



Advancing High Performance Health

White Paper

AMGA Advocacy

***Taking Risk, 4.0:
Clearing a Pathway
to Value-Based Care***

**AMGA's Fourth Annual
Risk Survey**

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Taking Risk, 4.0:
Clearing a Pathway to Value-Based Care
AMGA's Fourth Annual Risk Survey



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For the fourth consecutive year, AMGA conducted a survey of its membership to gauge their progress in the transition to value, what barriers to risk or value are hindering them, and what percentage of member revenues are risk-based.

Findings from the 2018 risk survey indicate that AMGA member revenues increasingly are risk-based, and AMGA members are continuing the journey to value. Moreover, AMGA members report clear preferences for some risk-based payment models over others.

However, survey data show that there continue to be significant impediments to taking risk that slow the progress to moving to an actual value-based healthcare system. Limited access to claims data, duplicative quality measure programs, and complicated regulatory schemes can serve as disincentives to move to, or continue the move to, value programs.

Executive Summary

Risk-based revenues: According to 2018 survey respondents, 56% of member revenues were risk-based in the federal setting, and 28% of revenues were risk-based in the commercial setting. Notably, federal fee-for-service (FFS) payments declined by 20% during the four years between our first survey in 2015 and the 2018 survey. During the same time span, commercial FFS payments declined by 8%.

Time to take downside risk: In 2018, 74% of respondents answered that they would be ready to participate in downside-risk payment models within two years. This is a marked change from 2015, when 42% indicated they would be ready to accept downside-risk payments within two years. Respondents also provided insights on what investments they made to prepare them to take risk.

Commercial payers: Forty-seven percent of AMGA respondents report that commercial payers are offering either no or limited access to risk products in their markets. This is an improvement since 2015, when 70% of respondents indicated they had no or limited access to commercial risk products. The data indicates that accountable care organizations (ACOs) account for most of the increase in commercial value-based arrangements.

Impediments to value: Similar to the past three surveys, AMGA members report ongoing obstacles in moving to value. External impediments largely involve a lack of access to administrative claims data from payers, lack of a uniform data submission and reporting standard, multiple quality measurement programs, and problematic financial-benchmarking and risk-adjustment methodologies, particularly in the federal Accountable Care Organization (ACO) program. Internal impediments involve building and financing the infrastructure necessary to take risk, change management challenges, and physician compensation issues.

Medicare Advantage: The 2018 results found that Medicare Advantage (MA) plans accounted for 30% of revenues, up from 22% in 2016. Moreover, fully capitated MA payments increased from 10% of MA revenues in 2016 to 24% in 2018. MA revenues are double the revenues from any other federal risk-based payment model.

Accountable care organizations: Respondents reported that 15% of federal revenues came from ACO arrangements—downside risk 7%, and upside-only risk 8%. AMGA members reported that 16% of commercial revenues originated from commercial ACOs. Since 2016, federal ACO revenues have remained flat, accounting for 14%-15% of total revenues. Commercial ACO revenues have fluctuated over the four years of the survey, ranging from a low in 2015 of 12% to a high of 21% in 2017.

Bundled payments: Survey respondents indicated little traction with bundled payment models. In 2018, AMGA members reported revenues from bundled payments amounted to only 1% of federal or commercial revenues. The level of engagement in this model has remained consistent since 2015.

MACRA: In 2018, survey respondents indicated that twice as many members participated in the Merit-based Incentive Payment System (MIPS) program than participated in Advanced Alternative Payment Models (AAPMs) or MIPS-APMs (i.e., upside risk only ACOs) under the Medicare Access and CHIP Reauthorization Act (MACRA). In 2019, more respondents expect to qualify as AAPMs than expect to remain in MIPS. Notably, the number of respondents unsure of which MACRA path they would choose in 2019 doubled.

Study Notes and Methods

Each year, survey methodology has remained consistent, with minimal changes to the wording of existing questions. This allows AMGA to track and compare survey results over time.

For the 2018 survey, there were a total of 75 respondents from AMGA membership, 70 of whom completed all of the questions. The survey gathered organizational demographic data, including organizational structure and number of full-time equivalent (FTE) physicians. Respondents were assigned a geographic region based on their primary state of business. As with previous years, due to the small number of respondents representing “Independent Physician Association (IPA),” these responses were left in the aggregate analysis, but not included when comparing differences by organizational structure.

For similar reasons, we combined FTE categories “1–49” and “50–149” into a single category for analysis, as well as “150–249” and “250–449.”

Table 1 provides detailed demographics of the survey respondents, where each respondent represents a unique AMGA member. Compared to surveys from previous years, demographics for the 2018 survey are consistent, with the exception of the proportion of respondents representing larger organizations, which has increased (e.g., in 2015 only 10% of respondents were from organizations with 1,000 or more FTE physicians, compared to 19% in 2017 and 27% in 2018).

Table 1: Respondent Demographics

Organizational Structure	Number of Responses	Proportion of Responses
Multispecialty Medical Group (MSMG)	30	40%
Integrated Delivery System (IDS)	23	31%
IDS with Health Plan	18	24%
Independent Physician Association (IPA)	2	3%
Other	2	3%
Number of Full-Time Equivalent (FTE) Physicians		
1 – 149	21	28%
150 – 499	22	29%
500 – 999	12	16%
1,000 +	20	27%
Geographic Region		
Northeast	9	12%
South	24	32%
Midwest	22	29%
West	20	27%

Respondents answered several questions related to the proportion of reimbursement revenue by payment model. For 2018, these questions were broken down by federal, commercial, and MA programs. They also were asked to project their reimbursement revenue from federal and commercial programs for 2019 and 2020. 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, partial capitation, and full capitation.

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, or ≥ 5 years) and what percentage of risk-based payment arrangements commercial insurers are offering in their market (none, 1%–19%, 20%–29%, 30%–39%, or ≥ 40%). The survey also asked respondents to rate impediments to taking risk on a scale of one to five, with one indicating no impediment and five meaning significant impediment. Finally, respondents were asked whether their organizations intended to participate under MACRA for 2019, 2020, and 2021 (MIPS, Advanced APM, both, neither, or do not know).

Results are presented overall and stratified by demographics: number of FTE physicians, organization type, and geographic region. Aggregate results from 2018 were compared to those from 2015, and sensitivity analyses were performed within each FTE category to account for potential confounding from differences in respondent demographics between years.

To provide context to the survey responses, respondents answered several follow-up questions related to trends highlighted by the data.

