CPC+ CARE DELIVERY REQUIREMENTS CROSSWALK

December 2019

2019 CPC+ Care Delivery Requirements Side-By-Side

Track 1 Requirements

Function	2018 Program Year 1 Requirements	2018 Program Year 2 Requirements	2019 Requirements
1 Access and Continuity	1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the electronic health record (EHR). 1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.	1.1 Maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice.	1.1 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.2 Optimize continuity of care for empaneled patients while preserving access.

Function	2018 Program Year 1 Requirements	2018 Program Year 2 Requirements	2019 Requirements
2 **Care Management**	2.1 Risk stratify all empaneled patients. 2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are likely to benefit from care management. 2.4 Ensure patients with ED visits receive a follow-up interaction within one week of discharge. 2.5 Contact at least 75% of patients who are hospitalized in target hospital(s), within two business days.	2.1 Use a two-step risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed. 2.2 Based on your risk stratification process, provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management, including medication reconciliation, to patients following hospital admission/discharge/ transfer (including observation stays) and, as appropriate, following an ED discharge. 2.4 Ensure patients with ED visits receive a follow-up interaction within one week of discharge. 2.5 Contact at least 75% of patients who were hospitalized in target hospital(s) (including observation stays) within two business days.	2.1 Ensure all empaneled patients are risk-stratified. 2.2 Ensure all patients receive timely follow-up contact from your practice after ED visits and hospitalizations, as clinically indicated. 2.3 Ensure patients with complex needs and likely to benefit receive proactive, relationship-based care management.

Function	2018 Program Year 1 Requirements	2018 Program Year 2 Requirements	2019 Requirements
3 Comprehensiveness and Coordination	3.1 Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payers' data. 3.2 Identify hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payers' data.	3.1 Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports. 3.2 Using CMS'/other payers' data, track timeliness of notification and information transfer from hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits. 3.3 Develop a plan for implementation of at least one option from a menu of options for integrating behavioral health into care, based on an assessment of practice capability and population need.	3.1 Ensure coordinated referral management, especially for high-frequency referral specialists and/or high-cost specialty care. 3.2 Provide integrated behavioral health care.
4 Patient and Caregiver Engagement	4.1 Convene a patient and family advisory council (PFAC) at least once in Program Year 1 and integrate recommendations into care, as appropriate. 4.2 Assess practice capability and plan for support of patients' self-management.	4.1 Convene a PFAC at least three times in Program Year 2 and integrate recommendations into care and quality improvement activities, as appropriate. 4.2 Implement self-management support for at least three high-risk conditions.	4.1 Convene a PFAC and integrate recommendations into care and practice improvement activities.
5 Planned Care and Population Health	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (eCQMs) (derived from the EHR) at both practice- and panel-level to improve population health management.	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both the practice- and panel-level to set goals to improve population health management.	5.1 Use data to continuously improve your patients' health, experience, and quality of care, and decrease cost.

Track 2 Requirements

Function	2018 Program Year 1 Requirements	2018 Program Year 2 Requirements	2019 Requirements
1 Access and Continuity	1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity. 1.4 Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living facilities), and/or expanded hours in early mornings, evenings, and weekends.	1.1 Maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice. 1.4 Regularly deliver care in at least one way that is an alternative to traditional office visit-based care, meets the needs of your patient population, and increases access to the care team/practitioner, such as e-visits, phone visits, group visits, home visits, and/or alternate location visits (e.g., senior centers and assisted living facilities).	1.1 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.2 Optimize continuity of care for empaneled patients while preserving access. 1.3 Use your CPC+ payments to deliver care in new ways that efficiently and effectively meet patient needs, leveraging the skills of your care team, beyond what you can currently accomplish in traditional fee-for-service (FFS) office visits.

