Issue Brief

Reconciling ASO Bundled Payment Contracts in a Multi-Employer Setting

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Section 1: Introduction

I. Bundled Payment: Why Employers Should Care

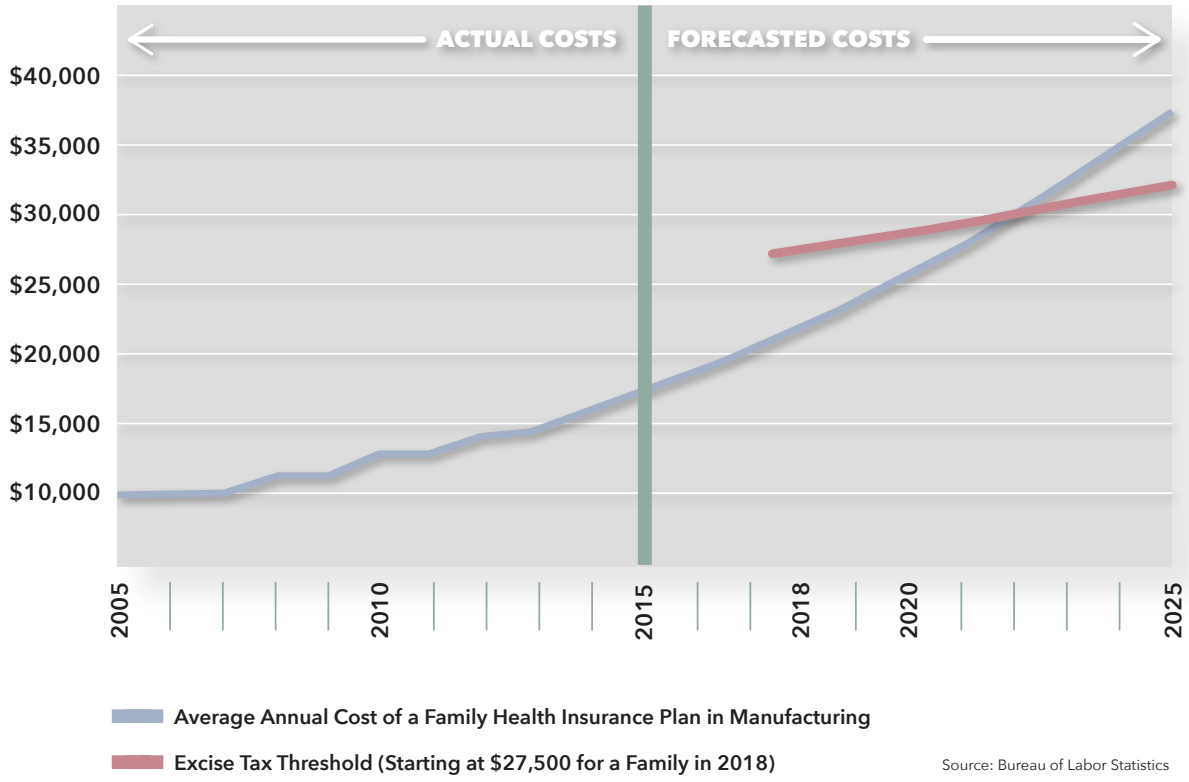
Since the passage of the Employee Retirement Income Security Act (ERISA) in 1974, many employers, especially larger ones, have turned from the costlier practice of purchasing health benefits from health plans in state-regulated marketplaces. By "self-funding" employee health benefits, where the employer acts as a mini health plan, employers can avoid the weighted costs of state mandated benefits. But what looks like a good deal in the short run, over time, may lock employers in a long-term trap: low quality, fee-for-service (FFS) medicine. Inherently inflationary, FFS medicine forces employers to pay for an undefined product that actually rewards health care providers for making expensive, even lethal, mistakes.

Bundled payment, or episode of care payment, may sound to employers like another irrelevant abstraction from the health policy echo chamber, but here's why employers should care: at least 40% of the money employers spend to pay for employee health benefits goes to things that either add no value or harm their employees. We call these events Potentially Avoidable Costs (PAC). For bottom-line companies who would never tolerate such an extreme defect rate from their normal business suppliers, it is routine from their health care vendors. FFS, the predominant reimbursement method for nearly all employers, masks this dynamic and, as the Figure 1 shows, reducing PAC rates by just 10% over the next five years would save employers $400 billion.

[1] The authors wish to acknowledge the contributions of Suzanne F. Delbanco, Ph.D., and Andréa E. Caballero of Catalyst for Payment Reform for their generous and insightful editorial comments.

In a recent report written by the National Association of Manufacturers, comes this startling graphic (Figure 1) of projected trends in the costs of employers sponsoring family health insurance plans over the next decade.[2] Not only does it reveal how expensive *average* health benefits are going to be by 2025 for families, but it also shows the point at which all average family plans paid for by employers are going to hit the ACA Excise, or "Cadillac," Tax. Simply put, the ACA imposes a 40% excise tax on all annual premiums exceeding $10,200 for individuals and $27,500 for families, starting in 2018. In the first 8 years, the federal government expects to collect $87 billion in revenue—that's $87 billion that, from an employer's point of view, is nothing but pure dead weight loss, creating no value to the company or in benefits to employees. Clearly, the federal government is sending a message: push your employees onto government subsidized exchanges and pay the fine, or find another way to lower your average plan costs.

