AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

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The Honorable Stephanie Carlton
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Reducing Regulatory Burden in the Merit-based Incentive Payment System

Dear Acting Administrator Carlton:

On behalf of the physician and medical student members of the American Medical Association (AMA), we greatly appreciate the Trump Administration's emphasis on reducing regulatory burden. The AMA believes there is no better opportunity to fulfill Executive Order 14192, *Unleashing Prosperity Through Deregulation,* than by cutting the morass of complicated rules and requirements for compliance with the ineffective Merit-based Incentive Payment System (MIPS) program in the 2026 Medicare Physician Fee Schedule (MPFS) proposed rule.

Despite being implemented in 2017, MIPS has yet to demonstrate better health outcomes for Americans or lower avoidable spending. Nevertheless, the program imposes steep compliance costs on physicians. In 2021, one *Journal of the American Medical Association (JAMA)* Health Forum study found that physicians spent $12,800 and 202 hours per year to comply with MIPS. In the 2025 MPFS final rule, CMS estimated the total burden on the U.S. health care system due to the MIPS reporting requirements finalized for CY 2025 would be 586,877 hours and $70,166,672. Even worse, the program disproportionately hurts small and rural practices, which are small businesses, by cutting their Medicare reimbursement up to -9 percent despite being "approximately as effective as chance in terms of identifying high versus low quality performance," according to a *JAMA* study.

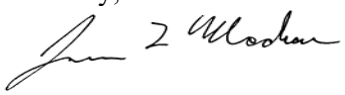
In the attached appendix, the AMA provides detailed recommendations and accompanying statutory authority to make urgently needed improvements that will reduce the regulatory burden of MIPS, including:

- Awarding multi-category credit and ensuring MIPS Value Pathways are clinically relevant so patients can compare quality and cost across physician practices.
- Reducing unnecessary quality measure reporting burden and eliminating arbitrary scoring rules that drive up the cost of compliance with MIPS and disincentivize reporting on new and substantially revised measures.
- Fixing the long-standing inaccuracies with the MIPS cost measures and nullifying their negative impact on Medicare physician payment and patient access to care until these issues can be properly addressed.
- Sharing timely, critical MIPS performance data and Medicare claims data with physicians to facilitate better quality and lower costs.

- Maximizing usage of electronic health records and other emerging technologies while minimizing wasteful "check the box" reporting exercises.

The AMA stands ready to work with CMS to implement our recommendations for MIPS deregulation. Should you have any questions about this letter, please do not hesitate to contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,



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APPENDIX
AMA Analysis: MIPS Deregulatory Improvements and CMS Authority

1. **Award multi-category credit and ensure MIPS Value Pathways (MVPs) are clinically relevant so patients can compare quality and cost among physician practices.**

MIPS Improvement Recommendation	Reasoning/CMS Authority
Provide multi-category credit for aligned measures across MIPS categories. The goal of MVPs is to provide a look at the value of care by grouping similar cost and quality measures in MIPS. The AMA has a long history of calling for reducing reporting burden and increasing the alignment between MIPS categories by awarding multi-category credit. A multi-category credit scoring structure would provide physicians with credit across categories for performing certain activities that touch on multiple MIPS categories. For example, if a physician participates in a qualified clinical data registry, the physician should receive credit in quality, cost, Improvement Activities, and Promoting Interoperability. The AMA outlined this recommendation in detail in a 2018 letter to CMS.	The MIPS provisions in the MACRA statute recognize that the four performance categories have some conceptual overlap. For example, as to the overlap between the quality category and the PI category, (q)(2)(B)(iv) incorporates the provisions of (o)(2) on determining meaningful EHR use, and in turn (o)(2)(B)(i)(I) requires CMS to "provide preference to clinical quality measures that have been endorsed by the entity with a contract . . . under section 1890(a)." CMS has previously used this overlap in their prior rulemaking and regulations, such as 42 CFR §414.1380 which provides that, in the scoring of the quality performance category, bonus points can be provided for using end-to-end electronic reporting. See 81 Fed. Reg. 77008, 77099, 77296 (11-4-2016). In addition, nothing in the MIPS provisions of the MACRA statute prohibits CMS from awarding credit in multiple performance categories, as described in the above examples. Moreover, CMS has great discretion in developing the methodology that is used to establish performance measures and score a physician's performance for purposes of the MIPS adjustment. While it is true that (q)(2)(B) specifies particular types of measures that must be included for each of the four performance categories, a particular measure can be broad enough to cover activities in more than one category. As long as the physician's particular activity or multi-category measure satisfies the requirements in each of the multiple categories involved, the physician should receive credit in each of those categories. For example, to receive credit in both PI and Quality for reporting a quality measure through an EHR, CMS could simply develop a multi-category

