TOOLS & SUPPORT
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The Road to Direct Contracting: **General Motors Company**

Read how auto manufacturer, General Motors Company, got on the road to high-value health care by contracting directly for health care services with Henry Ford Health System.

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Case Study
The road to direct contracting

Founded in 1908, General Motors Company (GM) designs, manufactures, and sells vehicles and vehicle components. In the United States, GM produces four makes of vehicles – Buick, Cadillac, Chevrolet, and GMC. The company is headquartered in Detroit, Michigan and employs over 180,000 people across five continents. Employees generally fall into one of two categories – the salaried workforce in corporate, design, engineering and information technology, and the hourly or unionized workforce in manufacturing.

GM provides health coverage for U.S. employees, as well as for their eligible under-65 retiree population. The direct contracting arrangement that this case study highlights applies only to GM's salaried workforce. Other subgroups have different arrangements. For example, union employees have collectively bargained benefits with minimal cost-sharing, while retirees have limited coverage with a cap on their benefits.

Did you know?

GM purchases health care for its 190,000 U.S. plan participants, spending $1.3 billion annually for health care.

To write this case study, Catalyst for Payment Reform primarily referenced a presentation by Sheila Savageau, GM's U.S. Healthcare Leader, from October 2019, "Match Made: An Employer's Approach to Direct Contracting," as well as information GM provided for CPR's online education course, A Purchaser's Guide to Direct Contracting. CPR also interviewed Amy Vandecar, Vice President, Value Based Reimbursement, and Chelsea Pollet, Director, Direct-to-Employer Relationships at Henry Ford Health System ("Henry Ford") for the provider perspective on the direct contract arrangement.

The Problem & Background

High costs, uneven outcomes and unsatisfactory plan member experience

Like many purchasers, GM and its plan members faced a series of challenges when it came to health care costs and the quality of care. Between July 2014 and March 2018, GM saw the per member per month allowed amount increase by 16% among salaried employees, and 24% among hourly employees. In addition, a significant portion of employees reported low satisfaction with their health coverage, with only 61% saying that their health plan met their (and

their families') needs. Moreover, the increase in cost did not correlate with improved quality and outcomes. When analyzing claims data, GM's benefits team identified concerning patterns in several geographies with a high concentration of plan members. For example, in Flint, Michigan, a study of 30 spinal fusion procedures showed a price range between $14,000 and $210,000, although the Centers for Medicare & Medicaid Services' (CMS) Five-Star Quality Rating System's regional composite quality score for spinal fusions was only two out of five stars. In St. Louis, GM found that 50 plan members had each experienced more than three inpatient stays per year, making up 33% of inpatient costs in the region. And in the Detroit area, 356 plan members had visited the emergency department (ED) more than five times during the prior year, for a total of 2,561 ED visits. GM is not alone in experiencing uneven and at times inappropriate and wasteful care – this situation plagues employers and patients across the country.

Designing the Strategy

Phase 1: The national strategy

GM's direct contract with Henry Ford Health System was part of a larger strategy of comprehensive health care reform. GM realized early on that no single solution could address the needs of every plan member, and that the opportunity for innovation in markets with high employee concentration (Detroit) differed from the solutions available in markets where GM had lower employee penetration, such as Atlanta, Austin and Phoenix. For lower concentration geographies, GM's goal was to introduce and expand access to providers in value-oriented payment contracts. GM selected Aetna as its third-party administrator (TPA) for these markets outside of Michigan, taking a diversified approach to map the right solution to each market, but with a consistent focus on member experience, network configuration and efficiencies, and potential quality improvements. Specifically, Aetna offered access to providers participating in an accountable care organization (ACO) in Atlanta and Austin, and an Aetna-Banner Health joint venture in Phoenix.

Phase 2: The Detroit-area strategy

GM saw a unique opportunity for its large, highly concentrated population in Detroit, hypothesizing that direct contracting had the greatest potential to improve the care and experience of their employees and families in the region. The Detroit market has several large competing health systems known for delivering high-quality care, including Ascension, Beaumont Health System, Henry Ford Health System, McLaren Health Care, Trinity Health, and University of Michigan – many of which could compete to treat GM's plan members.

Once GM confirmed that its TPA, Blue Cross Blue Shield of Michigan (BCBS-MI), would support a direct contracting strategy, the next step was choosing the right provider partner. To ensure a data-driven provider selection process, GM hired Willis Towers Watson to gather market intelligence, assist with determining quality measures to track and creating quality guarantees, and develop the financial model for its direct contract strategy. With its TPA and consulting partner on board, GM was eager to evaluate providers.

Provider selection criteria

To examine the readiness of potential provider partners for direct contracting, GM focused on three factors –health system maturity, connectivity, and network access for GM's covered population.

