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White Paper

AMGA Advocacy

Taking Risk, 3.0: Medical Groups Are Moving to Risk ... Is Anyone Else?

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

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AMGA's Third Annual Survey on Taking Risk

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AMGA conducted its third annual risk survey to determine whether AMGA members are transitioning from reimbursements based on volume to payment models based on value and to identify impediments to taking insurance risk. The findings in this year's survey are similar to the past two surveys in that the responses show that a transition to value is occurring, despite structural impediments that make this change extremely challenging.

Based on respondent comments and a structured set of follow-up questions, survey respondents provided a clear rationale for pursuing risk, including local employer and payer network demands, qualifying as an Advanced Alternative Payment Model (AAPM) in Medicare, serving as a market leader, and purposefully pursuing risk because fee-for-service (FFS) payments are considered unsustainable over time. It is also clear from the data and respondent comments that medical group leaders are carefully assessing their entrance into or increased participation in risk-based arrangements. Impediments to taking risk, first identified in 2015, have not been addressed and create a disincentive to moving toward value. Lack of access to risk products is problematic, as are publicized stories regarding uneven provider success in risk contracts.

Importantly, AMGA respondents noted that this transition to value is happening largely in the provider setting only, while other key industry players continue to be relatively unengaged. Congress and the Department of Health and Human Services (HHS) need to address the structural impediments and create incentives for other industry players to enter into the risk market or many of these current market leaders will reassess their active involvement in making this transition successful.

Key Findings

Reimbursement Trends. Survey respondents confirm that they continue to move away from FFS payments to some sort of risk-based payment model. The survey shows that Medicare FFS payments are expected to decrease by 17% by 2019, while commercial FFS payments will decline by 11%. However, these expected decreases in FFS spending are lower than predicted in both the 2015 and 2016 surveys, indicating that the transition to risk is happening more slowly than predicted.

Impediments to Risk. Significant impediments remain in transitioning to value. The most critical obstacles involve data, particularly the lack of access to administrative claims data, health plan data that is not actionable, and reporting data to duplicative quality measurement programs. Internal impediments revolve around the need to develop and finance the infrastructure necessary to take risk.

Commercial Payer Involvement in Risk. Fifty-nine percent of respondents state that they have little to no access to commercial risk products in their local markets. While this 59% represents an increase in payer involvement since 2015, the survey demonstrates that commercial payers are still largely not engaged in the risk market.

Readiness to Take Risk. Despite the challenges in moving to value, 60% of respondents in this year's survey stated they would be ready to take downside risk within two years. Federal legislation (i.e., Medicare Access and CHIP Reauthorization Act or MACRA), increasing employer and payer demands, and market leadership are some of the major factors that drive respondents to pursue value.

Medicare Advantage. Survey respondents expect Medicare Advantage (MA) revenues to essentially equal Medicare FFS payments by 2019. AMGA members are reacting to payer and beneficiary activity in MA. Commentary from respondents clearly points to participating in MA as a strategic priority. MA payments remain largely FFS-based.

Accountable Care Organizations. Revenues generated by accountable care organizations (ACOs), whether federal or commercial, are not expected to increase by 2019. Respondents suggest that interest in these delivery models may be plateauing as success in ACOs (especially federal models) is increasingly difficult. However, participation in ACOs will continue because they are viewed as the most viable transition tool which allows medical groups to develop the competencies needed to take downside risk in the market.

Study Notes and Methods

In 2015, AMGA first surveyed its members about transitioning from FFS to value-based payment models. AMGA repeated this process in 2016 and 2017 to assess member progress on the transition to value or risk. Respondents answered the survey between June and August 2017 via AMGA Survey Analytics. Eighty respondents from AMGA member groups began the survey, and 74 answered all of the questions. The survey gathered organizational demographic data, including organization structure and number of full-time equivalent (FTE) physicians. Respondents were assigned a geographic region based on their primary state of business.

As with last year, a small number of respondents selected “Independent Physician Association (IPA)” as an organizational structure. The responses were left in the aggregate analysis as they did not skew the data.

Table 1 provides detailed demographics of the survey respondents. The vast majority of respondents were from unique organizations within AMGA.

Table 1: Respondent Demographics

Organizational Structure	Number of Respondents	Percent
Multispecialty Medical Group (MSMG)	35	44%
Integrated Delivery System (IDS)	28	35%
IDS with Health Plan	13	16%
Independent Physician Association (IPA)	3	4%
Other	1	1%
Number of FTE Physicians		
1 – 49	5	6%
50 – 149	23	29%
150 – 249	11	14%
250 – 499	18	22%
500 – 999	8	10%
1,000 +	15	19%
Geographic Region		
Northeast	6	8%
South	30	37%
Midwest	23	29%
West	21	26%

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 2017. They also were asked to project their reimbursement revenue for 2018 and 2019 for federal and commercial programs. Options for federal reimbursement revenue were FFS Medicare, FFS Medicaid, ACOs, 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 and 2016.

As with previous years, respondents were asked for how much time they need before they can accept downside risk (< 1 year, 1–2 years, 3–5 years, and 5+ years). This information was aggregated as a whole and broken down based on demographics. The survey also asked respondents to rate impediments to taking risk on a scale of 1 to 5, with 1 indicating no impediment and 5 meaning significant impediment.

Reimbursement Trends

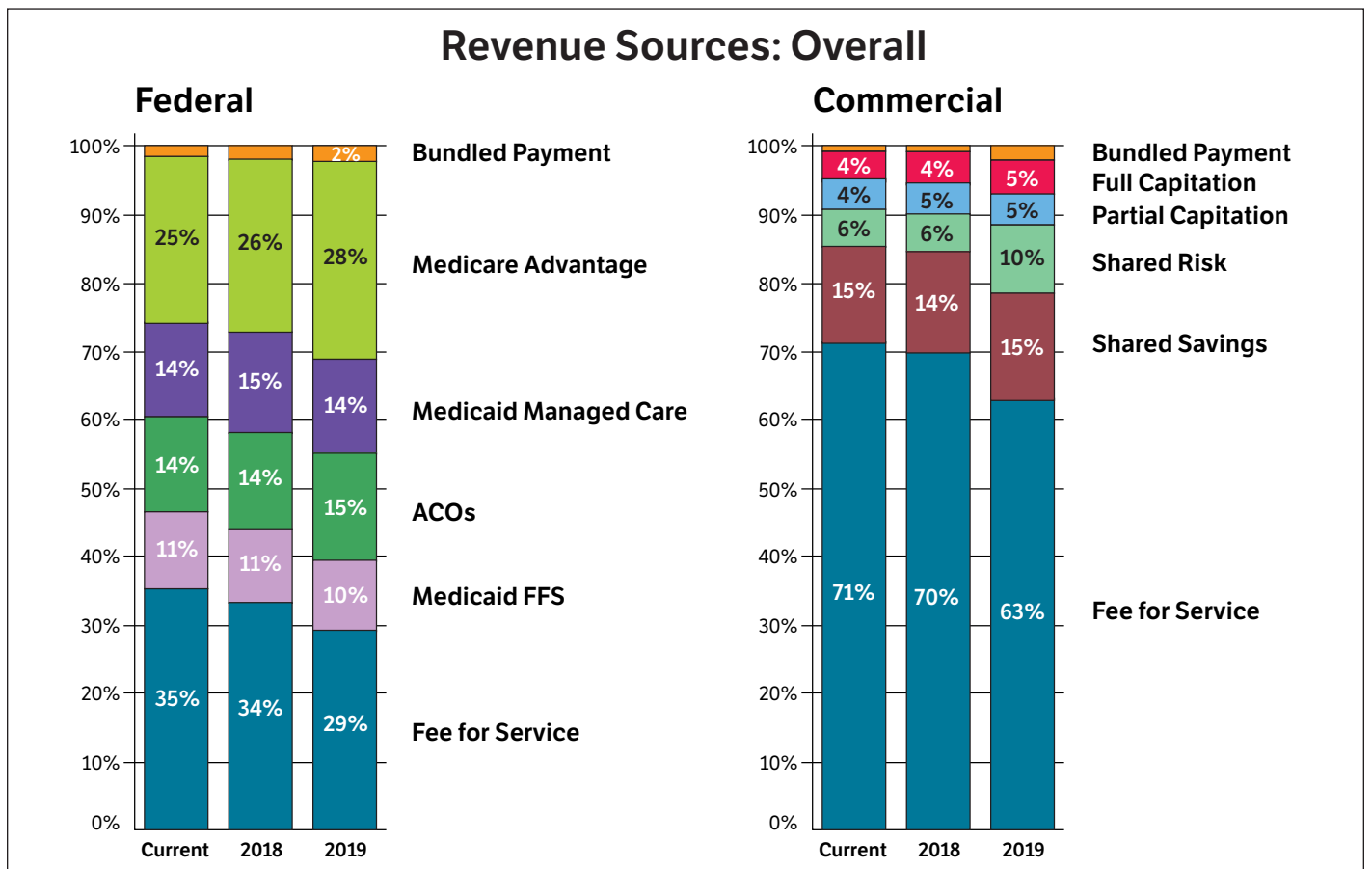
Aggregate Reimbursement Trends

Federal Setting

The 2017 survey data shows that the transition from volume to value continues among AMGA survey respondents. Aggregate survey data shows that Medicare FFS payments are expected to decline from 35% of federal revenues in 2017 to 29% in 2019. Medicaid FFS and managed care revenues are expected to remain relatively unchanged through 2019. MA revenues are expected to increase 12% over that period, while ACO revenue remains flat. Bundled payments are expected to increase from 1% of revenues to 2% by 2019.