	measure for reporting a quality measure through an EHR (e.g., PI_MCC_Quality).
Develop clinically relevant MVPs based on patient condition, episode of care, and clinical priority areas, not by specialty. Rather than arbitrarily limit MVPs to one per specialty, CMS should work with the national medical specialty societies to prioritize MVPs that hold physicians providing similar services accountable to one set of measures to inform patients about where to find the care that meets their expectations, incentivize care teams to partner with patients to achieve patient goals, and help inform care teams about areas in need of improvement. As currently drafted, most finalized and proposed MVPs repeat many of the problems with traditional MIPS—notably a lack of clinical relevance to physicians and the way they practice, as well as individualized patient needs.	The statute is silent regarding the required focus of measures and/or measure weights. Section 1848(q)(2) provides broad authority to the Secretary to establish measures and activities under the performance categories (which has enabled the creation of MVPs). Section 1848(q)(10) of the SSA requires the Secretary to consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities specified for each category, the methodologies for the composite performance score, and regarding the use of qualified clinical data registries.
To incentivize participation in MVPs, reduce the burden of MVPs. The changes finalized to date (e.g., reporting as few as four rather than six quality measures) are modest and may not offset the added burdens of reporting MVPs, such as forming a new subgroup. As CMS' reasons for moving to MVPs include better alignment of measures and activities and reducing reporting burden, we urge CMS to increase scoring simplicity and predictability by not imposing additional restrictions, such as requiring reporting on a certain minimum number of measures or by assigning varying measure weights. CMS should propose removal of these complicated scoring and reporting requirements via rulemaking.	The statute is silent regarding the required focus of measures and/or measure weights. Section 1848(q)(2) of the SSA provides broad authority to the Secretary to establish measures and activities under the performance categories (which has enabled the creation of MVPs). Section 1848(q)(3) of the SSA provides broad authority to the Secretary – providing only three, general guiding principles – to establish performance standards with respect to measures and activities. Therefore, it would be within the authority of CMS to make changes to performance standards for measures within MVPs.
Remove or tailor population health quality measures, which CMS has added as a foundational MVP requirement and new category on top of the general quality measure requirements and the three other MIPS categories. While measuring improvement on population health is important, this should be incorporated into existing criteria and tailored to the MVP to avoid unnecessary complexity. CMS should not require a population health measure for each MVP and/or add a new population health category. If the category is not	The statute is silent regarding the required focus of measures and/or measure weights. Section 1848(q)(2) of the SSA provides broad authority to the Secretary to establish measures and activities under the performance categories (which has enabled the creation of MVPs). Section 1848(q)(3) of the SSA provides broad authority to the Secretary – providing only three, general guiding principles – to establish performance standards with respect to measures and activities.

eliminated, at a minimum, the population health measure should be tailored to the MVP.	
MVPs should remain voluntary. Currently, MVPs are untested, require a significant leap in financial risk for eligible clinicians, and offer little upside compared to traditional MIPS. MVPs will increase administrative burden to most participants in MIPS who currently report as a group and would be required to form subgroups to participate in MVPs. Furthermore, there are not viable participation options for all specialists.	MACRA expressly provided a phase-in of MIPS requirements while gradually increasing the downside financial risk to participants. Requiring a substantial shift in requirements (i.e., making MVPs mandatory) when the financial risk is a -9% payment penalty conflicts with this deliberately phased-in policy approach. Additionally, the statute encourages MIPS participation by groups via combining tax identification numbers (TINs) rather than participation by subgroups (via subdividing TINs). Under 1848(q)(5)(I)(iii), the process for creating a virtual group includes combinations of TINs: "provide that a virtual group be a combination of tax identification numbers…". Section 1848(q)(1)(D) of the SSA requires CMS to establish a process to assess group practices on the quality performance category and enables the Secretary to establish processes for assessing group practices on the other categories.

