Case Studies, Custom Networks, and Contract Terms
“Direct-to-Employer” Arrangements

Physicians interested in Direct-to-Employer arrangements should consider the strategic implications and familiarize themselves with the unique terms and conditions of each arrangement. The AMA has developed two other resources to help physicians navigate these opportunities: a Model Checklist and Snapshot addressing key issues to consider when evaluating Direct-to-Employer arrangements. This document is intended to supplement the AMA’s other materials on Direct-to-Employer arrangements and includes:

• Two case studies of Direct-to-Employer arrangements;
• A discussion of “Custom Network” models; and
• An overview of important contract terms to consider when negotiating Direct-to-Employer arrangements.

Case Studies

Sample Retainer Arrangement
Dr. X is an internal medicine specialist with a solo-practice located in a suburban metro area. Five years ago, Dr. X was seeing 25 patients per day, spending about 15 minutes with each, and spending the rest of the day fulfilling administrative and billing-related responsibilities. Increasingly, Dr. X felt that she wasn’t spending enough time with her patients to give them the care and attention they needed. Dr. X’s patient panel was aging, so it wasn’t a surprise that more issues needed to be addressed. On the other hand, she knew that if she spent more time per patient without a change in payment, she would have increasing difficulty covering her overhead. Dr. X started looking to whether transitioning her practice to a retainer model might work. After considering her patient panel, her practice’s financial health, her own professional satisfaction, and the AMA Code of Medical Ethics Opinion 11.2.5 on Retainer Practices, Dr. X. decided to make some changes.

Today, Dr. X’s practice charges an annual $5,000 membership fee in exchange for a “personalized medicine experience.” In addition to her professional medical services (for which she still bills insurance directly), Dr. X now also responds to patients within one hour, via phone, text, or email, on a 24/7 basis, offers same-day appointments, covers the valet parking provided at her medical office building, offers beverages in the waiting room, and makes house calls one day per week. In an average day, Dr. X sees 7 patients, spending about 45 minutes with each. With fewer administrative and billing-related tasks, Dr. X has more time to do same-day research on clinical topics, follow up with patients, and review patient records to identify those who are behind on recommended preventative procedures.

After Dr. X moved to a retainer practice model she experienced a drastic reduction in the size of her patient panel; more than she was expecting. Many established patients were not willing or not able to pay the annual $5,000 fee in addition to the premiums they were already paying to maintain health insurance coverage.

To make ends meet, Dr. X decided to market her new retainer practice directly to employers. She learned that a major local employer was expanding with plans to attract top-level talent, in part, by revamping its executive concierge medicine program. After a few months of discussion, Dr. X entered into a contract with the employer to be one of a small group of retainer-model practices available to executives with...
the employer paying the $5,000 annual fee on the executive's behalf. Since then, Dr. X has entered into similar agreements with two other employers. She occasionally visits these executives at their place of work in addition to providing 24/7 support via phone, text, or email among other services.

Compared to five years ago, Dr. X has seen a small uptick in her practice's financial health. But for her, the most drastic change has been an increase in her professional satisfaction. The additional time she now spends with patients and on patient care has directly translated to better outcomes for her patients, particularly reduced emergency room visits and hospital admissions and improved management of chronic conditions.

**Risk-Based and Value-Based Arrangements: General Motors and Henry Ford Health System**

Beginning in 2019, General Motors (GM) began to offer a new health benefit option to its 24,000 non-union employees in Michigan: a Direct-to-Employer, risk-based arrangement with Henry Ford Health System. The Henry Ford Health System is a multi-hospital, fully integrated health care system that employs or contracts with thousands of physicians. Henry Ford also maintains an experienced clinically integrated network (CIN) and accountable care organization (ACO), demonstrating significant population health, care management, data tracking, and integrated EMR capabilities.

GM was driven by a desire to have greater control over the structure of its benefit plan than its third-party administrator was prepared to allow in order to provide a more responsive and convenient network for the employees living and working in the defined service area. GM also wanted to customize its benefit plan to give providers greater flexibility by encouraging them to furnish medical care without the limitations of traditional managed care, while also creating financial incentives for providers to manage costs without sacrificing quality. Lastly, GM preferred to be directly involved in negotiating the fees for services provided, instead of delegating that function to its third-party administrator.

The result is a new, value-based benefit plan option named ConnectedCare. Under ConnectedCare, Henry Ford's costs must stay below mutually agreed upon annual limits and Henry Ford must meet 19 quality, cost and utilization metrics. If Henry Ford achieves these objectives, it will share in any savings realized by GM. If it is unsuccessful, Henry Ford will be responsible for some amount of the losses incurred. GM and Henry Ford have agreed on prices for medical services provided to beneficiaries. Both organizations have partnered with Blue Cross Blue Shield of Michigan to manage claims-processing and otherwise administer the program.

