



Advancing High Performance Health

## White Paper

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AMGA Advocacy

# ***Taking Risk: Where Healthcare Financing Is Going and How to Get There***

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## Taking Risk: Where Healthcare Financing Is Going and How to Get There

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### *White Paper, September 2015*

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Policymakers in Congress and the U.S. Department of Health and Human Services (HHS) have made it clear that they are embarking on an ambitious transformation of the way healthcare is financed. Recent HHS pronouncements on tying 90 percent of Medicare payments to value by 2018 and Congressional passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) essentially mandate healthcare providers to take on payment risk over the next several years. AMGA members, which include multispecialty medical groups (MSMGs) and integrated delivery systems (IDSs), support this transformation to a value-based payment system, realizing that volume-based, fee-for-service (FFS) payment models are unsustainable.

While there has been much discussion on where the system needs to go, there has been far less discussion on how it gets there. With notable exceptions such as Kaiser Permanente, most providers have little experience operating in a risk environment. For that matter, few payors have extensive experience sharing risk with providers. What then, are the current impediments to accepting risk that could hinder the transition to value? And what tools do providers need to successfully deliver care in a value-based system? Federal policymakers need to understand and act on these two critical issues or their laudable goal of transitioning to a value-based healthcare system will, at best, stall, or at worst, fail.

If done right, value-based payment has the potential to improve care and reduce healthcare costs. However, this transition will be challenging, and truly collaborative partnerships between government, providers, payors, and patients must be developed to make this transition successful. Indeed, alignment between Federal and commercial settings on value-based payment will result in a faster and more successful transition.

To gain a clearer view of how healthcare financing is changing and, more importantly, to better understand the current impediments to accepting risk and to identify the tools necessary for providers to take risk, AMGA conducted a survey designed to capture data that addressed these issues. Briefly, the survey data demonstrated a definite trend away from FFS payments and greater participation in risk-based payments. Respondents also clearly identified current impediments to taking risk, as well as the tools they need from the Federal government and commercial payors that will allow them to meet the Congressional and HHS goals of moving to a value-based financing system.

## Study Notes and Methods

In May 2015, AMGA sent an e-mail to c-suite level executives at all of its member medical groups, inviting them to participate in a 20-minute, online survey about the transition from FFS to value-based payment. We received responses from 115 executives at 101 member organizations. In addition to risk-focused questions, respondents were asked to provide certain demographic information on their organizations, including organizational structure,

number of full-time equivalent (FTE) physicians, and geographic region. This information was internally validated with similar data routinely collected by AMGA. Results in this paper are presented in aggregate, as well as stratified by organization structure, size, and region, in order to elucidate any differences.

When compared to overall AMGA membership, organizations included in the survey results are more concentrated in the South and less in the Midwest. The respondent sampling mirrors AMGA membership as a whole, but with a slightly smaller proportion of groups with 3-50 FTE physicians. Organizational demographic data among the 115 respondents included in the survey results are detailed in Table 1.

### **Reimbursement Revenue by Payment Model**

Respondents were asked for the distribution of Federal and commercial reimbursement revenue by payment model, for the current year (2015), and projected for 2016, and 2017. Payment models for Federal reimbursement revenue included: FFS, Medicaid, Medicaid managed care, Medicare Advantage, Accountable Care Organizations or ACOs (MSSP/Pioneer/Next Generation), bundled payments, and others. Similarly, for commercial revenue, respondents were asked to attribute reimbursement to FFS, shared savings/ACO, shared risk, partial capitation, full capitation, bundled payment, and others. The distributions of reimbursement method were aggregated across all respondents and calculated as unweighted averages by respondent. Multiple responses from the same organization were generally similar. We stratified our analyses by differences in organization demographics. Trends were analyzed over time and across different strata.

To complement our analysis of reimbursement revenue and to get a clearer understanding of how prepared medical groups are to accept risk, respondents were also asked to indicate how much time they needed before they could accept downside risk (<1 year, 1-2 years, 3-5 years, 6+ years).

**Table 1: Demographics**

	<b>Number of Respondents</b>	<b>Percent</b>
<b>Organizational Structure</b>		
Multispecialty Medical Group (MSMG)	49	43%
MSMG with Health Plan	6	5%
Integrated Delivery System (IDS)	43	37%
IDS with Health Plan	17	15%
<b>Number of Full-Time Equivalent (FTE) Physicians</b>		
3-50	8	7%
51-150	36	31%
151-500	48	42%
501-1,000	12	10%
1,000+	11	10%
<b>Geographic Region</b>		
Northeast	21	18%
South	42	37%
Midwest	22	19%
West	30	26%

**Impediments to Taking Risk**

The survey asked respondents to rate 10 impediments to operating under risk-based arrangements. These impediments were each rated on a scale of 1-5, for Federal and commercial insurers separately. In our results, we classified impediments as either internal or external. We ranked the impediments based on the average rating and analyzed differences among impediments both individually and aggregated by type (internal vs. external).

