



Advancing High Performance Health

White Paper

AMGA Advocacy

***Taking Risk, 2.0:
Is the Transition to
Value Slowing?***

**AMGA's Second Annual
Survey on Taking Risk**

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Taking Risk, 2.0: Is the Transition to Value Slowing?

AMGA's Second Annual Survey on Taking Risk

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In 2015, AMGA conducted a survey of its membership (multispecialty medical groups and integrated delivery systems) to determine if healthcare financing was beginning to transition away from fee-for-service (FFS) payments to risk-based payment arrangements. The survey also asked respondents to identify challenges to taking risk and what tools they needed to address these challenges. The survey showed FFS payments were expected to decline over a three-year period and those revenues would be replaced by risk- or value-based reimbursements.

AMGA conducted its second annual risk survey to determine if the transition to value is continuing and if obstacles to taking risk remain. Additionally, the survey asked respondents a new question related to how they were reimbursed under Medicare Advantage (MA).

Briefly, the 2016 survey showed FFS revenues continue to decline by more than 20 percent, with value-based payments increasing proportionally. A majority of members indicate they are ready to accept downside risk within two years. Respondents also report that commercial payers generally are not offering risk products in their local markets. Relatedly, impediments to taking risk remain relatively unchanged and largely involve the need to improve data sharing with payers and creating the internal infrastructure to take risk. Finally, respondents indicated that the majority of MA reimbursements are tied to some type of FFS payment structure.

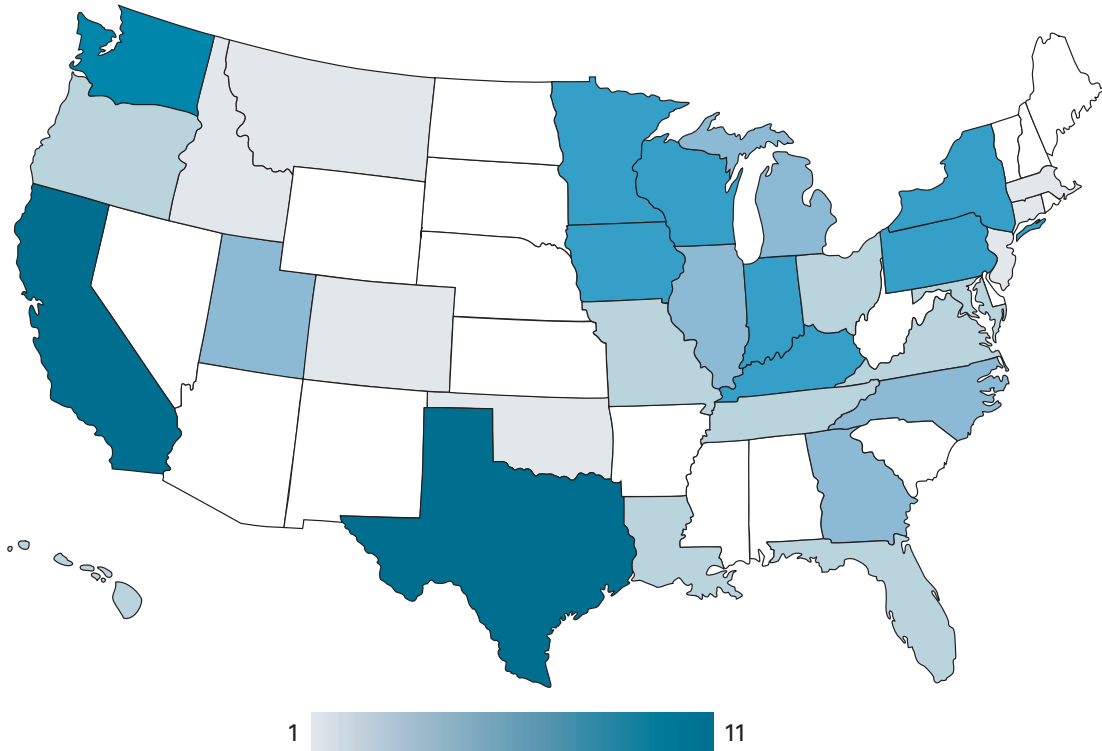
Despite this expected decline in FFS revenue, the transition to risk-based arrangements appears to be slowing. While a majority of 2016 survey respondents indicate they are ready for downside risk within two years, they also report that FFS payments will make up a larger percentage of revenues in the next three years than predicted in the 2015 survey. Moreover, predicted revenues from more advanced risk-based arrangements like shared risk and partial- or full-capitation products declined significantly compared to 2015 predictions.

The reasons why this is occurring are multifaceted and described in the Discussion/Observation section of this paper. It is clear, however, that impediments to taking risk identified in last year's survey, including data-sharing issues and the lack of commercial risk products, largely have not been addressed. Policymakers need to resolve these issues to give providers the confidence that they can succeed in a new value-based payment system. If left unaddressed, the laudable goal of transitioning the system to one that rewards results will be, at best, delayed and, at worst, unrealized.

Study Notes and Methods

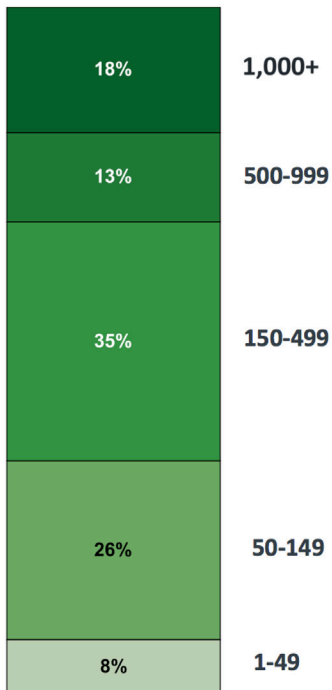
In 2015, AMGA surveyed its members about transitioning from FFS to value-based payment models. AMGA repeated this process in 2016 to assess member progress on the transition to value or risk. Respondents answered the survey between April and July 2016 via Survey Monkey. A total of 205 respondents signed into the survey, 115 answered at least some of the questions, and 73 answered all questions. The respondents represented 168 different member organizations. The survey first gathered information on organizational demographics, including organizational

Map of Number of Complete Responses

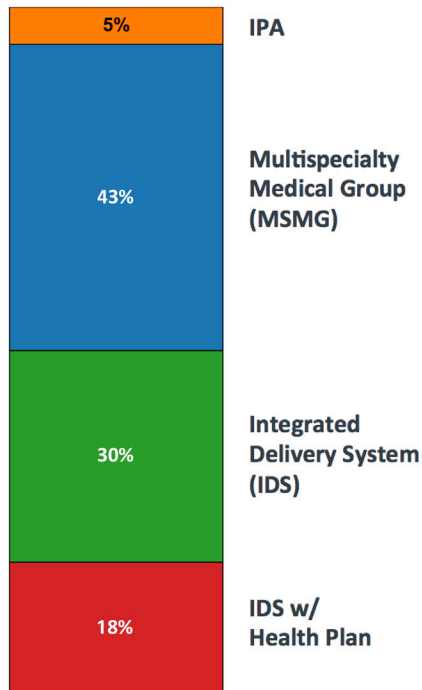


Demographics

of FTE Physicians



Organization Type



Role

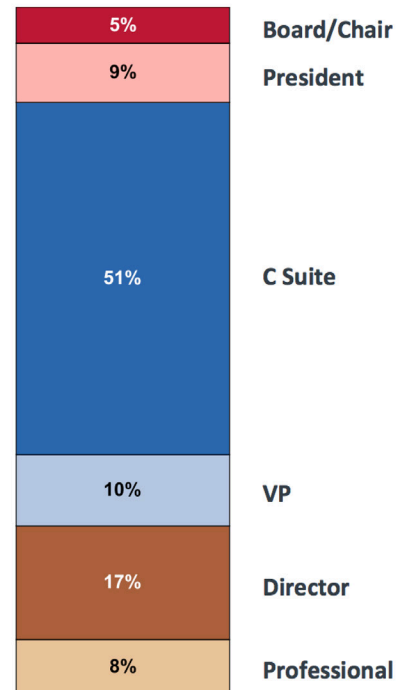


Table 1: Respondent Demographics

	Number of Respondents	Percent
Organizational Structure		
Multispecialty Medical Group (MSMG)	49	43%
Integrated Delivery System (IDS)	34	30%
IDS with Health Plan	21	18%
Independent Physician Association (IPA)	6	5%
Other	5	4%
Number of FTE Physicians		
1 – 49	9	8%
50 – 149	30	26%
150 – 499	40	35%
500 – 999	15	13%
1,000 +	21	18%
Geographic Region		
Northeast	17	15%
South	36	32%
Midwest	32	28%
West	29	25%

structure and number of full-time equivalent (FTE) physicians. Members were assigned a geographic region based on their primary state of business.

A few small changes were made to the analysis from the previous year. In 2016, the option of “Independent Physician Association (IPA)” was given as a potential organizational structure. There were a small number of respondents who identified their organization as an IPA, and they were left in the aggregate analysis as they did not skew the data. Respondents were given the option of “Multispecialty medical group with health plan” again in 2016, but this year there were only two respondents who selected that option. As a result of such a low number identifying as a multispecialty medical group with health plan, these responses were deleted from the stratified data.

The respondents were representative of the overall AMGA membership in terms of geographic regions; however, there were more respondents from groups with 1 – 49 FTE physicians than is representative of overall AMGA membership. Table 1 provides more detailed demographics of the survey respondents.

Reimbursement Revenue by Payment Model

Respondents answered several questions related to reimbursement revenue. These questions were broken down by federal, commercial, and MA programs for 2016. They were also asked to project their reimbursement revenue for 2017 and 2018 for federal and commercial programs. Options for federal reimbursement revenue were: Medicare FFS, Medicaid FFS, ACOs (Accountable Care Organizations), Medicaid Managed Care, MA, and Bundled Payments. Options for commercial reimbursement revenue were: FFS, Shared Savings, Shared Risk, Full Capitation, Partial Capitation, and Bundled Payments. When asked about MA, reimbursement revenue options included: FFS, FFS with bonus, Shared Savings, Shared Risk, Full Capitation, and Partial Capitation.

The results were stratified by each demographic category: number of FTE physicians, organization type, and geographic region. They also were aggregated as a whole and compared to results from 2015.

As with last year, respondents were asked again for how much time they need before they can accept downside risk (<1 year, 1 – 2 years, 3 – 5 years, and 6+ years). This information was aggregated as a whole and broken down based on demographics. The information provided a good comparison between viewpoints of 2015 and 2016.

