the absence of clinical necessity, IDSA is concerned that a dedicated vaccine adverse effects code could have the unintended consequence of undermining public confidence in vaccines. Establishing a distinct payment mechanism framed around vaccine adverse effects risks conveying, to patients and physicians alike, that such effects are more common or more clinically significant than the evidence supports. As physicians on the front lines of immunization, the evaluation of adverse events following immunization and the treatment of serious vaccine-preventable diseases, infectious diseases specialists are acutely aware of the fragility of vaccine confidence and the real-world consequences of vaccine hesitancy for individual and population health. Payment policy should not be structured in a manner that, however inadvertently, lends credence to misperceptions about vaccine safety or that could be leveraged to amplify vaccine-skeptical narratives. **For the same reasons, IDSA opposes the creation of any stand-alone code for encounters devoted solely to a vaccine-related complaint, and we do not believe a crosswalk to HCPCS code G2212 is warranted, as the establishment of such a code raises the same concerns regarding clinical necessity and vaccine confidence.**

Accordingly, IDSA urges CMS not to finalize HCPCS code GADV1 or any related stand-alone code. To the extent CMS identifies specific circumstances in which existing E/M codes do not adequately capture the work of managing a genuine, medically significant adverse event, IDSA would welcome the opportunity to work with the agency to address those circumstances through the established valuation process, in a manner that does not single out vaccine-related care in a way that could erode public trust in immunization.

Valuation of CPT code 90481

CPT code 90481 describes the immunization administration, by intramuscular injection, of each additional component of a SARS-CoV-2 (COVID-19) vaccine, reported separately in addition to the code for the primary administration. Although the code is now available for use, it has not been assigned relative value units under the Physician Fee Schedule and therefore carries no established payment amount.

IDSA urges CMS to value CPT code 90481 by crosswalking it to CPT code 90461, which describes each additional vaccine or toxoid component administered and is likewise reported in addition to the code for the primary immunization administration. A crosswalk to CPT code 90461 is clinically and methodologically appropriate because the two codes describe fundamentally the same physician and clinical staff work: the incremental administration of an additional vaccine component beyond the primary component captured by the base administration code. The resources associated with administering an additional COVID-19 vaccine component do not differ in any material respect from those associated with administering an additional component of another vaccine or toxoid, and valuing the two services consistently would ensure that CPT code 90481 is neither undervalued nor left without a payment basis.

Assigning appropriate value to CPT code 90481 is important to preserving patient access to COVID-19 immunization. A code that remains unvalued creates uncertainty and payment gaps for the physicians and practices that furnish these services, which can discourage the delivery of guideline-recommended vaccination. As the nation's leading organization of infectious diseases physicians, IDSA has a longstanding commitment to protecting and strengthening immunization access, and we view accurate valuation of vaccine administration services as an essential component of that commitment. **IDSA therefore recommends that CMS establish RVUs for CPT code 90481 through a crosswalk to CPT code 90461.**

E/M visit complexity add-on (HCPCS code G2211)

CMS proposes to replace HCPCS code G2211 with a new modifier, MOD1, reported under the same circumstances in which G2211 is currently billed. Rather than paying a flat add-on amount, MOD1 would increase payment for the associated office/outpatient (or home or residence) E/M visit by 16%, an amount CMS derived from a weighted average of the percentage that the flat G2211 payment historically represented relative to the associated E/M codes, weighted by G2211 utilization, such that the change is calibrated to be budget-neutral in the aggregate. CMS also proposes a second

modifier, MOD2, valued at 32% of the associated E/M visit, for physicians participating in a Medicare Shared Savings Program ACO or the Long-Term Enhanced ACO Design model.

IDSA understands this proposal to be a largely mechanical change in how the existing complexity recognition is paid, shifting from a stand-alone flat add-on to a percentage-based increase reported under the same circumstances and budget-neutral in the aggregate. The recognized service itself is unchanged: MOD1 continues to reflect the same inherent visit complexity that G2211 recognizes today, and nothing in the proposal alters the work being recognized. What changes is only the payment mechanism: Because a percentage-based amount scales with the level of the base E/M visit, the dollar value of the recognition will be lower than the current flat amount for lower-level visits and higher for higher-level visits. IDSA notes that, because CMS calibrated the 16% figure to a utilization-weighted average, the aggregate effect is budget-neutral, but the effect on any individual practice will depend on its distribution of E/M visit levels. **Because the triggering criteria are unchanged and the complexity recognition itself is preserved, IDSA does not oppose the proposal.** We continue to view accurate recognition of visit complexity as fundamentally important to ID physicians, whose value to Medicare beneficiaries lies overwhelmingly in cognitive rather than procedural care, and we appreciate CMS' continued commitment to that principle.

We offer the following comments to ensure the transition works as intended:

- **CMS should confirm the change preserves recognition across visit levels.** Because a percentage-based modifier ties the add-on to the level of the associated E/M service, IDSA asks CMS to affirm that appropriately reporting the modifier will continue to fairly recognize complex care regardless of the level at which the underlying visit is coded, and to monitor utilization after implementation to confirm the change does not inadvertently disadvantage any group of physicians.
- **Clear guidance is needed to prevent inappropriate denials.** As the billing mechanism changes, IDSA urges CMS to affirm in the preamble and in subregulatory guidance that infectious diseases physicians and other longitudinal specialties may appropriately report the modifier whenever they serve as the continuing focal point for a patient's care or manage a single, serious or complex condition, so that a change in mechanism does not become a new basis for claim denials.
- **IDSA strongly appreciates CMS' establishment of HCPCS code G0545, which appropriately recognizes the intensity and complexity inherent in inpatient infectious diseases care.** G0545 reflects the disease-specific work of managing a confirmed or suspected infection in the hospital, including transmission-risk assessment, public health investigation and testing, and complex antimicrobial therapy counseling, and it is well suited to the care infectious diseases physicians furnish in the inpatient setting. IDSA urges CMS to preserve and protect G0545, which provides meaningful and appropriately targeted recognition of inpatient infectious diseases care.

For this reason, IDSA does not urge CMS to extend G2211 or MOD1 to inpatient or other facility E/M services. Because complexity recognition in the inpatient setting is already appropriately provided for infectious diseases care through G0545, extending the office/outpatient add-on to inpatient settings is unnecessary for our specialty and could prove counterproductive. Given that MOD1 is calibrated to be budget-neutral in the aggregate, broadening its application across all physicians and settings would enlarge the pool of services drawing on a fixed amount of funding and could dilute the value of the recognition, reduce reimbursement elsewhere in the fee schedule or place existing targeted mechanisms such as G0545 at risk. **IDSA urges CMS to maintain G0545 as the appropriate vehicle for recognizing the complexity of inpatient infectious diseases care rather than extending the office/outpatient complexity add-on to the inpatient setting.**

IDSA appreciates CMS' continued attention to valuing the complexity inherent in evaluation and management services and welcomes the opportunity to ensure these policies fully recognize the cognitive care furnished by infectious diseases physicians across all sites of service.