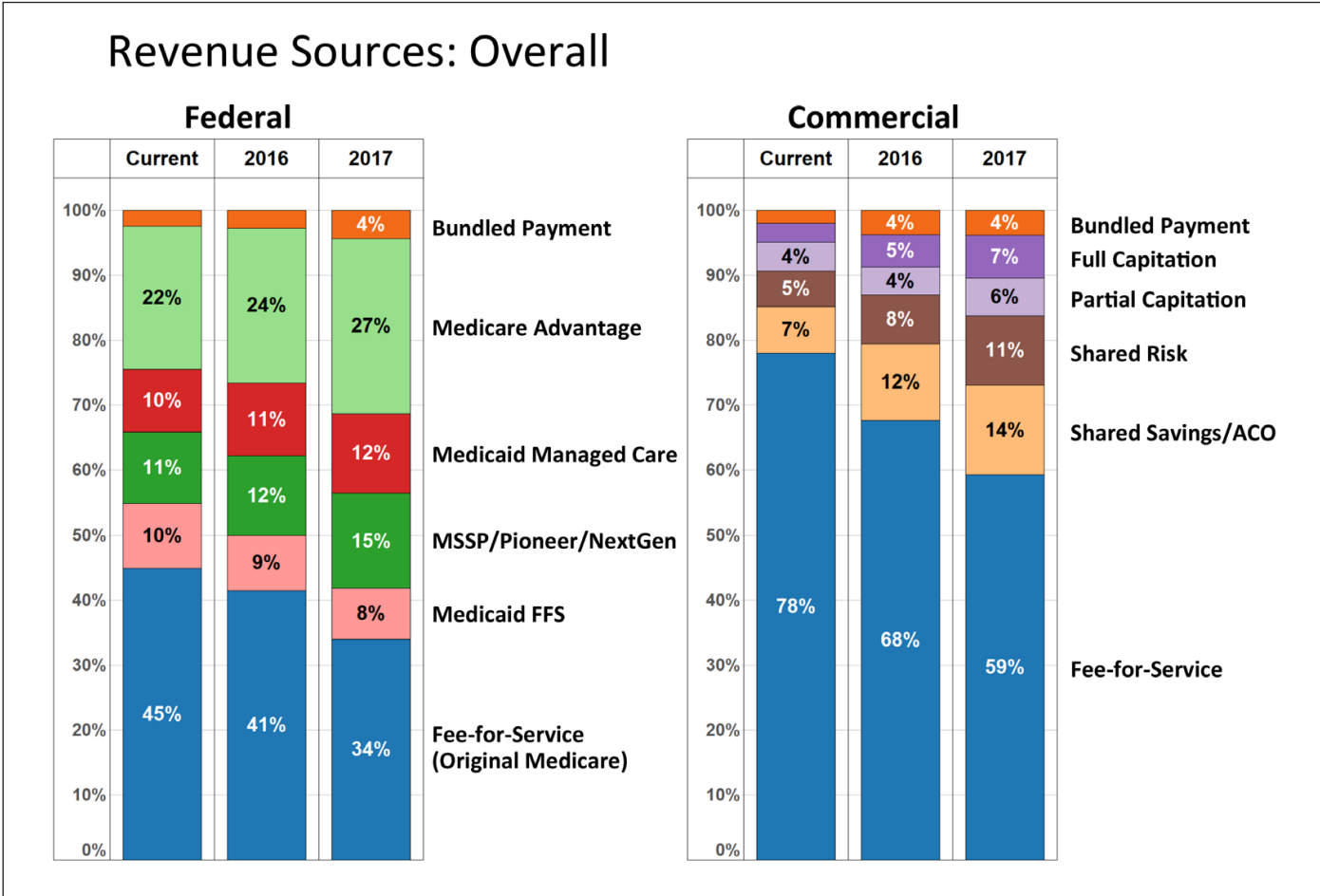
**Tools Providers Need in Order to Take Risk**

The survey also asked respondents to rate a variety of tools they would need to help them succeed in risk-based arrangements. As with impediments, tools were rated on a scale of 1-5 and ranked based on averages. Respondents were asked to rate tools for succeeding in risk-based arrangements with the Federal government and commercial insurers separately.

**Survey Results**

**Aggregate Reimbursement Results**

Responses showed an expected reduction in FFS payments from 2015 to 2017 and an expected proportional increase in payment under risk-based arrangements. In the aggregate, FFS payments from both Federal and commercial payors are expected to decrease by 24 percent by 2017. During the same time period, for Federal programs, revenue from Medicare Advantage (MA) payments are expected to increase by 20 percent, ACO



products are expected to increase by 36 percent, and Medicaid managed care payments are expected to increase by 20 percent.

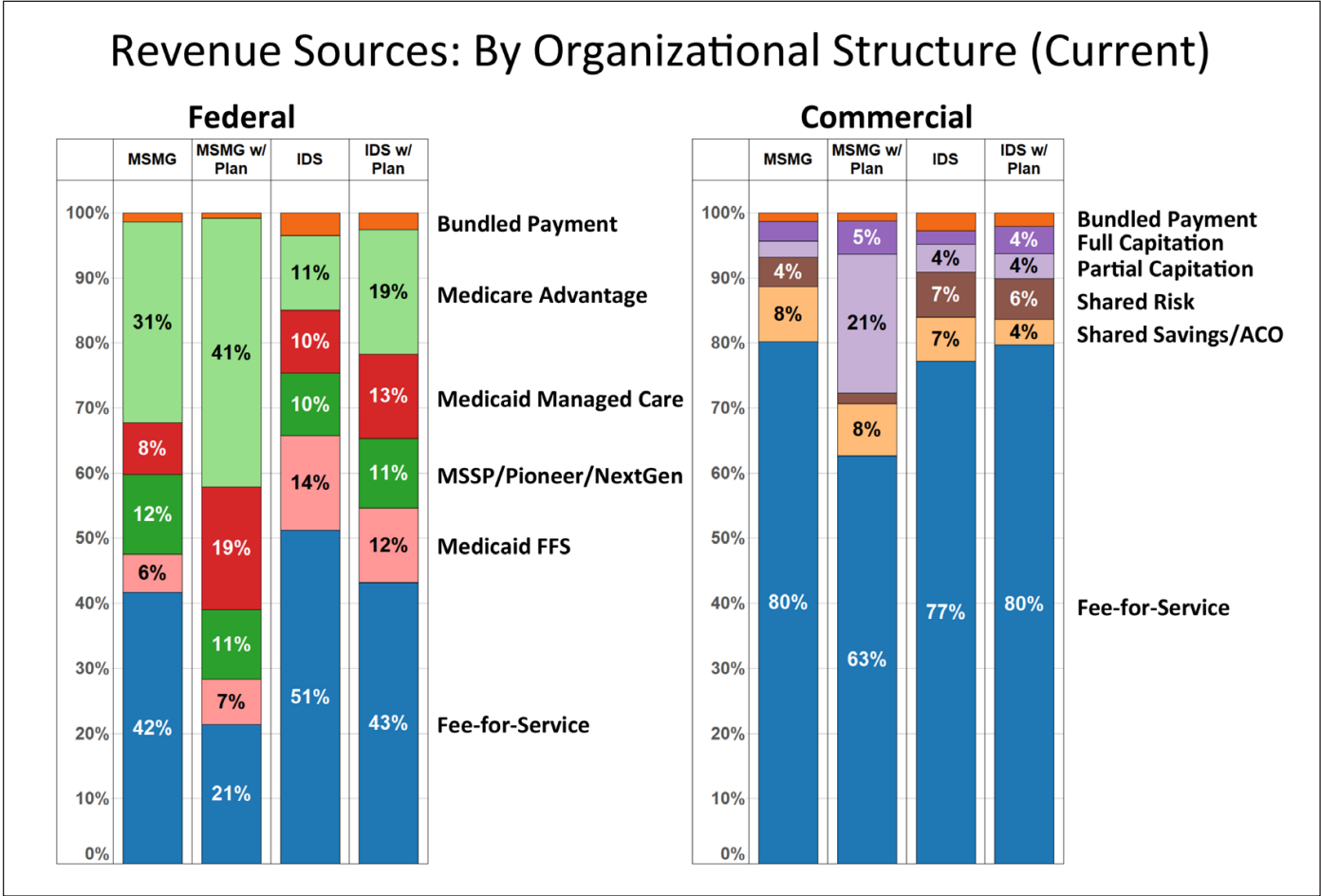
In the commercial setting, risk-based products are expected to increase significantly. Both shared savings (upside risk only) and shared risk (upside and downside risk) reimbursement are expected to double by 2017. Combined, partial- and full-capitation payments are also expected to increase by more than 100 percent by 2017. However, respondents indicated minimal participation, currently and in the future, in bundled payment arrangements in the Federal and commercial setting.