Commercial Setting

In the commercial setting, respondents predict that FFS revenues in the aggregate will decrease from 71% of total payments to 63% by 2019. Partial and full capitation payments are predicted to total 10% of revenues by 2019. Shared savings products, traditionally found in commercial ACO programs, remain flat, similar to their federal counterparts. Shared risk products are expected to increase by 66% by 2019. Bundled payments are expected to increase from less than 1% to 2% by 2019.



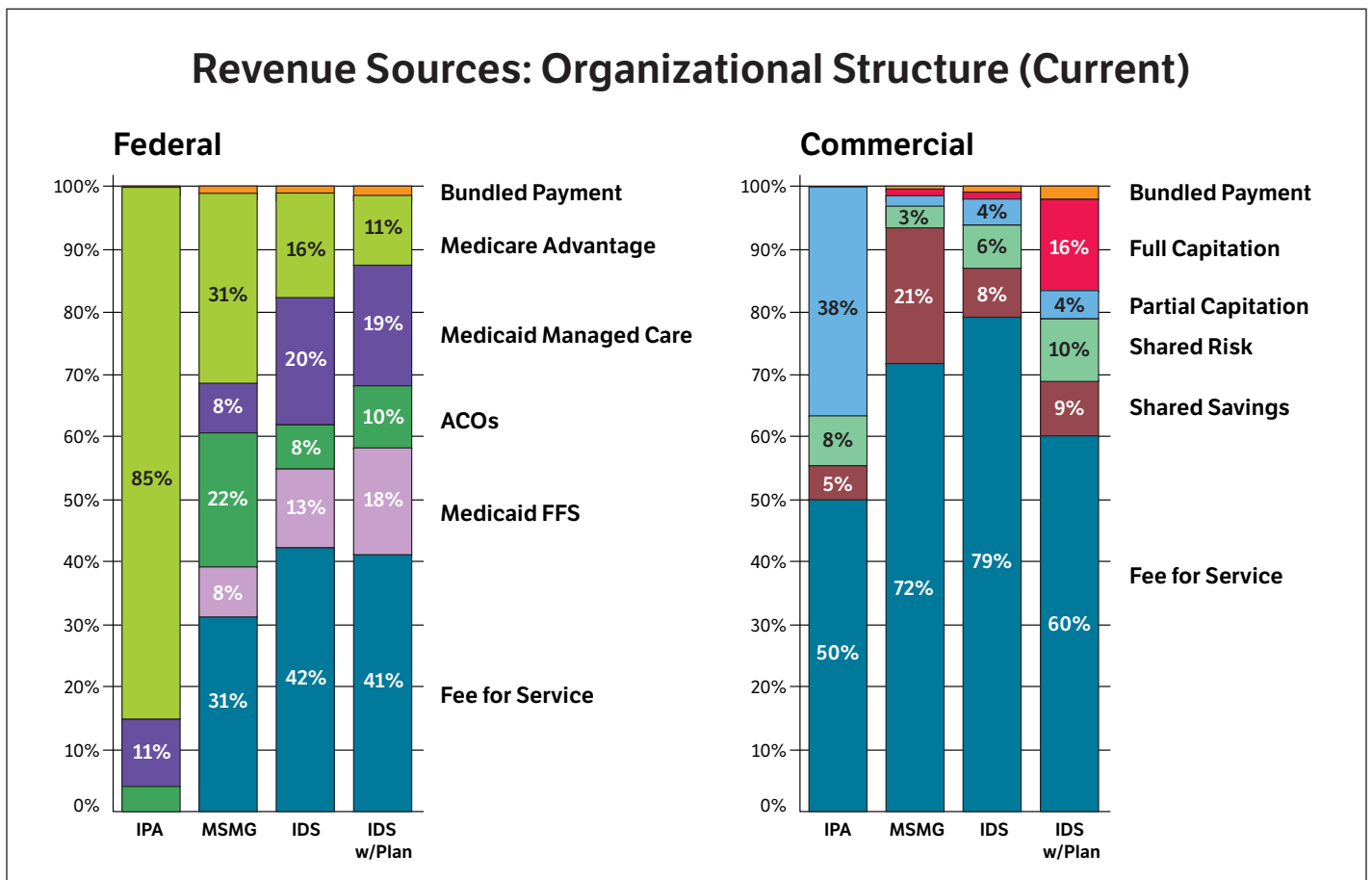
Reimbursement Trends by Organizational Type

Federal Setting

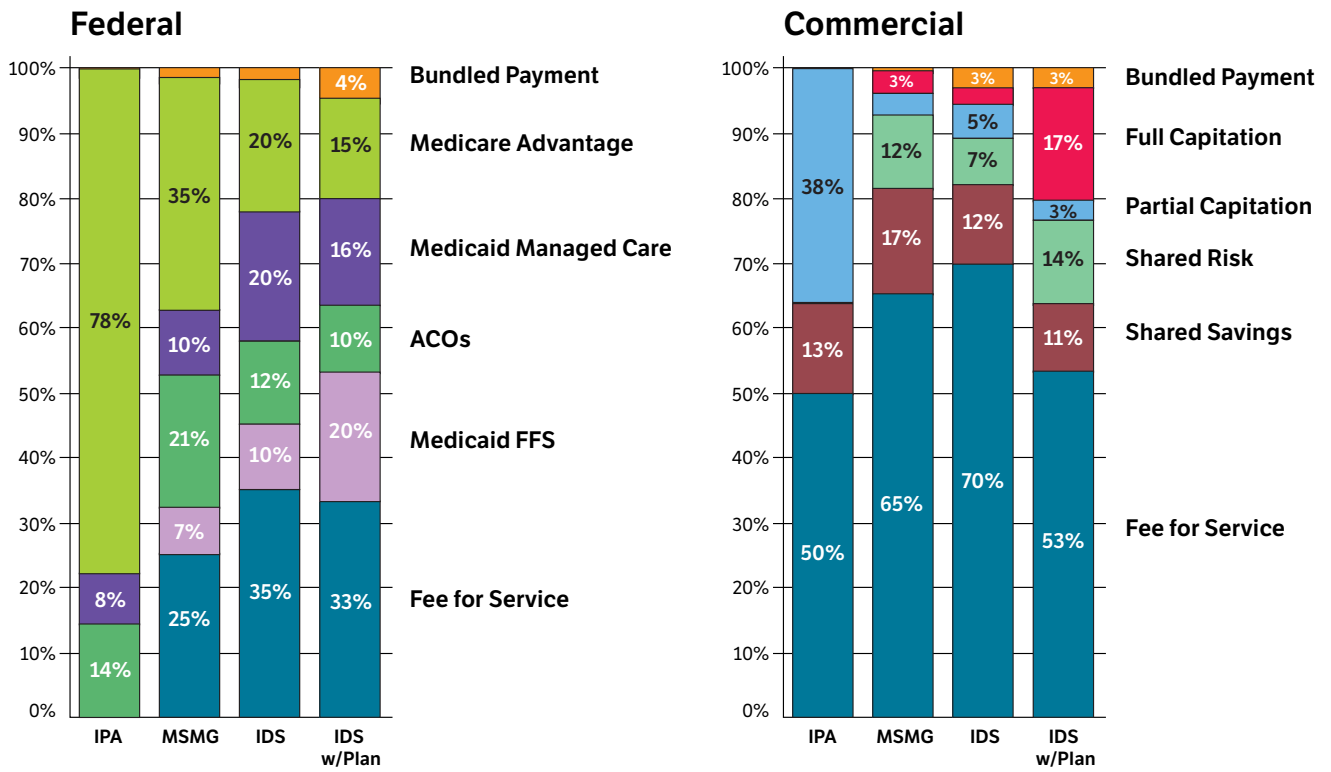
Revenues by organization types show similar trends. Multispecialty medical groups (MSMG), integrated delivery systems (IDS), and IDSs with a health plan all predict that Medicare FFS revenues will decline between 16% and 20% by 2019. Medicaid FFS and managed care revenues are expected to remain relatively unchanged from 2017 to 2019. All organization types also expect to increase their participation in MA plans, while federal ACO revenues remain flat except for among IDSs, which expect revenues to increase from 8% to 12% by 2019. IPAs participate in MA to the virtual exclusion of all other payment models.