GM measured maturity by examining the health system's experience in two-sided risk contracts or any other value-oriented contract. GM considered a health system more mature if it had operated as an ACO, had piloted or implemented a value-oriented arrangement for its own employees, or had participated in the Medicare Shared Savings Program. GM also looked at whether the health system had demonstrated success in implementing system-wide transformation. Examples included improvement in the quality measures mandated by CMS and in Health Enhancement Data Information Set (HEDIS) measures, reducing hospital-acquired infections, receiving high provider ratings by consumers in Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, as well as established quality rewards for individual providers.

GM's indicators of health system connectivity focused on whether the system had an interoperable electronic medical record system and whether it could measure individual provider performance. These factors would allow GM to measure health system performance directly, instead of relying on external measurement. Finally, GM considered whether the health system had a process improvement plan in place -- a health system already invested in self-evaluation is more likely to understand its own strengths and weaknesses.

The final criterion GM used to judge the suitability of a health system partner was access – did the health system have capacity to meet all or most of the health care needs of GM's plan members? GM leveraged Medicare Advantage access criteria, considering access for its Detroit-area population to primary care, specialty care, pediatric care, behavioral health care, children's hospitals, complex care like transplants, virtual care, and retail clinics.

Seeking certain provider commitments

GM sought a health system partner that would initially agree to accept financial risk for cost and quality performance (with a commitment to evolve the payment model in future years), provide enhanced member experience, and partner with GM on governance. Moreover, the health system had to be willing to accept risk for *all* of the care enrolled GM members sought – even if they sought care outside of the contracted system, such as emergency care. Further, GM required all incentive payments to go directly to those delivering care, not to health system leadership. In addition, GM required the provider to accept a deeper fee schedule discount in exchange for the added volume GM would steer to the contracted provider through benefit design incentives.

GM also required the health system to demonstrate a commitment to customer service; for example, the health system had to offer high-touch concierge and advocacy services, access to an online patient portal, same day appointments, online and/or virtual care, and maintain strong results in the CAHPS survey.

About Henry Ford Health System

- Established in 1915 in Detroit.
- Has over 30,000 employees.
- Employs 1,200 providers and contracts with 1,800 independent providers who make up the Henry Ford Physician Network (HFPN).
- Comprises five hospitals, three behavioral health facilities, 40+ ambulatory facilities staffed by Henry Ford Medical Group employed physicians, and 400+ primary and specialty care locations staffed by HFPN private practice physicians.
- Provides access to primary care, multi-specialty medical centers, outpatient surgery, urgent care, emergency services, and a wide variety of community and retail services such as pharmacy, durable medical equipment, dialysis, and home health.
- Covers 535,000 lives through Health Alliance Plan, its health plan.

Finally, GM looked for a health system *partner* in every sense. To GM, being a true partner meant:

- Quick attention to resolving issues;
- Establishing a joint operating committee and meeting quarterly;
- Sharing responsibility for measurement and reporting;
- Using detailed implementation and operations plans;
- Being willing to share data and implement data sharing agreements, and;
- Committing to continuous improvement.

GM, Meet Henry Ford Health System

Equipped with its market knowledge and strategy, GM issued a request for proposals to six health systems, including Henry Ford, in April 2017. Henry Ford viewed the opportunity to establish a direct contract with an employer as promising due to its history of success under pay-for-value contracts and a long-standing commitment to managing population health. Prior to 2016, Henry Ford's medical group implemented a shared risk payment arrangement for

Medicare Advantage enrollees and for its own covered population. In 2016, Henry Ford launched its NextGen ACO as part of the Medicare Shared Savings program. Henry Ford also participated in Blue Cross's physician group incentive program. Henry Ford's success with these programs gave them confidence to implement a large, at-risk contract directly with an employer, even though they knew they would have to build up and modify their infrastructure to meet GM's requirements.

The Contract: Combining Cost & Quality

GM and Henry Ford entered a good faith agreement in the fall of 2017 to begin working together on a direct contract that would be available to GM's covered population in January 2019. Negotiating what GM called "ConnectedCare" took several months.
Under the ConnectedCare contract, Henry Ford committed to stay within a total cost of care budget and meet targets for the quality of care. If Henry Ford exceeds the goals and savings are achieved, these savings are shared with GM, but Henry Ford is held financially responsible if costs exceed the established targets. A joint operating committee analyzes the performance relative to contractual targets, collaborates on how to improve performance and experience, and has a process to address disagreements between the parties.

Using data from IBM Watson Health, GM's data warehouse provider, GM and Henry Ford collaboratively selected 19 quality metrics for the ConnectedCare contract that align with the health risks and conditions in the GM population. The metrics cover member satisfaction, acute and preventive care, and chronic care management.