Reimbursement Results by Organizational Structure

Federal Setting

The proportion of payments in FFS vs. some type of risk arrangement differed by organizational structure. For 2015, in the Federal sector, FFS payments ranged from 21 percent to 51 percent of total revenue. MSMGs were less likely than their IDS counterparts to receive FFS payments, and they were also more engaged in Federal risk offerings such as MA and ACOs. This was the case to an even greater degree for MSMGs with their own health plan. IDSs with a health plan also were less likely than IDSs without a health plan to rely on Federal FFS payments and to engage in more commercial risk products.

In years 2016 and 2017, respondents in all structural categories predicted a smaller proportion of payments coming from FFS—except MSMGs with a plan, where an already-low percentage of FFS payments remains stable. MSMGs



and MSMGs with a plan were more likely to contract with MA plans than other structures, although by 2017, IDSs and IDSs with a plan intend to increase their MA contracting by 63 percent and 21 percent, respectively.

In 2015, the percent of revenue from Federal ACO programs was similar for all categories. In 2016 and 2017, IDSs predict increased engagement in ACO programs, while respondents from other structures anticipate reduced or stable participation in Federal ACOs. As described more fully below, all structures, except MSMGs with plan, intend to double their participation in commercial ACOs (i.e., shared-savings and shared-risk products). Medicaid managed care payment percentages remain relatively stable from 2015 to 2017. As already noted above, bundled payments in both the Federal and commercial setting are not gaining traction with any of the organizational structures except for a predicted increase by IDSs (especially IDSs with more than 1,000+ physician FTEs).

### ***Commercial Setting***

In the commercial setting, for all structures, FFS payments accounted for 77-80 percent of commercial payments, except for MSMGs with a plan, which totaled 63 percent.

In 2015, IDSs and IDSs with a plan received 20 percent and 19 percent, respectively, of their revenues from risk-based products, ranging from full capitation to shared-savings products. MSMGs received approximately 15 percent of revenues from the same risk products. MSMGs with a plan were much more active in the commercial risk market, averaging 36 percent of revenues from non-FFS payments.

MSMGs predict that they will increase their percentage of revenues from risk products from 15 percent in 2015 to 35 percent in 2017. MSMGs with a plan will increase their share of risk revenue from 36 percent in 2015 to more than 55 percent in 2017. IDSs predict increases in risk-based payments from 20 percent in 2015 to 46 percent in 2017, including 6 percent of revenues coming from bundled payments. IDSs with a plan expect to increase their percentage of revenues from risk-based arrangements from 19 percent in 2015 to 37 percent in 2017.

While respondents expect all risk arrangements to increase more than twofold by 2017, full- and partial-capitation plans remain small percentages of total revenue for all categories except for MSMGs with a plan, which expect 41 percent of their revenues to come from partial and full capitation. The other structures expect a greater share of revenues to flow from commercial ACO products.