FIGURE 1: Forecasted Average Family Plan Cost Trends: 2005-2025

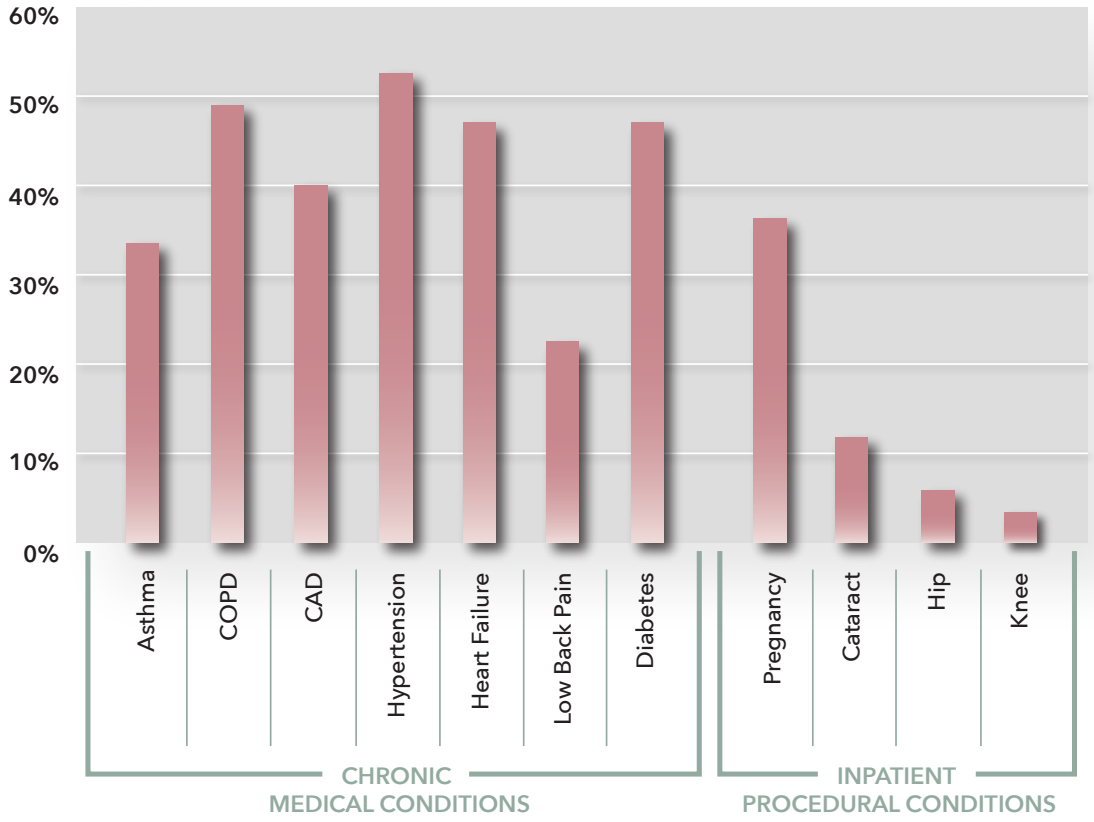


Source: Bureau of Labor Statistics

[2] "Shaping Up: Manufacturers Seek Flexible Health Care Options to Reduce Costs," *National Association of Manufacturers,* 2015. Available at http://www.nam.org/Data-and-Reports/Reports/Shaping-Up/Shaping-Up-Report.pdf.

Figure 2 shows another way to lower costs, that is, concentrate on new contracting methods that lower the defect rate in health care delivery. Instead of focusing on Total Cost of Care (TCOC) rates, break up health care delivery into discrete episode of care product lines, and reward providers for reengineering care processes that reduce PAC rates. The PAC rates revealed in Figure 2 come from very recent analyses HCI[3] has performed on commercial health plan data, and are not at all out of line with employer experience across the country. The point is that these rates, so heavily driven by FFS payment incentives, are also driving the trend rates in Figure 1.

FIGURE 2: Current Empirical PAC Rates for Commercial Plans



For several decades now, health plans, third party administrators (TPA) and benefits consultants have been promising employers they have solutions to alter these trends, but they continue unabated. By focusing attention on TCOC numbers and not zeroing in on discrete episode of care product lines (and the fairly massive variance in cost and defect rates per episode type), employers gain a false sense of total cost management. Clearly, employers need to embrace a radical break from long-established purchasing strategies. Realigning payment and benefits from scattershot FFS to episode of care product lines can help to accomplish the much-needed break.

Bundled payment converts the amorphous, costly and error-prone healthcare delivery system into a transparent, competitive marketplace; it forces health care providers to sell their products and services the same way employers have to sell their products and services (price for value); and applies all the principles of supply-chain management to healthcare purchasing.

Bundled payment converts the amorphous, costly and error-prone healthcare delivery system into a transparent, competitive marketplace; it forces healthcare providers to sell their products and services the same way employers have to sell their products and services (price for value); and applies all the principles of supply-chain management to healthcare purchasing. After all, no company would pay $2.00 per unit from a supplier when they could pay $1.50, especially if the lesser-priced unit is of higher quality. A bundled payment for an episode of care is the same idea as a quoted purchase price for a car, or laptop computer, or any other complex product for which there are many input factors coming from many suppliers. And because companies have to compete on price and quality, they have a powerful incentive to search after better ways to offer their products. Bundled payment brings the same incentive to healthcare providers, and gives them the same line-of-sight management concepts by turning FFS healthcare episodes into specialized products that employees can understand and shop for the best deal.