Commercial Setting

All organizational types besides IPAs report that they will continue to move away from commercial FFS. MSMGs expect to increase their shared risk revenues by 400% by 2019. Similarly, they expect capitation revenues to increase by 66% within two years, though capitation remains a small percentage of total revenues. IDSs with a health plan predict a comparatively aggressive move to commercial risk products, which are expected to account for 47% of revenues by 2019; 17% of these revenues are expected to be fully capitated. This rapid transition makes sense, as these fully vertically integrated delivery systems are able to align delivery models with appropriate financial incentives. IDSs predict a 50% increase in shared savings revenues as well as increased participation in bundled payment models.



Revenue Sources: Organizational Structure (2019)



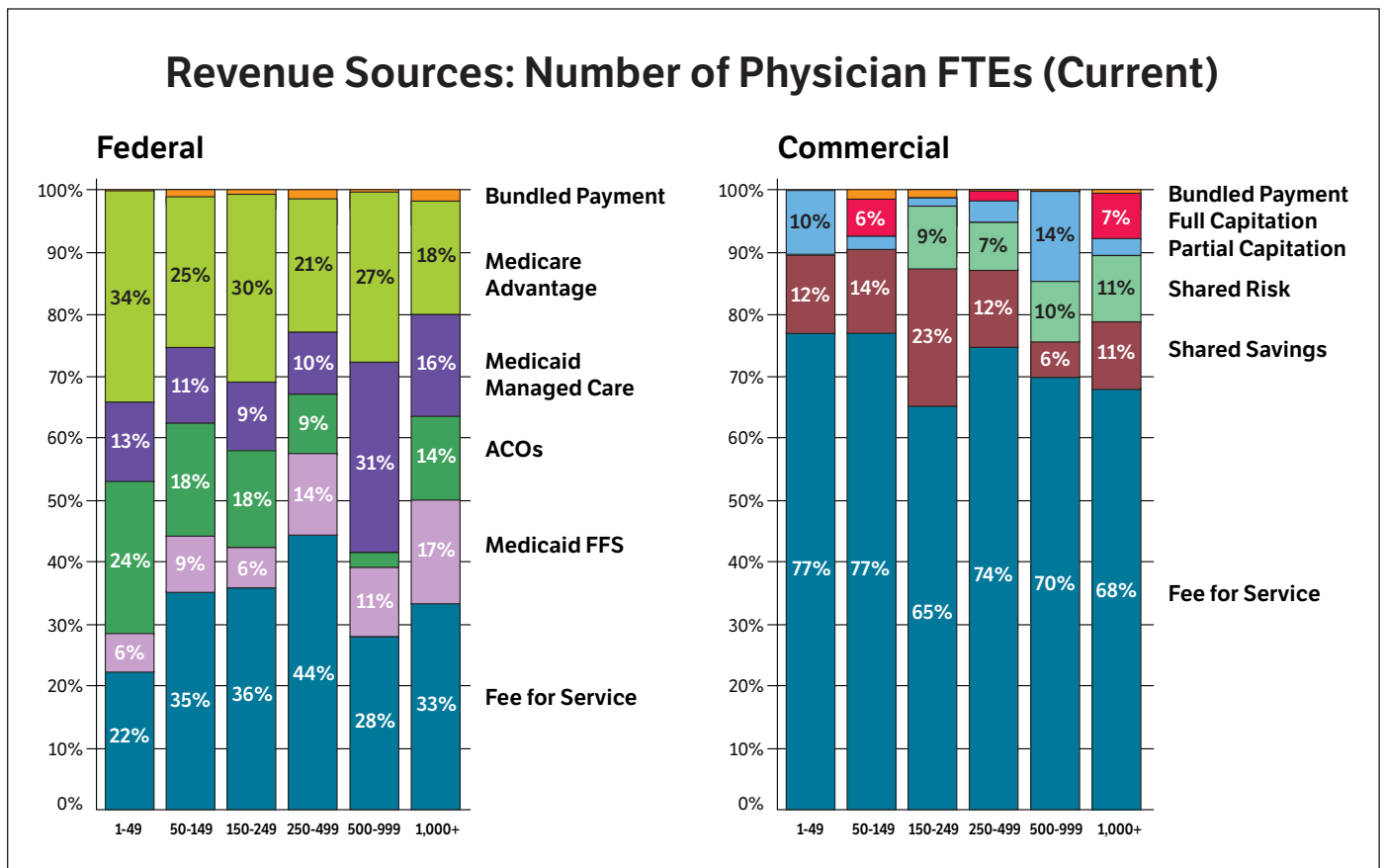
Reimbursement Trends by Size

Federal Setting

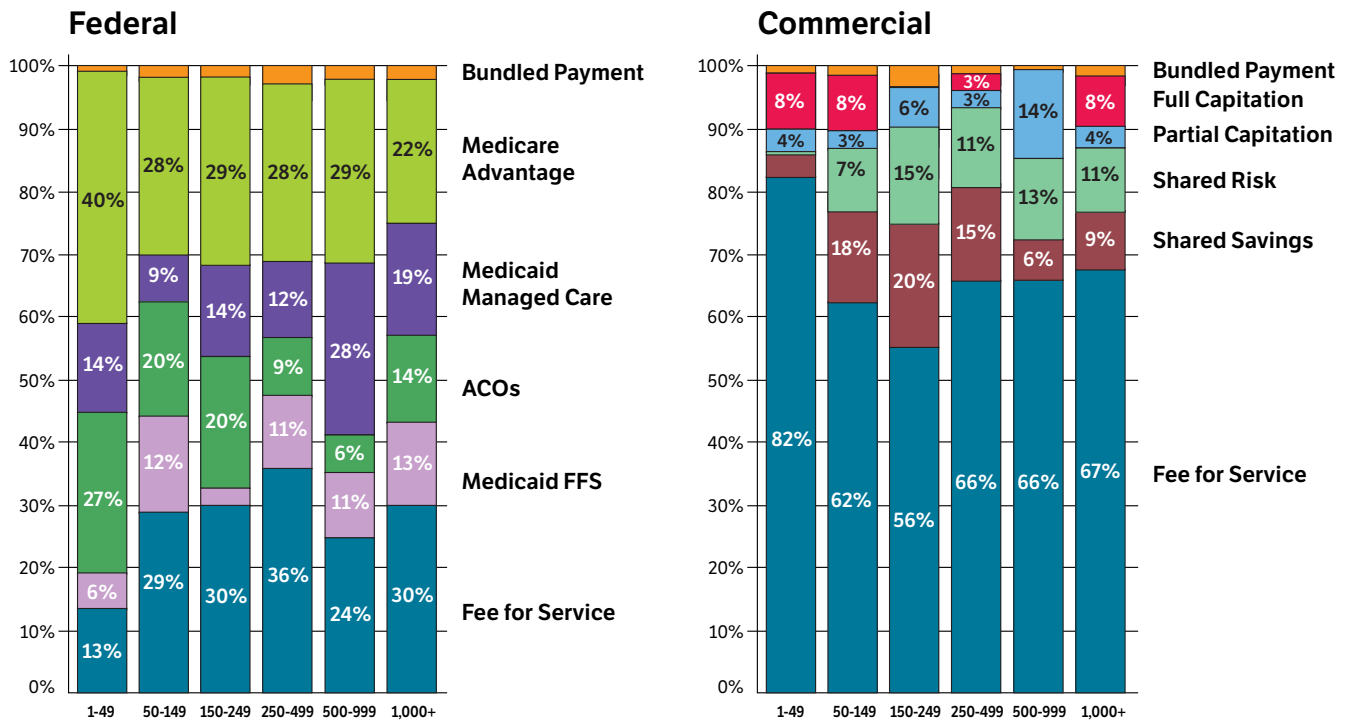
Likewise, respondents of all sizes predict moving away from federal FFS revenues and increasing their participation in risk-based products, particularly MA. This is especially true for the smallest groups (1-49 FTE physicians), which expect FFS revenue to comprise only 13% of total revenues by 2019 while MA payments will total 40%. As far as MA is concerned, size does not appear to matter, as all size categories, except the largest, expect MA revenues to equal almost 30% of total revenues in two years. While respondents expect MA revenue to grow by 2019, ACO revenue remains relatively flat for all sizes through 2019.

