November 16, 2015

The Honorable Andy Slavitt,
Acting Administrator,
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
Submitted electronically at: http://www.regulations.gov

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 Administrator Slavitt:

The American Medical Informatics Association (AMIA) appreciates the opportunity to submit comments regarding this Request for Information (RFI) on implementation of the Merit-based Incentive Payment System (MIPS), promotion of Alternative Payment Models (APMs), and incentive payments for participation in Eligible Alternative Payment Models (EAPMs). This RFI was published by the Centers for Medicare & Medicaid Services (CMS) in the October 1, 2015, issue of the *Federal Register*.

AMIA is the professional home for more than 5,000 informatics professionals, representing researchers, front-line clinicians and public health experts who bring meaning to data, manage information and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA members play a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across settings and patient populations.

We appreciate your recognition of the need to seek broad stakeholder input on the next-generation payment system for physicians through this RFI. While the RFI contains numerous questions, across several facets of how best to implement MIPS and promote APMs, we focus our comments on the technological and informational underpinnings of the programs, including:

- Certain aspects of the Quality Performance Category, such as reporting mechanisms, data accuracy, and the use of Certified EHR Technology (CEHRT);
- The Meaningful Use (MU) Performance Category;
- The use of CEHRT in the promotion of APMs; and
- Clinical Practice Improvement Activities (CPIA).

Before we address specific sections and questions posed by the RFI, available in the attached document, we wish to highlight some overarching comments.

Quality Measurement in support of Value-based Payment

AMIA supports the overall direction of moving to an outcomes-based payment system, predicated on demonstrating value for payment. As we transition away from fee-for-service payment, so too must we move away from the quality measurement paradigm underlying that system. Despite earnest efforts, quality measurement has not become "a by-product of care delivered," as envisioned, but rather an end unto itself. We are concerned the current mode is insufficient to enable the desired state – especially as it relates to electronic clinical quality measures (eCQMs).[1] The focus on collecting numerous, process measures that may not reflect a patient-centered perspective on quality needs to be replaced by focusing on a more targeted number of important outcome measures.

AMIA recommends that federal officials do not reflexively expand the current approach to quality measurement in developing these new policies. Rather, opportunities should be sought to retire existing process-based measures while looking for ways to develop more outcomes-based measures. New process-based measures should be added only after carefully considering the impact on physician workflow and documentation time and assuring that the value the measure will provide is greater than the burden imposed on physician workflow. To improve the current approach, officials should devote more resources to testing both the accuracy of the measure calculation as well as the feasibility of the data collection requirements, and pilot all new eCQMs before their release for use; establish a regular cadence of updates/revisions to eCQMs, ensuring adequate time is allowed for implementation of revisions by both the vendor and provider; and ensure that all information and tools located in the eCQI Resource Center are complete and up-to-date. Likewise, CMS should enhance current testing and validation tools by improving the kind of information conveyed in error reports during testing and submission. Lastly, closer integration between ONC certification requirements and CMS "form and manner" requirements will improve the ability of certified technology to produce accurate and complete eCQMs.

Adoption and Use of Health IT in the Value-based Era

As it relates to meaningful use and the policies meant to encourage adoption of certified technology, we wish to highlight two observations of the current state meant to provide context to our recommendations. First, the optimal information systems infrastructure for managing population health or analytics functions is not yet well understood. Unlike computerized provider order entry (CPOE) or e-prescribing (eRx), which are well-defined functionalities to which harmonization through certification has value-add, we do not yet have enough experience with how population health and other APM tools and functionalities should be defined to a degree that certification could or would provide needed value. Innovation should be encouraged and we are concerned that relying on certification prematurely may thwart such innovation.

[1] Amster A., Jentzsch J., et al. "Completeness, accuracy, and computability of National Quality Forum-specified eMeasures," J Am Med Inform Assoc 2015;22:409–416. http://bit.ly/1RpUiRb

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Second, we are increasingly convinced that certification and meaningful use-related measurement requirements have had the serious and unintended consequence of limiting the design and innovation of EHRs to-date. The developer community continues to warn that certification-related regulatory burdens inhibit their ability to make customer-prioritized functionality and usability enhancements to their products. Meanwhile, providers' concerns over usability and interoperability are well-documented. We are concerned that a focus on conformance to certification criteria has inadvertently led to a "develop-to-the-test" approach, and has affected the functionality and usability of EHRs in ways not sought or prioritized by clinicians. This dynamic is likely an important contributing factor to the challenges faced by vendors and providers alike, and it should be examined further as the federal health IT certification program evolves.

