Navigating the Maze of Utilization Management Companies

NORTHWEST CHAPTERS’ EXPERIENCE AND STRATEGY FOR MOVING FORWARD
Learning Objectives

- Participants will understand:
  - Chapter experience in addressing capitated utilization management
  - The PT mandate to move from capitated UM to Value based UM (VBUM)
  - The need for PT stakeholders to collectively adopt practice infrastructure to promote VBUM.
Presenters

- Tom Howell, Idaho payment specialist
- Larry Post, Washington, payer liaison
- Chris Murphy, Oregon, president
- Aaron Hackett, Utah, payment chair
- Peter Rigby, Washington, VP and reimbursement committee chair

- Overview of chapters shared experience
- Provider fatigue and feedback
- Importance and methods of data collection
- Lessons learned
- Transitioning from FFS to VBUM
Setting the Stage – The Players

The Patients:
Top concerns are familiar:

• Interrupted care with loss of any gains
• Were patients getting the PT benefit they paid for?

The PT/PTA Members and Provider Representatives:

APTA
WA, OR, ID, UT Chapter Payment & Leadership Representatives

Also involved in this directly or peripherally:
APTA PPS, NWRA, NARA, State Insurance Commissioners
The Insurer:
Cambrria Health Solutions which includes:
- Regence BlueShield of WA
- Regence BlueCross/BlueShield of OR
- Regence BlueCross/BlueShield of UT
- Regence Blue Shield of ID

- 2.5 million covered lives
- Significant loss of market share over last 5 years

The Specialty Benefits Management Company
Care Core National LLC
- Founded 1994 to manage imaging, lab and cardiology services
- Acquired Landmark Health (specializing in Physical Medicine Utilization) in 2013
- Selected by Cambria in 2013 to manage “skyrocketing” physical medicine costs
2012-2013:

2012: NWRA submits UM proposal – rejected

Spring 2013: Cambria announces plans for pre-authorization in provider newsletter

Summer – Fall 2013: Chapter reps starting with OR and WA, then ID & UT begin hearing more from Regence reps about coming pre-authorization; Meetings begin in OR and WA to offer alternative UM systems; APTA is involved in the process

October 2013: Cambria insurances begin “TEST” period which is plagued with problems including poor or no communication, poor education, and little provider response due to little incentive and increased cost in order to test
2014:

January 2014: Chapter meetings with Regence and/or Care Core continue; WA initiates meeting with WA OIC

Feb 2014: Regence/Care Core pre-authorization goes live with immediate and significant problems; Initial phone conference with state chapter and PPS reps held during CSM; PTWA suggests to Regence that a Provider Advisory Group be formed

March 2014: APTA sends letter to Dr Mera (Regence Medical Director) and Karen Jost & Chris Murphy meet with Regence and Care Core reps; Regence Provider Advisory Committee formed and meet (quarterly meetings planned)

March – Sept. 2014: Chapter reps attempt to collect data via online surveys and continue problem solving; Care Core policies are updated twice requiring two additional letter in response from the APTA; Chapter reps have online meeting (July 15) to discuss what the next steps should be including value-based and outcomes based UM; online conversations and planning continues...
Setting the Stage – The problems

Chapters and the APTA began receiving complaints almost immediately after the system went live.

Complaints poured in and included:

- Delays causing patients to cancel visits and interrupt care
  - Phone delays of upwards of an hour or more
- Web based system was locking out office staff and providers
  - Authorization was coming in small increments
- No help from Regence or Care Core provider reps – each was saying to call the other
  - Units and visits not matching need
  - Tiering system not working
  - Medical necessity definition problems

What is also missing???
All of us were concerned about a UM system that was in no way based on outcomes!