Request for information on the CPT code set and the American Medical Association

CMS requests input on longstanding concerns regarding federal reliance on the Current Procedural Terminology (CPT) code set, owned and copyrighted by AMA and used by CMS under a royalty-free license, as the sole coding system for physician services, and on whether alternatives to CPT should be considered as part of the national coding standard. The RFI raises the possibility of permitting private competition alongside CPT, developing alternatives to the AMA RUC valuation process, and paying for physician services on the basis of other code sets, including the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), potentially grouped or bundled into payment categories analogous to Medicare Severity Diagnosis Related Groups or Ambulatory Payment Classifications.

IDSA

IDSA appreciates the opportunity to comment and shares CMS' underlying commitment to a coding and valuation system that is accurate, transparent and responsive to the realities of contemporary practice. We caution, however, that the stability, clinical validity and interoperability of the coding system that underpins physician payment are matters of the highest consequence for patient care, and that any change to the national coding standard carries substantial risk. IDSA urges CMS to approach this question with great care and with significant and substantial involvement of medical specialty societies and Congress. It is essential that any changes to the CPT code set do not destabilize physician payment and patient access to care.

Our comments are informed by the following considerations:

- **CPT is a clinically grounded standard that physicians rely on daily.** The CPT system reflects decades of accumulated clinical input, is maintained through an open and evolving editorial process, and is deeply embedded in electronic health records, claims processing, quality measurement and payer systems across the entire health care sector. This ubiquity is not an incidental feature but a core strength: A single, coherent national standard allows a service furnished by an infectious diseases physician to be described, billed, measured and compared consistently across every setting and payer. IDSA is concerned that introducing competing or fragmented code sets could undermine this interoperability, increase administrative burden and cost for physicians and practices, and create confusion and payment disputes that ultimately harm patients.
- **Alternatives built on ICD-10-PCS or DRG-style bundling are poorly suited to cognitive care.** IDSA has serious concerns about any proposal to pay for physician services on the basis of ICD-10-PCS procedure codes or to group physician services into bundled payment categories modeled on inpatient or outpatient facility prospective payment systems. ICD-10-PCS was designed to describe inpatient facility procedures, not the cognitive, longitudinal and diagnostic work that constitutes the overwhelming majority of infectious diseases practice. Procedure-based or bundled coding frameworks systematically fail to capture non-procedural physician work, and adopting such an approach for physician services would compound the very undervaluation of cognitive care that infectious diseases physicians already experience. For a specialty whose contribution to Medicare beneficiaries lies almost entirely in evaluation, diagnosis and management rather than discrete procedures, these alternatives would be especially damaging.
- **Concerns about the valuation process are best addressed through refinement and transparency, not displacement.** IDSA recognizes that the AMA RUC valuation process has been the subject of longstanding and well-deserved debate, particularly with respect to the relative valuation of cognitive versus procedural services. We share an interest in ensuring that the process produces accurate, evidence-based valuations and appropriately recognizes cognitive care. These are important objectives, and IDSA welcomes CMS' continued use of its own data, methodologies and refinements to the recommendations it receives. But the appropriate response to concerns about a valuation process is to improve its transparency, evidence base and balance, not to discard the coding standard on which the entire health care system depends**. Specialty societies, including IDSA, play an essential role in providing the clinical expertise that ensures codes accurately reflect the resources and complexity of the services physicians furnish, and any reform should preserve and strengthen, rather than diminish, that clinical input.**

IDSA stands ready to work with CMS to strengthen the accuracy, transparency and fairness of physician coding and valuation, particularly as it relates to the recognition of cognitive care, within the framework of a stable, clinically valid and universally adopted national coding standard.

Medicare Telehealth Services List

CMS proposes to add several HCPCS codes to the Medicare Telehealth Services List, including GSMAS (a voluntary, group-based medical session involving multiple patients with common medical conditions receiving care in a group setting) and GADV1 (an add-on code for the office or other outpatient evaluation and management of vaccine adverse effects, reported in 15-minute increments in addition to the office/outpatient and home or residence E/M base codes).

IDSA appreciates CMS' continued commitment to preserving and expanding access to telehealth services, which have become an essential modality for infectious diseases care, particularly for medically underserved and rural populations, for patients managing chronic infections such as HIV and hepatitis C, and for antimicrobial stewardship and outpatient parenteral antimicrobial therapy oversight. **We support the general principle of maintaining a robust Medicare Telehealth Services List and evaluating additional codes for inclusion where telehealth delivery is clinically appropriate.**

IDSA cannot, however, support the addition of GADV1 to the Medicare Telehealth Services List. As detailed in our comments on the proposed creation of this code, IDSA opposes the establishment of GADV1. We do not believe a separate add-on code is warranted to describe the diagnosis and management of vaccine adverse effects: Such reactions are rare, and the clinical work involved is already fully captured by the base evaluation and management services to which GADV1 would be appended. Beyond its lack of clinical necessity, IDSA is concerned that creating a distinct, separately reportable code framing vaccination as a source of billable "adverse effects" risks reinforcing vaccine hesitancy and undermining public confidence in immunization at a time when protecting and strengthening that confidence is a paramount public health priority.

Adding GADV1 to the Medicare Telehealth Services List does not resolve these concerns and, if anything, compounds them by extending the reach of a code IDSA believes should not be established in the first place. Accordingly, IDSA urges CMS not to add GADV1 to the Medicare Telehealth Services List, and to decline to create the code itself. Should CMS nonetheless finalize GADV1 over IDSA's objection, we take no position on its telehealth eligibility relative to that of comparable office/outpatient E/M services, as our objection is to the code itself rather than to the modality through which it would be furnished.

Modifiers for certain telehealth claims

As required by statute, CMS notes that it is establishing two new modifiers, BB and BC, for certain telehealth claims. Modifier BB would apply to claims for services furnished through telehealth virtual platforms, and modifier BC would apply to claims for telehealth services furnished incident to a physician's or practitioner's professional service. CMS indicates that guidance on the use of these modifiers will be made available on the CMS website.

IDSA does not object to the establishment of modifiers BB and BC and appreciates that CMS is implementing them in accordance with its statutory obligation. We note, however, that new claims modifiers frequently create administrative burden and confusion during implementation, and that improper or inconsistent use can result in inappropriate claim denials. **IDSA therefore urges CMS to publish clear, detailed and timely guidance on the appropriate use of these modifiers well in advance of their effective date, and to educate Medicare Administrative Contractors accordingly, so that infectious diseases physicians and other practitioners can apply them correctly and without disruption to appropriate reimbursement for telehealth services.**

Telehealth critical care consultations

CMS proposes to revise the code descriptors for the telehealth critical care consultation codes G0508 and G0509 in order to clarify the service requirements associated with these codes. **IDSA supports this proposal.** Infectious diseases physicians frequently furnish critical care consultations for the sickest hospitalized patients, including those with sepsis, complex or resistant infections, and other life-threatening conditions, and telehealth critical care consultation has proven a valuable means of extending scarce infectious diseases expertise to facilities and patients that would otherwise lack timely access to it. IDSA appreciates CMS' effort to clarify the service requirements for G0508 and G0509, as clear and precise code descriptors reduce billing confusion, promote consistent application across Medicare Administrative Contractors and help ensure that physicians can furnish and appropriately bill for these services without undue risk of denial. We encourage CMS to ensure that the revised descriptors accurately reflect the clinical work involved in furnishing critical care consultations via telehealth.

