HENRY FORD HEALTH SYSTEM

Physician Organizational Structures and MACRA
Henry Ford Health System Physician Structures

Henry Ford Medical Group (HFMG)
- 1200 physicians and biomedical researchers in Southeastern Michigan
- Academic medical group structure
- Fully integrated with Henry Ford Hospital and the Health System

Henry Ford Employed Physicians
- Several hundred physicians employed by community hospitals within the health system
- No separate governance structure
- Most associated with independent physician organizations (other than HFMG) and ACOs

Henry Ford Physician Network (HFPN)
- Clinically integrated network with independent governance
- Henry Ford Medical Group and 650 private physicians (190 primary care)

Henry Ford aligned physicians
- Approximately 2500 physicians who practice primarily at Henry Ford Health System facilities
- Some in PSA models and some contracted directorships
Henry Ford Health System MACRA Approaches

Henry Ford Medical Group (HFMG)
- APM track as a Next Generation ACO participant
- HFMG members not on ACO roster will submit MIPS measures per practice specialty or as a group through EPIC

Henry Ford Employed Physicians
- Several may participate as HFPN members as APM track via Next Gen ACO
- If in other MSSP groups, quality will be reported via MIPS APM and then do practice improvement

Henry Ford Physician Network (HFPN)
- Several members participating as APM track via the Next Gen ACO
- Remainder of HFPN providers were offered assistance with “CPC plus” application via a Michigan wide super CIN
  This will qualify these practices for APM track

Henry Ford aligned physicians
- Educational support with MIPS compliance is being provided by the System

Health System Strategy: in that we own an insurer (Health Alliance Plan) we generally would like to move patients into our Medicare Advantage program and delivered by a narrow network of high performers
Henry Ford Health System MACRA Concerns

• **Dollar or patient thresholds required for QP status**
  • Thresholds calculated on a percentage basis with dollars or patients in an Advanced APM in the numerator and Part B E&M activity in the denominator
  • Multispecialty group like HFMG have a great deal of “specialty E&M” activity (consults, postsurgical follow-ups) for patients who could not possibly be attributed to their own ACO and may be attributed to other ACOs
  • A large number of such patients makes it difficult to achieve 50-75% thresholds after year 1 of MACRA
  • As such we expect HFMG will Not qualify for QP status after 2018 despite participation in Next Gen ACO

• **Absence of socioeconomic adjustment in many MIPS measures**
  • Many MIPS quality measures (HbA1c and blood pressure control) are significantly influenced by patient SES and demographic characteristics
  • In HFMG clinics, there is a correlation in the range of 0.6-0.7 between neighborhood factors like percent below poverty level and scores on HEDIS measure like HbA1c
  • We estimate absence of SES adjustment will essentially guarantee a negative payment adjustment for up to 9% for providers serving inner-city or poor rural areas; this does not seem to be good public policy
Henry Ford Health System MACRA Concerns

- **Compression of final scores in MIPS**
  - In order to make MIPS participation more palatable and attractive for a large number of clinicians, a number of features of MIPS create the opportunity to achieve high scores in the three domains other than cost.
  - After 2018, the structure of the program requires that physicians below the mean or median on the final score distribution receive negative payment adjustments, which are mainly derived from the cost part of the calculation (since most participants will likely achieve top scores in the other domains).
  - Since relative cost scores can’t be known in advance, it will be impossible to predict one’s eventual financial outcome in MIPS, even with some knowledge of the prior year performance (e.g., QRUR reports).
  - As such, MIPS will largely be a “game of chance”.
  - Clinicians involved in “MIPS APM” have somewhat different scoring rules, but are not exempt from the final score compression problems.
  - They are required to report APM scores, therefore not being able to choose those measures on which they do particularly well (they do get some bonus points for APM participation).
  - Final score will be based on relative performance on the full set of APM measures plus the bonus points for APM participation; it is not clear participants will enjoy any advantage at the final score level.
  - Specialists will likely do poorly in MIPS due to fewer quality measures; with compression this more or less guarantees a negative payment adjustment.

Thank you to Dr. David Nerenz, Henry Ford Health System