My colleague, Larry Post will go into these problems in more depth next…
Physical Therapy Services Are Considered *Not Medically Necessary* Under Any of the Following Circumstances

1. **Training in nonessential self-help or recreational tasks such as:**
   - Homemaking, gardening, educational activities and driving
   - Return to sport or recreational activities (e.g., golf, tennis, running, jogging, swimming, basketball, gymnastics, football, baseball, martial arts, dance, etc.), or for the performance of work-related or other specific vocational tasks.
Provider Fatigue

The table below illustrates how UM Tiers are assigned according to utilization:

<table>
<thead>
<tr>
<th>SUV</th>
<th>RAVE &lt; 6.29</th>
<th>RAVE 6.29-7.91</th>
<th>RAVE &gt; 7.91</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 3.50</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>&gt; 3.50</td>
<td>B</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

As you can see from the table above all providers with an average RAVE below 6.29 visits, and an average SUV below 3.50 are assigned to UM Tier A (shaded in green). Providers with a RAVE below 6.29 visits, but an SUV of 3.50 services or greater are assigned to UM Tier B (shaded in yellow). Providers with a RAVE between 6.29 and 7.91 visits and a SUV less than 3.50 services are also assigned to UM Tier B (shaded in yellow). Providers with a RAVE between 6.29 and 7.91 visits but a SUV of 3.50 services or greater are assigned to UM Tier C (shaded in red). Providers with a RAVE of 7.91 or greater are also assigned to UM Tier C (shaded in red).
Provider Fatigue

- Medical Necessity Definition: Access to Care
- Tier Impact to Patient Access and Experience
- Tier validity concerns
- Population statistics UM vs the individual patient
- UM based on Claims without Outcomes
“In God we trust. Everyone else, bring data” - Michael Bloomberg

Data-collection methodology, shared among Payers and Providers, designed to promote connection between -

Regence reported that physical medicine codes were disproportionately high
Tiering issues
Incredibly long call times
Almost entirely driven by impairment rather than function
Data - Early Resolution

Reported specific cases and calls
Benchmarks for call time and web portals were established
Recorded calls were reviewed
Positive changes
  Portal and worksheets were remapped
  Phone pathways were changed to match worksheets
  Call times reduced
  Faxes were accepted
  PSFS was scored in original fashion
Data - Next Steps

Regression toward the mean
  Medically necessary care or management of utilization?
  What language are we speaking?
  Can we get our systems to communicate?

"I've been reading to him every day for a month and his feet have grown 4 cm"
Lessons Learned

**State Level**
- Maintain contact with APTA staff
- Need to network more often with surrounding states and see what they are facing.
- Not everyone has the level of education on the issues at hand

**Consistent and persistent contact with local Regence/Cambria reps**
- Lack of valuable and consistent data
- How to use technology to collect data from members for a problem such as this
- The possible need for a regional presence of some type
Lessons Learned

Anticipate and mitigate Provider Fatigue

- Regulatory and payment policy reform continues to reduce revenue.
- PCL UM strategy requires time from front-line providers, which increases cost.
- **Strong** Regence and CC “open-door”, coupled with...
- **Weak** connection between numerous complaints and few tangible impacts

Immediate multi-chapter collaboration to promote provider awareness

Focus early on Medical Necessity versus Administrative burden

Create data-collection tool that will connect issues to resolution
Why We Are Here

HC reform requires insurers to no longer use pre-existing conditions as a barrier to insurance coverage. Lifetime limits are also removed.

Insurers re-calculate their actuarial tables and determine their costs will increase.

Insurers maximize their control over costs by Counting/Limiting Procedures (CLP).
An agreed upon point between Payor and Provider where investment in each patient’s outcome is optimized.
Future

- Assume identity of a VALUE to be leveraged in driving **positive outcomes** to meet the “triple aim”... not a COST to be contained by **counting procedures**
- Need data to demonstrate **VALUE** of PT services to all stakeholders
- Need to facilitate Direct Access
- Must collaborate w/insurers... consider and address needs of all stakeholders
- Get PT out of the silo and into total episodic cost of care
- Alternatives to UM must facilitate Act proactively- try to prevent implementation of UM- hard to stop once in place
THANK YOU