November 17, 2015

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

Andrew Slavitt, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Acting Administrator Slavitt:

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to respond to the request for information regarding implementation of Alternative Payment Models (APMs) and Merit-Based Incentive Programs (MIPS) called for in the Medicare Access and CHIP Reauthorization Act (MACRA). IDSA represents over 10,000 infectious diseases physicians and scientists devoted to patient care, disease prevention, public health, education, and research in the area of infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, serious health care acquired infections, antibiotic resistant bacterial infections, as well as emerging infections such as Middle East Respiratory Syndrome coronavirus (MERS-CoV) and Ebola.

ID specialists have had a low participation rate in the Physician Quality Reporting System (PQRS) and, those that do participate outside a large physician group are likely subjected to the Measures Applicability Verification (MAV) Process, largely due to a dearth of relevant measures. We see the implementation of MACRA as an opportunity to improve quality measurement reporting to be something more meaningful to our members and to dramatically advance towards value-based payment. Below we submit our specific responses to questions posed in the RFI and hope that, in collaboration with other stakeholders, we can move to a system that reduces administrative burden on providers, recognizes patient diversity, and promotes choice and transparency. Given the complexity of the issues that need to be addressed to ensure successful implementation of MACRA, we strongly urge CMS to approach this transition in a thoughtful and deliberate manner that includes ongoing consultation with the clinical stakeholders that will be most directly impacted by these changes.
It is important to characterize the circumstances that impact our members in clinical practice, as it relates to reporting to PQRS and other quality programs. The majority of ID specialists in clinical practice are employed physicians within large multispecialty groups affiliated with large hospital systems and/or academic medical centers. Of those that are in private practice, most are in small ID-focused practices with less than 5 physicians. ID specialists are not “proceduralists” but rather cognitive specialists, providing most of their services under Evaluation & Management (E/M) codes. Across all ID specialists in clinical practice, the overwhelming majority of E/M codes billed are for services provided in the inpatient setting. In fact, from CMS data, we can report that 83% of the 6.6 million E/M consults by ID specialists, reimbursed by Medicare in 2012, were conducted in the inpatient setting. Within the inpatient setting, ID specialist involvement in the care of patients with severe infections has been well-documented to show reduced mortality, reduced length-of-stay, fewer readmissions, and/or lower costs. The importance of highlighting the inpatient focus of ID specialty care, as well as the practice affiliation, is particularly significant when considering new ways to measure quality, attribute resource use, and enhance EHR adoption. Currently, those who are employed within large practices have very little control over PQRS measure selection and reporting decisions made by practice management. Those who are in small practices have faced increased administrative burden in attempting to comply with PQRS, EHR Meaningful Use, and the VM. As CMS reports, “Compared with physicians in practices with 25 or more physicians, those in solo practice were less likely to participate in PQRS.” We believe this applies to many ID specialists in solo or small practices.

Given these current challenges, we cannot overemphasize the need for CMS to ensure that this new system does not become a series of meaningless steps that place administrative burdens on practices without providing true incentives to increase the quality and efficiency of the care provided to patients. The current system places too much emphasis on compliance and reporting simply to avoid penalties. The focus needs to shift to incentivizing investments in more meaningful activities that make sense to the provider and ultimately improve the care of the patient. In order to achieve that, CMS must provide physicians with flexibility over decisions related to measure selection, reporting mechanisms, and levels of accountability. CMS needs to recognize quality improvement efforts at multiple levels and calculate performance in a manner that is congruent with the multiple ways that providers practice and are organized. Most important of all, individual physicians must have direct control over the selection of mechanisms that work best for his/her practice.

I. MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PROVISIONS

A. Eligible Professional Identifiers & Virtual Groups

*Using TINs, NPI, or a Combination Thereof*

While IDSA does not have a specific recommendation here, we remind CMS that a major problem with the current system is that if a group practice elects to participate using its TIN (e.g., under the PQRS Group Practice Reporting Option or GPRO), every individual eligible provider (EP) in that group is automatically associated with that group for accountability purposes. As such, the individual EP has little to no control over the selection of measures on which the group practice is held accountable, often does not have direct access to performance feedback reports, and sometimes might not even know that the group is participating in the PQRS. While these physicians might get a “free ride” in that they can sometimes avoid penalties without really doing any extra work, they are also disengaged from the process given their lack of autonomy to demonstrate quality in a manner that is most appropriate and meaningful to their practice.

