CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum: Developing Outpatient Therapy Payment Alternatives

Conference Leader: David Bott
Moderator: Natalie Highsmith
August 6, 2008
2:00 pm ET

Operator: Good afternoon. My name is (Mindy) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Developing Outpatient Therapy Payment Alternatives.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Ms. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Mindy), and good day to everyone who's joined us here in Baltimore. And good day to the participants on the phone lines, and thank you

for joining us for the Special Open Door Forum focused on developing Outpatient Therapy Payment Alternatives.

This special open door is intended primarily for providers of physical therapy, occupational therapy, and speech language pathology services reimbursed under Part B.

The Developing Outpatient Therapy Payment Alternatives project has a special emphasis on how data will be collected and how facilities, practices, and individual providers may become involved and contribute to this ground-breaking research.

The contract for implementing this project was awarded on January 29 of this year to RTI International. You can send comments, including interest and participation to the project email address which is optherapy-comments@rti.org. The agenda was posted on the CMS Open Door Forum Web site. You can go there to download that at www.cms.hhs.gov/opendoorforums -- with an S -- and you will find it under the Special Open Door Forum's page on the left hand side under the Download section.

I will now turn the call over to Mr. David Bott who is in our CMS Office of ORDI.

(David)?

David Bott: Thank you, Natalie.

Good afternoon to everybody here and on the phone.

First, let me introduce myself. I'm David Bott. I'm a sociologist and health services researcher in the Office of Research Development and Information here at CMS, and I'm the project officer for this data collection and research project. And that means that I oversee the research contractor, RTI International, and in this case it also means I serve as liaison to other CMS components where related projects are housed and you the stakeholders.

Second, I'd like to thank you all on behalf of CMS for participating in this Special Open Door Forum on Developing Outpatient Therapy Payment Alternatives project. We at CMS believe that this project will be successful only through participation and feedback from people such as yourself.

Our goals in organizing this forum today are three: to share with you the outlines of the project, what it is and what it is not; to solicit your participation in the data collection aspect of this project; and to answer any questions you may have.

The agenda for this meeting was posted, but let me just go over it again. First, there's a brief introduction of key members of the project team; second, a word from Renee Mentnech, the Director of the Research & Evaluation Group in the Office of Research and Development and Information or ORDI; and third, a description of the project and what we need from you by Ed Drozd, the Project Director from RTI International; and finally, a question and answer period. We'll try to be brief.

First, I've already mentioned Ed Drozd. On his left and also on the phone is Barbara Gage, RTI International. She's an expert on therapy assessment and she has been involved in the development of the CARE Tool which some of you are probably very well aware of.

We also have on the phone, Trudy Mallinson from the Center for Rehabilitation Outcomes Research at the Rehabilitation Institute of Chicago. She's a - they're a subcontractor to RTI. We also have on the phone Dr. Alan Jette, Professor of Health Policy and Management at Boston University. And he's been involved in the development of a number of therapy-related assessment tools. Dorothy Shannon is on my far right. She's from the Centers for Medicare Management. She is involved in a number of therapy payment policy decisions and research projects in the past, and she's one of the people that I work with here at CMS.

And two people that aren't here - well, actually, they are here. They - I wasn't sure they were going to make it. Judy Tobin from the Office of Clinical Standards and Quality is involved and she's the Project Officer for the development of the CARE Tool. And Shannon Flood who is from ORDI as well. And she is involved as the Project Officer for the Data Collection and Analysis from the CARE - using the CARE Tool.

So, with that, that's all the participants. I'd like to turn the microphone over to Renee Mentnech to give a few words about the context in which this project resides.

Renee Mentnech: Thank you, David.

I want to thank everyone for participating today and taking the time to learn about this very important project.

David did introduce me and just as a little bit more background, the Office of Research Development and Information has several groups; one of them is the Research and Evaluation's group. It is that group that I direct. And the -

David's project as well as the project to develop - to implement the Post Acute Care Payment Reform Demonstration is also out there.

This project is one of several related projects addressing therapy issues within the context of a CMS strategy focusing upon patient-centered payment. Through these developmental projects, we hope to improve our ability to link payment to patient need with less emphasis on the setting that someone goes to.

Specifically, this Outpatient Therapy project is a five-year research and development effort focused on therapy services paid under the Part B part of the program. And it complements the CARE Tool being used in the Post Acute Care Payment Reform Demonstration.

For those who are unfamiliar, we've mentioned it a couple of times. So it's worth saying a little bit more about that tool and that other related projects. I'll provide some brief background.

The CARE Tool was developed to support the Collection of Patient Assessment data from the point of hospital discharge through four different post acute care settings that are reimbursed under the Medicare Part A program. That project has been underway for some time. This project that we're talking to you about specifically today is therapy services specifically under the Part B part of the program.

Because the cost-cutting nature of this developmental work, several components within CMS are involved in the effort to improve our data collection on patient health functioning and outcomes. To that end, there are consultation and coordination efforts among CMS components and among the various project officers to ensure that the assessment for all patient needs, for

all patients needing therapy services across all setting will be addressed appropriately.

In the case of the Outpatient Therapy services, the fact that we are focused on the research and development project with a five-year timeline does not mean that CMS is ignoring the uncertainty in the Part B therapy environment due to the presence of the therapy cap.

These data collection efforts take a while to unfold and for us to do the research to the long-term sort of policy goal. So, CMS hopes that preliminary data collected in this project might support short-term steps taken to address the issues that surround the therapy cap. So while we have a long-term view for this project, we do recognize that there are more short-term payment considerations that need to be addressed.

At this time, I want to introduce the RTI team -- I think David's actually already done that -- working with us on this project to develop the Outpatient Therapy Payment Alternative. Some of the RTI members working on this project, the Outpatient Therapy project, are also involved in the Part A Post Acute Care Payment Reform Demonstration and in fact were the - RTI was the organization that developed, in consultation with CMS, the CARE Tool.

So they come to the table with a tremendous amount of experience and with a very strong team including their subcontractors. Ed Drozd will then start with providing a little bit more background about the project. We are, as David said, going to give you an opportunity to ask questions towards the end of the agenda.

David Bott: That's correct.

Renee Mentnech: Right. Thank you.

Edward Drozd: Thank you, Renee. Thank you, Dave. And also thank you to everyone who is here in the room and also on the phone. We do thank you for the interest that you have expressed by being here on the phone in this project. You know, we and CMS - we all know that it is a very important project and is part of CMS's initiatives in this area as David and Renee had mentioned on patient-focused payment.

First, I would like to just describe and touch more our team. In addition to our people at RTI, as well as at our subcontractors, Rehabilitation Institute of Chicago and Boston University, we also have consultants from the National Rehabilitation Hospital, Focus On Therapeutic Outcomes, as well as the University of Pennsylvania. And they have provided valuable input to us on helping us in our initial stages of this project. And they presumably will continue to provide such valuable input.

Furthermore, I would also like to thank everyone who has so far provided us with input on their concerns, suggestions, their comments through - in the provider community and elsewhere, through our technical expert panel which was held last month, as well as comments submitted to us through our project email address which Dave has mentioned, and I will get back to at the end of my little speech here.

I'm going to try to, in terms of talking through our - the backgrounds, our approach, a description of the project and some timelines and other things, I'm going to try to be, you know, go into, you know, to some sufficient detail. However, I do want to make sure we leave enough time for, what we assume to be the many comments and suggestions and expressions of concern. We do

welcome the feedback. It's the only way we will understand your suggestions and concerns if you let us know.

With that said - and finally, as was mentioned, this is a five-year project, in these discreet events of Open Door Forum, technical expert panels of which we plan on having in a few years when we get into the more specifics on payment alternatives, and I'll describe the process of the project in a few minutes. In addition to those discreet events, we do encourage you throughout the period to provide us, through whatever form you wish -- email, Web site, phone calls, letters to us, whatever it may be -- so that we don't want this to be, well we come out - poke our heads up and see what's going on and go back underneath. Rather, we want to have this be a continual process of understanding your concerns.

So just as a little bit of a background, in the title of the project, "Developing Outpatient Therapy Payment Alternatives," when we're talking about outpatient therapy, these are therapy services covered by Medicare Part B provided by physical therapists, occupational therapists, speech-language pathologists.

Rather than there being a uniform population out there covered by this benefit with care provided by these therapists rather, in the very least one can imagine - one can see - the ambulatory populations, seeing clinicians in offices or other more ambulatory setting -- outpatient rehabilitation facilities, hospital outpatient department, et cetera -- in addition, there is a non-ambulatory population -- patients in nursing facilities, skilled-nursing facilities, more chronic patients.

And under this large umbrella of outpatient therapy we have, you know, these two large groups of patients and within those other subpopulation and, you

know, this is part of the challenge of this work, is to help CMS determine some alternatives to the existing payment method for outpatient therapy services.

