Deregulation of Medicare Program RFI Question Responses

CMS is seeking specific information from health care providers, researchers, stakeholders, health and drug plans, and other members of the public to inform the development and implementation of strategies to support the goals of the aforementioned EO. Specifically, CMS invites responses on the following topics:

Streamline regulatory requirements

- Q: Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents or policy statements) that could be waived, modified or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?
    - A: IDSA strongly urges CMS to review and streamline the documentation requirements associated with evaluation and management (E/M) services, particularly for inpatient care. The current regulations require ID physicians to spend excessive time on duplicative or low-value documentation, detracting from direct patient care and contributing to physician burnout. Streamlining these requirements – such as eliminating redundant elements in progress notes and allowing more flexibility in documentation for complex infectious diseases cases – would reduce administrative burden while maintaining patient safety and care quality. IDSA has concerns with the electronic health record (EHR) having to be built out within individual health systems before billing for any new add-on codes. Streamlining this process via EHRs to automate would be helpful. Modifications in these areas would allow ID physicians to devote more time to patient care, antimicrobial stewardship and infection prevention initiatives, while ensuring that the value and complexity of ID care are fully recognized and appropriately reimbursed.
    - These administrative burdens exacerbate known guideline-practice gaps, where front-line ID specialists struggle to reconcile evidence-based recommendations with inflexible regulatory demands. Studies show that overly complex or impractical requirements – such as rigid progress note templates or excessive attestations for infection control compliance – lead to clinician burnout and reduced adherence to best practices (PMC7166687, PMC7173761). For instance, CMS' current emphasis on volume-driven metrics fails to account for the cognitive labor involved in managing complex infections (e.g., multidrug-resistant organisms), which IDSA guidelines prioritize but Medicare policies inadequately value.
    - IDSA recommends aligning Medicare documentation standards with modern IDSA guideline frameworks, which emphasize flexibility, interoperability and outcomes over process measures. Streamlining redundant elements (e.g., eliminating duplicate HAI reporting to both NHSN and Medicare) and adopting automated data extraction tools would reduce burdens while preserving program integrity.
- Q: Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?
    - A: The most significant administrative burdens for ID physicians stem from the duplexity and volume of quality reporting requirements across multiple quality programs, as well as the siloed nature of the Merit-Based Incentive Payment System (MIPS), which results

in clinicians needing to report measures in each individual MIPS category even though there is a lot of overlap in activities across those categories. Infectious diseases physicians would benefit if CMS provides multicategory credit on measures that touch multiple categories (e.g., EHR-based quality reporting should contribute to both quality and PI categories). Additionally, CMS could expand cross-program credit so that MIPS clinicians receive credit for relevant reporting in other quality programs (e.g., either expanding or basing off the facility-based scoring currently in place in MIPS).
    - Additionally, IDSA has a few concerns regarding the SEP-1 measure from a burden perspective. For instance, measure specifications undergo frequent updates to align with changes in national guidelines and to address technical issues, which can make it difficult for hospitals/clinicians to implement in terms of educating staff and updating their EHRs. Also, chart abstraction for the measure can be time and resource intensive and duplicative of other efforts that hospitals are undertaking around quality improvement. Currently, SEP-1 is a process-oriented measure that does not evaluate patient concerns, and the definition used in SEP-1 has poor specificity and results in overprescribing of antimicrobials.
- Q: Are there specific Medicare administrative processes, quality or data reporting requirements that could be automated or simplified to reduce the administrative burden on facilities and providers?
    - A: IDSA recommends that CMS reduce the frequency of certain required reports, particularly those that have not demonstrated clear value in improving patient outcomes. For example, annual reporting of unchanged protocols or infection prevention plans could be shifted to a biennial schedule, provided there are no significant changes in practice or outcomes. Additionally, CMS should consider adopting a risk-based approach to documentation audits, focusing on providers or facilities with higher rates of noncompliance or adverse outcomes, rather than applying blanket requirements to all. Simplifying the attestation process for participation in quality programs and eliminating redundant documentation – such as requiring the same information in multiple locations – would further reduce unnecessary administrative burden.
    - IDSA also recommends automating data extraction from EHRs for commonly reported measures and developing more ID-specific quality measures that reflect the value of infection prevention, antimicrobial stewardship and management of complex infections.

<u>Opportunities to reduce administrative burden of reporting and documentation</u>

- Q: What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?
    - A: IDSA recommends that CMS streamline reporting and documentation by adopting standardized templates and allowing for greater use of EHR automation. For example, enabling autopopulation of commonly required data elements and reducing duplicative entry across different forms would lessen administrative workload without sacrificing oversight. CMS should also prioritize the elimination of low-value or outdated documentation requirements that do not directly contribute to patient safety or quality

improvement. Additionally, CMS could implement attestation-based reporting for certain measures, allowing providers to confirm compliance without extensive narrative documentation. These changes would help ID physicians focus more on patient care while maintaining the integrity and goals of the Medicare program.