Teaching physician billing of telehealth services

CMS proposes to revise its policy governing teaching physician billing for telehealth services involving residents. Rather than requiring the teaching physician, resident and patient each to be in a different location, CMS proposes to allow teaching physicians to bill for services involving residents when either the teaching physician or the resident is in the same physical location as the beneficiary.

IDSA strongly supports this proposal. The current requirement that all three parties be in separate locations is unnecessarily restrictive and does not reflect the realities of clinical teaching, and its removal is a welcome and common-sense flexibility. Infectious diseases is a specialty that depends heavily on training the next generation of physicians, and academic medical centers and teaching hospitals are central to infectious diseases care and workforce development. Permitting teaching physicians to bill when either they or the resident is physically present with the patient will facilitate high-quality supervised care, support infectious diseases graduate medical education, and better reflect

how teaching physicians and residents actually collaborate in delivering telehealth services. IDSA urges CMS to finalize this proposal.

Remote physiologic monitoring and remote therapeutic monitoring

CMS proposes several changes to the requirements governing remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services. Among these, CMS proposes to require that RTM services, like RPM services, be furnished only to established patients; to require that practitioners reporting RPM or RTM furnish a separately reportable initiating visit conducted by the billing practitioner during a face-to-face (in-person or telehealth) encounter at which RPM or RTM is discussed; and to limit payment to services furnished by clinical staff employed by the billing practitioner's practice. CMS also seeks comment on a restructured set of new G codes (GRPM1, GRPM2, GRTM1 and GRTM2) intended to better describe the initial set-up and ongoing monitoring components of these services.

Remote monitoring is an emerging and increasingly valuable component of long-term antibiotic management and OPAT and is therefore of direct relevance to infectious diseases practice. Just as remote monitoring has been shown to improve outcomes in the management of cardiopulmonary conditions, it holds significant promise for OPAT and other prolonged courses of antimicrobial therapy, where devices that track doses administered and applications that facilitate symptom checks and physician communication can allow programs to identify and address problems early. The benefit is particularly pronounced for patients with poor access to care, including those in rural and underserved areas, and for patients who face barriers to traditional monitoring, such as those with mild cognitive impairment, those who decline facility placement, those who are not homebound and therefore ineligible for home health services, and those who struggle to interpret symptoms, manage line complications or attend in-person appointments. For these patients, the ability to alert an OPAT program to an emerging problem through a monitoring application, rather than presenting to a local emergency department, can meaningfully improve both outcomes and the efficiency of care.

IDSA's principal concern with the proposal is the requirement that the billing practitioner personally furnish a face-to-face initiating visit before RPM or RTM services may be reported. This requirement adds inefficiency and unnecessary cost to a process that functions effectively today, and it will make it more difficult for smaller hospitals and practices, precisely those with the fewest resources, to offer remote monitoring. The practical effect would be to limit access to remote monitoring for the very patients it is best positioned to help, thereby exacerbating the access problems that RPM and RTM are intended to address. IDSA urges CMS not to impose a mandatory face-to-face initiating visit by the billing practitioner, and instead to preserve flexibility that allows remote monitoring to be initiated efficiently and in a manner consistent with existing clinical workflows. IDSA appreciates CMS' continued attention to the code structure for these services and views the proposed new G codes (GRPM1, GRPM2, GRTM1 and GRTM2) as potentially beneficial, to the extent they more accurately describe the set-up and ongoing monitoring components of remote monitoring. IDSA welcomes the opportunity to work with CMS to ensure that RPM and RTM policies support, rather than hinder, the appropriate use of remote monitoring in infectious diseases care.

Request for information on duplicate laboratory testing, imaging, and result sharing and interoperability

CMS seeks input on two related topics: first, mechanisms to address duplicative payment for duplicative diagnostic laboratory and imaging tests, including the potential use of frequency limitations; and second, opportunities to improve interoperability for diagnostic laboratory tests and imaging services, recognizing that ongoing gaps in result sharing can cause beneficiary harm and raise program integrity concerns. IDSA shares CMS' interest in eliminating genuinely avoidable duplicative testing and in ensuring that Medicare resources are used efficiently**. Our response to these two topics differs substantially, however, because the two proposed pathways carry very different consequences for infectious diseases patients. IDSA strongly supports efforts to improve interoperability and result sharing, but we urge CMS to exercise significant caution before pursuing frequency limitations or automated duplicate-payment edits, which risk denying medically necessary care.**

Interoperability and result sharing

IDSA strongly supports CMS' efforts to close the interoperability gaps that lead to avoidable repeat testing. When prior laboratory results and imaging studies are unavailable at the point of care because they reside in a different health system, were performed at an outside facility or cannot be readily exchanged between electronic health records, physicians are frequently compelled to reorder tests that have already been performed. This is the most common and most addressable source of truly duplicative testing, and it directly harms beneficiaries through unnecessary blood draws, radiation exposure, delayed diagnosis and added cost. Infectious diseases physicians routinely care for patients

who transition across care settings, between the community, the emergency department, inpatient wards, long-term care and specialty clinics, and who arrive without access to critical prior results such as culture and susceptibility data, prior imaging or serologic testing. Ready access to these results is not merely a matter of efficiency; it is essential to antimicrobial stewardship, to avoiding redundant or inappropriate therapy, and to timely, accurate diagnosis**. IDSA therefore urges CMS to prioritize interoperability as the primary means of reducing duplicative testing and to advance standards that make prior laboratory and imaging results reliably available across systems and payers.**

Duplicative payment and frequency limitations

IDSA urges CMS to proceed with great caution before adopting frequency limitations or automated duplicate-payment edits, which are poorly suited to the realities of infectious diseases practice. In our specialty, repeat and serial testing is frequently not duplicative but medically necessary and, in many cases, the standard of care. Clinicians appropriately obtain serial blood cultures to document clearance of bloodstream infections, trend inflammatory markers to assess response to therapy, perform serial viral load or other molecular testing to monitor treatment of chronic infections such as HIV and hepatitis, conduct therapeutic drug monitoring to ensure safe and effective antimicrobial dosing, and repeat imaging to evaluate the response of infections such as endocarditis, osteomyelitis and deep-seated abscesses to treatment. A test that appears "duplicative" from a claims-data perspective — identical code, same patient, short interval — may in fact be clinically essential to managing a serious infection and guiding antimicrobial therapy. Frequency limitations and automated edits that cannot distinguish clinically indicated serial testing from genuine redundancy risk denying necessary care, disrupting evidence-based management, undermining antimicrobial stewardship, and imposing substantial administrative burden through appeals and documentation requirements. IDSA therefore urges CMS to reject blanket frequency limits and to ensure that any mechanism intended to address duplicative payment includes robust, workable clinical exceptions; preserves physician judgment; and is grounded in clinical evidence rather than claims-data proxies alone.