And so with that said, you know, I think that's an important point to make here. And by no means do we intend to ignore or brush under the rug any of those subpopulations. And in particular, when - if you do have concerns about any of these populations, large or small, we encourage your feedback.

So I just wanted to also give a little bit of legislative background. As many or all of you know, there has been quite the history, in legislation, of changes to payments for these services. Certainly, we can go back to the Balance Budget Act of 1997 when all of the outpatient therapy -- as I described -- was to be paid under the same coverage and payment rules that had previously only covered independent therapists who directly billed Medicare, using the Medicare Fee Schedule.

So this was definitely an expansion of the application of that payment methodology to the wider set of patients and providers.

There were cap limits applied to that benefit that hospital outpatient departments were excepted from those coverage limits.

Subsequent legislation over the intervening years -- applied caps, put moratoria on those caps, reapplied the caps, provided exceptions process -- there has been some amount of change going on in the payment system, but generally speaking, it continues to be under the Medicare Fee Schedule. And to this day, we have the caps.

Recently, we've had the exceptions process extended and a change from the prior payment methodologies or coverage methodologies -- might be a better word. Speech and language pathologists are now able to bill directly to Medicare program, which is a definite change from previous practice.

Now previous studies that various portions of the government -- federal government - MedPAC, GAO, or the studies conducted by Advanced Med or CSC under contract to CMS -- determined that claims data alone are insufficient for case mix adjustments, certainly also for outcomes, for these populations covered by the outpatient therapy coverage. And that patient assessment data are necessary. We need to go outside of claims in order to correctly or more accurately describe these patients.

However, these studies also recognize that there's no existing standard tool used by Medicare or for Medicare to use, or set of items and measures that are comparable across the settings for providing - for Part B therapy services. And therefore, what we are trying to do as I will describe in a moment, this is an important study. I expect not the final study on outpatient therapy services, but certainly it is also one of the number of the CMS initiatives as Renee Mentnech had described related to patient-focused payment. This one is specific to therapy services covered by Medicare Part B Outpatient Therapy.

So now the purpose of this project.

CMS has uhh, tasked us with a (code?) of research and development project that would collect primary assessment data on the spectrum of patients in the range of setting where outpatient therapy is provided in order to assess the feasibility of developing case mix adjusters and outcomes measures to use within the payment system for outpatient therapy, and to develop alternative

payment models and methods, and the pros and cons for the CMS to understand, supported by feasible case mix adjusters and outcomes measures.

So kind of the three important points are what we have been tasked with. And in order to conduct this study, we have a few general principles that we are operating under. The first is that the data collection that we are conducting is for items to measure case mix and outcomes and the feasibility of using these in the payment system. Not for setting payment rates, not for determining an assessment tool that would be used for care planning. We presume that that would be a much wider set of items for CMS to collect and not necessary for care planners, presumably a great deal more information that as needed for individual clinicians to provide care to their individual patients.

Our focus, as I mentioned, is on applying case mix adjusters and outcome measures to models based on the Medicare Fee Schedule. That is our principal focus. Now that doesn't necessarily imply that we will not consider other models that one can envision. And it's certainly the case that our data collection needs to be flexible enough that we can evaluate the feasibility of those case mix adjusters - potential case mix adjusters and outcomes measures on another model. But right now our focus is on - principal focus on alternatives for case mix and outcomes that generally fit within the existing system.

And I want to make one last point - few more points. Data collection and the assessment items, you know, need to be appropriate to the different patient populations who are covered by this benefit. And I'm intentionally using the plural of populations, and we take that seriously that there are patient populations for which some items may be appropriate and some items might not be. And then in our data collection we need to balance, collecting

information that we can use for the different populations in a manner that is not too burdensome for providers.

Now, in the data collection instruments that we will produce, there may be items that one would end up at the end of the day, not wanting to include in the payment system but need to be included for research purposes. We don't have any preconceptions of which are the specific items that are the ones that will be used in the payment system, rather as alternative. And we need to collect the information to get that.

Our approach consists of and what I see as three main steps. And there are obviously several components in each step, but three main steps.

So assessment tool development selection need to develop our data collection instruments. Because of CMS budgetary constraints, we are only using paper data collection. Unlike in some of the other initiatives, for instance the Post Acute Care Payment Reform Demonstration where CMS was able to put more resources into an electronic data collection system, unfortunately we need to use a paper-based mode generally. And there are certain compromises that need to be made when taking that approach.

And I do want to recognize, you know, people might be thinking out there well, in the world of assessment data collection for outpatient therapy providers. Many of you are presumably using some computerized data collection system. Unfortunately, because of these budgetary constraints, we are not able to field the, you know, CMS or RTI, whomever, developed data - electronic data collection system.

For the data collection for assessment, we should build on current plans and recent development in creating a more unified approach to patient assessment.

So rather than having a multitude of assessment instruments, we want to move towards the more unified approach as seen in CMS's CARE Tool initiative, also still a work in progress, but - for which there's already been extensive work.

For our data collection purposes -- and again here's the compromise here -- as I just mentioned that we are moved - what we'd like to move towards to the unified assessment data collection. Recognizing that the ambulatory and non-ambulatory populations have different needs and there are different circumstances of data collection, we are proposing to field two different data collection instruments. This does not imply anything about what would be in a payment system of two or ten or whatever different data assessment tools. Rather, we have our two data collection instruments here for the two types of settings recognizing differences in those patient populations.

The ambulatory tool is currently in the development process. And the non-ambulatory tool would build on CMS's efforts for the development of the CARE Tool, plus some additional communication and fall and function items appropriate for treating these types of populations.

Second step of our study, the primary data collection itself. We are - at the moment, we believe we need to recruit roughly and somewhat less than 200 providers nationwide. So this would include hospital outpatient departments, nursing facilities, comprehensive outpatient rehab facilities, and other, as I mentioned, rehabilitation facilities -- private practices and other settings -- where these patients - where patients are receiving outpatient therapy services.

We need to be able to ensure that we have the spectrum of patients and the range of providers in our data collection. And we are - will enroll these

providers, clinicians, over a one-year period starting in the second year of our project.

Providers would participate, which involves collecting these assessment data, for up to six months. And particularly may depend - this particular length of data collection may depend on the size and scope of the provider.

The data will be collected on the provider's Medicare Part B (payment) - the patients receiving outpatient therapy covered by Medicare Part B. And so, this could be a - portion of these patients as long as it's, you know, randomly selected, working with their subcontractors and consultants, TEP members, associations who have provided us with comment and suggestion and concerns to develop the tool with the limited items for patients' response and the limited items for therapists' response -- that's the ambulatory tool, the TEP helped us with domains, to identify limited items, consider the best respondent for the particular domains, again, trying to reduce as much as feasible the burden on providers and review the TEP reviewed items from leading tools including the (AM PAC), FOTO tool, NOMS, OPTIMAL, CARE Tool and others for domains and items. So we did encourage the TEP to consider these.

The proposed tool we expect to be submitted to OMB this fall for under Paperwork Reduction Act requirements, to be published for public comment in the Federal Register as part of the review process, we expect a date somewhere in late winter or early spring of next year 2009. The revised tool will be used in the data collection.

And as part of the primary data collection assessment forms, training materials will be provided by RTI.

And before I get to the next step, we do encourage comments today on these processes that I'm describing.

And as far as the third step, the payment model analysis is where we take the primary data that we would have collected from the participating providers who we would - in advance, I want to thank them, whoever they will be, for their participation. We'll take utilization from claims data and merge those with the primary data. And we would present CMS with pros and cons of different alternatives. And we encourage feedback from the provider community on different payment alternatives. And we would certainly work with CMS and the direction of CMS to develop these alternatives.

Now for a timeframe. The first year in the project -- current year -- is where we are developing our assessment tools, the data collection instruments. The second and third year starting during the second year would be primary data collection. Again, it depends on the review process for the Paperwork Reduction Act. And in the fourth and fifth years of the project is where we plan on focusing on the payment - the analysis of payment alternatives.

Now of course, the primary data that we collect is obviously with the mind of that we need to conduct the analyses. So it's not - well we're not going to think about anything regarding payment systems now. We try to be mindful of them but are focus is what I just described in our timeline.

And finally we encourage, as I mentioned or mentioned repeatedly; I will repeat again. We encourage your feedback, comments and suggestions. (Unintelligible) comments and suggestions you may have on process and purpose of the project. Any comments you have here about what we need to be mindful of in assessment tool development, we encourage them here. Feel

free to present your comments here at the meeting or you can, through email, afterwards. We certainly take those seriously.

And just to reiterate, the email address for this project is O-P-therapy hyphen comments -- with an S at the end -- @rti.org. That's O-P-T-H-E-R-A-P-Y -- hyphen -- C-O-M-M-E-N-T-S@rti.org.

