Michigan Physical Therapy Association

July 26, 2019

RE: Upcoming Meeting with MPTA

Dear Ms. Stewart,

The Michigan Physical Therapy Association appreciates the opportunity to meet with BCBSM 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 the eviCore utilization management program, the MPTA remains concerned about denial of medically necessary care and the substantial administrative burden imposed by prior authorization processes. The eviCore program substantially adds to the cost of healthcare delivery by providers and to costs of BCBSM benefits administration. Based on data previously reported to MPTA, the average number of visits under the highly managed BCN/BCNA program was a mere 0.21 visits less than that of the PPO/MA (where the MA program is a relatively small proportion of the overall case mix). It is hard to see how the minimal cost savings outweighs the cost to BCBSM, providers and patient satisfaction.

The use of eviCore is particularly problematic for the care of individuals with non-musculoskeletal problems, especially those with neurologic conditions. The allowed number of visits and units per visit are woefully below evidence-based practice standards for dosing the intervention to achieve established outcomes in the research literature.

It should also be noted that the BCBSM average of approximately 9 visits is substantially below the 12-14 visit range required to achieve clinically meaningful change in patient-reported outcome measures that was recently reported in an analysis of 375,000 patient episodes in all 50 states.[1] Continuing to attempt to suppress visits to less than eight or nine visits will result in clinically ineffective care and ultimately greater downstream healthcare costs. This preliminary study highlights the critical importance of linking utilization to outcomes and risk adjustment. The approach taken by eviCore continues to subjectively and arbitrarily make authorization decisions based primarily on utilization targets.

[1]Brooks JM, Chapman CG, Lutz A. Evaluation of Legacy Patient Reported Outcome Measures as Performance Measures in Rehabilitation. Completed by the Center for Effectiveness Research in Orthopedics. July 11, 2019.

The MPTA would like to know BCBSM's plans for either expanding or discontinuing the eviCore program in light of the corporate merger of Express Scripts (which acquired eviCore) and Cigna. 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 participation in accredited clinical registries, 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 of how the categorization process is linked to utilization management. 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.

    - It should be noted that MPTA appreciates the streamlined categorization process across all BCBSM/BCN products.

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.

    - MPTA is supports exploration of outlier-based utilization management programs, however, MPTA also recognizes that execution of key elements is critical. These include the risk-adjustment process used to determine the outlier threshold(s), whether the program is provider or payer funded, and if provider funded, whether payment increases will be made to offset these costs, etc.

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.
    - See *Carey K et al. Health Insurance Design and Conservative Therapy for Low Back Pain. American Journal of Managed Care 2019;25(6):e182-e187*: " Modification of health

insurance benefit designs offers an opportunity for creating greater value in treatment of new-onset LBP by encouraging patients to choose noninvasive conservative management that will result in long-term economic and social benefits."

https://www.ajmc.com/journals/issue/2019/2019-vol25-n6/health-insurance-design-and-conservative-therapy-for-low-back-pain

We look forward to our upcoming meeting.

Sincerely,

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