Discussion: The Move to Value

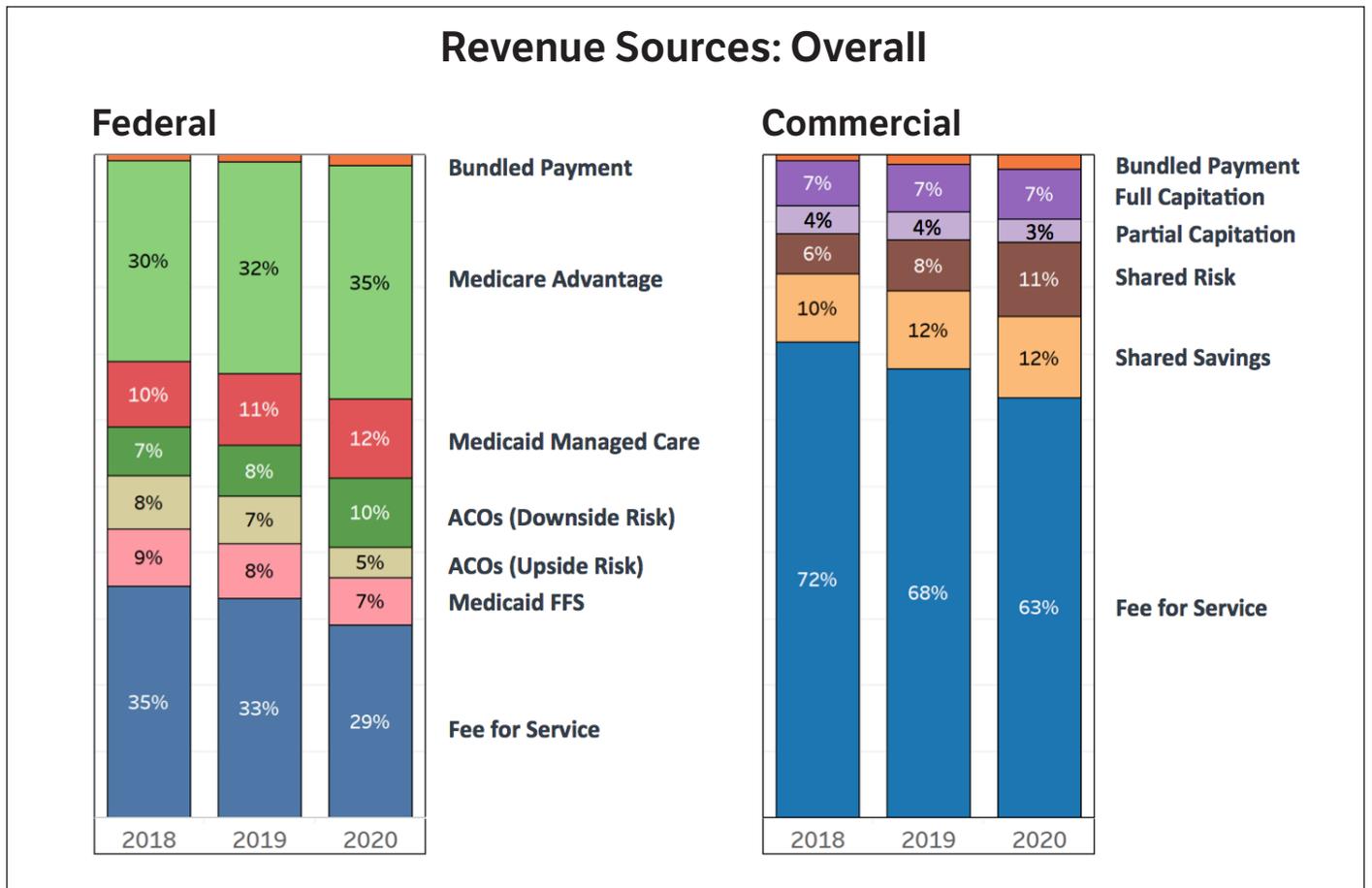
Reimbursement Trends

Federal Setting

Taken together, respondents reported that 56% of revenues came from a value-based payment model, including 30% from MA and 15% from the federal ACO program. By 2020, respondents predict that MA revenues will outpace Medicare FFS revenues by 6% and revenue from downside risk ACOs will double that of upside only ACOs. Bundled payments amount to 1% of total revenues in 2018 and are expected to remain flat in 2020.

Multispecialty medical groups (MSMGs) were the most active organization type in MA, with 38% of revenues coming from that program. Integrated delivery systems (IDS) and IDSs with a health plan reported similar percentages of MA revenues (24% and 23%, respectively). IDSs were most likely to have higher percentages of FFS payments within MA (44%) and lower levels of fully capitated payments (19%) than either IDSs with a health plan or MSMGs. MSMGs also were more invested in ACOs than were IDSs or IDSs with a health plan.

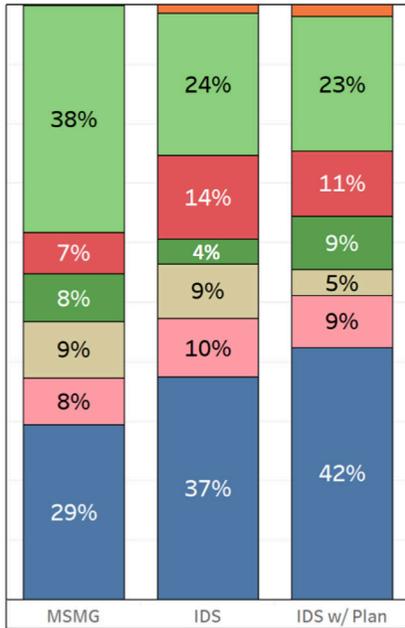
All size categories looked to MA as part of their risk-taking strategies in the federal setting. However, larger groups, those between 500 to 999 FTE physicians and those with 1,000 or more FTE physicians reported much higher percentages of capitated payments from MA (46% and 38%, respectively). This indicates that larger AMGA members are more likely to accept higher levels of risk than smaller groups. Notably, groups with 500-999 FTE physicians reported only 2%-3% of revenues from the MSSP program. Comparatively, groups of 1-149 FTE physicians reported 21% of revenues coming from ACOs, while groups with 1,000 or more FTE physicians reported ACOs made up 16% of revenues.



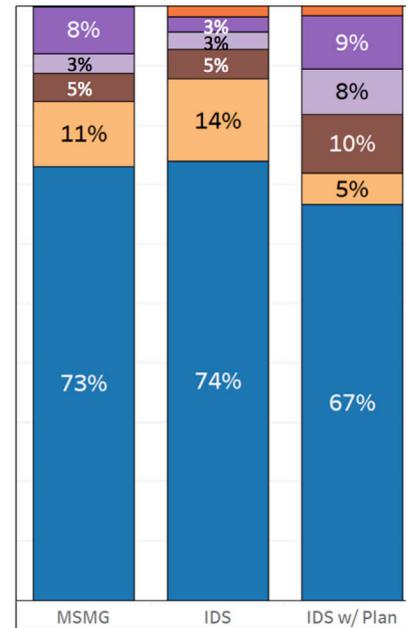
Unsurprisingly, MA is the most prevalent value-based arrangement in the West, with respondents reporting 44% of revenues from MA, while ACO revenue accounted for 2%. Results from the East Coast were the opposite, as only 24% of their federal revenues were MA-based and 31% came from the MSSP program.

Revenue Sources: Organizational Structure (Current)

Federal

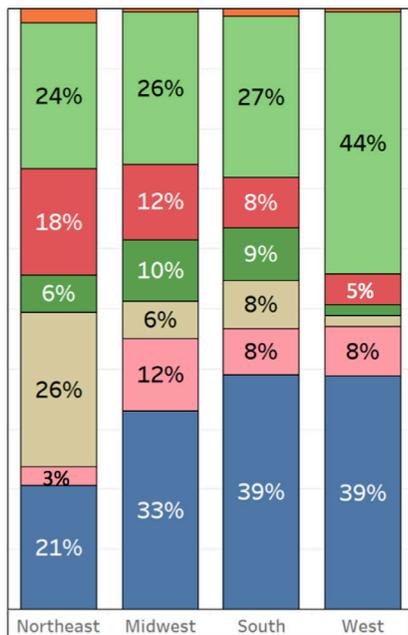


Commercial

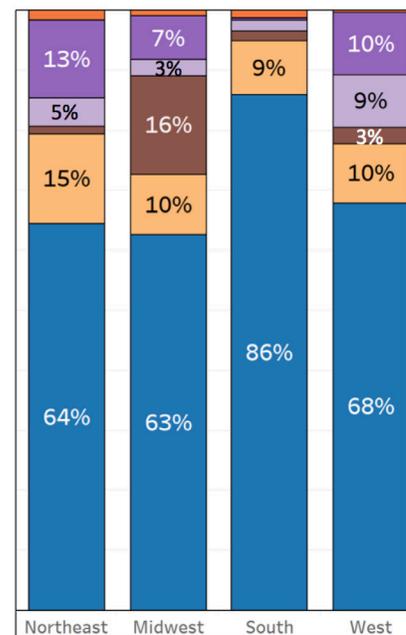


Revenue Sources: Region (Current)

Federal

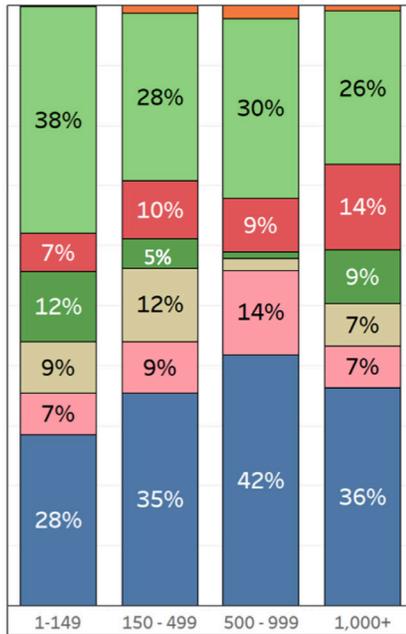


Commercial

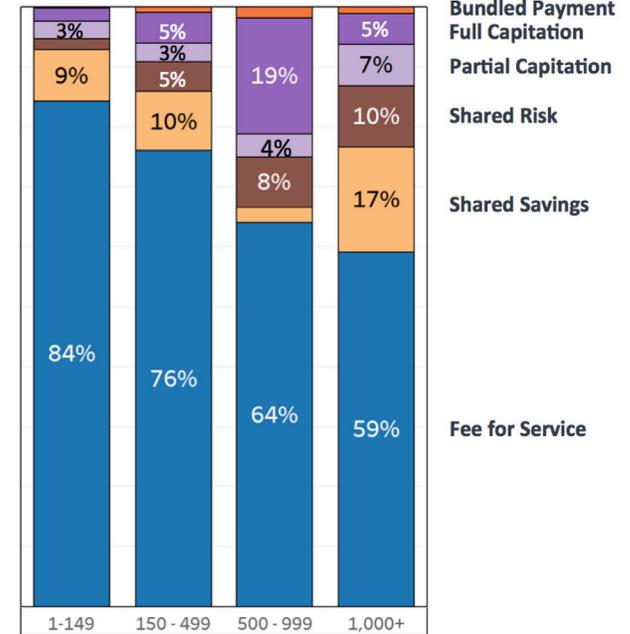


Revenue Sources: FTE (Current)