Ours is a dynamic environment of innovation and invention. AMIA sees policy development for MIPS and APMs as not just an opportunity to change our payment system, but as an opportunity to revisit policies meant to spur adoption and guide use of health IT. In much the same way that fee-for-service era policies skewed incentives and provider behavior, overly prescriptive documentation and "use" requirements of the same era have influenced how health IT is developed, implemented and leveraged to improve care.

AMIA recommends federal officials avoid overly prescriptive requirements to determine how providers use informatics tools, but rather focus on the outcomes sought by the use of such tools. We recommend that "use" of certified technology be outcome-oriented and loosely defined for APMs, and other value-based models. For example, "use" could more closely reflect the definition of "adopt, implement, or upgrade" as defined by the Medicaid EHR Incentives Program. Another option would be to require APM participants to demonstrate the ability to perform a task that requires advanced use of informatics tools, such as the ability to generate, receive and integrate a standards-based electronic patient summary (e.g., C-CDA). For providers engaged in MIPS, the definition of "use" will depend on factors outside the scope of this RFI. Nevertheless, we encourage CMS be cognizant that success of MIPS will depend greatly on the success of the EHR Incentive Program.

Further, we recommend that any efforts to certify health IT functionalities related to population health and analytics meet some threshold of "demonstrated need." We are concerned that certification in this emerging area may hinder development of new features and functionalities that have not yet come to the marketplace. By developing a framework to evaluate "demonstrated need," stakeholders can debate the rationale for certification versus other means of conformance, and officials can more confidently identify when certification is likely to have the intended impact.

<u>Implementation Timelines</u>

We also appreciate the amount of work regulators must accomplish before such a paradigm can replace the current fee-for-service reimbursement system. With statutory deadlines coming into force in 2019, we encourage regulators to structure implementation of MIPS, APMs, EAPMs and Physician-Focused Payment Models (PFPMs) cognizant of the unlikely scenario that the ideal or

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long-term structure of these programs will be in place by January 1, 2017, the start of the first MIPS reporting year. Rather, we suggest CMS take a stepwise approach to implementation, focusing first on the foundational requirements needed to reimburse physicians based on quality and performance.

AMIA recommends that federal officials develop a public implementation roadmap, aligned with HHS goals for shifting Medicare reimbursements from volume to value.[2] This roadmap should clearly articulate the CMS quality strategy, beginning with a focus on accurate, complete and valid eCQMs. If CMS continues its plan to require electronic submission of CQMs, and payment depends on those quality measures beginning in 2017, all stakeholders must be confident that those eCQMs represent an accurate picture of care delivered. Over time, iterative harmonization in the number of CQMs and data submission pathways can take place as stakeholders gain experience with these programs.

We hope our comments, attached below in Table 1, are helpful as you undertake this important work. Should you have questions about these comments or require additional information, please contact Jeffery Smith, Vice President of Public Policy at jsmith@amia.org or (301) 657-1291. We look forward to continued partnership and dialogue.

Sincerely,

Douglas B. Fridsma, MD, PhD, FACP, FACMI
President and CEO
AMIA

Blackford Middleton, MD, MPH, MSc
Harvard TH Chan School of Public Health
Chairman
AMIA Board of Directors

[2] Department of Health and Human Services, "In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," Jan. 26, 2015 http://1.usa.gov/1kMBssI