In terms of cost and quality, FFS makes no sense to employees as consumers because no one can tell them what an episode of care will cost or who has the best quality. And why should a company pay for that? But a bundled payment for pregnancy or total hip helps because employees see the exact price for the complete product and compare providers. It makes even more sense for self-funded employers because specialized product competition among providers means that the cost of benefits go down, or at least flatten out, because the pricing model makes it profitable for providers to lower defect rates (as opposed to being rewarded for high defect rates). And with lower defect rates, employee productivity goes up, due to fewer lost days on the job. Bundled payment, therefore, represents a great product revolution in healthcare that has historically not materialized because the focus has always been on the total cost of care, or meaningless network discount rates.

II. The Need to Aggregate Employer Purchasing Power

There are a number of reasons why a product revolution is emerging in healthcare, and these range from the passage of the ACA in 2010 to a number of state reform efforts like Tennessee pressing forward with 75 episode product definitions, to blue-chip companies leading the way as pioneers in bundled payment. Initial efforts by these kinds of purchasers make sense because they are large and prominent. But most of the nearly 155 million Americans who receive health benefits receive them from medium and small size companies of less than 1,000 employees. These companies do not have the heft to organize such a big change on their own.

To take advantage of bundled payment, these companies will have to band together and press their TPAs to take action. Bundled payment is a way of putting providers at risk for the cost and quality of the medical services they offer. But if a company of less than 10,000 employees tries to pay providers on an at-risk basis, they typically do not have enough episodes of care in any plan year to entice providers to take on these kinds of contracts, nor do they have enough volume to support the kind of risk adjustments providers would demand for sicker patients. We often refer to this as the "Tyranny of Small N." ERISA allows employers to act as mini health plans, but the problem lies with mini. As individual companies, they just don't have the numbers to make value-based reimbursement like bundled payment work. ERISA may allow employers to avoid costly state mandates, but it also partitions companies into very small and fragmented purchasing agents that structurally prevents them from behaving like health plans, large employers or federal / state governments, even though they are engaging in the same economic activity.

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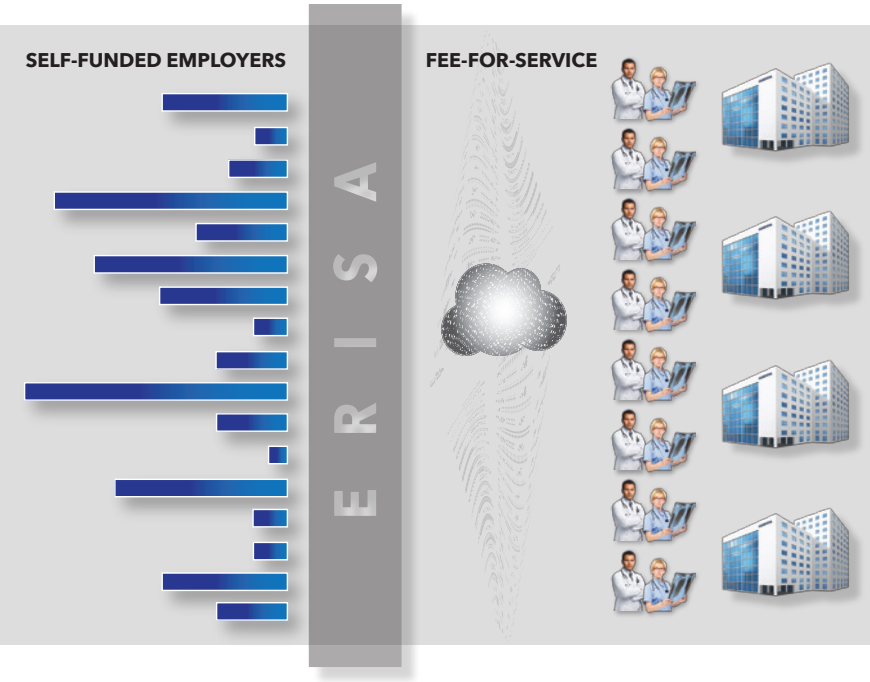
One way to picture this state of affairs, structurally (Figure 3), is to see isolated, self-funded purchasers (companies) on one side of the ERISA partition. Bars of relative length represent different company sizes with divided and uneven purchasing clout. And, on the other side, a fragmented delivery system that "produces" healthcare in an uncoordinated environment where doctors, hospitals and ancillary providers work in discontinuous incorporated siloes. Even though they may be managing the care of the same patient for same type of episode, they cannot communicate with each other, nor can they know what happens to the patient once he or she leaves their walls. For a simple cold requiring a single office visit, this doesn't present much of a problem. But for complex episodes like surgeries or chronic diseases, where coordinated management is indispensible to quality care, it's huge. Taken in full, most employers would interpret this as an almost complete lack of supply-chain management—and they would be right.

Exacerbating and reinforcing the problem is how all these providers get paid, represented by the "cloud" of FFS reimbursements between the employers and provider "networks." Since none of the providers is at economic risk for competing episode of care product lines, they only have two economic incentives: maximize both FFS retail unit prices and volume of those services performed. This, in turn, creates a perverse incentive that rewards high defect rates in the delivery of care (seen in Figure 2).

More to the point, the lack of purchasing coordination among employers that comes as a result of the ERISA exemption means that FFS is structurally "baked in." The thousands of payment codes in the FFS "cloud" is the only statistically defensible payment mode (from the providers' point of view) that can economically work given how small and divided the individual employer purchasing pools are. In other words, fragmentation on one side of the ERISA partition begets fragmentation on the other side, and so constitutes a mutually self-reinforcing feedback loop.