Federal



Commercial



Commercial Setting

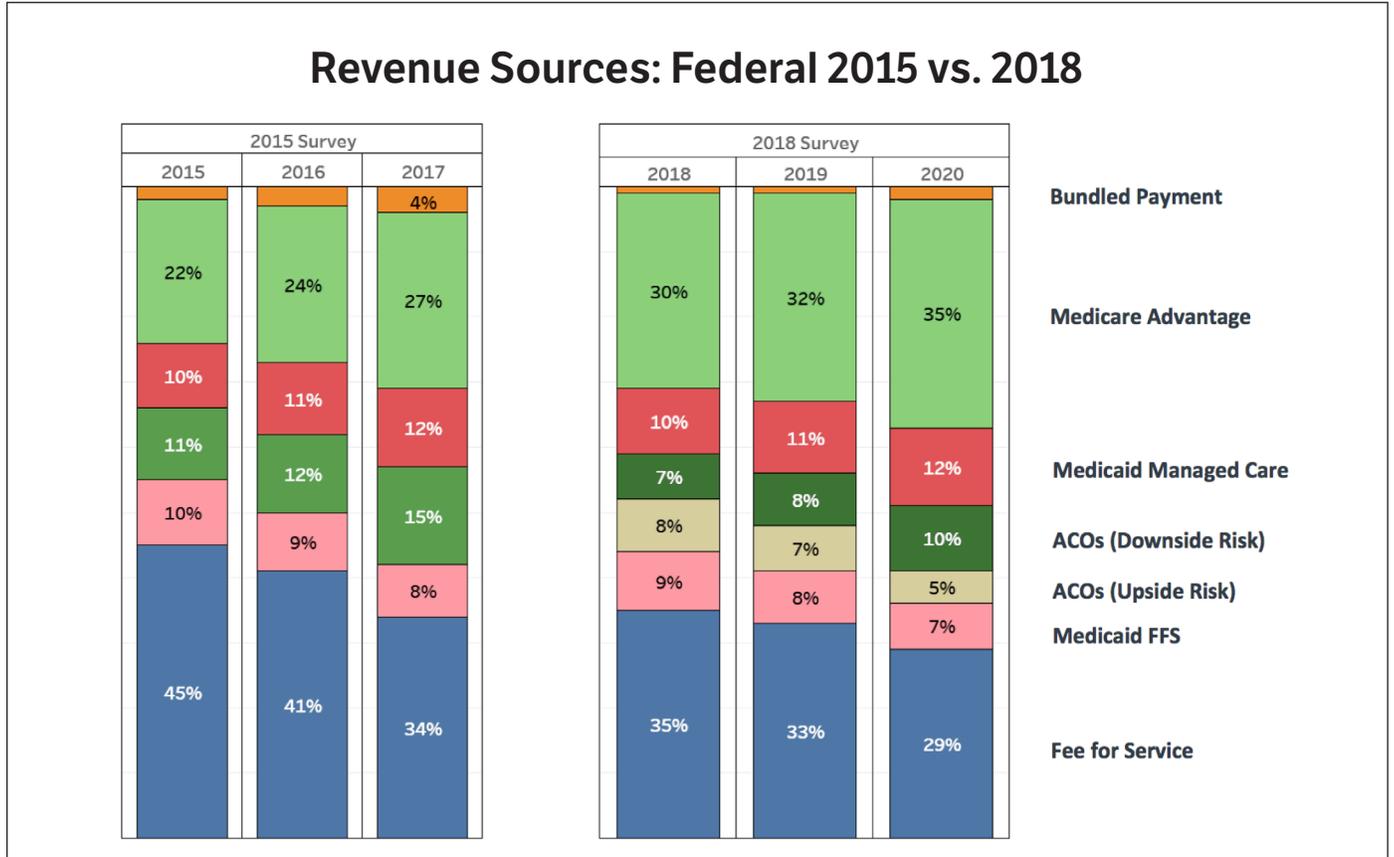
Risk-based payments in the commercial setting accounted for 28% of total revenues in 2018. By 2020, respondents expect risk-based payments to increase to 37% of total revenues. During that time period, shared-risk ACO revenues are expected to almost double from 6% to 11% of total revenues, while shared-savings ACO revenues will increase from 10% to 12%. Full and partial capitation payments remain flat at 7% and 3% of total revenues, respectively. Bundled payments represent 1%-2% of total revenues for 2018, 2019, and 2020.

The organizational type most likely to be involved in capitated payments in the commercial setting is IDSs with a health plan, which reported 17% of total revenues from that advanced payment model. IDSs with a health plan also are more involved in shared-risk arrangements than IDSs and MSMGs, and they reported the least amount of FFS payments, at 67% in 2018. MSMGs reported higher levels of revenues coming from capitated payments than IDSs (11% to 6%, respectively). IDSs reported more participation in shared savings ACOs and bundled payments than MSMGs.

Much like the federal setting, Western respondents were more likely to receive capitated payments (19%) than other regions. Members from the South reported that between 2% to 3% of revenues were capitated in 2018. The South also reported the largest percent of FFS revenues (86%). Midwestern respondents reported strong engagement in shared-risk products (16% of revenues) and capitation (10%). While Northeastern respondents were the least likely to take capitation in the federal setting, they reported 18% of commercial revenues coming from capitated-risk models.

2015-2018 Survey Results Compared

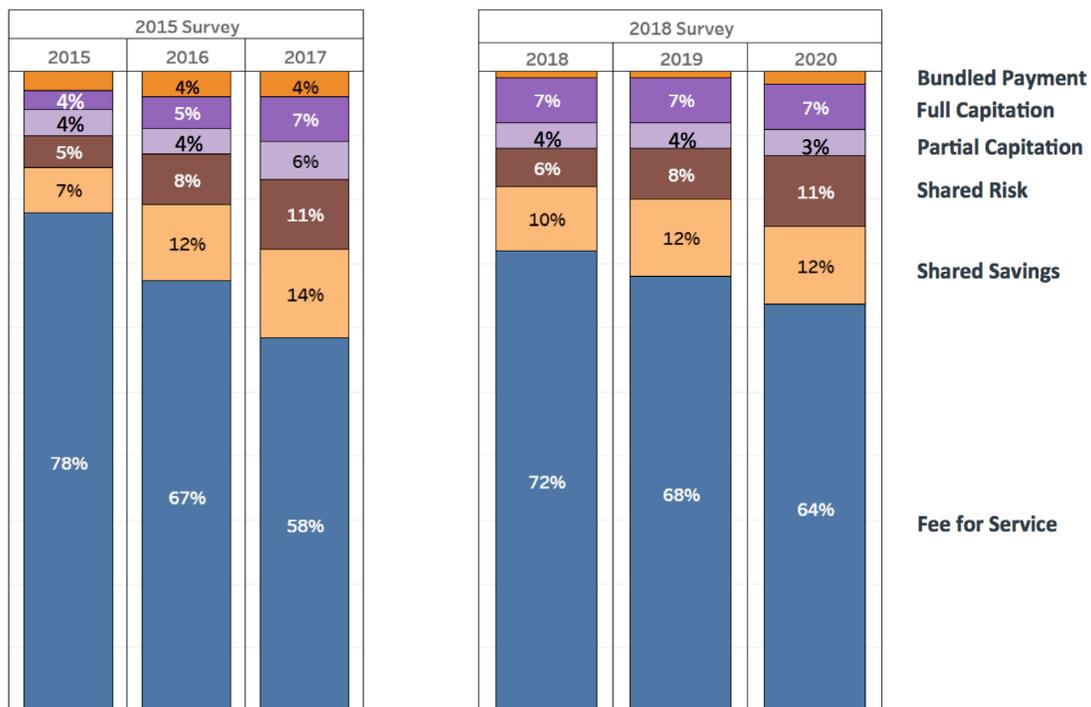
When comparing responses from AMGA members for the 2015 (n=115) and 2018 surveys for overall reimbursement trends, it is clear that they are moving to risk-based payment models. This comparison is especially meaningful for results in the “current” year from the respective surveys (i.e., comparing 2015 revenue in the 2015 survey to 2018 revenue in the 2018 survey), since this represents actual reimbursement numbers and not projections.



Federal Setting

In 2015, 55% of AMGA member federal revenues were FFS based. Four years ago, the survey found that 22% of total revenues flowed from MA, while 11% came from the MSSP program. Medicaid revenues, which totaled 20% of total revenues, were equally divided between FFS and Medicaid risk arrangements. In 2018, FFS revenues declined to 44% of total revenues. MA payments increased to 30% of total revenues. ACO revenues increased by 36% (note: in 2015 ACO revenue was not broken down by upside or downside risk), and Medicaid revenues, whether FFS or risk-based, remained flat. Bundled payments also remained constant at 1% of total revenues over the four-year period.

Revenue Sources: Commercial 2015 vs. 2018



Commercial Setting

In 2015, 78% of AMGA member commercial revenues were FFS-based. Twelve percent of revenues were in the ACO market, and 8% were in some type of capitated model. By 2018, FFS revenues had decreased to 72% of total revenues, while ACOs comprised 16%, with most of the growth coming from upside-risk only ACOs. Capitated payments increased to 11% of revenues, while bundled payment revenues remained insignificant in both 2015 and 2018.