Table 1: AMIA Comments to Select RFI Questions

IMPLEMENTATION OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)			
MIPS Quality Performance Category			**AMIA Comments**
MIPS	**Quality**: Reporting Mechanisms & Criteria **Q1**	Should CMS maintain all PQRS reporting mechanisms currently available for MIPS?	We suggest CMS maintain all reporting mechanisms in the near-term while determining if all options are equally utilized as well as produce the desirable result of demonstrating value. We suspect that some options are more popular than others, and we suspect that some options are better suited to ensure data are complete, accurate and conform to standards. We suggest devising a way to monitor and evaluate reporting mechanisms, looking for ways to reduce reporting burden over time.
MIPS	**Quality**: Reporting Mechanisms & Criteria **Q2**	What policies should be in place for determining which data should be used to calculate a MIPS EP's quality score if data are received via multiple methods of submission? What considerations should be made to ensure a patient's data is not counted multiple times? (E.g., if the same measure is reported through different reporting mechanisms, the same patient could be reported multiple times).	Intentionally left blank
MIPS	**Quality**: Reporting Mechanisms & Criteria **Q3**	Should CMS require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender?	While acknowledging the benefits of being able to stratify data by demographic characteristics, especially from a public health and population health management perspective, we urge caution against requiring more data collection to do so. To strike a balance, we recommend CMS limit stratification criteria to those already being captured, for example, demographics currently gathered as part of Meaningful Use.

MIPS	**Quality**: Reporting Mechanisms & Criteria **Q4**	What are the potential barriers to successfully meeting the MIPS quality performance category?	Without question, the biggest potential barrier to successfully meeting the MIPS quality performance category would be continued reliance on process-oriented quality data, such as those currently being captured using certified technology. Such an approach may not be reflective of a patient-centered vision of quality and may degrade physician efficiency for questionable value. Payment contingent on quality data puts a high degree of pressure for such data to be accurately reflective of care, and today's quality measurement paradigm reflects only a partial picture of care delivered. The focus on collecting numerous, non-reflective process measures needs to be replaced by focusing on a few important outcome measures. If MIPS expands on the current model, the opportunity to devise a better system will be lost. While we are cognizant of the difficulty in developing outcome measures, we do not believe it a sufficient enough reason to carry forward the current model of process measures.
MIPS	**Quality**: Data Accuracy **Q5**	What should CMS require in terms of testing of the qualified registry, QCDR, or direct EHR product, or EHR data submission vendor product? How can testing be enhanced to improve data integrity?	In our view, there are two types of testing that must occur to better ensure accurate, complete quality measurement: (1) testing for individual, specific quality measures and (2) testing for valid submission of quality measures, generically, based on CMS requirements. To improve the first kind of testing, CMS should put more emphasis on testing both the accuracy of the measure calculation as well as the feasibility of the data collection requirements and include piloting all new eCQMs before their release for use, establish a regular cadence of updates/revisions to eCQMs, ensuring adequate time is allowed for implementation of revisions by both the vendor and provider and ensure that all information and tools located in the eCQI Resource Center are complete and up-to-date. To improve the second type of testing, CMS should enhance current testing and validation tools. We note significant misalignment between what ONC's certification program requires and what CMS requires in order to successfully submit quality data.

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			ONC's certification program contains certain requirements for quality measures, such as the ability to record, calculate, report, import, and export clinical quality measure (CQM) data. But these requirements are not sufficient to meet CMS requirements, which are more complicated, specific and dynamic. At a minimum, this gap must be closed, insofar as it is practical to do so. We recommend that CMS work with ONC so that certification yields better assurance to providers that CQM data gathered and calculated will be successfully accepted by CMS. Multiple changes to requirements for eCQM throughout any given program year, and from program year to program year, make it difficult for vendors to modify their products. Changes to Cypress, multiple updates to versions of QRDA and implementation guides make it hard to keep track of where developers and users should look for the single source of truth. To improve the current state, we recommend CMS reduce the number of revisions required throughout the year and we encourage CMS to develop a more stable process. If CMS were to put more emphasis on testing and piloting eCQMs before their release for use, we anticipate fewer updates / revisions would be needed. Furthermore, stakeholders would be able to test and validate eCQMs with a higher degree of confidence because the eCQMs have been well-vetted. Additionally, ONC and CMS should devote more resources to expanding test data sets used by Cypress, as well as enhancing the submission engine validation tool (SEVT). Currently, the data sets offered by ONC to test the accuracy of eCQM calculation only reflect some of the available. We recommend that test data sets be expanded to accommodate a greater number of likely workflows. In addition, the SEVT should be enhanced so that it checks the submission files for data accuracy and completeness before accepting the data, and rejects