Commercial Setting

Similar trends are seen in the size categories, where all respondents predict increased participation in risk-based commercial products, except for groups between 1-49 FTEs, which expect FFS revenues to increase by 7% by 2019. Interestingly, this group also expects capitated products to equal 8% of total commercial revenues in two years, the same amount of time as the 1,000+ FTE-sized groups. Notably, the two largest sized categories also show they are more likely to move into downside risk arrangements at the expense of FFS and shared savings revenues.



Revenue Sources: Number of Physician FTEs (2019)



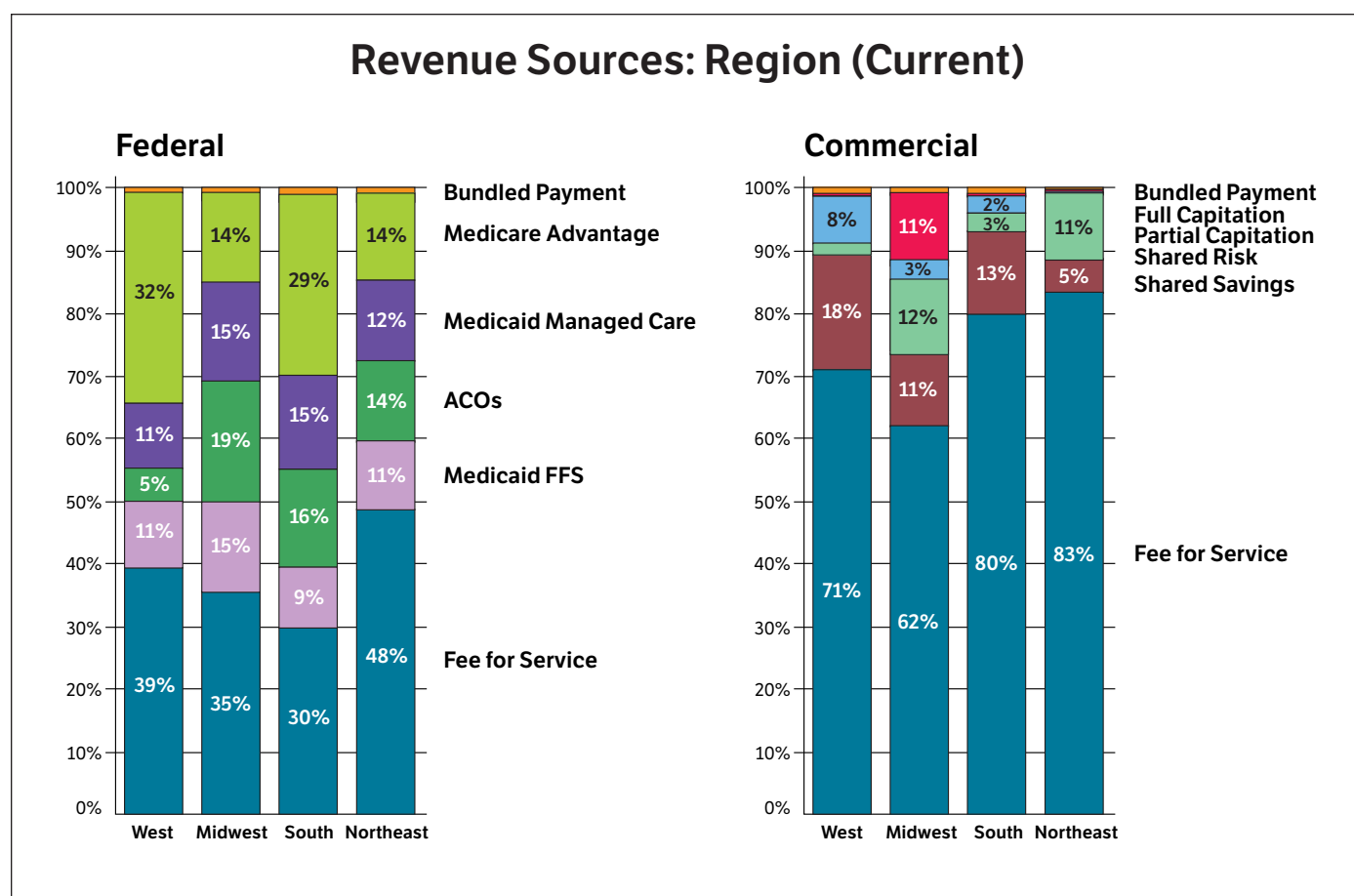
Reimbursement Trends by Region

Federal Setting

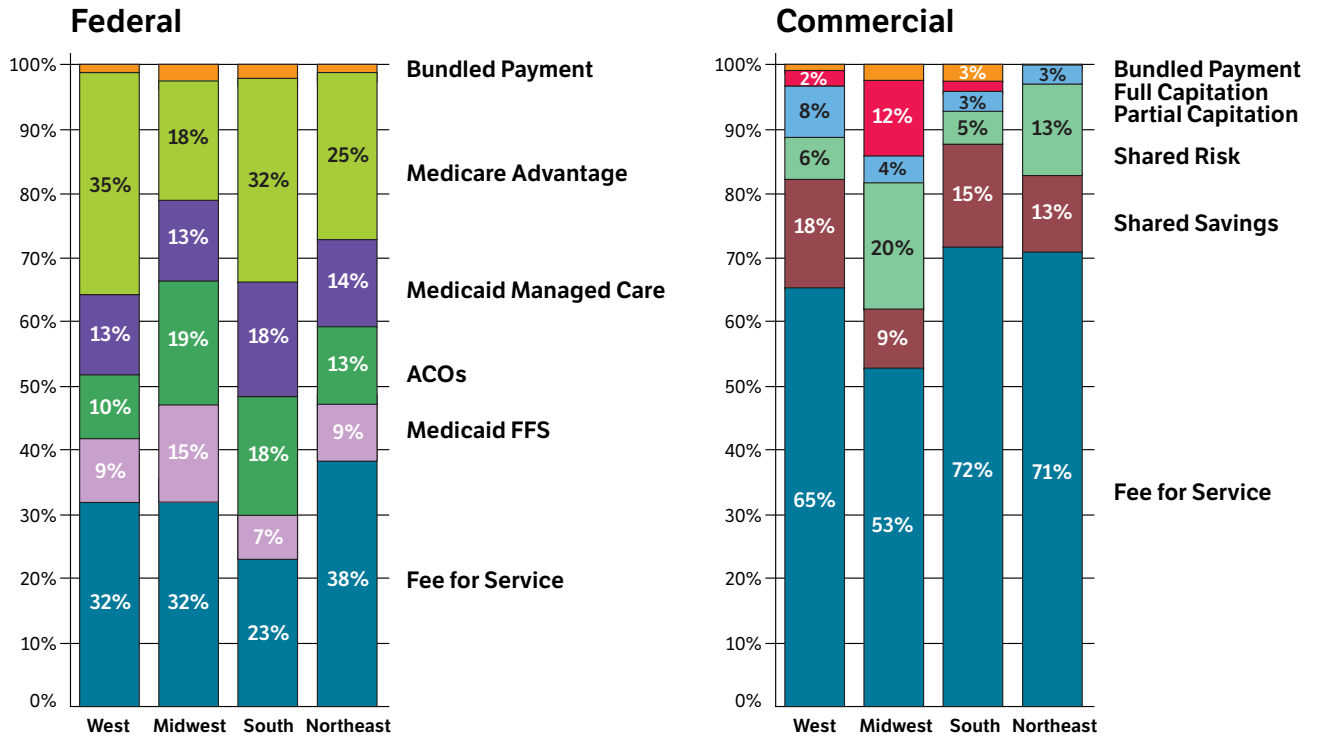
Respondents in the west region report the largest percentage of revenues coming from MA by 2019 (35%), but those in the southern region predict they will be in more risk-based arrangements than any other part of the country (70%). Interestingly, these numbers are not replicated in the commercial setting, where respondents in the south indicate a larger percentage of revenues will remain in FFS. Respondents from the east region expect the largest growth in MA payments, from 14% in 2017 to 25% in 2019.

Commercial Setting

Midwest respondents reported higher percentages of current and expected revenues from capitated and shared risk products, followed by the west. Respondents from east and south regions report larger percentages of revenues coming from FFS, which is to be expected, as these regions do not have the history with risk that the midwest and west regions do.