You can also email CMS directly for any comments or suggestions, criticisms, whatever you may have -- hopefully not too many criticisms; not that we expect none -- at DOTPA@cms.hhs.gov. So if you're to look at the - if you have the agenda items, it's the first letters of the project name -- Development Outpatient Therapy Payment Alternatives, DOTPA, @cms.hhs.gov.

And we also have the new project Web site that will continue to be expanded during the course of this project. And it will actually be used during the primary data collection to help disseminate information to the participating providers' training materials, other support. And that Web site, the URL is http://optherapy.rti.org. There's no www in there . It's just OP-T-H-E-R-A-P-Y.rti.org.

And those are my comments for now. And I believe we're opening the floor and phone lines up for your comment, suggestions, et cetera.

David Bott: So thank you, Ed and Renee.

And I just want to summarize that this is essentially a data collection process that we're looking for help in obtaining data that we cannot get through the claims. And we rely upon the providers to voluntarily do this. We can't pay you for it. But I think your interest in forming - formulating good policy

would trump that in case, and so we look forward to hearing from you in terms of your interest and participating in the data collection process.

As you can tell as Ed highlighted there's a number of challenges including the broad nature and the very nature of the Part B therapy population, and the various interest of the different types of providers of those services. So we look forward to hearing more about your participation.

In the meantime, I'm going to turn this back over to the moderator, Natalie, and she can begin the process of asking and answering questions.

Natalie Highsmith: Okay, thank you , David.

Since we do have participants here in Baltimore and on the phone lines, I want to ask our participants here in Baltimore if you have a question to line up behind this microphone here in the center aisle. If you have a question or a comment, you can line up there now if you wish. We're going to go two questions here in Baltimore and two questions from the phone lines until either are exhausted and then we'll just keep going back and forth until the time has ended or we have exhausted all comments and questions.

So, (Mindy), if you could give the instructions to the participants in how to get into the queue to ask questions. And everyone, please remember when it is your turn, to restate your name; for the phone lines, what state you're calling from and for everyone to restate their name and what provider or organization they're representing today.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, press star and the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

We'll pause for just a moment to compile the Q&A roster.

Natalie Highsmith: Okay. We have a question here in Baltimore.

Bruce Gans: Thank you. I'm Dr. Bruce Gans. I'm here representing several organizations -- the Kessler Institute for Rehabilitation in West Orange, New Jersey; Select Medical Corporation, a national provider of outpatient therapy services; and the American Medical Rehabilitation Providers Association Trade Organization.

I have a number of questions and comments, but feel free to stop me if I'm overplaying my hand.

First, I really like to express my appreciation for holding this open door forum. I think it's very appropriate and we appreciate having the opportunity to have this transparency, the communication and willingness to listen. I think we all share your concerns that this is an important project and I'd like to see it done well, done right. And this effort of communication is really appreciated.

First question I'd like to ask is if the premise is having new payment system is that in addition to paying for things that you do want to pay for, there are things you don't want to pay for because there are services that you think are not perhaps medically appropriate or necessary or whatever. And I wonder if you try to characterize those in any specific way.

If you've been able to look at payment activities, look at services, because in my mind at least, it would be very helpful to you if you knew specifically that there are certain things you wanted to be able to identify because you didn't

think they were appropriate for payment and as a test for whatever tool you've come up with.

And you might want to have somewhat sort of a gold standard for saying this is not medically appropriate, this is not clinically appropriate, so that you have a way of knowing whether the instrument is working itself to filter out things that should be paid for versus things that shouldn't.

So, that's one specific question and I suppose also a suggestion.

Earlier, the comment was made that the whole philosophy is moving towards the sense that setting is sort of not important and the service - payment for the service should be sort of neutral regarding to the setting. And forgive if I'm mischaracterizing the comment, but I would like to suggest that there are at least certain situations I can consider where setting really is terribly critical and essential to the appropriateness for a service. To be silly about it just for example, pay for pool therapy services would make no sense in a facility that didn't have a pool.

So setting can be a very specific and relevant contextual factor for whether payment is appropriate. And I encourage some consideration of other more reasonable and perhaps subtler strategies as the reasons why context would make a difference as to whether payment was appropriate.

A third issue - and I know we talked about this in the technical expert panel. And forgive me if I'm not characterizing your intent properly in regard to the - how to measure the therapy services and payment in a skilled-nursing facility setting or a setting that's not the traditional outpatient setting but something more residential.

And I'd like to suggest that you consider one way of characterizing services that are provided in a residential setting differently whether the purpose of the person being admitted to that facility was to receive services as opposed to the fact that the person is living in that facility and happened to need therapy services, but that wasn't the purpose or intent of the person's stay.

Obviously, somebody's admitted to a skilled-nursing facility for the purpose of receiving the defined program rehabilitation services. That's a quite a different circumstances than if somebody was in a skilled-nursing facility maybe through medical problems, and for some reason develops new onset of back pain and needs the full course of physical therapy that's different. And that might be one strategy that you could look at to help differentiate the purposefulness of the setting.

Another notion is that at least in our current system, we really talk about medical necessity is a reason why services are clinically appropriate and should be covered. And really physicians really do prescribe and refer and certify the delivery of therapy services. And physicians have a big stake in having patients - their patients - have access to patient therapy services.

And I'm going to suggest that you might want to consider getting more formal input from the relevant physician specialty organizations that are the high users and high providers for therapy -- physical medicine and rehab, orthopedics, neurology, neurosurgery. There may be value in getting structured input in some form of TEP someway getting input from that professional group to help give you their perspective of what would be useful, what are the factors that they look at in terms of clinic data collection use and how physicians on therapy practices. I'm sure you're going to want to have some of those as a setting.

So that might be a strategy you could pursue to get additional input that would be helpful.

Natalie Highsmith: Okay. Let me stop you right there and see if our panel wants to address any of those comments.

Edward Drozd: Well I think the first point, the question about appropriateness of services. I think that Dave will correct me if I'm wrong, but out of the - that would whether or not services are appropriate or not would be outside the scope of our particular contract. Not that it is unimportant and not that, you know, CMS shouldn't be interested in that, but the - whether or not services are appropriate at all or in a particular setting or not is outside the scope of what we are specifically doing.

I don't know if anyone from CMS wants to remark further on that.

However, if you do have comments about that, I'm sure that CMS would be very interested in hearing about whether (unintelligible) management needs to do something or whether that would be able to be used for, but we are not - that's outside the scope of what we're doing.

So, if anyone - Bruce, you or anyone else has comments about it, I mean you - we do urge you to - feel free to let us know and we would definitely transmit that information to CMS and also tell CMS as well. And it's important for us to hear that and, you know, I thank all of you, Bruce, and all of you in advance for doing all of that.

Regarding the comment about setting being critical, you know, thank you for expressing that. Our proposal to have the two data collection instruments, I think, is reflective of that. If there are other comments about either we need,

you know, to have - you know, I don't want to have too many of these obviously, because then it starts getting quite difficult to compare. But if there are other comments about that issue, you know, we do encourage that.

Renee Mentnech: Ed, can I interject?

I think around that point in the setting, I think that the - I may have made - and I think the point that we're trying to convey is that you want payment policy to be related to patient need.

Bruce Gans: Uh-huh.

Renee Mentnech: This is particularly an issue on the Part A side...

Bruce Gans: Okay.

Renee Mentnech: ...more so on the Part B side - more so than in the Part B side.

On the Part A side, very similar patients can go to different settings that have associated with them very different payment amount. So it really is an issue on the Part A side. But across Part A and Part B, the take-home message is really that we want payment to be tied to what the patient needed.

Edward Drozd: Uh-huh.

And, Bruce, you had two other points about the residential setting and about medical necessity. And again, those are important issues to note that need to be heard by us and by CMS. So thank you for this comment.

Bruce Gans: Okay.

David Bott In the interest of hearing from other people...

Natalie Highsmith: Okay, (Mindy), you can go to the phone lines, please.

Operator: Your first question comes from (Catherine Anastasio). Your line is open.

(Catherine Anastasio): Hi. I'd like to find out some information. I'm calling from New York and I'm in a private practice setting and I've been doing outpatient physical therapy for over 20 some odd years. And I've been active with the state association working with the local Medicare carriers.

The outpatient tool like you're talking about, this CARE Tool is not familiar to most of us in private practice. Is that the tool that you're saying will become the paper tool that RTI will be using or are you developing something else because I'd like to hear comments about this CARE tool?

Ed Drozd: Okay. Right. So, in the ambulatory setting so, in which it would include private practices, we are putting together a data collection instrument specific for those settings. That include patient reported - set of patient reported items as well as a small set of clinician reported items.

So, we're not proposing to use the CARE Tool and I'm afraid I can't recall the Continuity Assessment Record Evaluation.. I believe… record - Barbara will correct me at the end of what I'm saying here.

