March 22, 2019

RE: Request for Meeting with MPTA

Dear Ms. Stewart,

The Michigan Physical Therapy Association requests a meeting in the near future to continue our discussion regarding the ways in which the physical therapy community and BCBSM can collaborate to improve access and quality and reduce costs of physical therapy care for your members.

Regarding utilization management, the MPTA would like to know BCBSM's plans for either expanding or discontinuing the eviCore program. If BCBSM has plans for significant changes, the MPTA would welcome the opportunity to provide input to any significant pending changes ***prior to*** implementation to avoid many of the implementation and execution issues previously experienced at the start of the eviCore program.

Regarding our ongoing discussion about value-based care, we would like to continue to explore alternate payment policies with BCBSM that facilitate a shift toward value-based payment. We previously have communicated about the following suggestions, which are again outlined below:

1. Incentivize systematic outcomes data collection and reporting - this could be through subsidizing fees for registries (FOTO, APTA Outcomes Registry, WebOutcomes), exempting providers who use registries or other systematic outcomes measurement and reporting process from corePath, or providing incentive payments based on performance on outcome measures.

2. Use a claims or visit threshold after which corePath would be required. If no clinical outcome measures were used to provide the basis for a request for continued care (or no extenuating circumstances were articulated), no further care would be authorized.

3. Reconsider the categorization process. Do not use corePath with Category A and B providers. To capture Category A providers who have low utilization but deliver poor quality care, screen Category A providers thru claims data to identify the frequency of patients starting care with another provider within 30 days as a proxy for low visits but poor quality care, and then subject those providers to corePath as well.

4. Identify a sample of outliers using a claims or visit threshold on a routine basis to initiate further inquiry. Providers who cannot provide evidence of clinical outcome measurement and/or confounding factors that demonstrate their unique patient population to justify their aberrant utilization should then be subject to corePath. Although this is similar to what is currently done with C providers prior to consideration of disaffiliation, initiating this contact sooner with a collaborative approach in the spirit of changing practice, rather than under threat of disaffiliation, would help move providers toward developing the necessary culture to effectively participate in a value-based payment environment.

5. Revise the physician prescription requirement to be consistent with Michigan state law which only requires a physician prescription for treatment after 10 visits or 21 days. The data are clear that direct access episodes of physical therapy care have lower costs, both with respect to the physical therapy-related costs as well as all costs associated with a condition, in part due to reductions in unnecessary physician visits, medication, and imaging costs.

We look forward to our upcoming meeting.

Sincerely,

Michael J. Shoemaker, PT, DPT, PhD
President
Michigan Physical Therapy Association