REPORT

DIRECT-TO-EMPLOYER CONTRACTING: WHAT HEALTHCARE PROVIDERS NEED TO KNOW

It's been a challenging year for healthcare providers. They can alleviate some of the pressures they continue to face by looking to direct-to-employer contracting

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OVERVIEW

Healthcare providers face an array of challenges in the current healthcare landscape: increased industry consolidation, pressure on margins, price transparency requirements, legislative uncertainty, and managing the ongoing public health crisis—to name just a few. As the organizations tasked with providing high-quality care in this ever-changing, uncertain environment, it can be hard to prioritize and determine the best path forward to support a mission and achieve profitability. Perhaps more now than ever before, direct-to-employer contracting is proving to be an excellent revenue stabilization strategy and competitive differentiator.

In this report, we'll explore the:

- Growing momentum behind direct-to-employer contracts, with a focus on two key pressures that they can help healthcare providers alleviate
- Primary forms of direct-to-employer arrangements
- Five essential considerations for any health system looking to pursue direct-to-employer arrangements

CHAPTER 1

Why direct-to-employer contracting, and why now?

TYPES OF DIRECT TO EMPLOYER CONTRACTING MODELS

TAILORED TPA NETWORKS	WELLNESS INITIATIVES	ON-SITE CLINICS	CENTER OF EXCELLENCE	BLENDED VBC/CAPITATED
TPA coordinates with smaller employers to structure benefits and provide access to specialized provider network	Providers support employer-sponsored health resources including clinical care, health information, and utilization management resource (in addition to health coverage benefits)	Provision of care at specified location exclusively for employees	Health systems perform pre-identified, specialized procedures for employees via a bundled payment model	Risk / Value-Based Agreements, typically leveraged by Accountable Care Organizations (ACOs)

Direct-to-employer arrangements were already growing in popularity pre-pandemic, and that momentum has continued through the global health crisis. For instance, a 2019 survey of 600+ small-large employers found that many were already offering a type of direct-to-employer arrangement (20% offering an onsite clinical service to staff, 45% offering center of excellence models, and 16% offering high performance networks). Jumping forward to 2021, we find another large survey of employer groups indicating that direct-to-employer contracting is still very much top-of-mind. Center of excellence partnerships and high-performance networks came in as the fourth and fifth top healthcare priorities for employers in the 2021 report, behind only virtual visits, mental health, and moderation of high-cost claims.

This upward-trending interest from employers has, of course, been part of the reason for the momentum behind direct-to-employer contracting in recent years. But this momentum is also being spurred by two prominent industry pressures that make direct-to-employer arrangements even more appealing, both to employer groups and healthcare providers: the need for revenue diversification and stability, and increasing industry consolidation.

REVENUE DIVERSIFICATION AND STABILITY

The cost pressures faced by both healthcare providers and employer groups present great opportunities for partnerships. The benefit is mutual: Direct-to-employer contracts cut claims costs for employer groups (while also offering the competitive advantage of a unique benefit to employees) and provide a diversified and stable revenue stream for healthcare providers as the contracted provider of healthcare services at a set PMPM or capitated rate.

There's never really a time when core operating margins aren't going to be top-of-mind for health system leaders, but they've become a topic of acute concern since COVID-19 began sweeping across the nation. One study predicted 39% of hospitals will have negative operating margins for 2021—compared to 25% before the pandemic—with the core causes attributed to a slow return of higher-dollar services and the reluctance (and inability) of some patients to present at hospitals and care facilities due to the ongoing battle with COVID-19.

Additionally, CMS temporarily paused new entrants to several programs and/or paused key programs, which healthcare providers often explore to obtain more predictable streams of revenue through capitated models and shared savings programs. The uncertainty surrounding these core revenue streams is prompting healthcare providers to seek out more stable sources.

Employer groups are facing their own financial pressures as well, with healthcare costs expected to rise for employer groups in 2021, and total cost per individual employee expected to break $15,000 for the first time, marking another year of seemingly unsustainable rises. At the same time, employer groups are also facing higher rates of attrition, with one recent employee survey finding that more than half of North Americans plan on looking for a new job in 2021. Better compensation and/or benefits were cited as the top reason people were looking to make a switch.