			any data files that do not comply with the expected format. CMS should also provide an accompanying report identifying any rejected files along with the reason for rejection.
MIPS	**Quality**: Data Accuracy **Q6**	Should registries and qualified clinical data registries be required to submit data to CMS using certain standards, such as the Quality Reporting Document Architecture (QRDA) standard, which certified EHRs are required to support?	Yes – there should be a common set of standards that are applicable across submission pathways that yield accurate and reliable results. Relative to QRDA, we believe that CMS should work with ONC and HL7 to devote resources to improve the standard, as it represents the best option currently available.
MIPS	**Quality**: Data Accuracy **Q7**	Should CMS require that qualified registries, QCDRs, and HIT systems undergo review and qualification by CMS to ensure that CMS' form and manner are met? (E.g., CMS uses a specific file format for qualified registry reporting. The current version is available at: https://www.qualitynet.org/imageserver/pqrs/registry2015/index.htm. What should be involved in the testing to ensure CMS' form and manner requirements are met?	We have considerable concerns with a CMS process over and above what certification requires. To echo earlier comments, we encourage CMS to work more closely with ONC to improve certification to give more assurance to users that their systems will be able to compute data in the proper form and manner. If ONC certification requirements are consistent with CMS requirements, then we see no need for further review if eCQMs are submitted via certified technology. If technologies other than those currently certified by ONC are used to submit eCQMs, we recommend any process of review and qualification have the same level of rigor and use criteria similar to that of certification. As an additional way to improve conformance, CMS should develop more robust implementation guides, and enhances its validation tools.
MIPS	**Quality**: Data Accuracy	What feedback from CMS during testing would be beneficial to stakeholders?	We applaud CMS for recently publishing documentation on what certain errors mean in the context of feedback from PQRS submissions.[3] Without such documentation, root-cause analysis can be challenging or impossible, so we

[3] Centers for Medicare & Medicaid Services (CMS) Hospital Quality Reporting (HQR) 8.0 System Error documents https://ecqi.healthit.gov/ecqm/ecqm-news/cms-posts-hospital-quality-reporting-hqr-80-system-error-documents

	Q8		again encourage more granular feedback similar to the Hospital Quality Reporting (HQR) 8.0 System Error documents that was recently published moving forward.
MIPS	**Quality**: Data Accuracy **Q9**	What thresholds for data integrity should CMS have in place for accuracy, completeness, and reliability of the data? (e.g., if a QCDR's calculated performance rate does not equate to the distinct performance values, such as the numerator exceeding the value of the denominator, should CMS re-calculate the data based on the numerator and denominator values provided?)	Provisionally, we would support CMS computing performance rates, then giving notification to the submitter that the data has been re-calculated, with a period of time for the submitter to review results. Alternatively, CMS could ask submitter to review performance rate, and resubmit data. As we previously commented, we also recommend that the CMS Submission Engine Validation Tool (SEVT) check the submission files for data accuracy and completeness during submission of data, before accepting the data, and reject any specific patient data files that do not comply. Ensuring that the data validator(s) allow testing of the submission files for any of these errors prior to final submission will improve the overall data integrity and accuracy rates. Again, accuracy, completeness and reliability will be improved with a consistent process and cadence of core requirement changes sought by CMS.
	Quality: Data Accuracy **Q10**	Should CMS not require MIPS EPs to submit a calculated performance rate (and instead have CMS calculate all rates)?	We would support this approach, but we note that most vendors will compute performance rates pursuant to provider-client's wishes to see them ahead of their submission time or alongside submission to CMS.
MIPS	**Quality**: Data Accuracy	If a QCDR omits data elements that make validation of the reported data infeasible, should the data be discarded? What threshold of errors in submitted data should be acceptable?	We cannot offer a recommendation to this question, as we believe the answer will be variable depending on the nature of the error. At a minimum CMS needs to supply an error report, including specific information on which files were rejected and why they were rejected, and allow for data to be resubmitted.