Going forward, we urge CMS to think carefully about:
1) The limitations of relying on an identifier such as the TIN which was developed for billing purposes and is not necessarily the most appropriate mechanism for assessing/capturing quality;
2) The fact that the identifier used to capture performance might need to be distinct from the identifier used to make performance-based payments;
3) The need to balance administrative simplicity with a physician’s freedom to select the level of analysis that he/she feels is most appropriate for his/her practice.

While we do not believe that CMS should adopt any dramatic changes to the current TIN/NPI reporting structure during the initial transition to MIPS, we do request that the agency keep in mind the unique challenges that the current structure presents to our specialty. We encourage CMS to consider ways to give individual EPs more freedom to designate participation (or nonparticipation) under a group’s MIPS election. For many of our members, there might be more relevant reporting options than what the larger group elects to report and for which to be held publicly accountable. Individual physicians should have the flexibility to choose the reporting mechanism and measures that are most relevant to both their patient population and their site of service.

*Virtual Groups*

The virtual group concept has the potential to become an important feature of this newly redesigned system since they account for multiple aspects of modern day medical practice that the current system often fails to account for. These include:

- The fact that physicians often work for multiple organizations or in multiple settings at the same time;
- The fact that those in smaller or independent practices do not have the same level of resources, negotiating power, or overall influence over more comprehensive care decisions that larger group practices and systems do;
• The fact that health care system consolidation is increasingly common, which makes it challenging to assess the performance of individual practitioners practicing in larger multi-specialty groups and minimizes the control that these individual practitioners have over selecting performance metrics that most accurately reflect the quality of their care.

The virtual group concept could be important for ID physicians, who currently have few opportunities to demonstrate their own, unique investments in quality improvement. We urge CMS not to limit the number or size of virtual groups, adopt prescriptive geographic standards, or limit the reporting mechanisms available to these groups, so long as they are able to satisfy minimum criteria. Such limitations would be arbitrary, would ignore the unique and diverse needs of virtual groups, and could impede collaborations that might benefit from this option.

**Place of Service Codes**

Since members of our specialty practice in a variety of settings, it is also important that MIPS capture place of service (POS) codes for services delivered when assessing quality or cost performance. The system must recognize that a service delivered in a hospital might not be comparable to the same services delivered in the outpatient setting. Incorporating the POS identifier into MIPS reporting also will be critical to ensuring that feedback reports and opportunities for improvement are meaningful.

**B. Quality Measures**

**Quality Measure Gaps**

As previously mentioned, PQRS participation rates remain low among ID physicians. Even when ID physicians have control over measure selection, they often find that there is a paucity of meaningful and relevant measures on which to report. Even for those practicing in the outpatient setting, very few PQRS measures are relevant across ID physicians, which results in data that is a poor indicator of overall quality. For example, the HIV/AIDS and hepatitis C virus (HCV) measures do not universally apply to our members as only a select portion of ID specialists focus on treating these patients. The remainder of ID specialists, to whom no specific measures apply, are then forced to report on measures that are only marginally relevant, such as Documentation of Current Medications or Smoking Cessation. We remain concerned that the current lack of ID-relevant measures will result in the public’s inability to make clear and meaningful comparisons across our specialty and potentially result in inaccurate conclusions about the quality of ID specialists in general. It also has resulted in little actionable data on which our own members can target quality improvement efforts.

Understanding the importance of having pertinent measures for performance-based payment adjustments and public reporting, IDSA continues to dedicate efforts to developing clinical quality measures relevant to the treatment of infectious diseases. We have developed measure concepts for *Staphylococcus aureus* and have submitted these measure concepts to CMS in response to the ongoing CMS Call for Measures. With the publication of the Medicare Physician Fee Schedule Final Rule, we note that the measure for
Appropriate Treatment of MSSA Bacteremia is included in the list of new individual quality measures for CY 2016 PQRS. We have also submitted these measure concepts to the National Quality Forum's (NQF) Measure Inventory Pipeline in hopes that we may engage other stakeholders in an effort to further develop these and other measures. We are also working on a multi-pronged strategy to promote better antimicrobial stewardship.