Revenue Sources: Region (2019)



Federal Risk v. Commercial Risk

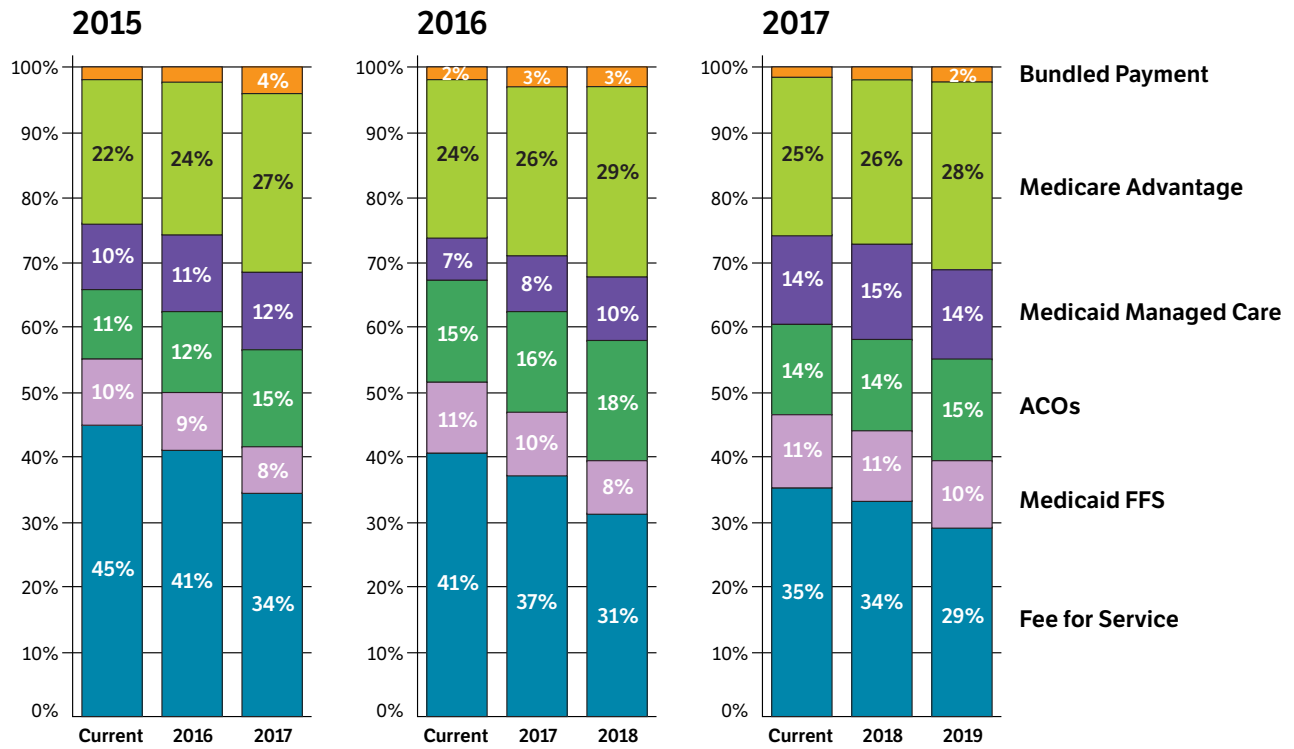
Respondents report significantly greater percentages of risk-based revenues in the federal setting compared to the commercial space. According to respondent comments, HHS has been proactive in offering a large suite of risk-based models to join. Many respondents note that joining an ACO allows them to enter the APM track under MACRA. The APM track provides some opportunity for AMGA members to recoup million-dollar investments they have made in the infrastructure necessary to take risk. Moreover, APMs are a more attractive alternative to the Merit-Based Incentive Program (MIPS), which AMGA members see as little more than a regulatory compliance exercise that offers little to no rewards for improving care and reducing costs. Respondents also note that commercial payers have been slow to offer risk products, meaning there is less opportunity to transition to risk in this setting.

Comparing 2016 Results to 2017 Results

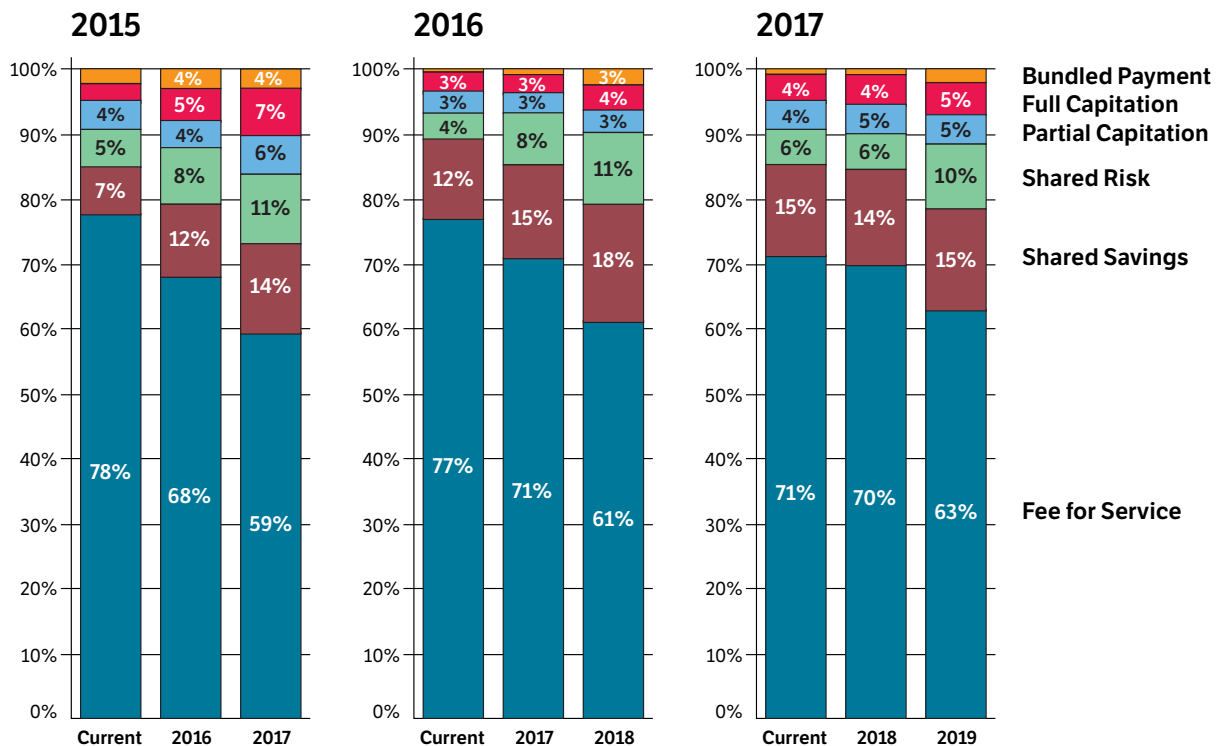
While the data show respondents transitioning to value, the pace of that transition has slowed in the past two years, especially in the commercial setting. In 2016, survey respondents predicted commercial FFS revenues would amount to 61.3% of total revenues in 2018. One year later, they predicted that 2018 FFS revenues will make up 70% of total revenues, a 14% expected increase. Respondents in 2016 predicted shared risk revenues would make up 11% of total reimbursements in 2018; one year later, they predicted that number would decrease to 6%. Similarly, respondents in 2016 anticipated shared savings products would make up 18% of revenues in 2018; one year later, that figure dropped to 15%. Comparing 2016 and 2017 responses, respondents predicted that only revenues from partial and full capitated products would increase.

This is not the first time the survey has indicated a slowing down of the transition to risk. AMGA's 2016 survey showed a pull-back to risk as well (see "Taking Risk, 2.0: Is the Transition to Value Slowing?"). This year, the reasons cited for this hesitation are varied and remain very similar to the reasons discussed last year. The "why" is discussed in greater detail in the Impediments section below.

