
# 2018 CPC+ HEALTH IT REQUIREMENTS

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*Center for Medicare & Medicaid Innovation*
*U.S. Department of Health & Human Services*

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## CPC+ Certified Health IT Requirements (Track 1 and Track 2)

The table that follows describes the health IT requirements under CPC+ and the date by which each must be accomplished. The table begins with health IT requirements for overall CEHRT adoption, followed by the requirements for quality reporting.

| Requirement | Date | Notes |
|---|---|---|
| **Overall CEHRT Adoption** | | |
| Adopt and maintain[i], at a minimum, health IT needed to meet the certified EHR technology (CEHRT) definition required by the Quality Payment Program (QPP) at 42 CFR 414.1305.[ii] | No later than January 1 for each Program Year | --- |
| **Certified Health IT for Quality Reporting** | | |
| Adopt and maintain, at a minimum, health IT meeting the definition of CEHRT required by the QPP at 42 CFR 414.1305 and the certification criteria found at 45 CFR 170.315(c)(1) - (3)[iii] for electronic clinical quality measure (eCQM) reporting, using the most recent update available on January 1 of the Measurement Period, for the eCQMs in the CPC+ measure set.[iv] | No later than January 1 for each Program Year | For each Measurement Period, practices must use the eCQM specifications for eReporting listed in the eCQI Resource Center as of January 1 of the Program Year. |
| Adopt and maintain technology with the capability to filter data for eCQM reporting at the CPC+ practice site level [practice site location, TIN(s)/NPI(s)] in order to filter eCQMs for reporting at the CPC+ Practice Site level [practice site location, TIN(s), NPI(s)]. | No later than January 1 for each Program Year | --- |

[i] For clarity, CPC+ requires adoption of relevant health IT for the entire Program Year unless otherwise specified. For instance, if an upgrade to a new Edition of certified technology is required to meet the CEHRT definition for a given year, the upgrade must be completed by January 1. Other CMS programs may allow adoption for less than 12 months; CPC+ is different.

[ii] The QPP Final Rule at 42 CFR 414.1305 CEHRT definition includes the use of both 2014 Edition and/or 2015 Edition CEHRT. CPC+ practices may use 2014 Edition, 2015 Edition, or a combination of the two throughout the 2018 calendar year.

[iii] Under the current definition of CEHRT required by the QPP at 42 CFR 414.1305, 45 CFR 170.315(c)(1)-(c)(3) refers to 2015 Edition CEHRT, while 45 CFR 170.314(c)(1)-(c)(3) refers to 2014 Edition CEHRT. For each of these sections, (c)(1) is the certification criterion for "Record and Export"; (c)(2) is the certification criterion for "Import and Calculate; and (c)(3) is the certification criterion for "Report".

[iv] Please note that the CPC+ Quality Reporting Requirements for the current Program Year can be accessed on CPC+ Connect. Per the CPC+ Request for Applications and practice-facing Participation Agreement, the final measure list and requirements for each Program Year will be communicated to practices in advance.

## Advanced Health IT Functions Required in Track 2

| Technical Enhancement | Timeline for Adoption | Objective for Use |
|---|---|---|
| **Program Years 1 and 2[v]** | | |
| Empanel patients to the practice site care team | No later than July 1 Program Year 2 | 1. Enable the practice to assign each patient to a care team or practitioner and sort and review the patients by assignment.<br>2. The assigned provider should be visible in the patient record to members of the care team. |
| Risk-stratify practice site patient population; identify and flag "Patients with Complex Needs" | No later than July 1 Program Year 2 | 1. Enable the practice site to assign a risk score/label that reflects assignment based on the practice's risk stratification methodology.<br>2. The methodology used to stratify practices should be clear and meet basic guidelines established by CMS.[vi]<br>3. The practice site care team should be able to sort patients by score and update risk scores as needed.<br>4. Based on risk stratification results, the practice site should be able to flag patients they identify as "complex patients" and/or as requiring episodic, short term care management, and generate reports or lists of patients using those labels to support clinic workflow. |
| Produce and display eCQM results at the practice level[vii] to support continuous feedback | No later than July 1 Program Year 2 | 1. Enable the entire practice team to view eCQM results at the practice site level to support continuous feedback on quality improvement efforts.<br>2. Measure results should be updated as frequently as possible so that measures reflect current progress.<br>3. This capability should present results in a usable, actionable manner that the care team can use to effectively manage population health. |

[v] These requirements do not require the adoption of technology that meets a specific ONC certification criterion.
[vi] The risk stratification methodology should include an algorithmic component as well as an aspect of clinical intuition that can enhance or override the algorithmic risk score, and risk stratification should be performed on the entire active practice site patient population, not just the attributed Medicare beneficiaries.
[vii] Practice site level refers to the CPC+ practice site location and CPC+ TIN(s)/NPI(s).

| Program Year 3 and Beyond | | |
|---|---|---|
| Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs | No later than January 1 Program Year 3 | 1. Enable primary care practices to electronically assess patients' psychosocial needs.<br>2. Enable primary care practices to capture or access electronically an inventory of resources and supports to meet patients' identified psychosocial needs. |
| Establish a patient focused care plan to guide care management | No later than January 1 Program Year 3 | CPC+ practices should utilize an IT-enabled, patient-centered care planning tool in order to support holistic care and a focus on beneficiary goals and preferences.<br>1. Enable providers to electronically capture the following care plan elements:<br>a. Advance directives and preferences for care<br>b. Patient health concerns, goals and self-management plans<br>c. Action plans for specific conditions<br>d. Interventions and health status evaluations and outcomes<br>e. Identified care gaps<br>2. The practice should have the ability to customize which of these elements are included within the care plan and how these elements are displayed.<br>3. Providers should be able to incorporate relevant triggers (e.g. a risk score or event) that indicate different care management actions.<br>4. The care plan tool should facilitate version control across care team members by capturing the date of the last review or change in plan and generating a scheduled date for reviewing and updating the plan.<br>5. Practices should be able to populate the care plan using data entered in the patient's record (e.g. without duplicative data entry).<br>6. The care plan should be available to the patient on paper and electronically, and available in electronic format to care team members outside of the practice that are involved in the patient's care. Care plan information should also be remotely accessible to practice team members delivering care outside of normal business hours. |

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| Document and track patient reported outcomes | To be specified by CMS at a later date | CMS is evaluating a patient reported outcome survey instrument that will be sent to CPC+ Track 2 patients to identify specific care needs requiring intervention/management by the CPC+ Practice Site team. CMS plans to use the data collected from the patient-reported outcome survey to develop a patient-reported outcome performance measure that may be included in CPC+ measure set in the later years of the model. The modes of administration are yet to be determined.<br>1. The health IT tool should provide the care team with the ability to administer the survey, store and track patient responses, and score results longitudinally for each patient surveyed.<br>2. The practice should be able to review the patient responses/results in their EHR or other health IT tool and, as appropriate, establish care plans /interventions for positive findings. |