The challenge that we face with these efforts is that to see measure development through the full process requires considerable financial investment. We are currently in the process of trying to engage other entities that may be willing to assist in further developing these measures, as well as patient outcome measures related to infectious diseases. However, it would help our specialty greatly if CMS expeditiously allocated funding authorized under MACRA to address current measurement gaps such as ours. We urge the agency to do so as quickly as possible and we stand ready to partner with CMS to further the work we have already started. Specifically, we ask that CMS prioritize funding allocation to the development of quality measures that capture the team-based activity of antimicrobial stewardship for facility-based (hospitals, long-term care facilities) providers.

Quality Measure Reporting Requirements

While MIPS represents an important opportunity to innovate with new ideas and improve what works in the current system, we also believe that the initial transition to this new system needs to be as simple and seamless as possible so that it does not disrupt clinical practice or minimize the time that physicians have to spend with their patients. As such, IDSA recommends that CMS maintain all of the current PQRS reporting mechanisms (e.g., claims, EHR, registries) to ensure flexibility for physicians with different needs and to account for those who still might not have access to some of these reporting mechanisms (e.g. EHRs or QCDRs).

At the same time, we urge CMS to reconsider the current PQRS requirement of 9 measures across 3 domains, which is an arbitrary threshold that often results in reporting simply for the sake of reporting. As mentioned earlier, this often results in physicians expending valuable time on a process that produces little of value to them or their patients. Within the current PQRS requirements, an ID specialist who sees the overwhelming majority of his/her Medicare patients within the inpatient setting would have to perform quality measures related to diabetes, stroke, and mental illness in order to report measures across three domains. When considering a reduction to the 9 measure threshold, CMS should keep in mind that, overall, MIPS actually increases the reporting burden of physicians by adding the new category of Clinical Practice Improvement Activities (CPIA). For some specialties, some or all of the activities captured through the CPIA category might actually be more meaningful and accurate representations of quality than the current set of PQRS quality measures.

IDSA also believes that the process for assigning measures to a single National Quality Strategy (NQS) domain is often arbitrary and conducted with little transparency and relevant stakeholder input. Although we support the need to ensure a balanced national scorecard for quality, it is often challenging to fit measures into these discrete boxes and ensure physicians within each specialty have an adequate suite of measures to meaningfully
participate and comply with the program. To further support meaningful participation in MIPS, we urge CMS to do away with the NQS domain requirement and instead use domains as a guide for tracking national quality goals or at the very least allow measures to be counted toward multiple domains, where deemed appropriate through consultation with relevant stakeholders.

IDSA also urges CMS to maintain flexibility by not requiring the use of any specific type of measure. While valid and reliable outcome measures could potentially lead to more direct measures of quality, these measures are not appropriate for all clinical scenarios. They also require a significant investment in the development of appropriate methodological standards and access to longitudinal data to ensure fair and accurate evaluations. Given these challenges, it is important that CMS recognize the ongoing role of both structural and process measures that are evidence-based. These measure types can be integral to closing gaps in care and improving outcomes in some specialties and they should be considered as a foundational step towards outcome measures.

MIPS should also recognize that some physicians might need to report independent measures through multiple mechanisms. Those measures, in total, should count toward satisfying the quality measure component of MIPS. For example, an EP might identify a handful of clinically relevant e-specified measures that can be reported through an EHR, but also might identify a few other relevant measures that are not yet e-specified and can only be reported through a registry or claims. Again, CMS should be as flexible as possible and recognize measures across multiple reporting mechanisms in order to promote meaningful engagement and to encourage EPs to experiment with different options.

**CAHPS Survey Measures**

While it is important to understand patient experience in the care setting, IDSA continues to believe that patient experience/satisfaction should not be a required element of reporting and should not be considered under the quality component of MIPS since these are often subjective in nature and not directly under the control of the physician (e.g., physician wait times in a hospital setting). In many specialties, there is no direct correlation between higher patient experience scores and better clinical outcomes. Furthermore, holding physicians accountable for patient satisfaction measures may result in perverse incentives that actually lead to lower quality care (e.g., antibiotic overuse to satisfy patient requests). We urge CMS to instead focus on evidence-based, physician-driven clinical quality measures for accountability purposes and to retain patient experience measures (including those that span beyond the CAHPS survey) as an option that physicians can use to satisfy the CPIA category.

