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Infectious Diseases Society of America₁

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September 11, 2023

Chiquita Brooks-Lasure
Administrator
Centers for Medicare & Medicaid Services

Dear Administrator Brooks-LaSure:

IDSA represents more than 12,000 infectious diseases (ID) physicians, scientists and other health care professionals devoted to patient care, prevention, public health, education and research in infectious diseases. Our members care for patients of all ages with serious infections, including influenza, pneumonia, HIV/AIDS, viral hepatitis health care associated infections, antimicrobial-resistant infections, infections associated with opioid use, as well preparing for and responding to pandemics and outbreaks including COVID-19, mpox, Ebola and Zika. This work enhances patient safety and provides essential expertise and partnership to public health, primary care and other medical specialties, allowing a wide array of medical services to be provided safely. In addition to emergency responses, ID physicians exercise constant vigilance to recognize clinical presentations of emerging infectious diseases and manage increasingly complex patient populations, as medical advances like transplantation, cancer care and growing use of certain biologics carry significant risks of complicated infections. It is with this background in mind that we submit our comments for your consideration.

Conversion Factor

IDSA remains deeply concerned about the steep reduction in the Medicare PFS conversion factor for CY 2024, particularly as inflation continues to rise. As proposed, the reduction is nearly -3.34% with more than half attributable to a new complex care add-on code, G2211 and the remainder stemming from a lower one year payment update provided under the *Consolidated Appropriations Act, 2023* for CY 2024 (1.25%), as opposed to CY 2023 (2.50%). Yet again, **ID clinicians are set to realize cuts in Medicare reimbursements for another year as a result of these policies.**

Since the inception of the Resource-Based Relative Value Scale (RBRVS), the conversion factor has remained relatively flat (see [graphic prepared by the American Medical Association \(AMA\)](#)). Meanwhile, other Medicare providers receive inflation-adjustment payment updates. While the Agency has limitations in terms of revising the mechanism for updating Medicare payments to physicians – for example, updating payments based on the Medicare Economic Index (MEI) – the

Administration could work with Congress to improve this formula in ways that would benefit ID clinicians, and the rest of the healthcare community, who are reimbursed under the PFS. We urge CMS to consider the comments below and work with lawmakers on substantive changes to the physician payment formula to ensure a more reasonable payment update is provided.

Medicare Payment for ID Services Remains Unacceptable and IDSA Demands Action

Infectious diseases (ID) clinicians, and the services they deliver, are unacceptably undervalued in Medicare’s physician fee schedule (PFS). While challenges with the overarching physician payment formula (e.g., the lack of updating reimbursements for inflation and the relatively (\$20M) low trigger for executing budget-neutrality adjustments) fall outside of the Agency’s control, **CMS has the authority to establish adequate relative values for the services delivered by ID physicians to beneficiaries with complex conditions managed by our specialty. Thus far, CMS has failed in this regard. We appreciate that CMS requested feedback on E/M code valuation in the proposed rule and we insist that CMS take immediate action on one or more of the following policy options (further detailed below) to improve ID physician reimbursement:**

- Include in the President’s Budget Request for FY2025 a new Incentive Payment Program for Infectious Diseases Services;
- Increase the values of inpatient E/M codes to reinstate the historic relativity between inpatient and office/outpatient E/M RVUs;
- Convene an expert panel to review research and recommend 1) improved methodologies for reviewing E/M codes and 2) data-driven updates to E/M codes; such a panel would work with the American Medical Association (AMA) RVS Update Committee (RUC) to address the inability of current methodologies to accurately determine intensity and value of cognitive services.

IDSA has pleaded with CMS to address the inequity in its payment for ID E/M services, offering multiple actionable policy options that are within the Agency’s authority to implement, to no avail. Our community is deeply frustrated by this lack of progress, particularly after leading efforts to combat multiple infectious diseases outbreaks, including the COVID-19 pandemic where our expertise and day-to-day actions were typically either un-reimbursed or under-reimbursed, while other Medicare providers saw boons in their revenues on the backs of ID clinicians.

As a country, we are wholly unprepared to manage another large-scale outbreak – let alone multiple outbreaks – given the inadequate ID physician workforce. Experts widely agree that outbreaks will become increasingly frequent, particularly due to climate change. We further lack the ID experts necessary to care for and prevent infections in the growing population of immunocompromised individuals, including patients with cancer, patients receiving organ transplants and patients taking biologics that impact the immune system.