Quality provisions

MIPS Value Pathways

CMS proposes to sunset traditional the Merit-Based Incentive Payment System (MIPS) and require all MIPS-eligible clinicians to report through a MIPS Value Pathway (MVP) beginning with the CY 2029 performance period, except for those reporting through the APM Performance Pathway (APP) as participants in an Alternative Payment Model (APM). IDSA shares CMS' goal of moving toward more clinically meaningful, specialty-relevant quality measurement, and we appreciate the intent behind the MVP framework. **We have significant concerns, however, about mandating the sunset of traditional MIPS by CY 2029 when the existing infectious diseases MVP does not adequately reflect the care our members furnish.** While CMS has established an infectious diseases MVP, the Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP, the measures available within it do not represent the breadth of infectious diseases practice.

The overwhelming majority of the pathway's measures are general or primary-care measures, such as appropriate treatment for upper respiratory infection, documentation of current medications, depression screening, chlamydia screening, and childhood and adult immunization status. The measures that are specific to infectious diseases are confined almost entirely to the care of patients with HIV and hepatitis C. As a result, an infectious diseases physician whose practice centers on the inpatient management of complex and serious infections (such as infections that frequently complicate cancer chemotherapy, organ transplants and other complex surgeries), consultative care, and antimicrobial stewardship would find few, if any, measures within the pathway that meaningfully describe the care he or she provides. CMS' estimate that its MVP inventory covers approximately 98% of MIPS-eligible clinicians reflects the existence of a nominally applicable pathway rather than a pathway populated with clinically appropriate measures for every specialty. Requiring our members to report through an MVP whose measures do not reflect the care they furnish would produce quality scores that are neither fair nor clinically meaningful. **IDSA urges CMS to strengthen the infectious diseases MVP by developing and incorporating measures that reflect the diagnostic, cognitive and stewardship-focused nature of our specialty, including the inpatient consultative and complex-infection care that constitutes the majority of infectious diseases practice, and to finalize concrete accommodations for subspecialists who lack applicable measures, before eliminating traditional MIPS.**

With respect to the RFI on MVP scoring, IDSA cautions that comparing clinicians to peers reporting the same MVP using normalized scores could disadvantage physicians in small specialties and those reporting through MVPs with limited or ill-fitting measure sets, where small reporting numbers and thin measure inventories can produce volatile and unreliable

comparisons. Any move toward normalized or peer-referenced scoring must include adequate case-size and reliability thresholds, transparency about the methodology and safeguards to ensure that infectious diseases physicians are not penalized as an artifact of the scoring approach rather than the quality of their care. **IDSA urges CMS to preserve traditional MIPS as an option until a clinically meaningful MVP and appropriate scoring safeguards are in place.**

Request for information on transition to FHIR-based digital quality reporting

CMS seeks input on a potential timeline for transitioning to digital quality reporting based on the Fast Healthcare Interoperability Resources (FHIR) standard. CMS describes a possible two-year transition period, beginning with the 2028 performance period, that would maintain existing reporting options while also supporting FHIR-based reporting for selected measures, followed by potential mandatory FHIR-based reporting for applicable measures beginning in 2030, at which point prior electronic reporting approaches would no longer be available for measures that have transitioned to FHIR.

IDSA supports the long-term modernization of quality measurement and shares CMS' goal of a more interoperable, less burdensome reporting infrastructure. A well-designed transition to FHIR-based digital quality measures could reduce manual data abstraction, improve data accuracy and better integrate reporting into clinical workflows. We urge CMS, however, to ensure the timeline is driven by demonstrated readiness rather than by a fixed date. The feasibility of FHIR-based reporting depends heavily on factors outside the individual physician's control, particularly the readiness of electronic health record vendors and the cost and technical burden of implementation, and these burdens fall disproportionately on small and resource-constrained practices, including many infectious diseases practices that lack dedicated informatics staff. **Accordingly, IDSA urges CMS to preserve existing reporting options throughout a genuinely voluntary transition period; to condition any move to mandatory FHIR-based reporting on evidence that EHR vendors and clinicians across practice settings are prepared to comply; and to retain flexibility to delay the proposed 2030 mandate if readiness has not been demonstrated.** IDSA welcomes the opportunity to work with the agency to ensure the transition strengthens quality measurement without disadvantaging the physicians it is intended to support.

MIPS quality measure inventory

CMS proposes a total of 180 quality measures, down from 190, and proposes to remove 20 measures. Among the measures proposed for removal is Measure 332, Adult Sinusitis: Appropriate Choice of Antibiotic (amoxicillin with or without clavulanate prescribed for patients with acute bacterial sinusitis). **IDSA is concerned by the proposed removal of Measure 332.** As the nation's leading organization of infectious diseases and antimicrobial stewardship experts, IDSA views measures that promote the appropriate selection of antibiotics as an important tool for combating antimicrobial resistance and improving patient outcomes.

IDSA recognizes that CMS proposes to remove Measure 332 on the basis that it is duplicative of Measure 331, Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse), which CMS characterizes as the broader of the two because it discourages antibiotic prescribing for viral illness. IDSA respectfully disagrees that Measure 331 captures the patient population and the stewardship objective addressed by Measure 332. The two measures assess fundamentally different clinical decisions in mutually exclusive patient populations. Measure 331 applies to patients with acute viral sinusitis and evaluates whether an antibiotic was inappropriately prescribed when none was warranted, that is, whether to prescribe at all. Measure 332 applies to patients with acute bacterial sinusitis for whom an antibiotic is indicated, and evaluates whether the correct first-line agent was selected, that is, which antibiotic to prescribe. Because a patient cannot simultaneously have viral and bacterial sinusitis, Measure 331 cannot, by construction, capture the population addressed by Measure 332, and it provides no signal whatsoever about the inappropriate use of broad-spectrum antibiotics in patients who genuinely require treatment. Eliminating Measure 332 would therefore leave an unaddressed stewardship gap: the selection of narrow-spectrum, guideline-concordant therapy over unnecessarily broad-spectrum agents, which is among the most important levers for slowing the emergence of antimicrobial resistance.

Acute sinusitis is among the most common indications for outpatient antibiotic prescribing and a frequent driver of inappropriate and overly broad antibiotic use, and a measure encouraging first-line, guideline-concordant therapy directly advances stewardship goals. **IDSA urges CMS to reconsider removing Measure 332 or, if the agency proceeds, to identify the specific replacement measures through which it will continue to promote appropriate outpatient antibiotic selection. More broadly, IDSA urges CMS to preserve and expand antimicrobial stewardship–relevant measures within the quality measure inventory, consistent with the national imperative to slow the emergence of**

resistant infections. Such an approach would align well with other HHS and CDC efforts to combat antimicrobial resistance.