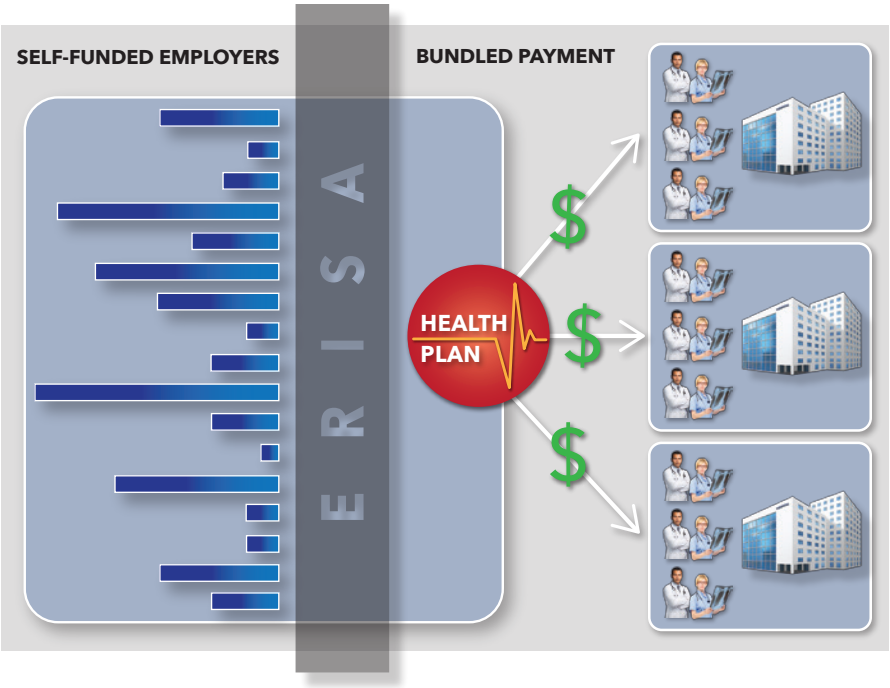
FIGURE 3: The ERISA FFS Status Quo Structure



The obvious solution is to aggregate employer collective numbers into regional purchasing blocs and concentrate value-based contracting through dedicated TPAs, who then contract bundled payment arrangements on their behalf. Insofar as ERISA is concerned, this is no different than self-funded Administrative Services Only (ASO) contracts with TPAs as they currently operate under FFS, except that employers are agreeing to allow the TPA to represent all of them as a single facing plan for the purposes of bundled payment. In this way, a multitude of companies present interested providers with an aggregated population of covered employees and potential episodes as if they were a regular health plan with tens of thousands of lives. All that has changed is the unit of contracting account: from fragmented FFS pricing units to episode of care, bundled product units.

In Figure 4, we see the same basic structure as in Figure 3, except that many employers have agreed to work with a health plan or TPA to contract with local providers for bundled payment episodes. Observe that no employers or providers literally reincorporate as unified businesses. The "integration" is virtual and achieved through contractual amendments. On the employer side, whereas they previously represented small, divided purchasers having 50 or 100 or 450 employees, by agreeing to let the TPA or health plan represent them collectively through coordinated purchasing, they can now "appear" to providers as a unified bloc of thousands of employees. Because this is the case, and now the numbers make sense, providers can also virtually integrate (or, ideally, structurally integrate), to accept the at-risk bundled care contract, say, for a total hip replacement, as we will describe in Section 2.

FIGURE 4: Virtual Bundled Payment



At that point, the total hip replacement has become a specialized medical product line. Note that in Figure 4, for total hip replacement at least, the FFS "cloud" has disappeared. In this new payment environment, multiple provider arrangements can compete for the employers' total hip replacement patients. And if the employers change their employee benefits to reflect the bundled price differences, at one stroke, a competitive marketplace has emerged where previously, under FFS, there was none.

While the concept is straightforward, putting it into motion is not. Because ERISA promotes a highly fragmented employer purchasing market, and traditional FFS promotes an equally fragmented delivery market, a number of problems arise. One of these is the way dollars flow between employers, TPAs and providers to make bundled payment work where providers are not sufficiently integrated to process a single payment for an episode of care. If healthcare providers were already clinically integrated around specialized episode of care product lines, bundled payment would present

no problems. When an episode of care starts, a single payment is made, and the medical delivery firm manages the funds internally the way any other private sector company processes payments. Although some provider organizations are coming on line to accept payment this way, they are only a small fraction of the national market. No doubt the pace will accelerate as Medicare, health plans and large employers increase the volume of dollars towards bundled payment, but for the time being, FFS fragmentation will continue to be the major mode of delivery system organization.

Regardless, for those purchasers wishing to move ahead with bundled payment, a "stop-gap" solution is required to bridge the gap between the FFS reality of today and the product revolution of tomorrow. In most instances, this means creating pre-budgeted episode contracts, paying contracted providers on a FFS basis, and comparing the actual cost of the medical episode to the FFS paid amount.

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What's important is for the experience of each individual employer to be reflected in the individual and collective transactions. In other words, if a provider managing knee replacements under a bundled payment contract stays under budget, there should be measurable savings for the employer, and that's what we suggest in this report.

In an upside only reconciliation, if the provider comes under budget, an additional payment is made that usually splits the difference between payer and provider so that the payer realizes a savings, and the provider a reward. In a full risk contract, providers pockets the full amount of the savings if they come under the budget, but if they go over, they owe the purchaser the difference. Under either mode, the TPA that intermediates the payments on behalf of the self-insured employers can create an accounting mechanism that reflects these basic effects.