CMS’ flawed payment policies that grossly devalue ID physician expertise and care are a significant contributing factor to the ID recruitment crisis. Last year, only 56% of ID physician training programs filled, while most other specialties filled all or nearly all of their programs. ID remains the fifth lowest paid medical specialty, below even general internal medicine despite an additional 2-3 years of training. **The U.S. cannot afford for the specialty to be further limited by insufficient policymaking, and IDSA demands action from this Administration – and this Agency, in**

particular – to appropriately address our concerns before the next outbreak(s) meets our doors.

IDSA Proposal: Incentive Payment for ID Clinicians

During a 2023 meeting with CMS, IDSA was advised that updates to E/M codes would impact numerous specialties and to consider policy options that would more directly target ID clinician needs. In response to that feedback, IDSA now recommends the creation of an ID Incentive Payment Program, which would provide a temporary 10% payment increase for all services provided by an ID clinician. This proposal is modeled after similar approaches used previously for primary care and general surgery. This approach would provide rapid relief to address significant ID workforce shortfalls that have resulted from inadequate reimbursement, providing a bridge to longer term solutions to better value ID physician services and improve opportunities for ID participation in more innovative payment models. We recognize this policy would require congressional action, and we urge CMS to include this proposal in the President’s Budget Request for FY 2025 to signal the Administration’s support and acknowledgement that urgent action is needed to improve ID reimbursement in order to strengthen ID physician recruitment and protect Medicare beneficiary access to ID physician care.

Potentially Misvalued Services Under the PFS

During a 2023 meeting with CMS, including officials in the Office of the Administrator (OA), IDSA was advised to nominate certain inpatient Evaluation and Management (E/M) services (i.e., CPT codes 99221, 99222, and 99223) as “potentially misvalued,” given 1) it is CMS’ formal process for entities to raise concerns about work values they believe are misvalued, and 2) a recognition that our request to reconsider the proposed work values in the CY 2023 PFS rulemaking, and the rationale on which that request was made, was not expressly addressed in CMS’ response to comments in the final rule.

In this CY 2024 PFS, once again, CMS has provided little explanation or rebuttal to IDSA’s arguments for why it refuses to improve the value of inpatient E/M services consistent with our request. Rather, CMS repeats language dismissing longstanding assumptions about the relativity of inpatient and outpatient/office E/M visits. Specifically, CMS expressed “*concern about assumptions made in the RUC recommendations for Other E/M visits that patient needs were inherently more complex, or work was more intense for E/M visits furnished in non-office settings (for example, inpatient, ED and home settings) when compared to the office settings . . . [CMS] stated that this direct comparison between Other E/M visits and the O/O E/M visit codes may not be appropriate or accurate, and laid out reasons why practitioners in office settings may expend more resources than practitioners in institutional and other settings.*” IDSA finds this parroted comment from the CY 2023 PFS rulemaking to be disingenuous and unpersuasive.

First, this underpinning of the relativity of the different E/M code sets was never part of the AMA Relative Value Scale Update Committee (RUC) review. For CMS to make this assertion after the fact as a rationale for undervaluing inpatient E/M services is neither rooted in process nor data.

Second, we continue to be utterly confused about CMS’ references to how practitioners “*expend more resources?*” in this rationale about the relativity of settings. Regardless of whether that is accurate, that is clearly a matter of practice expense (PE) values – not work values. CMS’ disregard for the *basics* of the Resource-Based Relative Value Scale (RBRVS) methodology calls into question the true motivations behind its refusal to appropriately value inpatient E/M visits.

Third, and more disturbing, CMS again asks the reader to ignore that the code sets they refer to include, not just office visits, but hospital outpatient visits in the descriptor. CMS is thus telling us in one breath that patients in the hospital do not require the same amount of work (or “resources”) as a patient in the office setting, but in the next breath increases the hospital outpatient payments. It is difficult to digest these incongruities, and we are not sure they have been made in good faith.