2015 v. 2016 Survey Comparisons

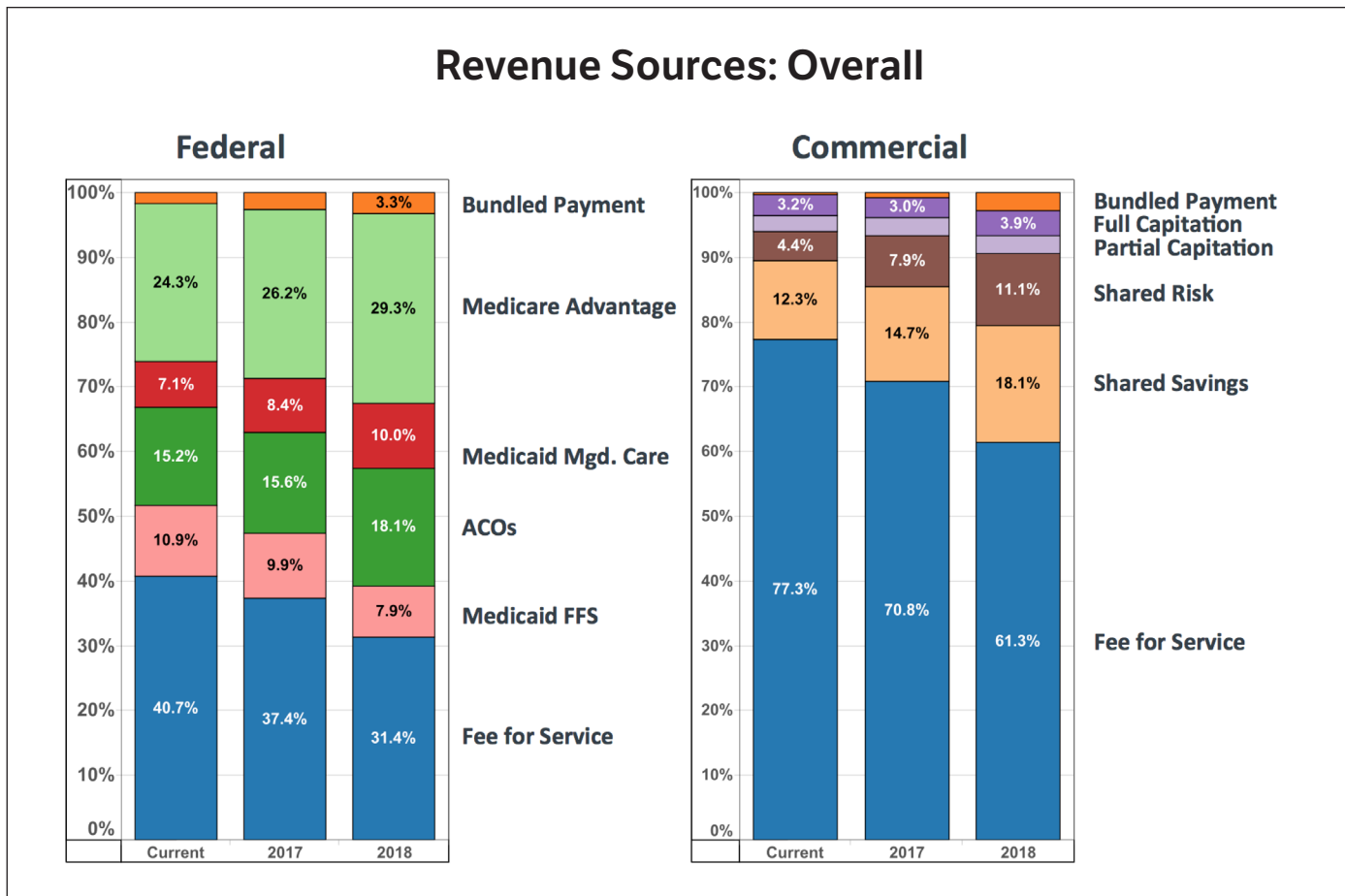
Several sections of this paper compare the results of respondent answers to the same survey question in 2015 and 2016. While these comparisons are critical to understanding how the pathway to risk is trending, there are limitations to the comparison. Approximately 20 percent of the same respondents answered the survey in 2015 and 2016, so it cannot be said that this paper contains an apples-to-apples comparison of risk-based issues. However, in both survey years, the respondents represent leadership in very large and complex organizations, and their answers can be relied upon to paint an accurate picture of the risk-bearing landscape and provide a reasonable basis for comparison.

2016 Survey Respondents

Aggregate Reimbursement Results

Federal Setting

Survey responses showed an expected 23 percent decline in Medicare FFS revenues from 2016 to 2018, while Medicaid FFS payments were expected to decline by more than 28 percent. Medicaid managed care revenues



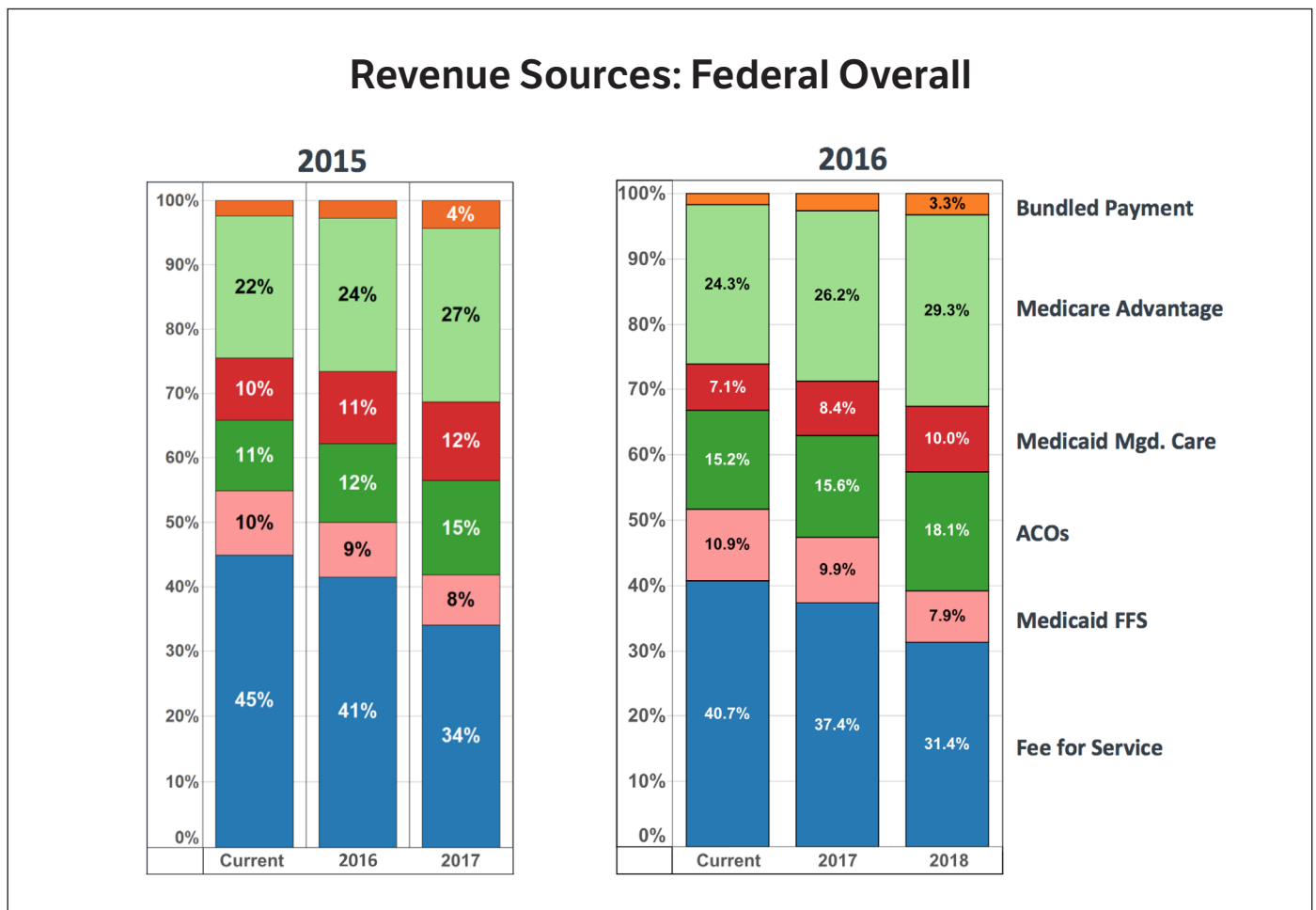
were expected to increase by almost 40 percent by 2018. MA revenues are predicted to increase by 20 percent in three years, and federal Medicare Shared Savings Program (MSSP/ACO) revenues are expected to increase by 19 percent.

Revenues from non-FFS payments account for almost 50 percent of expected revenues by 2018. However, it is not clear if payments from these products are risk-based. As will be discussed later, respondents reported that MA reimbursements are largely FFS-based, and most federal ACOs are in Track 1, which is a shared savings program with no downside financial risk.

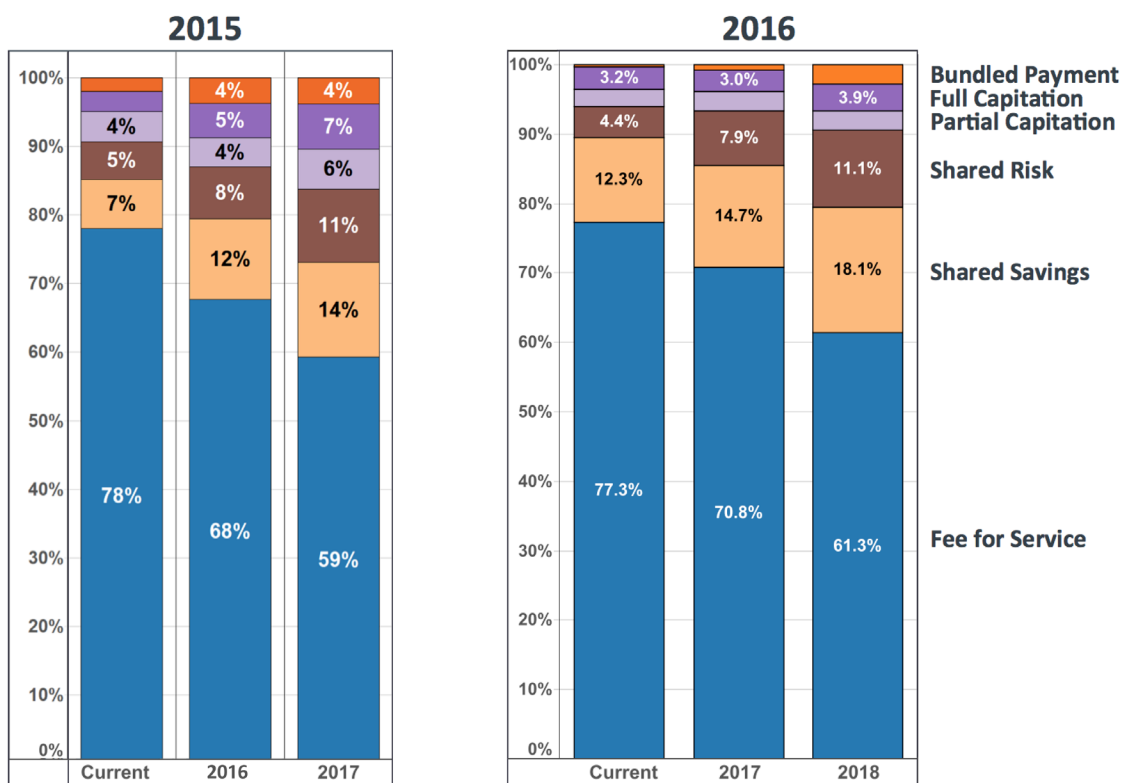
Commercial Setting

In the commercial setting, respondents predict FFS payments to decrease by 21 percent in three years. Revenues from shared-risk products are expected to increase from 4.4 percent of revenues in 2016 to 11.1 percent by 2018, a 152 percent increase. Shared savings revenues are expected to increase from 12.3 to 18.1 percent of revenues within the same three-year period, representing a 47 percent increase.

Full capitation revenues will increase by 22 percent (3.2% to 3.9%), while revenues from partial capitation products remain stable for all three years (less than 2%). Revenues from bundled payments are not expected to increase, and account for an insignificant percentage of provider revenues in both the federal and commercial settings. In total, revenues from capitated products are expected to make up less than 6 percent of total commercial revenues by 2018.