Impediments to Taking Risk

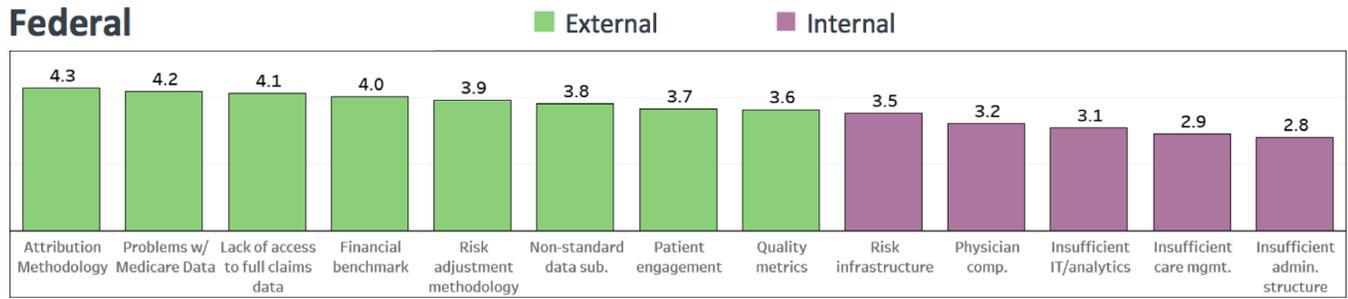
Commercial Setting

AMGA members reported two types of barriers to taking on risk, external and internal.

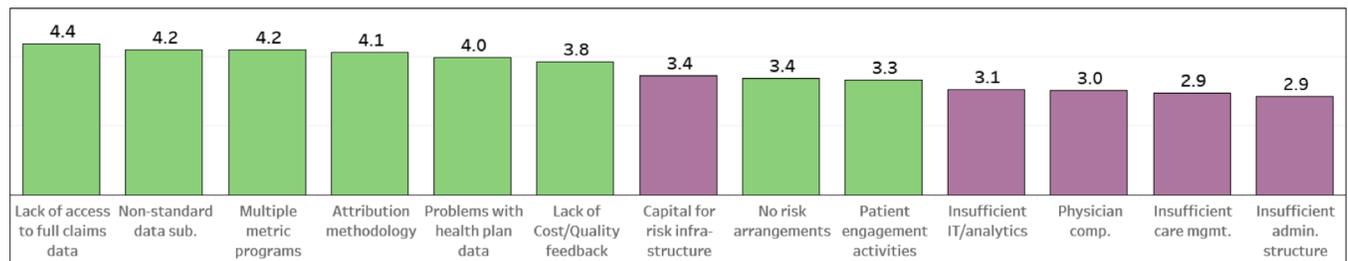
For the fourth year in a row, a lack of access to administrative claims data remains the most significant external obstacle to moving to value. Respondents report that few payers are willing to share administrative claims data, making it challenging at best to manage large populations of patients, a key ingredient for success in risk arrangements. Relatedly, AMGA members report that they submit and receive data from different payers in different formats, necessitating increased deployment of resources to information technology (IT) departments. A 2017 AMGA Consulting survey found that for every 100 physicians employed by an AMGA member, the medical group employed 17 IT professionals to support them. Risk survey respondents also identified multiple and duplicative quality measure programs as a major impediment to value. Collecting data and reporting on hundreds of quality measures (that also have little impact on improving quality) has been linked to the serious issue of provider burnout.

Impediments to Taking on Risk: Federal/Commercial (2018)

Federal



Commercial



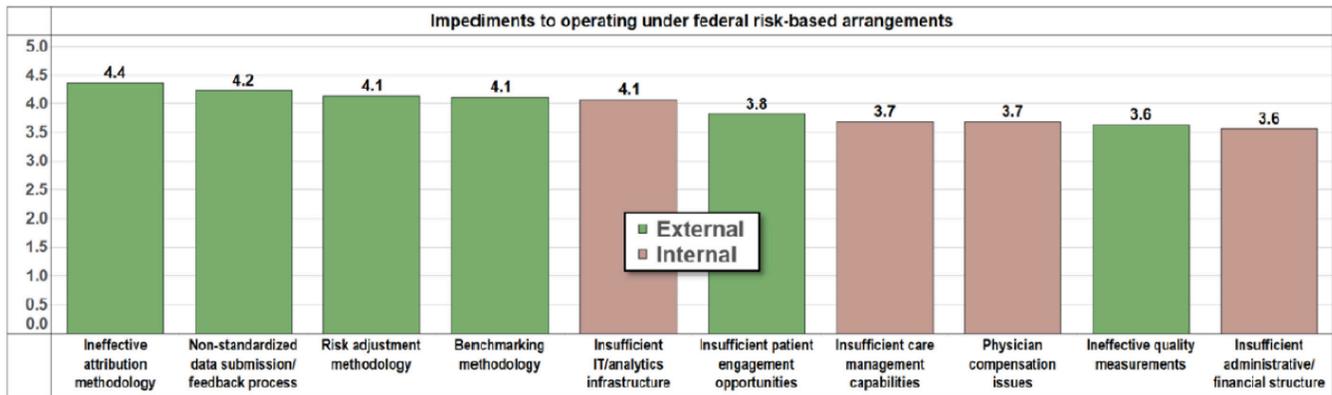
Regarding internal impediments, AMGA respondents report that an insufficient care management, data analytics, and administrative infrastructure is an obstacle to taking risk. Respondents also commented on the significant change management skills required to shift large complex organizations from FFS to value-based models. The way care is delivered in a value-based arrangement differs significantly from how it is delivered in FFS arrangements. For example, organizations participating in value-based models need to develop new roles and responsibilities, revise compensation plans to reflect outcomes, and redesign care processes. They need to make million-dollar investments in IT and people to develop programs for high-cost patients. In addition, significant management skills from medical group leaders and buy-in from rank-and-file providers are necessary for a successful transition to value-based care models.

Federal Setting

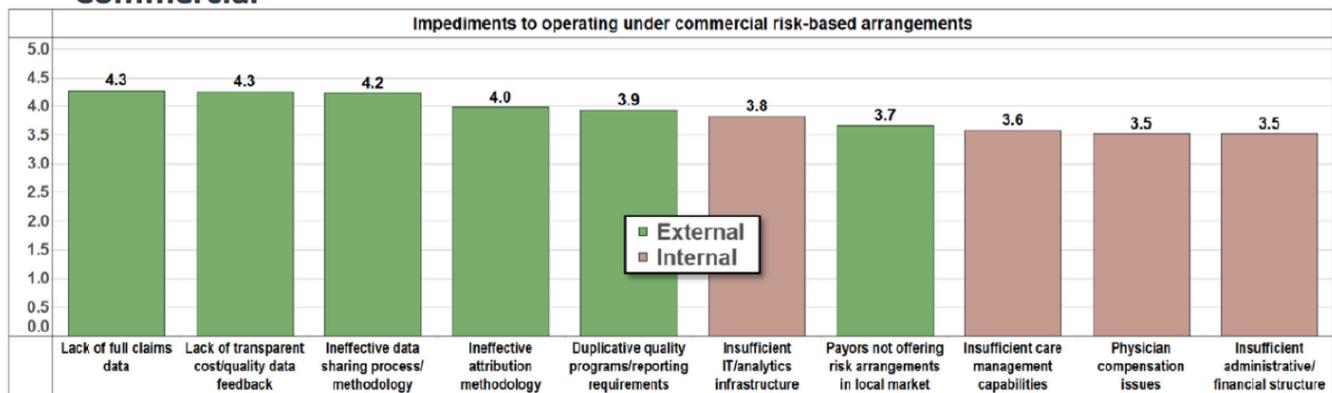
Respondents report that data from the Centers for Medicare & Medicaid Services (CMS) is often not actionable nor timely, making it difficult to make changes in care processes to address gaps in care or address performance issues in a judicious fashion. Lack of access to Medicare claims data also is an issue. CMS' methodologies in the ACO program for patient attribution, risk-adjustment, and financial benchmarking methodologies also are significant problems for AMGA members. Duplicative quality measures that have little impact on improving care are also cited as impediments to moving to value in the federal setting.

Impediments to Taking on Risk: Federal/Commercial (2015)

Federal



Commercial



2015-2018 Survey Results Compared

When comparing survey responses from 2015 and 2018, it appears that medical groups are addressing internal impediments to moving to value. For example, in 2015, insufficient IT infrastructure scored a 3.9 out of 5 as an impediment to risk in the commercial setting. By 2018, respondents scored that as a 3.1. Similarly in 2015, respondents rated insufficient administrative/financial structure a 3.5 as an obstacle to value. By 2018, that score had dropped to 2.9. In the federal setting, respondents scored physician compensation issues as a 3.7 in 2015; by 2018, that score had decreased to 3.2.

Scoring for external impediments however, has remained largely unchanged. For instance, in 2015, respondents scored lack of access to claims data a 4.3 as an obstacle to value. In 2018, that score actually increased to 4.4. In the federal setting, respondents scored attribution methodologies a 4.4 as an impediment to risk. In 2018, respondents rated attribution a 4.3.