- Q: Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?
    - A: Yes, there are significant opportunities to reduce both the frequency and complexity of reporting for Medicare providers. IDSA urges CMS to consider shifting from annual to biennial reporting for measures where clinical practices and outcomes remain stable, such as infection prevention protocols that have not changed year to year. CMS should also explore consolidating overlapping reporting requirements across different programs and agencies, allowing providers to submit a single report that fulfills multiple obligations. Simplifying measure specifications and reducing the number of required data points – especially for specialties like infectious diseases where many current metrics are not directly relevant – would further decrease burden. These steps would preserve program integrity while freeing up provider resources for direct patient care and quality improvement initiatives.
- Q: Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number.
    - A: IDSA has identified that the documentation requirements for inpatient E/M services, particularly those related to history and physical exam elements, are often redundant and do not always contribute to clinical decision making. For example, CMS Form 1500 (OMB Control Number 0938-1197) and the requirements associated with MIPS quality measure reporting frequently require ID physicians to document the same information in multiple formats or systems. This redundancy is exacerbated by the lack of interoperability between EHR platforms, which forces providers to re-enter data that should be automatically transferred. IDSA recommends that CMS harmonize these requirements and leverage health IT to enable single-entry documentation that satisfies multiple reporting needs.
    - Prior authorization remains a major burden for ID providers, especially for antimicrobials, diagnostics and OPAT. IDSA recommends that CMS streamline or waive prior authorization for evidence-based ID treatments. Current delays in prior authorization can compromise timely care for serious infections. IDSA encourages the adoption of real-time electronic prior authorization tools.

<u>Identification of duplicative requirements</u>

- Q: How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting or compliance monitoring?
    - A: IDSA encourages CMS to adopt a flexible, outcomes-focused approach that prioritizes alignment with evidence-based best practices in infectious diseases. For telemedicine, CMS should maintain and expand the flexibilities introduced during the COVID-19 public health emergency, including payment parity and relaxed geographic restrictions, to

support ongoing access to ID expertise in underserved areas. In digital health and integrated care, CMS should incentivize the use of interoperable EHRs and clinical decision support tools that facilitate coordinated care for patients with complex infections. By focusing on outcomes and supporting innovation, CMS can promote high-quality, patient-centered care without introducing additional regulatory burdens.

- Q: How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health and integrated care systems?

    - A: Medicare can better align its requirements with best practices and industry standards by emphasizing flexibility, interoperability and outcome-based approaches rather than introducing additional regulatory mandates. In telemedicine, CMS should maintain and expand the flexibilities established during the COVID-19 public health emergency, such as payment parity, expanded practitioner eligibility and relaxed geographic restrictions, to ensure continued access to infectious diseases expertise in underserved and rural areas. For digital health and integrated care, CMS should prioritize alignment with FDA and industry standards for device approval and data interoperability, enabling seamless integration of new technologies and remote monitoring tools into clinical workflows without creating duplicative or conflicting requirements. CMS can further support best practices by incentivizing the adoption of evidence-based care coordination models, facilitating data sharing across providers and payers, and streamlining quality reporting to focus on meaningful, specialty-relevant measures. IDSA also recommends extending telehealth flexibilities introduced during the COVID-19 PHE and support cross-state licensure compacts or waivers for ID consults. IDSA also recommends that CMS expand eligible originating sites and reimbursement parity for virtual ID services. By collaborating with stakeholders and leveraging existing industry frameworks, Medicare can support innovation and high-quality care while minimizing unnecessary administrative burden.

Additional recommendations

- Q: We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on health care providers and suppliers that participate in the Medicare program.

    - A: IDSA recommends that CMS establish a formal process for ongoing stakeholder engagement to identify and address administrative burdens as they arise, particularly for subspecialties like infectious diseases that face unique challenges. CMS should also consider piloting demonstration projects that test streamlined documentation and reporting requirements for ID physicians, with the goal of scaling successful approaches across the program. CMS should recognize and reward the value of complex cognitive care provided by ID specialists – such as outbreak response, infection prevention and antimicrobial stewardship – by ensuring that payment models and quality measures accurately reflect the time, expertise and impact of these services. Reducing administrative burden in these areas will help sustain the ID workforce and improve patient outcomes in Medicare.

- Additionally, IDSA strongly urges that CMS maintain the Infection Prevention and Control and Antibiotic Stewardship Conditions of Participation requirements for hospitals and health care facilities. These requirements are foundational to patient safety and are critical in combating antimicrobial resistance, which remains a growing global threat. Effective infection prevention and stewardship programs have been shown to reduce health care-associated infections, improve clinical outcomes and lower health care costs. Weakening these standards would undermine national efforts to control the spread of resistant organisms and jeopardize progress made in safeguarding both individual patient health and public health. Beyond strengthening the standards, guidance and expectations regarding appropriate staffing of programs for safe operations (i.e., expected hires/100 hospital beds) should be clearly delineated.
- The lack of regulation and policy by CMS sometimes creates challenges, as noted with outpatient parenteral antimicrobial therapy (OPAT). There are S codes that can be used in the private sector, but those are not billed to Medicare. Providers do not have a clear pathway to bill for ongoing OPAT care outside of billable clinic visits and have to find other ways to bill for a service that saves the government money.