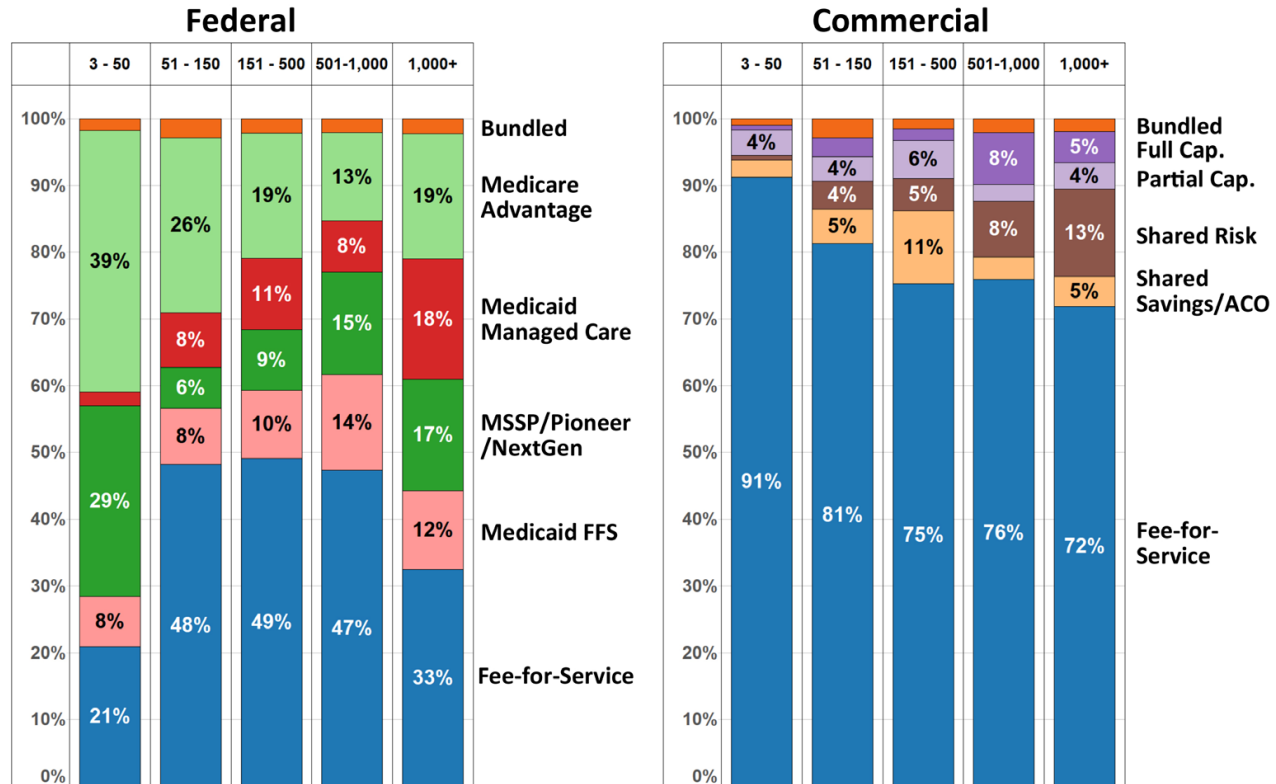
### ***Reimbursement by FTE Size***

There are substantial differences in revenue sources by organization size, measured by physician FTEs. In 2015, groups with 3-50 physician FTEs reported being heavily engaged in Federal risk offerings, which account for more than 70 percent of their revenue, 39 percent of which comes from MA. By 2017, these respondents expect 82 percent of their Federal revenues to come from MA and Federal ACO programs. However, in the commercial setting, 91 percent of their revenue comes from FFS products, and that proportion decreases only modestly, to 81 percent, by 2017.

Organizations in the three size categories covering FTEs between 51 and 1,000 report similar percentages of revenues from FFS, in both Federal and commercial settings, although there is some variation in predictions for 2017. While these three groups share similar FFS percentages, they differ in engagement with Federal and commercial risk arrangements. The larger the size, the less they are engaged in MA. However, respondents with 501-1,000 FTEs are more involved in Federal ACO programs.



## Revenue Sources: By # FTE Physicians (Current)



Respondents with 1,000+ FTEs were more likely to rely on risk-based payment in the Federal setting, with only 45 percent of total revenue coming from FFS. That figure decreases to 37 percent by 2017, while MA revenues are expected to increase by 26 percent. Medicaid managed care makes up 20 percent of Federal revenues. Participation in Federal ACOs is expected to drop 11 percent by 2017. In the commercial setting for 2015, 1,000+ FTE respondents receive 72 percent of total revenues from FFS, the smallest percentage among all respondents. These respondents also report the largest percentage of revenues coming from risk-based products, especially shared-risk products.

While partial- and full-capitation payments increase for all respondents, the greatest growth in risk products in the commercial setting is in ACO products. Combined, shared-savings and shared-risk products increase between 66 percent and 200 percent, depending on FTE size.

### Reimbursements by Geographic Region

There was some variation in payor type based on geography. In 2015, in the aggregate for Federal programs, respondents in the West were more likely to contract with MA plans than those in the rest of the country, and they received a smaller percentage of revenue from FFS as well. Respondents from the West were less likely to participate in Federal ACO programs and received twice the percentage of payments from Medicaid managed care as respondents in the Midwest and South (though respondents from the Northeast had the same proportion as the West).

In 2015, in the commercial setting, payment percentages were largely similar except that the Northeast region had the highest proportion of full capitation, while the West showed the greatest proportion of revenues in partial capitation products.

In 2016 and 2017, the respondents anticipating the largest increase in taking risk were in the Midwest. Western respondents were more likely to have higher percentages of revenues remaining in FFS in 2017, compared to other parts of the country. Growth in shared-savings/shared-risk products is expected to be robust by 2017, with smaller gains in partial and full capitation.

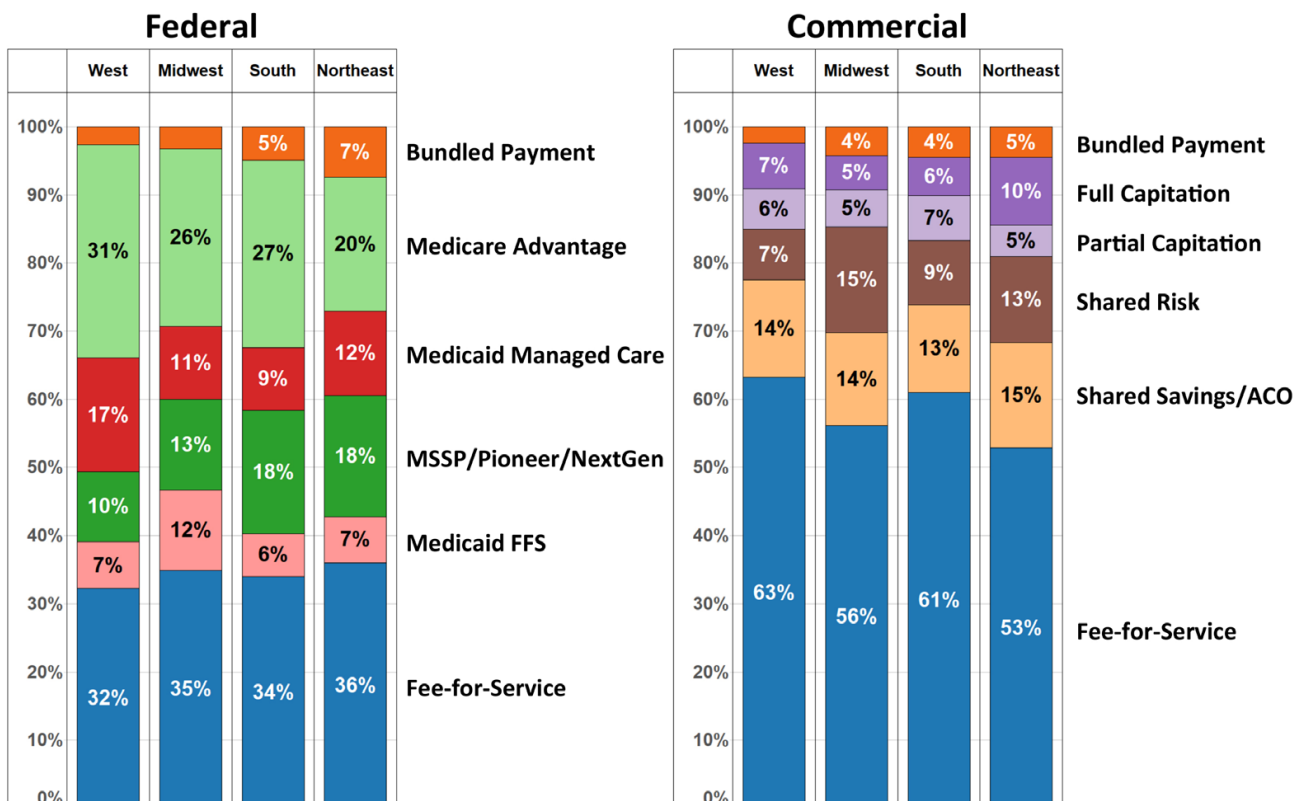
### Time Needed to Take Risk

Given the ambitious timeframe Congress and HHS have set for provider risk-taking, the survey also asked respondents to indicate how much time was needed before they could accept downside risk.