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	Q11		We again reiterate the importance of a robust data validator tool, so that problems can be identified prior to submission.
MIPS	**Quality**: Data Accuracy **Q12**	If CMS determines that the MIPS EP (individual EP or as part of a group practice or virtual group) has used a data reporting mechanism that does not meet CMS data integrity standards, how should CMS assess the MIPS EP when calculating their quality performance category score? Should there be any consequences for the qualified registry, QCDR or EHR vendor in order to correct future practices? Should the qualified registry, QCDR or EHR vendor be disqualified or unable to participate in future performance periods? What consequences should there be for MIPS EPs?	Consistent with overarching comments, we recommend a higher degree of flexibility in the early years of the program. Given the difficulties associated with determining root-cause, we urge CMS to continue to work collaboratively with all stakeholders to improve the process and learn from early challenges. Additionally, we recommend that whatever policy CMS develops in response to this kind of situation strikes a balance between unduly punishing well-intentioned providers and the need to avoid the moral hazard situation where providers don't worry about their submissions. If ONC's certification process is enhanced to include this kind of functionality, it would be appropriate for some formal corrective action plan to be levied on vendors, if errors above a certain – yet-to-be-defined – threshold are seen. If those errors go unmitigated, then the consequences should be more severe.
MIPS	**Quality:** Use of CEHRT **Q13**	Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data?	In reviewing this question, we identified a prerequisite need to use consistent standards so the data is expressed in a sufficiently standard way. However, the nature of ONC's certification program is evolving away from the traditional notion of complete EHR, and we note there are several ways to aggregate data, and submit data, for quality measurement absent CEHRT. The core question then becomes, should certified technology be required to submit quality data, should certified technology be required to compile quality data, or both?

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			As a matter of general principle, if the quality data is compiled (recorded, calculated, etc.) using certified technology, and the reporting requirements are built to only accept data compiled in a standardized way, than it should not matter if the submission technology is certified. Likewise, if the data is not compiled in a standardized way, but can be made standard through certified technology before submission – and it meets the requirements set by CMS – than this should be acceptable. In short, if certified technology is used during the recording, calculation, reporting, importing or exporting of quality data – and the data can be accepted by CMS – the requirement to use CEHRT should be satisfied.
MIPS	**Quality:** Use of CEHRT **Q14**	Instead of requiring that the EHR be utilized to transmit the data, should it be sufficient to use the EHR to capture and/or calculate the quality data? What standards should apply for data capture and transmission?	Given the preceding comment, it should be sufficient to use *certified technology* to capture or calculate quality data, as long as the data transmission conforms to CMS requirements (e.g. QRDA and associated implementation guide).
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES CATEGORY			
MIPS	**CPIAs**	General Comments re: Clinical Practice Improvement Activities Performance Category	Given that clinical practice improvement activities (CPIAs) are likely to be composed of complex, dynamic and highly-variable set of actions, we strongly encourage CMS to avoid process measurements wherever possible. While we believe informatics-informed use of technology will be an important component to CPIA success, we do not believe such activities are sufficiently defined to determine prescriptive technology requirements. Specifically, we urge CMS not look to EHRs for measure reporting or reporting of other demonstration activities under this performance category.

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			Furthermore, we note specialty societies' rich history of designing, validating and evolving CPIAs, using a host of processes and tools to do so. As such, we recommend CMS work directly with specialty societies to determine measures or other demonstrations of activity, as they are much better positioned to monitor adherence to and achievement in the CPIA performance category. In addition to helping define the contours of the CIPAs, specialty societies may also prove valuable conduits through which results of MIPS participants can be transmitted to CMS for purposes of this performance category.
MEANINGFUL USE PERFORMANCE CATEGORY			
MIPS	**Meaningful Use** **MU1**	Should the performance score for this category be based be based solely on full achievement of meaningful use? (For example, an EP might receive full credit (e.g., 100 percent of the allotted 25 percentage points of the composite performance score) under this performance category for meeting or exceeding the thresholds of all meaningful use objectives and measures; however, failing to meet or exceed all objectives and measures would result in the EP receiving no credit (e.g., zero percent of the allotted 25 percentage points of the composite performance score) for this performance category).	AMIA supports efforts to change the question of successful participation in Meaningful Use (MU) from one that is currently binary to one that is more linear, at least in part, and scales with the number of measures met, can accept nuance, especially now that we have moved into the penalty phase of the EHR Incentive Program. Insofar that MU will count for 25 percent of the MIPS composite score, we recommend CMS develop a scaled approach that would allot percentage points of the MU performance category score commiserate with the percentage of MU measures and objectives met by the MIPS EP.

