June 25, 2012

9:00 a.m. – 4:00 p.m.

MEETING OF THE
MEDICARE ECONOMIC INDEX TECHNICAL ADVISORY PANEL

Held at:
Centers for Medicare & Medicaid Services
Media Center
7500 Security Boulevard
Baltimore, MD 21244

CART Services Provided by:
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Home Team Captions

>> John Poisal: Good morning. We're just about at the time for the break.

[Laughter]

We'll go ahead and get started. We have everybody back. I want to thank everybody for their attendance and thank the panelists once again for making their way into town. I was joking earlier that we're already ahead of the first meeting in that it wasn't raining this morning. So that's a plus.

Just a few housekeeping issues before we get started. If everybody would just silence their phones and Blackberries, that would be helpful. You do not have to turn off this time as we had to last time. The transcriptionist is doing it the complicated way or a way I would never be able to do myself but no need to turn off cell phones today.

We do ask for the attendees that the conversation and the dialogue be limited to the table unless we ask a question directly of somebody. We do have a public comment period at the end of the day that the chairman will recognize when we get there.

Ernie, it's up to you how you would like to proceed. We have the agenda about how we thought things might play out with suggested times. But that is certainly as flexible or as stringent as you and your colleagues would like it to be.

>> Dr. Ernst Berndt: Any amendments to the suggested agenda? Let's go forward then.

>> John Poisal: Ok. I don't know if we should go around the table. We kind of have name tags out but for anybody that might be new for the second, probably not a bad idea.

I'm John Poisal, Deputy Director of the National Statistics Group. I'm also the Designated Federal Officer to help with the panel. So I wear multiple hats. I direct the work that's associated with the market baskets, directed on Steve's and Rick's behalf, associated with the market baskets and the Medicare Economic Index.

>> Dr. Ernie Berndt: Ernie Berndt, MIT Sloan School and Harvard MIT Division of Health Science and Technology.

>> Bruce Steinwald: Bruce Steinwald. I'm here through the firm that CMS contracted with HCDI. It's my principal responsibility to write your report.

>> Kathryn Kobe: Kathryn Kobe. I'm from ECS. I'm an economist.

>> Dr. Kurt Gillis: Kurt Gillis from AMA, economist.

>> Dr. Robert Berenson: I'm Bob Berenson. I'm a physician, and I am a Fellow at the Urban Institute. I will be doing a lot of standing today because my back is sort of out. It's nothing personal. But I may be standing, pacing a bit.

>> Dr. Zachary Dyckman: I'm Zach Dyckman. I'm a healthcare economist, and I'm self-employed at Dyckman and Associates.

>> Rick Foster: Rick Foster, Chief Actuary for CMS.

>> Steve Heffler: I'm Steve Heffler. I'm the Director of the National Health Statistics Group and also the Actuary at CMS.

>> Dr. Ernst Berndt: How do you want to proceed with the summaries of the meetings?

>> John Poisal: I think what we thought we would do is suggested we allot some time to speak to these issues but it's up to the panel to determine sort of the extent to which we would like to go back over these things. I don't know if there were any lingering questions or additional follow-ups that we might be able to either answer today or answer between now and what we expect will be probably a third meeting.

>> Dr. Robert Berenson: I have just one thing I want to add. Its commentary and then a question. Ernie, you sent around an article from "The Times" by Gardiner Harris on sort of the reasons why docs are getting employed. I don't know if we need to discuss that or not.

I guess my question is, does it matter for our work? Because I thought there were some things wrong with that article. I've done some writing in this area myself, but I don't know how useful it is to get into why docs are getting employed

or anything like that. Does it really matter to what we're doing I guess is my question.

>> Dr. Ernie Berndt: I don't know the answer to that. The reason I raised the issue was because there is a perception that there's a shift of physician office practice away from the onesie-twosies to larger groups to hospitals, and to the extent that we affect the composition of expenses in a typical physician office, that could have an impact on our MEI. So I just – yeah, I sent that around for purposes of eliciting a discussion rather than having a particular point of view. So I'd be very curious what your --

>> Dr. Robert Berenson: No, I just -- I thought most of it was right. I do think they're overestimating some of the employment related to one and two become ACO's and taking financial risk, because some of it is much more concretely about provider-based payment, differentials, cardiologists, in particular, for whom the payment to an outpatient department is significantly higher than it is in a physician's office. So it's an immediate ability to generate hospital revenues in the fee-for-service system.

The other thing related to that is -- in all the interviewing I've been doing with center for studying health system change the hospitals are trying to avoid the mistake they made in the 90's of just putting docs on salary by giving them productivity incentives which are basically based on work RVU's off the Medicare fee schedule. So there's sort of -- on the one hand sort of this aspiration that there will be integrated groups and doing shared savings or even full capitation. And at the same time, in the short term, it really seems to be a fee-for-service payment model that they are reinforcing. There are lots of other reasons I think that physicians want to now be employed. I just thought that article in particular overemphasized the aspirational part of the employment rather than some of these practical taking advantage of the provider-based payment differentials as well as reinforcing productivity incentives.

Again, I'm not sure. I do get the point that if a large number of physicians are now employed, what does that say about who's remaining and then do their cost structures differ. I think that would be the major thing we would want to be

thinking about rather than really the motivation for why physicians were getting employed.

>> Dr. Ernie Berndt: Do you have any suggestions, Bob, as to how to proceed?

>> Dr. Robert Berenson: Just being aware of that. I don't know what that says about -- I mean I do think that the onesies and twosies will sort of fade, but not right now. I mean right now there's still a large residual. So I'm not sure that it has any particular implications, but I'm open to -- no, so I don't have specific suggestions.

>> Dr. Ernie Berndt: Kate, sent around some materials from the census I believe.

>> Kathryn Kobe: I sent around the SBSB data, the statistics for U.S. businesses which through 2009 are not showing a huge shift between the size of the practices, but we were beginning to see some shift in the payroll shares which may imply that physicians are going from self-employed to employed without necessarily majorly changing the size of the practice.

I think -- I was curious as to the timeframe Bob had seen some of the activities taking place, because it may be that the census data have not picked it up.

>> Dr. Robert Berenson: It's a lot is happening. I mean some of the specific phenomenon of the cardiologists was just sort of – it was the precipitating factor was the Medicare cuts. I think that article exaggerated how much, but -- maybe. But basically significant reductions in payments for nuclear studies and other services performed by cardiologists.

It was interesting. The initial reaction in the cardiology community was to sort of fight them. And then suddenly it switched as cardiologists were figuring out that they could sort of cash out and get employed by hospitals. And I think this provider-based payment thing was a major component of that.

That phenomenon had little to do with integrated care to become ACO's. The more general phenomenon of physicians hiring -- hospitals hiring physicians to be set up to be ACO's I think is also taking place. I think perhaps on not

nearly as fast a process. But that is also taking place.

And I've heard from many sources confirmation of – I think that article cited MGMA -- that at least half of the new graduates of residency programs are going into employment relationships and there's not too many people employing other than hospitals. So that is true. But I think it will take a while before that sort of flows through the system.

>> John Poisal: You'd like to have -- in front of you I think in each of your packets we pulled together some graphics of what Kathryn sent around. If you wanted to look.

>> Kathryn Kobe: It's still showing a very large percentage of the actual firms are quite small. But I think there are trends that are causing that to change. And I think the main concern we might have for this type of index is the next time you change the weights or – you know, how long can you hold on to 2006 weights that are reflecting a different structure?

>> Dr. Robert Berenson: The other thing I would say, though, is at least some folks, I know specifically from writing by Jeff Goldsmith -- I don't know if you know Jeff, but he does a lot of work with hospitals and all. He thinks that it's not a financially sustainable strategy to be buying up all of these doctors just like it wasn't in the 90's. He's projecting that some of these will unwind again unless they become successful ACO's.

But just without that, it may, again, be a phenomenon which doesn't have any lasting change. So I don't think we really know what it's going to look like 10 years from now in terms of the -- where physicians are practicing.

>> Dr. Zachary Dyckman: I think the -- as Bob said initially, or both of you said, it may not be very important why but what's happening with the physicians and essentially assume that more -- many more physicians are working for hospitals now than 10 years ago -- seven, eight years ago, whenever the best data is available. Is a production function essentially different? Is the mix of resources very different for a hospital-based practice for providing the physician services?

And there may be an issue with getting good data because the hospital does many other things than provide physician services. You have to get into their systems to determine how costs are allocated.

But to the extent that the way physician services are provided is not very different, then it's not a major factor. To the extent it is very different, it is more capital intensive or perhaps more labor intensive as they use more auxiliary personnel, support personnel, then perhaps the physician office might – then you have to account for that.

>> Dr. Robert Berenson: Why do we have to I guess is my question. I thought we had to deal with the self-employed physician's office.

>> John Poisal: I think there's flexibility there in terms of, you know -- in the past we leaned on the self-employed physicians because that was the vast majority of physicians. And we've always made that the focal point of the data that we incorporated into the index itself.

However, I do think we do have some flexibility here that to the extent to which we feel it would be technically appropriate to expand sort of the scope of doctors, the different types of practices, I think we do have some flexibility there that we could look beyond just the self-employed.

At the end of the day, I think, you know, we want the index to be reflective of sort of nationally what those cost structures look like to provide physician services. So I think that was even along the lines of why Ernie originally raised this point is there seems to be this trend going towards either the larger practices or the hospitals --

>> Dr. Robert Berenson: But let me push that a little bit. The Medicare fee schedule, the employed physician, the costs structure is the hospital's cost structure not the physician's cost structure. There's a separate facility fee.

Why would we care if that is governed by a different payment

mechanism?

>> Dr. Zachary Dyckman: If the hospital is employing the physician, the physician fee component -- or the professional service component is the same as it was --

>> Dr. Robert Berenson: Professional component. But the technical component is not part of it. I mean, yes. I get –

>> Dr. Zachary Dyckman: I'm not sure that -- if you look at billing records, I just don't know this, but I wouldn't be surprised if the distribution between – well, put it this way. When physicians are employed by a hospital, I think they bill as if it's not in a facility setting. They have offices on the grounds of the hospital or next door to the hospital, and they billed the – the services billed to Medicare and other payers probably the same way as it was billed before.

>> Dr. Robert Berenson: But the payments --

>> Dr. Zachary Dyckman: The payment is the same. The payment would be the same. If it's not for a general -- an internist visit, if the physician is at an office that's in a hospital-owned building, medical office building next door to the hospital, I would think the physician service would be billed the same way as before and would be paid the same way as before unless the – because I don't think -- I don't think a separate technical component would be billed by the hospital if it's in a –

>> Dr. Robert Berenson: No, I think that's wrong. That's what MedPAC has a whole chapter -- MedPAC recommended -- right now the differential -- there's a facility fee that goes to the hospital.

>> Dr. Zachary Dyckman: I understand that.

>> Dr. Robert Berenson: And the professional fee. And the total would be as much as 80% more than it would be under the physician fee schedule, and MedPAC made a recommendation that they should be the same at least for office visits, raising the hackles of the hospital industry. So they are clearly different. There still is a remnant technical component that is associated with the physician's work in the fee schedule.

But the costs -- the dominant part of the costs that would be included in the physician's fee schedule are now excluded from the payment and that payment goes to the hospital.

>> Dr. Zachary Dyckman: I wasn't aware that -- I guess I'm wrong. I assumed that if it's an office, an office setting in an office building – like, I go to a physician at GW, a block away from the hospital. I had assumed that the billing and payment would be the same, but you're telling me otherwise.

>> Dr. Robert Berenson: Just by putting that plaque on the wall saying that that's now the outpatient department, that produces what is called provider-based payment and is a dramatically higher payment, which is the reason that cardiologists -- a reason why cardiologists were so attractive to hospitals and were able to cash out.

>> Bruce Steinwald: Then it's being billed under the outpatient perspective.

>> Dr. Robert Berenson: But not the professional. The professional services aren't.

>> Bruce Steinwald: They are still billing.

>> Dr. Robert Berenson: It's an alternative. What would have been -- the technical component of the total -- the practice expenses of the physicians are altered. There's some component that's associated with the work that's included but not the cost of the hospital.

>> Rick Foster: I think you're both actually correct that it all depends on is that plaque on the wall or not.

>> Dr. Robert Berenson: Yeah.

>> Rick Foster: We can check with Kent or somebody in the Center for Medicare and fine-tune this discussion. But I think you're both making correct points depending on whether the physician essentially has his own office that happens to be somehow associated with the hospital or whether that physician is working on behalf of the outpatient department.

We'll dig into that and get an answer for you.

>> Dr. Zachary Dyckman: By the way, private payers, at least as of a year ago, for the most part were paying the full physician fee for most – for office visits, at least, regardless of setting. They didn't pay the lesser -- even if the hospital may be billing something, they weren't too careful about that. It's moving a little bit, but from their perspective. They're double paying.

>> Dr. Ernie Berndt: So, Rick, do you want to –

>> Dr. Robert Berenson: That's interesting.

>> Dr. Ernie Berndt: Should we have time to have a discussion on this, continuing this in our next meeting, after you and your colleagues take a look to see if it also has a change in the composition of revenues?

>> Rick Foster: I think it would be a good idea, because it's an issue that doesn't fit neatly within the existing methodology and the process.

>> Dr. Ernie Berndt: Right.

>> Rick Foster: The question has come up informally a couple of different times to what extent should the MEI be based on something broader than traditional and self-employed physician model only. I don't know if, John or Steve, you want to comment further.

>> Steve Heffler: Yeah. I actually have a question for Kurt about the PPIS data and the way that was collected because in the MEI we have a subset, self-employed, to come up with the distribution. So for those non-self-employed, though, that would have made the cut, they were asked the same questions. Right?

>> Dr. Kurt Gillis: Right.

>> Steve Heffler: Places. So how would they use the system filling that out? Would it get affected by some of the PPIS issues? I'm curious on the underlying data.

>> Dr. Kurt Gillis: We had a hard time collecting the expense data from the employed physicians. Eventually, I believe, we just dropped that. We had very low response rates. When they were providing expenses, they were providing their own expenses.