That is a tool that CMS is in the process of putting together as Renee Mentnech remarked about using that in the Part A settings, so long-term care hospitals, rehab facilities, skilled-nursing facilities for patients paid under Part A and home health agencies. So, that's a separate data collection instrument

that would have some amendments, additions made to it that we would use in the non-ambulatory settings, nursing facilities. So, in private practices, we would have - we would not be using the CARE Tool but rather a data collection instrument focused specifically on those patients who are ambulatory.

David Bott And so we essentially, we were trying to collect data on patients for all of Part B therapy and we would like to use the same tools but we're faced with the fact that the patient has such a broader range of health status, of functional status that ..and because of the setting, the access to those patients in an institutional thing like a skilled-nursing facility may be more difficult for our patient response tool.

But on the same hand, we have beneficiaries who have a joint replacement and are just looking to improve themselves for their golf game. And to have one tool cover that broad range of population would be a very large number of items and a very complex tool if we try to accomplish that.

Perhaps in the future with a computerized system where select questions can be asked of the people based upon their personal health status and setting, we might be able to get to that point. At this stage, CMS did not have the resources to do that for the outpatient setting. We have to use a paper tool and therefore, we were sort of forced to use a tool that works in one population and another tool that works for the rest as best as possible.

That's one of the binds that we're in, in the current situation; it's not ideal, but we believe RTI is working very hard in engaging the providers to find out how best we can address that problem. And they also have the experts that can tell us in terms of whether our instrument's going to collect the right data or

not, so in one sense this is a feasibility study trying to determine how broad a population we can cover with the tool.

Ed Drozd And by the way, I just want to add a comment that if anyone in the room or on the phone has specific suggestions for domains items or what have you to include in either of those two data collection instruments, we do encourage your suggestions. And this may not be the easiest venue to be able to do that, so through the project email address which could also, you know, access via the website. That one I mentioned before.

(Unintelligible) turn on.

Natalie Highsmith:: Okay. We'll take our next question here from Baltimore.

(Alan Sober): Good afternoon. My name (Alan Sober) and I represent RehabCare. RehabCare is the largest provider of therapy services to the skilled-nursing environment.

One of the issues that you've raised and it's going to continue to be an issue is the setting issue. And I find it something you're not going to be able to really avoid. I agree with you, Renee, you clarified your position about having patients received what the need is regardless of where they get it.

So, to my colleague, Dr. Gans, you know, back pain is back pain whether you have it in the skilled-nursing facility or you walk in and you get in an outpatient clinic, you're still paying, you're still deserving of a care necessary to, you know, that you receive.

On the same token, by defining your study between non-ambulatory and ambulatory, you've inherently separated it by setting, because the non-

ambulatory people go to one place and the ambulatory people go another. So, in some way, I think it'd be wise for the group to just acknowledge that setting will play a role, it will impact in some way what methodology that you come up with. But I think if you hold true to the opportunity for the beneficiary to receive the care that he or she would need regardless of that setting and not because they're in a setting, I think that would be a very wise approach.

Couple of logistics questions for you. One is the industry - RE has a clock ticking and that clock is going to expire on January 2010. And myself and many of my colleagues would love to have this permanently resolved by then. So, we're going to work real hard to figure out something on a more permanent basis to have that resolved. And if we're successful, that leaves you three years left on this deal which may or may not be necessary.

So, I'm interested in your thoughts on that regard if we're successful to get something more on a permanent basis on this payment methodology rather than that. So, those are my two questions. Oh, by the way, how much money do you need to do this electronically?

Renee Mentnech: A lot.

(Alan Sober): A lot? Okay.

((Crosstalk))

Barbara Gage: Could I just respond to the first piece?

The issue where we're going back and forth about setting is by getting the right level of the severity in using an item that reflects the patients appropriate - their level of need, their level of severity. And the problem that we run into

using one small set of item is that you'll have floors and ceilings depending upon how healthy or impaired the patient is.

So, the difference in item, we're working to have a consistent approach and the items that were presented in the technical expert panel, the domains were very similar to the domains within the inpatient behind the CARE Tool. But the exact items that measure that less impaired patient needs to be different than the item that measures the more impaired or you won't pick up the variation, you won't pick up the improvement. And so, that's the basic underlying problem that we're dealing with in selecting those specific items for the outpatient.

(Alan Sober): And, Renee, I think you had - you were responding.

Renee Mentnech: Regarding your one point about the - we actually had several things. I was being somewhat facetious when I said a lot, but in truth it is a lot. We did an electronic platform for the CARE Tool for the Post Acute Care Payment Reform Demonstration that's on the Part A side. It was a very expensive project.

Ideally, in the future, what we would move towards is, because the technology exists, to have some sort of a uniform tool that's available to all provider types that allows for one to enter information, to skip pattern and a very tailored instrument to the patient asset setting at that time. But everyone sort of going against the same source, one uniform tool across all of provider types across A - Part A and Part B. That's I think sort of the future vision. We're not there yet, but I know the technology exists.

As far as what do we do with the remaining three years if something happens and the industry convinces Congress to act in the meantime, it wouldn't be the

first time. We'll have to regroup and figure out what direction to go. But we've had many experiences where we've got a project underway and Congress acts in the meantime.

David Bott: And I can add that you will hear from a number of the providers as we heard from technical experts in the panel that there are a lot of very difficult issues to resolve. And when we put out the RFP for this contract, we actually asked contractors if they could do this in less time, give us a shorter timeline for the development of this project, and we would take that into account when awarding the contract. And nobody was able to do that, because the scientific work that's needed is - it takes time. And we realized that's a problem with...

((Crosstalk))

(Alan Sober): No - and you're correct. I do understand that. I think what's the real point is as you work through these next 12 to 18 months and things do gain momentum legislatively, it would be very helpful to share what you have, so that if things are accelerating and decisions are being made on say maybe less than desirable research data because you need five years, it's still going to be more beneficial if that information comes forward than just to sit and wait. I And think you've commented on that earlier when you started to. So, thank you very much. Thank you.

Natalie Highsmith: Okay. We'll take our next question from the phone line.

Operator: We ask that when you ask a question over the phone line, you please speak a little louder so that the presenters are able to understand your question.

Your next question comes from (Andrew McGill). Your line is open.

Natalie Highsmith: Hi, (Andrew)?

Operator: Mr. (McGill), your line is open.

We will go ahead and take the next question. Your next question comes from (Margaret Fraser). Your line is open.

(Margaret Fraser): We would like to know what the criteria is to participate in the project.

Ed Drozd: Participants would be providers of outpatient therapy services, and any provider who does would be considered. We will have - may have some minimum volume criteria just so that, again, for our data collection it's just easier for the providers that may need some for. But, you know, we're not intending that to be a highly exclusive criteria. We do want to make sure that we have a range of providers. And again, we're not restricting to any particular markets - or set of markets. We're not restricting to urban/rural, whenever we want to be sure to have as much as the range of providers as possible.

David Bott: I might add to that that the strategy for sampling is essentially to get sufficient numbers within each of the types of populations of beneficiaries that receive this Part B services. And yet, we have to recruit providers because it's you, the providers, that will be handling the data collection process and that will be burdened quite a bit with this. And so we haven't place any restrictions upon this except that we need to try to over sample the smaller populations that still have significant problems like cognitive issues or speech problems. Those are a much smaller population than physical therapy, and we'll need to over sample those types of providers.

We would encourage everybody to apply. One of the advantages of having a paper tool is you don't even need to have an electronic health record or an Internet access in your facility in order to participate in this data collection process.

Natalie Highsmith: Okay. We'll take the next question here in Baltimore.

Christina Metzler: Good afternoon. Christina Metzler from American Occupational Therapy Association.

Hello, old friends. We've all been working on these things for a long time. And I've become pretty passionate about some of the aspects to this. And today's presentation has raised a couple of concerns for me and (unintelligible) a little bit of confusion.

First, I think - and this has been said before. We need to understand what are the problems that we're trying to solve. And I think that was referenced by an earlier commenter, what don't we want to pay for. I think we have to recognize the cap with the - is recognized as an ill-conceived policy choice. And that the real Reform of `97 was moving to the fee schedule and making payment equal and even and the same across all settings. And what you also have the same across all setting is the coverage criteria.

And one of the things - couple of things I heard today that are of concern to me are that moving to a patient-centered system of payment is what the fee schedule is all about. That clinician makes the judgment to determine what they're going to provide and the fee schedule determines how much is paid for that service.

The issue of ambulatory and non-ambulatory as previously speakers have noted is, you know, lots of (yellow lights need to be going on about that because it does bring in the issue of setting. And while setting is a factor, once - if you start off splitting setting as the first criteria, I think you're going to end up in inappropriate place in terms of perhaps skewing toward one setting or another, in terms of how much is paid to coverage criteria; all of these patients are the same. The clinical judgment that has to be applied to these patients is the same across board. And what you're trying to do is capture that.