Revenue Sources: Federal Overall



Revenue Sources: Commercial Overall



Impediments to Risk

External Impediments

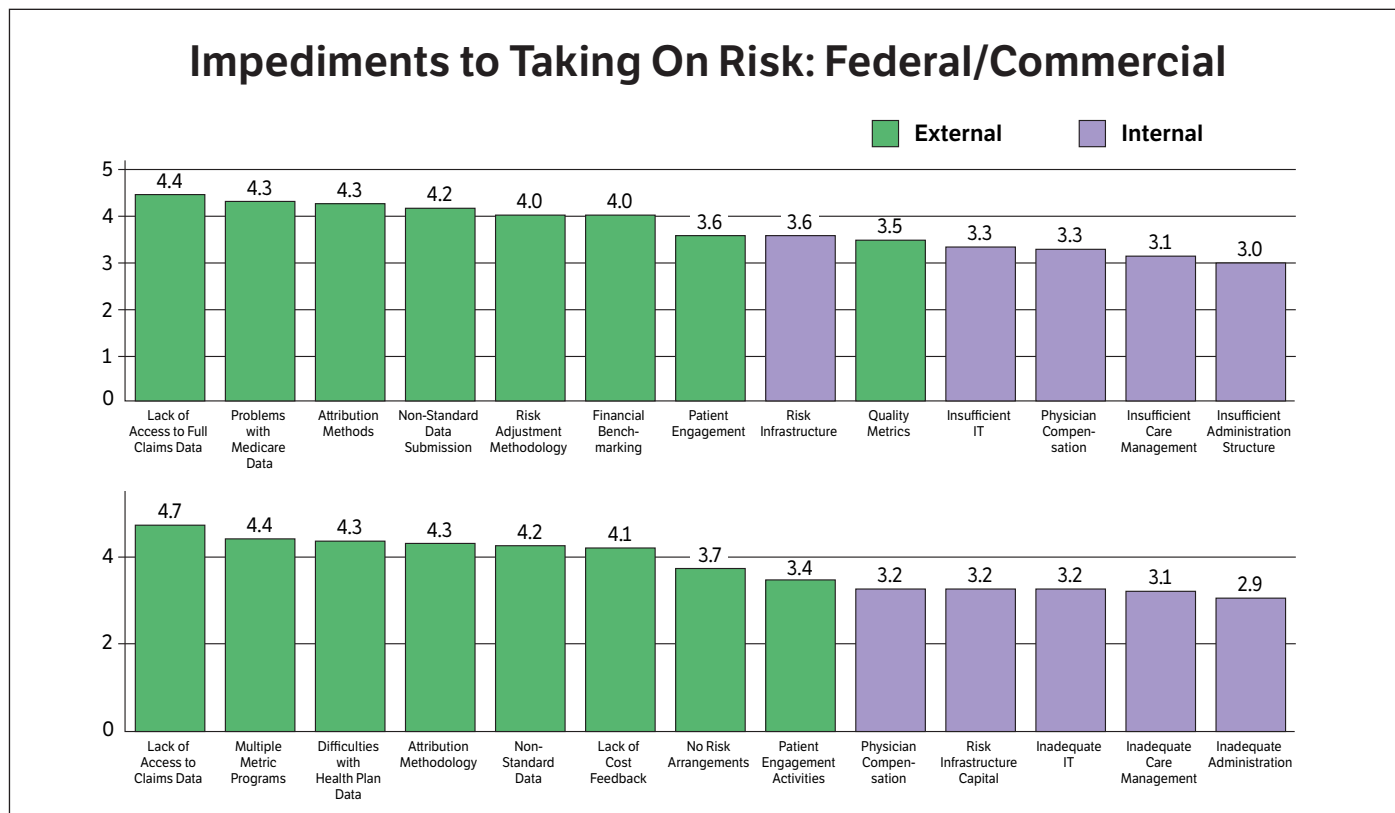
At the federal setting, lack of access to claims data is the chief obstacle to taking risk, but respondents also note programmatic challenges, such as inadequate risk-adjustment and financial benchmarking methodologies, as significant barriers to success. This echoes concerns that AMGA has long made regarding the federal ACO program.

In the commercial setting, survey respondents have consistently rated a lack of access to administrative claims data as the most significant barrier to taking risk. Comments from respondents indicate that while some payers share this data with them, the majority of payers do not. Without this data, however, it is challenging at best to manage the cost and quality of a population of patients, which is the goal behind moving to value. Respondents also cite the data submission and reporting process as problematic, as they are required to submit and receive data in different formats from different payers. Data described as unhelpful also is an impediment to taking risk, as are the multitude of quality measurement programs.

Internal Impediments

While external impediments serve as greater obstacles to respondents' success in risk payments, internal impediments also play a role. These impediments revolve around a lack of infrastructure necessary to take risk. This infrastructure includes hiring skilled clinicians trained to coordinate care, investing in electronic medical records systems and the analytic software and people that can analyze clinical data, as well as creating the administrative and financial processes that are able to handle risk-based payment models. Internal impediments essentially mirror each other in both the federal and commercial setting.

Relatedly, access to capital is an obstacle to taking risk. Infrastructure costs are enormous, and accessing the capital that allows groups to make these investments is a challenge. Capital is also needed to maintain reserves to take on increasing levels of risk. This issue is particularly true for physician-owned medical groups whose retained earnings are taxed at the state and federal corporate level.

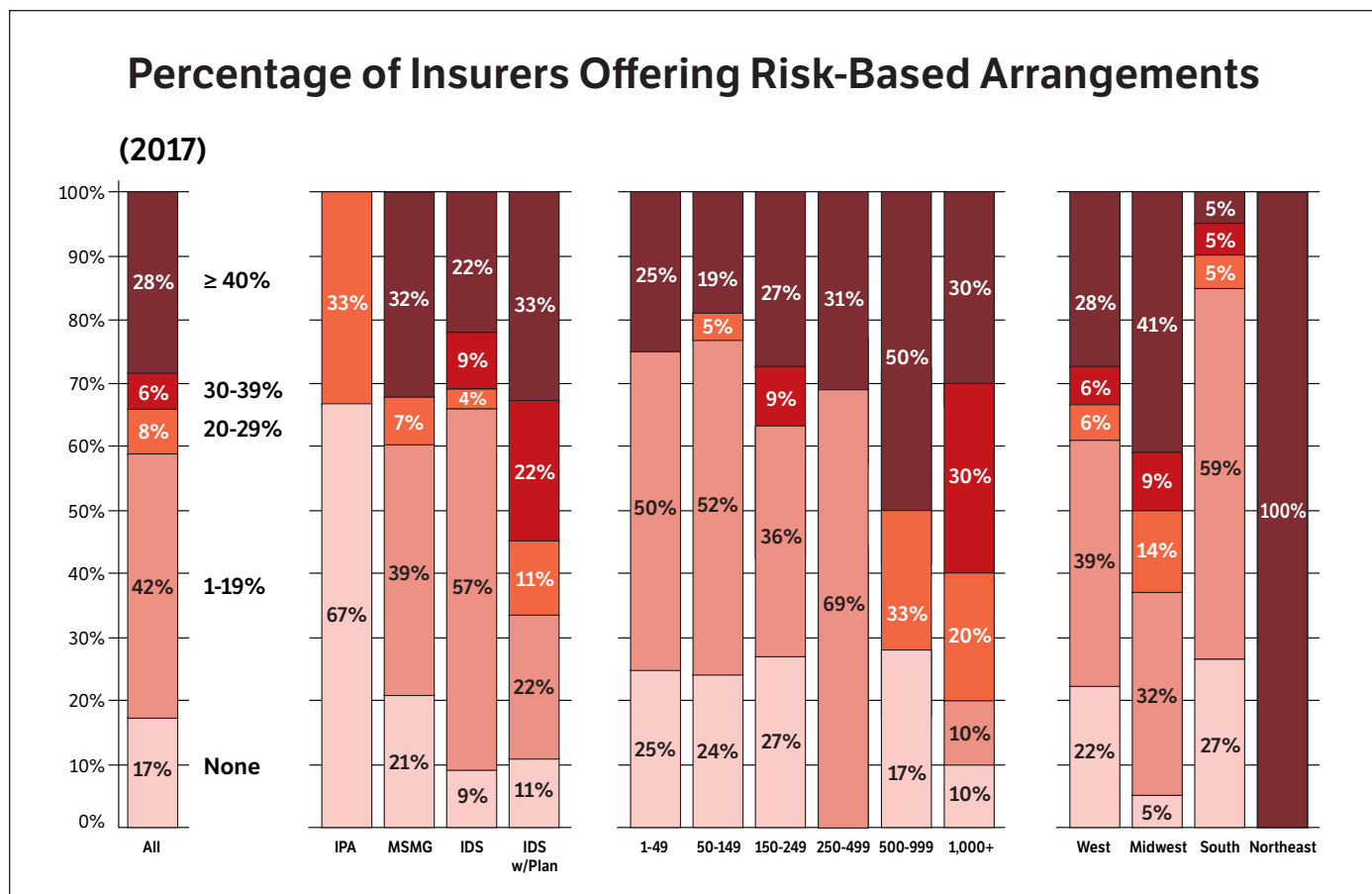


Commercial Engagement in Risk Products

For the third year in a row, respondents report that commercial payers are largely unengaged in offering risk products in the provider’s local markets. The 2017 survey showed that 17% of respondents had no access to any commercial risk plan, while another 42% reported less than one in five plans were offering risk products in their markets. It should be noted however, that these figures represent an increase in payer engagement since AMGA’s first survey in 2015, when 70% of respondents stated they had little to no access to commercial risk plans.