Even though we really emphasized we want the practice's expense, we want to know what it costs to actually make what you do not just your own POI or whatever they're paying out of their own pocket.

But, you know, self-employed physicians, they're really -- if they're in a practice with employed physicians, they're really -- when they report their share, we're assuming that they're giving us a share among the owner that would reflect the expenses for the employed physicians in the practice also. So it's not just -- we're not just getting somehow what it costs that self-employment physicians practice. It's really that whole practice.

>> Rick Foster: So back to your question earlier, it might be a moot point to the extent that there is not any suitable data currently. On the other hand, I can imagine the panel considering the idea of a recommendation to pursue this further, for us to pursue this further, to the extent that the employment basis is changing over time, however fast or slow. It might be a wise idea to look into possible methods of getting the right candidate and expanding with that., even if we can't settle immediately that it should be done or shouldn't because we don't know how good the data is.

>> Dr. Ernie Berndt: A related issue, I think, is when we see this employment relationship changing, how does this change access to IT, the IT share that it would cost? I just don't have a good sense for that.

>> Rick Foster: Right. That goes back to -- I forget -- one of you raised the issue about within a hospital setting how well can you break out the expenses directly associated with the physician's sources, which at the moment is tough, I gather.

>> Steve Heffler: Bob, you were raising the point which I think is sort of pushing back about how important of a point this is. And Rick, you said, well, it could be moot if the data is not there. It sounds like conceptually there's some issues that need to be resolved about whether it should reflect if there is a change in the mix or not. Data-wise, clearly there are some issues there. So --

>> Dr. Ernie Berndt: Am I correct in interpreting the original legislation that it was in the context of almost all physicians were self-employed?

>> Steve Heffler: Right.

>> Dr. Ernie Berndt: So it's not clear what the spirit of the law is versus the letter of the law.

>> Steve Heffler: Right. So I'm curious whether to move this forward and kind of piggyback off of what you said, Rick, is given that the information that's available now in sort of talking about -- is it appropriate at this point to focus just on the self-employed knowing that there might be issues that have to be considered, but, you know, as we continue the discussion in the proxies and weights and things like that, that we don't let these other issues kind of complicate -- you know, like the IT issue which is, yeah, it could be different but we don't know. We don't have the data. We're not sure conceptually whether we really want to go there or not.

I think Bob is raising a really important point which is we do have the flexibility to have a broader scope than just the self-employed. We don't have the data or really the instruments and kind of the knowledge at this point to create that type of a framework or distribution and so forth.

>> Dr. Ernie Berndt: Do we have any data on payments to self -- on the composition of payments to physicians that are self-employed versus that are employed?

>> Rick Foster: We should, I would think.

>> Dr. Ernie Berndt: That might be a good start just to see how that's changing over time.

>> Dr. Robert Berenson: But it’s employed by hospitals versus employed by the practice.

>> Rick Foster: By practices.

>> Dr. Ernie Berndt: Right.

>> Dr. Robert Berenson: That's the distinction of employment.

>> Rick Foster: It's not something we normally track for our purposes. We look at physician expenditures in total. But it seems like that could be tabulated. We will see.

As a practical matter of where you go with this question, let me suggest three possibilities. One is, you may just, given the limited time, kind of throw up your hand and say, ok, we recommend this issue be further pursued with or without directors, that sort of thing. So recommendation is one thing.

Second thing would be, two or three of you might form a sub group. And in between meetings just think it through, discuss it and debate it and come back to the full group with thoughts or ideas.

The third option is, you could all do that. There's only five of you. On the other hand, I'm trying not to burden the entire panel with already necessary --

>> Kathryn Kobe: Rick, this seems like a broader topic than just physician payments. Because this must also impact a little bit the conceptual basis about how all the payments for Medicare are being done in that you're seeing kind of this shifting distribution across the types of activities that you used to have separated out into buckets.

I guess my question is -- this is probably not the only place where this concept is being discussed. I was wondering if you knew of other research that was being done in this area in general.

>> Rick Foster: Not off the top of my head, Kathryn. You raised potentially a whole bunch of issues. I'll give you just one example.

>> Kathryn Kobe: I understand that. I don't know the answers, I just know the questions.

>> Rick Foster: If you take inpatient hospital services as an example, way back in 1983, the inpatient process -- [inaudible] -- it was all based on an existing cost reports, cost distributions, at the time. Basically type of service by type of service, the resources that went in producing the services were tabulated and counted and so forth. That's

however long, about 20, 30 years almost.

Now, you would think from time to time that the DRG's would be rebased in a way that reflects today's level of resources across the board of relative costs. But that has never happened. It can't happen without a solution to allow it.

We have had sort of what I call lesser updates, a new DRG comes along, you adjust point of price on that one, adjust the other prices. So you do all of that. But that original basis for the hospital's specific costs for different types of services has never really been based. It's probably a great idea to do so, although it could unleash chaos, I suspect. Because many services would go up quite a bit, many would go down.

But to the extent -- going back to the original question, to the extent that many services that used to be performed at an inpatient basis are now routinely outpatient, sometimes even in the physician's office. That almost certainly has to change the hospital's cost structure in many ways.

Things like that, to my knowledge, have not actually been studied or considered. Now, for all of these other market baskets, we do look and update periodically the three, four years, however many we are we in for, I guess, the cost factors, cost distribution, just like we do for the MEI.

But, again, that doesn't really reflect for payment purposes, DRG purposes, how things interpreted. I don't know if you want to add anything to that or in the back room here.

>> Dr. Zachary Dyckman: Isn't CMS looking for new activities, new projects?

[Laughter]

>> John Poisal: Full Employment Act was passed a couple of years ago it seems like. Many there are others.

>> Rick Foster: Depending if there's any news at 10:00 or not.

[Laughter]

Who knows what we'll be doing.

So anyway, Kathryn, I don't know of anything else. But for physicians, I think it's a question that merits more attention.

>> Katheryn Kobe: I agree.

>> Rick Foster: But it's not going to help us answer the immediate questions about the cost categories, the price proxies, factors like that, based on how the MEI is currently done.

>> Dr. Ernie Berndt: Do panel members have any thoughts on the three options that Rick put forward? One was to --

>> Rick Foster: Study it further.

>> Dr. Ernie Berndt: All involves studying it further, but the three different ways of doing it. Any thoughts on that?

>> Dr. Robert Berenson: I'd be happy to participate in a group. My problem is tomorrow night I'm going to take my grandson to Normandy, D-Day beaches, and we'll be out of country until 9th. So between now and the 11th, I'm not sure unless we scheduled it for the 9th. But I'd be happy to participate on the subject discussion.

>> Dr. Zachary Dyckman: I'm not sure how much progress we could make.

>> Dr. Ernie Berndt: That's my concern.

>> Dr. Zachary Dyckman: So I think that a recommendation for CMS to look into this further is a significant issue, to look into it further is probably best.

>> Dr. Ernie Berndt: Want to make -- what's our protocol here?

>> John Poisal: You have to hammer your hand on the table and declare. No. I think we had allotted some time in the afternoon for the panel to talk about some possible findings and recommendations. We can be sure to make sure that we get that written down. And you guys can formally recommend.

>> Dr. Ernie Berndt: The scribe is taking the notes.

>> Bruce Steinwald: This is where I have an interest in making sure that all five of you

agree to what you're recommending, which means having language on the screen or in front of the panel would be a pretty good idea.

>> Rick Foster: Yeah, that's generally the idea.

>> Dr. Ernie Berndt: Shall we do that now or this afternoon?

>> Rick Foster: Why don't -- should we draft up -- this is like a three-sentence recommendation.

>> Dr. Ernie Berndt: Right.

>> Rick Foster: That the language then you all can look at in this session, John.

>> Dr. Ernie Berndt: Let's plan on that.

>> John Poisal: Ok.

>> Steve Heffler: Or we can go with Bob's grandson.

>> Dr. Robert Berenson: You can all come to Normandy.

>> Rick Foster: At no cost.

>> Dr. Ernie Berndt: Other related issues that were raised? Carryover from the last meeting?

>> John Poisal: So we had done some research and provided additional background on the Electronic Health Records. We have ordered and secured the latest MGMA data and sent around some of the characteristics and traits of that data.

So, Kurt, I know you had had some thoughts about that survey and what might be available in it, as I recall. I think it was actually in response to the article Ernie sent around that used the MGMA data. Is that fair?

We looked at potentially different cuts of office expenses, fixed capital proxies, which Hudson Osgood will cover in his presentation shortly, some of the allowed changes to the MEI. That kind of gets back into Bob's point about do we have to use self-employed or can we expand? The IT information, the medical equipment share. And it's changing over time.

All of the write-ups are in your packets that were sent around. If

everybody's satisfied with what those results were and findings were and don't feel a need to discuss anything further, that's ok. I just wanted to make sure that we left all the opportunity to do so if you felt you wanted to.

>> Dr. Kurt Gillis: But there weren't decisions on a lot of those things.

>> John Poisal: That's right. That's correct.

>> Dr. Kurt Gillis: It's open-ended.

>> John Poisal: So some of those you can either discuss now or to the degree you think appropriate we can certainly address them in the afternoon when we think about findings.

>> Dr. Ernie Berndt: Shall we start, just to go through some of the documents briefly?

>> Dr. Kurt Gillis: Sounds good.

>> Dr. Ernie Berndt: I have in my packet, several of them, one being the MGMA cost survey 2011 document. Again, this is for the observations of group practice, not a onesie-twosie.

Is this data available for a number of years or just for 2011?

>> Heidi Oumarou: We have the data from 2006 to 2010. So it is available for more years than just one.

>> Dr. Ernie Berndt: And does this data provide any insights on the previous issues that Bob, someone, raised? Are there compositional changes going on here that might have an effect on the cost structure?

>> Heidi Oumarou: Well, in the write-up that I sent around, I only showed the most recent years data of just the general composition, I guess, of their sample.

So on the write-up, it was on Page -- it's either the third page, there was the comparison of the organization ownership. So being the hospital ownership or the physician ownership. And then the way that they reported the data is by either multi-specialty practices or simple specialties. They don't have a combination of those two together. So I included that distribution there.

>> John Poisal: I think, too, Ernie that there was a process from the last meeting. We ordered the data, we got it. We really just wanted as best we could to provide like a snapshot of what's there and some of the characteristics and the types of things.

I think as a staff we still have quite a bit of burrowing in to sort of get under the hood and really work with the data and examine some of the trends. This might be one of the other things that you, as a panel, suggest that we really devote some resources towards better understanding what's there and what its possible uses would be in terms of helping to inform the MEI's construction.

So I think we haven't had quite enough time to really get in and get to know these data intimately at least as yet.

>> Dr. Zachary Dyckman: What interests me, on Page 3, you mentioned the table, is that we all know of the change of the move towards hospital employment of physicians, but the numbers to me are striking. For multi-specialty organizations, 53% of the groups are owned by a physician -- of physician groups are owned by hospitals. For single specialty, 65%. Perhaps incorporating the cardiology, owned by hospitals.

My guess is that seven, eight years ago, the situation might have been reversed between physician-owned and hospital-owned. The numbers here, to me, are pretty dramatic. For single specialty, 65%.

>> Dr. Robert Berenson: That's very surprising. I agree with that.

>> Heidi Oumarou: And again, this is of their samples. So, I mean, it's not necessarily representative.

>> Dr. Ernie Berndt: So this excludes self-employed.

>> Heidi Oumarou: Yeah.

>> Dr. Zachary Dyckman: No. It excludes small, two, three physicians.

>> Dr. Ernie Berndt: Yeah.

>> Dr. Zachary Dyckman: But it includes groups eight, 10 doctors.

>> Dr. Kurt Gillis: And it is members of MGMA?

>> Dr. Zachary Dyckman: They have a pretty large membership among group practices, I think.

>> Heidi Oumarou: On the fifth page there is a table that shows for the equivalent physicians, how many are in the practices, multi-specialty, single specialty. So a lot of them, for the multi-specialty, are higher -- I mean, above 10. For single specialties most of them are 10 or fewer.

>> Dr. Zachary Dyckman: So they have a lot -- I don't recall if it's three physicians. Kurt, you may know, someone else may know. They -- four and five physician groups belong to MGMA.

>> Dr. Kurt Gillis: Yeah.

>> Dr. Robert Berenson: They go down to three.

>> Yes.

>> Kathryn Kobe: Have you all done the line-by-line comparison, say the 2007 distribution against the 2006, weight that have been used?

>> Dr. Ernie Berndt: Are you referring to the very last stage?

>> Kathryn Kobe: I'm looking at the second to the last page.

>> Dr. Ernie Berndt: The second to last page, yeah.

>> Kathryn Kobe: It looked like -- I see the note is that they forced the drugs to zero so that the distribution would be kind of on a similar basis. It looks like the physician compensation number tends to be quite a bit lower in this group.

>> Dr. Ernie Berndt: Sorry, I can't hear you.

>> Kathryn Kobe: It looks like the physician compensation share, as I understand it, down at the bottom -- I haven't looked at this table except this morning. Total is 38.3. I guess the question is, is that directly comparable to the 48.3 that’s in the MEI?

>> Heidi Oumarou: It's not directly comparable, because the MEI data is based on the PPIS data, which is the self-employed. So that would be the net income piece. This would be, how they record it, is I guess the provider compensation. So that it's

comparable but it's not directly comparable because net income, the definition isn't necessarily the same.

>> Kathryn Kobe: So it could be as simple as this is not reflecting the people who are collecting sort of the return on equity as opposed to possible PPIS issue.

>> Right. Possibly, yeah. So I mean the weight that we get for 2006 for the physician compensation share and MEI was about 48% in this data. We didn't have access to the 2006 because of the different format. I couldn't get our IT staff to give us permission to access that, so we bought it.

[Laughter]

For 2010, like you're saying here, for the median, it was about 40% compared to that 48%. And when you look at the median, it was 44%. And this is just the multi-specialty data. It does not include the single specialty, which you'd have to come up with a way to weigh it in.

>> Kathryn Kobe: Ok. Thank you.

>> Heidi Oumarou: The PPIS data is all specialties. It's not directly comparable, but it’s -- we tried to get it as close as possible in terms of generally comparing.

