4/24/18

Dear Dr. Di Franco,

The MPTA is again grateful for the opportunity to have been able to provide essential feedback about the current eviCore program, and appreciates the discussion during our previous meeting in March.

As we discussed, the MPTA is gravely concerned about the ability of providers to sustain the administrative burden associated with the corePath program if it were to be rolled-out to all BCBSM products, and that medically necessary care is not able to be delivered to your members. Data from our experience thus far demonstrate continued significant administrative burden and inappropriate denials of care. Even if there were some additional efficiencies achieved through better provider and eviCore staff education, the majority of the time/burden is due to the policy itself. Requiring 2-3+ authorizations for every patient, when scaled up to 30-50%+ of a practice's payer mix is catastrophically not sustainable.

We are grateful that the July 1, 2018 implementation date for corePath will all BCBSM products has been postponed as this will enable time for a collaborative effort, not to simply find process efficiencies, but to develop a feasible and effective approach to utilization management for both BCBSM and providers.

We believe that BCBSM ultimately wants to ensure that effective, cost-efficient care is delivered to its members. Although the current corePath program is beginning to consider how to include outcome measures in its processes, the fact remains that systematic data collection and reporting for physical therapy care has not yet sufficiently matured and proliferated to effectively link utilization management to comprehensively risk-adjusted clinical outcome. However, MPTA believes we should actively work toward that goal.

Upon your invitation for a collaborative approach, we propose several ideas/concepts as starting points for discussion about alternative approaches that would be more feasible in the short term, accomplish BCBSM short-term goals of reigning-in ineffective, over-utilizing providers, and move BCBSM and physical therapy providers toward value-based health care delivery in the long term:

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.

We also have included a variety of peer-reviewed papers demonstrating the cost-effectiveness of removing the physician prescription requirement for accessing physical therapy in the United States. 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.

BCBSM has, for decades, concluded in its provider class plan annual reports that the physician prescription requirement for physical therapy effectively managed physical therapy utilization, although this conclusion was never based on any presented data. Further, if we are successful in a collaborative approach to utilization management that can be implemented across all BCBSM products, the physician prescription requirement will be unnecessary, and will in fact contribute to overall expenditures for a given condition. We are therefore hopeful that consideration can be given to the elimination of the physician prescription requirement in the broader context of our discussion.

We look forward to our upcoming discussion.

Sincerely,

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