In the aggregate, 58 percent of respondents need 3 to 6 or more years to be ready to accept downside risk while 18 percent need less than a year and 24 percent need 1 to 2 years. Significant variations on respondent replies exist based on organizational structure and number of FTEs.

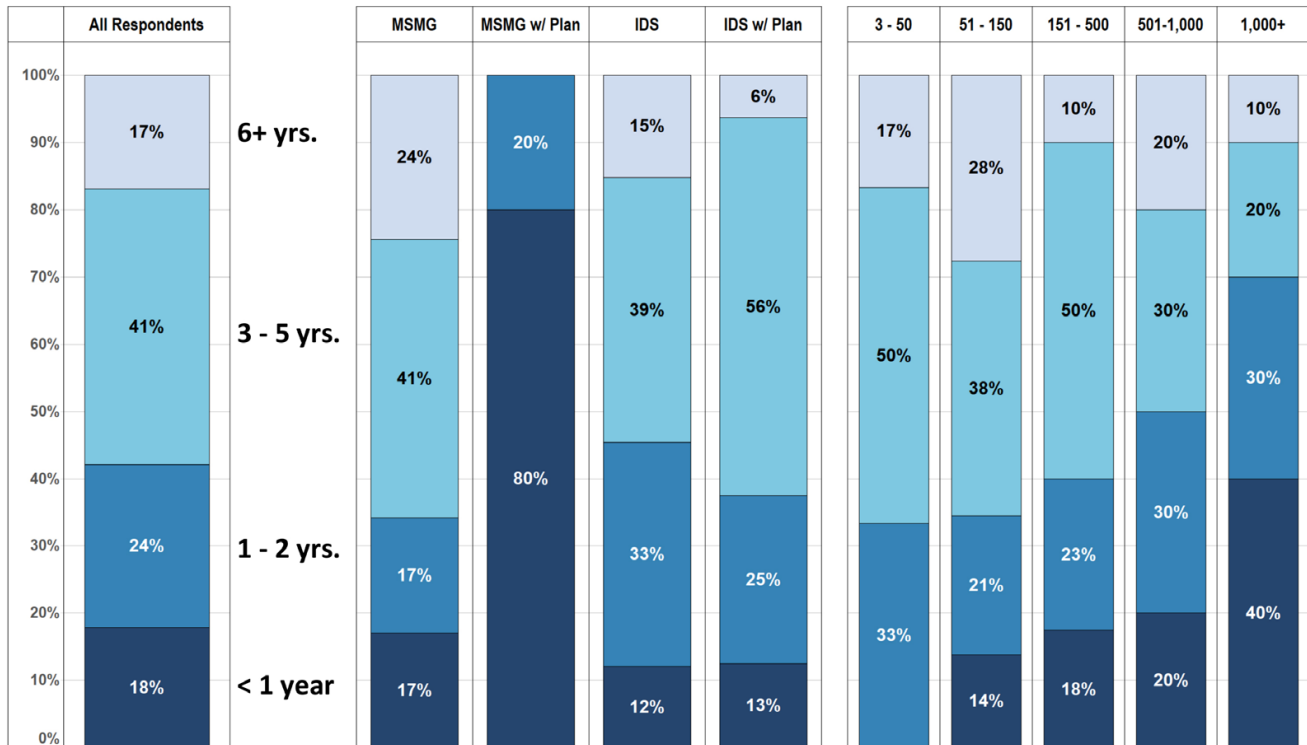
MSMGs with a plan were most ready to accept downside risk, with 80 percent ready to accept downside risk in less than a year and 100 percent ready to take downside risk within 2 years. Forty-five percent of IDSs stated they were able to take risk within 2 years, compared to 34 percent of MSMGs and 38 percent of IDSs with a plan.

## Revenue Sources: By Region (2017)





## Length of Time Before Able to Accept Downside Risk



Number of FTEs demonstrated wider variation in time needed to accept risk. Seventy percent of 1,000+ respondents stated they could accept risk within 2 years. Fifty percent of 501-1,000 FTE respondents stated they would be ready to take risk within 2 years, while 41 percent of respondents with 151-500 FTEs were ready to take risk within 2 years. Thirty-five percent of respondents with 51-150 FTEs were ready to take risk within 2 years. However, 67 percent of respondents with 3-50 FTEs needed at least 3 years before they were ready to accept downside risk.