III. ASO "Notional Pooling"

There are two problems that arise from retrospective reconciliation in a FFS environment: Problem 1) secondary reconciliation payments, and Problem 2) partition risk.

As described above, in a retrospective bundled payment model, primary FFS payments are made as individual providers bill the TPA for their services throughout the time duration of the triggered episode. If they come under budget, the payer shares the savings by making an additional, or secondary payment, as a reward for beating the budget. This is currently the way most pay-for-performance (including PCMH) and ACO-type rewards are paid, and the net effect for the employer is that if the provider saves money relative to a set target, or achieves a defined quality score, the employer pays out additional money.

Our field experiences as well as the experience of others have shown this method to be controversial at best. In fact, many employers balk at making a secondary payment—even if it can be demonstrated that the overall money paid represents a savings. Whether falsely perceived or not, a secondary reconciliation payment feels to employers like they are paying twice. So that's Problem 1.

Problem 2, "partition risk," is a little trickier to explain. If 50 employers band together to contract with multiple providers through a single TPA, for any given episode of care, each will have different actuarial experiences year over year, both as to the number of episodes triggered per company, and to the risk-adjusted costs per episode (some patients being more cost intensive to treat).

Think of it this way: the TPA, as the network-contracting agent, has a one-to-many relationship with the providers. Budgetary reconciliations are made to contracted providers as if they are dealing with a single health plan (not 50 employers). At the same time, the TPA, acting as a financial fiduciary, also has a one-to-many relationship with the 50 employers. If we view the TPA as an intermediary virtually aggregating what are, in effect, 50 separate health insurance plans, then actuarially speaking, each employer will have unique cost exposures—not only in relation to the other similarly situated employers with a plan year, but in relation to itself, year over year.

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Since each employer is actuarially partitioned from the others because they are all independent self-insured plans, but sharing in the reconciliation dollars paid out to contracted providers acting as a virtual collective, the contribution of an employer with a bad year will feel like an unfair subsidy to other employers who have good years. Like Problem 1, secondary reconciliation payment, partition risk is as much perception as it is reality. Where it matters, and should matter, is in the simple mathematical effect of the TPA's many-to-one financial relationship with employers, and one-to-many relationship with providers. And to illustrate the point, let's take a simple example of a TPA contracting an "upside-only" deal for total knee replacement bundles at $30,000 apiece with a network provider on behalf of two employers:[3]

Employer A has 10 triggered bundles for a total budget of $300,000 and the actual cost—claims paid—is $250,000. In other words, the employer wins because Actual < Budget by $50,000. Under the terms of the agreement with the provider, the Employer is expected to pay out $25,000 or half the savings.

Employer B also has ten triggered episodes for a total budget of $300,000 and the actual cost is $350,000.As such, the provider overshot the budget by $50,000. And since the deal is upside only, the employer does not save anything and the provider pockets the excess $50,000.

[3] We choose $30,000 because it is a nice, round number for the calculations below. It includes all clinically indicated services, not just inpatient facility and professional charges. For simplicity's sake, we have not included severity adjustment calculations; however, we note that severity adjusted budgets would not materially change the overall method.

The total experience, from the TPA's and the Providers' perspectives, is that there were 20 triggered bundles for a total budget of $600,000 and the actual costs came in at budget ($250,000 + $350,000). As such, the provider is not entitled to any gain-sharing.

If the employers insist on maintaining the artificial partition, then Employer A would pay out $25,000 to the Provider when, in fact, the employer shouldn't pay anything.

Therefore, a solution must be found for these two problems to obtain employer buy in. We call our solution "Notional Pooling" because it's a way of pre-paying each triggered episode according to the pre-budgeted episode of care contract without requiring the need for a secondary reconciliation payment (if the actual comes under budget), and because of the method we have devised for TPAs to take the pre-paid pool of triggered episodes for gainshares that partially evens out any sense of unfair yearly cross-subsidization. In fact, there is no cross-subsidization under Notional Pooling and the individual experience of each employer is merely a reflection of the collective experience.

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The idea of a "notional" account is not entirely alien to employers; it's how Health Reimbursement Accounts (HRA) work. HRAs are a kind of an accounting fiction with no cash value and which employees do not own. It is a pre-determined amount of dollars set aside from which FFS medical services are paid, at no cost to the employee, so long as expenses are kept at or under the HRA amount. Unused amounts rollover to the next year, so long as the employee remains with the company. Thus, it is "notional."

Like an HRA, a pre-budgeted episode of care is notional. When an episode triggers, the employer sends the budgeted dollar amount to the TPA, which holds it as a notional account from which FFS contracted provider billings are deducted. But instead of rolling over unused amounts to the next year, unused amounts are rolled back to the employer based on the employer's individual and collective experiences. It is from this shared notional pool, administered by the TPA, that a gainsharing formula is applied for provider distributions. Using a total knee replacement example, the remainder of this Issue Brief will be dedicated to explaining the financial mathematics of how ASO Notional Pooling works for bundled payment in an "upside-only" contracting model and in a full risk model.