Revenue Sources: Commercial Overall



2015 v. 2016 Survey Response Comparisons

As described above, 2016 respondents predict a continued transition away from FFS. However, when comparing 2016 predicted revenue streams to 2015, it is clear that participation in risk-based arrangements is expected to slow while revenue from FFS increases. For example, 2015 survey respondents indicated that in 2016, 68 percent of commercial revenue would come from FFS. Respondents in 2016 indicated that their actual 2016 FFS revenues accounted for 77.3 percent of revenues, a 13 percent increase. Respondents in 2015 indicated that 8 percent of commercial revenues would come from shared-risk products, while 2016 respondents showed only 4.4 percent of revenues coming from shared-risk products, a 45 percent decline. In 2015, revenue from capitated products in 2016 was expected to compose 9 percent of total commercial revenues; in 2016, the figure was 5 percent.

More significant differences occurred when comparing the two surveys' responses for predicted 2017 revenues. Respondents in 2015 predicted that partial- and full-capitation products would make up 13 percent of commercial revenues by 2017, while 2016 respondents predicted less than 5 percent of revenues will come from these mature risk products, a decline of 62 percent. Shared-risk revenues are predicted to be 28 percent less in 2017, according to 2016 respondents. On the FFS side, 2015 respondents predicted that 59 percent of their commercial revenues would be FFS, while 2016 respondents expect 70.8 percent of their revenues will be FFS, a 20 percent increase.

Predicted revenue sources in the federal sector were generally consistent each year, though revenues from Medicaid managed care were 35 percent lower than expected in 2015. Because Medicaid managed care plans are state specific, it is not clear why there was a significant drop in this revenue stream in 2016. Federal ACO revenues were 27 percent higher in 2016 than predicted in 2015 (15.2% v. 12%).

Take-up of risk products in the federal sector also decline when comparing predictions in the two surveys. While MA revenue projections remain fairly consistent, Medicaid managed care revenues are expected to be 35 percent less in 2016 than in 2015. Respondents in 2016 predict Medicare and Medicaid FFS revenues to be almost 13 percent higher than predicted in 2015.

Reimbursements by Organizational Structure

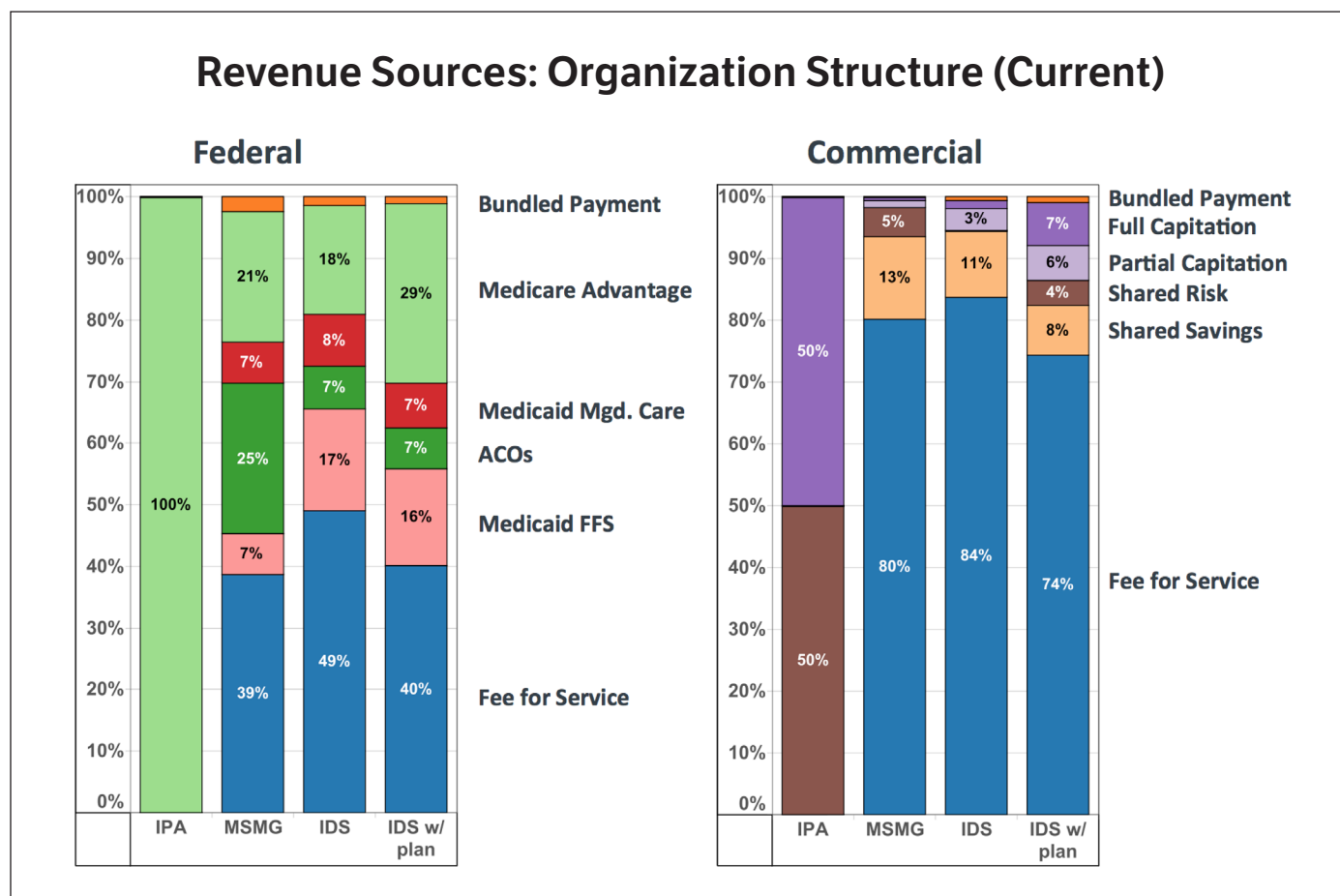
Federal Setting

FFS payments from the Federal Government are expected to decline between 10 percent (MSMG) and 35 percent (IDS) across all organizational categories from 2016 to 2018. MSMGs report that they expect to see increased revenues from MA plans while decreasing their participation in the Medicare Shared Savings Program (MSSP). Conversely, IDSs and IDSs with a health plan expect to fill in the decrease in FFS revenues with increased participation in both MA and the MSSP program, though the survey did not break down MSSP into risk-bearing and non-risk-bearing ACO tracks (e.g., track 1 v. track 2/3 and Next Generation models).

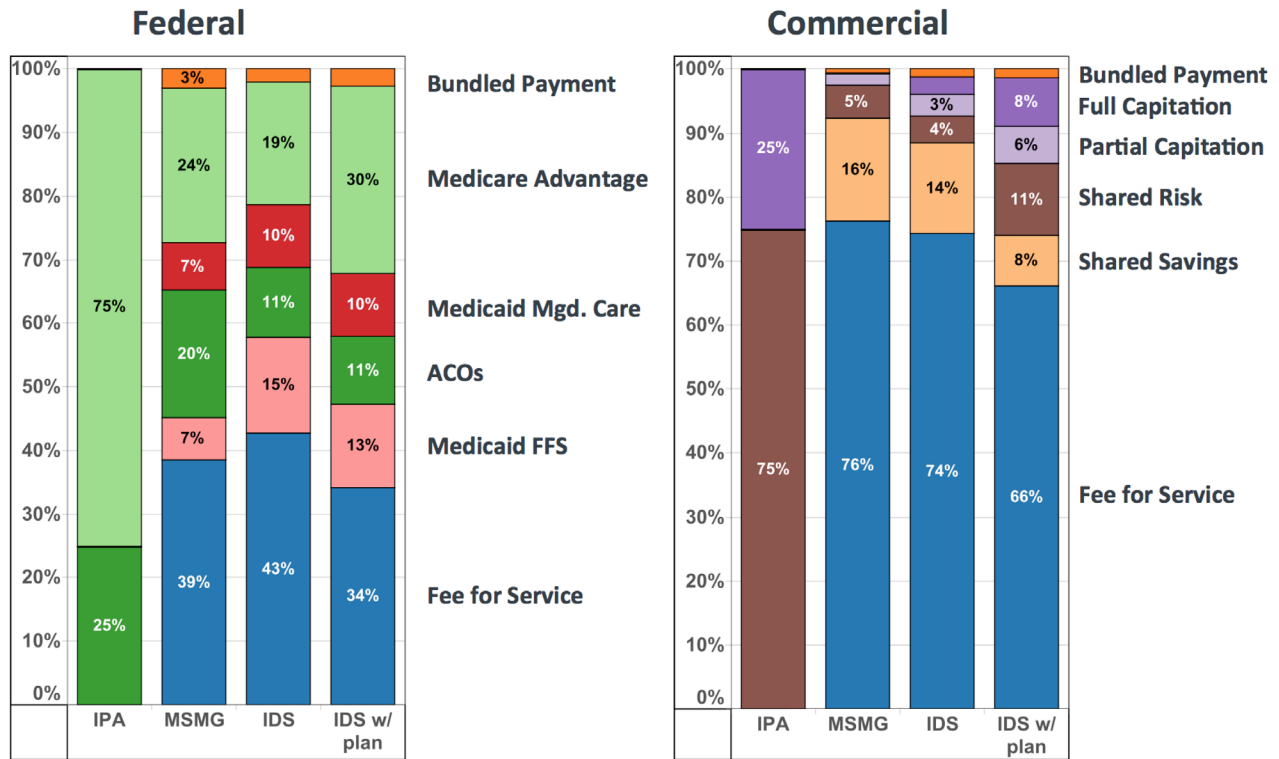
Not unexpectedly, IPAs report between 75 and 100 percent of their federal revenues will come from MA or the MSSP program. IPAs have assumed risk for decades and the survey demonstrates this remains true.

Commercial Setting

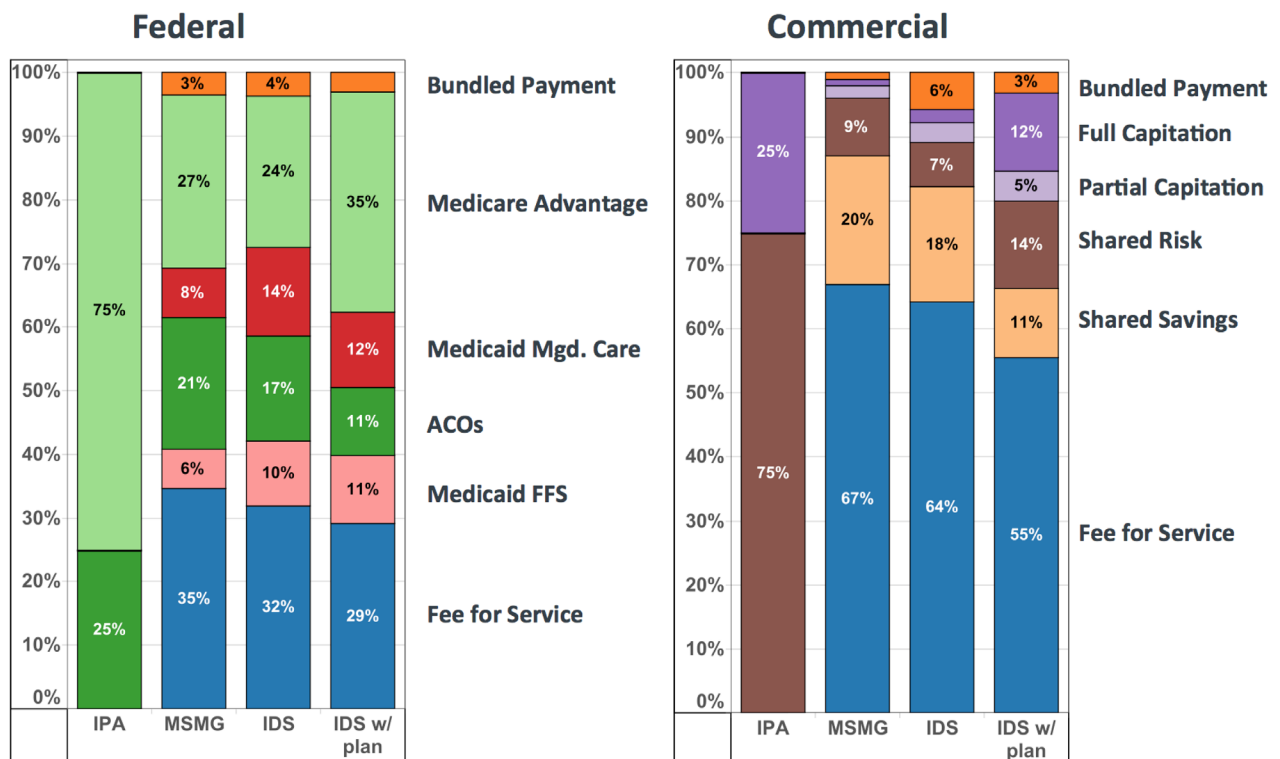
All organizational types expect FFS revenues to decline over the next three years (16% - 26%). IPAs report no revenues coming from FFS, and MSMGs expect their share of FFS revenues to be higher than IDSs, IDSs with a plan, and IPAs. Respondents expect to replace their FFS revenues with projected increases in shared-savings products and shared-risk arrangements. Bundled payment revenues remain relatively insignificant in both federal