Insight

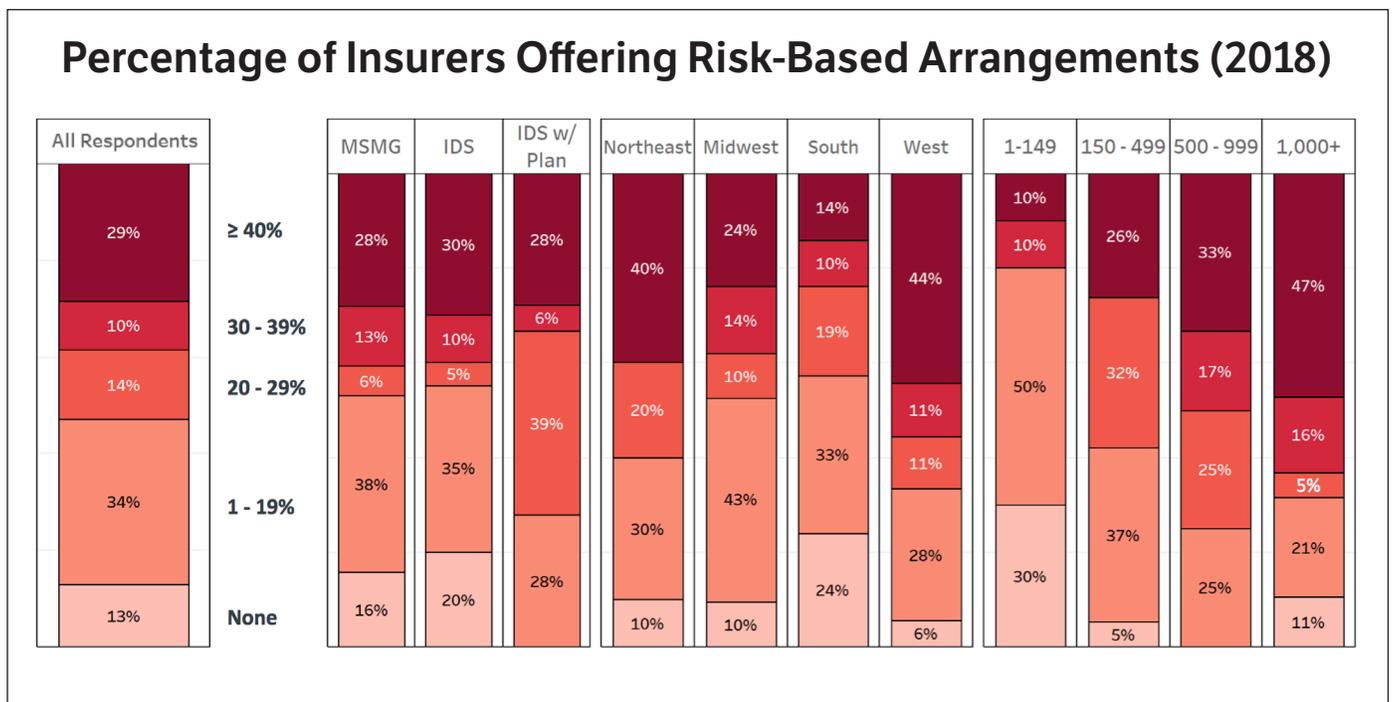
It appears that AMGA members have been addressing impediments to risk that are within their control (i.e., internal impediments). As discussed more fully below, medical groups are investing in the people, processes, and IT necessary to build the infrastructure to move to value. These investments can range from millions to several millions of dollars per medical group and represent a commitment from leadership that the move to value is a strategic, tactical, and patient priority.

Conversely, external impediments in the transition to value have not improved in four years. Respondents commented that this dichotomy between addressing internal impediments, at tremendous cost, while simultaneously experiencing a lack of movement on the external front is frustrating both at the leadership and front line provider level. Respondents noted that these impediments serve as disincentives to invest in the people, technology, and culture changes necessary to succeed in risk-based payment models.

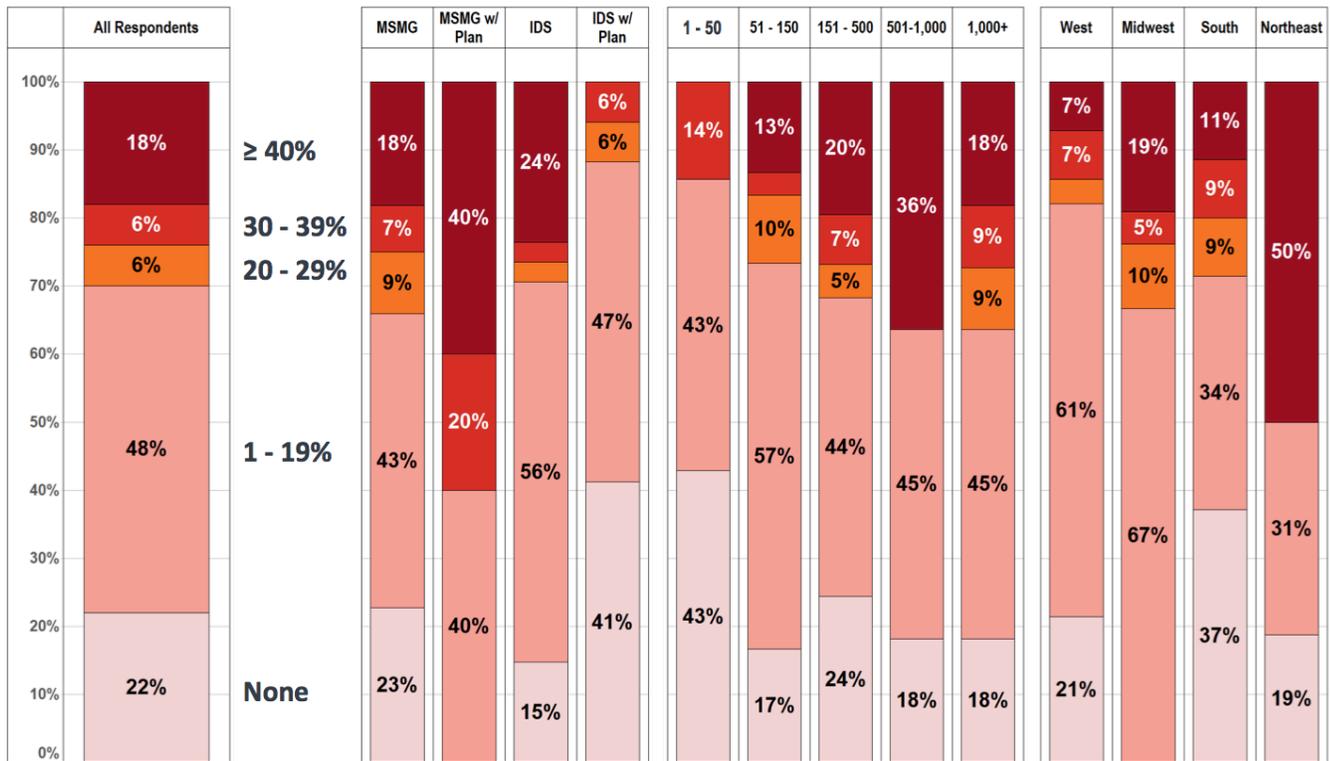
Relatedly, respondents stated there was a need for Medicare and commercial payers to offer meaningful incentives, both financial and administrative, to support the investments respondents were making to move to value. Stability and predictability in value programs and payer relationships are important, according to respondent comments. A minority of respondents stated that operating in FFS was administratively and operationally easier and posited that if incentives to move to value remained overly complex, a move back to FFS was not unreasonable.

Commercial Payer Engagement in Risk Arrangements

This year’s survey found that 13% of respondents reported having no access to risk-based arrangements in their local markets. An additional 34% reported that only 1%-19% of insurers were offering risk-based arrangements. Twenty-nine percent of respondents reported that more than 40% of insurance companies were offering value arrangements in local markets. Smaller groups (1-149 FTE physicians) were more likely to report issues accessing commercial risk plans than larger groups with 1,000 or more FTE physicians (80% and 32%, respectively). Organizationally, MSMGs and IDSs reported similar problems accessing risk contracts in their markets (54% and 55%, respectively). As was the case since our first risk survey, AMGA members in the South report the least amount of risk arrangement penetration in the country.



Percentage of Insurers Offering Risk-Based Arrangements (2015)



The survey shows increased risk engagement by payers compared to 2015, when 70% of respondents reported they had no (22%) or little (48%) access to commercial risk plans in their markets. According to the survey data, most of the increased risk-based offerings are expected to be in the ACO space.

Insight

Four years of data clearly demonstrates that the move to value is slower in the commercial setting than in the federal space. Respondents provided several explanations for this dichotomy. Payer infrastructure, like many providers' infrastructure, was and remains designed to process claims in a FFS model. Restructuring IT and administrative functions to develop risk models is costly and time-consuming, and it provides little increased shareholder value (for for-profit payers). Indeed, any savings achieved by a provider in FFS (such as, for example, addressing re-admissions or ED visits) inure to the benefit of the payer, providing them with little incentive to develop risk-based payment models. Unlike their experiences in MA, respondents reported that negotiating risk-based arrangements with commercial payers has generally not progressed beyond attempts to reduce reimbursement rates without corresponding incentives to providers.

Importantly, employers have been slow to demand value arrangements. Large employer human resources generally focus their benefit strategies around increasing employee access to providers, not on harder to define "value" arrangements. Additionally, many providers do not have a sufficiently sized patient population that would support downside-risk arrangements.