Section 2: Upside Only ASO Reconciliations

I. Example: TPA Contracts Total Knee Bundle for 5 Employers

In this example, a TPA has organized a total knee bundled contract with a local orthopedic group for $30,000. That price is a discount from the actual average historical costs for knee bundles in that region, but the orthopedic group is willing to accept that discount because the TPA represents a large number of self-insured employers. The group does not own the hospital operating room facilities or rehab therapists, but has agreed with a national implant manufacturer to use only its implant device for a discount. Having looked over the claims data with the TPA, the orthopedic group feels confident that with the implant discount, the average inpatient charge from the hospital to which it refers, along with a sub-agreement with its favorite rehab group, that it can manage a minimum volume of 50 total knee patients at $30,000 per episode. Since it is an early stage arrangement, the group is not willing to go at risk and absorb the costs of cases that go over $30,000, but it does agree that at a later date, with program success and additional employers coming on board, it will consider accepting a contract with downside risk.

With contract in hand, the TPA succeeds in marketing the program to 5 mid-sized employers, who are willing to be early adopters, and who already have an ASO agreement with the TPA. All that is needed to engage the program is an addendum to the already existing ASO FFS agreement in place with the 5 employers that describes the bundled payment program, how the funds will flow, reporting activities, and each party's obligations.

The addendum explains the Notional Pooling method. Each time a patient selects the contracted orthopedic group and a total knee episode is triggered, the TPA will draw $30,000 from the employer's account. Because it is a retrospectively reconciled contract, the $30,000 is not paid directly to the orthopedic group, but from the employer's point of view, it feels like a prospectively paid bundle to an integrated provider. The TPA holds the $30,000 as a "credit" in a notional account against which FFS claims from the orthopedic group, the hospital, implant device (which is usually buried in the hospital charge) and the rehab group are "debited." The TPA keeps a running tally of each triggered episode, all related total knee FFS billings, and reports back to the employer the over / under calculations. From those calculations, the TPA applies a formula that determines the gainshare with the orthopedic group and the employer as remittances (if under), and if over, nothing changes. The contract behaves like a normal FFS arrangement.

II. Explaining Upside Only Notional Pooling in Practice[4]

Below, in Table 1, we see the running tally of each employer's experience under the total knee contract, expressed as actual FFS cost per triggered episode with an accompanying over / under amount to the right in the True Up column. Over is black; under is red. In the bottom row we see the totals per employer. Employer A experienced 14 complete episodes. The projected budget for the time period was $420,000. The actual FFS performance of the contracted orthopedic group for Employer A was $397,834, or $22,166 under the projected total, with similar tallies for Employers B, C, D and E. For one Employer, B, the orthopedic group ran over the projected total by $16,495.

TABLE 1: Actual Experience by Employer: Upside Only

EMPLOYER A	TRUE UP	EMPLOYER B	TRUE UP	EMPLOYER C	TRUE UP	EMPLOYER D	TRUE UP	EMPLOYER E	TRUE UP
$30,244	$244	$27,765	$2,235	$25,911	$4,089	$31,490	$1,490	$23,079	$6,921
$32,999	$2,999	$31,118	$1,118	$22,764	$7,236	$34,602	$4,602	$31,929	$1,929
$32,962	$2,962	$27,871	$2,129	$33,735	$3,735	$23,258	$6,742	$30,997	$997
$24,721	$5,279	$32,283	$2,283	$27,654	$2,346	$25,252	$4,748	$27,654	$2,346
$24,567	$5,433	$35,984	$5,948	$30,990	$990	-	-	$23,521	$6,479
$26,380	$3,620	$36,461	$6,461	$24,737	$5,263	-	-	$34,115	$4,115
$31,424	$1,424	$32,158	$2,158	$24,526	$5,474	-	-	$30,255	$255
$35,994	$5,994	$32,891	$2,891	$25,674	$4,326	-	-	$23,695	$6,305
$24,789	$5,211	-	-	$33,588	$3,588	-	-	$31,366	$1,366
$28,891	$1,109	-	-	$25,909	$4,091	-	-	$36,468	$6,468
$25,662	$4,338	-	-	$34,455	$4,455	-	-	$22,973	$7,027
$23,678	$6,322	-	-			-	-	$23,201	$6,799
$25,057	$4,943	-	-	-	-	-	-	-	-
$30,466	$466	-	-	-	-	-	-	-	-
TOTALS									
$397,834	$22,166	$256,495	$16,495	$309,943	$20,057	$114,602	$5,398	$339,253	$20,747

[4] For those readers who wish to experiment with original spreadsheet calculations, please see http://www.hci3.org/sites/default/files/files/ASO%20Account%20Reconciliations%20Double%20Sided%20Risk.pdf

In Table 2, we analyze the method for distributing a year's end gainshare, and how Notional Pooling solves the twin problems of secondary reconciliation payments and partition risk. Since the total knee contract is with the TPA, and not with each individual employer, the first step is to total the actual FFS costs of all triggered episodes versus the total budgeted amount, which for the year measured was $1,418,127 (Grant Total Actual) and $1,470,000 (Grand Total Budget). In aggregate, the orthopedic group beat the budgeted amount by $51,873 for the 5-company population of 49 total hip patients. Therefore, to make the orthopedic group whole under the contract, the TPA owes them $51,873.

But notice that this amount does not square with the Sum of Employer Owed ($68,368), which is the total amount that Employers A, C, D and E came under. In most proposals we have examined for multiple employers participating in a bundled payment arrangement, the gainshare formula is equally distributed amongst all employers, either from a pre-paid pool or a post hoc formula where the TPA goes back to the employers for their portion of the gainshare.

If the latter, we run into Problem 1: secondary reconciliation payments, which we have seen, employers are loathe to do. But if the former, we must consider Table 1 in light of Employer B's experience. Employer B did not experience a savings, and so asking Employer B to contribute to the gainshare feels like adding insult to injury.