>> Dr. Kurt Gillis: And fixed capital is about 6.5% if you add occupancy and depreciation for 2010, compared to, what was, 8%?

>> Hudson Osgood: 9%.

>> Dr. Kurt Gillis: 9%?

>> Heidi Oumarou: Yeah. And these data also would include not only just the physician-owned but also the hospital-owned. It's everything together.

>> Dr. Ernie Berndt: Is the liability share similar? Here it's down to 1.4% in 2010. I thought it was a bit larger. Wasn't it?

>> Heidi Oumarou: Yeah.

>> John Poisal: Not much larger, the MEI.

>> Heidi Oumarou: It's 3.0%

>> Hudson Osgood: 4.3%.

>> Heidi Oumarou: 4.3% currently.

>> Dr. Zachary Dyckman: I think also of interest, at least to me, is the Information Technology is one of the discussion -- there's a discussion about it, but it's relatively small. It's a new thing. It's a focus on it. It's about 1.5%.

>> Heidi Oumarou: The nice thing, I guess, about this data is the categories they have broken out I think makes a lot of sense. But I think there's a lot of -- how the data is reported, collected, considerations to take into account which we would have to further look into which we haven't had the time, but.

>> Dr. Ernie Berndt: It seems to me a useful sort of thing for CMS staff to do is to take a closer look at this data and see, digest it a bit, see if there is some trends that seem to be going away from the shares in distribution that we're using MEI from. Perhaps if possible -- I know there's much work to be done, but if it's possible to have a presentation on that.

>> Rick Foster: No problem. Right, Heidi?

>> Heidi Oumarou: Sure.

>> John Poisal: We'll have it by 12:30 actually.

[Laughter]

>> Kathryn Kobe: And is it possible to get some sort of understanding as to what percent of the whole physician confirmation this subset might represent? I don't know if that's feasible given how -- the information that you have about it, but it would be helpful to understand that.

>> Heidi Oumarou: I can try to get that information.

>> Kathryn Kobe: Ok.

>> Dr. Ernie Berndt: Is MGMA headquarters in the DC area? No?

>> Dr. Zachary Dyckman: Colorado.

>> Dr. Ernie Berndt: Colorado.

>> Dr. Zachary Dyckman: I think also of interest is malpractice –

>> Dr. Ernie Berndt: Yeah.

>> Dr. Zachary Dyckman: -- is about 1.5%, which is considerably less than the MEI weight. 4%?

>> Heidi Oumarou: Yeah.

>> Dr. Zachary Dyckman: I don't know if we have comparable data on physician net income, but we had reason to look at MGMA data on income by specialty. Certainly for some specialties we're dealing with $400,000, $500,000, $600,000 netting, which I don't -- the AMA data is much -- you haven't done anything recently, as I recall, but I don't know if it would be that high even for those specialties.

>> Dr. Ernie Berndt: The source of the data you're referring to is what?

>> Dr. Zachary Dyckman: MGMA data.

>> Dr. Ernie Berndt: Ok.

>> Dr. Zachary Dyckman: They have surgical versus non-surgical. And then they have data for individual specialties, detailed specialties.

I was interested in orthopedics for a certain project. The median and medians were $400,000, $500,000, $600,000 category.

>> Dr. Robert Berenson: I can contribute a little on that one because we did a study for MedPAC in which we simulated what physicians' income or compensation would be if every payer used the Medicare fee schedule. We used MGMA data because now physicians submit RVU's. So we were able to cross their patient population so that we could do that calculation. But the issue going in was because of representativeness issues and low survey response, which has been a problem with MGMA data, we sort of looked at where their numbers compared to I think a dozen surveys of physician income. And they were pretty much in the middle of the range. I can provide that to you. But it looked like at least given their relatively small response rates and skewed population, at least their compensation data seemed to be in the middle of the others,

for whatever that's worth.

>> Dr. Zachary Dyckman: I assume the others also had small response rates.

>> Dr. Robert Berenson: Sure, that’s right. But you do have about a dozen different ones. I think we had the AMA in there as well, if I remember.

>> Dr. Ernie Berndt: Any other comments on the MGMA document?

We'll take a brief look at the Electronic Health Records resources.

>> Steve Heffler: Hudson, the Number 3, the CDC data, we didn't put an estimate in there. But I saw a report this morning, Friday or the weekend or whatever it was with the issue that somewhere around 50% to -- 55% to 60% of all physicians participating in Medicare had electronic health form access, some Electronic Health Records in place in whatever year they started. I don't know if it was 2011. They referenced in there that it was consistent and the estimate with the CDC data. I don't know if it's this CDC data or not. That was the statistic reported. Like 57% of all Medicare participating physicians were using some form of -- I don't know if you -- I don't know if that came out Friday.

>> Dr. Robert Berenson: I don't know about that, but I've seen other data sources which were something like that. Same range.

>> Hudson Osgood: We'll check.

>> Steve Heffler: Ok.

>> Dr. Ernie Berndt: Any further thoughts on that?

>> Dr. Kurt Gillis: I was wondering what the share is that we're coming up with for IT EHR. Was it around 2% or so? Did I see that somewhere?

>> Dr. Zachary Dyckman: The MGMA?

>> Dr. Ernie Berndt: 1.5%? Right.

>> Dr. Kurt Gillis: Ok. But we didn’t have it separately in the documents.

>> Right.

>> Dr. Robert Berenson: I would make an observation that the way practices are used the EHR is still evolving, until maybe a couple of months ago which sort of two problems

were perceived. One is that the obligation -- the physicians sort of enter everything on to the screen during a patient visit is interfering with sort of communication. And because physicians are spending more than two hours after hours completing the work, a number of practices now are actually -- have scribes who is the third person in the room who is actually doing all the EHR entering while the doctor and the patient are having their encounter, their visit. This is a nascent activity – it's just some practices are describing this is a more efficient way to do it, but it would be changing the cost structure with a substitution effect, substituting other personnel for the physician.

How fast -- whether this kind of thing takes off and becomes standard or not, I have no idea. But I just think how practices are using the EHR's is still a revolutionary phase. So going forward, I would be aware of that.

>> Kathryn Kobe: Do we have any idea what's covered in these annual maintenance fees? Because it seems like somebody might have to put someone on the staff to deal with the Electronic Health Records. And these numbers seem low for that to be taking place. I was wondering what was -- if anyone has a concept about what's being covered in these ongoing, yearly costs.

>> Hudson Osgood: Sure, Kathryn. Some of the components of the ongoing maintenance costs, one with Health Affairs figures, software maintenance and support, hardware replacement. They did have a line item in the Health Affairs annual maintenance costs for internal IS staff and IS contractors. Then the internal Healthcare Information Management figures, their annual costs were primarily licenses, license maintenance, and hardware, network and implementation services.

>> Kathryn Kobe: Ok. Thank you.

>> Dr. Robert Berenson: There's a substitution effect there, too, because the people who had to maintain the paper record now are not there. And the substitution of IT people presumably fewer but higher pay. So there is a substitution going on which will evolve as more practices adopt the EHR's.

>> Dr. Ernie Berndt: Any other comments, thoughts, on the EHR data sources document?

>> John Poisal: We can ebb and flow however you see fit.

>> Dr. Ernie Berndt: We're going to stay on schedule. We have about five minutes left. There are a number of -- at least three more documents. One is on contract services with other professional expenses and all other services, costs. Another is classification expenses related to payroll for clinical staff that bill independently. And categories under office expense, can they be collapsed?

>> Dr. Kurt Gillis: There were a couple of options under the last --

>> Dr. Ernie Berndt: Yes. Kurt, go ahead.

>> Dr. Kurt Gillis: It might be worth talking about.

>> John Poisal: I'm sorry, Kurt. Under which?

>> Dr. Ernie Berndt: Can office expenses be collapsed?

>> Dr. Kurt Gillis: Right. It seems like there were two options there as far as proxy, the price proxy. We were going to try to make things simpler. I think one option was to use the all item CPI. Remember? And the other option was to keep the detailed price proxies for each category, and just present the data.

>> Dr. Ernie Berndt: That would be numerically equivalent to what is being done now.

>> Dr. Kurt Gillis: It seems the second would be better because you still have -- you still are taking into account what's really going into office expense and not just proxy some general measure of inflation.

>> Dr. Zachary Dyckman: I agree the second would be better in retaining the focus on the category without pointing out individual items that have virtually no way to wonder why they're there.

>> Kathryn Kobe: Some of these components could certainly move dramatically different from others in any given time frame. So I agree the second one seems a smarter way to go.

>> Dr. Ernie Berndt: I do take it there's a consensus to -- in taking with option two? That is to say, aggregate them out but retain the components?

>> Kathryn Kobe: Yes.

>> Dr. Kurt Gillis: Yes.

>> Dr. Ernie Berndt: This is our first formal census.

>> John Poisal: Write down the date and the time, 10:12.

[Laughter]

>> Dr. Kurt Gillis: The only thing I would add is in the presentation, both in the rule and on the website, for anyone -- I don't know who else does this, but to go in and replicate the MEI that it does help to have all of these detailed categories. On the web there's a market basket. It's an accumulative index. In order to replicate the MEI you need to know the accumulative value. So can we do it -- can we still have the information on the subcategories out there somewhere?

>> Steve Heffler: Yeah. Definitely.

>> Rick Foster: Could be made available by request quite reasonably.

>> Steve Heffler: Yeah.

>> Dr. Kurt Gillis: Ok.

>> Dr. Ernie Berndt: All right. Why don't we postpone discussion of the three other documents until later this afternoon. Let's carry on with our initial presentation.

>> John Poisal: Ok. So I'll introduce Hudson Osgood who is going to walk us through the price proxy presentation.

>> Hudson Osgood: Again, my name is Hudson Osgood. I'm the economist in the National Health Statistics group. I'm working with John and Steve. Today I'll be walking you through the price proxies that we assigned to each of the cost categories in the MEI.

Just to quickly go back and review what we discussed on May 21. Again, we last did an MEI in 2011. What we are looking at, at the bottom, is the same

cost categories that we reviewed just in a slightly different layout. We will present everything on a horizontal axis to show you all the subcomponents. But what we have at the end of this is 21 different cost categories. And these are the separate cost categories to which we had a price proxy.

So, again, we have the general office components within the MEI, the physician compensation was almost 48%. And there are two categories within that. And then the other element is practice expenses. And within that we have 19 different cost categories. Again to which we will add a price proxy to.

As we go through the presentation, what we're looking for from the panel today, for the panel's consideration, are several questions. The first is, are these price proxies -- are the price proxies used in the index appropriate? Are there other price proxies that should be considered? Are the proxies used for physician's earnings, are these reasonable and consistent with Congressional intent?

And then the last two concerns, liability insurance, does the method used for determining professional liability insurance prices -- price changes seem reasonable? And are there concerns that only commercial data is used for determining price changes? And, again, we'll get into that in more detail when we cover the actual Professional Liability Insurance proxy.

Now, on the first slide we identified 21 cost categories. Of those 21, there are about five which have garnered the most attention. And we gauge that primarily from the cost categories where we have received the most comments.

So, therefore, we recommend to the panel that the panel focuses on five categories. The first is going to be the physician compensation piece, which is the largest piece of the MEI, 44%. The second is physician compensation benefits at 4%.

And then the remaining three are from the practice expense categories. So one is the fixed capital which represents 9%, again, primarily about 7% of that is office rents, and then the remaining two, moveable capital, contains IT

hardware. Again an area where we received a lot of comments from the public. And then the remaining category we recommend that the panel consider is the Private Liability Insurance proxy. And together these five categories represent approximately 63% of total costs of the MEI.

Again, at the panel's discretion, the remaining categories we have information on those as well and we can go into those if the panel so chooses.

>> Kathryn Kobe: Could you just give us some idea as to -- you said you got a lot of public feedback on these specific components. Is it the movement in these components that the public is concerned is not representative or the weight? Can you give us some general idea as to why the public comments on these components?

>> Hudson Osgood: Sure. One, with movement capital, even though it's a small weight, the concern is, you know, costs are increased in various practices. You wonder, again, there are a variety -- a lot of folks in rubbers, plastics, postage, what given that granular level of detail, could there be something for IT. So these are questions on the capital element. On fixed capital as well, this is a fixed capital is actually new for the 2011 MEI. In 2004, there was an overall office expense category to which was applied to CPIU for just housing. So since some of these categories are new, I think they garnered a bit more attention than usual.

Regarding comments on physician compensation, I should look to my team. Regarding the comments there, was there any specific, you know, area?

>> Heidi Oumarou: I think in general the comments that we received on the physician compensation proxy that we use is that it's just a general earnings level and that that isn't really consistent with their inflation costs for the employment. They issue something different like a P&T. I think that's generally been the concern over time.

>> Dr. Zachary Dyckman: I missed a word. It should be something different like?

>> Heidi Oumarou: Professional and technical or something -- physician specific. There's been a lot of comments over the years. It's generally a problem, I guess, as

sort of a general earnings level.

>> Steve Heffler: I think the weight really matters on that one. It's almost half the index. Professional liability, just because it swings so much, it gets a lot of attention. And I would say as an overall comment, things where people generally think that costs are rising really fast tend to see prices not going up that fast and then that drives kind of reaction.

If you've got to buy a lot more professional liability coverage and your expenses themselves went up 40% and then you see a price index that went up five, I think something's out of touch here. This cannot be reflective of what's going on.

So each of these tend to have those types of dynamics to them. It doesn't seem like the price movements are in line with the cost movements.

>> Kathryn Kobe: Ok. Thanks.

>> Dr. Zachary Dyckman: Hudson, of the excluded categories, the largest one employee wage and salaries?

>> Dr. Ernie Berndt: Non-physician.

>> Dr. Zachary Dyckman: Non-physician. Yeah.

>> Dr. Ernie Berndt: It's about 13%. Or 19%.

>> Hudson Osgood: Yeah. So about 8% for the compensation piece. And then -- [Inaudible]

Again, since Steve pointed out physician compensation wage and salary 44%, we'll have a separate slide on that looking at advantages and disadvantages of the current price proxy issues. That addresses some of the issues that the public commented about.