**C. Resource Use Measures**

*Additional Cost or Resource Use Measures, (Including those Identified by Choosing Wisely)*
IDSA Comments – CMS Request for Information on MACRA Implementation

IDSA has been an active participant in the Choosing Wisely Campaign and has created a list of recommendations to avoid inappropriate use of resources.⁶ We believe that CMS should consider the lists of recommendations generated by medical societies for possible resource use measures. For example, IDSA’s recommendation “Don’t treat asymptomatic bacteruria with antibiotics,” might be used to construct a measure of appropriate antimicrobial use within hospitals and long-term care facilities. As noted, “the presence of a urinary catheter increases the risk of bacteruria, however, antibiotic use does not decrease the incidence of symptomatic catheter-associated urinary tract infection (CAUTI)... The overtreatment of [asymptomatic bacteruria] with antibiotics is not only costly, but can lead to C. difficile infection and the emergence of resistant pathogens, raising issues of patient safety and quality.” We believe the data sources to calculate this measure and other similar measures reside within the facility’s EHR system. There are challenges for an individual EP to extract data from a facility-owned EHR for purposes of provider-level quality measurement. Such a measure is one of several opportunities for CMS to prioritize funding to address measure gaps and focus efforts that capture the team-based activity of antimicrobial stewardship for facility-based (hospitals, long-term care facilities) providers. With adequate funding, interconnectivity issues between facility-based EHRs and specialty registries can be overcome to enable provider-level quality measurement.

Current Flawed Measures

The RFI implies that CMS may keep all the current value-based modifier (VM) cost measures and then expand upon them. In addition to other flaws, the current set of VM cost measures are irrelevant for many ID physicians—either because no patients get attributed to them or because they had little to no opportunity to influence the costs that are attributed to them. Shortcomings in the attribution and risk adjustment methodology exacerbate the problem. Furthermore, many of the measures were developed for hospitals and are inappropriate for individual physician or even group practice accountability since they do not have Medicare patient populations that are large enough or heterogeneous enough to produce an accurate picture of their resource use. As a result of these problems, the data produced from these measures are confusing, complex, and of questionable value to both our members and their patients.

Episode-Based Cost Measures

If properly selected and designed, measures tied to episodes of care could increase the relevance, reliability, and applicability of resource measures and make physician feedback reports more actionable. More specific episode-based cost measures also would offer an opportunity to adapt risk adjustment and attribution methodologies to the individual condition or service being measured. IDSA looks forward to working more closely with CMS and other relevant stakeholders to develop episode groupers specific to our specialty or that otherwise encompass our specialty. It is critical that CMS develop these measures under a transparent process, with the input of all relevant, and practicing, clinical stakeholders. Most importantly, when ready for use, these measures should replace, rather than supplement, the current set of broad-based cost measures.

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Risk Adjustment

Regardless of the strategy adopted, risk adjustment that accounts for beneficiary severity of illness, as well as other patient characteristics such as socio-demographic factors, are critical to ensuring that MIPS does not unintentionally divert resources or otherwise restrict access to care for our most vulnerable populations. The development and application of appropriate risk adjustment methodologies also helps to encourage program engagement among participating physicians.

Alignment of Cost and Quality Measures

CMS must also keep in mind that the VM currently relies on a flawed value equation. The current set of cost measures has little to no relevance to the more condition/procedure-specific quality measures used to calculate the VM. Going forward, CMS should strive for better alignment between cost and quality measures to ensure they result in accurate determinations regarding a physician’s overall value.

Benchmarking

It is imperative that when calculating resource use attributable to particular groups or individual physicians that CMS compares similarly situated practices. Currently, due to the limited number of relevant cost (and quality) measures, physicians from various specialties with very different patient populations often rely on the same measures (e.g. the advanced care planning measure). When calculating benchmarks to evaluate performance, CMS must be careful not to lump all physicians together and consider them the same. Instead, CMS should either calculate separate benchmarks for each specialty (and in some cases, each subspecialty) or otherwise adjust performance calculations to ensure fair comparisons among similar physicians. Resource use benchmarks should also account for longer-term value that might not be realized over the short term (i.e., services or therapies that might be costly in the short term, but increase in value over the long term). An example of this relevant to ID is the care of patients with hepatitis C virus, where available therapies are costly yet achieve “virologic cure” where patients might otherwise progress to more costly conditions, (i.e. requiring a liver transplant).