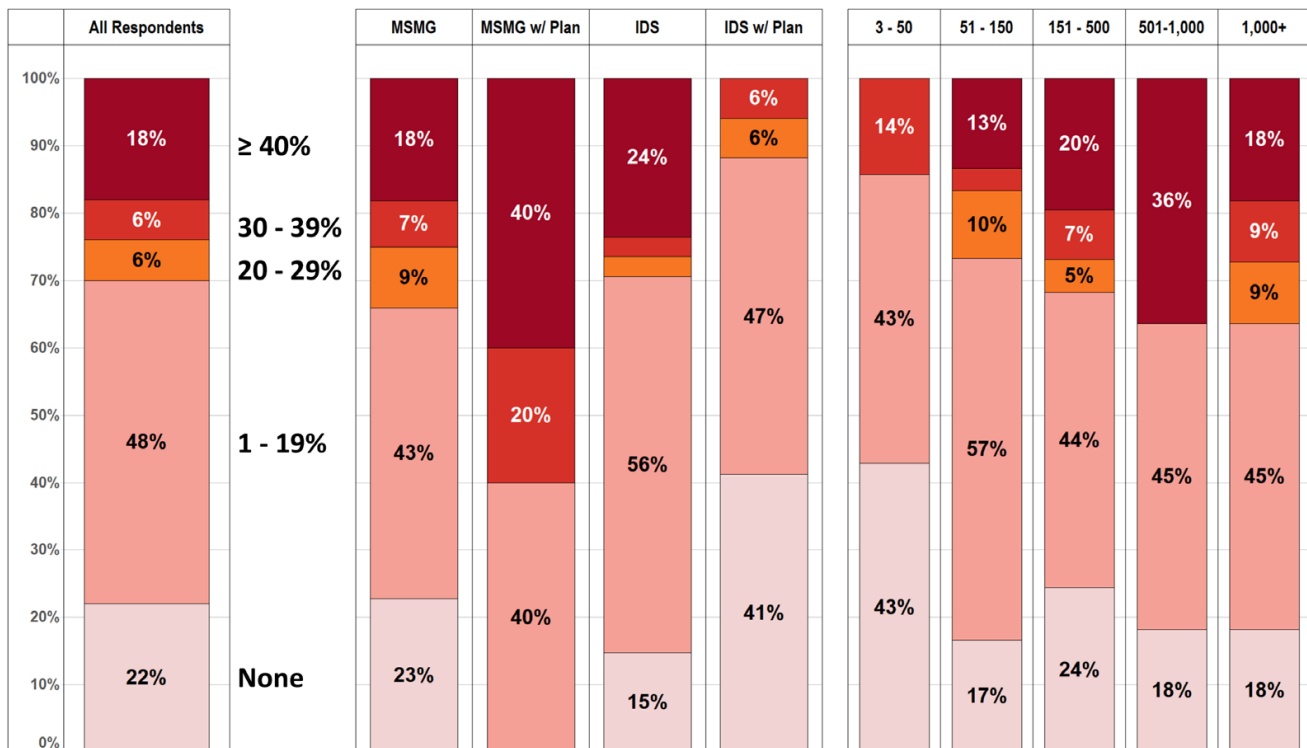
### ***Impediments to Taking Risk***

While the survey results demonstrate that providers are preparing to take on increasing levels of risk by 2017, respondents also noted significant impediments to accepting risk-based payments.

### ***Percentage of Insurers Offering Risk-Based Arrangements***

The survey asked respondents to list the percentage of commercial insurers in their market that were offering risk-based payment arrangements. Twenty-two percent of respondents answered that no payor was offering risk products in their market, and an additional 48 percent stated that between 1 and 19 percent of insurers were offering risk-based arrangements in their market. Eighteen percent of respondents replied that more than 40 percent of insurers were offering risk products in the local market.

## Percentage of Insurers Offering Risk-Based Arrangements



When viewing results based on organizational structure or number of FTEs, the results remain fairly consistent though smaller groups (3-50 FTEs) and IDSs with a plan report a much larger percentage (43 percent and 41 percent, respectively) of insurers that are not offering any risk product in their market.

### External and Internal Impediments

In addition to a limited offering of risk products by commercial insurers, respondents report other impediments to taking risk. These impediments are divided into external, i.e., payor-driven impediments, and internal, i.e., provider-driven issues. Additionally, the Federal and commercial settings present, in some cases, different challenges to taking risk, as reflected in survey responses.

### Commercial Setting

In the commercial setting, lack of access to full administrative claims data, and a lack of transparent cost/quality data feedback were rated the most significant challenges. Ineffective data-sharing and attribution methodologies also rated as impediments. Duplicative quality measurement requirements were also selected.

Internal factors included insufficient information technology (IT)/analytics infrastructure as well as insufficient care management, administrative, and financial capabilities. Changing physician compensation to better align incentives in a risk-based environment was also listed as an internal factor.

## Federal Setting

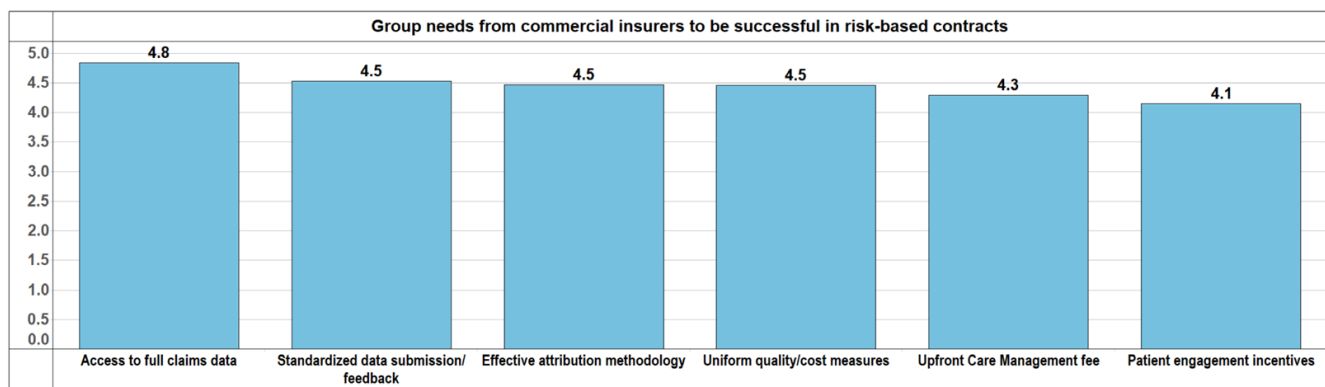
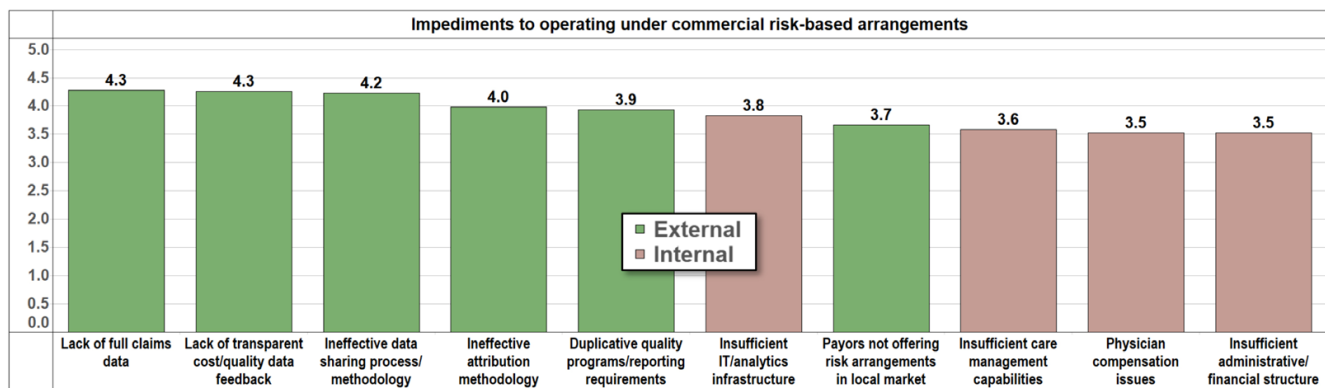
Respondents reported different impediments to participating in Federal risk programs and generally highlight already known operational difficulties found in the ACO programs. The largest impediment to risk-taking in Federal programs was ineffective attribution methodology, followed by the lack of a standardized data submission and feedback process. HHS' risk adjustment and current financial benchmarking methodologies were also reported as impediments. Other external factors included insufficient patient engagement opportunities and an ineffective quality measurement regime.