>> Kathryn Kobe: Ok.

>> Hudson Osgood: So when we selected proxies, we generally use or select from one of four categories. Again, each reviewed further. The first proxy category is AHE, Average Hourly Earnings. This is AHE for production and non-supervisory workers. It's

calculated by taking total gross payrolls and dividing by total hours.

The key item about the AHE is this is reflecting the mix of employment over time. It's also available for a variety of specific industries as well as for the economy-wide.

Next is the ECI, Employment Costs Index --

>> Dr. Ernie Berndt: Can I ask you a question?

>> Hudson Osgood: Yes.

>> Dr. Ernie Berndt: That is a production workers?

>> Hudson Osgood: Production, non-supervisory workers.

>> Dr. Ernie Berndt: When that series initially put together we had a much more manufacturing-intensive economy in which we thought of production workers as being folks on the line on the production line. Somehow that doesn't seem representative to me of what's happening in the physician's office where I think more of nurses, technicians, clerical. I'm not sure what else is there.

>> Hudson Osgood: General. Yes. That's an excellent point. We'll get into that on the following slide, or the coming slide, that the original professional intent was to reflect changes in general earning levels. So that was part of the 1972 Senate Finance Report. They had language in specifically saying that the MEI focus on just that.

So one of the questions, again, we have the panel is, should we move to something more?

>> Dr. Ernie Berndt: Specific.

>> Hudson Osgood: Yes.

>> Dr. Zachary Dyckman: This is a conceptual issue in that -- I guess for average hourly earnings we're talking about the physician's -- adjusting the physician's own time. And it's not for the expenses of people in the office. There's another category.

>> Dr. Ernie Berndt: Gotcha. Ok.

>> Dr. Zachary Dyckman: But one good thing is, is it the CPI-type thing, is it earnings?

It's sort of -- I think the intent was how the overall economy is doing or the typical person was doing and not so much on what the physician's experience is or what they purchased necessarily, but some measure of what's fair and appropriate in terms of societal.

>> Hudson Osgood: So the next proxy category is ECI. ECI's measure the rate of change in employee wages per hour worked. Unlike the AHE, the ECI for weight and salary is not impacted by employment mix and therefore is a measure of the pure rate of change available in a specific industry.

Similar to the ECI for wages, wages and salaries, is the ECI for benefits. Again, these measure the rate of change for employee expenses, employee benefits, health insurance, pension and so on.

>> Dr. Ernie Berndt: A period of both of these top two monthly, quarterly, annual?

>> Hudson Osgood: The ECI's should be available monthly?

>> Heidi Oumarou: ECI quarterly. AHE's are monthly.

>> Kathryn Kobe: The ECI's are for a specific month, but they're one month out of each quarter.

>> Hudson Osgood: Right.

>> Dr. Ernie Berndt: Ok. Thank you.

>> Hudson Osgood: And so the ECI for benefits is available as well. But, again, the ECI for benefits is not impacted by shifts in the employment.

And then the last two are CPI, Consumer Price Indexes, which measure the price in the final goods and services used by consumers. And the last, PPI, which, again, measures price change of final goods or goods in the intermediate stage of production.

We also have four proxy criteria that we use in selecting data proxy. First is relevance. We want to make sure the proxy we're using is reflected of goods and services in a specific cost category. Second is reliability. High sampling variability

are reasons for concerns, as well as erratic patterns over time.

So we are also using proxies that have been well established over time.

And then the last two, one is the timeliness. So, again, we prefer monthly and quarterly data to annual. And then the last is public availability. Of course, where possible we want to use price proxies available to the public.

So going into the specific cost categories. First is the physician compensation piece, wages and salaries. And then what we are using as that proxy is an AHE for production on supervisory employees for the private, non-pharm economy. So, again, the top-level AHE.

As a reminder, we are determining the costs weight for physicians' compensation based on primarily the PPIS survey for, again, self-employed physicians and physicians who report expenses at the individual level.

As we discussed earlier, this is a proxy -- this is a general economy proxy. But we also want to point out that in the previous MEI, the 2004 MEI, we use the same proxy. So we have a history of using this specific proxy.

For the panel's consideration, we also added -- you can see this for the remaining five proxy categories, possible alternate proxies. So one is another AHE but perhaps something slightly more focused on the industry AHE for education and health services. And on the following slide we have this charted also. So you can see changes over time.

Another possible alternate proxy is ECI for hospital workers, an ECI for healthcare and social assistance, and finally ECI for professional or professional specialty and technical workers.

At the bottom of this table we want to point out a quote from, again, the 1972 Senate Finance Report. The second bullet says that "Initially, the secretary would be expected to base the proposed economic indexes on presently available

information on changes in expenses of practice and general earnings levels."

So again, we come back to this line in Congress about general – and this was the original Congressional intent.

So just quickly jumping ahead to the next slide, looking at what we see as advantages and disadvantages. One of the advantages to using current AHE is – again, this reflects original Congressional intent -- in that Congress has also never instructed CMS through the life of the MEI to change this proxy.

The AHE at the economy-wide level avoids a lot of the volatility that you see and will see on the following slide for industry-specific indexes.

The AHE at the economy-wide level avoids the potential self-inflation of industry-specific indexes as physician productivity increases.

And then looking at the fourth bullet, general earnings should be reflected. AHE captures, again, the average wage -- and average wage. That includes skill mix change.

Of course, disadvantages, the AHE doesn't reflect the specific changes of health specific indexes. And it doesn't reflect changes impacting wages and salaries in the health industry.

If we only want pure wage trends to be reflected and we don't want skill mix changes, then the AHE isn't as relevant as an ECI.

So these -- yes?

>> Dr. Zachary Dyckman: Question regarding -- well, my view of the first bullet is not necessarily a disadvantage, but we have different views of that.

The second one, currently, if for the economy as a whole there is a decline -- if we go for service-oriented jobs and some of them are lower skill, this would be reflected in a lowering of the index values or changes of the index. Correct?

>> Steve Heffler: [Nodding]

>> Dr. Zachary Dyckman: Something I think we should consider.

>> Dr. Ernie Berndt: Zach, I didn't quite understand the point you made a few minutes ago. Conceptually what is it you want?

>> Dr. Zachary Dyckman: I think conceptually what the Congress wanted was that physicians' earnings, their take-home, should be adjusted in a way that society's earnings -- to sort of reflect changes in society's earnings. I think that was the intent. The typical worker, the average workers, American workers as a whole. I think that was the intent.

Again, we're just -- we're not talking about physician expenses. That's taken care of. It's just what the physician takes home at the end and how that's to be adjusted.

I'm just raising a question. I don't know that I have an opinion on this. But I'm raising the question. As the mix -- the employment mix in society changes – now, it could go up to higher skill and higher earnings on average or go down to lower skill. As -- one factor is the reduced power of unions and reduced importance in the manufacturing sector which has traditionally had higher hourly earnings than the other service efforts. That's having an impact.

I don't know the answer. Perhaps others here do, but my guess is that on average hourly earnings are probably adjusting -- well, probably declining. Because of the changing mix. And over time this reduces the value of that index relative perhaps to CPI or any particular earnings measure that's not reflected by changes in mix. I'm just raising that issue, that's all.

>> Dr. Ernie Berndt: Suppose we -- don't quote me on this -- ignored Congress and said as professional economists, what is it conceptually we want? Have you thought about that, Zach?

>> Dr. Zachary Dyckman: Well, one of them is in there, I think one of the options, professional and technical workers. I mean, physicians are -- they live a style of life. They're expected to be professional. They may have the same consumer pattern

expenditures.

One of the first things I did as a study of physicians -- well, I did a study of physicians' fees in 1978 or so. And I looked at historically physicians' earnings.

Now, before 1940, they tended, physicians' earnings, tended to be comparable to the sort of the higher level of professional technical workers like accountants, engineers. And then they jumped up after the wars as a result of increase in demand, mostly insurance coverage. That was the biggest thing. And Medicare sort of adopted the health insurance -- the payment measures that were used -- payment techniques used under private insurance, sort of the UCR type.

But before that they certainly reflected professional and technical. And I could see a rationale for having their earnings adjusted as other professional and technical. That's one opinion. I don't know if it's necessary, in my opinion, but it might be.

[Laughter]

>> Dr. Robert Berenson: I was going to say that sounds right to me. I'm concerned -- could you go back to the previous one? The first bullet on the disadvantages does not reflect specific changes impacting wages and salaries in the health industry. I'm just thinking of other health workers like nurses in particular. There are unique factors that determine what happens with them when we have a recession and nurses come out of retirement back into the workforce or the ability to recruit from other countries.

I mean, I think there's so many sort of unique factors that may not apply to physicians. I think sort of physicians is part of professional makes more sense to me than as reflecting health industry trends I guess would be my going in view.

>> Kathryn Kobe: The average hourly earnings has always been the non-supervisory production workers. The ALS has a broader measure of average hourly earnings.

>> Dr. Ernie Berndt: For non-professional --

>> Kathryn Kobe: Includes more of the supervisory people. Have you ever looked at

how that compares to this index?

>> Steve Heffler: The HE for all employees?

>> Kathryn Kobe: Right.

>> Steve Heffler: The new measure.

>> Kathryn Kobe: It's only been around for a couple of years.

>> Steve Heffler: It's one of the dilemmas. It doesn't have the long-time series where we can look at that. But we certainly could compare it with a shorter time period. I don't know if the trends are much different or not. I would suspect the last couple of years maybe aren't that representative because of the recession. But we can certainly look.

>> Kathryn Kobe: Conceptually, it seems like the Average Hourly Earnings index is not the right index simply because the concept behind it doesn't seem to match this group of people at all in that they're very high education, they have management responsibilities.

But then when I look at the actual graph here comparing the index movements, that one seems to be very much in the middle or maybe even on the high side.

So you look --

>> Dr. Ernie Berndt: Are we confusing --

>> Kathryn Kobe: The professional and technical workers and they are kind of down in the dumps there.

>> Dr. Ernie Berndt: I was confused there. I thought -- what was confusing was level versus change.

>> Kathryn Kobe: Right. Absolutely.

>> Dr. Ernie Berndt: This is talking about change. So the level could be quite different.

>> Kathryn Kobe: And I guess the level --

>> Dr. Ernie Berndt: And the level --

>> Kathryn Kobe: Is being determined by the weights.

>> Dr. Ernie Berndt: Right.

>> Kathryn Kobe: How often are the weights being changed now?

>> Steve Heffler: It was just done in 2011. Before that it was 2004.

>> Kathryn Kobe: So every five, six years.

>> Steve Heffler: So it had been a while.

>> Kathryn Kobe: Whether your proxy is --

>> Steve Heffler: We would like to do it much more regularly than we have.

>> John Poisal: It's a question of data availability.

>> Kathryn Kobe: Right. As long as you have some method of adjusting it. If your proxy isn't quite on -- it matters less if you're adjusting it.

>> Steve Heffler: Remember, the level gets reflected in the weight.

>> Kathryn Kobe: Right. That's what I'm saying.

>> Steve Heffler: But the level of payment or the appropriate, that's sort of outside the scope of the MEI. So the MEI ends up just being about the rate of change.

>> Dr. Ernie Berndt: This is the part that's confusing.

>> Kathryn Kobe: Ok. Understood. This is the part that makes it very confusing. I mean, conceptually average hourly earnings doesn't seem like the correct proxy to use conceptually, and yet it seems to track with these other indexes relatively well. So it may not be that bad of a proxy.

>> Rick Foster: And conceptually, there's also the issue of -- it's almost more philosophical at this point. As Hudson mentioned, that original conference report from the Congress creating the MEI explicitly said what we have in mind is a general economic index, not specific to physicians. At least initially is the way they put it.

Some of the thinking back then -- this goes back into deep dark history, as Zach would know really well. But part of it was, if I remember my history ok, Congress didn't really want an index that would be unduly affected by physician's own behavior.

>> Dr. Zachary Dyckman: Yes. That's correct.

>> Kathryn Kobe: Right.

>> Rick Foster: So if physicians raise their charges by a whole bunch, then they didn't want that being picked up in the index that would then affect the medical payments. So that was a key factor leading into this general economy wages.

Now, philosophically, that's most appropriate. That language isn't binding for today. Hudson made a good point, sort of just mentioning briefly, nowhere in the 48-year history or whatever of the index has Congress come along and said we really don't like how you're doing this index, do it some other way.

What they have done is they've used that index and specified it over and over again, use the MEI for this, for that.

So you could interpret that or infer from that that Congress is not happy with your basis -- the current basis for the MEI. It's still not binding. If there's a good technical reason to be made for using a more industry-specific or an ECI versus an AHE, which that at least holds the employment mix constant, then I think we have that power, we have that authority. But it's really much more into philosophy, I think. I wouldn't say that I know what the answer is.

>> Kathryn Kobe: I think part of the confusion in my own mind is that -- [coughing]

Excuse me.

The weight that's applied to this is kind of a mixture of wages but also return on your ownership interests. And those two things over a business cycle are probably somewhat differently or -- but none of these indexes would reflect that, that concept, either, I don't think.

>> Dr. Ernie Berndt: Carry on?

>> Dr. Zachary Dyckman: A brief question. This is interesting, but it's somewhat erratic. Do you happen to know what the average is over either -- for the various indices other the -- over the entire area for segments of the time period? It's hard to tell

from here. Are they all within a quarter percent of each other? Are there more significant differences?

>> Hudson Osgood: I don't have that with me now. It's something we could get to you shortly after this meeting.

>> Dr. Zachary Dyckman: That might be helpful.

>> Dr. Ernie Berndt: The optical metrics here looks pretty similar.

>> Dr. Robert Berenson: But on the proxy criteria, relevant reliability, timeliness and availability, the AHE, ECI have any significant differences? Are they roughly comparable?

>> Steve Heffler: Our --

>> Dr. Ernie Berndt: Compositional changes, I think.

>> Steve Heffler: Our preference has been on other market baskets using ECI's to not reflect the compositional change. Try to isolate the wage or just the benefit change and not let mix things get in there.

>> Dr. Ernie Berndt: So that's pretty easy.

>> Steve Heffler: We have preferred ECI for almost all of our indexes. And over time have evolved to use -- this is one instance -- like on the non-physician payroll piece.