Length of Time to Take Downside Risk

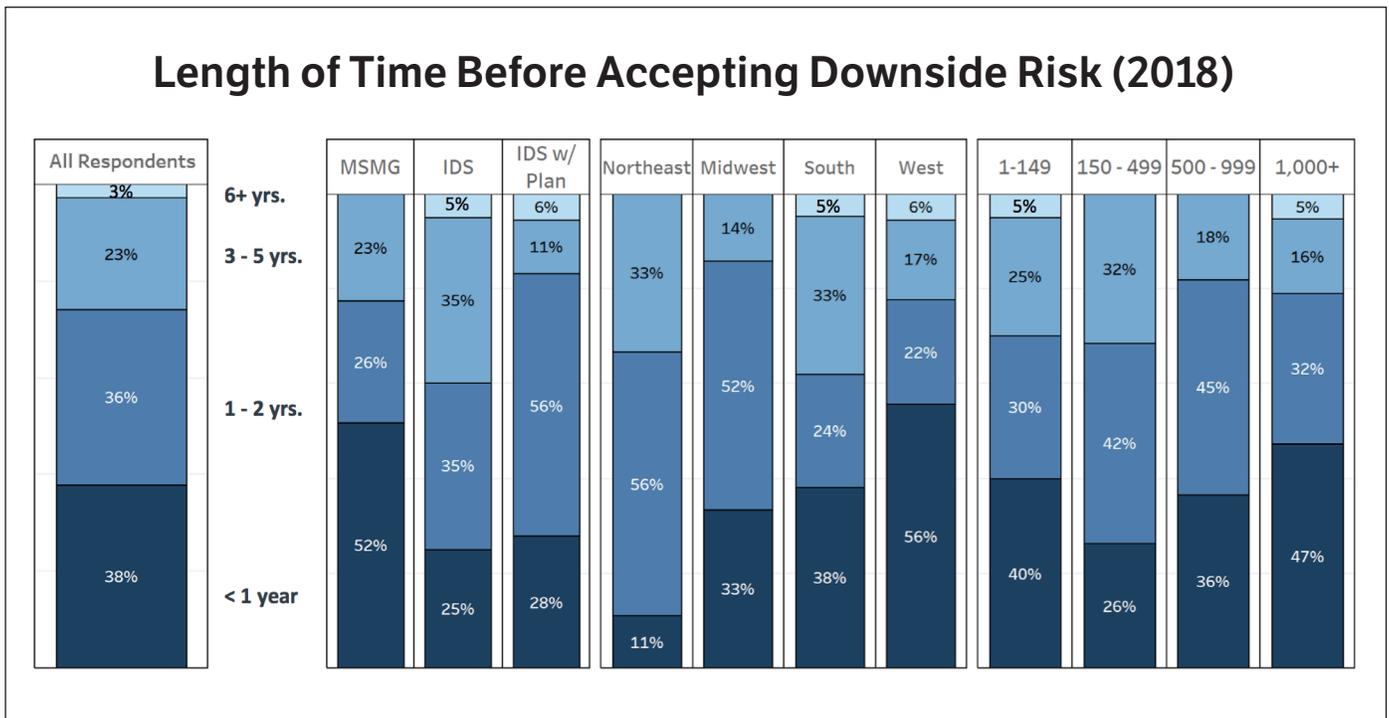
Seventy-four percent of 2018 survey respondents reported they would be ready to take downside payment risk within two years. This is up significantly from the 42% of respondents who indicated in 2015 that they would be ready to take downside risk within two years. The 2018 results also found that MSMGs reported being the most likely to take downside risk quickly, with 52% of respondents stating they could take risk in less than one year. Twenty-eight percent of IDSs with a health plan reported being ready to take risk in less than one year. Forty-seven percent of groups with 1,000 or more FTE physicians were ready to take risk within one year.

Investments

Respondents were asked to name the most important investments they made to prepare them to participate in risk-based payment arrangements. Investments covered three main categories: care process redesign, IT solutions, and care management personnel. On the care process redesign front, respondents reported investing in post-acute utilization management programs, transition-of-care programs for patients discharged from a hospital, wellness and prevention programs, and developing teams to perform outreach and close gaps in care. IT investments included software for risk stratification to guide care interventions, solutions to convert and interpret claims data and help with complete and accurate coding of diagnoses, development of quality and utilization dashboards, and risk adjustment for analytics. Personnel needs focused on staffing analytics departments and case managers to work with high-risk/high-cost patients. Additionally, care managers and clinical support staff, such as medical assistants, were being hired to better support clinicians and relieve burnout issues.

Insight

Given the challenges in moving to risk, respondents were asked to provide reasons why their medical groups were moving to value. AMGA members commented that the volume-based FFS payment model was unsustainable and incentivized overutilization of healthcare services. Moreover, AMGA members stated that risk-



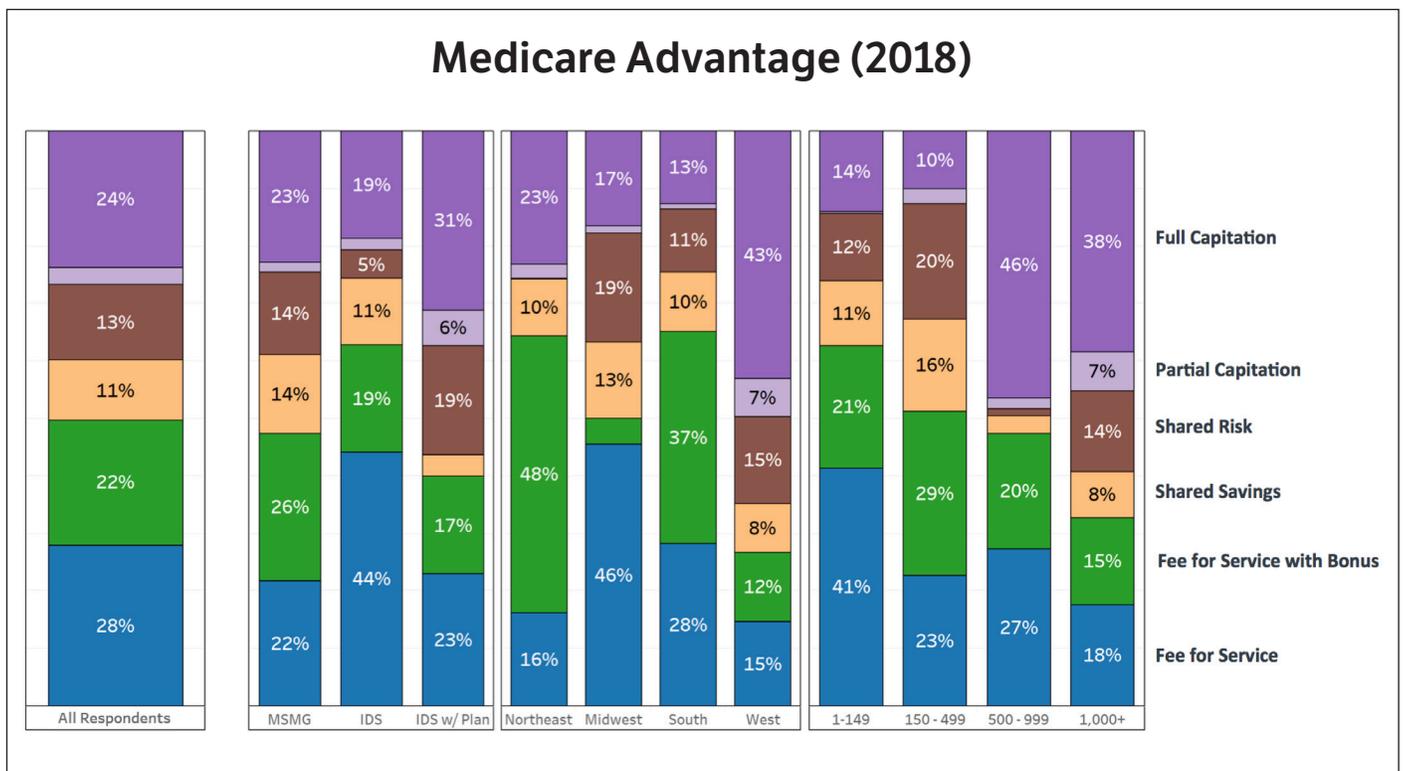
based arrangements aligned well with their team-based and coordinated approach to care delivery, as the models focus on rewarding prevention, appropriate utilization, and patient experience and outcomes. Risk arrangements also allow AMGA members the opportunity to capture their investments in care process redesign, analytics, and personnel to manage large populations of high-risk, high-cost patients.

Additionally, many AMGA members are intentionally adopting a value-based strategy to ensure their place in evolving local markets. There was significant sentiment that medical groups had to move to value on their own terms before other players in the healthcare sector developed additional risk programs that do not reflect the way care is delivered. Almost all commentators remarked that they felt moving to value was better for the patient, and caring for patients was the reason respondents entered the healthcare field.