Revenue Sources: Organization Structure (2017)



Revenue Sources: Organization Structure (2018)



and commercial settings across all organizational categories except IDs, which expect 6 percent of commercial revenues to come from bundles by 2018. This higher-than-average percentage may reflect revenues expected to come from the bundled payment models recently mandated by CMS.

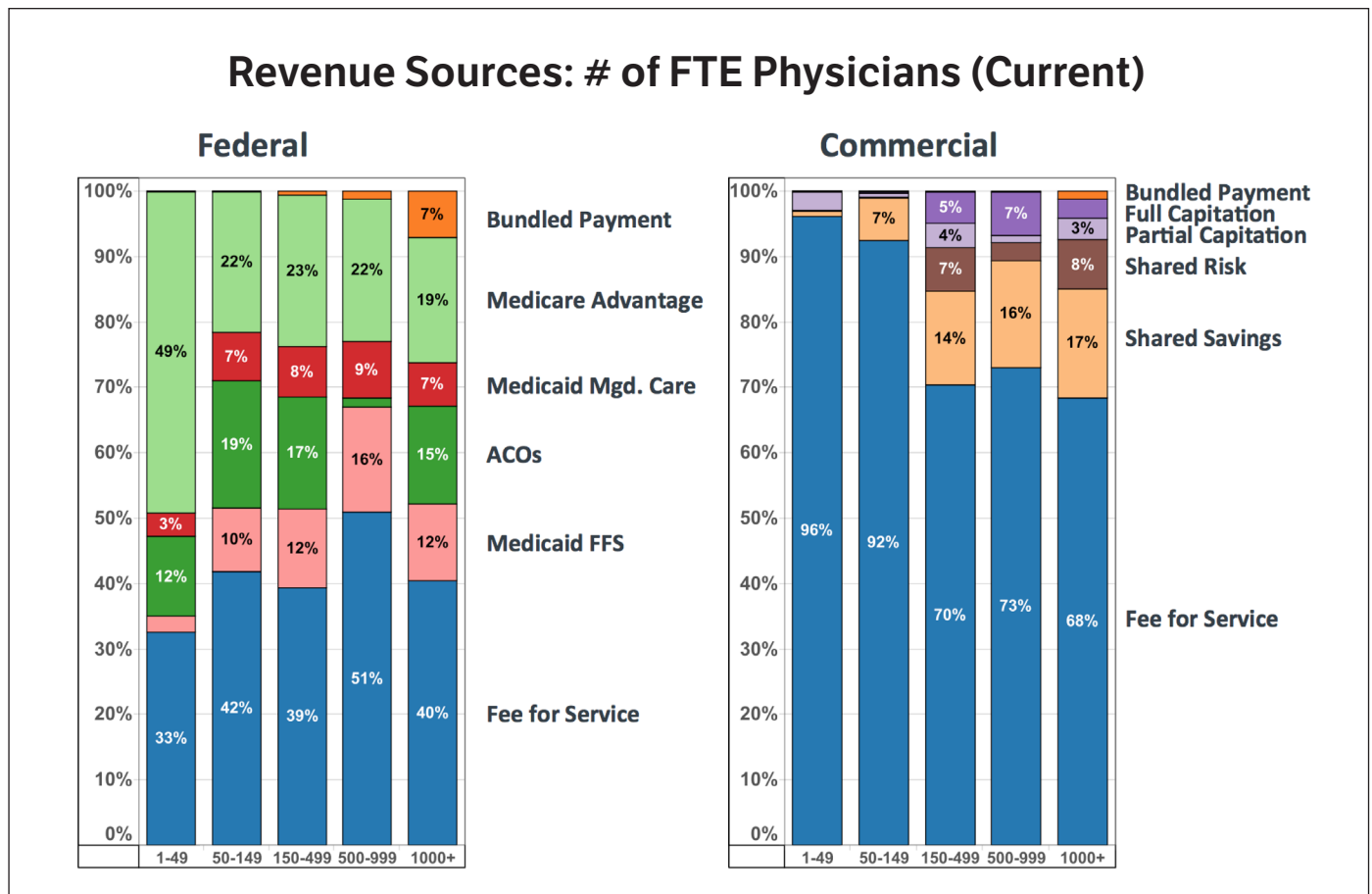
For MSMGs and IDs, expected revenues coming from partial- and full-capitation projects are relatively insignificant, representing less than 4 percent of total revenues by 2018. IDs with a plan differ in their projected revenues from partial- and full-capitated arrangements, expecting revenues from these products to make up 17 percent of their revenues by 2018.

As noted above, IPAs are firmly entrenched in risk-based payment models and report that 100 percent of their expected revenues come from shared-risk or full-capitated arrangements.

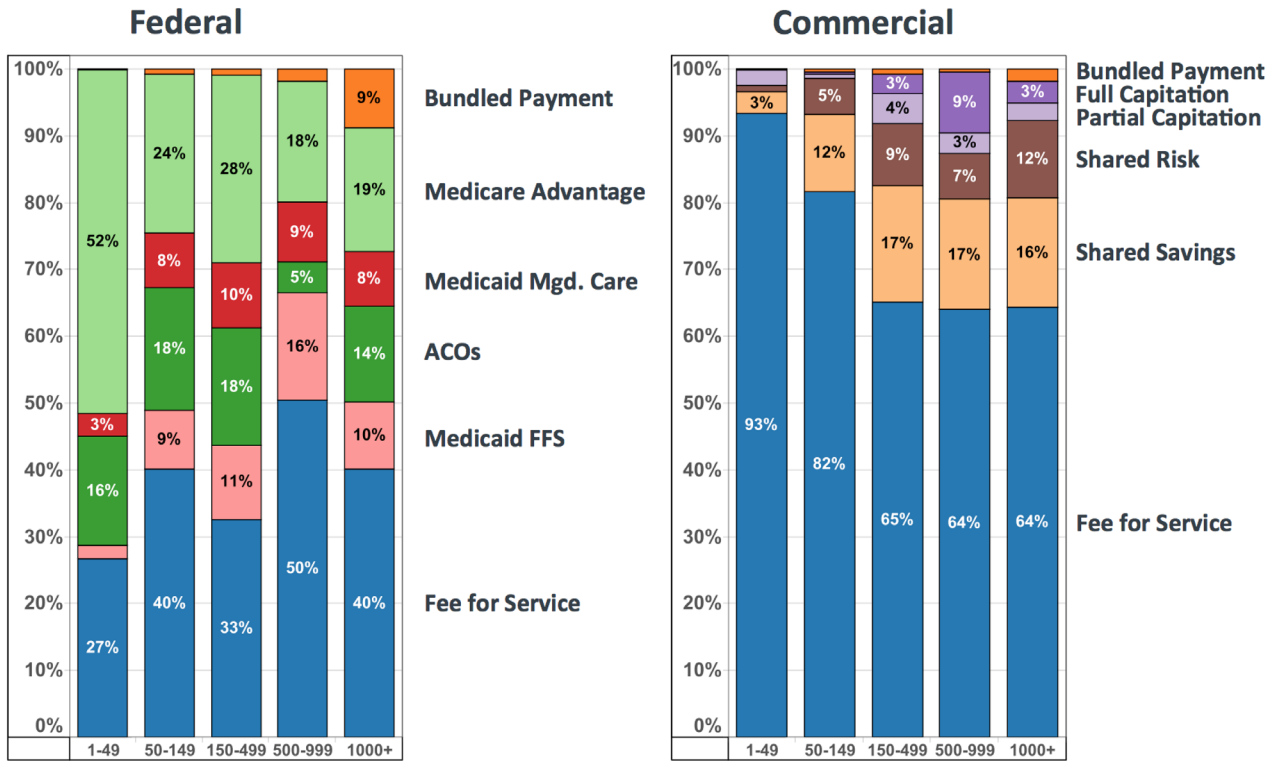
Reimbursements by FTE Size

Federal Setting

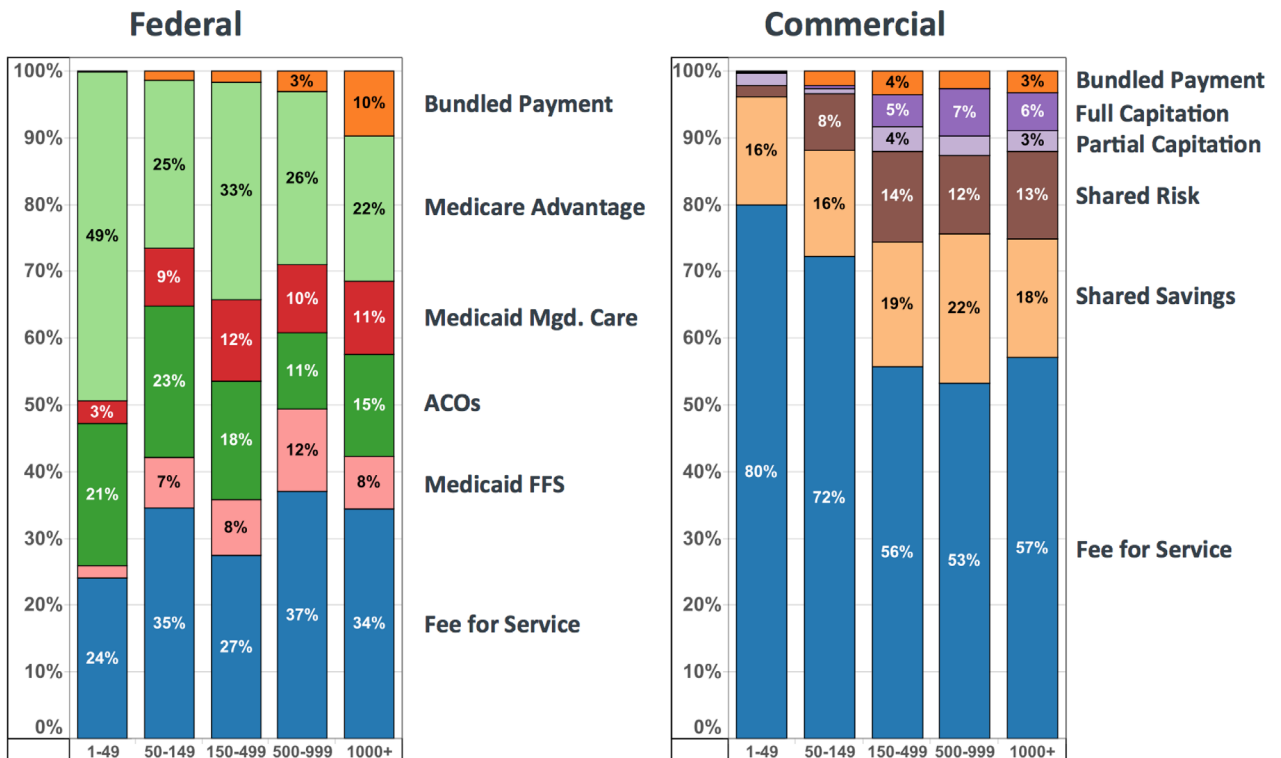
FFS payments in the federal sector are expected to decrease between 16 and 31 percent across all size types between 2016 and 2018. Groups with 1-49 FTE physicians predict they will receive 73 percent of federal revenues from non-FFS models by 2018, half of which are predicted to come from MA payments. MA payments are expected to increase across all FTE types and represent a significant percentage of federal business. Bundled payments remain an insignificant factor in reimbursements for all categories except for groups in the 1000+ FTE physicians category, which report 10 percent of revenue is expected to come from bundled payments by 2018. Medicaid managed care revenues also see increases across all group sizes by 2018, with proportional decreases in Medicaid FFS.