This describes Problem 2, partition risk. Because the TPA is functioning as a virtual aggregator to get the necessary volume of lives and dollars to interest providers in bundled payment contracts and make it statistically viable, it "appears" to be acting like a health plan collecting premiums. But, in fact, it is not; by definition, TPAs serving as administrators only for self-funded employers take no premium, or insurance risk. That risk falls on the employers and their reinsurance companies. This being the case, ERISA "partitions" self-insured employers on the other side of the virtual TPA aggregator as self-contained health insurance plans.

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Table 2, ASO Account Reconciliations, shows how we solve for Problems 1 and 2. In the first two columns, we again see Grand Total Actual ($1,418,127) and Grand Total Budget ($1,470,000). In the third and fourth rows, we see Owed By Plan ($51,873) and Sum of Employer Owed ($68,368). If the bundled payment arrangement treated each employer as directly contracted to the orthopedic group, then each employer that had a good experience would get back the exact amount of the underage for its own experience. But because the employers have agreed to pool their experience through the TPA to take advantage of their united purchasing power, the gainshare must also be pooled, but only amongst the employers who had a good experience. Employer B had a bad experience, so we extract them from the gainshare formula. In an upside only contract, the orthopedic group is not at risk for Employer B's total knee experience, so it functions like a regular

FFS contract. Insofar as Employer B is concerned, there is no harm done from the pooling arrangement because this is no different than if they had no bundled payment contract. However, the negative experience of Employer B pooled with the positive experience of the other employers creates the overall experience from the provider's perspective and reduces the payout of the "winning" employers. In other words, the winning employers benefit from the bad experience of employer B, but Employer B is no worse off than if it contracted directly with the provider. It is, very literally, an upside only model for all concerned.

TABLE 2: ASO Account Reconciliations: Upside Only

		EMPLOYER A	EMPLOYER B	EMPLOYER C	EMPLOYER D	EMPLOYER E
GRAND TOTAL ACTUAL	$1,418,127	-	-	-	-	-
GRAND TOTAL BUDGET	$1,470,000	-	-	-	-	-
OWED BY PLAN	$51,873	-	-	-	-	-
SUM OF EMPLOYER OWED	$68,368	-	-	-	-	-
OWED BY EMPLOYER	-	$16,818	$0	$15,218	$4,096	$15,741
EMPLOYER GETS BACK	-	$5,348	$0	$4,839	$1,302	$5,006

To determine the actual amount that will be owed to the provider by employers A, C, D and E, we divide each employer's underage amount by the Sum Of Employer Owed, and get the percentage share each owes from the pooling arrangement to the orthopedic group. Employer A's underage from the True Up column in Table 1 was $22,166, which, when divided by Sum Of Employer Owed, comes out to $16,818 (or, roughly 32% of the pot). And when done for Employers C, D and E, we get $15,218, $4,096 and $15,741 respectively. In other words the formula is designed to calculate how much must be taken from each employer with realized savings to pay out to the provider. The sum paid out must equal $51,873 which is the net amount owed to the provider across all employers.

The final calculation is to determine how much should be refunded to each employer. Remember, $30,000 has been taken out from each employer's account for each episode triggered, and since the net amount owed to the provider is less than what each employer would have paid individually, there is a net "rebate" to each winning employer. As a result, an employer who actually saves under the bundled payment arrangement is likely to get some money back at the end of the year. The formula is quite simple:

1. Divide employer True Up (E_x, E_y…E_z; from Table 1 True Columns, if under 0) by ***Sum Of Employer Owed = Owed By Employer*** (which TPA distributes from notional pool to contracted provider in one lump sum);

2. Then ***subtract Owed By Employer (x,y…z)*** from employer (x,y…z) True Up columns = bundled payment "rebate" per employer.

Section 3: Downside ASO Reconciliation

I. Explaining Downside ASO Notional Polling in Practice

Even through we have solved for secondary reconciliation payments and partition risk, it's easy to see why employers would press quickly towards downside risk: all employers want to eliminate FFS for total knees and move to fixed price contracting, limiting their exposure to unwarranted variation. So, for Section 3, let's assume that the first year's experience was acceptable to both employers and the orthopedic group. The overall employer experience was under the total projected amount, and the orthopedic group saw that, while some episodes went over budget, in sum, they could beat the contracted amount for the employers' collective total knee episodes.

They have not yet achieved sufficient integration for a prospective payment, and will retain FFS payment as day-to-day cash flow management, as well as the previous year's $30,000 per episode budget, but the group will be at risk for the total contract price of total knee replacements. In the group's amended contract with the TPA, they agree to cut a check to the TPA if they run over the total budgeted amount; the TPA will take that check, plus any amounts left in the combined notional accounts of the employers, and make whole any employers whose actual FFS payment went over budget. Note: there are other mechanisms to put contracted providers "at risk" in a FFS environment, but we choose this method for the sake of simplicity, not to mention the fact that it would send a strong signal of provider commitment to employers. Now, let's see how this works.

In Table 3, we see (as in Table 1), the running FFS tallies for a year's worth of total hip replacements for the five employers. Notice that, unlike the True Up columns in Table 1, the True Up columns in Table 3 reflect overages as zeros. Although the actuals went over, the downside contract keeps the employers capped at $30,000 per episode in a notional accounting system. In Table 4, we see how the downside accounting is calculated.

