MILLIMAN CASE STUDY

Milliman PRM helps Accountable Care Options take on its toughest patients

Improving quality of life... at lower cost.

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Client profile

Accountable Care Options Florida (ACOFl) is an accountable care organization (ACO) which was founded in July 2012 in Boynton Beach, Florida. ACOFl supports 20 physician practices and had an initial Medicare Shared Savings Program (MSSP) enrollment of approximately 6,700 beneficiaries. In 2014, Accountable Care Options was attributed with Medicare savings of over $9.9 million, resulting in distributable shared savings totaling over $4.4 million.

Challenge

Richard Lucibella, ACOFl CEO, was seeking a breakthrough care management model to maintain the ACO's initial success. Lucibella was also concerned that, despite its initial success, savings would be difficult to achieve once the "low hanging fruit had been picked." Also, as the ACO continued to grow, the physicians wanted to ensure that the care they provided improved the quality of life for its population.

Lucibella's goals for a new model were twofold: (1) he needed a platform that would identify the most impactable high-risk patients for his care team to manage, and (2) he sought a proven, equitable tool to allocate distributable shared savings to individual physicians in his practice.

Lucibella knew he needed to find a new model to address escalating healthcare costs among the ACO's most severely ill patients. The emerging physician consensus for this group was there was nothing more that the ACO could do to help them beyond regular office visits and being reactive to their acute care needs. He also knew that a significant portion of costs could be influenced by care provided outside of the acute healthcare system. According to Lucibella, "Docs truly care about their patients – they're the reason they went into medicine in the first place. And they'll tell you they often lose sleep over severely ill patients. Once they've done everything possible in the doctor's office, they find it incredibly disappointing to see a patient's health continue to decline, show up in the emergency room or in the hospital."

Solution

ACOFI identified the Milliman PRM solution as the foundation for its new model. The selection was made due to PRM's ability to simultaneously identify actuarial risk and the potential where clinical intervention may reduce that risk. Lucibella says, "The Milliman PRM model sparked the entire journey that we're on today. We have complete confidence in their model's ability to look deeper than historical costs and predict avoidable costs down to the individual patient in a manner that is actionable for our team."

Inspired by Milliman's unique PRM solution, Lucibella and his team launched an innovative multidisciplinary program in the fall of 2015 led by a paramedic as well as physicians, pharmacists, nurses, case managers, and behavioral health experts. ACOFl relies completely on the Milliman model to identify the top 5% of its patients who are the most impactable. The initial patient care plan begins with a traditional chronic care management approach and then moves on to palliative care, when and if the patient, physician, and care team agree on this transition.

Results

According to Mitchell Perelman, MD, one of the participating physicians, "With the introduction of the Accountable Care Options program, we've seen a dramatic 25% to 30% reduction in ER visits among a population of 75 chronic care management patients. Based on the median charge for an ER visit,* this would result in a savings of at least $27,742 for my practice alone this year. And the best part is that Milliman PRM is identifying patients who the medical community would've given up on."

ACOFl has found great breakthroughs with non-conventional interventions that help people overcome real-life barriers to accessing care. In one case, the team worked with Home Depot to build a ramp at no cost for a diabetic patient. This enabled her to more conveniently attend her follow-up appointments. In another case, added behavioral support helped keep an alcoholic patient sober for 52 days, and in ACOFl's judgment avoided at least two hospitalizations, which for average Medicare payments,

would save $24,300 in total costs.** According to Perelman, "I have an 80-year-old patient who was unexplainably losing consciousness. I clearly didn't have the bandwidth or resources to reach out and monitor her on a daily basis, but now I, and the rest of her care team, receive alerts via text whenever she experiences an adverse event. She's now carefully managing her meds and hasn't had any more episodes. This is the type of patient who'd eventually end up in the ER, things would snowball, and you'd spend $30,000 before you know it."

According to Lucibella, "By identifying the proverbial 'needle in the haystack' and providing better care for patients previously considered unmanageable by our physicians, this program has dramatically improved how we care for chronically ill elderly patients, while leaving our physicians' workflows intact. In fact, they're so engaged, most participate in grand rounds meetings in-person every two weeks. One of the most rewarding benefits we've achieved through the use of PRM is the remarkable improvement in our patients' quality of life, and consequently our satisfaction scores have skyrocketed."

In addition, early ACOFl reports show dramatic cost reductions for Medicare and the patients themselves – which increases incentive payments for participating physicians. Says Lucibella, "We anticipate significant shared savings this year, and Milliman's Physician Risk and Credibility Adjusted (PRCA) reports have enabled us to accurately measure and fairly reward physician performance. This actuarially adjusted methodology is far more precise than the conventional RVU-based allocation. This approach was universally accepted by our physicians and took a huge load off my shoulders knowing that I was being fair in dividing up the savings."

* According to a 2013 National Institutes of Health study, the median ER visit cost was $1,233.

** Based on FY2014 Medicare Charge Inpatient DRG Summary Report for DRG 896.

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