So, be cautious about that ambulatory and non-ambulatory, even as we recognize the breadth of the types of patients involved which involved - which may be why, you know, it's been so troublesome to try to come up with the payment alternative. Maybe this is not the question we should be asking.

The 2006 MedPAC report says who are these people that are getting into therapy and what are we accomplishing in the therapy. Those are critical questions.

And this other thing that made me concerned was that appropriateness is outside the scope of this project. This has to be related to the Medicare coverage criteria. And we can't develop a payment system and come up with payment and possibly even payment amount if we are not looking at the underlying appropriateness of the service. A previous speaker mentioned, what are we going to pay for and what don't we want to pay for. Those things have to be considered.

I think also if you look at the legislative language across these ten years, you will find that Congress did not only want to look at payment alternatives; they did assume that there was an alternative established by the move to the fee

schedule, but they also wanted to look at different ways to manage utilization. And that's one of the other underlying issues that we have to consider here.

When the whole billing system moved away from - moved to less information rather than more information, less review rather than more review, we wanted to be simple, easy, and quick. Well, clinical judgments aren't simple, easy and quick. And our payment systems have to be able to reflect the variety of clinical judgment that's at work.

So that the Congressional language also referenced this managing appropriate utilization, which gets to the appropriateness of care, gets to the amount of care frequency and duration issues. And - but it was not solely focusing on an alternative payment system. And AOTA has always stood firm that we believe that we should continue to be paid on the basis of the physician fee schedule, but that the management options, the utilization review, the ways we determine whether or not people should be getting through the door to therapy, whether they get the right amount of therapy and then what we accomplished with the therapy, those are the questions we need to look at. And the payment needs to be maintained on the physician fee schedule.

Thank you.

Natalie Highsmith:: Okay?

Next question from the phone line, please.

Operator: Your next question comes from (Rose Potacio). Your line is open.

(Rita): Yes. Hello. My name is (Rita). We're from Magee Rehabilitation Hospital in Philadelphia. And we came in on part of this, so please excuse the question if

it's been answered. But we are wondering with this out of cap. Is this also going to be for hospital-based facilities or are we just speaking of ambulatory centers and free-standing facilities?

Ed Drozd: This would include hospital outpatient department, yes. So, if by that, if hospital-based, you mean hospital outpatient department, then yes.

(Rita): Okay, under the Part B.

And when are we looking at it a timeline for this, you're going to do studies on this?

Ed Drozd: During the second year of our project we are aiming to begin data collection. So data collection would be in the second and the third years of the project. So, some time starting, perhaps, in mid 2009 early to mid 2009.

David Bott: Yeah. Can I add to that a little bit that the project is slated to submit an OMB package for the instrument, the data collection instrument, this fall. And then it will depend a little bit on that review process timeline at OMB, the Office of Management and Budget. They will have a 60-day - at least one 60-day comment and review -- public comment and review period that will occur prior to their approval. And so the data collection cannot begin until that approval has occurred. So, you have both an opportunity to comment on the instrument and you have an opportunity to see it better when the data collection can begin based on that review timeline.

(Rita): Okay. Are we looking at amounts? because I know currently, with some of these data cap, isn't it a $1500 cap...

Woman: Seventeen...

(Rita): ...- $1700 cap?

Ed Drozd: Yeah. Well, whatever the current policy is. I mean it's somewhat higher than that, yes.

(Rita): Okay. Thank you.

David Bott: Dorothy, do you want...

((Crosstalk))

Ed Drozd: Yeah. But one thing about the - I'm sorry...

Dorothy Shannon: The current cap is 18, yeah.

(Rita): Okay, yeah.

Natalie Highsmith:: Okay. Next comment here from Baltimore.

Ken Harwood: Thank you. This is Ken Harwood from the American Physical Therapy Association. And first of all we want to recognize both RTI and CMS for actually being open to the comment with the whole process, and we actually valued the time that we spent with you and went through this.

But I think, Barbara, you brought up a point that I think one of our major concerns with the whole project is really that an issue of both looking at a fairly complex - not fairly, a complex patient base that has probably multiple domains that need to be assessed and multiple domain thresholds, which

basically need to be assessed as we pick our patients that require assessment and require care.

In addition to that, I guess in my thought process too, so you have this fairly complex methodology that you need to and somehow pick up through your assessment tool. But in addition, you need to address clinical utility -- I mean it can't be obviously something that's going to take three hours per patient to fill out -- and then also making sure that you're going back to the premise of Medicare is to make sure that services that are required are in fact given and given appropriately.

So I guess my concern at this point is during that analysis phase, how are you going to assess clinical utility? That is how are you going to make sure that this actually is a process that the clinician can not only do, but do efficiently in an effective way, especially if it's based on a paper-based system, as well as just showing our cases that really do require to be assessed and the provided services are in fact not - we're not going to leave people out.

Thank you.

Ed Drozd: So thank you.

In regard to the question about ensuring the clinical utility -- and we call it trying to minimize burden -- and in fact even prior to the analysis phase, first through comments and suggestions now and throughout the process, you know, we certainly want to take into consideration the burden to patients and to providers.

Second, during the data collection process, well, prior to any pilot collection that we will do as well as (promulgated) collection, we will get a much better

understanding of the burden that it is - various items, and sets of items, whatever, would place on patients and providers and that is something certainly we would take into consideration.

So, you know what, throughout the process, we do encourage the comments and experience with the various data collection instruments that we will field with regard to burden. And that is something that we are mindful of and would certainly advise CMS on.

Natalie Highsmith: Okay, next comment from phone lines, please.

Operator: Your first question comes from (Cindy Weather). Your line is open.

(Cindy Weather): In regards to what tools that you're going to be using, how will you accommodate a facility that has a combination of both ambulatory patients and the non-ambulatory patients? Will you be restricted to one type of data collection tool or will we have the option of using either?

Ed Drozd: That's a very good question.

You know, first I'll give my, you know, the reply of, you know, we certainly are interested in recommendations of what to do about that and it's certainly not something that we have finalized in our thoughts yet. But we do understand that it is a potential issue. And it could be that when we are in recruitment phase, some providers may be interested in both, some may only be interested in one type of their - one set of their patients being included.

But if anyone has suggestions and recommendations on what to do we are - we encourage them to let us know.

David Bott: Well, the one thing I wanted to add is that that kind of situation is something that we need to have our attention drawn to, what are the different settings and conditions in which this data collection will occur, and what problems there will be in administering the instrument. The more those of kind of questions and issues that you raise - we have them raised at the technical expert panel as well, although we were focusing more on the content at that time. But the administration is a big issue and it seems that we would want to have your type of facility involved in the data collection process because that is important for us to understand it, even if this is only a tool designed for this particular project and not for the long term.

(Cindy Weather): Okay, thank you.

Natalie Highsmith: Okay.

Next comment here in Baltimore.

(Carolyn Zoller): (Joan Salem) with the American Medical Rehabilitation Providers Association. It's nice to see everybody.

I just want to reiterate some principles that we had suggested early in this process to the chairman of our Outpatient Committee and that probably maybe redundant; two things that said earlier. And that’s to look at our organizing principles as you’re picking the items and picking the domain is what is the need for these services, what if - should they’d be continued is the patient continuing to benefit? And then the black box, how can you show that the therapy actual made a difference, and how well the patient turned out? So that is the black box.

And the other thing is we talked a lot about - I want to reiterate here, is that looking at items that in what explanatory statement has made about the tool at the time the study is implemented that it's very clear, you know, what things are (ambulatory) potential payment in the items and what things might be strictly for outcomes quality – (we use those unintelligible) for the moment -- and then which might be an item that could go both ways. Because I think sometimes it may - and that also may lead to a burden issue.

So I just wanted to reiterate those points. And thank you for again, I would echo, I believe it was (Alan's) comment regarding the transparency CMS is using in this process and also that's been used in the CARE Tool and encourage you to do so.

Thank you.

Ed Drozd: Thank you.

Natalie Highsmith: Okay, next comment from the phone line.

Operator: Your first question comes from (Heidi Wood).

Your line is open.

(Danielle): Hi. This is actually (Danielle) from Dragonfly Therapy with (Heidi).

We are a seven-therapist practice (PT-OT) in private practice. We have the large Medicare geriatric population. And we are seeing patients within our clinic, in their home, so again we run into two different setting, which I believe is going to be an issue. I also think that it's a huge (undertaking) creating one tool that can take into account setting, the diagnosis in a one tool

that can be vertigo, incontinence, (unintelligible) (department, pharmacology), in addition to taking into consideration that comorbidities like dementia and diabetes.

I also am very concerned about less the ambulatory and non-ambulatory and more the consideration for cognitively impaired and non-cognitively impaired. You made reference earlier that the assessment tool would have a patient portion and a clinician portion and many of our patients have dementia or memory issues and them filling out a portion where (reporting to us a portion) would not lead to an accurate measure.