2. **Reduce unnecessary quality measure reporting burden and eliminate arbitrary scoring rules that drive up the cost of compliance with MIPS.**

MIPS Improvement Recommendation	CMS Authority
Lower the quality data completeness requirement to 60% of eligible patients. This policy does not take into consideration the administrative burdens or technological challenges. Many physicians practice at multiple sites of services and may not be able to access the data needed for reporting (e.g., a physician who provides care in a skilled nursing facility that does not have an EHR and cannot easily share data). Health information technology standards must also mature to seamlessly aggregate data from EHRs or registries as there currently is a lack of agreed upon semantic and syntactic standards, data privacy concerns, and patient misidentification.	Section 1848(q)(3) of the SSA provides broad authority to the Secretary – providing only three, general guiding principles – to establish performance standards with respect to measures and activities. Accordingly, the Secretary has authority to modify performance standards (including the data completeness requirement) for the quality measures.
Eliminate the scoring cap on all topped-out measures and measures without a benchmark. Due to the limited availability of measures for many specialties, the measure cap has resulted in	1848(q)(2)(D)(i)(II)(aa) directs the Secretary to establish an annual final list of quality measures by updating the final list of quality measures from the previous year, to include removing quality

physicians being unable to meet the performance threshold and being ineligible to earn an incentive. Topped out measure rules become more challenging when a physician is subject to re-weighting of one of the categories because the quality category then weighs more heavily, and the physician does not have a chance to earn maximum points. Existing policies for topped out measures significantly harm certain specialties. Furthermore, topped out measures are essential when the goal is cost reduction or control because they ensure savings are not achieved by reducing quality. New measures are needed to fill gaps, but it can take time to develop them and create benchmarks. There also must be incentives to offset the investment and risk of reporting new measures.	measures, as appropriate. This process "may" (but is not required to) include removal of measures that are no longer meaningful (such as measures that are topped out). The statute, however, does not specify a timeline for removal nor does the statute mandate treatment of such an identified measure (while still on the list) for purposes of scoring or reporting. Accordingly, the Secretary has discretion regarding how to treat the measure for scoring purposes while it remains on the list. Additionally, while Section 1848(q)(3)(B) directs the Secretary to consider historical performance standards, improvement, and the opportunity for continued improvement in establishing performance standards, the statute does not further define these terms. Accordingly, the Secretary has discretion in evaluating and applying these considerations, and could consider other factors (including the availability of other measures for certain specialties) in determining how to apply these considerations as well.
Explore a new methodology for scoring measures. The current decile (10 point) approach arbitrarily distinguishes care and does not allow scoring to consider scientific evidence. The methodology also ignores how physicians are scored under Care Compare. As a result, physicians receive two separate and often conflicting scores—one for MIPS incentives and the other for public reporting on Care Compare. CMS should move to a uniform scoring policy across quality programs.	Section 1848(q)(3) of the SSA provides broad authority to the Secretary to establish performance standards with respect to measures and activities. The statute is silent with respect to benchmarks for scoring measures. The 10-decile benchmark methodology was created by regulation and can, therefore, be modified by CMS through rulemaking. Accordingly, CMS should propose revisions to the MIPS quality measure benchmarks that reflect a range of reasonable costs that are permissible for high-quality performers.