Among its features, ConnectedCare covers hospital, outpatient, behavioral health, pharmacy and physician services in a seven-county area. It offers same-day appointments with primary care physicians, appointments with specialists within 10 days, extensive telehealth options, and an exclusive phone line for GM beneficiaries to schedule appointments and get answers to questions.

ConnectedCare is GM's lowest-cost plan option and is projected to save employees hundreds of dollars per year in payroll contributions. Functioning like a PPO, ConnectedCare has a $1,500 deductible and has a larger cost sharing differential between in-network and out-of-network providers than GM's other plan options. For ConnectedCare to succeed, beneficiaries need to obtain services from Henry Ford providers, and avoid out-of-network providers as much as possible. Henry Ford is financially responsible for all costs of care, including costs incurred by non-Henry Ford providers.

**Custom Networks Discussion**

Most employers don't have thousands of employees or a sophisticated approach to structuring health benefit plans. For these employers, the full scale, risk-based, Direct-to-Employer approach that General Motors took with Henry Ford Health System isn't a viable option for either employers or providers. These employers might, however, be in a position to partner with a third-party administrator that is able to assist it in taking an initial step in that direction by establishing a customized provider network.

Technically, custom provider networks are not a Direct-to-Employer arrangement as there is typically no direct contract between the providers and the employer. Instead, a third-party administrator maintains, manages, and pays the provider network on behalf of the employer. Nevertheless, because employers play an influential role in how they are developed, physicians interested in Direct-to-Employer arrangements should also understand custom provider networks.

To determine how to best position themselves for inclusion in custom provider networks, physicians first need to understand the selection criteria employers use when developing the network. While employers
are free to develop unique criteria, most focus on cost, quality of care, and patient satisfaction. Employers will set minimum standards for these and other provider criteria based on data maintained by the third-party administrator. As a result, physicians who are statistical outliers on any of the typical selection criteria may find themselves excluded from an employer’s custom provider network. Cost can be a particularly difficult selection criterion to reconcile. Some physicians may have cost rates that are acceptable to one of their third-party administrators, but may find that the same rates make them a statistical outlier within the employer network.

Physicians considering participation in a custom network should consider whether the potential benefits of participation in a custom network (potentially higher patient volume since there are usually fewer qualified providers) outweigh the potential drawbacks (need to offer competitive rates, ability to meet utilization, quality of care, and other custom network participation criteria).

**Contract Terms**

Direct-to-Employer arrangements come in such a wide variety of forms that there are few contract terms that are applicable to all, or even most, forms. Still, there are certain concepts that physicians should consider in almost every contract for Direct-to-Employer services.

- **Disclaimers About Insurance**
  The regulatory requirements that apply to entities offering insurance products, such as licensure and financial reserve requirements, can be onerous. The majority of Direct-to-Employer arrangements are not intended to trigger these regulatory requirements. Some Direct-to-Employer arrangements can, however, include elements that can “look like” insurance. For example, some models involve full capitation where physicians receive up-front payments at regular intervals to cover a specified scope of care, regardless of the actual cost of care. If appropriate, it may be important to establish business expectations for the Employer by including a disclaimer making clear that the arrangement is not actual insurance. Despite establishing clear expectations for the Employer, physicians should always consider whether an arrangement actually triggers insurance licensure or other regulatory requirements as a legal matter.

**SAMPLE CONTRACT LANGUAGE:** The parties acknowledge and agree that the services described in this Agreement do not constitute health insurance and will not cover hospital services, specialist services, or any other services not directly provided by the [Provider] under this Agreement. The Services provided by Provider hereunder are not a substitute for health insurance or other health plan coverage and are not intended to replace any existing or future health insurance plan coverage.

- **Limitation of Liability**
  As the service provider, practices should include a provision limiting the physicians’ legal liability to the extent possible. The use and scope of these types of provisions may be restrained by state law, so it is always best to consult with an attorney.

**SAMPLE CONTRACT LANGUAGE:** [Employer] specifically agrees that [Provider] shall not be liable for any consequential, incidental, indirect, special or punitive damages or failure to realize expected savings arising from or relating to any breach of this Agreement or the relationship covered by this Agreement, regardless of any notice of the possibility of such damages, and hereby waives its rights thereto.

- **Independent Medical Judgment**
  Provisions stating that physicians are free to maintain and exercise their independent medical judgment are common in managed care contracts. But most employers are not managed care organizations. A contract provision such as the one provided below is necessary to clarify for the employer that it may exert control over the plan, but it cannot exert control over the physician’s practice of medicine.

