

# THE GREAT DIVIDE

How Payers and Physicians  
View Value-Based Arrangements

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Since the passage of the 2010 Affordable Care Act (ACA), healthcare payers and physicians – in concert and independently – have been preparing for value-based reimbursement programs in which meeting quality-of-care and cost-reduction targets would result in benefits both for payers and providers and for the nation as a whole. FTI Consulting conducted a Payer-Provider survey in April and June of 2014. According to the survey, it has not been easy for payers and physicians to get on the same page, and it will not be a simple matter to bridge the gap that divides them. Indeed, 41 percent of physicians not currently in a value-based relationship say their biggest obstacle to entering into one is their distrust of payers. This lack of trust will be a huge hurdle for payers to overcome as they often cite physician buy-in and engagement as critical to the success of any value-based arrangement. This article highlights the areas of difference revealed by our survey and points out where both parties may find common ground to improve the quality of U.S. healthcare while reducing or at least slowing the rise of its unsustainable costs.

## The Gap between Payers and Providers

While most payers and providers are taking steps to prepare for the value-based arrangements incentivized by the ACA — with 80 percent of payers in the FTI Consulting Payer-Provider survey saying these types of contracts are “very important” to their strategic objectives and 92 percent of physicians saying they are either “somewhat important” or “very important” to them — the traditional fee-for-service contract still predominates in

the healthcare industry. Fifty-five percent of payers say many of their commercial contracts remain fee-for-service, and only 10 percent report that they no longer have any fee-for-service arrangements. At the same time, 15 percent of polled doctors say they are “only interested” in the fee-for-service reimbursement model, which the American Public Health Association has said directly leads to [“overtreatment and overbilling.”](#)

For value-based arrangements to succeed, this divide between payers and physicians must be bridged.

## PHYSICIAN PROBLEMS WITH RISK SHARING

In the post-ACA healthcare landscape, payers are moving inexorably toward value-based reimbursement strategies such as capitation, in which physicians are paid a fixed amount per patient over time, and accountable care organizations (ACO), in which payers and physicians [share in the savings they achieve for the Medicare program](#). Nearly four-fifths of payers currently are building ACO-type arrangements. In bundled payments and other value-based arrangements,

# Clinical integration cannot be achieved without a high degree of IT sophistication.

many experts believe it is essential that payers and providers eventually share risks to control costs and improve quality. However, the FTI Consulting survey found that the gap between the two groups continues to widen. Payers believe that a mere 5 percent of providers are willing to accept the downside risks necessary for value-based models to work. As one payer respondent says: “The [providers] approaching us ready to talk about risk are prepared to discuss only upside shared saving programs. They’re not willing to take downside risk. If they had their preference, they would stay at fee-for-service.”

This payer perception of physician attitudes largely is validated in the physician section of the FTI Consulting survey, where only 16 percent of physicians say they are willing to accept risk (more than the 5 percent of payers but still not a lot). And almost half (49 percent) mostly are interested in upside risk-sharing models; that is, physicians and physician groups are eager to reap the rewards of improving quality and controlling costs but are less confident in their ability to curb factors that could lead to missed targets, making the parties vulnerable to penalties.

It stands to reason that providers — including hospitals and independent physician practices — would be leery of entering into arrangements in which their revenues and income are placed at hazard with a partner they do not trust.

## THE TECHNOLOGY LAG

Risk sharing is not the only disconnect between payers and physicians, according to the FTI Consulting survey. Payers seeking to partner with providers in value-based arrangements have identified capabilities they wish potential partners would possess. Payers want

to see providers invest in healthcare information technology (IT), especially in systems and software supporting clinical integration and population health management (PHM).

Indeed, 80 percent of payers say they likely would contract with a clinically integrated hospital and provider system. One payer respondent says: “I see much more success in the larger provider groups than in the providers that may not be able to have the best technology available.”

