NYC Health

Primary Care Information Project Bulletin

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MACRA Finalized and Quality Payment Program Launches

The Centers for Medicare and Medicaid Services (CMS) released the final rule the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which ended the Sustainable Growth Rate formula, which negatively impacted clinicians participating in Medicare and led to the implementation of a new unified framework called the Quality Payment Program (QPP).

Clinicians who are eligible to participate in QPP include:

- Physicians (MD, DO, DPM, OD)
- Dentists (DDS, DMD)
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

QPP has two participating tracks: The Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). MIPS is a combination of three previous quality-based reporting incentive programs – Physician Quality Reporting System (PQRS), the Value-Based Modifier (VM), and Medicare EHR Incentive Program. Advanced APMs are a subset of APMs that let participants earn more incentives by taking on some risk related to patients' outcomes. APMs are payment approaches, developed in partnership with the clinician community, that provide added incentives to clinicians to provide high-quality and cost-efficient care.

Under MIPS, eligible clinicians will be measured on four performance categories:

- Quality
- Improvement Activities
- Advancing Care Information
- Cost

Performances in these four categories will create a final score for participating clinicians. Per rules under MACRA, MIPS eligible clinicians will be subject to positive, negative, or neutral payment adjustments to their Medicare Part B claims based on their respective final score when compared to a performance threshold of other MIPS participating clinicians in their region.

To be eligible for participation in Advanced APMs, a clinician must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the respecting reporting year. Qualified APM Participants (QPs) that are able to sufficiently participate in Advanced APMs are exempt from any MIPS reporting requirements and payment adjustments.

For both MIPS and Advanced APMs under QPP, any payment adjustments will be applied to the calendar year two years following the performance year. For example, payment adjustments for performance in 2017 will not be applied until 2019.

For participation in QPP, eligible clinicians must bill more than $30,000 in Medicare Part B charges *and* see more than a hundred Medicare Part B unique patients a year prior to 2017. Clinicians participating in Medicare for the first time in 2016 are not required to start MIPS in that respective reporting year.

QPP begins on January 1, 2017. Participation in MIPS in 2017 is flexible and ranges from submitting a full year of data, submitting data from a 90 day reporting period, or submitting one quality measure or one improvement activity. All participating clinicians must submit performance data by March 31, 2018. Starting in the 2018 reporting year, all participating clinicians will be required to collect and submit data for the entire calendar year.

NYC REACH will be developing additional resources as more information becomes available.

Please visit www.nycreach.org for additional resources. For more information on the final rule, visit www.qpp.cms.gov.

In This Issue

Luis E. Guerrero MD: Connecting Patients with Local Resources

Between 1993 and 2011, the percentage of adults with diabetes in New York City has more than doubled.[1] In 2011 650,000 adult New Yorkers reported having diabetes and an estimated 230,000 additional New Yorkers were unware that they were living with diabetes.[2] In New York City, three of the neighborhoods with the highest prevalence of diabetes are located in the Bronx: Fordham-Bronx Park (14.6%), Northeast Bronx (13.9%), and the South Bronx (13.9%).[2]

Dr. Luis Guerrero, a private independent primary care practitioner, has been practicing in the Soundview area of the South Bronx for over 25 years. Being located in a neighborhood with one of the highest prevalence of diabetes, Dr. Guerrero sees a high volume of patients who have prediabetes and can potentially develop type 2 diabetes. "The Bronx has a high population of [people at risk for diabetes],"emphasized Dr. Guerrero. Because of this, Dr. Guerrero decided to take a proactive approach and look for ways to engage with his patients who have prediabetes in an effort to reduce their chances of developing type 2 diabetes.