>> Dr. Robert Berenson: Unreliability in terms of --

>> John Poisal: When there's other measures, they both stand up pretty well.

>> Steve Heffler: Yeah.

>> Dr. Ernie Berndt: Is there any more general but still somewhat professional or educated ECI, professional technical? Is that sort of a major category? Is there something above that in the ECI hierarchy?

>> Heidi Oumarou: There's a professional and related.

>> Dr. Ernie Berndt: I beg your pardon?

>> Heidi Oumarou: There's a professional and related category which is more robust than the professional.

>> Kathryn Kobe: There's also a white collar category. Isn't there?

>> Heidi Oumarou: There used to be.

>> Kathryn Kobe: They discontinued. Ok.

>> Dr. Robert Berenson: Do we know how much physicians make up of professional and technical?

>> Hudson Osgood: Again, I don't have that with me. But we can -- that will be published.

>> Dr. Ernie Berndt: In line with your thinking, Steve, it would seem using the ECI but perhaps a little more general than professional and technical might be a better blend of reflecting the overall.

>> Dr. Zachary Dyckman: What would that be?

>> Dr. Ernie Berndt: I think she said professionally related?

>> Heidi Oumarou: Professionally related. I think there's a total of private.

>> Dr. Zachary Dyckman: There's a total of private I think.

>> Dr. Ernie Berndt: Is there?

>> Heidi Oumarou: Yeah. We can get you the list of what's available.

>> Dr. Ernie Berndt: Fine.

>> Kathryn Kobe: The professional and technical – I mean, the management people are completely separate. Right? They're not professional or technical at all.

>> Heidi Oumarou: I don't believe so. I think there's a management general category and then there is also I think -- there are several categories of managers that you could use.

>> Kathryn Kobe: Ok.

>> Steve Heffler: It sounds to me, just to summarize what I've heard, if we threw out -- didn't look at the language at the bottom of what Congress said 40 years ago, that conceptually that you guys all feel it actually is most appropriate not to use something that’s very health specific.

>> Dr. Ernie Berndt: Correct.

>> Steve Heffler: Or that could reflect things that are health specific because they might have different sort of dynamics than general, and that ECI's are preferable to AHE's and -- but something that's not as broad as the overall all workers that could be influenced by manufacturing or more blue-collar type. That wouldn't be as appropriate either. So somewhere trying to triangulate this, because that's where you're honing in on. Is that --

>> Dr. Kurt Gillis: Why wouldn't you account for changes in skill mix? What if there were changes and demands on physician's practices? Changing --

>> Steve Heffler: I was talking more generally about the physician's work time. You wouldn't want to reflect the fact that over time there's more and more service workers in the economy. And they get paid a lower wage relative to manufacturing. So because of that -- relative to manufacturing so because of that the AHE doesn't -- that's more the issue.

>> Dr. Kurt Gillis: Ok.

>> Dr. Zachary Dyckman: The intent, Congressional intent, correct.

>> Steve Heffler: Right. We're taking that off the table. The way Ernie asked the question before, if you could abstract from that. Is that a fair summary?

>> Dr. Ernie Berndt: I think of it more as returned education. So that's where it -- you know, it's skill mix and things like this.

>> Dr. Zachary Dyckman: Return to education without the decision making process to go into medicine.

>> Dr. Ernie Berndt: Of which occupation. Right. Or law. Right.

>> Dr. Zachary Dyckman: I think that's a reasonable approach.

>> Dr. Robert Berenson: Yeah, exactly. I think if we pick the category -- if it was professional, technical or something, even broader where physicians make up a minuscule portion of it, then I think we're following Congressional intent to not have that

reflected in the index -- I mean the physicians' higher compensation reflected in the index. I think we're following intent. If there's other reasons to shift, I think we could justify.

>> Dr. Zachary Dyckman: I would be surprised if physicians represent as much as 5%.

>> Dr. Robert Berenson: Exactly. I think it would be trivial and therefore that would work for me or something broader.

>> Rick Foster: It's sort of like a one step in the direction of a more specific basis. The hour -- average hourly earnings reflect really what the economy is doing overall including the changes like the move towards more service, etc. And to the extent that philosophically that's what's desired, it's still a perfectly good index.

At the other end of the spectrum, there's a various, say, physician-specific kind of measure. You guys discussed there may be good reasons not to go that full way.

Now, if you go to an ECI, and then you lock in the distribution of skills and particular physicians, then that's one step away from what the economy is actually doing in practice. But one, as Kathryn, you said, when you think about it, what is the basis? Maybe that's a step in the right direction.

But it does so without going to the extreme of the potential volatility or potential self-generating aspect of being physician specific. So it's --

>> Dr. Zachary Dyckman: Or even healthcare specific.

>> Rick Foster: Exactly. Yes.

>> Dr. Ernie Berndt: All right. Carry on.

>> Hudson Osgood: Ok. The second slide, categories we'll be discussing, is the physician compensation piece for benefits. A cost weight of approximately over 4%. Also that weight is based on PPIS data.

So similar to the wages compensation piece this reflects an economy-wide measure, this case economy-wide benefits. Again, this holds skill mix

constant.

So one opportunity, again, is ECI. Again, we list it as possible alternate proxies, again, compensation, change based on what we just discussed regarding the potential possible alternate proxies in the previous cost category here.

With ECI for benefits for hospital workers, ECI, again, for healthcare and social assistance, and ECI benefits for professional and technical workers.

We repeated the quote from the 1972 Senate Finance Report. Again, trying to reflect in the original intent of Congress to reflect general earnings.

So we have -- the economy-wide measure of ECI benefits is tracking quite similarly to the more hospital-specific ECI benefit measures. So I guess the question for the panel is, do we feel ECI benefits for economy-wide is suitable? Or should we get something that has -- even though it might be a small portion, something that reflects the health industry more specifically or more at a general level.

So I leave it open to the panel if they have any questions on the ECI for benefits.

>> Dr. Ernie Berndt: Currently you do what?

>> Hudson Osgood: Currently we use the ECI, the proxies, the general economy-wide benefits for private workers.

>> Dr. Ernie Berndt: So you use AHE for total private, and you use ECI then --

>> Hudson Osgood: That's correct. So AHE for the wages and compensation portion of physician -- wages and salaries element of physician compensation. And then ECI for benefits, for the benefit portion of the physician compensation.

>> Dr. Ernie Berndt: I think the discussion we just had for wages and salaries will go for benefits as well.

>> Hudson Osgood: [Nodding]

So again, we can pull some of the relative importance of more of the general categories.

>> Dr. Zachary Dyckman: I agree.

>> Steve Heffler: Is there a -- do you see a -- in the index where wages and benefit pieces are proxied at the same level of aggregation in the economy?

>> Dr. Ernie Berndt: Yeah, that's where --

>> Steve Heffler: If private was the most appropriate, you would do it for both? Is that kind of?

>> Dr. Ernie Berndt: Yeah.

>> Dr. Zachary Dyckman: If you don't, you'd have to explain why you decided to use different ones.

>> Kathryn Kobe: I remember a few years ago in the benefits, the ECI benefits, was being affected a lot by the changeover and how pension plans were being funded. I don't know. Is there anything that's conceptually different about how pension plans --

>> Dr. Ernie Berndt: Defined benefit versus defined --

>> Kathryn Kobe: Right. Part of it was defined benefit plans were being frozen, defined contribution plans, of course, growing. There was a period of time in which businesses weren't really making contributions to some of their benefit plans at all. That was showing up in the growth and the benefits portion of the ECI. Although I haven't looked at that time really carefully in the last year or so.

I wasn't sure if there was anything specific to this industry and how their retirement is paid that might be better reflected in these indexes.

>> Dr. Zachary Dyckman: Which industry are you talking about?

>> Rick Foster: Physicians.

>> Kathryn Kobe: The physicians.

>> Dr. Zachary Dyckman: Physicians.

>> Kathryn Kobe: Again, I'm not sure that would be -- I agree with you that if you choose something different, you're going to have to explain why. That is probably the best reason to stick with something that's more along the lines of professional and

technical, something in that range. It's just something that I was bringing up as a fault because I had seen some differences in the growth rate depending on how the pension payments were handled by industries. It was affecting the different growth rates.

>> Dr. Zachary Dyckman: At least historically physician practices were often partnerships or corporations that were owned by physicians and then they made decisions based on tax law, based on their own interests. It didn't reflect any personnel policy as much as what's best for the owners of the practices, the physicians.

>> Kathryn Kobe: Right.

>> Dr. Zachary Dyckman: It's a very different situation than manufacturing or other employers.

>> Kathryn Kobe: Right.

>> Dr. Ernie Berndt: We're running a little behind schedule.

>> John Poisal: I was going to propose, if it's ok, Ernie, since we were a little behind from a break perspective if we could take a quick 10-minute break and then pick up. And then we have lunch orders we'd like to take for the panelists to ensure that when we do get to lunchtime, we can be expeditious in moving through it as we did last time.

Is that ok?

>> Dr. Ernie Berndt: Sounds fine to me. Thank you, John.

So a 10-minute break.

[A break was taken at 10:54 a.m.]

[The meeting resumed at 11:12 a.m.]

>> Hudson Osgood: When we left off last, the discussion of physician compensation for benefits. Again, if we have no further questions or comments we'll move on to cost benefit.

The third of the five categories that we'll be reviewing is fixed capital, office expenses, and within that the fixed capital component. The assigned approximate is the CPI for Owners' Equivalent Rent. Again, this is about a 9% or is 9%

of the MEI overall costs.

The definitions for fixed capital costs category are expenses for building lease, building leases, mortgage interests, and depreciation on medical buildings.

We've included, though it's not the best definition for the CPI Owners' Equivalent Rent, a question from the Consumer Expenditure Survey to give you a general overview of the components of Owners' Equivalent Rent. And the question is, if someone were to rent your home today, how much do you think it would rent for monthly, unfurnished, and without utilities?

And as Kat and I were discussing, this isn't the most ideal corporate description but it is a description.

>> Kathryn Kobe: I think it gives an idea of what the concept is supposed to incorporate. But for anyone who isn't familiar about how this CPI component is actually put together, this is not how they're collecting the data to put that index together. That was another point that I wanted to make certain everyone was clear on. Because it's actually being determined by collecting rent prices of homes.

>> Hudson Osgood: And now in the 2004 MEI, we did not use this proxy. That reason was because in the 2004 MEI, we didn't break out fixed capital. The 2004 MEI, to look back to the aggregation, we just used an overall office expense category. So in 2011, we broke out some of the -- we added further detail of some of those components within office expenses. And one of those, of course, is the fixed capital.

Within fixed capital, we assumed that approximately, of the overall 9% cost weight, about 7% of that is regarding or attributable to Visas, and the other 2% will be attributable to depreciation.

So in 2004, for the overall office expense cost category, we used a CPI for housing. As a relative importance, we see that the Owners' Equivalent Rent is -- represents approximately 60% of the CPI of the housing.

Now, as possible alternate proxies, one option would be to go back to the previous proxy, which is a CPI for housing, and then a non-residential proxy, one, and this was discussed previously, May 21 meeting, is the PPI for lessors of non-residential buildings.

On the following slide, again, we have the largest, thickest black line is the current proxy in use by MEI today. Again the CPI, the Owners' Equivalent Rent. We also show the CPI housing. Again, the Owners' Equivalent Rent takes up about 60% approximately of the CPI for housing. And we've also charted the PPI for lessors of non-residential buildings.

One of the items that -- we mentioned this actually in the fixed capital write-up that we provided to the group -- was that we did consider the pass, the PPI for lessors of non-residential buildings, but one of the concerns that we have was that the changes in office building prices are slightly -- were different from your smaller, you know, physician-based offices, as well as a lot of physician offices are located more in residential areas and not in major offices. So again 2011 MEI currently used in the CPI.

Moving on to the fourth of the five categories we'd like the panel to consider is moveable capital. Again, this is also broken out from office expenses. This is new for the 2011 MEI and only -- it reflects possibly 1.5% of the overall MEI costs.

To review the definition of the moveable capital category, it's costly, includes expenses depreciation for non-medical equipment, including -- this is where a lot of the discussion, especially comments we've received from the public, have focused on computer equipment and software.

We have used, again, a new cost category for 2011 MEI. We've assigned the PPI for machinery and equipment. Machinery and equipment includes a variety of components, some of the largest of which are the general purpose machinery and equipment.

One alternate proxy which isn't included in this, but is the PPI for

electronic computers and computer equipment. That makes up approximately 4.5% to 5% of the overall PPI for machinery and equipment. But other elements within that would be electrical, machinery equipment and so on.

So as possible alternate proxies, one is a subcomponent of the PPI for machinery and equipment which is the PPI for general purpose machinery and equipment. And another possible alternate proxy would be the PPI for electronic components and accessories.

>> Dr. Ernie Berndt: None of these really encompass software, do they?

>> Hudson Osgood: The general purpose machinery equipment does not. Yes, so neither of them do.

>> Dr. Ernie Berndt: My sense is that the BEA has a measure which includes software. I don't remember what it is though. They made a big deal out of capitalizing software expenditures.

>> Hudson Osgood: Again, I don't have the BEA in hand, but it's something we would look into and get back to the panel on the specifics of that.

>> Dr. Ernie Berndt: My understanding is that software ends up being almost as important if not more important on an amortized basis as hardware. And one can see the prices going in somewhat different directions.

>> Kathryn Kobe: I was just going to say the Census Bureau, I think, separates out in its index looking at IT purchases.

>> Hudson Osgood: Is this the probation and communications -- the ICT survey you sent out last --

>> Kathryn Kobe: Right. It seems to separate out software from some of the others.

>> Hudson Osgood: Yes.

>> Kathryn Kobe: I'm not sure it's fully inclusive of all the types of equipment that physicians are purchasing.

>> Hudson Osgood: Yeah. There was a category in the census information, physician

offices, and specific for software section. We could look at the levels.

>> Kathryn Kobe: Then, I think, in the PPI's, software tends to be a different industry. So there may be a software index specifically. I'm not sure how applicable it would be to the type of software their purchasing. But it might be worth looking at.