However, the survey found that only half of physicians report that their organization has implemented new technology or software to support PHM and value-based reimbursement, 32 percent have not and 18 percent either don’t know or are unsure. Clinical integration means having a physician-led system that brings clinical and research programs, along with an insurance provider, together on a single IT platform. It also requires that physicians follow standardized, evidence-based best practices in treating certain conditions and performing specific procedures in all integrated facilities — an unwelcome shock to some physicians accustomed to operating independently in their medical practice.

Clinical integration cannot be achieved without a high degree of IT sophistication. With the proper IT and analytic tools, health risks can be mitigated by identifying groups that need special care and attention, especially those with the chronic conditions that are becoming pervasive in an aging U.S. population. By possessing detailed information on patient populations, payers and physicians can deploy resources more efficiently to care for these groups, ideally controlling the conditions before they become

increasingly expensive to treat. This is critical to meeting quality and cost-reduction targets in value-based arrangements.

In fact, 84 percent of payers report they are implementing healthcare IT and PHM tools such as:

Electronic medical records platforms

Portals for physicians and patients

Analytics

Customer relationship management tools

Integrated medical records systems

Patient management profiles

Integrated electronic health records (EHR) platforms to connect providers and case managers

Clinical integration, while it can improve quality, save money and keep communities healthier, can also raise antitrust concerns. Healthcare organizations that undertake integration must be careful to consider and comply with Federal Trade Commission (FTC) guidance and advisory opinions, as well

as with Department of Justice (DoJ) and FTC Statements of Enforcement Policy in Healthcare, all of which contain important clinical integration guidance.

For instance, Reading Health System created Reading Health Partners (RHP) — a wholly owned, clinically integrated subsidiary — with the goal of creating shared value for physicians, employers and payers. [FTI Consulting collaborated with Reading Health System](#) to provide advice on how to structure the organization efficiently and in compliance with FTC guidance. In addition, and critical to RHP's success, was the fact that its physicians helped build the new system and are intimately involved in its governance.

Clinical integration establishes the scale that endows organizations with the revenues and capital to invest in the advanced IT capabilities required to succeed in a value-based world. Half of all FTI Consulting survey respondents say scaling up will be necessary to their success going forward. Some of the ways payers can scale are:

- Mergers and acquisitions of other plans

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- Product line extensions

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- IT and infrastructure build-outs

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- Expansion across state borders to increase Medicare/Medicaid activity

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- Bids for federal or state payer programs

One respondent notes: "I feel that growth in the next three years will be in government programs."

## Wellness Programs: Healthy Costs Less than Sick

In the FTI Consulting Payer-Provider survey, most payer respondents say their organization is attempting to create wellness programs as an integral part of value-based care and as a way to reduce preventable hospital admissions. These programs include:



Financial incentives (discounts and contributions) for gym/health club memberships.



Incentives (lower deductibles and co-pays) for employee health screenings.



Health fairs (with blood pressure, diabetes checks and mammograms made available).



Health coaching (online or live).



Healthy office environments (including providing healthier food choices in cafeterias and vending machines).

Wellness programs are most effective when complemented by healthcare IT. As one survey respondent says: "We've put in place technology for our employees to track their lab results and monitor their care to gain an understanding of whether or not they're improving. We also have a program in which employees can get a discount on their insurance premiums by earning 200 points or more. You don't have to do it, but why wouldn't you?"

Unfortunately, the healthcare IT that provides the foundation for clinical integration and scale is costly, it's often difficult to implement, and it's frequently beyond the capability of individual physicians or smaller independent physician groups to purchase and deploy.

For example, at Primary Partners, a Florida-based ACO, most of the

physicians were using electronic health records. However, each one had its own EHR system, and connecting all the practices' systems to a single registry proved difficult and expensive as the process required the assistance of the individual EHR vendors. In fact, one vendor flat-out refused to connect its system to Primary Partners' platform. Ultimately, the practice using that vendor's EHR could not join the ACO,

as the cost of switching to a new, compatible system was unaffordable.

