AMA
AMERICAN MEDICAL ASSOCIATION

Direct-to-employer arrangements
Model checklist

Employers that self-insure their health benefits are looking to engage directly with physicians in efforts to improve their employee experience, improve employee health outcomes and better control their health care expenditures.

Physicians considering direct-to-employer arrangements should be cognizant of key issues when negotiating with an employer. Each arrangement can be highly customized by the employer, who may have very specific goals in mind. The checklist below outlines suggested topics for physicians to explore when considering a direct-to-employer arrangement. The American Medical Association has developed two other resources—a "Direct-to-employer arrangements: Snapshot" and a "Custom network and contract terms: Case study"—to help physicians navigate these opportunities and, if desirable, negotiate terms that reflect the practice's goals and preferences.

Assessment of practice capabilities

☐ **Physician practice financial health and strategic plan**
Direct-to-employer arrangements may not be appropriate for every physician and every practice. Physicians and practices with already full patient panels may not have the capacity to accept more patients. Those physicians nearing retirement may prefer not to assume the financial risk of a new payment arrangement. Lastly, physicians already associated with accountable care organizations (ACOs), clinically integrated networks (CINs), or large health systems that are currently working on their own direct-to-employer offerings may not desire to engage in their own direct-to-employer contract (or may be prohibited from such arrangements under agreements with these entities). Direct-to-employer arrangements may require significant investments of time, money and effort, potentially crowding out other business opportunities now or in the future. Physicians should also consider their practices' finances, strategic goals and relationships with other providers.

☐ **Physicians, non-physician health care professionals and equipment/supplies**
Prior to entering a direct-to-employer arrangement, physicians should assess whether they have the capability and capacity to provide the necessary services and fulfill their own and the employer's goals and objectives. Direct-to-employer arrangements are not the same as new managed care arrangements in which a physician's existing practice model can be applied to new patients coming from the new payer. If, for example, a direct-to-employer arrangement includes staffing an onsite clinic on the employer's campus, practical issues such as whether other patients can be scheduled at the clinic, whether travel to and from the clinic will be an issue, the supplies and equipment that need to be transported to the clinic and the logistics of such transportation should be considered. Employer agreements also may require the physician to take on risk—in some cases for services outside their direct control. Alternatively, employer arrangements may require close coordination with other providers (such as a local health system), so physicians should evaluate whether they will be required to modify any elements of their practice.

Compensation issues to consider

☐ **Clarity about covered services**
Not all direct-to-employer arrangements cover the furnishing of medical services. Any direct-to-employer agreement should specifically state whether the payments received include payment for medical services furnished (vs. wellness or administrative services). If the compensation covers the professional medical service, the physician should not submit a separate bill to the employer's third-party administrator for that service, as doing so could result in being paid twice for the same service. In agreements that do not cover these services, the expectation is that the physician will separately submit claims to and be reimbursed by the third-party administrator.

☐ **Accepting payments from health savings accounts**
Funds withdrawn from a health savings account (HSA) are tax-free only when used to pay for "qualified medical expenses" as defined by Internal Revenue Service rules. See, e.g., I.R.S. Pub. 969 (2018); I.R.S. Pub. 502 (2018). Some direct-to-employer arrangements involve payments for services that are not qualified medical expenses. For example, concierge medicine arrangements often include payments to ensure a physician's availability on short notice. Such availability is not a medical service. When the direct-to-employer arrangement includes payments from employees (instead of from the employer), physicians should consider whether they can or should accept payments from the employee's HSA.

☐ **Value-based, direct-to-employer arrangements**
Many direct-to-employer arrangements tie compensation in part to performance on certain value-based metrics. Prudence should be taken when selecting and committing to specific performance metrics; physicians should ensure they are well-defined and measurable using available data sources and systems reasonably achievable and relevant to the population to be served. Metrics used in other existing value-based arrangements may be similar and yet different from those in a given direct-to-employer arrangement. In addition to clinical metrics, it is not uncommon for value-based payments to also be tied to nonclinical metrics such as patient satisfaction or access to care. Physicians should be aware of value-based metrics that will necessitate significant changes to workflow, require significant investments or are associated with incentive payments that will not cover the cost of implementation.