>> Dr. Ernie Berndt: They had separate price indexes, I believe, for sort of customized software versus off the shelf software.

>> Kathryn Kobe: I know – I think the BEA looks at those. I don't remember whether the PPI indexes break it down like that. It's possible that they do.

>> Hudson Osgood: So --

>> Heidi Oumarou: We have somebody from the PPI here. She says they do.

>> Bonnie Murphy: We publish a software publisher's index, but we don't publish an index customized software. So off the shelf software publishers we do publish.

>> Dr. Ernie Berndt: Greetings. Good to see you.

>> Hudson Osgood: Thank you, Bonnie. Those are areas we'll pull more information for the panel and give you that information.

As I said, the only -- on another note, within the moveable capital from some analysis that Molly had done, we show, I believe, the IT component from our information available is somewhere between 10% and 20% of moveable capable was relatable to IT expenses. Again, costs category by 1.5%.

We also want to note, looking at the following slide, the index on the bottom, the PPI for electronic components and accessories, a lot of the IT proxies show very, very negative price trends.

We also don't have it available, but when we looked at the PPI for electronic computers and computer equipment that sat on average, I think, about 5% to 10% below the PPI for the electronic components and accessories. So again, it's a very, very -- price proxy with considerable negative up trends.

>> Kathryn Kobe: Do physicians tend to buy these as IT services as opposed -- are

they buying all of this computer equipment themselves? Or are they just buying IT consultants who are making all of those decisions as far as what they're purchasing? Are they purchasing basically the business service and then the equipment through the business services or are they making their purchases separately?

>> Hudson Osgood: I don't know what the divide would be but some were doing it in-house, purchase the equipment and services in-house, staff management. And then the other side of that coin are the physicians who purchase some of the hardware but then have cloud services. So they, in essence, outsource the management of some of those records and so on.

From the EHR information, we didn't have the breakdown on what that was. I think there was a private study which included a figure I think of annual costs. If it was managed in a cloud. We didn't have a breakdown on who would be doing it in-house versus in cloud.

>> Dr. Kurt Gillis: And this category should have office equipment in, too. We're not just talking about IT.

>> Hudson Osgood: Yes. IT was a small portion of this. So I think it was the non -- industrial machinery equipment, but all non-medical equipment category, too.

>> Bruce Steinwald: It seems so low relative. Not intentionally. Because of the ARRA, the incentives that physicians' offices have to adopt Electronic Health Records and all the publicity. Yet it's 20% of -- 1.5% total. It seems like it doesn't square very well.

>> Hudson Osgood: Again, that's where the IT hardware portion and all other services. There's some element of IT services as well. All of the services you can see is approximately 4%. I think that's a slightly larger portion regarding IT services. But still overall, yes, it's a small percentage. As Heidi was saying, or it was brought up earlier, the MGMA data, 1.5% IT costs. So looking at a rather small portion relatively overall. MGMA. Of all the costs.

>> Dr. Zachary Dyckman: When one takes sort of a 20,000-foot -- it would seem that

the index used is much broader or the proxy used is much broader than what physicians actually purchase. It's all kinds of equipment.

>> Hudson Osgood: Yes.

>> Dr. Zachary Dyckman: Manufacturing equipment. Manufacturing equipment.

>> Dr. Ernie Berndt: Desks. That's furniture.

>> Dr. Zachary Dyckman: That's right. Yeah.

>> Hudson Osgood: For example, I think within machinery equipment the largest component of that was electrical machinery and equipment, about 40%.

>> Dr. Zachary Dyckman: Yeah. That's not at all relevant for physician practices. I don't know if we can get to something that's relevant without getting to a whole bunch of detailed indices.

>> Hudson Osgood: Ok.

>> Dr. Zachary Dyckman: It's just not satisfactory, but it's, you know, how much concerned are we that 1.53%, then we're capturing some. It just doesn't sound good essentially is what I'm saying. Maybe that's the best we can do.

>> Hudson Osgood: Ok. And then now the fifth and final category we recommend the panel consider is professional liability insurance. Again, this isn't -- this is the situation where cost category we don't use the BLS proxy. The Office of the Actuary uses information that we collect on -- directly from the insurance industry.

So again, the cost category weight is directly from the PPIS survey. And regarding how this proxy is built, what CMS does is it solicits information from commercial carriers. This is on a voluntary basis from a bunch of carriers. We collect information for a specific set of levels. So one is insurance for $1 million per occurrence and a $3 million annual limit. This information is collected from each state for each physician specialty as well as each risk level. This information is collected. That's then aggregated out to a national level based on physician -- accounts of physician by state and specialty based on figures from the AMA. Based on that information collected,

CMS builds its own index of professional liability financial premiums.

Another note is that there is also comprehensive data on professional liability insurance from state insurance commissioners. But, again, a concern here is regarding our criteria for proxy is timeliness. This information isn't always readily available. So we feel our current CMS proxy is the best proxy given the circumstances.

Regarding 2004 MEI, we've used the same proxy in the past. Regarding possible alternate proxies, there is a PPI for premiums of medical malpractice insurance, but given the significant rise in premiums in the industry recently, we have felt that the premium -- this PPI particular may not be reflective of all the increases and costs in the industry. Another possible alternate proxy is the PPI for premiums with property and casualty insurance.

Now, this goes back to some of the original questions we have for the panel. Another concern or question that we have is a lot of physicians choose to self-insure. And based on a report which quoted a statistic from the Physician Insurance Association of America which stated that approximately 60% of all physicians were self-insured or insured through -- do we feel although using commercial information, you know, comfortable with us using the commercial data as a proxy for potential self-insured -- self-insurance costs?

>> Dr. Zachary Dyckman: The 60% figure, I think that can be misleading because I would assume most of that are people who are insured through captives. These are physician-administered, self-insured plans, physician-owned self-insurance plans. They are very similar to their experience -- one in particular, their claims experience is not very different from the commercial carriers. So I think a good proxy for their premiums would be what you observe in the market for commercial insurers.

I would assume the proportion that are self-insured is low because, am I correct, Bob, that most hospitals require -- certainly surgeons and other physicians who practice there to have malpractice?

>> Dr. Robert Berenson: My only understanding is that Florida seemed to be the one place where physicians are essentially self-insured. For various reasons everywhere else they have to be insured.

I just wanted -- I'm not sure what you mean. So you think that, for lack of a better term, the bedpan mutuals, the physician-owned insurance companies --

[Laughter]

Are included in this concept of captives? I'm thinking that these are physicians who are employed by hospitals who are self-insured through captive insurance companies and provide the insurance for their employed physicians, that the physician-owned insurance companies actually are insurance, not self-insured.

>> Dr. Zachary Dyckman: Whatever I think is irrelevant.

[Laughter]

>> Steve Heffler: I think we agreed. We used the word “captive,” but I think that's the concept we're getting at, physician-owned.

>> Dr. Robert Berenson: The concept that 60% are physician-owned which are insurance companies. They are regulated by insurance companies. I believe. As opposed to hospitals which will be self-insured and often have an offshore captive as the actual entity.

>> Steve Heffler: Right. And I think there is -- a number of self-insured. I think it is a very small number. Just purely self-insured. Like 1% or 2%.

>> Dr. Robert Berenson: I would think that would be very small and I bet they all come from Miami.

>> Dr. Kurt Gillis: We had a question in the PPI survey in 2007 and 2008, and we got 90% said they were covered by a policy purchased from an insurance carrier.

>> Dr. Zachary Dyckman: Wow.

>> Dr. Robert Berenson: I guess my question is I don't know what the data would be to get from the self-insured, truly self-insured. I don't know what we would have other than

true insurance.

>> Kathryn Kobe: Does the PPI medical malpractice insurance pick up insurance quotes from these captive groups? Do we know that?

>> Steve Heffler: I don't believe so. Do you know?

>> Bonnie Murphy: I think our sample is insurance, commercial insurance carriers. I'd have to check.

>> Dr. Zachary Dyckman: Why check the experience and therefore claims, costs, and premiums to be very different for captives than for commercial?

I'm comfortable with the way you're doing it.

The only question I would have is the assumption you made -- you're costing this out for a fixed level. In fact, is there any dramatic change occurring in level -- are many people buying higher amounts now and therefore are they experiencing larger premium increases as a result of some sense of a required change or highly desired change in coverage?

>> John Poisal: I think the cost aspect of that, Zach, would be to the extent they're buying more coverage, more than the $3 million limit and the $1 million per occurrence, which would show up in the cost weight that came out of the PPIS. But that type of policy still remains a popular policy and thus that's why we latch on to it from a price growth perspective.

So the change in level, again, would, again, flow through to the cost weight and then the price piece, we still assume that is a good proxy for -- even if you have a different level of coverage, that's still a reasonable price movement to apply to the index.

>> Dr. Ernie Berndt: Could we go to the next slide which has a picture of these? What happened in 2004?

>> Rick Foster: The sky fell.

>> Dr. Ernie Berndt: Why?

>> Dr. Robert Berenson: That's what I was going to get at, which is the timing here is really important. That's when there was a real crisis and premiums were going through the roof and the AMA -- the cover of "Newsweek" had pictures of states that the AMA declared as you can't get -- it was a real time when premiums were going way up, and now it flattens, as this also shows, below zero. That is the issue, timeliness of this data, strikes me. That does reflect what was going on in the world in those days.

>> Dr. Ernie Berndt: But the PPI's didn't pick that up. Certainly you wouldn't expect it from property and casualty. But I am surprised it's --

>> Steve Heffler: We've had some general concerns about that PPI category. First of all, it was newer. So there's not a whole time series. And I think, you know, there are issues -- one of the things we've over time really tried to strive for is to ensure there was geographic measures in this measure because that can be very different across the country. So we weight that together and we're not sure how well the PPI captures that.

This is kind of a lower-level index for them. So I don't know how much time, effort, you know, number of quotes.

>> Dr. Robert Berenson: They don't use weighted average or anything do they, over an extended period of time?

>> Steve Heffler: I don't know exactly. I wouldn't think so. I would think they would use the actual -- for that period. Just the trend -- like Bob said, we knew in 2002, 2003, 2004, that it was a tremendous crisis at that time and it wasn't showing up in that data. That worried us. I'm not 100% sure why not.

>> Dr. Ernie Berndt: Bonnie, any thoughts on that?

>> Bonnie Murphy: We have a national sample. And medical malpractice is one of our lower level indexes. We price -- the price that we capture is an annual. Each item in our index is only measured annually, which is true for all property and casualty insurance. I don't know if that may have something to do with the smoothness.

>> Dr. Zachary Dyckman: Sensitivity to specialty to what's happening for individual

specialties is particularly important here.

>> Dr. Ernie Berndt: OBGYN.

>> Dr. Zachary Dyckman: Yeah. You have specialties that are in some states well over $100,000, 150,000 and others $5,000, $10,000. It's location and specialty. It's so sensitive to that.

>> Steve Heffler: That's a good point, actually. We do it that way, aggregate it that way, too, by specialty.

There's another report out there, professional liability monitors, I think. They've just got a small sample of specialties. So it's like is that really representative of the average of everyone? That’s always been a concern.

>> Kathryn Kobe: How many quotes are you basing your inputs on?

>> Molly Knight: For actual insurers? We get like eight or nine. Then we have every specialty, and then the states that they provide coverage for. Then using that information we weight up.

It was a big insurer. That one covers 50 states. So quite a few observations. We try to get at least two insurers for each state, and we've chosen the insurers based on their market share, based on AMS best data. As best as we can.

We try to go to the state insurance commissions to get information, but, again, the issue is a lag. And you have to actually go there to get them. They won't make copies for us.

[Laughter]

So we volunteered to go to Hawaii.

>> John Poisal: Given the budget situation.

>> Molly Knight: Heidi and I said we'll go to Hawaii.

[Laughter]

It wasn't in the budget. So that's the difficulty we have with collecting the data from the insurance commission.

>> Steve Heffler: What would you say on average, like for a given state, those top one, two, three insurers like we have in the state are of market -- commercial market? Are we typically 40% 50%, 60% that they write?

>> Molly Knight: Yeah. I'd say for some, maybe a few states that are smaller, we don't quite have the big insurer in that state sometimes. But our thought was that another insurer proxy should have the general price trend that we're seeing.

We sort of kind of observe like for the insurer that we have, like are they doing anything differently? And if so we look at them.

But interestingly, like you said, you can go with an OBGYN, look at West Virginia and then look at Rhode Island and be completely different numbers. So we weight everything together and try to come up with something that gets as close to the price change for that specialty as we can, then weight up to the national level based on the specialties.

>> Dr. Robert Berenson: And then occasionally you'll have state legislature changing malpractice. Like Texas. That will then cause a state-specific change of rates of increase.

>> Bruce Steinwald: Keep in mind the variability in malpractice premiums is captured in two other ways in the payment system. One is the geographic adjustment, and the others are the RVS.

Each procedure has a malpractice component. If you're in a specialty like OBGYN where malpractice is high, the services that you provide are going to be paid higher because of that.

>> Dr. Robert Berenson: But the geographic adjustor doesn't take into account the differential sort of state malpractice regimes. Like Indiana has low premiums because it just has total caps on damages, and other states -- so that doesn't capture that piece of it.

That's the problem with this, across specialty and across geography,

you just have huge differences. Though, in fact, rate of increase helps rather than just base on that but we are really -- this is one area where this is sort of rough justice to come up with a single wave.

>> Dr. Ernie Berndt: Any other comments on this one?

>> Kathryn Kobe: When you're doing the price change from one year to the next, are you holding the distribution on specialties and positions constant from one year to the next? Or do you mix them first before you calculate the change?

>> Molly Knight: We calculate the change.

>> Kathryn Kobe: Ok. So you're calculating --

>> Molly Knight: We calculate the change but we do monitor them. We actually created a program to help disentangle these two, but we monitor to see how much of the change in the indexes from the distribution in the specialties versus the change in the premiums. We were looking, usually, the physician distributions are pretty similar when you get up to the national level and everything. It's the premiums that really determine that price change.

>> Kathryn Kobe: So most of this price change is coming from the premium change as opposed to the change in mix.