And finally I would be curious to know how you're defining ambulatory versus non-ambulatory? Is the patient, the therapist defining this? Is it physical or a functional definition? And I believe that's it.

Ed Drozd: Okay, thank you.

With regard to the last point on the ambulatory, non-ambulatory, generally, they will be, you know, we're principally thinking about the setting, however if there are other comments about if you - if people have a better definition of how to practically with a paper data collection instrument be able to reflect the different assessment needs in the sense of avoiding ceiling and floor effects and such on a particular item and making sure that items are appropriate for particular patient, you know, we do, really do, encourage any feedback that anyone here in person or on the phone may have.

With regard to patients with a dementia, I'll broaden that to say that we are in the process of trying to develop a way of identifying whether the proxies - well - how to get a proxy to report rather than the patient because there may

be circumstances in which the patient is unable to respond for themselves but where a proxy would be entirely appropriate.

So in those situations we also do encourage if anyone has suggestions and especially from experience where some of you maybe using existing assessment tools that focus on patient report, but where proxies are used. So if anyone has suggestions on that as well to advise us as we are developing criteria for a proxy report.

Woman: And I can say that we have in our clinical use (Optimal) with other patients (unintelligible) report tool. And we find that people who have dementia or memory to drive cognitive impairment, it's not worth using and it's not worth using a proxy, and it's better to use an objective measure because we find that's more reliable if in focusing on what is the outcome.

Ed Drozd: Okay. Thank you very much.

Natalie Highsmith: Next comment here in Baltimore.

(Larry Lane): Larry Lane with Genesis HealthCare, I share (Christine's) comment: it is nice; second decade of us coming together that we talk about the same issue.

A couple of comments if I could. First, I appreciate that CMS is finally focusing with seriousness on this issue. It's been a decade when the therapy cap was put in. There was language in that cap language in (BBA) that talked about a study focusing on some of the things we've been talking about. And it just seems that it's - has not had the priority. So we appreciate that it's getting some attention and getting some priority.

At the same time, I share (Alan Sober's) point that we are left continually with a overhang as it deals with the exception process, at the same time that a five-year study when you have an 18-month reprieve from the warden doesn't necessarily help at practitioner level.

Principal comments would be one, I'm a little concerned as - and Joanne served on the TEP and obviously we worked together on this stuff. A little concerned that there seems to be a starting from square one and not building particularly on the work that CSC did, the OTAP studies, even Urban Institute studies that were done. And I want to - I know there's always a time for a separate direction, but I'm not sure if we are missing some opportunities by not dusting off the decade of work that has been done. And I would urge to be the study group to take very careful note on that.

B'cause it also then leads - so the other series of concerns that I have and that is the product at the end of this. If you've got "200 sites" which I think you were talking about and in my mind I just run through the old (Don Muse) study of this isn't a continuum but a lattice people entered get services and flow through the system based upon their need, not necessarily on variables that may be self-assessed.

The - I see us potentially at the end of a five-year period having something that just may not get us anywhere. And that is what my biggest concern is that there doesn't seem to be a very clear articulation, this stratification that you're using whether it's going to be stratified based upon the clinical nature of the study of the items that (Moran) identified or that OTAP-that CSC- identified that at least allows us to begin to look back at where things have been and how do we stratified it.

But then you take that stratification and you start looking at settings and you all of a sudden 200 sites you got -I mean the variables that affect. And there's enough studies that have been done on those variables that essentially I have a sense at the end of it, we have a study that might be a vapor that doesn't clearly get us to some policy conclusion, might look good in a journal article, but don't get us to a point that we've make systematic change.

And I would say that I think we need to look much more careful and I would, Dave, to you when you put the stuff into OMB, I would hope that a stratification plan or at least the sampling cohort and some explanation of them would be allowed because, you know, having years of looked at this stratification issue and just the SNF side gives me some great concerns that you come up with 10 facilities and how representative, are 10 facilities across a setting where there are 15,000 different facilities.

One point I would suggest that I would say maybe as a recommendation, I know the three professional groups have done some serious work on this. I know that a number of the trade groups, AHCA and NASL have done some work on this, I think you ought to build in some sort of validation plan, some potentially tapping in the data that is being done by them.

You may be the science, but we are the guys doing the business today. And I would clearly say that, you know, I think there is a potential here for partnering that would broaden some of the items that you're doing with what has already been collected over a decade and that we may be able to truncate some of the steps here.

My final point -- a 53-item self-assessment won't work. Period. And I think (Joanne) has already in her letter back to you has identified from our

perspective it just does not work. You scared our patients away and/or they are not capable of doing it in the care professional (unintelligible).

Barbara Gage: Larry, thank you for your comment.

The - and just to reassure you and the rest of the field that we have built - and thank you for the compliment on our - from our work at urban. We have been - we are building on the science. Part of our team is the FOTO folks and the AM-PAC folks we have been consulting with, the OPTIMAL folks, and the ASHA and the other parts of the field because we believe very intensely in building on the science and not reinventing the wheel. So thank you for bringing that up today. We appreciate your comments about the 53-item.

The tool that (Larry) is referring to is the material that we circulated at the technical expert panel. It's not a tool by definition. It was a set of items. The purpose of the panel was to help us think through what types of domains are important, how would you measure that. We had a lot of people around the table that came from different settings to - so that there would be input in thinking about their respective patient population, thus this do we need to measure this domain in order to have baseline information on complexity, is this the appropriate item for measuring my type of patient, is it the appropriate item for measuring your type of patient. So we're just at the very beginning of this effort and we agree wholeheartedly a 53-item tool is not that way to go.

So we are and once again as Ed keeps repeating, we are looking for inputs in the field. You're each treating different types of patients; this needs to be used across the Medicare population. And we are looking for feedback in terms of the types of items that you currently use. Many of you use - there are the basic issues that there are many ways to measure your patients. And even the four leading measurement systems each approached inpatient measurement

differently. So until there is a consensus in the field, we're really looking for input from all of the practitioners to identify what makes the most sense.

David Bott: And I just wanted to add from a project management perspective that in the contract, one of the tasks is stakeholder engagement. We made sure that that is something that is continuous and ongoing. This open door forum is one aspect of that. So we are working with the groups. RTI's met the professional groups you've mentioned before.

We are also looking for opportunities to analyze and build on the data and work that has already been done. And so if there are datasets that you think are appropriate and available to CMS for informing this work, please let us know.

Ed Drozd: And one final comment on voting on prior studies, you know, the CSC-Advanced Med work, you know, one of the things that they did identify was that the existing, you know, currently CMS does not have at its disposal the ability to just take the existing instrument and just comparing them across each other and so that additional work would -- is necessary. And certainly the prior work that CMS has contracted has certainly informed some of the work that we do.

Larry Lane: Just comment on the stratification (unintelligible).

Man: Oh, yes. Certainly we will - you will be in the Paper Reduction Act material that we submitted to OMB. There certainly will be the stratification of the different types of facilities. We want to make sure that it's - the facility - that providers that we include - sorry, providers who we include are not haphazardly chosen, but rather make sure that we have representation of the - as much of the variation in providers providing this care as possible. So we do

take seriously the fact that it is important to have the range of providers included in our sample frame, and that it would be systematic rather than haphazard.

Natalie Highsmith: Okay. Next comment from the phone line.

Operator: Your next question comes from (Selena Horner). Your line is open.

(Selena Horner): Hi. I have a question for you guys which regards to the single tool. I have concerns over it because in my practice -- I'm in Michigan -- in a small practice that I own and I use the (PF-10) along with the condition specific tool.

The problem that you're going to have with this general tool is what they're mentioning - the feasibility- of having too many items on the tool which means it will take too much time to complete that tool. And with the timeframe that you're talking about, will you guys be able to have the psychometric properties determined and will you also be able to determine their minimal clinically important differences for that tool.

And the other problem you might have doing one tool across a very large population is that you may have differences in your minimally clinically important differences depending on the patient that you're seeing in front of you.

So I'm not sure how you're going to be able to define your effectiveness and your effectiveness is supposedly going to be tied to your payment alternatives. Would there be a way since it sounds like that’s going to be your biggest barrier. Would there be a way when you look at the OTAP2 data out there to instead, look at maybe what’s your best top 6 diagnoses that are seen when

you're looking at report, and then use the condition specific tool for those types of diagnosis so you would have more valuable information as you're making your decisions in moving forward.

Ed Drozd: Thank you.

With regards to the issue of trying to use a single tool, or two data collection instruments I guess in case, is we are trying to adopt a core and supplemental type of approach where it is - we don't expect it to be the case -- that each and every patient would respond to each and every item, several items that do not apply and that would be skipped over.

So, and that said, we try to incorporate that logic from the get-go so that we're not unduly burdening patients with items that would not be appropriate.