Internal impediments largely mirror those present in the commercial setting: insufficient IT/data analytics capability, insufficient care management infrastructure, insufficient administrative and financial capacity to take risk, and a need to redesign physician compensation plans to align incentives with value.

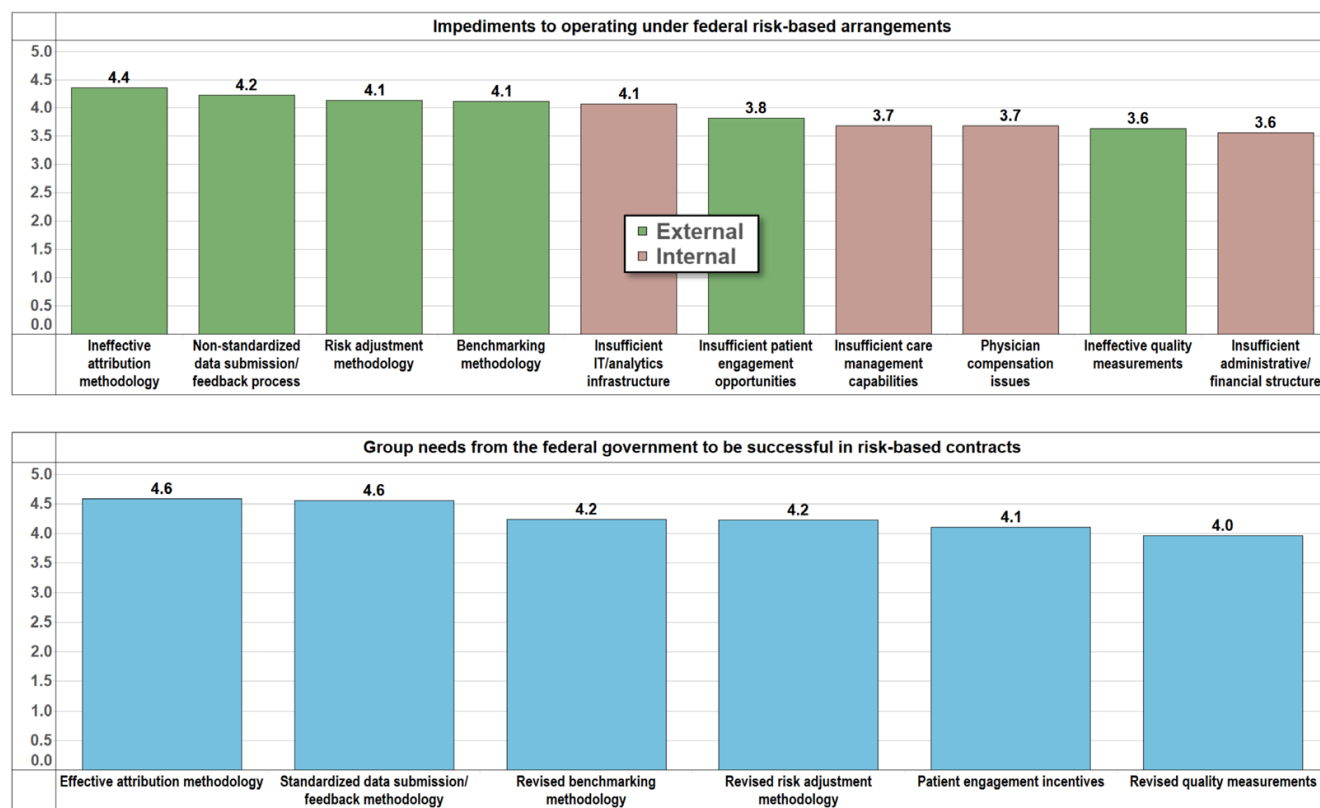
## Tools Providers Need in Order to Take Risk

Respondents identified tools both the Federal government and commercial payors can provide that will help providers meet the Federal government's goal of transitioning to a value-based payment system. Generally, the tools needed are operational in nature and mainly relate to data issues and revising attribution, risk-adjustment, and benchmarking methodologies.

## Impediments and Tools Needed to Take on Risk: Commercial



## Impediments and Tools Needed to Take on Risk: Federal



### Federal Programs

The tools identified by respondents as necessary for them to successfully take risk in Federal programs include: an effective attribution methodology, a standardized data submission/feedback process, revised financial benchmarking and risk-adjustment methodologies, meaningful patient engagement incentives, and revised quality measures.

### Commercial Setting

Tools needed from commercial payors share common themes with respondents' views on Federal programs, but with some differences. The most important tool needed from commercial payors, and this was the highest rated answer in the survey, was the need for full access to administrative claims data. Respondents also noted that commercial payors need to agree on a standardized data-submission and feedback process, create more effective attribution methods, and agree on a uniform set of quality and cost measures. Respondents also identified upfront care management fees to help build out care management processes and patient engagement tools that provide incentives for the patient to seek care with the providers as important tools.

## Discussion/Observations

### **Reimbursement Trends**

The survey data shows FFS payments as a percentage of provider revenue will decline measurably over the next two-and-a-half years. Concomitantly, data shows respondents anticipate increased participation in risk-based products, particularly commercial payor ACO offerings.