Function	2018 Program Year 1 Requirements	2018 Program Year 2 Requirements	2019 Requirements
2 **Care Management**	2.1 Use a two-step risk stratification process for all empaneled patients: Step 1. Based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition). Step 2. Adds the care team's perception of risk to adjust the risk stratification of patients, as needed. 2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an ED visit or hospital admission/discharge/ transfer and who are likely to benefit from care management. 2.4 Ensure patients with ED visits receive a follow up interaction within one week of discharge. 2.5 Contact at least 75% of patients who are hospitalized in target hospital(s), within two business days. 2.6 Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management.	2.1 Maintain and review a two-step risk stratification process for all empaneled patients, addressing medical needs, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed. 2.2 Based on your risk stratification process, provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management. 2.3 For patients receiving longitudinal care management, use a plan of care containing at least patients' goals, needs, and self-management activities that can be routinely accessed and updated by the care team. 2.4 Provide short-term (episodic) care management, including medication reconciliation to patients following hospital admission/discharge/ transfer, (including observation stays) and, as appropriate, following an ED discharge. 2.5 Ensure patients with ED visits receive a follow-up interaction within one week of discharge. 2.6 Contact at least 75% of patients who were hospitalized in target hospital(s) (including observation stays) within two business days.	2.1 Ensure all empaneled patients are risk-stratified. 2.2 Ensure all patients receive timely follow-up contact from your practice after ED visits and hospitalizations, as clinically indicated. 2.3 Ensure patients with complex needs who are likely to benefit from it receive proactive, relationship-based care management.

Function	2018 Program Year 1 Requirements	2018 Program Year 2 Requirements	2019 Requirements
3 Comprehensiveness and Coordination	3.1 Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payers' data. 3.2 Identify hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payers' data. 3.3 Enact collaborative care agreements with at least two groups of specialists, identified based on analysis of CMS/other payer reports. 3.4 Choose and implement at least one option from a menu of options for integrating behavioral health into care. 3.5 Systematically assess patients' psychosocial needs using evidence-based tools. 3.6 Conduct an inventory of resources and supports to meet patients' psychosocial needs. 3.7 Characterize important needs of subpopulations of high-risk patients and identify a practice capability to develop that will meet those needs and can be tracked over time.	3.1 Maintain collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports. 3.2 Using CMS/other payers' data, track and improve, as needed, the timeliness of notification and information transfer from hospitals and EDs responsible for the majority of your patients' hospitalizations and ED visits. 3.3 Develop a plan to provide comprehensive medication management to patients discharged from the hospital and those receiving longitudinal care management. 3.4 Advance implementation of at least one option from a menu of options for integrating behavioral health into care. 3.5 Address common psychosocial needs for at least your high-risk patients: • Routinely assess patients' psychosocial needs. • Prioritize common needs in your practice population and maintain an inventory of resources and supports available to address those needs. • Establish relationships with at least two resources and supports that meet patients' most significant psychosocial needs. 3.6 Define at least one subpopulation of patients with specific complex needs, develop capabilities necessary to better address those needs, and measure and improve the quality of care and utilization of this subpopulation.	3.1 Ensure coordinated referral management, especially for high-frequency referral specialists and/or high-cost specialty care. 3.2 Provide integrated behavioral health care. 3.3 Provide comprehensive medication management to patients receiving care management and in transitions of care who are likely to benefit. 3.4 Identify patients' high-priority health-related social needs and resources available in your community to meet those needs.

Function	2018 Program Year 1 Requirements	2018 Program Year 2 Requirements	2019 Requirements
4 Patient and Caregiver Engagement	4.1 Convene a PFAC in at least two quarters in PY 2017 and integrate recommendations into care, as appropriate. 4.2 Implement self-management support for at least three high risk conditions.	4.1 Convene a PFAC at least quarterly in PY 2, and integrate recommendations into care and quality improvement activities, as appropriate. 4.2 Implement self-management support for at least three high-risk conditions. 4.3 Identify and engage a subpopulation of patients and caregivers in advance care planning.	4.1 Convene a PFAC and integrate recommendations into care and practice improvement activities. 4.2 Ensure patients' goals, preferences, and needs are integrated into care through advance care planning.
5 Planned Care and Population Health	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both practice- and panel-level to improve population health management. 5.2 Conduct care team meets at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.	5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both the practice- and panel-level to set goals to improve population health management. 5.2 Conduct care team meetings at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.	5.1 Use data to continuously improve your patients' health, experience, and quality of care, and decrease cost.