3. **Fix the attribution, validity, and reliability problems with the MIPS cost measures and nullify their negative impact on Medicare physician payment and patient access to care until these issues can be properly addressed.**

MIPS Improvement Recommendation	Reasoning/CMS Authority
Remove the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician measures. Measures should only cover costs that physicians can reasonably control. Neither the TPCC nor MSPB clinician measure, as currently specified, can meet that criterion	CMS should propose removal of both cost measures in the 2026 Medicare Physician Payment Schedule (MFS) and Quality Payment Program proposed rule. In the 2020 MFS proposed rule, CMS considered removing the TPCC measure from MIPS. Ultimately, however,

because the measures hold physicians accountable for patients' medical conditions that are managed outside of their organization and for costs they cannot influence, such as drug prices.	CMS decided against removing TPCC at that time because there were few episode-based cost measures that captured primary care spending. Now is the time to revisit whether TPCC is necessary. Unlike in 2020, there are now 33 episode-based MIPS cost measures currently in use and many more in the development pipeline. Many of these measures address the costs of primary care. Further, episode-based cost measures now account for 33.4% of all Medicare Parts A and B spending.
Resolve the problems with the cost measures. For example, the cost measures hurt specialists whose patients incur higher spending when they receive evidence-based care and are misattributed to physicians who are not providing the care being evaluated by the measure. The AMA documented the numerous problems with these measures in a December 18, 2023 letter and an October 27, 2023 letter to CMS. The agency should consult with the national medical specialty societies and clearly and transparently address how it will remedy the problems with these measures. We recommend that the agency release a fact sheet or Frequently Asked Questions document outlining the steps taken to ensure that the cost measures are not unduly and unfairly penalizing physicians for costs outside of their control and outside the intended specifications of the measure. If the necessary changes to address the identified problems with the cost measures cannot be made prior to impacting physician's MIPS scores and Medicare payment, then the Cost Performance Category should be reweighted (on the basis discussed above) or the measures should be excluded (based on the standard set forth in 42 CFR 414.1380(b)(2)(v)(A)) from all applicable MIPS eligible clinicians' scores.	Section 1848(r)of the SSA ["Collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement"] contains numerous mentions of stakeholder consultation. For example, section 1848(r)(5)(D) states that the "Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms." The statutory requirement to seek comments from physician specialty societies regarding the development of the "resource use" (cost performance) methodology inherently requires CMS's consideration and incorporation of relevant and expert comments into the MIPS cost measures. We cannot imagine that Congress would require CMS to only seek, but not to consider and incorporate, these expert insights – as that would be a fruitless and wasteful exercise for all parties. Section 1848(q)(10) of the SSA also requires the Secretary to consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities specified for each category, the methodologies for the composite

	performance score, and regarding the use of qualified clinical data registries. 42 CFR 414.1380(b)(2)(v)(A) provides, "Beginning with the 2024 MIPS payment year, if data used to calculate a score for a cost measure are impacted by significant changes during the performance period, such that calculating the cost measure score would lead to misleading or inaccurate results, then the affected cost measure is excluded from the MIPS eligible clinician's or group's cost performance category score. For purposes of this paragraph (b)(2)(v)(A), 'significant changes' are changes external to the care provided, and that CMS determines may lead to misleading or inaccurate results. Significant changes include, but are not limited to, rapid or unprecedented changes to service utilization, and will be empirically assessed by CMS to determine the extent to which the changes impact the calculation of a cost measure score that reflects clinician performance."
Reweight the Cost Performance Category to zero percent of MIPS final scores to nullify the negative impact of the problematic measures on Medicare physician payment as issues are being addressed.	**Section 1848(q)(5)(F)** of the Social Security Act (SSA) directs the Secretary to reweight the performance categories in cases in which there "are not **sufficient** measures… applicable and available to each type of eligible professional involved." In such cases, the "Secretary shall assign different scoring weights (including a weight of 0)… which may vary from the [specified] scoring weights…". 42 CFR 414.1380(c)(2)(i)(A) further clarifies the circumstances under which there are "not sufficient measures available and applicable under section 1848(q)(5)(F)." These circumstances include: • "For the cost performance category, CMS cannot reliably calculate a score for the cost measures that adequately captures and reflects the performance of the MIPS eligible clinician." 42 CFR 414.1380(c)(2)(i)(A)(2) • "Beginning with the 2020 MIPS payment year, for the quality, cost, and improvement activities performance