The data indicates that respondents may be “experimenting” with risk products in the Federal setting while simultaneously maintaining a strong footprint in commercial FFS products in order to maintain financial stability. However, survey respondents predict that this FFS footprint rapidly decreases in both Federal and commercial settings in 2016 and 2017. Generally speaking, IDSs—especially IDSs with more than 1,000 FTEs—were more likely to be engaged in risk products than the other categories except MSMGs with a plan. IDSs may be more engaged currently and more willing to be engaged in risk products in the future because they can access capital that allows them to invest in the care management, IT/analytics, as well as the financial and administrative infrastructure necessary to accept risk. Additionally, IDSs typically have very large patient populations, which allow them to spread risk over a much larger pool.

The data did point out some interesting anomalies. Respondents with 3-50 FTEs received only 21 percent of their revenues from Federal FFS payments, while 91 percent of their commercial revenues were FFS. This wide variation may corroborate the findings that commercial insurers are not offering risk products in these groups’ markets.

The results also seem to show that while participation in Federal ACO products is expected to grow by 36 percent by 2017, commercial ACO products are expected to experience more than 100 percent growth. This may indicate that providers are aware of longstanding issues related to the Federal ACO programs (attribution, benchmarking, coding) and are instead opting to pursue shared-savings and shared-risk products in the commercial setting where providers are better able to agree on contractual expectations. Additionally, the predicted growth in these commercial ACO products allows providers to learn the competencies necessary to take risk before entering into full-blown partial- and full-capitation arrangements.

### **Downside Risk Timeline**

The survey also provided a timeline respondents need before they accept downside risk. In the aggregate, 58 percent of respondents need at least 3 years before they believe they are able to accept downside risk. The data corroborates other respondent answers showing that larger IDSs and MSMGs with a health plan are most able to accept downside risk in the shortest period. As noted, larger IDS have the financial capital to invest in the infrastructure necessary to take downside risk.

MSMGs with a plan most likely created the health plan with the strategic goal of entering into partial- and full-capitation contracts. Smaller groups need more time, indicating perhaps more limited resources to create the care management and IT infrastructure needed to take risk. However, this trend could also reflect a lack of payor readiness to provide risk contracts in their local markets. Creating incentives that permit MSMGs to use retained earnings on a tax-free basis, if used to invest in care management or IT infrastructure, could accelerate MSMG entry into the risk environment.

## ***Impediments and Tools***

### ***Impediments***

Respondents identified internal and external factors that serve as obstacles to successfully accepting risk. Internal impediments were largely the same in the Federal and commercial settings and related to the need to improve care management and IT/analytic capabilities and create administrative and financial structures to manage risk. Developing new provider compensation models to align physician payment with performance was also cited as an internal factor. External factors related to accessing data in a standardized format in the commercial setting and revising various methodologies in Federal risk programs, particularly ACOs.

Respondents rated external impediments as more significant than internal impediments to taking risk. This may reflect the view that providers can control their own challenges to taking risk and are largely willing to make the clinical, cultural, financial, and administrative changes needed to succeed in a value-based environment. However, these multimillion-dollar investments and change management strategies can be negated if payors, both Federal and commercial, are unwilling to provide them with the tools they need to be successful in this transition.

One notable obstacle to risk-taking is the lack of payors offering risk products in some markets. This may mean that payors are either not offering risk products at all or are not offering risk products to some of the survey respondents. In any event, this lack of product offering may demonstrate that payors are equally as unfamiliar with risk as providers. Policymakers need to monitor this situation closely. Providers should not be punished for not taking risk if payors are unwilling to enter that segment of the market.

### ***Tools***

While respondents rate these impediments as significant obstacles to accepting risk, they also identify tools that address these obstacles. Providing respondents with access to all administrative claims data allows them to have a complete picture of their patients and allows them to identify high-risk patients, manage them, and reduce the cost of care. Requiring Federal and commercial payors to standardize the data-submission and feedback process addresses the problem of submitting different data in different formats to different payors, costing valuable staff time and expense. Similarly, creating uniform cost and quality measures would alleviate administrative burden and cost.

Accurate patient attribution methods are critical when managing the cost and quality of care for a population of patients. It is challenging at best to succeed in a risk-based arrangement if providers do not have a clear picture of who is in their patient population. Respondents believe both Federal and commercial payors need to incentivize patients to get their care within the four walls of the respondents' medical groups. Managing patient cost is almost impossible if they are able to receive care from any provider, without consideration of cost or quality.

In the Federal ACO program, respondents indicated a need for HHS to revise its current risk-adjustment and benchmarking methodologies. Respondents do not believe that risk scores should only decrease, as is the currently the case in the ACO program. For respondents in cost-efficient parts of the country, the current benchmarking process puts them at a disadvantage.



## Conclusion

Congress and HHS have created an ambitious path for providers to take risk over the next several years. While it's generally understood that this is the route healthcare financing will take, it is not clear how easy or difficult this transition to value will be.

AMGA's survey provides data that demonstrates that MSMGs and IDSs are already transitioning from volume of services to value but there are significant impediments, both structural and policy-related, that make it challenging for these groups to take risk. However, the survey respondents also listed several tools that address these impediments—among them, full access to claims data, standardized data exchange formats, and improved attribution and risk-adjustment methodologies. In fact, the respondents provide policymakers with a blueprint that will accelerate the transition to a value-based payment system. And, importantly, almost all of the tools cited by the survey neither increase Federal spending nor diminish shareholder value.

If policymakers want to successfully transform the current volume-based payment system to one based on value, they need to understand these impediments to risk-taking and offer the tools providers need to make this transition successful. If these issues are overlooked, the opportunity to reform the system for both the benefit of patients and programmatic efficiency may be lost.

AMGA is a 501(c)(6) trade association representing medical groups, health systems, and other organized systems of care, including some of the nation's largest, most prestigious integrated delivery systems. AMGA is a leading voice in advocating for efficient, team-based, and accountable care. More than 170,000 physicians practice in AMGA member organizations, providing healthcare services for 120 million patients (one in three Americans). Headquartered in Alexandria, Virginia, AMGA is the strategic partner for these organizations, providing a comprehensive package of benefits, including political advocacy, educational and networking programs, publications, benchmarking data services, and financial and operations assistance.



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