TABLE 3: Actual Experience by Employer – Downside

EMPLOYER A	TRUE UP	EMPLOYER B	TRUE UP	EMPLOYER C	TRUE UP	EMPLOYER D	TRUE UP	EMPLOYER E	TRUE UP
$36,609	$0	$26,649	$2,235	$33,569	$4,089	$37,531	$1,490	$26,579	$3,421
$25,347	$4,653	$37,446	$1,118	$23,881	$7,236	$37,275	$4,602	$30,915	$0
$23108	$6,892	$36,032	$2,129	$23,029	$3,735	$34,286	$6,742	$30,020	$0
$33,611	$0	$37,269	$2,283	$35,053	$2,346	$34,992	$4,748	$24,463	$5,537
$36,804	$0	$24,548	$5,948	$36,226	$990	-	-	$32,180	$0
$30,130	$0	$36,216	$6,461	$24,243	$5,263	-	-	$23,675	$6,325
$26,053	$3,947	$32,344	$2,158	$28,880	$5,474	-	-	$36,206	$0
$32,167	$0	$25,122	$2,891	$25,528	$4,326	-	-	$34,914	$0
$25,121	$4,879	-	-	$36,549	$3,588	-	-	$36,130	$0
$32,476	$0	-	-	$28,432	$4,091	-	-	$31,202	$0
$30,580	$0	-	-	$25,891	$4,455	-	-	$32,801	$0
$26,362	$3,638	-	-	-	-	-	-	$33,834	$0
$24,176	$5,824	-	-	-	-	-	-	-	-
$37,426	$0	-	-	-	-	-	-	-	-
TOTALS									
$419,970	$30	$255,626	$15,626	$321,308	$8,692	$138,084	$18,084	$372,925	$12,925

Note that in Table 3 Employer A owes the providers $30 and employer C owes the providers $8,692, but Employers B, D and E are each owed money back because the providers went over budget. The total amount owed to the three employers is $46,635. From the provider's perspective, they know they owe the TPA, and Table 4 illustrates how the reconciliation works out.

As opposed to Table 2 (Upside Only), we see two new features in the first two left columns of Table 4: Owed By Provider and Sum Of Employer Below Budget. Owed By Provider is simple enough. It is the difference between the total projected budget and actual, if over, across all episodes. In this case, the orthopedic group was over by $37,913 ($1,507,913 - $1,470,000), and thereby owes the TPA that amount. But as we can see from Table 4, that would not be enough to make the employers whole. And here's where notional accounting comes into play. Because it's a fixed price contract and the providers are owed the difference between the contracted amount and actuals, there is a residual in Employer A's and C's accounts totaling $8,722. That, combined with the $37,913 owed by the providers makes Employers B, D and E whole. As a result, each employer's experience is exactly that of the contract: they paid a fixed amount of $30,000 for each total knee. Not a penny more, and not a penny less.

TABLE 4: ASO Account Reconciliations – Downside

		EMPLOYER A	EMPLOYER B	EMPLOYER C	EMPLOYER D	EMPLOYER E
GRAND TOTAL ACTUAL	$1,507,913	-	-	-	-	-
GRAND TOTAL BUDGET	$1,470,000	-	-	-	-	-
OWED BY PLAN	$0	-	-	-	-	-
OWED BY PROVIDER	$37,913	-	-	-	-	-
SUM OF EMPLOYER BELOW BUDGET	$8,722	-	-	-	-	-
OWED BY EMPLOYER	$0	$0	$0	$0	$0	$0
EMPLOYER GETS BACK FROM PLAN	$46,635	$0	$15,626	$0	$18,084	$12,925

Except for the idea of a residual amount left in the ASO Notional Pool for total knee bundled payment ($8,722), the downside reconciliation method is more straightforward than upside only. Formulaically, it can be expressed in this way:

1. Subtract ***Grand Total Budget*** from ***Grand Total Actual***, (if over) = ***Owed By Provider***;

2. Add ***Sum Of Employer Below Budget to Owed By Provider*** = ***Employer Gets Back From Plan***;

3. Subtract Employer Experience (E_x, E_y…E_z; if over 0; in Table 3 True Up columns) from ***Employer Gets Back From Plan*** = Bundled Payment "Rebate" Per Employer.

Of course, this only holds true if the contracted provider went over the total projected budget; if they come under, Rows 4-7 turn to zeroes, and the provider keeps the difference between Grand Total Budget and Grand Total Actual in columns 1-2. Everybody wins.

Section 4: Summary

While there are many ways to process reconciliations of actual to budget for various forms of value-based payments, there are significant advantages to employers for using the method proposed in this brief:

1. Individual experience is reflected in the accounting while benefiting from the collective experience—In the upside only model, employers who experience savings get money back and the "notional pooling" eliminates the potential for overpaying a provider when the collective experience of all employers in the program is considered. Put simply, employers contract with providers through TPAs to benefit from discounts and a collective purchasing power. Notional pooling of bundled payments accomplishes that goal and eliminates the need for employers to pay out additional moneys when savings are realized.

2. Employers never pay out more than they should—that's true in the upside only model and just as true in the upside/downside model.

3. The collective purchasing experience is more likely to engage providers in true care transformation.

4. It's administratively simpler to have notional accounts funded by each triggered episode than clawing back savings after the close of a fiscal year.

5. In addition to the aforementioned observations, we would like to add that ASO Notional Pooling lends itself just as well to chronic conditions—where all the really big self-funded medical expenses reside. We kept this brief to a simple total hip episode of care, but with success, we feel the methods explained here are even more appropriate to managing disease states like diabetes and asthma, the most forceful contributors to the alarming trend rates exemplified in Figure 1. ■

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