>> Molly Knight: Yeah.

>> Steve Heffler: To that question, Kathryn, is it fair to think about this index almost like it's like a chain weighted type index where we're always allowing -- you know, kind of using the price levels in one year, the price levels in another, and they're weighted based on the base year and the current year and then we keep moving them year by year?

So sort of trying to eliminate the bias that would occur if we kept it fixed back to the base period but within that change we're kind of picking up a little bit of mix type of thing, but from period to period we're not showing much of a change in the mix. I don't know if that's a fair way to think about it. But I think that's probably as close

to how we're doing this, maybe like a true --

>> Dr. Ernie Berndt: As opposed to the fix.

>> Steve Heffler: Keeping it fixed from like six, eight, 10 years ago.

>> Molly Knight: To provide some context, we do the specialty by states. So we have -- I don't remember how many specialties. 20, then by 50. When you get to that level of aggregation, the rates from year to year don't change that much because you're at such a detailed level.

>> Kathryn Kobe: Ok. I assume there's no question about CMS expending the resources to put to this index together. They're not looking for a way to get out from under calculating this. Right?

>> Molly Knight: Expenses are Heidi and I.

[Laughter]

We're on salary.

>> Steve Heffler: The labor costs are going through the roof.

[Laughter]

>> Dr. Ernie Berndt: Do you publish this at the state/specialist level?

>> Steve Heffler: No.

>> Molly Knight: Because we're collecting the data. They send them to us voluntarily. They just send out e-mails. People send them to us. We just don't share them. We aggregate up. But we do in our analysis look at the states for our own purposes just to see -- a lot of it is just a checking process to make sure, too, that we -- there's not something that we typed in wrong, just to give things a glance, but also to compare what's going on from state to state.

>> Steve Heffler: I think our biggest concern is the organizations aren't so much the resources because we don't know we have a lot of alternatives. We have to decide what type of resources we need if we need a good measure. I think the bigger issues are, is it relevant to what we're doing? We're concerned about that because of the

commercial data.

And the other thing is, we're completely relying on people supplying us this data in a timely manner. They stop. It's not like we have BLS to fall back on and they report it every quarter. All of a sudden, what do we do? If we're going up to eight or nine and seven say we're too busy, we're not sending. We have to send Molly to Hawaii.

[Laughter]

Those are possibly our two big concerns. Luckily over time we've had pretty good participation. But that's always the concern.

>> Heidi Oumarou: We have, like, specific contacts. It's been a long-term thing. But if the people leave, it's a process to try to figure out who the other person is.

>> Steve Heffler: And we haven't had a lot of success with the insurance commission data and some of the other things on the same basis in a timely manner.

>> Dr. Ernie Berndt: Any other comments on component number five?

Anyone have any questions about components other than the five that have been flagged?

I have one that is non-physician wages, which is the first of the appendix, where the proxy is basically -- for administrative support. Oh, separately for clerical. So clerical is done. That makes sense. Then administrative support. But for technical, where do nurses fit?

>> Hudson Osgood: It would be professional.

>> Dr. Ernie Berndt: This gets back to the issue either Zach or Bob raised that the nursing market is a very peculiar one in terms of being counter cyclical, leader supply, and wages. I'm curious as to how well the professional and technical series would capture that.

>> Dr. Zachary Dyckman: I think I agree. I don't know if it's counter cyclical, but it's probably poorly -- [Inaudible]

To the extent that the medical staff can be identified in one, two, or three categories, such as nurses and technicians that run medical equipment, if we can get indices that reflect their changes, I think we're better off than using a broad professional.

>> Dr. Ernie Berndt: I forgot the name of the organization. There is an organization that comports to represent nurse practitioners, which is one level up from a regular nurse. They had prescribing privileges in most states. I don't know if they publish any data. There might be something to look at.

>> Dr. Zachary Dyckman: I'm wondering what data BLS makes available relating to medical personnel. I --

>> Dr. Ernie Berndt: Bonnie doesn't know.

>> Bonnie Murphy: I can't answer that.

>> Dr. Ernie Berndt: Kurt, do you know? Are there professional associations analogous to AMA in the nursing?

>> Dr. Kurt Gillis: I imagine there are.

>> Dr. Ernie Berndt: You're not familiar with them and what they do.

>> Molly Knight: In the other market baskets we have used the hospital index and -- so that reflects the large nursing staff of RN's, particularly a large proportion actually. And so if that's something the panel wants us to consider.

>> Dr. Ernie Berndt: That might be more relevant.

>> Molly Knight: We used OES data. Heidi compared physician industry and hospital industry, and we sort of did a blend based on that.

>> Dr. Ernie Berndt: That would pick up the lab technicians you are talking about.

>> Molly Knight: We could look into something like that if the panel would like.

>> Dr. Ernie Berndt: My sense is it might be worth looking at. I would think it would be a better proxy.

>> Dr. Zachary Dyckman: I would think so.

>> Dr. Robert Berenson: A lot of the professional is below the level of the RN. It's medical assistants, it's LPN's.

>> Dr. Ernie Berndt: Point well taken.

>> Dr. Robert Berenson: That varies also.

>> Dr. Zachary Dyckman: A lot of the professionals in the physician's office or in the hospital?

>> Dr. Robert Berenson: No, in the physician's office. In the hospital would be dominated by RN's. But the physician's office is often below RN. Medical assistants are very common. But I'm sure somebody has that.

>> Kathryn Kobe: Who's considered in the clerical wages? That's like the front office staff or the people who used to do the medical records?

>> Heidi Oumarou: Yeah.

>> Dr. Ernie Berndt: Scheduling.

>> Heidi Oumarou: Administrative, front office. Let's see.

>> Kathryn Kobe: And then who's included in the service wages?

>> Heidi Oumarou: I think I handed out last time a list of all of the SSC's. But if not, I can get it to you guys. But there's a whole list of different occupational --

>> Dr. Robert Berenson: That's what I was looking for.

>> Heidi Oumarou: -- categories. So for clerical we have things like customer service representatives, file clerks, interviewers, receptionists and information clerks -- which make up the majority, actually -- billing and posting clerks, billing account collectors; secretaries, administrative assistants.

And then for the service occupations, we actually put the lower level medical assistants and other health support occupations in there because we felt like they wouldn't necessarily get like a PT type wage. But their wage growth would be similar to like a lower level -- [Inaudible]

And then like some of the aides in there, too, janitorial workers,

cleaners.

>> Kathryn Kobe: So the medical assistants are in the service workers, basically.

>> Heidi Oumarou: Yes, they are.

>> Kathryn Kobe: Ok. I was looking at the OES distribution.

>> Dr. Robert Berenson: Maybe I'm wrong, I would have thought medical assistants as a category would be a much higher weight than professional.

>> Heidi Oumarou: That is not just the employment -- these are employment from CPS. Then when we put that together with the OES wage data, we come up with the rates. It's not just pure employment.

>> Kathryn Kobe: The OES data show that medical assistants make an average of $30,000, basically.

>> Dr. Robert Berenson: So that's why they're represented.

>> Dr. Ernie Berndt: Any comments, questions about other categories?

>> Dr. Zachary Dyckman: Just a question. When we add this category to the others, we're over 80%, aren't we?

>> Hudson Osgood: The first five categories was 63% of the cost weight. Then this would be another --

>> Dr. Ernie Berndt: Six.

>> Heidi Oumarou: It's another 13.

>> Hudson Osgood: 13.

>> Heidi Oumarou: And 19. 18.6.

>> Dr. Ernie Berndt: Like 75%.

>> Dr. Zachary Dyckman: No. It's over 80.

>> Steve Heffler: When you include the benefits.

>> Dr. Zachary Dyckman: Yes. Ok.

>> John Poisal: All right?

>> Dr. Ernie Berndt: All right.

>> John Poisal: Why don't we plan to adjourn for lunch. I invite the panelists to the conference room similar to last time. For everyone else, there is a cafeteria downstairs. Hopefully it isn't too crowded today. Mondays and Fridays tend to be better than Tuesday, Wednesday, Thursday.

We'll plan to reconvene roughly 12:35-ish, 12:40 maybe. Is that ok?

>> Dr. Ernie Berndt: Fine.

>> John Poisal: Very good. Thank you.

[A lunch break was taken at 11: 55 a.m.]

AFTERNOON SESSION

[The meeting reconvened at 12:45 p.m.]

>> John Poisal: We're going to get started again for the afternoon. That was a good discussion with the proxy work. I assume we'll follow the same format, which is Molly Knight will walk us through the multi-factor productivity portion of the day and the productivity adjustment in the index. As we go through and we have questions and you want to share insight, we are happy and eager to hear it.

Molly?

>> Molly Knight: I'll spend the next half-hour discussing productivity adjustment. We sent out the presentation as well as a technical memo. We will get into that presentation.

To start us off, we just wanted to discuss a little bit of the history of MEI productivity adjustment. The interpretation of the legislative mandate was the nationally involved index –

[Speaker asked to speak louder by CART.]

I'm shouting at the children.

[Laughter]

>> Rick Foster: We're not drawing an analogy.

>> Molly Knight: The legislative mandate was interpreted to mean that the MEI should be a broad index like the Consumer Price Index. Absent this adjustment, the productivity in the form of the physician's own productivity producing outputs and then the productivity affecting the wage index, updating the adjustment.

The productivity adjustment is a resource-based concept. So the outcomes are not considered. They are tied to utilization. Since the MEI included an economy-wide wage measure to proxy for price changes to physician's incomes, it was decided to use an economy-wide productivity measure. And the productivity growth were greater than the rest of the economy, they kept these productivity gains as higher incomes. The initial productivity adjustment was the non-pharm business output per hour.

Beginning in 2003, following the recommendation of a panel with CMS and MedPAC they decided to change the productivity adjustment in the formula to a 10-year moving average of private non-pharm business economy-wide multi-factor productivity rather than the prior techniques of having a labor productivity adjustment applicable.

So moving forward, this is a little bit about the BLS multi-factor productivity. They published this annually with a one-year lag. And the most recent data is usually a preliminary data. The NAICS-based MFP is 1987 moving forward. There is a SIC-based MVP in the 1940's. They publish estimates for select manufacturing industries on an annual basis. The service industry manufacture MFP is not published regularly.

>> Dr. Kurt Gillis: In the MEI, there’s not a projection for the one-year that's missing there? Do you just use the actual data?

>> Molly Knight: We use the data that's the last historical data point that gets applied to the accumulative update for that year. If the most recent historical data I believe is now 2011, that number would be -- I think it's one -- or 1.1% would be what would go

into the payment update with this schedule affected for the 2013.

It's usually a couple of years' difference, but it depends -- some conversions, some changes they made. Sometimes it was a little bit of a three-year lag. But it's whatever the historical data point is available is what we're going to use.

This shows the 10-year moving average of the private non-pharm business sector multi-factor productivity. We use the 10-year average with the cyclical nature of things. You'll notice in 2008, 2009 the productivity has kind of fallen. That is two things, you had negative productivity growth in 2008 and 2009. So the recession. And then what's dropping out of that 10-year average is 5% productivity that was in the 90's. In 2010 the productivity was up about 3%. That's a bounce back of the recent dip.

And then in 2010, they did publish some estimates of MFP for service industries, specifically ambulatory healthcare. And the ambulatory healthcare services comprises physician offices about 50% also made up of these other NAICS industries which is dentists, other practitioners, some outpatient care centers, labs, home health and other ambulatory healthcare centers.

And BLS estimated these compounded annual growth rates. From 1987 to 2006 we found the productivity was negative, .7%. 90-95 was also negative, 3%. And 95 to 2000, slightly negative. And most recent, 2000-2006 was slightly positive at .6%.

The rest of the presentation we will discuss some physician office multi-factor productivity analysis. This was originally done by Charles Fisher and published in the winter of 2007-2008 "Healthcare Review." His estimates were resource-based from 1983 to 2004.

We have later -- in the last couple of months we've been working on the updated 2010 which we will show and was also presented.

Fisher's methodology relied on merging various data sources on physician office outputs and inputs. Part of the difficulty in measuring physician office

productivity is not one government data source collects all of the data put together. So we sort of have to merge the data sources and sometimes conceptual issues.

Dr. Newhouse provided a technical review of Fisher's methodology and stated that he's carried out an analysis of physician productivity that is the most thorough to date. Because of limitations in the data, however, he is forced to make many assumptions to arrive at his estimates. He also pointed out the task of pointing out uncertainties in Fisher's estimates is much easier than in his task of estimating physician productivity. We provided the links to both the Fisher analysis as well as the Dr. Newhouse review.

1983 to 2004 time period, Fisher estimated that physician office MFP was about 2/3 of the economy-wide. And over select periods found the MFP exceeded the economy-wide.

This was published in the article. You'll see some of the area, 1983 to 2004, 0.8 and 1.2%. The percentages that we present are going to be average annual growth rates and not compounded. We won't indicate that on the average chart, but.

So from the 2001 to 2004, he found that it was much closer at 1.7 and 1.9. And the 90's to the 2000 it was actually negative. And then from 1983 to 1992 he found it economy-wide.

We didn't spend much time looking at the values, but we did note in the memo there were a lot of things gone wrong with the healthcare issues as well as with the SGR. So to the extent it affected productivity or estimates, we leave that as a big question mark.

So here is the methodology and formulas. So before we go on to the formulas, Dr. Berndt brought a suggestion of calculating this with more --

>> Dr. Ernie Berndt: A conventional way.

>> Molly Knight: Using the law of differences. You gave me credit. But Bridget did it.

I didn't do it. I started it and -- in the meantime, from his comment on Friday, we were able to calculate using the MFP, using this more sophisticated method. We found that the growth rates were similar. There was a percentage point difference in the latest decade. So we'll discuss that a little bit more.

But generally when you use this method, it's easier to kind of back out some of the contributions. So what's presented here is based on this method as well as the contribution charts calculated using these.

So the change of outputs over inputs. And the inputs are weighted based on poor components, physician labor, non-physician labor, intermediate inputs and capital. Intermediate inputs could be contracted services, anything not in those tabulated.

Do you have any questions?