**SAMPLE CONTRACT LANGUAGE:** The standards of medical practice and professional duties of [Provider] shall be in compliance with applicable law. [Employer] will not act or assert authority in any manner that would constitute the unlawful practice of medicine. [Employer] shall not have or exercise control or direction over the methods by which any Physician or Licensed Non-Physician Provider performs professional services pursuant to this Agreement or with respect to medical decision-making and [Provider] and its health care providers shall have sole authority regarding such clinical decisions.

- **Compensation – Shared Savings**
  Contract provisions governing compensation vary widely depending on the type of Direct-to-Employer arrangement and on other negotiations between the parties. One common type of compensation model entitles physicians to a portion of any annual health care cost savings
realized by the employer on an annual basis. These payments for shared savings are in addition to fee-for-service payments under physicians’ other arrangements with an employer’s third-party administrator. In addition, it is not uncommon for shared savings payments to also be conditioned on achievement by the physician of specified quality metrics during the applicable year.

SAMPLE CONTRACT LANGUAGE: The parties will develop and manage an integrated system of comprehensive health care services and will operate a financial payment model that will promote accountability for high quality care in the most appropriate setting, and high levels of patient satisfaction and experience, while ensuring value and cost effectiveness as further described in this Agreement. Pursuant to the terms and conditions of the participating provider agreement, physician providers shall provide the Covered Services to designated and attributed member employees of Employer. Physician providers will receive fee-for-service compensation as set forth in the participating provider agreement. Additionally, Physician providers shall have an opportunity to share in a portion of net savings as set forth herein. Net savings payments to the physician providers are subject to achievement of quality measures as set forth herein.

Quality/Performance Metrics

One aspect of Direct-to-Employer arrangements that employers find attractive is the ability to customize the health plan design to the specific needs and desires of their employees. An employer with high prescription drug costs, for example, may be interested in new strategies to reduce those costs in ways that its third-party administrator cannot accommodate. One common method of employing these strategies in Direct-to-Employer arrangements is through the use of quality or performance metrics.

SAMPLE CONTRACT LANGUAGE: Physician providers shall participate in and comply with the terms and conditions of the programs and activities described herein and updated from time to time. Physician providers shall use best efforts to cooperate with and improve applicable delivery of care quality metrics and data. [Examples of quality metrics may include (not exhaustive) goals for minimum percentage of instances in which patients are able to schedule same day appointments or within one day of initial call, how quickly referrals can be made for specialists and ancillary services, meeting goals for use of care coordinators related to assistance with medication adherence and facilitation of follow-up care and specified reductions in rates of preventable readmissions]. Each quality metric described herein shall be assigned a weight signifying the portion of any quality payment for which the quality metric is responsible. At the end of each performance year, Employer shall pay to each physician provider that portion of the quality payment to which the physician provider is entitled based on achievement of each quality metric and its associated weight.

Data Sharing and Reporting Obligations

Successful administration of Direct-to-Employer arrangements often depends on access to accurate and timely data. Cost, practice management, patient encounter and other types of data are often necessary for the physician practice to be successful and to enable the employer to make objective assessments of physician performance. Direct-to-Employer arrangements that rely on such data should have contractual provisions specifying the type of data to be tracked, which party is responsible for tracking it, the content, timing and format of any reports that the employer and physician rightfully expect from each other, and ownership of such data.

SAMPLE CONTRACT LANGUAGE: Physician providers shall submit the required quality measures data and other required information pertaining to Covered Services provided to Employer’s employees (and dependents) that are designated or attributed to the network. The parties will mutually agree to an acceptable format for the required reports and data extracts, subject to the constraints of the providing parties’ operational requirements, administrative policy requirements, and information technology systems. Physician provider shall comply with the data privacy and security and related obligations set forth herein.

Employer (on behalf of itself and its sponsored health plan (herein referred to as “Plan”)) has reserved all right, title and interest in and to: (i) all data owned, generated, collected, processed, or otherwise held by Employer, the claims administrator, the network administrator, or their agents, service providers regardless of whether such information is confidential including participating providers’ PHI, other information created, maintained, or communicated by the Plan, its business associates and its business associates’ subcontractors, but excluding PHI created by physician providers and other participating provider as set forth below (ii) information concerning physician provider compensation created, maintained, or communicated by the Plan, or its agents; and (iii) information and data reported by physician providers or other providers as part of the quality achievement program and related functions, regardless of where the data or information is stored. Notwithstanding the foregoing, as between the parties, all PHI created, generated, collected, maintained, processed, or otherwise held by physician providers and other providers as part of treatment, payment and health care operations of the provider or its agents and subcontractors will not be considered Employer-owned information or data.