With gross disrespect for the specialty that continues to carry the burden of the COVID-19 pandemic, CMS points out that our potentially misvalued code request “*did not offer appreciably new information relative to last year’s nomination/consideration.*” Further, CMS [indicated](#) (p. 607) that increases to the values of inpatient E/M codes were not justified because there had not been an increase in time. This reasoning discounts the increased complexity of these patients and of the medical decision-making they require and fails to value the unique expertise of ID physicians. IDSA is merely seeking a useful response to the rationale we have already provided in support of the aforementioned improvements, and for which the Agency has failed to articulate a worthwhile response in either its CY2023 or CY2024 rulemaking.

For an Agency that claims to be deeply committed to improving the value of services that support “primary care” and longitudinal care of complex patients, we are astonished by its refusal to take the necessary action – or any action, for that matter – to improve the value of the very inpatient E/M services ID physicians use to deliver that exact care.

Outbreak Activation

Medicare’s physician payment system does not include a mechanism to reimburse ID, or other clinicians, for critical activities associated with managing infectious disease outbreaks. Along with our colleagues in emergency and hospital medicine, IDSA has advocated for an “outbreak activation” policy, whereby CMS would automatically initiate increased payment to clinicians under the PFS for direct and indirect work associated with these unanticipated events, within certain parameters, when they occur. This proposal included appropriate “triggers” to activate the policy, along with important program integrity safeguards, including coding and documentation requirements, to prevent abuse.

To date, CMS has not explained how it intends to compensate clinicians for the unreimbursed costs associated with responding to health care outbreaks, nor why the proposals our groups have forwarded for consideration are not actionable.

CMS must establish a fair and reasonable payment policy to meet its statutory obligation to cover items and services that are “reasonable and necessary” and pay based on the resource costs associated with delivering those services.

Evaluating E/M Services “More Regularly and Comprehensively”

In concert with a series of key questions, CMS says it “*continues ongoing work to establish resource-based relative units for PFS services,*” and is “*seeking information about how [it] might evaluate E/M services with greater specificity, more regularly and comprehensively.*” Considering the line of questioning that follows, it is clear that CMS acknowledges the limitations of the current process used to establish recommended values for cognitive work, on which the Agency frequently relies. We appreciate this recognition and urge that it be rapidly followed by concrete steps to improve the valuation of ID physician services.

As CMS is aware, IDSA continues to encourage Congress to work with medical specialty societies to develop approaches that will accurately value the complexity and value of cognitive care, with the goal of ensuring our health care system has the diverse array of specialists needed to provide high quality care to an increasingly complex Medicare population. **IDSA supports proposals to establish a technical expert panel that would advise CMS on a data-driven approach to adequately value E/M codes.**

In addition, IDSA offers responses to applicable CMS' questions below:

a. Do the existing E/M HCPCS codes accurately define the full range of E/M services with appropriate gradations for intensity of services?

Consultations are a common E/M service delivered by ID clinicians, particularly in the inpatient setting. Unfortunately, these services are no longer recognized by Medicare. This has resulted in a significant reduction in the ID "pool" and a direct reimbursement "hit" to ID clinicians, further exacerbating the issues described above. Moreover, there is no accurate way to report on Medicare claims when this service has been provided to beneficiaries and be assured reimbursement is based on the resources necessary to deliver the services. The current set of E/M codes recognized by CMS do not accurately identify and value what is provided by an ID clinician during a consultation. To address this, CMS should restore "active" status to consultations and establish values that are commensurate with the time *and* expertise ID clinicians provide when they deliver these services.

In addition, ID physicians spend a significant amount of time performing services that are not reimbursable despite providing significant value to the health care system, such as leading infection prevention and control, antimicrobial stewardship, and emergency preparedness and response programs; and managing outpatient parenteral antimicrobial therapy (OPAT) and other transitions of care. The current system's lack of a mechanism to reimburse for these critical services – some of which involve "evaluation" and "management" – further devalues the essential work of ID clinicians.

b. Are the methods used by the RUC and CMS appropriate to accurately value E/M and other HCPCS codes?

No. Current values for E/M codes, particularly inpatient E/M, are far too low to accurately capture the value of services provided, and the methods must be improved to deliver more accurate results. In particular, ***current approaches have no adequate way to measure the complexity of care delivered or the value of a clinician's expertise.*** The overreliance on measuring time fails to capture complexity and can actually penalize a clinician with greater expertise who may be able to deliver higher quality care that results in a better patient outcome in less time. For example, it could take less time for an ID physician to address the needs of a patient with septic shock than it would be a primary care provider. This is directly attributable to the ID physician's additional training, and thus, expertise in diagnosing, treating and managing this condition. The current system devalues experience and judgement.