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MIPS	**Meaningful Use** **MU2**	Should CMS use a tiered methodology for determining levels of achievement in this performance category that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the Medicare EHR Incentive program's meaningful use objectives and measures? (For example, an EP who scores significantly higher than the threshold and higher than their peer group might receive a higher score than the median performer.) How should such a methodology be developed? Should scoring in this category be based on an EP's under- or over performance relative to the required thresholds of the objectives and measures or should the scoring methodology of this category be based on an EP's performance relative to the performance of his or her peers?	We see this approach as being overly complex, and it further ingrains a focus on thresholds and process measurement, which is counter to the outcome-based focus of MIPS and APMs.
MIPS	**Meaningful Use** **MU3**	What alternate methodologies should CMS consider for this performance category?	We reiterate our base recommendation that CMS use this set of policies to transition away from process measures that focus on percentages wherever possible. With MIPS, the establishment of outcome components to payment should enable the process measure approach to MU to be scaled back. In the context of this question, alternate methodologies that might give full or partial credit to MIPS EPs for this category could include:

			• Having certified EHR technology enabled, with documentation proving this enablement, similar to what was required for Medicaid during first-year participation in the EHR Incentive Program; and/or • Deeming the quality measure component of MU for participants in MIPS because of duplicative requirements in other MIPS dimensions;
PROMOTION OF ALTERNATIVE PAYMENT MODELS (APMs)			
APMs	**EAPM Entity Requirements:** Use of CEHRT **A1**	What components of certified EHR technology (as defined in section 1848(o)(4) of the Act) should APM participants be required to use? Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid EHR Incentive Programs or should CMS other consider requirements around certified health IT capabilities?	We recommend that CMS not require components of certified EHR technology above / beyond what the Medicare and Medicaid EHR Incentive Programs require, and that CMS consider various combinations of fewer components from the current CMS CEHRT definition. At a minimum, CMS should not require functionality solely meant to support the EHR Incentive Program, such as automated measure calculation.
APMs	**EAPM Entity Requirements:** Use of CEHRT **A2**	What are the core HIT functions that providers need to manage patient populations, coordinate care, engage patients, and monitor and report quality? Would certification of additional functions or interoperability requirements in HIT products (e.g., referral management or population health management functions) help providers succeed within APMs?	We note two observations of the current state meant to provide context to our recommendation. First, the mold for how to best manage population health or use analytics functions is not set. Unlike computerized provider order entry (CPOE) or e-prescribing (eRx) which are well-defined functionalities to which certification has value-add, we do not yet have enough experience with how the set of population health and other APM tools and functionalities should be defined. Second, we are increasingly convinced that certification and meaningful use measures have had the unintended consequence of limiting the design and innovation of EHRs to-date. Ours is a dynamic environment of innovation and invention, and we are deeply concerned that certification in this new area

			may hinder development of new features/functionalities that have not yet come to the marketplace.
APMs	**EAPM Entity Requirements:** Use of CEHRT **A3**	How should CMS define "use" of certified EHR technology (as defined in section 1848(o)(4) of the Act) by participants in an APM? (For example, should the APM require participants to report quality measures to all payers using certified EHR technology or only payers who require EHR reported measures? Should all professionals in the APM in which an eligible alternative payment entity participates be required to use certified EHR technology or a particular subset?)	In deliberating how to define "use" by participants in an APM, we first identified the need to be flexible to account for the myriad of ways EAPMs and individuals who participate in APMs will most efficiently utilize certified technology to achieve their quality and cost goals. How EAPMs or QPs use certified EHR technology should be up to the EAPM given the metrics upon which they are evaluated. This is an opportunity to transition health IT policy from a FFS-era policy to one based in the new value-based era. As a practical consideration, we suggest CMS consider using Medicaid Adopt, Implement, Upgrade as an exemplar policy that more closely equates "use" to "adopt." Another way to approach the practical question of defining "use," would be to equate "use" with the ability to create or receive a consolidated clinical document (CCDA) as defined by ONC regulations. Such an approach would portent the use of certified EHR technology to generate structured data and ability to send/receive (and incorporate) such data. Finally, we note that in addition to QPs, participants in an APM are likely to include hospitals, specialty nursing facilities (SNFs), home health organizations, behavioral health, and other professionals. This reality suggests that requirements around use of certified EHR technology focus first on QPs and subsequently look for ways to increase the percentage of other APM participants' use of certified technology over time.