Revenue Sources: # of FTE Physicians (2017)



Revenue Sources: # of FTE Physicians (2018)



Commercial Setting

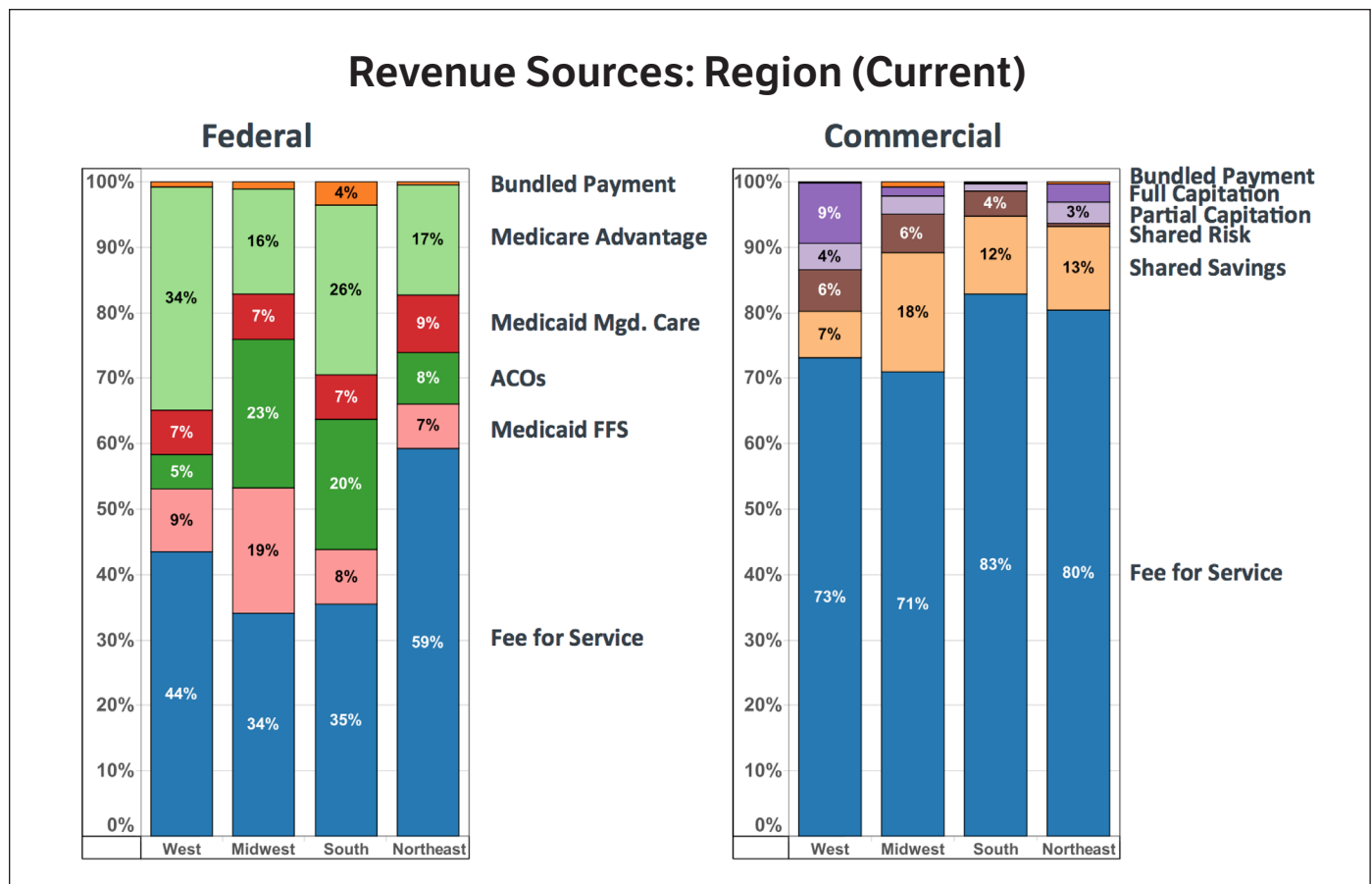
While federal revenues are largely non-FFS related, a higher proportion of commercial revenues are FFS. Most notably, groups in the 1-49 FTE category, while very engaged in non-FFS models in the federal sector, are firmly entrenched in commercial FFS, reporting that 96 percent of revenues come from FFS. Organizations in the 50-149 FTE category also report a high percentage of revenues from FFS (92%), and groups in both categories expect little engagement in partial- or full-capitation arrangements by 2018. Groups in the larger FTE categories show less revenue flowing from FFS and expect to see double-digit increases in shared-risk product revenues. These large-sized groups also expect to receive larger percentages of revenues from partial- and full-capitation products, though the total percent remains less than 10 percent of total commercial revenues.

2015 v. 2016 Survey Comparisons

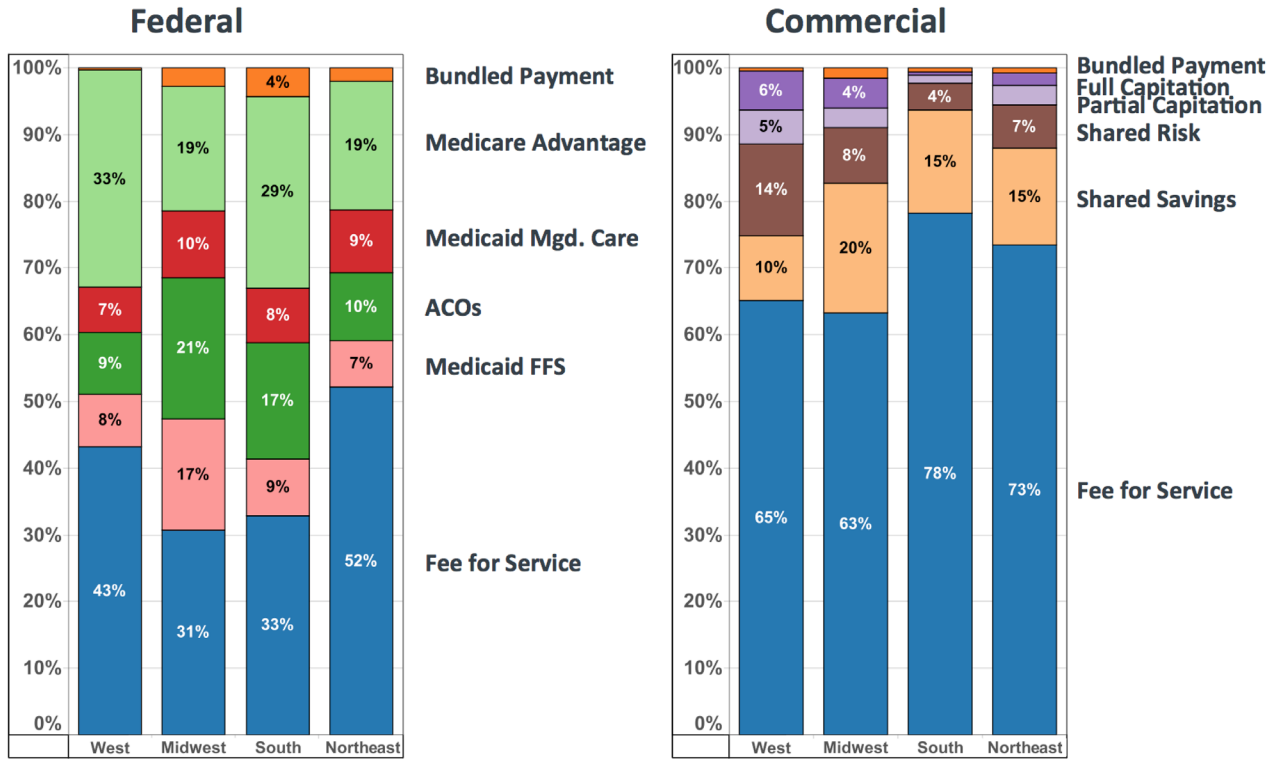
While respondents in 2016 expect FFS payments to decline within this category, this year's results show a pulling back of expected participation in risk-based payment models. Respondents in 2015 expected greater percentages of revenues to come from capitated products (17% for 1000+ category in 2017, compared to 4% in the 2016 survey). Additionally, FFS reimbursements are expected to be higher according to 2016 survey respondents, compared to 2015 results. For example, in 2016, groups between 50-149 FTEs expect FFS revenues to account for 82 percent of their commercial budget; in 2015, respondents expected FFS revenues to account for 63 percent of their budget. Similar differences are seen in the federal sector as well.