We believe that the proposal of the new complexity add-on code is an acknowledgement by CMS that current codes do not adequately reflect complexity; however, the application of this add-on payment only to office and outpatient codes is a missed opportunity to improve the valuation of

inpatient E/M services and ultimately contributes to an expected overall reduction in payment for ID physicians under the proposed rule. Complexity of care required is a common trigger for hospital admission and inpatient care is inherently more complex than outpatient care, as the inpatient setting typically includes sicker patients, greater risk of adverse events and poor outcomes, higher degree of medical decision-making, more comorbidities and greater need for coordination across specialties.

The AMA RUC has also acknowledged the inherent greater complexity for inpatient care in the SOR for CPT 99205 regarding 99223: “Initial hospital care for patient with problems of high severity, with times and work RVU of 15/55/20/90/3.86, and 99220, Initial observation care for patients with problems of high severity with times and work RVU of 15/45/15/75/3.56. The panel determined that the survey median total time and work RVU place 99205 in proper rank order with both key reference services. While all three services require high complexity medical decision making, 99223 and 99220 are reported for patients in a hospital or observation setting so the RVUs should be higher.”

e. What are the consequences if services described by HCPCS codes are not accurately defined?

Generally, when HCPCS codes are poorly defined, clinicians and other health care professionals may be challenged with when and how to *confidently* adopt HCPCS codes in their clinical practice. Confusion about when and how to use HCPCS codes can lead to clinicians and other health care professionals, and their administrative staff, to inadvertently misuse or misapply a HCPCS code, leaving them vulnerable to program integrity audits. For example, clinicians and health care professionals may insufficiently document the service(s) in the medical record, and coding and billing staff may incorrectly code and submit a claim to payers for the service(s).

To mitigate this risk and to increase beneficiary access to services outlined by HCPCS codes, code descriptors should be clear and understandable. Importantly, billing and coding guidelines should be established that include a range of examples across clinician types, along with reasonable documentation requirements, to ensure clinicians and other health care professionals can use HCPCS codes with confidence.

f. What are the consequences if services described by HCPCS codes are not accurately valued?

We are already experiencing dire consequences of inadequately valued inpatient E/M codes. First, ID physicians are the fifth lowest compensated medical specialty, below even general internal medicine despite an additional 2-3 years of training. Low compensation relative to other specialties is routinely cited by medical students and residents as a chief barrier to entering the field of ID, decimating our recruitment to the ID specialty. In 2022, only 56% of ID fellowship training programs filled, while most other specialties filled 90-100% of their fellowship training programs. This leaves us without enough ID physicians to meet growing patient needs and perpetuates burnout among existing ID physicians.

The proposed rule would result in an estimated 2.25% decrease in reimbursement to ID physicians, exacerbating rather than addressing current challenges.

Inaccuracies in the valuations of E/M codes profoundly affect patient care. Poorly defined and undervalued services lead to uncompensated clinically intense E/M patient care. Inadequate reimbursement is a chief driver of workforce shortages. If there are significant workforce deficiencies, as is the case with the ID field, achieving equitable access to high quality care will be impossible. In fact, lack of a sufficient ID workforce is already contributing to inequitable outcomes for serious infections, as we have seen with COVID-19.

Services Addressing Health-Related Social Needs: Principal Illness Navigation (PIN)

We applaud CMS for establishing coding and payment for a series of services that would provide reimbursement for “resources to obtain information from the patient about health-related social needs and risks, and formulate diagnosis and treatment plans that take these needs into account,” by clinicians and their staff. We are particularly pleased with CMS’ proposed coding and payment for Principal Illness Navigation (PIN), and that CMS acknowledges the benefit of this service for unique patient populations that we diagnose, treat, and manage – namely those with HIV/AIDS. We recommend that CMS expand list of examples to include those with other chronic infectious diseases, including those associated with a public health emergency (e.g., COVID-19, mpox).