Dr. Guerrero soon realized that engaging with his patients who have prediabetes would be more challenging than he initially thought. One of his main challenges was educating his patients about the importance of lifestyle changes, such as physical activity and a sustainable diet. Without weight loss and moderate physical activity, 15 to 30% of patients with prediabetes could develop type 2 diabetes within five years.[3]

By collaborating with NYC REACH's Clinical-Community Program Linkages team, Dr. Guerrero was able to learn about evidence-based intervention (EBI) programs available for his patients. One EBI program that has helped Dr. Guerrero and his patients is the National Diabetes Prevention Program (NDPP). The NDPP is a lifestyle change program designed to help participants lose 7% of their body weight to prevent or delay the onset of type 2 diabetes. Participants of the NDPP have been proven to reduce their risk of developing type 2 diabetes by 58%. Moreover, this reduction in risk rises to 71% in participants over 60.[4]

Dr. Guerrero has been practicing in the Bronx for 25 years
Photo credit: city-data.com

Dr. Guerrero was one of the first NYC REACH providers to start referring his patients to the NDPP. Initially, clinical providers referred their eligible patients to the NDPP using a paper referral system. Through this method, referrals would be hand-written and faxed over to the location that offered the workshop.

Because this paper-based method presented some challenges with program coordination, a streamlined process was needed. The CCPL team contracted with the Quality & Technical Assistance Center of New York (QTAC-NY), a national online registration and data management portal, to develop a new online tool that allows providers in clinical settings to search and register for NDPP classes being offered within their community by a diverse set of organizations, which became the QTAC-Compass Portal.

The QTAC Physician Portal offers providers and healthcare staff the ability to choose from workshops based on location, time of day and language. QTAC also provides feedback to providers regarding their patients' attendance in the NDPP workshop, weight loss, and physical activity. "QTAC has been very helpful," said Tania, a nurse working at Dr. Guerrero's practice. "Before we were making referrals through hand-written fax, and sometimes they were never received.

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1) New York Department of Health and Mental Hygiene, Epi Data Brief: Diabetes in New York City. April 2013. Available at http://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief26.pdf
2) Centers for Disease Control and Prevention, National Center for Health Statistics. 2011 National Diabetes Fact Sheet: Estimate of Diabetes Prevalence Using Various Definition Criteria. Available at http://www.cdc.gov/diabetes/pubs/factsheet11/tables1_2.htm
3) Centers for Disease Control and Prevention. Prediabetes: Could It Be You, 2014. https://www.cdc.gov/diabetes/pubs/statsreport14/prediabetes-infographic.pdf
4) Diabetes Prevention Program Research Group, Knowler WC, Fowler SE, Hamman RF, Christophi CA, Hoffman HJ, Brenneman AT, Brown-Friday JO, Goldberg R, Venditti E, Nathan DM. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135022

Luis E. Guerrero MD: Connecting Patients with Local Resources

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But now, it's so much easier." Vanessa Cordero, a staff member at Dr. Guerrero's practice, emphasizes the importance of these progress reports. "Once Dr. Guerrero receives the progress report, he'll refer to it and speak to his patients about it when they come in to see him."

Dr. Guerrero is one of many NYC REACH member providers utilizing the QTAC-Physician Portal to refer his patients to evidence-based intervention programs in the community. Since the implementation of QTAC, there has been an increase in the number of referrals. Between January and December of 2016, providers all over New York City have referred over 3,000 patients to an EBI program.

Dr. Guerrero with some of his staff. In 2015, Dr. Guerrero's practice was recognized by the New York City Department of Health and Mental Hygiene for its excellence in the delivery of outstanding preventative care

For questions or additional information on how QTAC can be utilized in a practice, please contact EBI_Referrals@health.nyc.gov.

EHR Incentive Program Updates

The Centers for Medicare and Medicaid Services announced a new rule impacting eligible providers (EPs) currently participating in the Medicaid and Medicare EHR Incentive Programs.

One of the changes that CMS has made is regarding reporting periods. *This is the only change impacting EPs participating in the Medicaid EHR Incentive Program.*

CMS has reduced the length of the reporting periods for the 2016 and 2017 reporting years to 90-days for all EPs participating in either the Medicaid or Medicare EHR Incentive Program. The new reporting period will now be any continuous 90-day period between January 1st and December 31st for both reporting year 2016 and reporting year 2017.

The other changes impact only EPs currently participating in the *Medicare* EHR Incentive Program. ***ALL Medicare EHR Incentive Program EPs will be required to participate and report for the Merit-based Incentive Payment System (MIPS), if they meet the eligibility criteria.***

New eligible providers who have not previously successfully attested for the Medicare EHR Incentive Program *and* plan to begin participation in 2017 will be expected to attest to Modified Stage 2 objectives and measures. However, participants beginning their participation in 2017 may be susceptible to a payment adjustment in 2018. To avoid a potential payment adjustment in 2018, new EPs will be required to either:

- Submit a significant hardship exception because of their transition to MIPS in 2017 - CMS is still in the process of finalizing the proposal that will determine who is eligible for this hardship exception, or
- Participate and successfully attest for the Medicare EHR Incentive Program for the 2017 reporting year prior to October 1, 2018.