With regard to the condition specific, we are trying to as much as possible use the more of a universal assessment approach that is something - certainly that is out there, the more condition specific assessment items. We want to be able to have as much comparability across the items as we can. And so, that's why we're adopting a more - for those couple of reasons, a more universal approach. However, to the extent that there we - people have feedback that they'd like to give us on that, we do encourage it.

Natalie Highsmith: Okay. Next comment from the phone.

Operator: Your next question comes from (Julie Ramsey). Your line is open.

(Mike White): This is (Mike White) also with Fairview Health Services in Minneapolis sitting here with (Julie).

Our question is related to what we were just talking about and really - so we got to mix this a little bit to add. One is, in a practice setting when we're - could we just talk about kind of the universal assessment tool? And the first part of the question, does that involve kind of a multi-disciplinary approach, so the PT, OT and speech?

And then also thinking about back to the ambulatory versus non-ambulatory care setting and we think about just ambulatory in this case, we've got a situation where we've got a very - kind of a unique ambulatory care setting where we see a lot of very complex neuro-based patients where sometimes it's even questionable whether they should perhaps be in a skilled-nursing setting as opposed to another one of our sites that sees a very orthopedic-based outpatient, very, very different patients but both considered under this criteria, ambulatory. And how do we - is the tool universal enough to cover those very different patients in an ambulatory care setting?

Ed Drozd: Okay. Thank you.

To your first question regarding multi-disciplinary approach, we certainly are taking that rather than having separate tools, separate data collection instruments for the- based on the discipline of the therapist.

Second, regarding the ambulatory versus non-ambulatory, -- we agree that they are, you know, I'll call them grey areas but you know, they could be large. And we seek your advice on that. That if there are additional criteria that people might suggest for trying to identify patients for whom a data collection instrument that includes more medical requesting information and more the medical condition of a patient, et cetera. We certainly seek feedback on suggestions on additional or alternative criteria.

Barbara Gage: These are the type of issues that are clinical (unintelligible) is considering, you know. We're all speaking as so the tool is set and still in development. That's the work that's going on.

Ed Drozd: Yes, exactly. So that's why we're seeking your feedback is so that we can be sure that we hear as many voices as we can. Maybe that didn't come out right.

Woman: Okay. Then, (Mindy)...

Man: But I think you understand what I'm trying to say.

Natalie Highsmith: Okay. (Mindy), next comments from the phone, please.

Operator: Your next question comes from (Mick Bates). Your line is open.

(Mick Bates): Yes, good afternoon. I'm calling from West Virginia and I'm a physical therapist in (unintelligible) practice here. I also serve on the American Physical Therapy Association Advisory Panel on reimbursement policy and planning and involved with the chapter here locally on reimbursement issues.

I got one comment and then I want to follow up on Ken Harwood's question about clinical utility and burden. I think the first thing is that we need to move away from this ambulatory/non-ambulatory description of the different tools. I think it's misleading and confusing as far as setting is concerned. And some of the method of describing these based upon their residential status or their community-dwelling status might be a better way of classifying these different tools. So that's a comment.

The question that I have is related to clinical utility and burden with the ambulatory tool, and I got to use that term because that's the one we're using.

The ambulatory term - ambulatory tool and the burden, both the self report and also the clinician, prior to the OMB review, are you in a position to comment about how long that is going to take to administer, self report and also the clinical tool and whether or not that data question instrument would be administered one time on multiple occasions, how would you see that occur?

Thank you.

Ed Drozd: Thank you.

We have regarding to your question regarding burden, we are - have conducted some very preliminary pilot testing and we will do somewhat larger scale pilot testing prior to OMB to try to understand how long it is taking patients to complete the form. I mean it's not our intention to have an extremely time-intensive data collection for patients. We want the patients to actually stay for their appointment.

(Mick Bates): Yes.

Man: And regarding the number of times that data would be collected, we are envisioning an admission tool - admission data collection instrument and a discharge data collection instrument potentially what we might call an Interim one. You know, we want again to want to have a multiplicity of data collection and, you know, particularly from the discharge.

On the discharge side, there could be issues of when is the discharge or not, and we're continuing to think through those ideas and encourage your feedback on how we can identify an endpoint or near endpoint.

And for those, the items that generally would not change for patient or would be more focused for --potentially more focused --for case mix may only be asked on the admission tool, so that, you know, the discharge one. It could be somewhat shorter or have a somewhat different set of items that would be more appropriate for a second data collection instrument for that patient as opposed to what one would want to take on intake.

Dave, do you want to add?

David Bott: This is David Bott as well. And I just wanted to add that we did address this question in the (TEP) even though it was an administration question rather than a content question and domain question. And we got a number of different potential strategies given to us. We think there are more out there. I've been going on preceptorship visits through a CMS program that allows me to go to facilities and see how things are - how care is delivered, what are the average person, you know, the average providers' problems or the non-average providers' problem. And one other question is how do we administer this. And so I've been taking notes on those visits and passing that to RTI for their consideration.

So I don't think we've come up with an answer yet, but we have a number of strategies that we have been offered.

Barbara Gage: And we've also been building - our colleagues are out there via the phone. So we've been building on some of the efforts that have been founded by the AM-PAC team and the FOTO team members.

So when it comes to your level of care, we are bringing in the expertise from the current mode of administration and collection data with your population.

Alan, do you want to add anything to that?

Okay.

Ed Drozd: Well maybe he doesn't.

Natalie Highsmith: Okay. Next comment from the phone.

Operator: Your next question comes from (Peter Clendenon). Your line is open.

(Peter Clendenon): Good afternoon everybody. This sounds like almost like in an alumni reunion of source with the number of source on it.

I represent the National Association to the Support of Long Term Care and we have a wide group of therapy companies, primarily contract therapy companies that provide therapy in the SNF setting, also on other settings in home care and other settings.

You've gotten some awfully good comments this afternoon. I think the one thing that we're very concerned with and particularly an early stage, you seem to interchange data collection and an assessment tool. And as I've listened to the call, I'm a little confused. And we spent some time with you, Barbara and Dave and Ed, I guess it was about a month or two back, talking about the approach we took.

The assessment tools as you know is at various stages of the development in different professions. I don't believe there's one that links with three disciplines. The approach we would suggest instead is take the exact medical conditions and patient characteristics that you can obtain from medical records, from the MDS, from OASIS, from good original documents and

describe the patient characteristics which CMS as part of different congressional directives has been asked to do for a number of years now and work to a data collection process from that approach, and then later if you can, try to predict the amount of therapy from that as opposed to what I think - what I hear you describing is an assessment process at the front end.

Obviously, I think this takes a much longer discussion than we have today and we would be glad to work with you on that. But it seems like you have a very good opportunity early on to not commit yourself fully to a patient assessment but instead collect objective medical data that already exists on each of these patients.

Ed Drozd: Thank you.

And, you know, we are trying to, you know, that's kind of a general approach we're going to take, which that as it has been recognized by others, there are for certain types of patients and whatnot, there may not be as comparable information across those patients as there may be in other settings or from other providers. So, I mean, this continues to be our challenge but we do - would like to work with - any of you on the phone or in here to help develop this process. So thank you.

Natalie Highsmith: Okay. Next comment here in Baltimore.

Christina Metzler: Christina Metzler from American Occupational Therapy Association. Sorry to come back again.

And I do want to echo everybody's comments that this project and particularly the convening of the technical expert panel was the first time that we were able to do this around therapy payment issues. But I know we've talked about

the connections with the PAC CARE Tool. What about the connections with the Physician Quality Reporting Initiative which seems to be a parallel track that - a parallel effort along the same track to ensure appropriate for services that patients need?

Renee Mentnech: It's not currently part of the scope of this contract, though, I think you raised a very interesting point which is, you know, sort of looking at the quality piece of the relationship between quality and payment. And I think ultimately that where the agency wants to go anyway.

And I believe that there are measures related to therapy that are part of the PQRI collection effort. That's something we can sort of go back and think about it. It's not currently part of the scope of work but - and it may not be something that we can tackle given that this is already a very complex project. But...

David Bott: I have had conversations with one of the persons in OCSQ has been working on PQRI and on outcomes measures, and we have been setting up dialogue and meetings to talk about what kind of measures we're using and whether they have any developmental information that could inform our project.

But as Renee mentioned, there was no explicit connection between PQRI and this project at this stage.

Natalie Highsmith:: Okay. Next comment from the phone line.

Operator: Your next question comes from (Dianne Wosum). Your line is open.

(Dianne Wosum) Good afternoon. I'm a facility manager in a rather large facility in Charlotte, North Carolina, and my question to you is how we can us as facility managers

prepare our clinicians for being successful in this new proposed payment system?

Ed Drozd: Thank you.