Risk-Based Payment Models

Medicare Advantage

MA payments comprised 30% of total federal revenues in 2018 and are expected to reach 35% of revenues in 2020. MA is the dominant risk-payment model for all AMGA organization types, all sizes, and in every region. It is clear that AMGA members view MA as the preferred value-based model in the federal setting. Indeed, based on respondent comments, MA is the favored payment model in all settings.



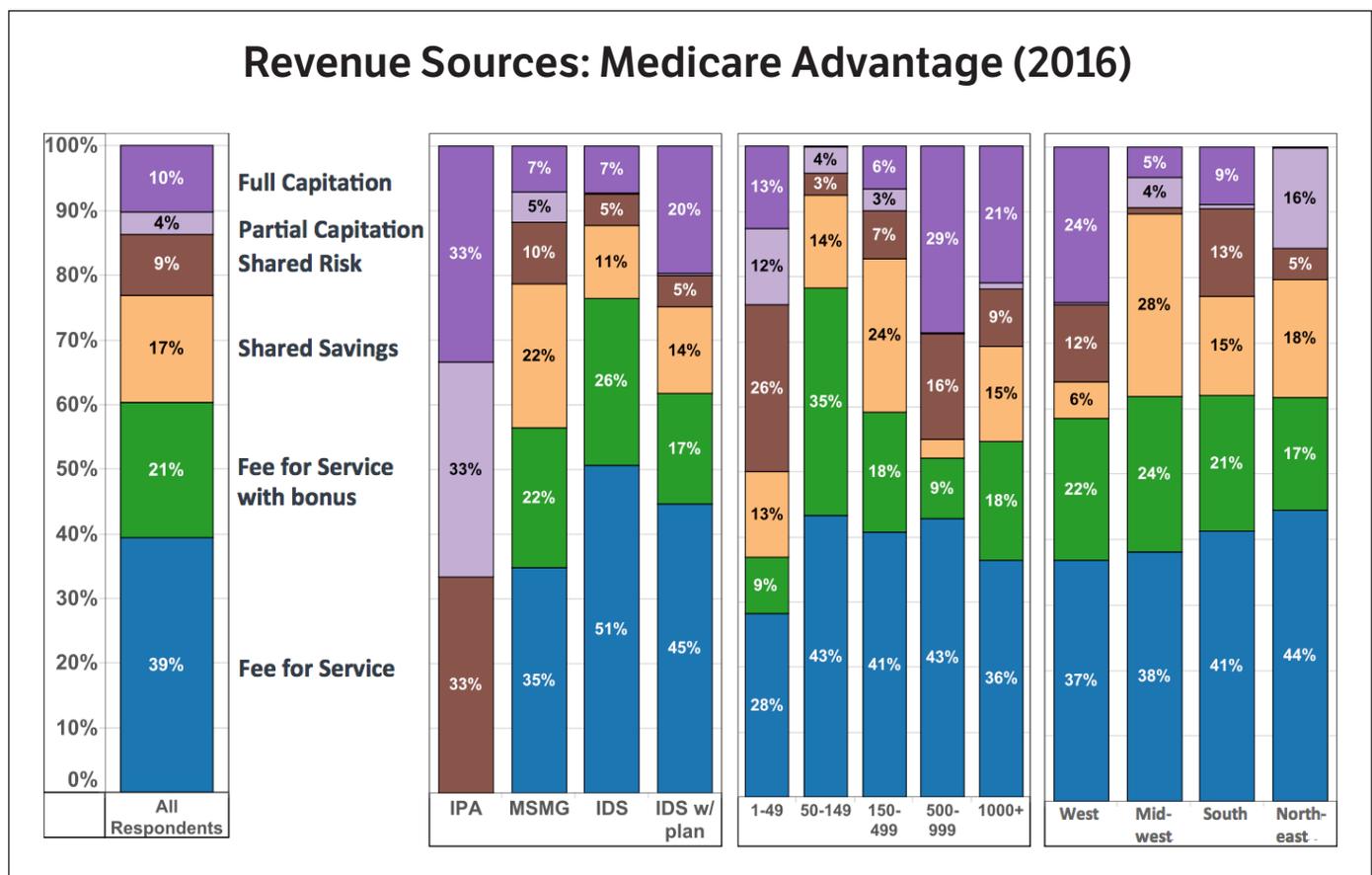
Capitation

According to the 2018 survey, MA payments are moving away from FFS and toward risk. In 2016, 10% of MA payments were fully capitated; by 2018, that number increased to 24%. Shared risk MA payments increased by 4% in 2018 (from 9% to 13%), while upside-only payments decreased from 17% of MA payments to 11%. While FFS payments accounted for 60% of total MA payments in 2016, that figure declined to 50% in 2018.

IDSs with a health plan had the highest levels of fully capitated payments (31%), as did the members in the West (43%). Larger medical groups also reported larger percentages of fully capitated payments than smaller groups (46% and 38%, respectively, for the two largest categories).

Insight

Respondents provided several reasons for their increased engagement with MA plans. For groups willing to take on increasing levels of risk, MA arrangements allow flexibility in care delivery efficiencies. MA arrangements can provide opportunities for AMGA members and MA plans to target, reward, and adjust for factors that both parties agree improves care and the patient experience. MA contracts can fund the services and infrastructure providers need to optimize outcomes for MA beneficiaries. MA allows for greater accountability and aligns incentives around utilization appropriately. MA also allows groups to affect the revenue side through appropriate risk adjustment, the expense side through improved care management processes, and the quality side by meeting MA Star ratings. Critically, because beneficiaries enroll in an MA plan, it does not share the patient attribution problem that is so prevalent in the ACO program. AMGA members know exactly who is in their MA patient population, which allows them to design programs around keeping patients healthy and to better manage patients with high-cost, complex conditions. Not surprisingly, AMGA members also are moving to MA because it is where their patients are going. New Medicare beneficiaries have experience in care delivered in a network and are willing to part with some level of access in exchange for a rich benefit package that can include vision, dental, and wellness care.



Accountable Care Organizations

Federal Setting

ACO revenues equaled 15% of total federal revenues in 2018 and are expected to remain flat through 2020. It is noteworthy, however, that respondents expect revenues from downside-risk ACOs to increase from 5% of revenues to 10% by 2020, while upside-only revenues will correspondingly decrease from 10% to 5% in the same time period.

MSMGs had a higher percentage of ACO revenue (17%) when compared to IDSs (13%) and IDSs with a plan (14%). Respondents from the East reported higher percentages of ACO revenue (32%) and Western respondents reported less than 3% of revenues coming from ACOs.

Commercial Setting

ACO revenues, both shared savings and shared risk, accounted for 16% of total commercial revenues in 2018. Unlike federal ACOs, however, commercial ACO revenues are expected to increase by 44% in 2020; shared-risk ACO revenues are expected to increase by 83%. ACO revenues by organization type were largely consistent (averaging 16%), while ACO revenues were greatest in the Midwest (26%-16% shared risk; 10% shared savings). Respondents with more than 1,000 physician FTE physicians reported 27% of their revenues came from ACOs (10% shared risk; /17% shared savings).

Insight

At the federal level, it seems clear that AMGA members are shifting focus from ACOs toward MA. Respondents report that the regulatory framework that has been promulgated around ACOs makes financial success in this model challenging at best. Patient attribution, financial benchmarking, and risk-adjustment methodologies have been problematic since the MSSP program's rollout in 2012 (though some positive changes around attribution and benchmarking were included in the 2018 MSSP final rule). Respondents noted the inherent difficulties in taking risk on a FFS chassis and that savings opportunities shrink year after year if the ACO maintains a strong savings performance. This issue is worsened by the fact that shared-savings payments are not made up to a year after the agreement period begins, meaning the ACO's multimillion-dollar up-front investment will not be recouped for a year, if at all. Moreover, the ability to control costs in the ACO setting are difficult and unpredictable, as patients are allowed to receive care outside the medical group setting. Respondents also report increasing levels of frustration with federal regulators who have in the past changed program rules in the middle of performance years, making it difficult to achieve program success and maintain momentum for championing the move to value at the provider level.

According to the data, ACO arrangements are the most prevalent risk-based model in the commercial setting, largely because that is the model being offered by payers in their markets. While ACO challenges are more fully described above, ACO arrangements are still relatively easier to execute compared to capitation arrangements for both payer and provider. They also allow providers and payers to gain experience in performing under a risk-based arrangement without the need to completely revamp administrative and IT functions.

Bundled Payments

Federal Setting

Respondents report that 1% of revenues come from bundled payment models in the federal setting. By 2020, that percentage is predicted to remain 1%. This lack of involvement in bundled payments is consistent with all organization types, sizes, and regions.