Substantive changes to existing MIPS measures

CMS proposes substantive changes to 43 existing quality measures. Below are thoughts on the two measures of greatest relevance to infectious diseases practice.

Measure 475: HIV Screening

IDSA strongly supports the continued inclusion of Measure 475, HIV Screening, in the quality measure inventory. Routine HIV screening is a cornerstone of early diagnosis, timely linkage to care and the national effort to end the HIV epidemic, and its value is well established**. IDSA has reviewed the specific modification CMS proposes to this measure, namely, the removal of the criterion "without an HIV diagnosis prior to the start of the measurement period" from the initial patient population, and we urge CMS not to adopt this change as proposed.** HIV screening measures are designed to identify undiagnosed infection among individuals not already known to be living with HIV. This is the express premise of the underlying screening recommendations: The U.S. Preventive Services Task Force recommends one-time screening for all adolescents and adults aged 15 to 65, and the Centers for Disease Control and Prevention recommends that all persons aged 13 to 64 be tested at least once, in both cases directed at persons whose HIV status is not already established. Removing the exclusion for patients with a known, pre-existing HIV diagnosis would fold individuals who have already been diagnosed, and who require ongoing treatment and monitoring rather than screening, into the population against which screening performance is assessed. This is clinically incongruous, as a patient already diagnosed with HIV cannot meaningfully be "screened" for it**. IDSA is concerned that the change would distort the measure's performance signal, would misalign it with the guideline-defined screening population, and could create inappropriate pressure for redundant testing of patients already engaged in HIV care, without advancing the measure's core objective of detecting new infections.**

Accordingly, IDSA recommends that CMS retain the existing exclusion for patients with an HIV diagnosis prior to the measurement period. If CMS' intent in proposing this revision is to capture a distinct clinical objective, such as ensuring appropriate testing among specific populations, IDSA urges the agency to articulate that objective explicitly and to pursue it through a separate, purpose-built specification rather than by broadening the denominator of a screening measure in a manner inconsistent with its clinical purpose. IDSA urges CMS to ensure that any substantive changes to this measure preserve its alignment with current screening guidelines and strengthen, rather than diminish, its ability to promote broad, guideline-concordant HIV screening across appropriate patient populations.

Measure 176: TB Screening Prior to Biologic or Immune Response Modifier Therapy

IDSA likewise supports the retention of Measure 176, which promotes tuberculosis screening before the initiation of biologic or immune response modifier therapy. Screening for latent tuberculosis prior to immunosuppression is essential to preventing reactivation of serious, and potentially life-threatening, TB disease.

IDSA has reviewed the specific change CMS proposes to this measure and supports it. CMS proposes to revise the measure numerator to clarify the appropriate tests for TB screening that satisfy the numerator quality action, so that the intent of the measure is met and numerator compliance is assessed consistently across all submissions. **IDSA agrees that this clarification is warranted and will strengthen the measure.** Accurate specification of the qualifying tests is clinically important because appropriate screening for latent tuberculosis infection is accomplished through validated diagnostic tests, namely interferon-gamma release assays (IGRAs) and the tuberculin skin test (TST), and not through tests that do not reliably detect latent infection. Specifying the acceptable tests ensures that credit is given only for clinically appropriate screening and prevents both the over-counting of noncompliant testing and the inadvertent penalization of physicians who perform guideline-concordant screening. IDSA further notes that IGRAs are frequently preferred in the population to which this measure applies, as they avoid the need for a return visit and perform reliably in patients who are already or soon to be immunosuppressed. To the extent CMS finalizes the list of qualifying tests, IDSA recommends that the specification recognize both IGRAs and the TST as acceptable screening modalities, consistent with established clinical guidance. **IDSA urges CMS to ensure that any changes to this measure maintain its clinical integrity and continue to support appropriate pre-treatment TB screening.**

New core measure requirement

Beginning in 2027, CMS proposes to replace the current outcome/high-priority measure requirement with a new core measure requirement applicable to both traditional MIPS and MVPs. Under the proposal, every physician other than those in small practices would be required to report at least one core measure, selected from 78 measures for traditional MIPS participants, or from the applicable MVP for MVP participants. CMS also proposes a self-attestation process for physicians who cannot identify an applicable core measure, who would then be required to report another measure.

IDSA's central concern with the core measure requirement mirrors our broader concern about measure availability for infectious diseases physicians: A requirement to report a core measure is only workable if a clinically applicable core measure exists. As discussed above, although CMS has established an infectious diseases MVP, its measures are heavily weighted toward general, primary-care, and HIV- and hepatitis-focused measures, and do not reflect the inpatient consultative, complex-infection and antimicrobial stewardship care that constitutes the majority of infectious diseases practice. This concern applies with equal force at the core measure level. For infectious diseases physicians reporting through the infectious diseases MVP, any core measure would necessarily be designated from within that MVP's existing measure set, the same set whose limitations we describe above. Of the measures currently included in the infectious diseases MVP, only the HIV- and hepatitis C–focused measures plausibly lend themselves to designation as outcome-oriented core measures, and even these would leave the substantial majority of our members, particularly those whose practice is predominantly inpatient consultative and stewardship-focused, without a core measure that meaningfully reflects the care they deliver. If CMS designates one or more measures within the infectious diseases MVP as core, IDSA urges the agency to do so in a manner that accounts for this limitation and to prioritize the development and inclusion of core-eligible measures that capture complex-infection management and antimicrobial stewardship.

Compounding this difficulty, the rule does not include a stand-alone, consolidated list of the proposed core measures, whether for traditional MIPS or within individual MVPs. Without such a list, neither IDSA nor its members can meaningfully evaluate whether a clinically applicable core measure exists for infectious diseases practice, or comment on the appropriateness of the specific measures CMS has selected. **IDSA therefore urges CMS to publish, in the final rule, a complete and clearly identified list of all proposed core measures, and to establish a transparent process for designating core measures that includes meaningful consultation with the relevant clinical specialty stakeholders.** The core measure designations for the coming year appear to have been made without such consultation, and decisions of this consequence for physician scoring should not be made without the input of the specialties they affect.

IDSA therefore strongly supports the inclusion of a self-attestation process for physicians who cannot identify an applicable core measure, and we urge CMS to ensure that this process is straightforward and transparent, and does not itself become a source of scoring disadvantage or administrative burden. We further urge CMS to ensure that any core measures designated for infectious diseases reflect the diagnostic, cognitive and stewardship-focused nature of our specialty as the measure inventory evolves.

Topped-out measure scoring

CMS proposes that topped-out measures no longer be subject to the 7-point scoring cap, and that 17 measures (down from 19 in 2026) instead be scored according to the defined topped-out measure benchmark. **IDSA supports this change, which allows physicians reporting a topped-out measure to earn up to the full available points under the defined topped-out benchmark rather than being limited to 7 points.** This is particularly meaningful for physicians in specialties with limited measure availability, who often have little choice but to report a measure that has become topped out because clinically appropriate alternatives do not exist for their practice. Removing the 7-point cap ensures that these physicians are not penalized for circumstances beyond their control rather than for the quality of care they furnish.