> These pressures are creating an impasse for employers and healthcare providers alike—both are looking for competitive differentiation while simultaneously reducing costs. By coming together, both healthcare providers and employer groups can tackle these challenges head-on.

INCREASED INDUSTRY CONSOLIDATION

As we've discussed previously, M&A activity continues to be a force across the health system and provider landscape, in an industry where the top 10 largest healthcare providers already control 25% of the market. The third and fourth quarters of 2020 saw a record number of health system deals, and the wave of mergers, acquisitions, and investments has far from abated since then.

In this high-velocity M&A environment, whether a health system is looking to be acquired or shore up their portion of the market to fend off competition, there's a significant opportunity to improve brand recognition and generate reliable referral streams. Partnering with a leading national or even local employer can accomplish precisely this, much as we've seen with GM and Henry Ford's risk-based contract or Walmart and Mayo Clinic's center of excellence program. Through strategic partnerships like these, healthcare providers can expect increased brand recognition, confidence from the community, and increased market share, while employer groups are able to provide a differentiated and high-quality benefit to retain and attract top talent.

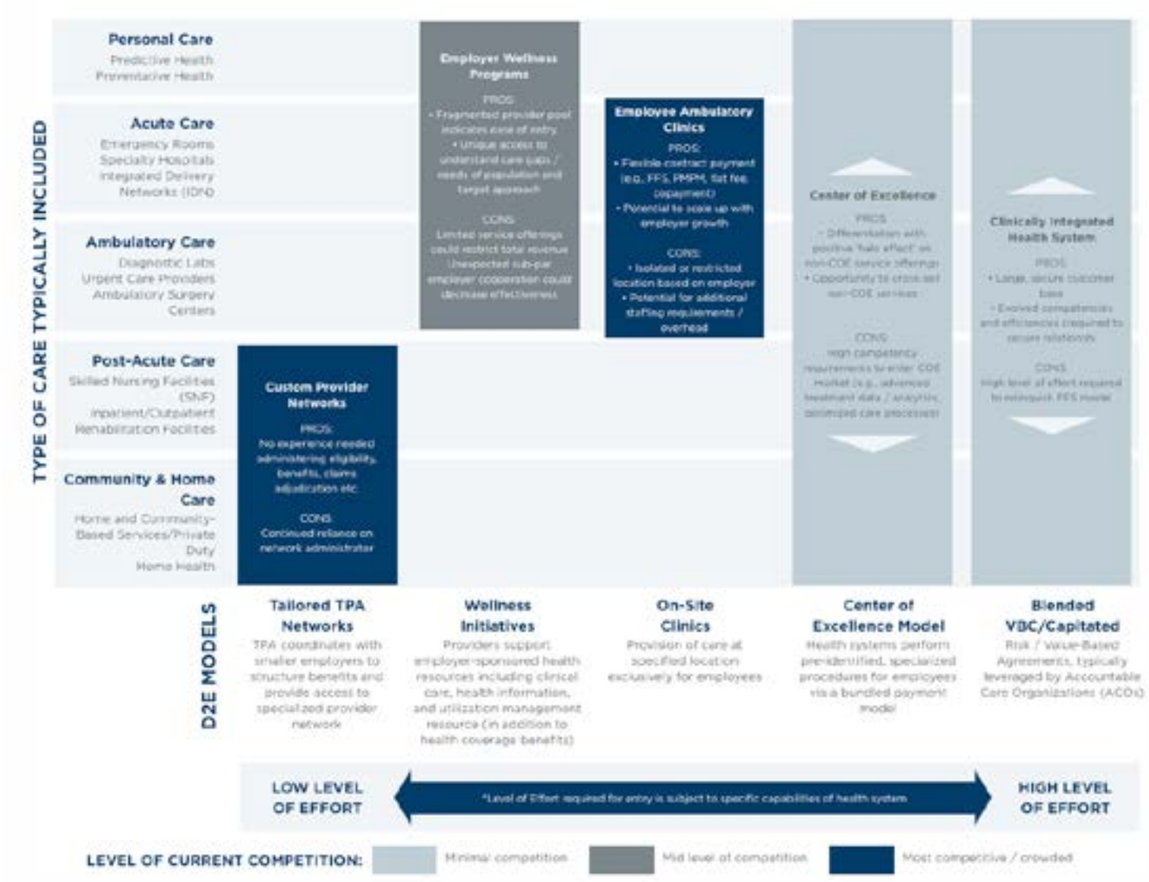
CHAPTER 2

Major types of direct-to-employer arrangements

Direct-to-employer contracts are not one-size-fits-all. We've narrowed the list to five primary types of arrangements, understanding that finding one that fits a given health system's specific needs and business objectives depends on the organization's overall strategy and vision.

The Direct-to-Employer Participation Matrix below outlines these five opportunities and highlights the effort that's typically involved, as well as noting the present level of competition in the marketplace around each.

MARKET OPPORTUNITIES EXIST FOR HEALTHCARE PROVIDERS OF ALL SIZES AND STRUCTURES TO ENTER D2E



1| TAILORED THIRD-PARTY ADMINISTRATOR (TPA) NETWORKS:

TPA networks are an entry-level opportunity for healthcare providers to directly contract with an employer group. In this kind of arrangement, the TPA serves as an intermediary, administrating customized provider networks. Employers typically drive the definition of criteria for network development, and may prioritize cost, patient experience, quality of care, or other factors.

Tailored TPAs are an ideal entry-level option for healthcare providers with no adjudication experience because the administrative burdens of claim processing, payment, and member services are handled by the TPA. However, the continued reliance on a network administrator can hinder long-term growth, and the required quality and cost metrics set by the employer groups in these arrangements can be difficult to abide by.

2| WELLNESS INITIATIVES:

Wellness programs are widely used by employer groups to improve population health among employees within the conventional employer-payer model. These programs drive employee health engagement through fitness programs, encouraging routine exams, and other initiatives which are often administered by ancillary benefit companies or specialized departments within large payers.

Healthcare providers are positioned well to facilitate these programs, given the low barrier of entry and industry fragmentation. To fully capitalize on this type of arrangement, they should engage strategically with employer partners who are willing to actively promote the benefit and the health system's brand or care specialty, and whose geographical presence has reach and reputation in the community.

3| ON-SITE CLINICS:

Having providers physically on-site at an employer location—which provides employees exclusive and convenient access to outpatient care—can be an advantageous option under the right circumstances, even with the increase in virtual visits. A strategic partnership that accounts for employee preferences for virtual vs. onsite care and allows for flexible contract payments could make this arrangement beneficial for healthcare providers and employers alike.

4| CENTER OF EXCELLENCE (COE).

In a COE model, healthcare providers perform a defined set of specialized services for employees via a bundled payment model. This model demands high levels of competency from healthcare providers, including advanced treatment data and analytics and optimized care processes. While the barrier of entry is high, the market saturation is relatively low, with increasing demand from employer groups. If a health system has the core competencies to enter a COE model, this is an excellent opportunity to highlight their competitive care differentiations and cross-sell non-COE services.

5| BLENDED VBC/CAPITATED;

Alongside COEs, value-based agreements, typically leveraged by accountable care organizations (ACOs), are one of the newest direct-to-employer models. These clinically-integrated models boast large, secure customer bases but require highly evolved competencies and efficiencies to secure employer relationships. Competition around these models is currently low, largely due to the persistence of typical fee-for-service models. As a result, healthcare providers that have the capabilities to stand up blended VBC/capitated arrangements have the chance to be among the early entrants to value-based contracting with employer groups.

CHAPTER 3

Five essential considerations for pursuing direct-to-employer arrangements

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For those healthcare providers looking to decide on a direct-to-employer contract that is right for them, or even for those that is already engaged in one, there are five considerations to ask that should be made to ensure healthcare providers get the most out of their direct to employer arrangements.

MARKET OPPORTUNITY AND SIZING:

Is this the best strategic play for the health system, given the local employer market, their brand recognition, and their own capabilities?

Healthcare providers should consider the local employer market landscape, established pathways for selling these arrangements, and even existing relationships with local business leaders when assessing the viability of partnering with employers.