	categories, CMS determines, based on information known to the agency prior to the beginning of the relevant MIPS payment year, that data for a MIPS eligible clinician are inaccurate, unusable, *or otherwise compromised* due to circumstances outside of the control of the clinician and its agency." 42 CFR 414.1380(c)(2)(i)(A)(9) These provisions require CMS to reweight the Cost Category based on the fact that flaws in the costs measures make it impossible to reliably calculate a score for any of the affected cost measures that "adequately captures and reflects the performance" of the MIPS eligible clinician. As a result, these measures are inherently insufficient, triggering the statutory reweighting provision.

4. Share timely, critical MIPS performance data and Medicare claims data with physicians to facilitate better quality and lower costs.

MIPS Improvement Recommendation	Reasoning/CMS Authority
Make Medicare claims data and meaningful MIPS attribution, measure, and performance data available on a rolling basis or, at a minimum, on a quarterly basis during the performance period consistent with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Currently, CMS provides physicians with an annual MIPS Feedback Report that includes information about their performance on MIPS metrics six to 18 months after they have provided a service to a Medicare patient. Taking the Cost Category as an example, the cost measures are calculated by CMS on the back end using claims. Physicians do not know at the time they provide services nor at any point during the performance year how they are performing on any of these cost measures that collectively account for 30% of their total MIPS score, including which cost measures they will be measured on, which patients are attributed to them, and for what costs or services provided by other health professionals or facilities outside of their own practices they will be held accountable. Without this information, physicians have no way to	MACRA requires CMS to provide timely MIPS performance feedback and Medicare claims data sharing. Section 1848(q)(12)(A)(i) of the SSA provides, "Beginning July 1, 2017, the Secretary shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals with respect to the [Quality and Cost] performance categories…" Section 1848(q)(12)(A)(iii) of the SSA provides, "the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional." Section 1848(q)(12)(B)(i) of the SSA provides, "Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this title that are furnished to such

monitor their performance, identify opportunities for efficiencies in care delivery, and avoid unnecessary costs.	individuals by other suppliers and providers of services…" Section 1848(q)(12)(B)(ii) of the SSA defines the types of information to be provided as "the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished" for the "most recent period for which data are available (such as the most recent three-month period)" and "historical data, such as averages and other measures of the distribution if appropriate, of the total and components of allowed charges."
Correct inconsistencies in the MIPS public use data files as soon as possible, particularly regarding why so many national provider identifiers (NPIs) are missing from the National Downloadable File. Specifically, there is one file that contains the MIPS scores for each clinician but does not have any information about the clinician other than their name and NPI. The National Downloadable File that accompanies this MIPS score file has information about clinicians, such as their specialties and the names of the group or groups with which they practice. However, we have found that there are almost 100,000 NPIs with a MIPS score that are not included in the National Downloadable File. As a result, it is difficult to drill down in the data to better understand how small practices and rural practices, for example, are performing in MIPS and why this might be the case. Ensuring this data is accurate is critically important to ongoing efforts to understand and improve MIPS, which is a shared goal of the AMA and CMS.	Section 1848(q)(9)(D) of the SSA provides, "The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category." The preceding paragraphs of 1848(q)(9) require the Secretary to make available on Physician Compare the composite score for each MIPS eligible professional and the performance with respect to each performance category and gives authority to the Secretary to make available performance with respect to each measure and activity. While no timing is specified, the information must be provided to the professionals in sufficient time to review it and submit corrections before the information is made public. While these provisions do not require CMS to post the clinician's specialty (or additional information) in connection with their MIPS scores, we believe that ensuring that such data is available and accurate in the National Downloadable File is essential to the goal of providing information to the public regarding quality performance and to enabling important research into quality performance trends.
Clarify the number of unique clinicians participating in MIPS in future Quality Payment Program (QPP) Experience Reports	Section 1848(q)(9)(D) of the SSA provides, "The Secretary shall periodically post on the Physician Compare Internet website aggregate information