IDSA notes that this change interacts directly with the proposed new core measure requirement in a manner that benefits infectious diseases physicians. Because CMS proposes to exempt core measures from the topped-out scoring cap and to score them instead under the defined topped-out benchmark, allowing up to 10 points, designating topped-out measures within the infectious diseases MVP as core measures would both expand our members' reporting options and protect them from the constrained scoring that would otherwise apply. Within the infectious diseases MVP, the measures that are currently topped out and subject to the 7-point cap are Measure 65 (Appropriate Treatment for Upper Respiratory Infection), Measure 130 (Documentation of Current Medications in the Medical Record) and Measure 134 (Preventive Care and Screening: Screening for Depression and Follow-Up Plan). **IDSA urges CMS to designate these measures as core measures within the infectious diseases MVP.** Doing so would give our members additional viable reporting options while ensuring that, when they must rely on a topped-out measure, they remain able to earn meaningful points reflective of their performance.

IDSA also requests that CMS expand its previously finalized scoring policy to incentivize the reporting of new measures to all non-benchmarked measures in the program. Since the 2022 performance year, new measures are subject to a 7-point scoring floor in the measure's first year, and a 5-point scoring floor in the measure's second year, as long as data completeness and case minimum requirements are met. While IDSA appreciates this policy, there are numerous measures in our specialty set and MVP that lack a benchmark, but were never eligible for this policy because they were already in the program when this policy was first adopted and were not technically "new" measures at that time. As a result, physicians to which these measures might be relevant never had the opportunity to benefit from this policy and are continually hesitant to report these risky measures since they would earn only 0 points (3 points for small practices) regardless of performance. As a result, these measures remain stuck in a perpetual cycle of lacking a benchmark. **We strongly urge CMS to subject all non-benchmarked measures in the program prior to 2022 to this two-year policy in order to encourage reporting of these measures and to provide a fair opportunity to build a benchmark.**

Improvement activities

CMS proposes six new improvement activities (IAs), modifications to five existing IAs and the removal of 11 IAs. IDSA comments below on those activities of particular relevance to infectious diseases practice.

New improvement activity: Understand and Improve Diagnostic Performance (IA_CC)

IDSA strongly supports the proposed new improvement activity focused on improving diagnostic performance by reducing diagnostic safety events and miscommunication through standardized processes for tracking discrepancies, near-misses and data accuracy. Accurate and timely diagnosis is fundamental to infectious diseases practice, and diagnostic error, including missed, delayed or incorrect identification of infections, can lead to patient harm, inappropriate or overly broad antibiotic use and the propagation of antimicrobial resistance. An improvement activity that encourages clinicians to systematically identify and learn from diagnostic discrepancies and near-misses aligns directly with both patient safety and antimicrobial stewardship goals, and IDSA urges CMS to finalize it.

New improvement activity: Clinician Use of Artificial Intelligence to Improve Patient Care (IA_AHW)

IDSA supports the inclusion of an improvement activity recognizing the responsible and transparent use of artificial intelligence to improve patient care. AI-enabled tools are increasingly relevant to infectious diseases practice, including in diagnostic support, antimicrobial stewardship and infection surveillance. IDSA supports rewarding physicians who thoughtfully adopt such tools, and we appreciate that the activity emphasizes responsible and transparent use. We encourage CMS to ensure that the activity's framing continues to stress appropriate clinical oversight, validation and transparency, so that AI is deployed as a support for, rather than a substitute for, clinical judgment.

Proposed removal of care transition improvement activities (IA_CC_10, IA_CC_11, IA_CC_12)

IDSA urges caution regarding the proposed removal of the care transition improvement activities — IA_CC_10 (Care Transition Documentation Practice Improvements), IA_CC_11 (Care Transition Standard Operational Improvements) and IA_CC_12 (Care Coordination Agreements That Promote Improvements in Patient Tracking Across Settings), on the basis that they are duplicative of other activities. Infectious diseases patients frequently transition across the community, emergency department, inpatient, long-term care and outpatient settings, and effective care transitions are essential to continuity of antimicrobial therapy, accurate transmission of culture and susceptibility data, and avoidance of redundant testing and treatment. While IDSA does not object to consolidating genuinely redundant activities, we urge CMS to confirm that the improvement activities retained after this consolidation fully preserve credit for the care coordination and transition work that infectious diseases physicians perform, so that this important activity is not inadvertently deemphasized.

MIPS Promoting Interoperability performance category

CMS proposes several changes to the Promoting Interoperability performance category, including modernizing the definition of Certified Electronic Health Record Technology (CEHRT) to align with the deregulatory proposals in the ONC "Deregulatory Actions to Unleash Prosperity" (HTI-5) proposed rule; removing the ONC Direct Review Attestation and ONC-Authorized Certification Body (ACB) Surveillance Attestation beginning with the 2026 performance period; removing the Security Risk Analysis measure beginning with the 2027 performance period; making the existing Electronic Prior

Authorization measure optional and bonus-eligible for 2027 before requiring it in 2028; and adopting a new Electronic Prior Authorization for Prescription Drugs measure beginning with the 2028 performance period. CMS also issues a request for information on potential future performance-based measures of electronic prior authorization. IDSA appreciates CMS' continued efforts to reduce reporting burden while advancing a more interoperable and efficient health information infrastructure.

CEHRT modernization and removal of ONC attestations

IDSA does not object to modernizing the definition of CEHRT to align with the HTI-5 proposed rule, or to removing the ONC Direct Review and ONC-ACB Surveillance attestations, and we appreciate the associated reduction in reporting burden. As CMS and ONC pursue these deregulatory changes, however, IDSA urges the agencies to ensure that they do not inadvertently weaken the underlying interoperability capabilities and oversight on which physicians depend. As we note elsewhere in these comments, ready access to prior laboratory results, culture and susceptibility data, and imaging across systems is essential to infectious diseases care and antimicrobial stewardship, and burden reduction should not come at the expense of the interoperability progress that makes such access possible.

Removal of the Security Risk Analysis measure

IDSA supports the proposed removal of the Security Risk Analysis measure beginning with the 2027 performance period. Because MIPS-eligible physicians are already covered entities obligated to conduct security risk analyses under the HIPAA Security Rule, retaining a duplicative MIPS measure imposes reporting burden with limited incremental benefit. Its removal appropriately reduces administrative burden without diminishing clinicians' underlying obligation to safeguard electronic protected health information.

Electronic prior authorization measures

IDSA strongly supports efforts to move prior authorization out of manual, paper- and telephone-based workflows and into standardized electronic processes, and we do not object to the proposed transition of the Electronic Prior Authorization measure to an optional and bonus measure for 2027 before it becomes required in 2028, nor to the new Electronic Prior Authorization for Prescription Drugs measure beginning in 2028. Prior authorization is a substantial and growing source of administrative burden and treatment delay for infectious diseases physicians and their patients. Our members routinely encounter prior authorization requirements for costly or restricted antimicrobials, for outpatient parenteral antimicrobial therapy, and for therapies to treat HIV, hepatitis C and other serious infections, delays that can postpone effective treatment, promote the use of less appropriate alternatives, and undermine both patient outcomes and antimicrobial stewardship.