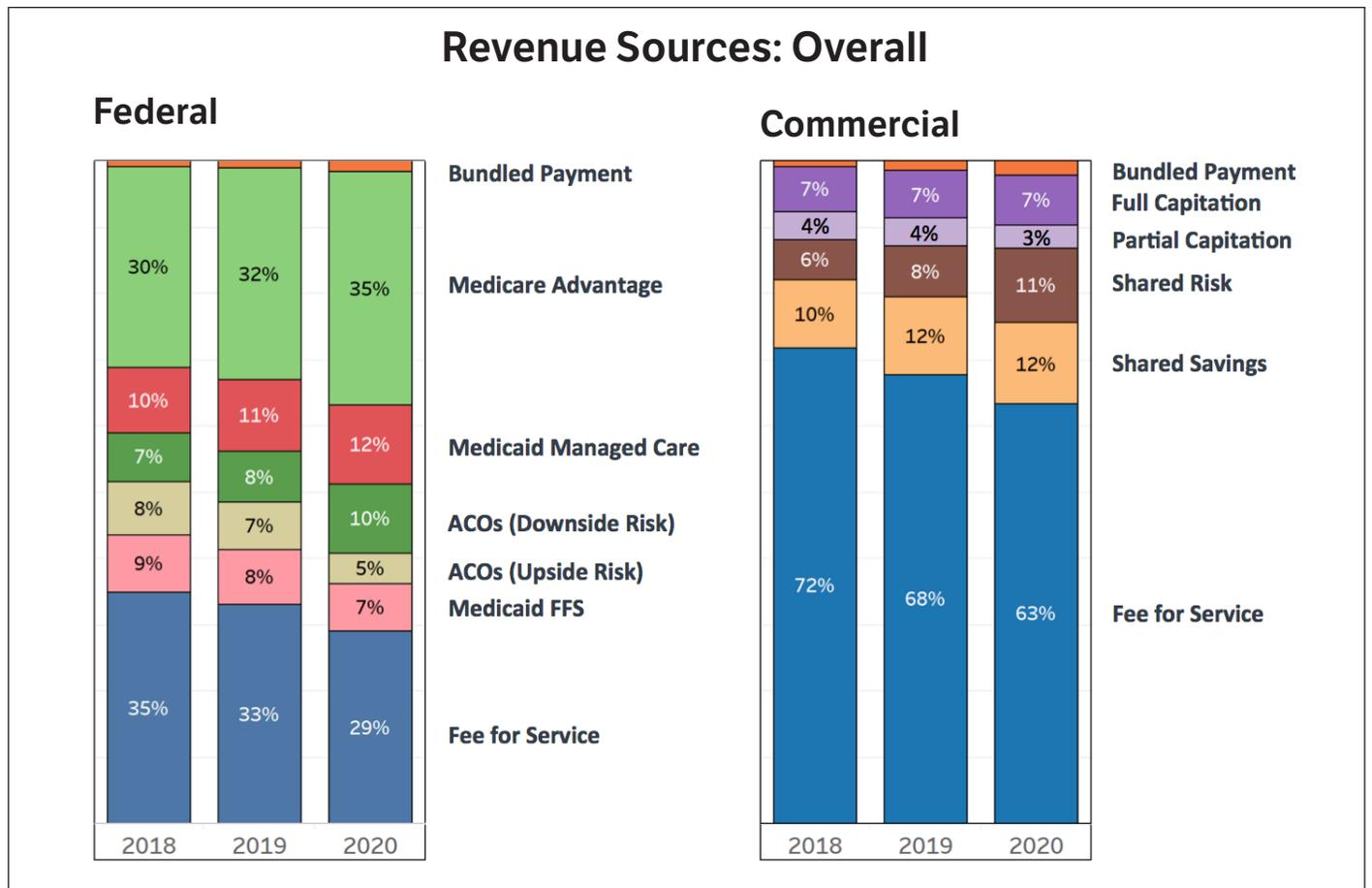
Commercial Setting

Similarly, there is a notable lack of traction for bundled payments in the commercial setting. Respondents reported 1% of commercial revenues from this payment model. Mirroring the federal setting, this lack of engagement in bundles is consistent for all organization types, sizes, and regions.

Insight

While bundled payment models can be attractive for hospitals with strong specialty practices like orthopedics, AMGA respondents commented that they are more likely to be engaged in risk models that cover large populations of patients—particularly those with chronic, high-cost conditions—and span their entire enterprise. AMGA members report they are more interested in taking risk for all the care of the patient and not just a smaller, discrete part of that care. Respondents also stated that defining the time, services, and patients to be included in a bundled payment could be problematic.

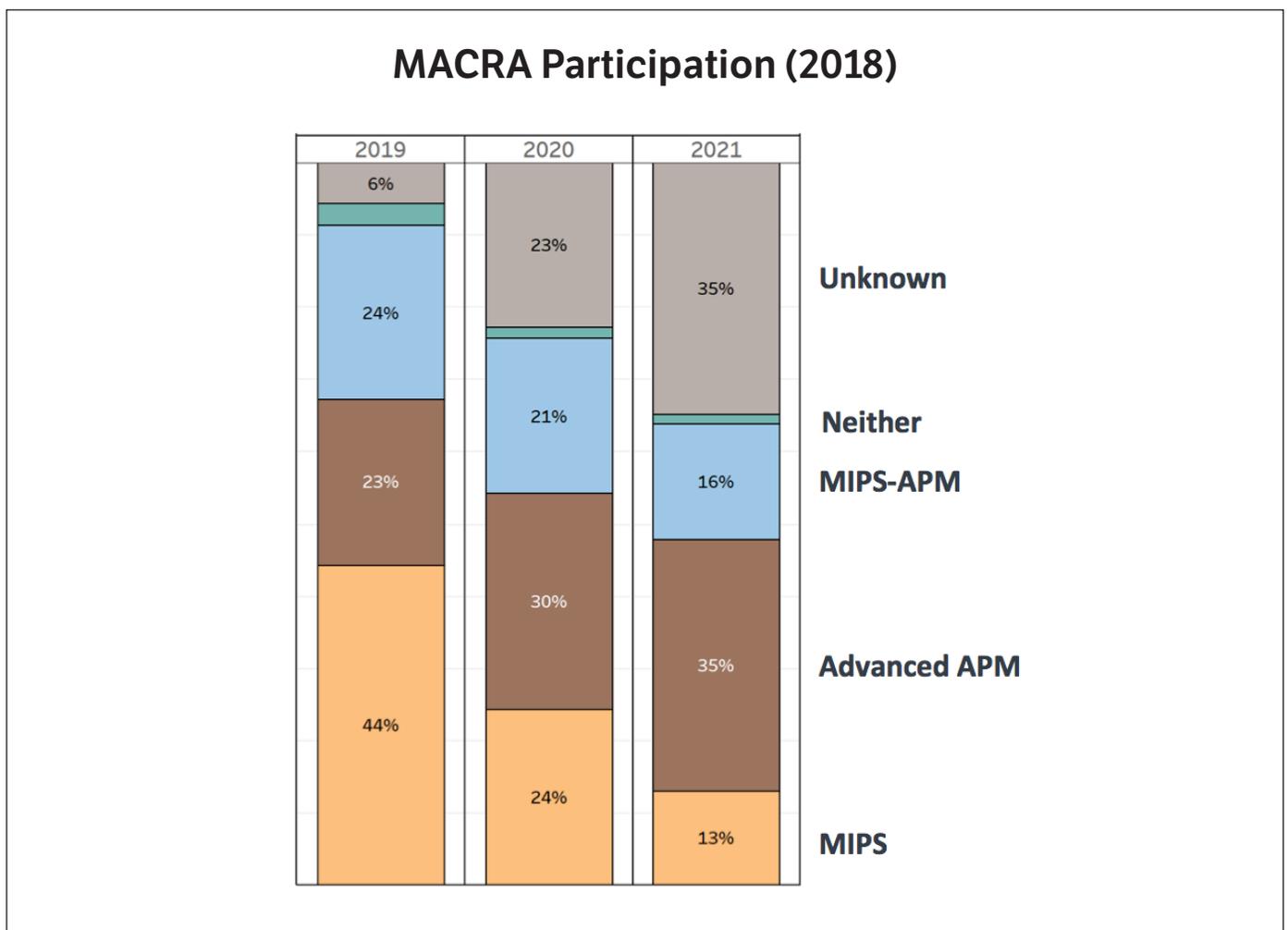
For AMGA member groups that participate in bundled payments, honing their experience in models that they can offer directly to employers was a major consideration.



MACRA

Not surprisingly, AMGA respondents predict they will move away from the MIPS program to AAPMs or MIPS APMs (i.e., Basic ACOs aka Track 1) in 2020 and 2021. More notable, however, is the four-time increase in the number of respondents who answered “Unknown” when selecting a MACRA pathway in those later years.

When asked why there was uncertainty around future MACRA paths, respondents stated that because of the significant changes to the MSSP program in November 2018, medical group leadership needed time to digest these new changes. On the AAPM front, several respondents stated that they could not meet the financial or beneficiary thresholds required to be eligible for the 5% bonus in that program. Other respondents noted that they were pursuing an MA strategy and that adopting another risk-based platform would divert them from their MA positioning. Respondents currently in Track 1 ACOs were monitoring their performance before committing to the MIPS-APM or AAPM path.



Conclusion

AMGA members continue to transition their care delivery models, investments, infrastructure, and culture toward value. This trend to value-based payments is especially clear when comparing survey responses from the 2015 and 2018 surveys. As with past surveys, respondents offer clear rationales for moving in this direction. However, respondents did demonstrate a higher level of frustration that external impediments to value have not been addressed. The data and comments suggest that stakeholders and policymakers should move to address these matters to ensure that the momentum to value continues.

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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