Please check www.nycreach.org or www.cms.gov for additional updates as information becomes available.

Department of Health Announces Launch of New Neighborhood Health Action Centers

On April 4, New York City Department of Health and Mental Hygiene (NYC DOHMH) launched the East Harlem Neighborhood Health Action Center. The East Harlem Neighborhood Health Action Center is one of three Action Centers scheduled to open throughout New York City.

This new Action Center, located on 158 East 115th Street, will provide residents of East Harlem with the following services:

- **Direct clinical services** – Primary care services integrated with behavioral and mental health services
- **Direct connection to social services** – Providers will be able to refer patients to sister agencies and non-profit organizations to connect them to social services
- **Family Wellness Suites** – Dedicated spaces to promote maternal and infant wellbeing and family health
- **Referrals to wellness programs and other neighborhood resources**
- **Space to work with local stakeholders**

Neighborhood Health Action Centers are a part of NYC DOHMH Center for Health Equity's mission to eliminate health inequities. The Action Center model takes previously underutilized City-owned buildings and uses them to provide government social services, successful community -based programs and clinical providers all under one roof with the goal of improving the health of residents in neighborhoods with poor health outcomes. New York City has committed $3 million to developing and implementing these three Health Action Centers in areas with high health needs.

Action Centers are also scheduled to open in Brownsville, Brooklyn and Tremont, in the Bronx. The Tremont Health Action Center will host initiatives focused around teen pregnancy prevention and adolescent sexual health. This center will also partner with local schools to promote healthy eating and active living. The Brownsville Health Action Center will provide support for health pregnancies, parenting, breastfeeding, and healthy living. Both of these Action Centers are in different stages of development.

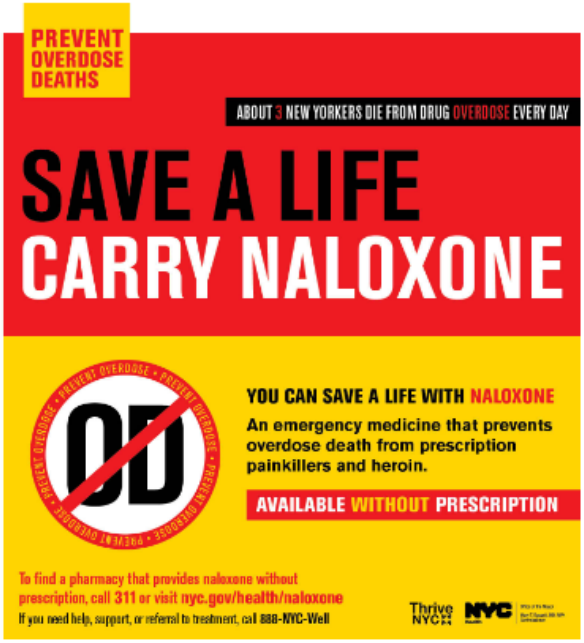
For more information regarding the Neighborhood Action Centers, please visit www.nyc.gov/health/actioncenters.

About the Health Department's Center for Health Equity

Founded in 2014, the Health Department's Center for Health Equity amplifies the agency's work to eliminate health disparities and improve health outcomes in neighborhoods with disproportionately high rates of chronic disease and premature death. The division takes a number of approaches to invest in key neighborhoods, eliminate the social barriers to good health and advance health equity throughout New York City. For more information on the Center for Health Equity, visit www.nyc.gov/health/CHE.

NYC Department of Health Launches Citywide Overdose Prevention Campaign

The New York City Department of Health and Mental Hygiene (DOHMH) announced the launch of the new "Save a Life, Carry Naloxone" campaign. This campaign will be mostly funded through ThriveNYC – the City's mental health roadmap – and will focus on reducing overdose deaths, raising awareness about the drug naloxone, and promoting effective treatment for opioid disorders. "Save a Life, Carry Naloxone" will consist of ads on digital and social media platforms, followed by ads strategically placed in local media outlets and venues targeting neighborhoods most affected by overdose deaths.



