CPC+ Certified Health IT Requirements (REVISED)

REQUIREMENT	DATE	NOTES
OVERALL CERTIFIED HEALTH IT ADOPTION REQUIREMENT		
Adopt, at a minimum, the certified health IT needed to meet the certified EHR technology (CEHRT) definition required by the Medicare EHR Incentive program at 42 CFR 495.4.	Practices must adopt the health IT meeting this requirement. All practices must upgrade to 2015 Edition technology by January 1, 2018.	• Practices should adopt the certified health IT modules which meet the definition of CEHRT according to the timeline and requirements finalized for use in CMS programs supporting certified EHR use (e.g. EHR Incentive Programs, proposed Quality Payment Program). • Consistent with these programs, practices can use either 2015 Edition or 2014 Edition technology in 2017, but must use only 2015 Edition technology starting in 2018.
CERTIFIED HEALTH IT REQUIREMENTS FOR REPORTING		
Adopt health IT meeting 2015 Edition certification criteria found at 45 CFR 170.315(c)(1) - (3) or 2014 Edition certification criteria found at 45 CFR 170.314(c)(1)-(3) using the 2016 annual update, for all of the electronic clinical quality measures in the CPC+ measure set.	By January 1, 2017.	• For the 2017 performance period, practices must use the latest eCQM specifications contained in the 2016 annual update, released in April 2016 (https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html). • As in the overall CEHRT requirement, for certification practices should follow the requirements and timeline of the EHR Incentive Program, i.e., practices can use either 2015 Edition or 2014 Edition technology in 2017, but must use only 2015 Edition technology starting in 2018.
Adopt health IT meeting 2015 Edition certification criteria found at 45 CFR 170.315(c)(1) - (3), using the 2017 annual update, for all of the electronic clinical quality measures in the CPC+ measure set.	By January 1, 2018.	• For the 2017 performance period, practices must use the latest eCQM specifications contained in the 2016 annual update, released in April 2016 (https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html). • As in the overall CEHRT requirement, for certification practices should follow the requirements and timeline of the EHR Incentive Program, i.e., practices can use either 2015 Edition or 2014 Edition technology in 2017, but must use only 2015 Edition technology starting in 2018.

REQUIREMENT	DATE	NOTES
Adopt technology which allows filtering of data by at least practice site location and TIN/NPI.	By January 1, 2017.	• Vendors do not need to have completed certification for the (c)(4) filter by January 1, 2017, however, they will be expected to provide practices with the capability to filter data by at least practice site location and TIN/NPI in order to support quality improvement activities during the 2017 performance period.
Adopt health IT meeting the 2015 Edition eCQM certification criterion at 45 CFR 170.315(c)(4).	By January 1, 2018 to use in submission of data from the performance period in CY 2017 and for use through the entirety of the performance period in CY 2018.	• In order to successfully report eCQMs as part of CPC+ beginning in 2018, practices will need to be able to filter their data by practice site location and TIN/NPI using functionality meeting the (c)(4) criterion.
TRACK 2 ENHANCED HEALTH IT FUNCTION REQUIREMENTS		
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9).	By January 1, 2019 – beginning year 3 of model.	• Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Social, Behavioral and Psychological Data" criterion found at 45 CFR 170.315(a)(15).	By January 1, 2019 – beginning year 3 of model.	• Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.

Health IT Functionalities/Enhancements Expected in Track 2

Practices in Track 2, supported by participating vendors, will be asked to develop the following health IT functions/enhancements. CMS will not prescribe how the health IT enhancement is accomplished, rather only that the health IT solution meets the CPC+ objective for use of the health IT by the CPC+ practice site team. CMS anticipates that some of these requirements will be completed in the first 6-12 months of model start-up while others will take longer. CMS expects that all health IT enhancements listed below will be completed no later than 24 months after model kick-off in January 2017.

Health IT Technical Enhancement	CPC+ Objective for Use of Health IT
Risk-stratify practice site patient population; identify and flag "Patients with Complex Needs"	1. Enable the practice site to assign a risk score/label that reflects assignment based on the practice's risk stratification methodology. 2. The methodology used to stratify practices should be clear and meet basic guidelines established by CMS. 3. The practice site practice team should be able to sort patients by score and update risk scores as needed. 4. Based on 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 to support continuous feedback	1. Enable the entire practice team to view eCQMs results at the practice site level to support continuous feedback on quality improvement efforts. 2. Measure results should be updated as frequently as possible so that measures reflect current progress. 3. This capability should present results in a usable, actionable manner that the care team can use to effectively manage population health.
Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs	1. Enable primary care practices to electronically assess patients' psychosocial needs. 2. Enable primary care practices to capture or access electronically an inventory of resources and supports to meet patients' identified psychosocial needs. 3. To support this objective practices must adopt certified health IT that meets the 2015 Edition criterion "Social, Behavioral and Psychological Data" found at 45 CFR 170.315(a)(15), within the first two years of the program.
Document and track patient reported outcomes	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. 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. 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.
Empanel patients to the practice site care team	1. Enable the practice to assign each patient to a care team or practitioner and sort and review the patients by assignment. 2. The assigned provider should be visible in the patient record to members of the care team.

Health IT Technical Enhancement	CPC+ Objective for Use of Health IT
Establish a patient focused care plan to guide care management	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. 1. Enable providers to electronically capture the following care plan elements: • Advance directives and preferences for care • Patient health concerns, goals and self-management plans • Action plans for specific conditions • Interventions and health status evaluations and outcomes • Identified care gaps 3. The practice should have the ability to customize which of these elements are included within the care plan and how these elements are displayed. 4. Providers should be able to incorporate relevant triggers (e.g. a risk score or event) that indicate different care management actions. 5. 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. 6. Practices should be able to populate the care plan using data entered in the patient's record (e.g. without duplicative data entry). 7. 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. 8. To support this objective, practices must adopt certified health IT that meets the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9), within the first two years of the program.
Optional: CPC+ practice site care delivery and documentation of the care touch documentation *Please note: if vendor cannot support this functionality, the practice can still be in Track 2 as this is not mandatory HIT.*	Current systems are designed for capturing office-based care encounters and payment. Presently, claims are used to understand which physicians are seeing a patient the most (i.e. attribution), what proportion of primary care services are provided at the assigned practice versus other practices, and other key parameters. However, as programs like CPC+ Track 2 encourage the use of non-visit-based services, providers as well as CMS will lose a key source of data for understanding primary care activity. As part of Track 2, CMS will work with vendors and providers to explore identifiers for non-visit-based care activities that will allow practices and the program to quantify the overall provision of care to the patient (such as emails, telehealth interactions, telephone encounters, text reminders, letters etc.).