and include a breakdown of the different scores unique clinicians receive through multiple groups or Alternative Payment Models (APMs).	on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category."
Expand QPP Experience Reports to include detailed data from both QPP and claims data sources to inform opportunities to improve quality, reduce costs, and develop MIPS Value Pathways (MVPs) and alternative payment models (APMs). Moreover, these reports should display longitudinal trends about whether quality or cost is improving or declining and provide a more complete picture of what makes a particular physician, group practice, or APM successful in MIPS. CMS should also include breakdowns by specialty and practice size. This type of granular data would also enable policy conversations about ways to consistently update and improve benchmarks over time, such as examining whether MIPS cost measures should move toward regional benchmarks similar to those used by accountable care organizations.	Section 1848(q)(9)(D) of the SSA provides, "The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category."

5. Maximize usage of electronic health records and other emerging technologies while minimizing wasteful "check the box" reporting exercises.

MIPS Improvement Recommendation	CMS Authority
All Promoting Interoperability (PI) measure reporting should be done through "yes/no" attestations.	CMS's authority to require Promoting Interoperability (PI) participation and certified electronic health record technology (CEHRT) use originates from the Health Information Technology for Economic and Clinical Health (HITECH) Act. Congress specified in HITECH that an eligible professional can satisfy the demonstration of meaningful use of CEHRT and information exchange through attestation (Section 1848(o)(2)(C) of the SSA). HITECH also permits reporting via "other means specified by the Secretary," granting the Secretary the authority to minimize CEHRT measure reporting through alternative, less burdensome methods.
Reverse mandatory reporting of PI data for all Medicare Shared Savings Program (MSSP) participants (regardless of Qualified APM Participant (QP) status), which started in 2025. This moves the Quality Payment Programs in the	The MACRA statute states "the term MIPS eligible professional does not include… an eligible professional… who is a qualifying APM participant… [or] a partial qualifying APM participant." Section 1848(q)(1)(C)(ii) of the SSA.

wrong direction; we should be shifting MIPS to emulate APM requirements, not vice versa. Furthermore, this change is directly at odds with the MACRA statute, which expressly states that qualifying APM participants are not MIPS eligible professionals, and therefore are not subject to reporting MIPS data. Instead, we believe CMS should leverage existing data from other sources, including ASTP/ONC, to demonstrate CEHRT utilization while minimizing reporting burden on APM participants. To move toward APM adoption, CMS should expand the more flexible CEHRT standard for APM participants to MIPS participants, not move in the opposite direction.	Previous CMS guidance also states: "QPs receive the following benefits, which include burden reduction and financial incentives: Exclusion from MIPS reporting …" Where the MACRA statute discusses CEHRT requirements for Qualifying APM participants, it says only that "certified EHR technology is used." Section 1833(z)(2)(B) and (C). We believe this broad definition of CEHRT utilization was intentional to achieve MARCA's goal of minimizing burden to encourage APM adoption and that attestation to using CEHRT technology, as has been the standard up until now, is both a sufficient and effective method to demonstrate utilization of CEHRT for APM participants.
Restore 75% CEHRT utilization threshold for Advanced APM participants. The AMA supports CMS's change to make the definition of CEHRT more flexible so it can be customized to the specific uses and needs of each APM. However, we believe that the accompanying proposal to remove the 75% CEHRT utilization threshold is a mistake. Requiring "all" participants to utilize CEHRT unless they receive a specific exemption will introduce significant, unnecessary burden for APM participants and CMS staff, and potentially discourage participation in APMs. As noted above, we believe CMS should leverage existing data from other sources, including ASTP/ONC, to demonstrate CEHRT utilization while minimizing reporting burden on APM participants.	Where the MACRA statute discusses requirements for Qualifying APM participants, it says only that "certified EHR technology is used." Section 1833(z)(2)(B) and (C). We believe this broad definition of CEHRT utilization was intentional to minimize burden and incentivize participation in APMs. We believe the burdensome requirements CMS continues to impose defies this statutory intent.