Reimbursements by Geographic Region

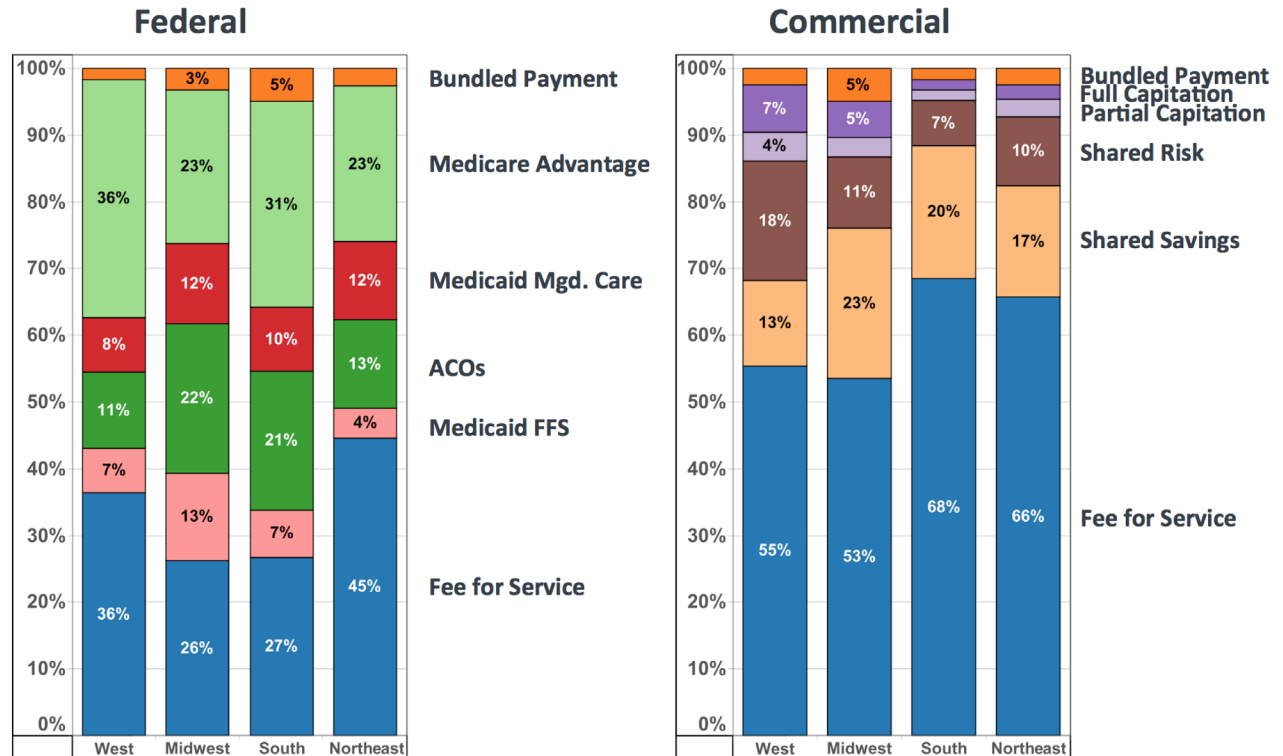
Not unexpectedly, respondents from the West were most likely to show increased participation in risk products compared to the rest of the country. Respondents in the Western region were more likely to receive revenues from



Revenue Sources: Region (2017)



Revenue Sources: Region (2018)



MA in the federal sector and partial- and full-capitated arrangements in the commercial setting. Because groups in the West have more experience in capitation, they also indicated decreased participation in the largely FFS-based MSSP program when compared to the rest of the country. Additionally, Western respondents reported a greater share of revenues coming from shared-risk arrangements. Respondents from the South and Northeast reported greater percentages from FFS payments in both federal and commercial settings, compared to their Western and Midwestern cohorts.

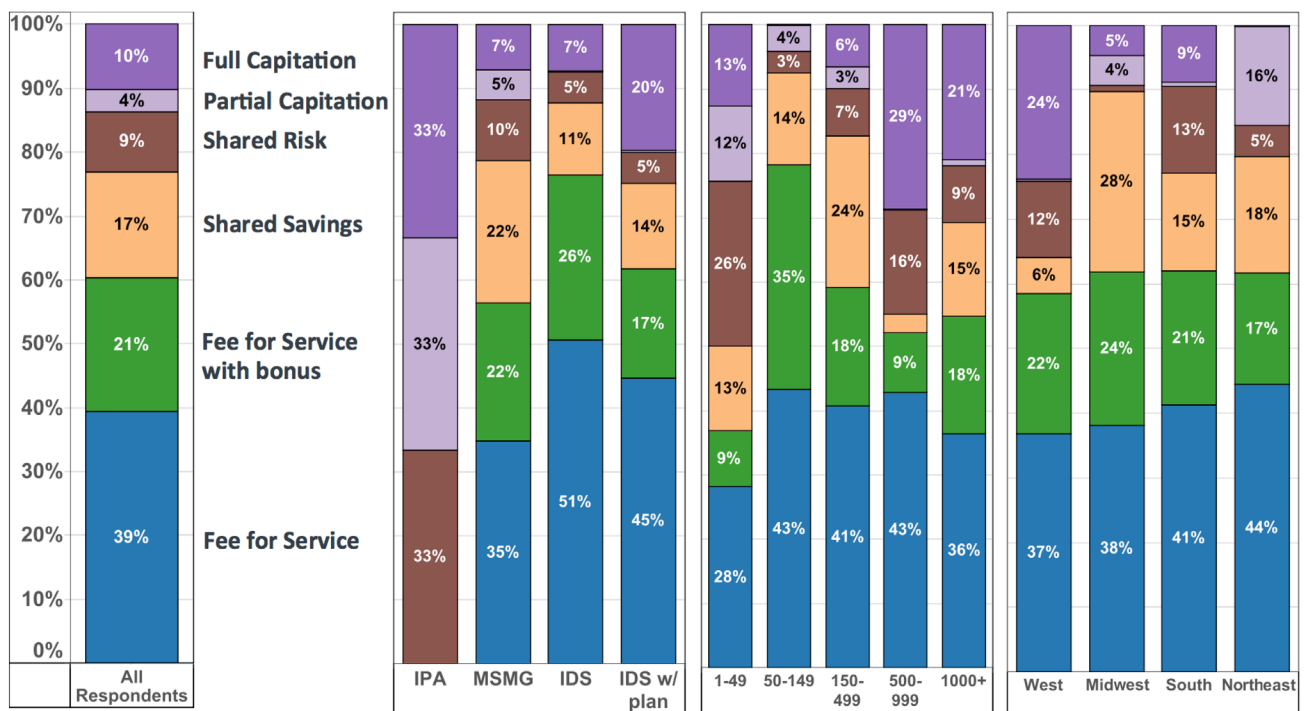
2015 v. 2016 Survey Comparisons

Like the organizational structure and FTE categories, 2016 responses based on region show a pullback from risk-based payment arrangements. For example, in the 2015 survey, respondents in the Northeast predicted 15 percent of their commercial revenues would come from partial- and full-capitation products by 2017; in 2016, respondents predicted a less than 5 percent share. Southern respondents in 2015 predicted 13 percent of revenues would come from capitated products by 2017, while 2016 respondents expect less than 3 percent to come from these arrangements.

Medicare Advantage

Approximately 30 percent of today’s Medicare beneficiaries are enrolled in an MA plan. MA plans receive a capitated per member/per month payment from the Department of Health and Human Services (HHS). While MA plans are capitated, how providers are reimbursed under these plans is not always transparent. To better understand this payment model, AMGA’s survey asked respondents how they are reimbursed under MA. Responses were for 2016 only.

Revenue Sources: Medicare Advantage



In the aggregate, respondents reported that capitated payments totaled 14 percent of MA revenues. Shared-risk revenues totaled 9 percent; shared-savings revenues totaled 17 percent. IPA MA revenues were almost wholly risk-based, with 100 percent coming from capitation and shared-risk products. IDs with a plan reported that 20 percent of revenues were capitated while MSMGs and IDs received 12 percent and 7 percent of MA revenues from capitated arrangements, respectively.

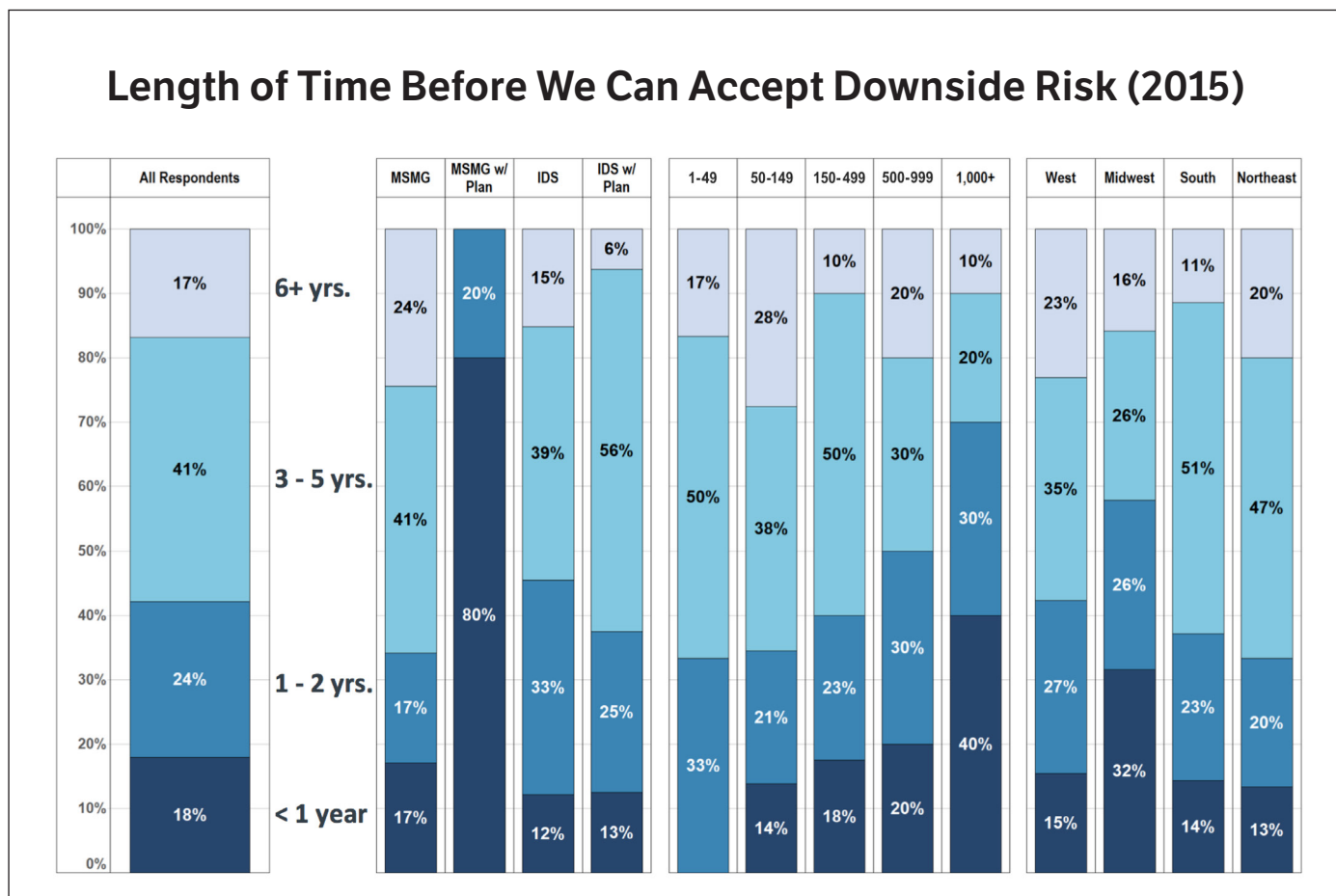
There were differences in revenues from risk products according to size. Groups with 500-999 FTEs reported the most capitated revenues (29%), while groups in the 1000+ category reported 21 percent. Interestingly, organizations in the 1-49 FTE category reported 25 percent of revenues coming from capitated products, which again contrasts with their participation in risk arrangements in the commercial setting.

Western respondents reported more MA payments flowing from capitation (24%) than the other regions.