Earlier this year, DOHMH disseminated a health alert that focusing on the involvement of fentanyl in nearly half of the confirmed unintentional drug overdose deaths in New York City since July 2016. Fentanyl is a synthetic, short-acting opioid analgesic with potency 50 to 100 times stronger than morphine. Provisional health department data through early November show that there have been 860 confirmed unintentional drug overdose deaths to date this year. In 2015, there were 937 confirmed unintentional overdose deaths throughout New York City and nearly 750 of those deaths involved an opioid.

First Lady Chirlane McCray stated "As part of ThriveNYC, we have expanded access to naloxone, which can save lives after opioid overdose and is available to anyone without a prescription at 700 pharmacies, in every borough of our city. We are also expanding access to buprenorphine, a medication that stops opioid cravings and prevents withdrawal symptoms, so people can get help before an overdose. We are working hard to close treatment gaps so that New Yorkers get the help they need to live free of opioid misuse."

Health Commissioner Dr. Mary Bassett emphasized how this campaign is assisting DOHMH on one of their key priorities. "Reducing opioid-related overdose deaths is a priority for the Health Department. We want all New Yorkers to know that naloxone can reverse an opioid overdose and save a life, and it is available without a prescription at pharmacies across the city."

To view the full press release, please visit https://www1.nyc.gov/site/doh/about/press/pr2016/pr102-16.page. For more information about opioid overdose prevention, naloxone and treatment services, search "prevent overdoes" at www.nyc.gov.

Clinical-Community Program Linkages: Connecting Providers with Local Educational Resources

Clinical-Community Program Linkages (CCPL) at the Primary Care Information Project strives to develop sustainable and scalable pathways from the clinical environment to evidence-based intervention (EBI) programs by connecting practices and community organizations with the appropriate EBI trainings. Overall, CCPL aims to:

- **Collaborate** with providers and colleagues to increase referrals to EBI programs
- **Support** clinicians and worksites to offer EBI programs
- **Increase** patient participation with EBI programs

CCPL partners with the Quality & Technical Assistance Center of New York (QTAC-NY), which disseminates and delivers evidence-based self-management wellness programs, such as Stanford Self-Management Programs, Chronic Disease Self-Management Program, Diabetes Self-Management Program, and Positive Self-Management Program, Falls Prevention Programs, and the National Diabetes Prevention Program. These programs help improve the health, wellness, and quality of life in the communities they are working with. QTAC-NY's services include workforce development, free/low-cost training, technical assistance, and data management.

To help streamline the referral process for all organizations, CCPL and QTAC-NY created a new online referral portal – the QTAC-Compass – for providers. Utilizing QTAC-Compass, providers in clinical settings can refer and enroll their patients into a variety of wellness programs. QTAC-Compass gives providers the ability to register patients for directly into programs and receive automated feedback on any of their patients' attendance and achievements, such as physical activity and weight loss. The QTAC-Compass portal does not require logins or passwords and meets HIPAA requirements.

Currently, CCPL is assisting with generating clinical referrals and setting up trainings and workshops for providers looking to refer patients to the National Diabetes Prevention Program, Diabetes Self-Management Program, or Chronic Disease Self-Management Program.

For questions and additional information about CCPL and QTAC-NYC, providers can contact CCPL at EBI_referrals@health.nyc.gov.

Health Bulletin: Living Well with Diabetes

The New York City Department of Health and Mental Hygiene (DOHMH) has developed resources on the most prevalent chronic diseases affecting New Yorkers – heart disease, cancer, stroke, and diabetes. DOHMH recently released a new bulletin that will help providers facilitate conversations with their patients regarding diabetes. This new bulletin, *Living Well with Diabetes*, gives a brief overview of diabetes and also provides tips to help patients make lifestyle changes.

Some practices covered in the health bulletin include simple tips on how to:

- Exercise for at least 30 minutes a day for five days a week
- Eat a healthy diet
- Maintain a healthy weight

In addition to *Living Well with Diabetes*, DOHMH has also created a resource tool, *My Diabetes Checkbook*. Using this checkbook, patients can track their blood sugar levels, list any medications, and keep track of recent lab results. Providers can leverage this resource to facilitate conversations with their patients to make necessary lifestyle changes.