We urge CMS to finalize its coding and payment for the aforementioned services, and look forward to working with you on guidance so that ID clinicians can make these services available to our Medicare patients.

Telehealth

IDSAs support CMS’ implementation of important telehealth provisions in the CAA, 2023, namely those that would maintain many of the flexibilities provided during the COVID-19 PHE, specifically, the temporary expansion of the scope of telehealth originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual’s home, and continued coverage and payment of audio-only telehealth services included on the Medicare Telehealth Services List as of March 15, 2020.

Telephone Evaluation and Management Services

We have previously shared the value of audio-only technology in management of ID conditions, as it is often the only means by which some Medicare beneficiaries will be able to access ID care, even absent the pandemic. Broadband internet remains limited or non-existent in many areas of the country, making access to audio-visual technology nearly impossible. Moreover, in our experience, some Medicare beneficiaries find audio-visual technologies difficult to use, while others feel uncomfortable using it altogether. This is particularly true for those with certain health conditions, including those managed by ID clinicians, and prefer the increased privacy afforded via audio-only care. We appreciate that CMS has deemed the telephone E/M services (CPT codes 99441-99443) as “telehealth services” and will remain actively priced through CY 2024, but **urge CMS to make that status permanent**. We further note that these services are woefully undervalued in regard to the cognitive effort and expertise required on the part of the provider, often managing conditions of high complexity that would be reimbursed at a higher, more appropriate rate if provided via a device with visual capability. We encourage CMS to improve reimbursement for telephone E/M services so that reimbursement reflects the care provided, not the device used.

Additions to the Medicare Telehealth List

IDSA appreciates that CMS will retain hospital inpatient E/M services on the Medicare Telehealth List through CY 2024, but is disappointed it did not propose to add these services permanently. Below we provide a number of examples for how this has been invaluable to beneficiaries seeking ID care.

- A hospital system in Virginia with smaller hospitals in West Virginia, was struggling with increased transfers from the smaller hospitals to the main hospital overextending the capacity of the main hospital. The implementation tele-ID services at the smaller hospitals reduced transfer needs by a minimum of 50% which improved the access to care and hospital capacity over all throughout the hospital system.
- A large urban hospital in Maryland, has struggled with recruiting a second ID physician to relieve the one ID physician onsite. Establishing a tele-ID service with remote providers has allowed the hospital to continue their operations, while having full access to ID services without the need to have to recruit another full time ID physician.
- Two hospitals in PA; both level II Trauma centers, lost their ID onsite ID physicians in an emergent way due to a medical illness, Tele-ID was the only immediate solution for access to ID expertise which was established within days; allowing continuity of care and eliminating the need to jeopardize patient outcomes or having to transfer them to another institution. There are no reliable locum tenens coverage in both areas and these hospitals had to wait for many months or years to recruit an ID physician.
- A community hospital in NM, level III Trauma center, a known catchment hospital for all orthopedic related trauma in the 3 neighboring, lost their in person ID coverage, Availability of a Tele-ID service allowed the hospital to continue services with access to ID specialists to a large population.
- An urban community hospital in Raleigh North Carolina, had no access to ID expertise and had to transfer all ID patients to the main hospital where onsite ID physicians are short staffed. The hospital needed ~0.3FTE of an ID physician and had no budget to recruit a full-time provider. Tele-ID was the only solution to provide the coverage needed and eliminate the need to transferring patients to the neighboring hospital.

In light of the comments above, **we urge CMS to reconsider this policy and add these services on a permanent basis.**

Frequency Limitations

IDSA strongly supports CMS proposal to remove the telehealth frequency limitations for subsequent inpatient visit codes. The “once every three days” limit created a host of challenges for ID physicians using telehealth as a means to closely manage beneficiaries setting with ID conditions in the hospital. Below are examples collected from our ID community to demonstrate why these limits should be removed.