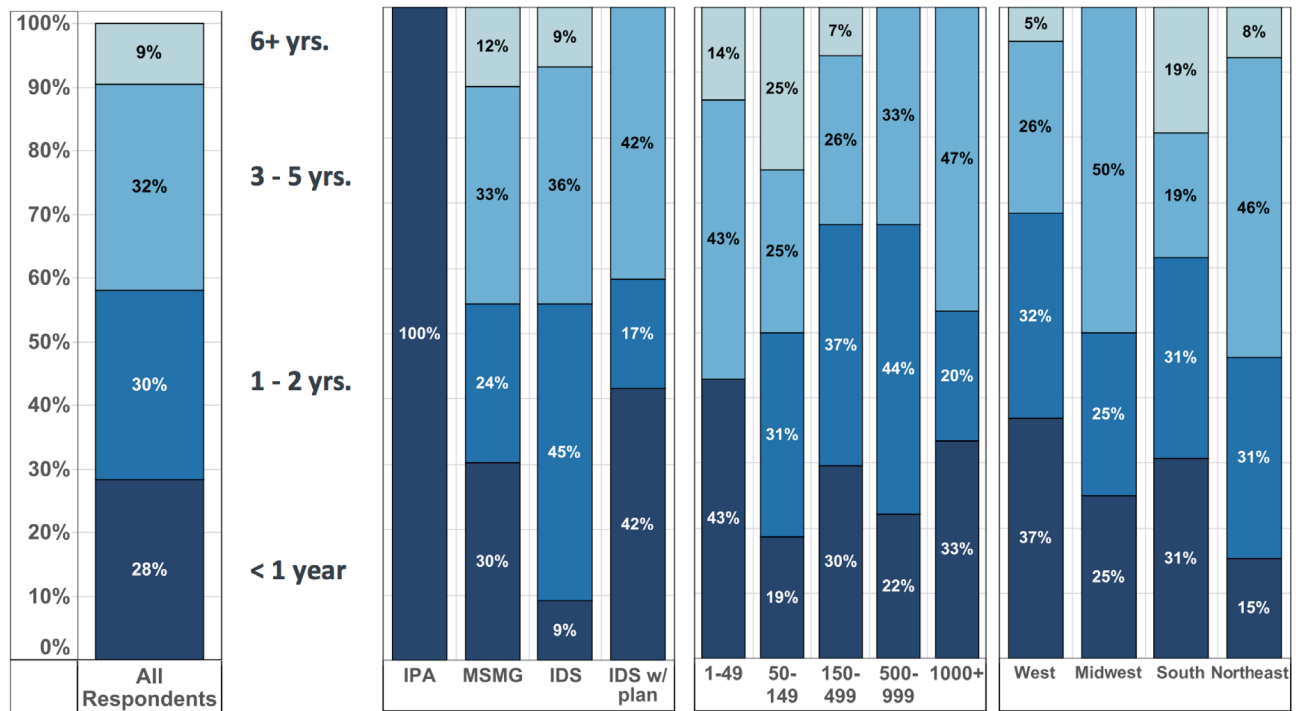
Time Needed to Take Downside Risk

With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and HHS Secretary Sylvia Mathews Burwell’s stated goal of tying 90 percent of Medicare payments to “value” by 2018, federal policymakers are requiring providers to take on increasing levels of risk. Consequently, AMGA’s survey asked respondents how much time they needed before they were prepared to accept downside payment risk.

In the aggregate, 58 percent of respondents indicated they would be ready to take risk within two years; and 41 percent indicated they needed three to five or more years before they could take downside risk. All IPAs indicated they were ready to take downside risk within one year. Among MSMGs, 54 percent indicated they were ready for



Length of Time Before We Can Accept Downside Risk (2016)



risk within one to two years; 54 percent of IDSs stated they were ready for risk within two years; while 59 percent of IDSs with a plan stated they would be ready within two years.

Readiness for downside risk varied according to FTE size. Among groups with 1-49 FTEs, 43 percent reported being ready for risk within one year; another 43 percent would be ready in three to five years. Groups with 50-149 FTEs reported they were less ready for risk, with only 19 percent indicating readiness within one year and 25 percent needing more than five years. Among groups with 1,000+ FTEs, 53 percent reported being ready to accept risk within two years, but this category also had the largest percentage needing three to five years (47%).

Regionally, respondents in the West were more likely to be able to take downside risk within two years compared to their cohorts. Southern respondents were the second most ready to accept risk (in two years), while the Midwest respondents came in third. The Northeast lagged behind the rest of the country in this category.

2015 v. 2016 Survey Comparisons

Respondents in this year's survey indicate a significant increase in their readiness to accept downside risk compared to 2015. In the aggregate, 2015 respondents indicated that 42 percent were ready for downside risk in two years; in 2016, that number increased to 58 percent. In 2015, MSMGs indicated that 34 percent were ready for downside risk within two years. In 2016, 54 percent will be ready within two years. In 2015, 45 percent of IDSs indicated they were ready for risk; in 2016, that number increased to 54 percent. In 2016, 59 percent of IDSs with a plan were ready to accept downside risk in 2016; only 38 percent were considered ready in 2015.

In terms of group size, the most dramatic difference between 2015 and 2016 occurred in the 1-49 FTE category. In 2015, 33 percent of respondents were ready for risk in two years; in 2016, that number increased to 86 percent. All other FTE size categories indicated an increased ability to take risk in 2016, except the 1000+ category, which reported 53 percent readiness for risk within two years in 2016; in 2015, 70 percent of respondents indicated they were ready for downside risk.

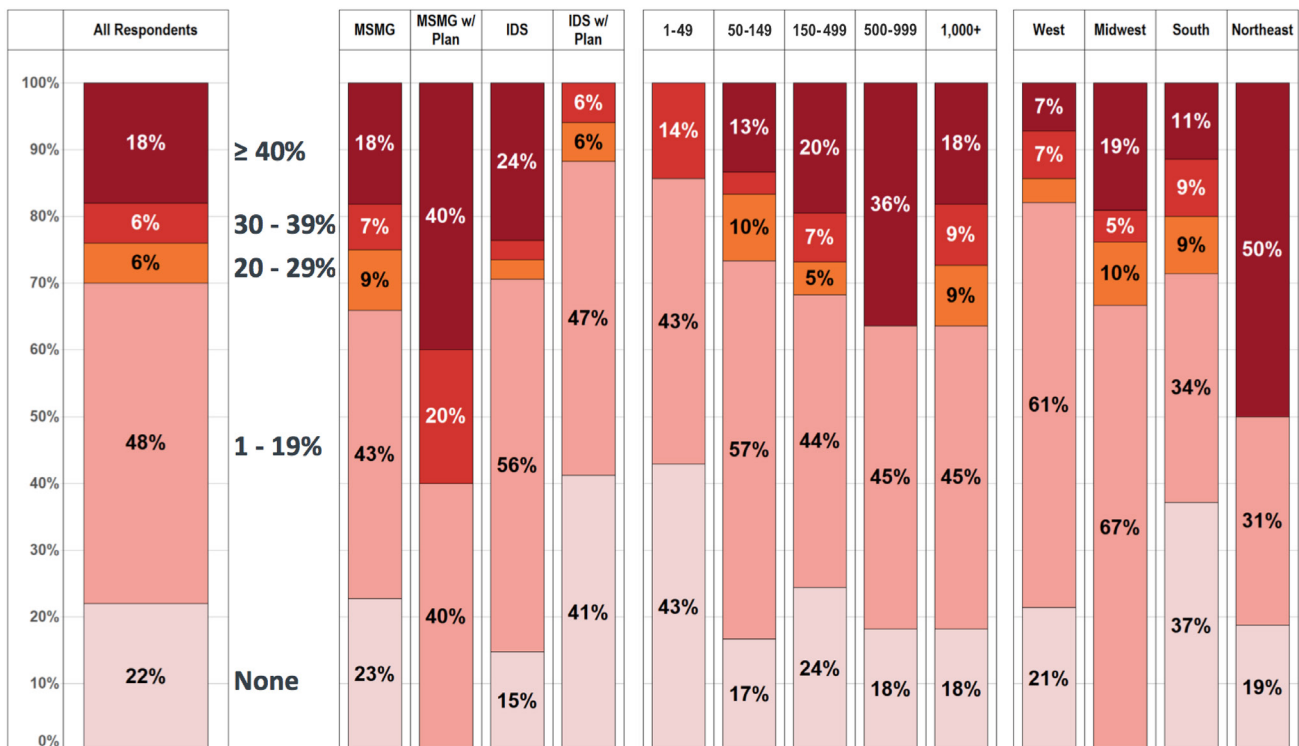
Percentage of Insurers Offering Risk-Based Arrangements

The survey asked respondents to list the percentages of payers offering risk-based arrangements in their local markets. This question is important, as MACRA offers incentives for those providers taking on significant levels of financial risk in the federal and commercial settings in the APM program. The responses indicate that there are insufficient commercial risk products that will allow providers to meet Alternate Payment Model (APM) incentives in local markets.

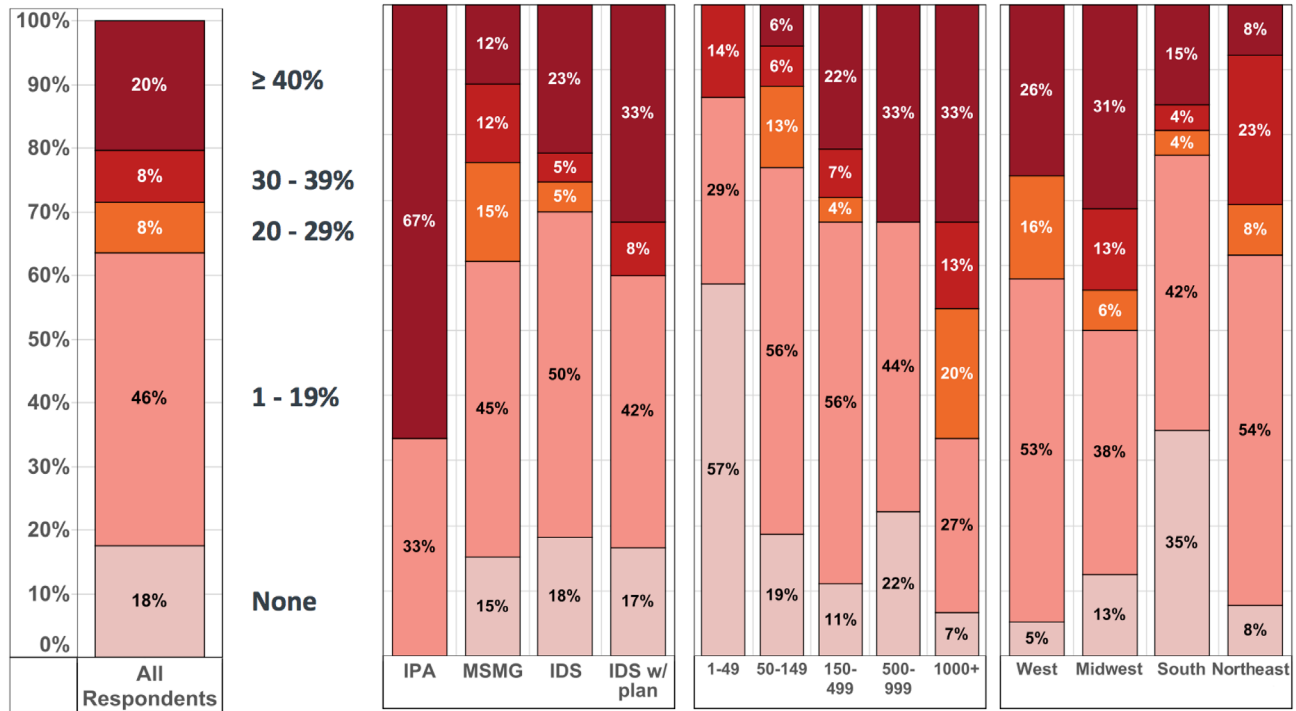
In the aggregate, 18 percent of respondents stated that no insurance company was offering risk-based payments in their local markets, and an additional 46 percent reported that only 1-19 percent of plans were offering risk products in their markets. Twenty percent of respondents indicated that more than 40 percent of commercial insurers were offering risk arrangements in their market.

IPAs showed a robust commercial risk market, but MSMGs, IDSs, and IDSs with a plan reported poor access to risk arrangements in their markets. Access to risk products increased depending on group size. Groups of 1-49 FTEs reported 57 percent of payers were offering no risk arrangements, while groups of 1000+ FTEs reported that 7 percent of plans were not offering risk products in their market.