The particulars can vary widely within a given geography—the employer groups' population size, health, and dispersal, the typical benefits offered, and the overall willingness of employer to partner with healthcare providers. The more a health system can understand their market, the better suited they will be to create a direct-to-employer arrangement that meets local demand while leveraging their capabilities.

CUSTOMER JOURNEY:

The customer/patient experience in today's marketplace is more important than ever. How can the health system prioritize the patient while also balancing employer objectives?

Healthcare providers need to ensure their patient portals and other interfaces are set up to drive personal engagement with their targeted employer group, as patients have come to expect the same level of digital and in-person consumer experience in healthcare as they receive in other industries.

Unique in-person considerations are equally as important. For example, COE models should consider the needs of their patients outside of the typical procedures and services rendered, including the qualification process, travel arrangements for medical tourism models, patient education, logistical support, and transition of care.

DATA AND ANALYTICS:

Does the health system have the data and analytics capabilities to support the employer's needs and realize desired returns?

Especially for those organizations exploring larger capitated direct-to-employer contracts, the ability to leverage patient data to better understand the employer population, make proactive care decisions, and identify high-risk individuals is crucial in reducing costs and improving the quality of care. Moreover, employer groups will have specific objectives when entering this arrangement, and the better equipped the health system is with data to articulate the value they are providing, the more satisfied the employer group will be.

While building up a highly effective data and analytics team requires significant investment and time, these capabilities are essential not only to supporting employer arrangements but also for the system as a whole as it enters into additional capitated arrangements and looks to get ahead of high-cost episodes of care.

CARE MANAGEMENT:

Especially for larger capitated arrangements, can the health system effectively manage the care of the populations they are responsible for?

An effective care management strategy is crucial to the success of capitated or ACO-style direct-to-employer arrangements. Industry-leading care management programs ensure that the end-to-end patient experience is cohesive through care coordination, clinical and population applications of data and analytics, and proactive outreach and interactions with patients. These functions not only improve clinical outcomes; they also reduce expenditures across the arrangement. One study of a of a high-risk Medicaid population found that care management reduced overall expenditures by 37%, and high cost inpatient utilization by 59 percent.

The cost savings and benefits available to a health system through effective care management can be substantial, but to be successful the care management team must be grounded in industry best practices, streamlined processes, and anchored in a digital platform that effectively supports them.

IMPLEMENTATION PLANNING AND ROAD MAPPING:

Does the health system have the project management and road-mapping experience to embark on a direct-to-employer arrangement?

Bringing two separate organizations together with different processes, cultures, and work styles to successfully manage a direct-to-employer contract is often challenging and requires careful planning. This may be the first time either organization has taken on such an initiative, so high-quality project management, implementation planning, and road mapping are key for any direct-to-employer arrangement. This provides a solid, agreed-upon foundation that can help the partnership weather any problems or disagreements that may arise.

CONCLUSION

The pressures of the current industry environment and the types of direct-to-employer contracting models presently available make direct-to-employer contracting an excellent strategy for healthcare providers to diversify and stabilize revenue, achieve or enhance brand recognition, and improve their operations across the board.

Similarly for employer groups, these arrangements with healthcare providers can help reduce costs and provide competitive differentiation, supporting the recruitment and retention of top talent.

While there's no single, universal way to approach direct-to-employer contracting, the good news is there are some tried-and-true models as well as opportunities for innovative organizations to lead the way into newer territory.

No matter the approach, the idea is that through strategic partnerships, healthcare costs can be contained and top-line revenue can be grown while improving care quality and the overall patient experience.

ABOUT WEST MONROE

West Monroe is a digital consulting firm that was born in technology but built for business—partnering with companies in transformative industries to deliver quantifiable financial value. We believe that digital is a mindset—not a project, a team, or a destination—and it's something companies become, not something they do. That's why we work in diverse, multidisciplinary teams that blend industry expertise with deep operational and technology capabilities—moving clients from traditional to digital operating models and creating products and experiences that transcend the digital and physical worlds. Our 2,000 employees have the opportunity to own a stake in the company, so when you partner with us you know we are committed—because your success is our success. Our undeniably different approach breeds undeniable results.

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