This lack of payer involvement makes sense from their perspective. Many payers are publically traded companies and as such, owe a fiduciary duty to maximize shareholder value. Moreover, if providers are willing to invest time and money into care management improvements that, for example, reduce hospital admissions or lengths of stay, these savings accrue to the payer. Consequently, there is little incentive for payers to pursue an aggressive risk strategy, especially in markets where providers are already doing so. On the provider side, smaller providers do not have the patient population numbers to justify either party entering into risk-based arrangements. Additionally, with smaller patient populations, one or two high-cost cases or an unexpected spike in product prices (for instance, specialty drugs) can eliminate a medical group’s cash reserves.

That said, this lack of payer involvement in risk products, while commercially understandable, is a significant impediment to taking risk. Providers and payers need to create commercially reasonable arrangements where both parties can succeed. Developing these relationships will result in decreased costs, improved care, and a more fully aligned financing model for care delivery. Congress’ goal of moving health care to value will be more readily achieved.



Time to Take Downside Risk

Despite these impediments to taking risk, 60% of respondents stated they would be able to enter into downside risk products within two years. This is a 42% increase from the 2015 survey, when 42% of respondents indicated they would be ready.

Among organization types, IPAs were most ready to take risk, followed by MSMGs, and IDSs with a health plan. IPAs were developed specifically to assist clinicians in entering into risk contracts. MSMGs are not associated with a hospital, which means they are not penalized by any savings they achieve on the inpatient side. IDSs with a health plan have likely made taking risk a strategic priority.

Size does matter for groups that are moving toward downside risk. Fifty percent of the largest and smallest sized groups expect to be ready to take downside risk by 2019.

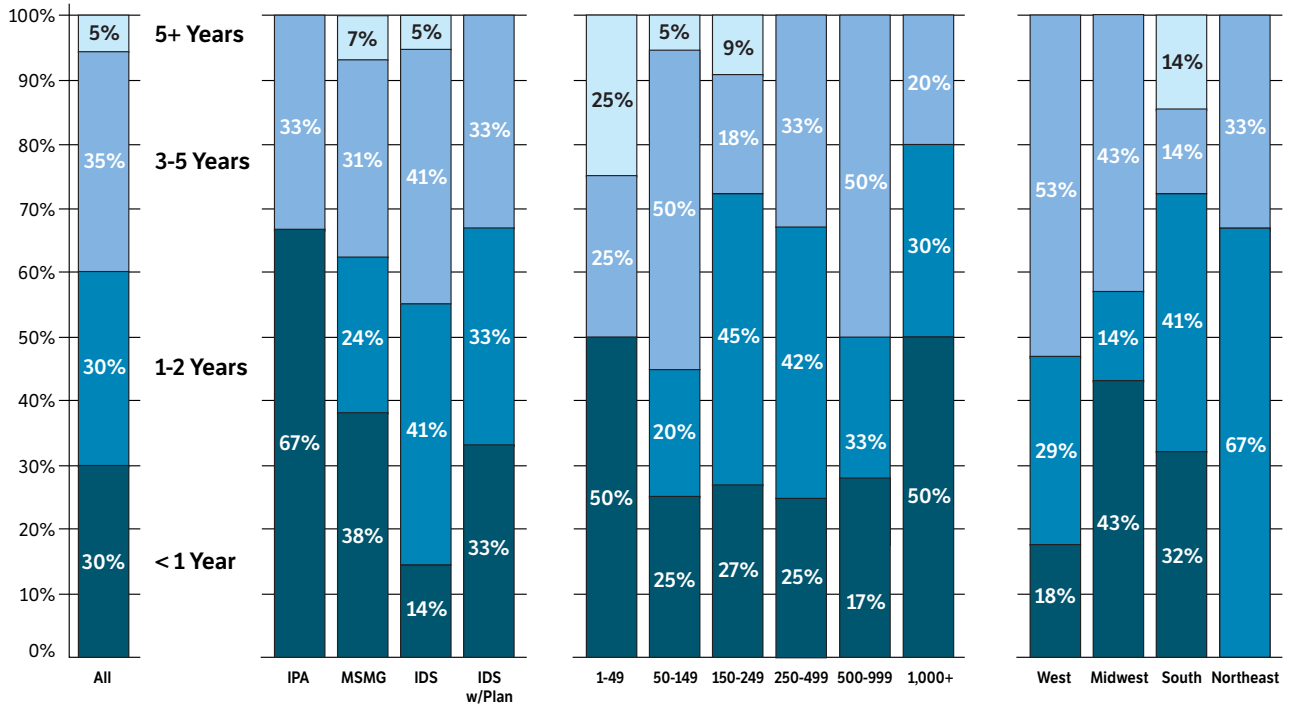
Regionally, respondents in the south are most likely to be able to take downside risk in two years.

According to comments provided by respondents, there are several reasons why they are pursuing risk and moving toward value despite significant obstacles. First, many are moving to risk in order to qualify as AAPMs under MACRA. AAPMs receive a 5% bonus on their Part B revenues, which is a significant incentive to move to value.

Many respondents are pursuing risk strategies with the idea of learning the competencies necessary to take risk now, as opposed to learning after the risk market has more fully matured. Being first to the risk market will allow providers to grow their market share. Additionally, respondents stated that many large employers are beginning to demand more value for their insurance dollars, and providers need to be able to demonstrate high quality and decreased costs to these local employers. Similarly, payers are reacting to costs by developing narrow provider networks. Respondents recognize the need to decrease costs in order to participate in these networks.

Respondents also disclosed that they are pursuing a Medicare value strategy and actively entering into MA or APM arrangements that will reward them for improved care and lower costs. Conversely, they see Medicare FFS payments as a disincentive to moving to value. The FFS model does not reimburse providers for the ever-increasing number of virtual visits. Nor does it provide any funding for population health management efforts, which are key to improving outcomes and reducing costs. Relatedly, many respondents believe the financial incentives in risk align very well with their delivery model, which focuses on coordinated care, population health management, and team-based care.

Length of Time Before Accepting Downside Risk (2017)