Percentage of Insurers Offering Risk-Based Arrangements (2015)



Percentage of Insurers Offering Risk-Based Arrangements (2016)



Regionally, Midwestern respondents reported the most active market for risk products, with the West close behind. However, even these two regions did not show a marketplace rich in risk offerings. The South lagged behind the rest of the country, reporting that 77 percent of respondents had little access to risk products.

2015 v. 2016 Survey Comparison

In 2016, 64 percent of respondents reported that they had either no access or very limited access to payers offering risk products. This represents a 9% increase in plans offering a risk product compared to 2015 survey results (64% v. 70%). For organizational categories, health plans offering risk products generally increased by less than 10 percent for each category except IDSs with a plan, which saw plan offerings increase by 41 percent. In 2016, three FTE size categories (1-49, 50-149, 501-999) reported small increased percentages of plans not offering risk products in their markets compared to 2015. The other two categories (150-499, and 1000+) reported an increase in plans offering risk arrangements in their markets compared to 2015 results.

Regionally, respondents reported more health plan offerings around the country compared to 2015. However, respondents in the Northeast reported a significant decrease in plans offering risk products in 2016.

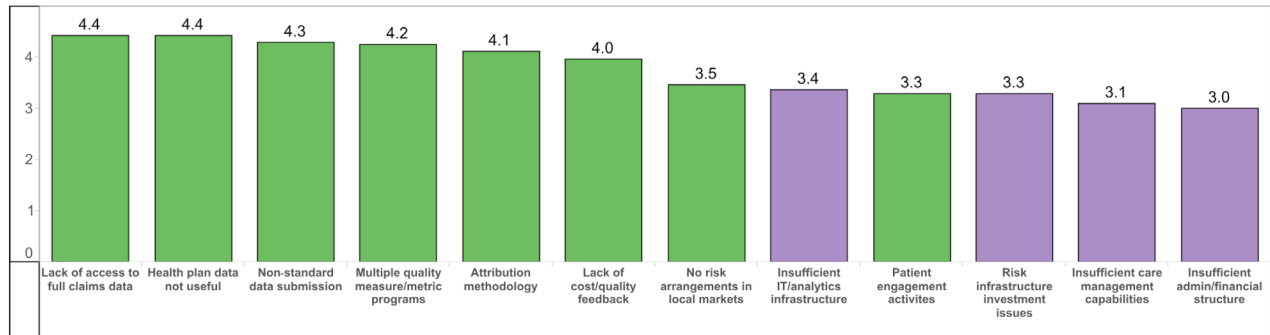
Impediments to Taking Risk

The survey shows AMGA members are making the transition away from FFS to value or risk, albeit perhaps more slowly than anticipated. Respondents identified several impediments to taking downside risk that likely contribute to this apparent slowdown. Impediments were divided into external or payer-driven, and internal, or provider-driven. Responses covered impediments in both federal and commercial sectors.

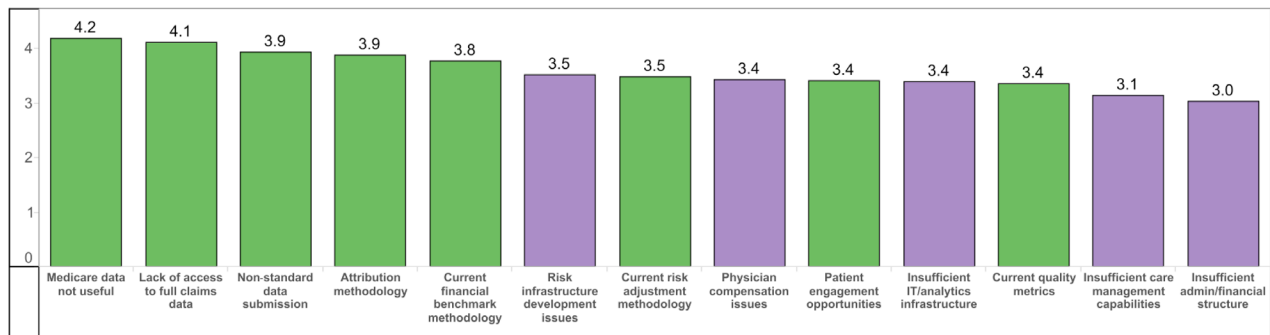
Impediments to Taking on Risk

■ External Factors
 ■ Internal Factors

Commercial



Federal



Commercial Setting

In the commercial sector, the highest ranked impediments to taking risk were a lack of access to administrative claims data and health plan data that was not useful. Non-standardized data submission requirements were also a major impediment, as were multiple and duplicative quality measurement programs and inadequate attribution methods.

Internal impediments focused on the need to invest in the infrastructure needed to take risk, including information technology needs and creating care management processes that allow providers to manage populations of patients. Inadequate access to capital was identified as a major impediment to taking risk, as was redeveloping physician compensation models.

Federal Setting

Reported impediments in the federal sector were consistent with those listed in the commercial sector, but also highlighted issues seen in the MSSP program for several years. Impediments include a lack of access to administrative claims data, data that was judged to be not useful, and non-standardized data submission processes. Issues largely seen in the MSSP program include attribution, financial benchmarking, and risk-adjustment methodologies that limit opportunities for provider success.

Internal factors mirror those found in the commercial sector.

The impediments identified by 2016 respondents are largely the same as those identified in 2015.

Discussion/Observations

It is clear that AMGA members are continuing to transition to value-based payment models. FFS payments are expected to decline, with value-based payments taking their place. In the federal setting, AMGA members expect MA, ACOs, and Medicaid managed care to make up more than 50 percent of their federal revenues by 2018. In the commercial setting, shared-savings and shared-risk products will make up a significant percentage of the respondents' book of business.

Revenues from capitated products are expected to rise by 20 percent, but are expected to make up a small percentage of total revenues. While HHS looks to bundled payments with enthusiasm, there is virtually no traction among survey respondents for this payment model. Declines in FFS payments are expected across all categories of survey respondents; however, there are differences in expected payer mix depending on size and organization type.

The survey clearly shows that AMGA members are increasingly ready to take downside risk, with a majority indicating they will be ready within two years. This represents a reversal from last year's survey, when a majority indicated they needed three to five or more years to get ready for downside risk.

Despite these findings, when comparing responses from 2016 to 2015, it is clear that the path to taking downside risk is slowing. Expected revenues from risk-based payment models declined significantly, while FFS payments will make up a larger share of revenues than expected in 2015. On the commercial side, shared savings products make up the largest share of non-FFS payments, but these products largely do not require downside financial risk. In the federal sector, while many look at MA as a capitated payment model, it is clear that providers largely are being paid on a FFS basis from MA plans.

Why Is the Pace to Risk Slowing?

The reasons why the pace to risk is slowing are many; however, there are some consistent themes from two years of survey data that offer plausible explanations.

External Factors

Lack of Access to Risk Arrangements

It seems reasonably clear that an immature commercial risk market impacts the respondents' ability to enter into risk agreements. While the 2016 survey showed more insurers were offering risk products than in 2015, 64 percent of respondents still noted that there were zero to limited commercial risk products in their local markets. On the MA front, respondents stated that MA reimbursements were largely FFS because that is the payment model being offered by the MA plans.

In many respects, this lack of a robust risk market is understandable. Payers do not have significant incentive to offer risk contracts. They are as likely to be as inexperienced in the risk market as providers, and they are comfortable offering FFS models. Many insurance company margins remain relatively healthy under FFS and for-profit companies have a fiduciary duty to increase shareholder value. Moreover, as providers invest in the infrastructure to manage care, payers have no incentive to subsidize that cost, as the savings accrue directly to them. Size plays a role as well. Smaller providers or providers in rural markets with a limited number of patient lives do not have a sufficient level of enrollees necessary for a return on insurer investment.

Data Issues

In addition to a general lack of a risk market, other structural impediments to taking risk remain. Providers must be able to access administrative claims data in both the federal and commercial settings. Without a complete picture of a population of patients, it is virtually impossible to manage the cost and quality of a patient's care. While some payers provide this data to clinicians, many do not.

Moreover, federal and commercial payers must improve on the data that is shared with providers. Respondents refer to Medicare and commercial data as being unhelpful and not useful. Additionally, providers and payers need to work on creating a standardized format for submitting and receiving data. According to a recent AMGA financial and operations survey¹, AMGA members employ an average of 17 information technology (IT) FTEs per 100 physicians. Much of their work revolves around data submission and reporting. It is clear that the lack of interoperability standards handicap electronic health record (EHR) utility. This same lack of standardization at the reporting level creates tremendous administrative and IT burdens for providers. Creating a standard reporting format would allow providers to divert reporting resources to patient care. Agreeing on a set of quality measures that focus on outcomes would improve care.

On the federal level, respondents continue to identify attribution, risk-adjustment, and financial benchmarking methodologies as impediments to success under the MSSP program. The MSSP, much lauded at its inception, is now in danger of being considered a failure because the current operational framework does not allow sufficient opportunities for provider success.

Internal Factors

Infrastructure Needs

On the provider side, the infrastructure needed to manage risk is expensive to purchase and time-consuming to implement. At a minimum, EHR systems must be utilized, but providers also need a sophisticated analytics team, either in-house or outsourced, to analyze the clinical data from the EHR system to identify at-risk patients and gaps in care. Care management processes must be developed, and additional clinical staff must be employed to manage these programs. Care must often be redesigned with an emphasis on prevention and health maintenance, and that requires significant organizational cultural change. This change also must be managed and requires significant leadership time, effort, and competence.

Financial Limitations and Uneven Risk Successes

Access to capital is a major impediment for AMGA members, particularly independent medical groups that are not tax-exempt. These groups typically finance infrastructure costs through physician contributions which, given multimillion-dollar price tags, is not a sustainable model. This lack of access to capital also is an unintended but major driver of consolidation, as even very large independent medical groups look to health systems, insurers, or other consolidators to help them finance needed infrastructure. Smaller provider groups do not have the sufficient numbers of patients to adequately spread risk. With smaller patient pools, one outlier case can devastate a provider's finances. Relatedly, a lack of sufficient reserves to offset these outlier cases is another significant financial impediment to taking downside risk.

Additionally, many providers have entered into some type of risk-based arrangement and realized afterwards how difficult it is to succeed under risk. For example, even in shared-savings and shared-risk arrangements, providers often must wait 18 months from the start of the contract until they receive shared savings (i.e., the performance year,

a 6-month run-out period, and time for analysis to determine results). This 18-month lag time can have a significant effect on cash flow given the upfront costs incurred to take on these arrangements. Poor experience in risk arrangements tempers enthusiasm.

Given the challenges in transitioning to risk—which includes revising compensation, incurring millions of dollars of infrastructure costs, and the need to redesign clinical practices—the change management aspects to this transition are daunting and require significant leadership heft. The development of the proper culture that welcomes or at least does not undermine these changes is a time-consuming and oftentimes disruptive process.

Conclusion

Congress, HHS, employers, and academics have clearly supported transitioning the healthcare system to value by mandating provider risk. AMGA members understand this dynamic and are preparing for it. What is clear is that the path to risk is more difficult and will take more time to accomplish than most advocates believe. What is similarly clear is that the impediments to taking risk remain problematic. In 2015, AMGA's risk survey white paper² noted that if policymakers did not address these obstacles, they would have to accept that the transition to value would be slowed. According to this year's data, that deceleration is already occurring. Congress and HHS need to address these impediments soon, or the transition to value will either be unnecessarily difficult and prolonged, or it may grind to a halt much like it did in the 1990s.

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