- Infectious diseases are acute in nature and patients can become septic in a matter of hours if not treated properly and in a timely fashion. Many infections need daily monitoring and close follow up to detect whether spread or seeding has occurred and whether patients are properly responding to therapy. For example, *Staphylococcus aureus* bacteremia is one of the most common infections seen by Infectious Diseases and if these patients are not monitored and examined daily by ID physicians, seeding to the joint/spine/eyes/psoas can easily be

missed. Additionally, it had been proven through multiple studies that ID consultation and management improves outcomes in the management of *Staphylococcus aureus* bacteremia and that is based on the model of doing daily follow up visits. (Forsblom E, Ruotsalainen E, Ollgren J, Järvinen A. Telephone consultation cannot replace bedside infectious disease consultation in the management of Staphylococcus aureus Bacteremia. Clin Infect Dis. 2013 Feb;56(4):527-35. doi: 10.1093/cid/cis889. Epub 2012 Oct 19. PMID: 23087397).

- Patients with neutropenic fevers, or fevers of unknown origin in an immunocompromised patient, can elicit new physical signs and symptoms on repeated exams even while on therapy during the first few days of admission, hence if not evaluated by an ID physician these manifestations can be easily missed by primary teams as they are not versed or trained to look for them.
- Even cases such as complicated cellulitis monitoring or progression to an abscess can be missed by the primary team.
- There are a wide array of infections that tend to progress and can be associated with high morbidity mortality if missed and not detected as soon as they occur: For example vertebral osteomyelitis/discitis with epidural abscess require serial monitoring to make sure no new neurologic symptoms are developing. Same applies for meningitis and CNS infections, HIV associated opportunistic infections, fungemia and many others.

For the reasons above, **we urge CMS to make this policy permanent rather than only for CY 2024.**

Virtual Presence

IDSA appreciates CMS' proposal to continue defining direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024. We continue to believe this flexibility should be made permanent in CY 2025 and encourage CMS to include this proposal in future rulemaking. The virtual presence policy allows ID physicians to extend their reach to patients, especially where ID care is not available, by using physician extenders to assist in providing life-saving care over long distances.

We also appreciate and support CMS' proposal to allow teaching physicians to use virtual presence in all teaching settings in clinical instances when the service is furnished virtually (for example, a 3-way telehealth visit, with all parties in separate locations) through December 31, 2024. Our members have shared how valuable it is toward teaching fellows or residents on how to conduct tele-ID visits, Of note, these teaching rounds occur very similarly to in person rounds. **IDSA would also appreciate CMS extending this policy beyond CY 2024, and for teaching Advanced Practice Providers (APPs), whether they are located onsite with the patient or remotely.**

Process Changes

IDSA appreciates and supports the Agency's proposal to improve the process by which services are added to the Medicare Telehealth List, consolidating services into either "permanent"(Category I) or "provisional" (Category II) categories. We agree with CMS that this will result in less confusion as services are nominated to be included on the Medicare Telehealth List, and **urge the Agency to finalize this policy.**

Merit-Based Incentive Payment System (MIPS)

MIPS Performance Threshold

Section 1848(q)(6)(D)(i) of the Act requires that CMS compute the performance threshold such that it is the mean or median of the final scores for all MIPS eligible clinicians with respect to a “prior period” specified by the Secretary. It also provides that the Secretary may reassess the selection of the mean or median every 3 years. In the CY 2022 PFS final rule, CMS established that for the CY 2022 performance period/2024 MIPS payment year through the CY 2024 performance period/2026 MIPS payment year, the performance threshold would be the mean of the final scores for all MIPS eligible clinicians from a prior period. For CY 2022 through CY 2023 performance periods/2024 through 2025 MIPS payment years, CMS selected a single performance period as the prior period to compute the mean of the final scores and establish the performance threshold. However, in this rule, CMS changes course and proposes to revise its policy for identifying the “prior period” on which to base the threshold beginning with the CY 2024 performance period/2026 MIPS payment year so that it is three performance periods (i.e., the mean of the final scores for the CY 2017 through CY 2019 MIPS performance periods). As a result, CMS is proposing to increase the MIPS performance threshold from 75 points to 82 points for the CY 2024 performance period/CY 2026 payment year.