To the extent that standardized electronic prior authorization can reduce these delays, IDSA welcomes it.
IDSA cautions, however, that these measures assess only whether the physician uses an electronic process; they do not address the volume, appropriateness or clinical impact of the prior authorization requirements themselves. Requiring physicians to demonstrate electronic prior authorization does not relieve them of the underlying burden if payers continue to impose extensive prior authorization requirements on medically necessary infectious diseases therapies.

MIPS final scoring

CMS proposes two administrative refinements to MIPS final scoring: allowing CMS to use data sources beyond the Provider Enrollment, Chain and Ownership System to make more accurate eligibility determinations for the automatic Extreme and Uncontrollable Circumstances (EUC) exception, and extending the deadline for clinicians to notify CMS when a third-party intermediary fails to submit their data. IDSA supports both proposals. Improving the accuracy of automatic EUC eligibility determinations and providing clinicians additional time to notify CMS of a third-party intermediary's failure to submit data are sensible measures that protect physicians, including infectious diseases physicians, from payment penalties arising from circumstances beyond their control, and IDSA encourages CMS to finalize them.

Public reporting

CMS proposes to remove the one-year delay currently applied before newly adopted improvement activities and Promoting Interoperability measures for MVP participants are publicly reported on Care Compare. CMS also issues a request for information on alternatives to the current star rating methodology used to display quality measure scores

collected under the administrative claims collection type, and potentially cost measures, on Care Compare. IDSA urges CMS to ensure that any acceleration of public reporting does not result in the display of scores before physicians have had an adequate opportunity to understand and reliably report newly adopted activities and measures. Publicly reported performance information should be accurate, fair and clinically meaningful. As IDSA notes elsewhere in these comments, infectious diseases physicians frequently report through measures that are limited in number or imperfectly suited to their practice, and public display of scores derived from such measures, particularly under a simplified star rating methodology, risks misrepresenting the quality of care our members provide. With respect to the request for information, IDSA urges CMS to adopt any public reporting methodology only after ensuring that it reliably reflects physician performance, incorporates adequate case-size and reliability safeguards, and does not disadvantage physicians in small specialties or those reporting through limited measure sets.

Qualifying Participants in Advanced Alternative Payment Models

CMS proposes to make Qualifying Participant (QP) and Partial QP determinations at the Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level rather than the NPI level, so that incentives are directed only to TINs actively participating in Advanced APMs, a change CMS expects to prevent approximately $2.4 billion from flowing to clinicians not actively participating in an APM. In accordance with the Consolidated Appropriations Act, 2026, CMS also updates the QP and Partial QP thresholds and the APM Incentive Payment. For the 2027 performance year, the QP thresholds increase again following a temporary reduction in 2026, making it more difficult for clinicians to attain QP status. Clinicians who achieve QP status in the 2027 performance year would be eligible only for the higher conversion factor update (0.75%, versus 0.25% for non-QPs) in 2029, as the separate APM Incentive Payment is no longer available.

IDSA does not object to more precisely targeting APM incentives to clinicians actively participating in Advanced APMs. **We are concerned, however, that the increase in QP thresholds for the 2027 performance year will make it meaningfully more difficult for infectious diseases physicians to attain QP status and to qualify for the higher of the two conversion factor updates.** As IDSA notes in its comments on the conversion factor, the divergence between the qualifying and non-qualifying updates institutionalizes a two-track payment system in which physicians who cannot meet the QP thresholds are relegated to a lower update in perpetuity. This structure disadvantages infectious diseases physicians in particular. Our members frequently practice in small, hospital-based or academic settings with limited access to, or control over, the Advanced APMs through which QP status is achieved, and many provide predominantly cognitive, consultative care that does not fit neatly within existing APM structures. Rising thresholds therefore fall especially hard on a specialty that has few realistic pathways to qualify, even as the elimination of the separate APM Incentive Payment removes a longstanding support for participation.

IDSA urges CMS to be mindful of these access barriers and to use its authority, and its recommendations to Congress, to ensure that the increasingly consequential distinction between qualifying and non-qualifying physicians does not systematically penalize infectious diseases physicians and other cognitive specialists who lack a meaningful opportunity to participate in Advanced APMs. IDSA further encourages CMS to continue developing APM pathways that are accessible and appropriate for infectious diseases and other consultative specialties, so that QP status reflects genuine differences in participation rather than differences in specialty or practice setting.

Request for information: Specialist integration in the Medicare Shared Savings Program and accountable care organizations

CMS requests input on potential changes to the Medicare Shared Savings Program (MSSP) and future Innovation Center accountable care organization (ACO) models intended to improve the integration of specialists into ACOs, including opportunities for meaningful engagement, the tools and supports specialists need, specialist performance measurement, and waiver flexibilities. Accountable care organizations have historically been organized around primary care, and the accountability and incentive structures of the MSSP have not meaningfully captured the value that specialist physicians, and infectious diseases physicians in particular, contribute to the total cost and quality of care. Improving specialist integration is both timely and important, and IDSA offers the following comments on how CMS can do so in a manner that reflects the distinctive contributions of infectious diseases physicians.

The value infectious diseases physicians bring to accountable care

Infectious diseases physicians deliver precisely the kind of high-value, cost-reducing care that accountable care models are designed to reward, yet that value is frequently invisible within current ACO structures. Antimicrobial stewardship led by infectious diseases physicians reduces inappropriate antibiotic use, adverse drug events, *Clostridioides difficile*

infection, the emergence of resistant organisms and avoidable length of stay. The management of complex and chronic infections, including HIV, hepatitis C, bone and joint infections, and endocarditis, prevents costly complications, hospitalizations and readmissions. OPAT, overseen by infectious diseases physicians, allows patients to complete prolonged courses of intravenous therapy safely outside the hospital, avoiding extended inpatient stays. These contributions directly advance the cost and quality objectives of the MSSP, but because they are largely preventive and cost-avoiding in nature, they are poorly reflected in existing ACO measurement and attribution methodologies. IDSA urges CMS to recognize this value expressly as it designs mechanisms to integrate specialists into accountable care.

Meaningful engagement of infectious diseases physicians

For specialist integration to be meaningful, infectious diseases physicians must be engaged as genuine partners in accountable care rather than treated solely as a source of referral cost. IDSA urges CMS to support models in which ACOs are encouraged and, given the tools, to embed infectious diseases expertise, including stewardship consultation, management of complex infections and OPAT oversight, into their care processes. Mechanisms that facilitate timely infectious diseases input, such as electronic consultation (e-consultation) and other collaborative arrangements between primary care and infectious diseases physicians, can extend scarce infectious diseases expertise across an ACO's population and should be supported and appropriately valued.