D. Meaningful Use

It is absolutely critical that CMS make changes to the current EHR Incentive Program requirements (particularly Stage 3) prior to implementation of MIPS to ensure that meaningful use of EHRs is achievable and “truly meaningful” for all physicians, including ID physicians. While we appreciate recently finalized alternative exclusions and measure specifications to temporarily ease the transition to Stage 2, CMS seems intent on requiring all providers to move to a much more rigorous and less flexible set of Stage 3 requirements by the time that MIPS begins.

While the requirements in and of themselves are problematic, the current program’s all-or-nothing scoring approach only exacerbates these problems since it assumes that every
objective and measure is equally relevant, appropriate, and feasible for every physician. As such, IDSA strongly urges CMS to instead give physicians partial credit that reflects their unique efforts and ability to satisfy the MU objectives. For example, if physicians meet a certain percentage of the measures, there should be an option for them to get credit for the percentage they were able to complete and to be held harmless from objectives and measures that are irrelevant to their practice or outside of their control.

In general, physicians who attempt to attest to MU should not be penalized for actions they cannot control. For example, CMS should ensure that each measure required for MU is one that providers are able to attest to without relying on the actions of other individuals (patients, technology, or other providers). In addition, it is critical that CMS preserve and expand exemptions for lack of control over EHR adoption decisions since this is a common problem for physicians—whether due to a larger institution or group practice retaining control over these decisions or the EHR vendor itself imposing restrictions on functionality.

We also believe it is important for any new MU objective, at least for the initial reporting period, to not be tied to any thresholds. Simply attesting to the fact that the functionality was enabled should be sufficient. Furthermore, the regulatory framework currently guiding meaningful use of EHRs must be revised to eliminate obstacles to technological innovation, enable interoperability, and improve usability to meet the needs of patient care and reduce the burden of excessive data collection requirements.

Finally, we recommend that CMS collaborate with national specialty societies to develop health IT-enabled alternatives or pilots that could be optionally used to satisfy the MU component of the MIPS composite score. ID physicians, for example, should be given the option to participate in MU Stage 3 or satisfy an alternative pathway that could be comprised of elements of MU, such as clinical data registry participation or implementing clinical decision support functionality. CMS could also implement additional health IT-enabled activities outside the scope of the current MU requirements such as structured reporting, enabling electronic orders, etc.

E. Clinical Practice Improvement Activities

Since this component of MIPS offers the greatest opportunity for physicians to be recognized for significant investments in more innovative quality improvement activities that do not necessarily fall into the “quality metric box,” IDSA recommends that CMS allow for the broadest interpretation of CPIAs as possible. Choice of activities should be optional and no established subcategory should be mandatory. Physicians also should be able to demonstrate their performance of CPIAs through a simple attestation process that occurs no more than annually. However, some CPIAs (e.g., a certification) may be granted by the certifying organization for more than a one-year period. In such cases, EPs should be allowed to attest to that activity for each of the years until the certification’s expiration. We do not believe that Congress intended for CMS to somehow measure whether or not a particular activity “improved” care. The logistics of measuring this across the wide variety of activities that should be recognized under this category would be virtually impossible to
achieve. Rather, we believe that the intent of the Act dictates that CPIA performance be based on completion or ongoing participation and suggest a specified number of clinical improvement activities rather than hours.

Here are a few CPIA examples which would benefit infectious diseases specialists and our patients:

- Implementation and/or on-going leadership of an antimicrobial stewardship program in an acute care or long-term care facility
- Implementation and/or on-going leadership of an infection prevention program in an acute care or long-term care facility
- Implementation and/or on-going leadership of a hospital-avoidance and timely discharge program enabled through outpatient parenteral antimicrobial therapy (OPAT)
- Development of treatment protocols for solid organ transplant cases
- Leadership of health care worker and/or population-based immunization programs
- Develop disaster preparedness-related protocols (i.e. facility/system-level Ebola response programs)
- Liaison activity related to hospital/health system engagement with local public health entities

We believe that these activities fall within the definition of CPIA that appears in the legislation (MACRA) in that they improve “clinical practice or care delivery and that... when effectively executed [are] likely to result in improved outcomes.” We look forward to further discussion with CMS as to how these activities can be accounted for as CPIAs in an efficient manner.