Providers looking for additional resources for patients regarding diabetes can visit http://www1.nyc.gov/site/doh/health/health-topics/diabetes-living-with-diabetes.page. These resources, and others from DOHMH, can be ordered for ***free*** by calling 311. Each resource is available in multiple languages.

MEIPASS Open for Medicaid Meaningful Use Attestations

The Medicaid EHR Incentive Program is now accepting Meaningful Use Attestations for 2015 and 2016.

Pre-Requisites

To successfully attest, eligible providers (EPs) must first ensure to meet the following prerequisites:

- Have registered with the Centers of Medicare and Medicaid Services (CMS) to participate in the EHR Incentive Program and ensure all contact information is up-to-date
- Be actively enrolled or recently revalidated in Medicaid Fee-for-Service (FFS)
- Ensure ETIN and ePACES account is active
- Satisfy the Medicaid Patient Volume eligibility requirement with up-to-date information
  Ensure all documentation to supporting attestation is complete and accurate

Attestation Process

In order to attest, EPs will be required to:

1. Log into MEIPASS and submit demographic and clinical quality measure information, *and*
2. Complete and email the Meaningful Use Workbook file (MS Excel) to NYSDOH, *and*
3. Mail printed copies of the Meaningful Use Workbook and signed attestation document to NYSDOH.

EPs can access the Meaningful Use Workbook file, as well as instructions on the NYSDOH website: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/meaningfuluseworkbook.htm

Note that EPs may **not** submit multiple participation years at the same time. For example, attestation for the 2015 participation year must be submitted, processed and payment issued **prior to** submitting attestation for the 2016 participation year.

Program Deadlines

- Meaningful Use for 2015
  - **June 30, 2017**: Last day to attest to Medicaid Meaningful Use for the 2015 participation year
- Meaningful Use for 2016
  - **September 15, 2017**: Last day to attest to Medicaid Meaningful Use for the 2016 participation year

Questions? Need Support?

For questions regarding missed deadlines or to request support from NYC REACH on Meaningful Use attestations, please contact:

NYC REACH at (347) 396-4888 or email pcip@health.nyc.gov

For questions regarding ePACES and MEIPASS, please contact:
New York State Medicaid at 877-646-5410 (option 1) or email meipasshelp@csc.com

For questions regarding participation status, please contact:
New York State Medicaid at 877-646-5410 (option 2) or email hit@health.ny.gov

Looking for resources or additional information on Meaningful Use?

Continue reading on page 8 to learn about resources available from NYC REACH.

Medicaid Meaningful Use Resources Available

NYC REACH has developed recorded webinars and resource guides to support Eligible Providers (EPs) with Meaningful Use attestations for the 2015 and 2016 participation years.

Click here to access the new Meaningful Use resources.

New resources include:

Meaningful Use Overview

- Recorded Webinar: *Meaningful Use 2015 and 2016 Objectives and Exclusions*
- Resource Guide: *Meaningful Use Objectives and Exclusions*

Meaningful Use Pre-attestation

- Recorded Webinar: *Pre-attestation Administrative Process*
- Resource Guide: *Calculating Medicaid Patient Volume*

Meaningful Use Individual Attestation 2015 and 2016

- Recorded Webinar: *Meaningful Use Stage and Year Guide*
- Resource Guide: *Know Your Meaningful Use Stage and Year*
- Recorded Webinar: *Meaningful Use Individual Attestation*
- Resource Guide: *Meaningful Use Attestation Checklist*
- Resource Guide: *Step-by-Step Instructions for Individual and Group Attestations*

Please visit the NYC REACH Resource Library to access these resources and many more.

To request support with Meaningful Use, contact NYC REACH at (347) 396-4888 or email pcip@health.nyc.gov.

For questions regarding ePACES and MEIPASS, please contact New York State Medicaid at (877) 646-5410 (option 1) or email meipasshelp@csc.com.

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The Primary Care Information Project (PCIP) is a NYC mayoral initiative charged with improving the quality of care in underserved communities through health information technology.

Questions about the newsletter? Please e-mail Anthony Cruz, Communications Specialist, at mcruz11@health.nyc.gov