One payer respondent notes, "The less savvy provider groups need technology training, and that requires resources." He laments that his organization had not done a good job in that area with a provider partner. "If it *had* done a better job, we would have made greater strides in more areas."

## Bridging the Gap

Highmark Inc., a Pittsburgh, Pa.-based insurer with 5.2 million members, announced in May 2014 that it was [changing its primary care model to an ACO](#), a value-based model in which the ACO shares in the savings it achieves for the Medicare program *if* the ACO delivers quality care and reduces costs. But as Highmark's medical director notes, "This is not a two-week project — it's a journey."

Progress, as Highmark's medical director indicates, has been and will be slow in cementing value-based contractual relationships between payers and physicians. Today, only 30 percent of payers are participating in shared savings programs, according to the FTI Consulting survey. However, experimentation is going on across the country.

### EXPERIMENTING WITH RISK

MaineHealth, one of Maine's largest hospital systems, teamed up last year with Anthem Blue Cross and Blue Shield to create the state's first ACO. Under the MaineHealth-Anthem agreement, physicians will continue to be paid under the predominantly fee-for-service model they prefer. But the agreement also contains quality measures and both upside and downside risk that MaineHealth's vice president of strategic initiatives says may be modified ["for different populations of patients as they are added to our agreement."](#) This is a



go-slow approach to breaking physician ties to the fee-for-service model, as well as a staged introduction to physician risk assumption — an exercise, if you will, in building the trust that our survey indicated is so sorely lacking.

On the other coast, in Washington state, Premera Blue Cross has 100,000 patients (out of a total membership of 1.5 million) enrolled in a global outcomes contracting program with The Polyclinic, Puget Sound's largest multi-specialty

## Methodology: How the Payer-Provider Survey Was Conducted

FTI Consulting's Strategic Communications and Health Solutions teams conducted 30-minute in-depth telephone interviews with U.S. payers. A total of 20 interviews were conducted from April 14-18, 2014. A cross section of payers from both for-profit and nonprofit institutions, as well as from national, regional and Blues organizations, was included in the sample. Participants were director level and above in managed care organizations and were screened to meet the following criteria:



Currently work in network management, contracting, managed care, managed care contracting, networks (excluding IT, accountable care, network development or provider networks);



Directly involved in negotiating contracts with providers on behalf of an employer; and



Engaged in some form of value-based reimbursement with providers.

FTI Consulting supplemented the qualitative research among payers with a quantitative survey of physicians. An online survey of U.S.-based physicians was fielded from June 23-25, 2014. A total of 251 physicians specializing in general practice, internal medicine and family medicine participated in the survey.

clinic. In this arrangement, provider payment again is fee-for-service-based, but Medicare savings are shared between Premera and The Polyclinic. There's no immediate downside risk for those Polyclinic physicians in the program, but, according to Premera's executive director, if they don't meet quality goals, the ultimate penalties "could range anywhere from not being in the program to renegotiating the underlying fee-for-service rate."

The pressure driving payers and physicians away from fee-for-service and toward value-based arrangements that depend upon the assumption of shared risk largely is coming from the Centers for Medicare & Medicaid Services through the Medicare Shared Savings Program. According to 40 percent of payer respondents to the FTI Consulting survey, Medicare Advantage ranked #1 in potential line-of-business growth, followed by Medicaid. Clearly, the landscape is moving from fee-for-service to value-based reimbursement, and payers and providers will need to shift with it, especially in terms of sharing risk. To accomplish that, provider attitudes will have to change (only a quarter of surveyed physicians not currently in a value-based relationship say they would be likely to enter a Medicare Shared Savings Program), and payers will need to bring providers along.

### ENGAGING THE PHYSICIANS

According to the FTI Consulting survey, 53 percent of payers consider the quality and degree of physician engagement a critical factor in making the decision to approach potential provider partners, and payers rank physician support as the second most important capability required for future value-based success (after the ability to measure quality and costs). As one respondent says: "It's all about the physicians. The degree to which you can manage or engage them is the key to success."