F. EPs in Specialties with Few Relevant Measures or Insufficient Data

For specialties that do not have enough measures in any one category, CMS should use its authority to re-adjust the weights of the other MIPS categories. Due to the serious flaws and barriers to meaningful participation in the current MU and Value Modifier programs, we strongly caution against automatically adding weight to the MU or Resource Use categories. Instead, we recommend that CMS either:

- Give more weight to the CPIA category, so long as this decision is made in cooperation with the affected specialties and sub-specialties. The CPIA category may provide the most flexibility for many physicians to receive recognition for the quality improvement activities that are most relevant to their practice and is also given the least amount of weight under MACRA. Therefore, we believe that when an EP does not have enough measures, CMS should allow for more weight to be given to this category.
- Alternatively, CMS could allow specialties to select which other category (ies) they would like to count more. We recommend that CMS work with the affected specialty to customize the performance requirements that are most appropriate for its members.
Also, it is important to highlight here that hospital-based specialists, who are not eligible for incentives related to meaningful use of EHRs, should not be held accountable for that activity. Their inability to satisfy the MU component of MIPS should not adversely affect their composite performance score.

**G. MIPS: Other Measures**

Due to the nature of our specialty, we believe it is important for CMS to allow for the optional attribution of facility-based scores to EPs who practice in or are employed by that facility, and compare it to the national average for similar facilities as the benchmark.

**H. Public Reporting**

IDSA reiterates its support for efforts to assist patients and consumers with health care decision-making, but we remain concerned that releasing too much data too rapidly could have the unintended effect of confusing and even misleading the public. Similar to current programs, such as the PQRS during the early years of MIPS, CMS should only publicly report data that indicates whether an EP satisfied the reporting requirements for the multiple components of MIPS. Attempting to accurately calculate and showcase performance data is an unrealistic goal for the initial years of this new program. There are currently too many unresolved problems related to risk adjustment, attribution, appropriate sample sizes and even the ongoing lack of relevant measures for certain specialties.

Moving forward, we request that CMS approach public reporting carefully and gradually by first evaluating which measures are most appropriate for public reporting and then testing the release of those measures to determine which reporting formats are most meaningful for both physicians and the public and to what extent the public is using the data for decision-making. IDSA appreciates that under current policy, CMS will only make available to the public measures that prove to be valid, reliable, and accurate upon analysis; are deemed to be statistically comparable; that prove to be valuable to consumers; that meet a minimum sample size of 20 patients; and that are not first year measures. We urge CMS to maintain these policies going forward. For measures that are not yet ready for public reporting, CMS should continue to provide physicians with confidential and clear feedback so that they can not only understand their performance, but provide CMS with valuable feedback on how these data could be better presented.

We also request that CMS take situations like ours into account when deciding which data to release to the public. For example, even if an ID physician’s performance on the Documentation of Current Medications measure proves to be valid and reliable and meets the minimum sample size requirements, these data still would not provide consumers with meaningful data regarding the quality of ID care. We also request that in instances where insufficient performance data exists that CMS provide clear disclaimers to the public that clearly explain why performance data for some physicians is not yet available and how the
public should not view this as an indicator of poor performance, but rather the unavailability of relevant measure data on which to evaluate such physicians.

I. Feedback Reports

We support CMS continuing to provide EPs with confidential feedback reports, so long as they provide EPs with the option to view more high-level, overall performance information as well as drill down tables with individual patient information. CMS also must continually consult with stakeholders to ensure data displayed is relevant and meaningful, and understood by the intended audience.

Feedback reports also need to be more universally accessible to individual physicians. While we recognize the need to ensure privacy and confidentiality, the current strategy of making these reports available only at the TIN level stands in the way of individual physicians accessing reports. As a result, individual members of the group whose data is reflected in the report often do not have direct access to the reports and many times, are not even aware that they have been distributed to the TIN. All physicians whose data are reflected in these reports should have equal access to the reports.

IDSA once again thanks CMS for the opportunity to provide preliminary feedback on these important policies. As we stated before, we believe the implementation of MACRA is an opportunity to improve quality measurement reporting to be something more meaningful to our members and to dramatically advance our health care system towards value-based payment. We look forward to providing specific input on more concrete proposals that CMS puts forward in the future. If you have any questions, please feel free to contact Andrés Rodríguez, Director for Practice & Payment Policy, at 703-299-5146 or arodriguez@idsociety.org.

Sincerely,

Johan S. Bakken, MD, PhD. FIDSA
President, IDSA