Appealing to enrollees through low premiums

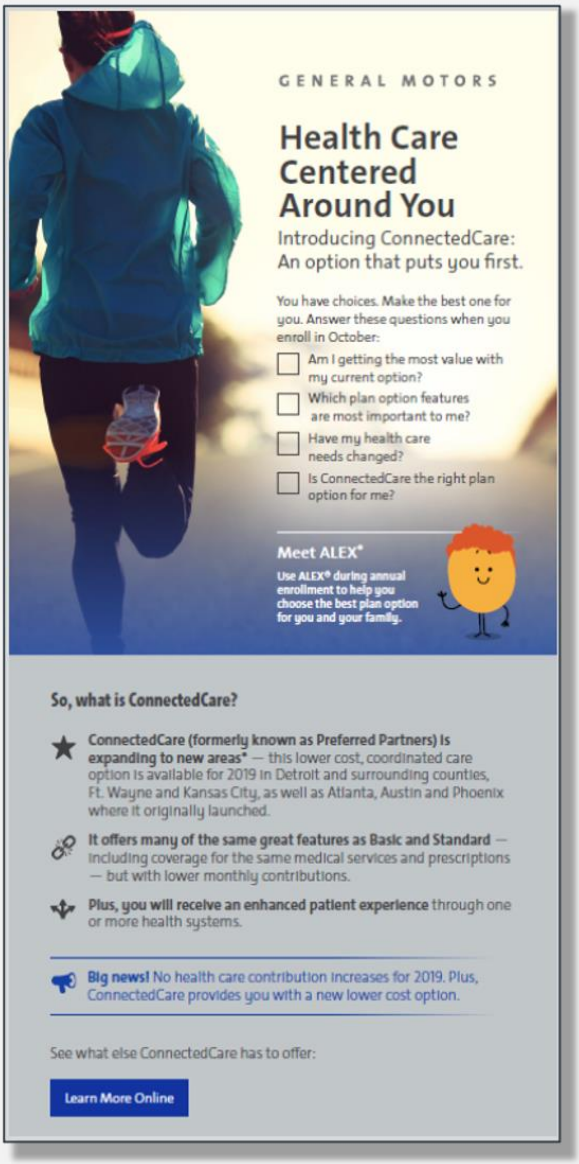
For its part, GM committed to drive patient volume to Henry Ford by positioning the ConnectedCare product with the lowest employee premium contribution and promoting the enhanced plan member experience.

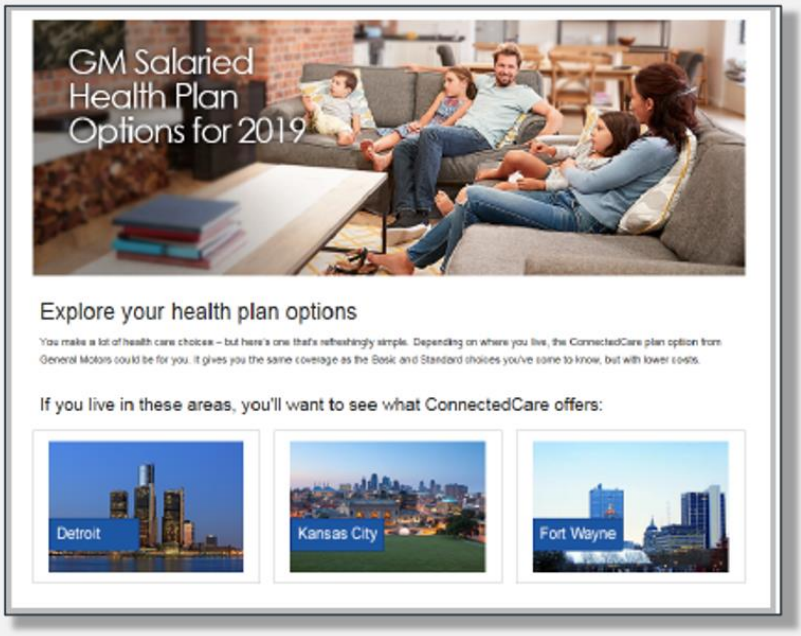
Rolling Out the Strategy

GM worked with Henry Ford to implement the new partnership over several months. To meet GM's expectations for access to care and a positive member experience, Henry Ford had to undergo structural changes and grow its provider network. Henry Ford hired a director to manage the direct-to-employer programs. To meet its member experience and care coordination obligation, Henry Ford created a concierge service, dedicated a phone line and webpage for GM's plan members, and expanded its 24/7 nurse line with additional staff to accommodate GM members. Henry Ford also expanded its care management programs from a focus on complex health needs of seniors to address the needs of GM's younger commercial population (such as maternity and children's health). Finally, the GM relationship served as a catalyst for the HFPN to redesign its physician governance structure. HFPN re-wrote its by-laws

and implemented a new governance model to provide equal representation for independent and employed providers to guide clinical models that support the GM contract in addition to other clinical programs.