While IDSA appreciates CMS’ rationale for relying on a three-year average, such as minimizing the impact of unusual fluctuations in performance specific to a shorter time frame and mitigating the impact of outliers— we do not believe that the CY 2024 performance year is the appropriate time to adopt this new methodology. **As such, IDSA strongly opposes CMS’ proposal to increase the MIPS threshold for the CY 2024 performance period.** This proposal fails to account for the fact that clinicians are providing care under a healthcare system that is still feeling the impact of the COVID-19 pandemic. Although the public health emergency has officially ended, there are ongoing staffing disruptions and other strains on infrastructure and resources, including CMS’ perpetual Medicare payment cuts to physicians, that will make it challenging for practices to prioritize investments in regulatory compliance with MIPS. CMS estimates that if it finalizes an 82 point threshold for the 2024 performance year, 54% of clinicians could receive a penalty in 2026, with the average penalty being 2.4%. This would devastate physicians, whose Medicare payments are already well below the rate of inflation, while doing very little to move the needle on quality. In fact, it would simply result in a transfer of money from practices that are already struggling to practices that are already well resourced and know equipped to play the game, which seems to contradict CMS’ goal of ongoing quality improvement.

CMS’ proposal to increase the performance threshold also fails to account for the number of clinicians who have relied on the COVID-19 hardship exception since 2019. MIPS was a very different program when these clinicians last participated in terms of reporting rules, measure inventories, and the performance threshold, which was at 30 points. These are the very clinicians that have been struggling to keep up with the administrative cost of compliance and that will be hardest hit if CMS finalizes a higher performance threshold for next year.

MIPS Value Pathways (MVPs)

CMS proposes a new MVP for the CY 2024 performance period titled, “Prevention and Treatment of Infectious Disorders Including Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV).” IDSA had a call with CMS last year during which we provided feedback on a draft version of this MVP. **We appreciate that CMS responded to our concerns by adding additional more broadly applicable quality measures that are relevant to infectious disorders and that**

encourage antimicrobial stewardship, medication reconciliation, and receipt of appropriate immunizations and preventive screenings. While some ID physicians only see HIV patients, others treat a broader population. The proposed expansion of this MVP will make it more accessible to members of our specialty.

At the same time, we have ongoing concerns about the inclusion of the Total Per Capita Cost (TPCC) measure in this MVP. As we have expressed in the past, this measure often captures aspects of care that ID physicians do not have direct control over. It also does not provide meaningful or actionable data to help clinicians hone in on what they can do to lower costs. Most importantly for our specialty is that this measure does not account for the fact that some things that might cost more over the short term actually result in savings and higher quality care over the long term. Similarly, it seems strange to hold clinicians accountable for total cost in the context of a chronic condition like HIV. We should be aiming to promote good stewardship of resources, not simply cost containment. Broad, total cost measures like this could result in harm to the patient. The goal should be to do the right thing the first time, even if that is more expensive upfront. We urge CMS and Acumen to work with our specialty to develop cost measures that more accurately reflect the care provided by ID physicians and the unique needs of their patients.

Overall, IDSA continues to have reservations about the manner in which MVPs are being implemented, and we question whether the framework goes far enough in terms of fundamentally fixing aspects of the program that have long prevented meaningful participation by our specialty. As IDSA has repeatedly expressed to CMS, the MVP framework does little to resolve the ongoing lack of relevant measures available to largely hospital-based cognitive specialists, such as ID physicians. Aside from the HIV and HCV quality measures, which are meaningful to only a small proportion of ID physicians in the outpatient setting who focus on these disease areas (as opposed to general ID), there are very few ID-specific measures on which ID physicians can report to avoid payment penalties. We remind CMS that ID physicians are not “proceduralists,” but rather non-proceduralists/cognitive physicians who provide most of their services using Evaluation & Management (E/M) codes, many of which are billed in the inpatient setting. Our specialty’s unique billing and practice patterns have made it challenging to develop additional quality measures that are feasible to report under a program like MIPS. Since 2013, IDSA has dedicated efforts to developing ID relevant clinical quality measures, such as the 72-hour Review of Antibiotic Therapy for Sepsis, Appropriate Use of Anti-methicillin Resistant Staphylococcus aureus Antibiotics, and Appropriate Treatment of Initial Clostridium difficile Infection to help fill this gap, but these measures have consistently been rejected by CMS when submitted for the Annual Call for Measures.