**ENGAGEMENT IS THE FIRST STEP TOWARD BUILDING TRUST**

At Crystal Run Healthcare, a large, physician-owned multi-practice group in New York, one doctor pointed out that physicians simply [aren't accustomed to receiving the feedback necessary to adapt to a value-based system](#). To address that, Crystal Run generated and then shared with physicians data on diabetes treatments and outcomes. With this evidence-based information, Crystal Run's doctors were able to see the variation in quality and cost correlated to inconsistent treatment methods. Having that data in hand, the physicians unified treatment across the practice, driving down patient costs 20 percent in one year.

When physicians are engaged, when they work in a coordinated manner, quality improves.

**The Work to Be Done**

It will be challenging for physicians to relinquish the certainty of fee-for-service reimbursement models, especially as long as their mistrust of payers and their unwillingness to assume risk run so broadly and deeply, but those that do remain dedicated to fee-for-service arrangements run the risk of being left out in the cold as the U.S. healthcare system moves inexorably toward value-based models. There already has been a great deal of success on many fronts.

In California, for example, Blue Shield has improved outcomes for knee and hip replacement surgeries for California Public Employees' Retirement System (CalPERS) members by identifying 16 hospitals reporting better outcomes at lower cost. Consequently, Blue Shield announced it no longer would fully cover CalPERS members' costs for those procedures unless performed at one of the specified hospitals. This strategy lowered CalPERS' health costs for those surgeries by 19 percent between 2010 and 2011 for participants in a pilot Centers of Excellence program.

The FTI Consulting Payer-Provider survey indicated that while there currently is a significant gap between what payers want

**Three Payer-Provider Disconnects**

**Risk**



of physicians are interested mostly in upside share savings models.



of physicians are willing to accept risk.



of physicians are interested only in fee-for-service reimbursement.



Payers want equitable risk sharing.

**IT**



Payers want to see providers invest in healthcare IT, especially in systems and software supporting clinical integration and PHM.



of physicians say their organization has not implemented new technology or software supporting PHM and value-based reimbursement.

**Clinical Integration and Scale**



Payers prefer to engage in value-based arrangements with large, more tech-savvy provider practices and hospital systems.



of physicians say they are "not very often" approached by payers for value-based arrangements.



Most physicians will have to learn how to operate within an integrated environment.

## Three Best Practices for Value-Based Patient-Provider Synergy



### PATIENT-CENTRIC CARE

Focus on care that manages the patient from discharge to readmission.

Include non-clinical aspects of care, ranging from transportation to and from clinical facilities to behavior modification through organized wellness programs (see “Wellness Programs: Healthy Costs Less than Sick,” page TK).



### PHYSICIAN ENGAGEMENT

Set expectations (and communicate them broadly) for provider groups for risk sharing.

Establish clinical teams to optimize communication and ensure continuity of care.

Maintain contact between payers and providers at all levels, from IT to financial.

Ensure that the provider group has a leader who will engage with physicians and will work toward aligning both payer and provider goals.

Make sure the provider organization approached for partnership in value-based arrangements is ready — technologically and philosophically — to engage.



### DATA AND IT

Payers should share clinical and administrative data with provider partners.

Payers and providers should integrate information systems and operate on a common platform.

Information systems and software should collect and track patient data and support PHM.

from providers and what providers are willing and able to do, there is evidence that the U.S. healthcare system is moving toward value-based arrangements that will require ever more cooperation between payers and physicians. It seems reasonable to assume that given current drivers, that trend will continue in the foreseeable future, varying with markets and geographies. And as physicians become more accustomed to working in teams -- in clinically integrated environments supported by evidence-based medicine and the technologies that “bake” cooperation into processes -- assuming risk in value-based reimbursement arrangements will become less of a leap of faith for providers. Given strong leadership on both sides, there’s reason to believe that the divide between payers and physicians can be bridged. And as trust grows between both parties, overall healthcare quality can be improved even as system-wide costs begin to be brought under control. ■

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