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AMERICAN MEDICAL ASSOCIATION

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Introduction

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 American Medical Association has developed this document, along with two other resources, the "Direct-to-employer arrangements: Model checklist" and the "Direct-to-employer arrangements: Snapshot," to help physicians navigate the opportunities and address key issues to consider when evaluating direct-to-employer arrangements. Below, you will find insights and guidance that touch four areas:

- Two case studies of direct-to-employer arrangements
- A discussion of new prominent arrangements
- A discussion of "custom network" models
- An overview of important contract terms to consider when negotiating direct-to-employer arrangements

Case study No. 1

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 increased difficulty covering her overhead. Dr. X started looking into 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 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. On an average day, Dr. X sees seven 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 had expected. Many established patients were not willing or not able to pay the annual 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 a contract with the employer to be one of a small group of retainer-model practices available to executives, with the employer paying the 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. However 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.

Case study No. 2

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.

Driven by a desire to have greater control over the structure of its benefits plan than its third-party administrator was prepared to allow, GM sought 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 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.

New arrangements

Since the COVID-19 pandemic, several new kinds of direct-to-employer arrangements have become prominent. Although the phrase "direct-to-employer" suggests direct negotiation between an employer and a practice, this is not always the case. Instead, the phrase simply means an arrangement under which a practice makes its services available to an employer without the involvement of a traditional payer.

As a result, practices now have several different pathways to become parties to a "direct-to-employer" agreement. For example, practices may be part of an ACO or CIN that is experienced with managing population health risks and is entering into an arrangement directly with an employer (or a group of employers).

Practices may also partner with a "primary" provider like a local health system to negotiate a more comprehensive deal since employers often turn to direct-to-employer contracting in an effort to address care fragmentation. Employers may turn to health systems for several reasons. First, health systems usually combine many different kinds of health services—including the acute care services that drive a large share of health care costs. Health systems also have existing relationships with independent practices through medical staff networks and referral networks. Second, there is a relatively well-established model for employer contracting with health systems in the form of "Center of Excellence" programs in which employers contract with hospitals and health systems for certain procedures or service lines.

Changes in the health care industry may also open up new options for employer contracting. For example, the number of companies offering population health management services has grown since the pandemic. These companies may provide actuarial and claims management functions that were previously only available through traditional third-party administrators. In addition, many companies are now offering technology-enabled services using telehealth, in-home care, remote monitoring and self-management solutions to address certain specialized or low-acuity services, arguing that these digitally enabled models are less expensive than traditional care. Finally, large managed service organizations are developing comprehensive multi-specialty models that may address employers' concerns about network size. Note that, depending on the services offered, these entities may be required to offer limited services or face regulation under state insurance law.

For physicians, this broader landscape means practices have more opportunities to engage in direct-to-employer contracting. A practice could collaborate with a hospital, technology company or management services organization to bolster a larger direct-to-employer strategy. However, this landscape also means a practice that wants to operate its own direct-to-employer initiative will have more competition. Physicians should also be aware that arrangements with other kinds

of entities may create their own risk of scrutiny under laws related to health care fraud and abuse, antitrust, licensure and the business of insurance. While this should not discourage physicians from exploring these relationships, it is essential to work with appropriate legal counsel in negotiating any such arrangement.

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 is not a viable option for either employers or providers. These employers might, however, be in a position to partner with a third-party administrator who can assist 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 (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).

Overview of 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 triggers insurance licensure or other regulatory requirements as a legal matter.

Sample language: Contractual arrangements guide

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 language: Limitation of liability

[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. However, 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 language: Independent medical judgment

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 language: Shared savings compensation

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 language: Quality and performance metrics

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 encounters, 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 language: Data sharing and reporting obligations

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.