Unfortunately, the MVP framework relies on the current inventory of MIPS quality measures and does little to incentivize the development or use of more innovative and meaningful measures. IDSA encourages CMS to adopt policies to address these shortcomings and to work with professional societies to increase the number of relevant clinical quality measures. **IDSA would greatly appreciate an opportunity to partner with CMS to explore the development of new measures to populate future MVPs for infectious diseases conditions that are reportable by multiple specialties within the hospital setting.**

We also encourage CMS to expand opportunities for facility-based clinicians to get MIPS credit for outcomes they contribute to within their institutions, which might be measured under a separate CMS quality program. The number of clinicians who have qualified for facility-

based scoring under MIPS to date has been lower than expected, which might signal a need to re-evaluate and update this policy. Doing so would not only provide ID physicians with a more meaningful participation pathway, but would also promote team-based approaches to care and minimize duplicative reporting.

Quality Category Measures

CMS proposes substantive changes to measure #45: One-Time Screening for HCV for all Patients. CMS proposes to revise this measure to include follow-up testing for HCV and, if viremia is detected, that treatment is initiated, or patients are referred to a clinician who treats HCV infection. This will be accomplished by stratifying the measure to create submission criteria (with corresponding performance rate) for patients who have never been tested for HCV antibodies and who receive an HCV test, and a submission criterion (with corresponding performance rate) for patients who have a reactive HCV antibody test and, if HCV viremia detected, have treatment initiated or referral for treatment. This revision would be reflected within multiple components within the specification.

IDSAs support these revisions, which will help to ensure actions are being taken once a screening is completed so patients receive the appropriate care resulting in positive health outcomes.

Quality Category Data Completeness Criteria

CMS proposes a Quality category data completeness threshold of 75% for performance years 2024 through 2026, and 80% for 2027. **As IDSA has stated in the past, we urge CMS not to increase the data completeness threshold.** In addition to our concerns about clinicians re-entering the program after not participating for the past few years, we are also concerned about the impact a higher data completeness threshold would have on facility-based clinicians. Many of our members are facility-based and often provide services across multiple sites that might not all participate in MIPS or use the same EHR. Even among those who practice in a single facility, they might not have direct control over their EHRs or the ability to obtain data in a timely or complete manner, which makes a higher data completeness threshold more challenging.

RFI: Publicly Reporting Cost Measures

For several years, CMS provided cost measure scores to clinicians for informational purposes only and did not publicly report clinicians' performance in this category. However, given the number of cost measures CMS has adopted in MIPS for at least two years and the PHE ending, it is evaluating ways to publicly report performance on cost measures beginning with data from the 2024 performance period being publicly reported in 2026. In this rule, CMS seeks feedback on this topic in preparation for a future date when it would formally propose through rulemaking to publicly report MIPS cost measures.

Given the lack of specifically relevant cost measures to our specialty and our concerns with the applicability of the TPCC cost measure, as expressed above, IDSA opposes CMS publicly reporting cost measure data at this time.

Improvement Activities

CMS proposes to add a new Improvement Activity to MIPS titled, "Improving Practice Capacity for HIV Prevention Service," which it also proposes to add to the "Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV" MVP. This medium-weighted activity would

recognize clinicians and practices that establish policies and procedures to improve practice capacity to increase HIV prevention screening, improve HIV prevention education and awareness, and reduce disparities in pre-exposure prophylaxis (PrEP) uptake.

IDSA supports the proposed HIV Prevention Improvement Activity to incentivize more clinicians to integrate HIV screening and prevention into routine clinical care to improve health outcomes and reduce health care expenditures. The Centers for Diseases Control and Prevention estimates that [13 percent of people in the U.S.](#) with HIV do not know it and only [30% of people](#) who could benefit from PrEP have been prescribed it. The proposed IA activity that would require clinicians to attest to implementing electronic health record prompts or clinical decision support tools to increase screening and require them to complete at least one educational opportunity on HIV prevention screening and PrEP initiation should help to increase the number of providers prescribing PrEP, and by expanding the provider pool reduce the significant disparities in PrEP access where only 11 percent of people who identify as Black/African American and 20 percent who identify as Hispanic/Latinos have been prescribed it. We also support the alternative attestation to assessing and refining policies for HIV prevention screening to integrate sexually transmitted infection and HIV testing processes, universal HIV screening and PrEP initiation.

We thank the agency for your consideration of our comments and hope to work with you to address the urgent needs of ID physicians. For additional information, please contact Amanda Jezek, IDSA senior VP of public policy and government relations at ajezek@idsociety.org.

Sincerely,



Carlos del Rio, M.D,

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