You know, CMS can expand upon this, but we are not - the purpose of this project is not to propose a - develop a payment system per se but rather some alternatives to the existing payment system.

Now with regards to data collection under this project, you know, we definitely do encourage providers to signal their potential interest to us. And, you know, this is a statement ought to make is that we would provide the people are who are helping us support the project and each of the facilities with a variety of materials and regional trainings.

But I'll turn it over to CMS to discuss the issues regarding payment systems versus this project.

David Bott: Even though this project has payment alternatives in the title, it is not at the endpoint going to produce a new payment policy.

We're not even a demonstration in which payment - current payment policy could be waived. We don't have authority as well. But we're doing is working on collecting the data that might inform the options that we can have at CMS for new payment policy.

So in terms of preparing your providers for new payment policy, I would suggest that they just continue with the current preparation for the current payment system. There is certainly interest in changing that as soon as

possible for the therapy caps as we've heard earlier today. But this project is not directly going to change payment policy.

Barbara Gage: This is a nice opportunity to get involved as a provider and as well as some of the other things, right?

Ed Drozd: Indeed.

Natalie Highsmith: Okay. Next comment from the phone, please.

Operator: Your next question comes from (Catherine Anastasio). Your line is open.

(Catherine Anastasio): Hi. Again, thanks for taking my call. And as a clinician in New York and as a member of the New York Physical Therapy Association, I am (Catherine Anastasio) and I have a couple of follow-up comments.

The gentleman -- and I'm not sure who answered the question in Baltimore -- suggested that these tools that will be developed -- the tool, exactly, that will be developed will have items that will not be specific to certain patient populations and they'll just skip over them. Well, I find that that's definitely going to be a burdensome in a Medicare population and in a practice setting.

And eventually, the intent - and the intent of this demonstration project, and this is a followup on the previous caller's question, that in a clinical setting, eventually it seems that this tool would be developed so that CMS could use it to develop a pay-for-performance model. And I have several concerns with the development of a tool that's going so (broad and) to cover all these different setting types and the various diagnosis type and actually be specific enough to show gradations and outcome improvement in all these settings so

that a provider is going to be appropriately reimbursed for the services that they are providing.

And I think if you're looking for - I am hoping that there will be different tools for occupational and physical therapy versus speech and language pathology. So I am concerned about understanding more of this. And I did read some of your information on your Web site while I was listening to the call. So I'm happy to hear that there is some input that is going to be asked for. But I would like to know are there going to be separate tools for the different special - of the different therapy specialties and is it the intent at the end of this project for CMS to use some kind of an outcome measure and linking it to pay for performance?

Ed Drozd: Okay. Two - there're, you know, I guess two questions. One is regarding whether we are having discipline/therapy specific data collection and we are certainly trying to avoid that just to be consistent with the other efforts that CMS has underway to reduce the number of different assessment instruments that exist to improve the comparability, recognizing the fact that different types of settings, providers or whatnot may have different models of patient care where there's more cross-discipline work potentially and wanting to avoid multiplicity of assessment items for all practitioner - for all the providers who are using them.

The second - and forgive me. Oh. Regarding outcomes and pay-for-performance, that is something that we have been asked in our scope to consider and, you know, that is something for which we would examine feasibility. But in terms of more specifics, you know, if anyone at CMS has some comment.

Renee Mentnech: I can add to that.

I think it's pretty clear that there's a desire across all payment systems to move towards value-based purchasing. So I would say that that is the future direction. I can't say when that will happen.

Our role here is to do the research to inform the policymakers. So we here sitting at this table won't make that kind of a decision. What we will do is the research that helps those who need to make those decisions make those decisions. But I can say that value-based purchasing is something that many are interested in.

(Catherine Anastasio): Thank you.

Operator: Your next question comes from (Gale Bloom). Your line is open.

(Gale Bloom): Yes, Medicare already has very specific guidelines on what needs to be on our documentation. And that serves all the different population well. And I wonder what's going to be in an assessment tool that isn't already required for payment in our evaluation and treatment form.

Ed Drozd: Would you be able to remark on the particular setting, the hospital outpatient, nursing facility, private practice and the specific requirement to which you're referring?

(Gale Bloom): I'm in a private practice setting. But in order to receive payment, anybody - any therapist who received payment from Medicare has to get subjective information from the patient. We have to have measurable goals and outcomes. They have to be patient-generated and patient-centered.

So a lot of the information that will be gained from a form, and it sounds like one form isn't an idea that a lot of people want to have. A lot of the information that needs to be gained is already in our documentation.

Ed Drozd: If you set the documentations that you may need to - so that you have the goals and such as the plan of care for therapy, you know, that is not something that would change necessarily. You know, that's an entirely different area than what we are trying to speak to here.

What we are trying to do is collect information and understand the feasibility of collecting assessment data for case mix, adjustment, and the feasibility for whether it could be used for outcomes measurement. But other documentation you may need to provide for payment, unless other changes are made, we continue to be a part of what you need to do. This is kind a separate piece.

(Gale Bloom): Right. And a lot of what's been discussed as far as we have a diagnosis information, we have number of visits per diagnosis, we have our documentation on what the different comorbidities are in our notes; That's a lot of the information that people have been talking about today already exist in their documentation. And as far as case mix, I'm not sure what you're referring to.

Ed Drozd: Well with regard to the information about diagnosis, comorbidities and such that one that would be submitted in a bill, it is - others - many others have noted that such information would not be sufficient for understanding the differences in patients that might be useful in at least for - may adjusting payments.

So that's kind of the case mix adjustment component. To the extent that for the exceptions processes, there are certain recommended assessment items.

Again, you know, during this whole process, you know, no changes to payment are - none of the existing payment rules have been waived at all. And a part of therapy - part of the payment alternatives would include alternative to current cap exceptions process.

(Gale Bloom): Okay.

I believe a lot of the information that you want is in the narrative evaluation that we already do.

((Crosstalk))

(Gale Bloom): ...evaluation and the reevaluations that we do on our patients. So the information already exists in the patient's chart. That was my point.

Ed Drozd: Well, thank you.

(Gale Bloom): Thank you.

Operator: Your next question comes from Marc Schaffer. Your line is open.

Marc Schaffer: Yes. I'm an occupational therapist in Cleveland, Ohio. I'm a rehab director at a very large skilled-nursing facility with also an assisted living. I'm also the President of the Ohio Occupational Therapy Association.

My concern is the non-ambulatory versus the ambulatory because I do have an outpatient and with the skilled-nursing facility. So I think that looking at the non-ambulatory versus ambulatory is a moot point because whether you're in a non-ambulatory setting or you're in ambulatory setting, we're still providing as therapists the same exact treatments, okay? That's the first thing.

The other thing that I was - I also agree with the PT from New York when he had asked the question in regards to about is there going to be a combined assessment tool between OT/PT and speech or separate. I truly believe it should be three separate tools, discipline specific. You're comparing apples and oranges when you're looking at the three different disciplines. It's not the same across the board. And the Medicare guideline itself specifies what OT can do, what PT can do and what speech can do. So I wanted to thank you.

And as far as the case mix adjusting, I heard that term as far as case mix looking at it for adjustments. Can you be a little more specific about what you're talking about with how is that kind of adjustment? I heard in regards to, you know, the different comorbidities and things like that, if you ever take a look at the diagnosis of people in long term care, there's about 30 different diagnoses. So if you could just expand upon that, I appreciate it. Thank you.

Ed Drozd: Thank you for your comments and suggestions.

With regard to case mix adjustment, the idea would be that some aspect of payment would be adjusted, modified based on diagnosis, function, other characteristics that would be collected in an assessment instrument rather than what is currently the case.

So, that’s what we’re intending is that there’s some aspect of payment would be based on some underlying patient characteristics. That might - may include diagnosis or function or pain, impairments, cognitive status, et cetera. None of which by the way we’re saying would be the case just that we are trying to collect the information to see if those or others would be feasible and potentially useful adjusters - case mix - adjusters to payment.

Natalie Highsmith:: Okay, (Mindy), we have reached our 4 o'clock hour here on the East Coast. Thank you all again for joining us.

David, did you have any closing remarks?

David Bott: I just wanted to thank everyone who came here in person as well as attended and asked questions on the phone. I wanted to remind you all that if you have a question that you did not get to ask or you have comments you did not get to state, we do have the email addresses. That was optherapy-comment@rti.org. And for our direct email to CMS, it's dotpa@cms.hhs.gov.

And we thank you again for your participation and we look forward to hearing from your more in the future and working with you.

Ed Drozd: Thank you.

Natalie Highsmith:: (Mindy), can you tell us how many people joined us on the phone?

Operator: We had 490 participants.

Natalie Highsmith: Wonderful. Thank you.

Operator: This concludes today's Centers for Medicare and Medicaid Services Special Open Door Forum on Developing Outpatient Therapy Payment Alternatives. You may now disconnect your lines.

END