GM announced ConnectedCare to members in August 2018. Beyond the concierge service Henry Ford provided, GM offered employees online resources to navigate the new product and hosted live events during which employees could ask questions. To GM, a strong communications strategy was essential. Below are a few examples.





Results

In 2020 – the second year of the contract – 12% of eligible employees enrolled in ConnectedCare; GM's leadership is optimistic that it will continue to grow ConnectedCare enrollment. Because GM implemented the contract so recently, it is too soon to assess changes in cost of care or member experience; however, GM did report that in the first year of the contract, Henry Ford met the targets for 16 out of 19 quality performance metrics and achieved the overall target quality score. During an interview with Catalyst for Payment Reform, Amy Vandecar and Chelsea Pollet at Henry Ford indicated that both organizations are happy with the relationship and are learning a great deal throughout the process. Furthermore, each organization continues to work to improve the experience of plan members. Henry Ford has co-presented with GM across the country to share the story of their partnership with audiences of employers and providers. The partners define success as being in the 90th percentile or above in the market for customer satisfaction, quality, and efficiency.

ConnectedCare sets an example for employers and other health care purchasers. While the 2019 Kaiser Family Foundation Employer Health Benefits Survey found that only 8% of large firms with a self-funded health plan contract directly with a hospital or health system, direct contracting is a growing trend. News of GM's strategy drew media attention, with articles published in the Wall Street Journal, Detroit Free Press, Bloomberg, and other outlets (below).


Detroit Free Press

Some GM employees to get 'direct-to-employer' health care option

JC Reindl, Detroit Free Press Published 4:01 p.m. ET Aug. 6, 2018 | Updated 2:11 p.m. ET Aug. 7, 2018


Bloomberg Opinion

Business

Forget Amazon, GM's Move Should Worry Health Insurers

More companies are cutting out the middleman and negotiating directly with care providers.


THE WALL STREET JOURNAL.

BUSINESS

GM Cuts Different Type of Health-Care Deal

Auto maker aligns with Henry Ford Health System in an attempt to cut coverage costs and improve quality of care

Insights & Lessons Learned

Collaboration is key

This arrangement marked the first time either GM or Henry Ford implemented a direct contract, and both parties continue to gain insights and knowledge along the way. Implementing a contract of this nature and scale requires a long runway. The partners needed to establish new processes for contracting, communications, and operations. Both partners invested significant time creating a contract that met the needs of both organizations. Coordinating and executing data sharing agreements also required time and effort. Communications entailed keeping internal stakeholders at both organizations apprised of progress and partnering on messaging to GM plan members. Both organizations established multi-disciplinary teams for implementation and ongoing program management.

Additionally, engaging providers proved to be a critical component. For example, Henry Ford had to ensure there were enough primary care and specialty providers to meet "network sufficiency" in the zip codes where GM employees and their families live in Southeast Michigan. It was also important to understand the staffing, capabilities, and tools available at each provider practice site – or enhance those resources – to ensure that all GM plan members had access to high-value care management services regardless of where they sought care.

Not all health systems are the same

GM recommends fully evaluating provider organizations and their commitment to alternative payment models and patient-centered care by interviewing representatives of the provider at both the leadership and supporting levels.

Direct contracting is resource intensive

The staffing and resources required to get the contract off the ground are significant as the employer is involved in the sourcing, negotiation, implementation, administration, and monitoring of the arrangement. GM established a joint operating committee that met monthly at first and now meets quarterly, and GM and Henry Ford leaders continue to touch base several times a week. This kind of close coordination and communication is essential to managing the relationship and resolving member issues quickly.

Employers, devote time to plan member education

According to GM, a key component of rolling out a program like ConnectedCare is to understand how employees will interpret the new program and make their benefits decisions. Sheila Savageau suggested employers spend 20% of their time learning about actuarial differences between plans and 80% or more of their time communicating those to plan

members. Plan members will have many questions about the differences in benefits, out-of-pocket costs, the provider network, and other logistics (e.g., receiving ID cards, transitioning care, accessing more information, etc.). During rollout, it's easy for plan members to lose trust in their employer if they only find out their providers are not in the network when they go in for a visit. GM also found that employees look closely at payroll contributions when they select benefits. This encouraged GM to use payroll contributions as the key differentiator between ConnectedCare and other options.

What's Next?

A continued focus on value-oriented care

Going into the direct contract's second full year, GM established a goal to increase enrollment in ConnectedCare to 13%. GM also made ACOs available to plan members through Blue Cross Blue Shield of Michigan in Fort Wayne, Indiana and Kansas City effective January 1, 2020 with enrollment results of 14% of eligible employees.

These efforts are part of GM's goal to offer value-oriented health care options to everyone it covers in the future. With its direct contract and expanding portfolio of value-oriented benefit options, GM is speeding down the highway toward higher value health care for its covered population.