Performance measurement appropriate to infectious diseases

IDSA cautions that specialist performance measurement within ACOs must be built on measures that are clinically meaningful for infectious diseases practice. As IDSA notes throughout these comments, meaningful, applicable quality measures for our specialty are scarce, and holding infectious diseases physicians accountable under measures ill-suited to their practice would neither reflect the quality of their care nor advance the goals of the program. IDSA urges CMS to develop specialist performance measures that capture the actual contributions of infectious diseases physicians, such as antimicrobial stewardship, appropriate management of complex infections and OPAT outcomes, rather than defaulting to generalized measures that fail to describe the care our physicians provide.

Waiver flexibilities

IDSA encourages CMS to extend to infectious diseases physicians participating in ACOs the waiver flexibilities that would enable them to deliver care most effectively. In particular, flexibilities that expand access to telehealth for infectious diseases consultation and OPAT monitoring, that facilitate e-consultation, and that reduce site-of-service and other administrative restrictions, would allow infectious diseases physicians to extend their expertise to underserved and rural populations and to support accountable care across the settings in which their patients receive care. Such flexibilities would directly reinforce the cost and quality goals that specialist integration is intended to achieve.

Tools, data and infrastructure to support infectious diseases participation

Meaningful specialist integration depends on the tools and data infrastructure that allow infectious diseases physicians to contribute effectively within an ACO. Infectious diseases physicians rely on timely access to culture and susceptibility data, prior imaging, prior antimicrobial exposure and results generated across the many settings in which their patients receive care. As IDSA notes in its comments on interoperability and duplicative testing, gaps in result sharing directly impede infectious diseases care and antimicrobial stewardship. IDSA urges CMS to ensure that any specialist integration framework is accompanied by the data-sharing capabilities, population-level infection and stewardship data, and analytic supports that infectious diseases physicians need to identify at-risk patients, guide appropriate therapy and demonstrate their contribution to an ACO's performance. Without these supports, infectious diseases physicians will remain unable to participate on equal footing, regardless of the incentives CMS establishes.

Attribution and financial methodologies

IDSA urges CMS to examine how ACO attribution and financial benchmarking methodologies affect infectious diseases physicians. Because attribution is generally anchored to primary care, the savings that infectious diseases physicians generate, through stewardship, avoided hospitalizations and effective management of complex infections, typically accrue to the ACO in the aggregate without being recognized as the product of infectious diseases care. If CMS intends specialists to engage meaningfully in accountable care, it should develop mechanisms that appropriately credit the cost savings and quality improvements attributable to infectious diseases physicians, so that their contributions are recognized rather than rendered invisible within a primary care–anchored methodology. Any shared savings distribution

methodology that ACOs are encouraged to adopt should likewise ensure that infectious diseases physicians share equitably in the savings their care helps generate.

Consistency with complexity recognition elsewhere in the rule

IDSA notes that CMS has, elsewhere in this rule, proposed to recognize the greater inherent complexity of care furnished within an accountable care relationship, for example, through the enhanced complexity modifier valued at a higher rate for physicians participating in an MSSP ACO or the Long-Term Enhanced ACO Design model. IDSA supports the principle that complex, cognitively intensive care delivered within accountable care arrangements warrants appropriate recognition. We urge CMS to apply that same principle to infectious diseases physicians, whose consultative and stewardship-focused care is central to the success of accountable care but is delivered predominantly in inpatient and other facility settings that current complexity-recognition policies do not reach.

Preserving the infectious diseases workforce

Finally, IDSA urges CMS to weigh the workforce implications of any specialist integration policy. Infectious diseases is a cognitive specialty facing a severe and worsening workforce shortage, driven in significant part by reimbursement that does not reflect the value infectious diseases physicians provide. The consequences are already acute: **Nearly 80% of U.S. counties do not have a single infectious diseases physician, leaving vast, largely rural and underserved areas without local access to specialized infectious diseases care.** The pipeline of new infectious diseases physicians is likewise inadequate: In the most recent subspecialty match, **only 45% of infectious diseases training programs filled their available positions, even as most other specialties filled 90% to 100% of theirs.** Against this backdrop, policies that integrate infectious diseases physicians into accountable care in a manner that recognizes and appropriately rewards their contributions can help sustain and strengthen this essential workforce. Conversely, integration frameworks that impose new accountability and measurement burdens without corresponding recognition or support would risk deepening the very workforce challenges that threaten patient access to infectious diseases expertise. IDSA urges CMS to ensure that specialist integration advances, rather than undermines, the sustainability of the infectious diseases workforce.

Conclusion

IDSA appreciates the opportunity to comment on the CY 2027 Medicare Physician Fee Schedule proposed rule and commends CMS for the many provisions in this rule that seek to modernize payment, reduce administrative burden, and advance a more interoperable and accountable health care system. We share these goals, and we stand ready to work with the agency to achieve them. At the same time, we write with a clear and consistent concern that runs throughout these comments. Infectious diseases physicians are among the most cognitive and least procedural specialists in medicine, and the overwhelming majority of the care they furnish to Medicare beneficiaries is delivered through evaluation and management, consultation, diagnosis, and antimicrobial stewardship in the hospital and other facility settings.

Time and again, however, payment policy rewards precisely this kind of complex, longitudinal, cognitive care, except when it is delivered where infectious diseases physicians deliver it. The compounding facility practice expense reductions, the office-only structure of complexity recognition, the scarcity of applicable quality measures and the barriers to participation in accountable care each fall with particular weight on our specialty. These are not isolated technical concerns; together they describe a payment system that systematically undervalues the physicians on whom Medicare beneficiaries depend for the diagnosis and management of serious infections. A payment system that continues to erode the value of infectious diseases care will accelerate this decline, and it is Medicare beneficiaries — those facing sepsis, resistant infections, HIV, hepatitis C and the next emerging threat — who will bear the consequences. Sustaining this workforce is not merely a matter of physician reimbursement; it is a matter of protecting patient access and safeguarding the nation's readiness to confront infectious diseases threats.

IDSA therefore urges CMS to adopt the recommendations set forth in these comments: to protect infectious diseases physicians from a second consecutive year of facility practice expense cuts by exempting cognitive evaluation and management services from the facility practice expense reduction; to extend complexity recognition to the inpatient setting; to preserve reporting flexibility and develop clinically meaningful quality measures for our specialty; to reduce, rather than shift, administrative burden; and to build accountable care and payment structures that recognize and reward the value infectious diseases physicians provide across every site of service.

IDSA

IDSA is grateful for CMS' continued engagement on these critical issues and welcomes the opportunity to work with the agency to ensure that Medicare payment policy accurately reflects, and appropriately sustains, the essential care that infectious diseases physicians provide to the nation's most vulnerable patients. If you have any questions or if we may be of any assistance to you, please do not hesitate to contact Yasmin Rafiq, IDSA's regulatory and reimbursement policy manager, at yrafiq@idsociety.org.

Sincerely,

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