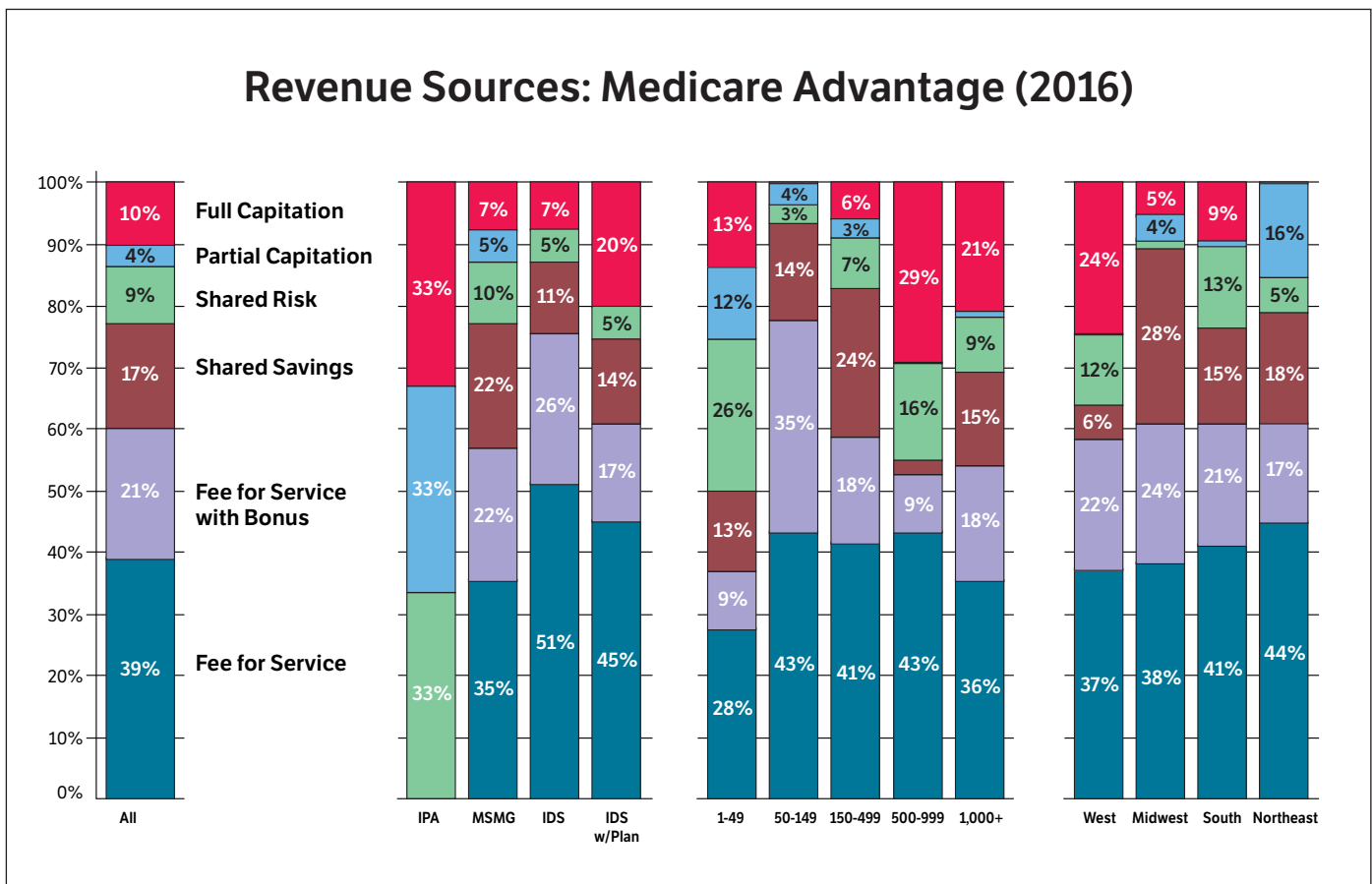
Medicare Advantage

While MA payments are capitated at the payer level, the majority of payments made to AMGA members remain in FFS. In 2017, capitated payments equaled 17% of total payments to providers, while shared risk payments were 13% of total payments. The remaining payments, 67%, did not include a downside risk component.

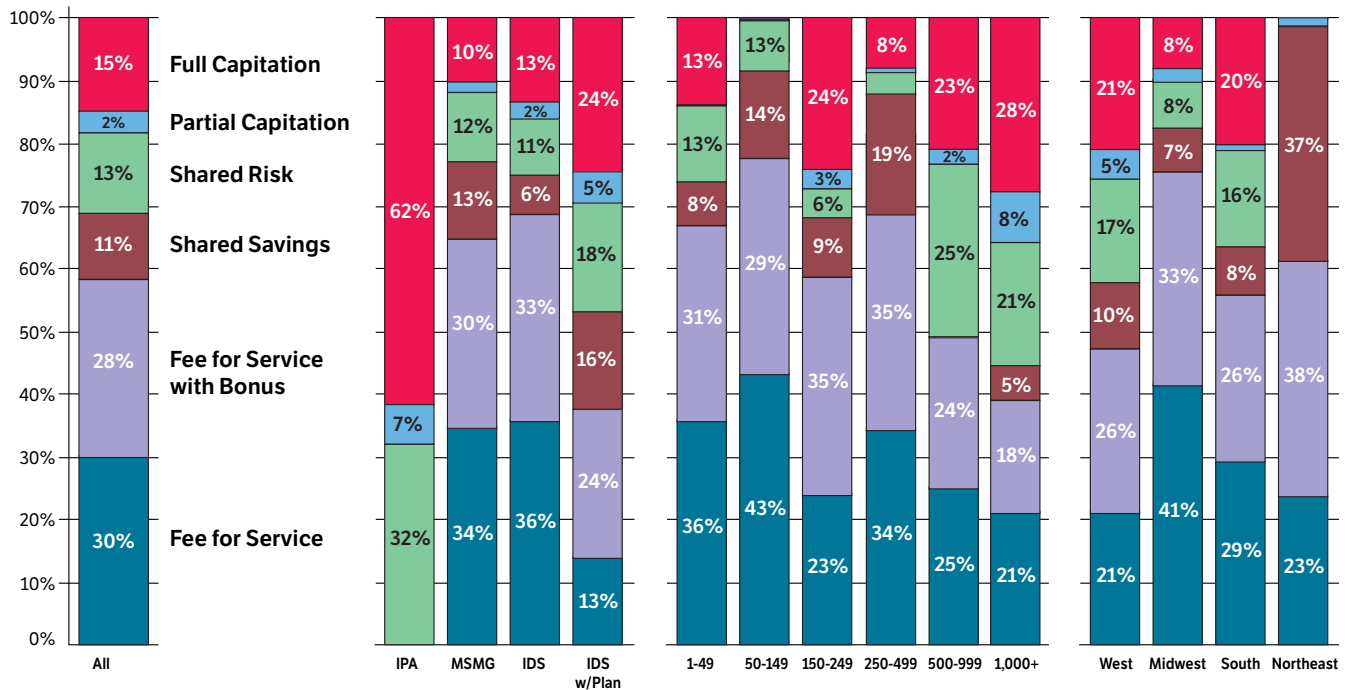
However, when compared to payments made in 2016, capitated payments to providers in 2017 increased by 21% in the aggregate. Further, in 2017, all organizational types showed increased levels of capitated payments compared to 2016, as did groups in all size categories.

As mentioned above, respondents expect MA to equal Medicare FFS revenues by 2019, demonstrating that AMGA members are increasingly looking to MA as the preferred financing model in the federal setting. MA is attractive to members because it is less administratively burdensome than other federal programs, such as ACOs. For instance, there are no attribution issues in MA, upfront capital may be available to fund care management efforts, and there is less patient “leakage” (i.e., patients largely remain under the care of the medical group because of most MA network plans).

Additionally, AMGA members state that Medicare beneficiaries, especially those just entering into the program, are increasingly enrolling in MA to receive benefits not found in traditional Medicare. New Medicare beneficiaries likely have prior experience with some type of HMO/PPO plan and see MA as an extension of those products. Payers are increasing their MA efforts to meet this demand, as are AMGA members.



Revenue Sources: Medicare Advantage (2017)



Accountable Care Organizations

The survey data shows that ACOs remain a key part of AMGA members' risk-based payments, making up 14% to 15% of total revenues for the next two years. AMGA members largely view ACOs as a well-known delivery model that provides experience on how to eventually take downside risk. Meeting quality and cost targets requires infrastructure investments in people and technology, as well as a change in management techniques to be successful. ACOs allow providers the opportunity to develop these competencies in an upside-risk-only model.

That said, the survey data also suggests that interest in ACOs is beginning to plateau, especially for federal ACOs. Comments suggest that after six years of experience with the federal ACO program, many providers are experiencing limited opportunities to be successful, despite multimillion-dollar investments. Programmatic rules around patient attribution and financial benchmarking, as well as a lack of patient incentives to receive care at the ACO, limit the opportunities for an ACO to recoup its investments, let alone be financially successful. This plateauing may be mitigated by MACRA, however, as groups look to federal two-sided ACOs as a way to avoid remaining in MIPS.

Summary

The survey clearly indicates that respondents continue to move to risk-based arrangements and away from FFS payments. Respondent commentary provides a clear rationale for pursuing increasingly higher levels of risk-based payments. The data demonstrates the move to value is occurring at the aggregate, organizational, size, and regional levels. Thus, it is reasonable to say the move to value is prevalent among a large majority of survey respondents.

However, AMGA members are pursuing value in an uncertain environment. Commercial payers remain largely unengaged in the risk market. Lack of data sharing is a significant burden in succeeding in value arrangements, yet this practice remains endemic in the industry.

On the federal side, respondents point to HHS as a willing partner to engage in risk models. However, HHS serves a dual role. As a regulator and in an effort to protect the Medicare program, HHS has created rules that greatly limit the opportunities for success in federal risk-based models, especially ACOs. Respondents report that HHS often will change contractual terms or program rules in the middle of a performance period, leaving their organizations scrambling to meet new and unexpected rules.

While these external impediments represent barriers to taking risk, internal issues also present challenges, chiefly the need to invest millions of dollars in building up a risk-based infrastructure. Accessing the capital needed to finance this infrastructure, particularly for physician-owned groups, is a critical barrier to risk. Additionally, there are significant change management challenges when moving huge, complex organizations to deliver care differently.

That said, AMGA members are moving in that direction. To reward this movement, Congress and HHS must address impediments to taking risk quickly or the groups that are most willing to make this transition will pare back their risk-based efforts. Similarly, policymakers must understand that virtually all value-based policies have been directed, or in other words, mandated, at the provider level. Congress and HHS must develop policies that incentivize other industry players to enter the risk market. The provider community would welcome the company.

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AMGA is a trade association leading the transformation of health care in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, and empower our members to deliver the next level of high performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. More than 170,000 physicians practice in our member organizations, delivering care to one in three Americans. For more information, visit amga.org.



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