Here is a list of some of the main data sources. For the output we used -- non-output we used the BEA's personal consumption expenditures for physician services. We deflated that by the PPI, 1998 to 2010.

Prior to that was backcasted. Fisher's methodology is provide a little bit of context in the Newhouse review because he gets into a little bit more about how he did his-- [inaudible]. I cannot answer any questions on this. I didn't have time to figure that one out.

The labor quantities are based on the product of the AMA total office space physician counts. And then some CPS data, for average hours worked and hours weeks per year for physicians in offices of physicians industry. The non-physician labor quantities are based on the current employment statistics.

The intermediate input expenses are calculated as a residual. So -- this feeds into the weights here, but how the nominal dollars are actually derived the weight is you start with a physician -- the non-physician compensation piece. But you would take the CPS data of average hourly and hours worked and make an estimate on

the ECEC benefits and wages. So you get a non-position comp. Then you have the capital piece which is based on the BEA depreciation ratio for ambulatory healthcare services and return on equity from I.R.S.

And then the physician labor income is based on a variety of sources. It's the ratio physician income to total office expenditures. The intermediate expenses becomes a residual. The intermediate expense in the nominal dollars becomes the quantities by taking a nominal and deflating it by the 2006-based MEI.

The only other piece left was the capital quantities. That's the BEA quantity indexes for ambulatory healthcare services.

Any questions thus far?

So we rally forward, pulled in all of the 2010 data that we could find, incorporated any insertable data that was available. We found that from 83 to 2010 the physician office grew at an average annual rate of 0.7% and compared to the private non-pharm business with 1.1%. Previously Fisher had 0.8 and it was 1.2, so the average stayed the same.

We did find in the 10-year moving average, in 2010, our last data point, that they were equal at 1.1. When we had recapped, based on Dr. Berndt's suggestion, it was actually 1.2 for the physicians, so that's where it actually made a difference on the averages.

So this is just an updated chart, Charlie is extending data through 2010, 0.7 to 1.1. It shows that the economy-wide physician MFP for the most recent decade is about the same or slightly exceeding-- [inaudible] -- similar for the 80 to 92 era.

This is a scatter plot, which was Rick's suggestion.

>> Rick Foster: I suggested something like that.

[Laughter]

>> Molly Knight: It took me a couple of times to figure out how to do it in Excel.

Couldn't get it to work, but we figured it out.

This is the scatter plot of the physician's office MFP and economy-wide. You can see -- the X acts as the physician's office. What we had here, which didn't show up so great with the boxes, but what we tried to do was box in the area from, like, negative 1 to 2.0, and then box economy-wide, zero up to three. That is like 50% of the year in there. Additionally, 2/3 go in that red box which extends the negative 2.0 and negative 3.0. And then those are some of the outlier points. You can see that a lot of those actually happened in the decade -- [inaudible]

>> Dr. Zachary Dyckman: That's as large as the .04.

>> Molly Knight: That's right.

[Laughter]

Not zero, right?

So this graph here, we decided to look at this since we had data through 2010. Kind of do decades -- [inaudible] -- 82-98, so we don't quite have a full decade there. But looking at this, we sort of do what we call a contribution. So you kind of think of this as the whole output growth and then you have the labor, non-physician labor, capital, intermediate inputs, and then the residual would be the physician MFP.

So when we sort of look at this from the change from the 80's to the 90's, you can see that the output gross went down from 1.3 -- I'm sorry, from 5.9% to 3.6%. And this was mostly coming from actual revenue, not necessarily the inflator. And then also contributing was the physician labor contribution which went up from 1.1 to 1.7. This was mostly coming from the quantities, and it's coming from the employment counts, the hours per week, as well as the average work weeks.

We should note that the employment tends to be the biggest contributor of the hours per week. The three-year don't make as much of a difference as the change in employment.

So the resulting MFP, if you count for the other pieces, is actually

negative .2 present in the 90's. Again, there's a lot going on there.

From the 90's to the most recent decade, MFP increased to 1.1%, the growth rate similar to the economy-wide measure as well as similar to what we had in the 80's.

And this is the output basically staying the same at 3.6%.

What we have here is the physician labor piece went from 1.7 to 0.2. These are contributions. They reflect the actual quantities as well as the share. And then intermediate inputs went from 0.8 to 1.4 -- [inaudible] -- contribution went down slightly.

>> Dr. Zachary Dyckman: Can I ask a question? And I apologize for asking it because I should remember and I should have looked it up before I asked. How is physician output?

>> Molly Knight: It's the personal consumption expenditures from BEA. Then it's deflated by the PPI for physician services, the quantities.

>> Dr. Ernie Berndt: So it's expenditures deflated.

>> Bruce Steinwald: Did you ever consider using a physical measure of output like RVU's?

>> Molly Knight: Not in the past month we didn't, but as that discussion come up, I think it was. Maybe John could speak to whether or not that was discussed.

>> John Poisal: Yeah. That wasn't discussed when Charlie initially pulled this together. It was -- everything was going to be on a dollar's basis, but deflated.

>> Dr. Zachary Dyckman: You didn't have data on RVU. You have it for Medicare.

>> John Poisal: Right.

>> Dr. Zachary Dyckman: Just for nobody else.

>> That's true.

>> John Poisal: I bet all of this brings back great memories, hey, Zach?

>> Dr. Zachary Dyckman: It does. I remember that I was -- two things I remember

about the analysis. One, my own discomfort with the measure of output. And also in the 90's a lot was going on, and you had breaks in available data. You had changes in managed care, you know, growth of HMO, moving away from HMO's. There was a lot of messiness, so I was skeptical about a lot of the data, particularly with the output data. Even if you would have accepted the measurement of output, which I think is somewhat problematic or simplistic or whatever.

>> Rick Foster: You were concerned for the 1990's in specific or just in general?

>> Dr. Zachary Dyckman: One concern I have is for the 1990's specifically, but I think we can focus on the 2000, 2010.

Another concern I have is you have to accept a lot in terms of the accepting validity of measures of output. That's it.

>> Dr. Ernie Berndt: General problem is service sector industries.

>> Dr. Zachary Dyckman: Yeah. But you have RVU's now. That would be great.

>> Dr. Ernie Berndt: But just for Medicare.

>> Dr. Zachary Dyckman: But that's the problem.

>> Bruce Steinwald: You can get RVU's – they exist for the federal employees, for example. And other payers do use them and there are databases that can be accessed. But you don't systematically have as universal a measure.

>> Dr. Zachary Dyckman: Right.

>> Rick Foster: One other issue to follow up – and, Bernie, I think this was a question for you. It's quite common, I believe, in productivity studies to use an expenditure or dollar amount for output.

>> Dr. Ernie Berndt: Yeah.

>> Rick Foster: The heart of the problem is that the service sector ends up being deflated because the price measures had limitations.

>> Dr. Ernie Berndt: Right.

>> Rick Foster: Particularly if you do not so much of a resource-based measure but

outcomes-based measure. How do you measure the value of health or the quality of the healthcare?

>> Dr. Zachary Dyckman: Absolutely.

>> Rick Foster: So I think the personal consumption expenditures, physician services, I think that's probably a pretty good measure itself. Then deflating it by the physician PPI's probably not bad. Again, if the quality of the service that is being paid for has improved in a way that you can't measure or pick up, then you can see the impact.

>> Dr. Zachary Dyckman: Sure.

>> Kathryn Kobe: Have you done any investigation as to the underlying components that cause the BLS's results from using the broader ambulatory healthcare? Turned out quite a bit differently?

>> Molly Knight: They don't have anything published. We didn't actually contact them. We tried to look on their website, but they did not publish anything but the article itself.

We could probably look into it more. It's my -- just based on the level of aggregation, I think they chose that because BEA has a lot of the data at the healthcare level. So you could get quantity indexes, output. So perhaps that --

>> Dr. Ernie Berndt: [Inaudible]

>> Molly Knight: Oh, is it? Ok.

>> Dr. Robert Berenson: I was just going to say in terms of RVU's, even if you could get, systematically get RVU's from all payers, there's at least an argument that it doesn't capture lots of activities that are being -- lots of outputs that are being generated that are not reversible. That is certainly the primary care physician complaint, that they're doing things that don't get captured. You'd have to deal with that issue.

>> Dr. Robert Berenson: Your revenue-based measures presumably exclude those things, too, because they don't generate revenue.

>> Dr. Robert Berenson: Probably. That's right.

>> Dr. Zachary Dyckman: Unless you're paying based on charges. To the extent that

some fees are based on charges. Of course, less so now than in the past.

For some private payers, at least in the past, a sizeable portion might be related to charges, not that charge, but related to charges.

>> Kathryn Kobe: This is probably a minor point. When I was looking through this, about the intermediate inputs, MEI, of course, as we discussed last week, had certain components that are subtracted out of it, because – I mean, for logical reasons for the MEI, but does that still make it an appropriate deflator for this residual intermediate input?

>> Molly Knight: We -- the other option would be to use the BEA ambulatory healthcare deflator, in Fisher's article. And I kind of agree that they would have all the other industries in there as well. So we could try to recalculate the MEIs to include some of those other, like drugs and supplies, and then go back and recalculate it. We just didn't have time before doing this.

>> Kathryn Kobe: I mean it may not make a big difference, on the weight of those components. But it was just a question I had when I was thinking about how well the deflators matched the underlying concepts.

>> Dr. Ernie Berndt: I guess you could also make the argument -- you might create something like a GEP deflator that sort of captures all.

>> Kathryn Kobe: Yeah. Although, I mean -- multi-factor productivity being sort of a residual itself.

>> Dr. Ernie Berndt: Right.

>> Kathryn Kobe: It's pretty sensitive to what things you don't capture in the other components.

>> Dr. Ernie Berndt: Right. That's why it was called measure of our ignorance.

[Laughter]

>> Kathryn Kobe: I like that one.

>> Molly Knight: We could certainly, you know, try that and see the impact.

>> Kathryn Kobe: It probably is not a major impact, but it was –

>> Molly Knight: Done with the percentage point, too, so.

>> Kathryn Kobe: Right.

>> Molly Knight: Could put it under. Could put it over.

Is there any more questions or do we want to move on?

So here we provide a similar chart. This is for the economy-wide measure. You can see it's a little bit of a different story as the most recent decade is equivalent to the physician MFP measure. The increase in productivity in the 90's to 2000 is [Inaudible]. This is mostly from the recession in the last couple of years, the labor. In 2010, the productivity went up from 4%, and mostly the labor stays kind of low and then the output kind of continued.

So in the time we did have, we wanted to conduct some sensitivity analysis, just kind of give the panel an idea of what happens when you change some of the assumptions.

Under the first sensitivity analysis, referred to as Scenario A, there's a lot of background to this. So to reiterate, the non-physician quantities relies on the BLS current employment statistic data for production workers. In Fisher's article he assumes that the production workers would not reflect – would only reflect non-physician employees and not physician employees.

At the time of his analysis, they didn't have other measures to kind of benchmark. The BLS CES now publishes all employees' measures as mentioned earlier. So what we tried to do was to merge together the CES and occupational employment statistics data, kind of benchmark to see if we could get an idea of whether or not some physicians are actually in the supervisory, the non-production worker measure.

What we found was when we looked at all the employee measure and then the BLS average hourly earnings, we get about $33 an hour. Then we then

tried to reweight OES data and took out the management occupations as well as the physicians, and we get about $18 an hour of production worker, average hourly earnings of $25. So it sort of implies that the physicians may now comprise a larger share of the CES production worker than originally theorized.

It sort of puts a little conceptual issue in trying to merge all of these data sources together and put physicians on one group and non-physicians in another group. And it's going to bring back the point of the corporates and that sort of thing as well.

So, there's really two options to address this. One would be go and adjust the production worker, measure somehow to remove the impacts of physicians. We didn't have time, because we had to pull all the old OES data. We didn't have time to do that.

So rather, we tried something more simpler, which was let's just use self-employed physician hours instead of the current measure which puts all physicians that are working in the industry. We tried to pull out the self-employed and said what happens if we -- was kind of like a, I don't want to say non-physician; we have employed positions, and then we have like true self-employed positions in the other part. Those compared to labor components.

So when we did this, we didn't really get a change on the actual average. We did get a change to the actual employment growth rate, so we went from 1.1, the base point, to 1.0. So just changing that one assumption knocked it down a tenth of a percentage point.

Just to let you know, like I said before, it's really the employment counts that make the difference. Theoretically, if people were to go – [inaudible] -- you would want to have a self-employed account physician measure that measures growth with physicians. I'm not sure if AMA publishes it. It was not in the big master book.

So as a possible sensitivity analysis, we discussed Scenario B, which

is physician income. This physician income is something Dr. Newhouse also brought up [inaudible]. A little bit of a concern is the methodology. Again, the physician income, as you can see in the physician weight, and then inputting expenses. Determine the quantity and weight first, and then the residuals.

So these two components combined are the difference between the total physician office expenditures, which is these number, less the non-physician labor compensation, depreciation and then – [Inaudible].

So you have this residual then we further divide this and physician income, and then take the ratio of physician income to total expenditures.

So the data that was used for this physician income ratio is a combination of data sources from the first study, from the IO data back into the 1990's. Then we use the AMA data for 2006.

So when we – rather, for the baseline MFP estimate from 2007 to 2010, we actually just trimmed this down by two percentage points using the SOI data as kind of like a gauge. For Scenario B we re-estimated, allowing the physician income percent totals do not decrease from 2007-2010.

You can see it actually causes -- [inaudible].

Now, one other option that we -- we didn't have time -- to perhaps calculate the intermediate expenses and then back out -- we didn't have time to look at some of the options for that as well.

Part of the difficulty is going back to 1980. So, consistently trying to be as consistent.

Then, again, Dr. Newhouse mentioned this, you know, as having an issue because you did kind of merge surveys and methodologies. Like you said – [inaudible].

So our conclusion is basically we think this position specific measure still requires a combination of data sources that aren't always best conception together.

But it continues to represent the best in the metric available. In extending this series forward, it has shown that the physician office productivity has not been widely disparate from economy-wide growth. However, we highlighted if you change the assumptions, you will change the 10-year averages.

And that would be all. I have additional questions for the panel. But also if there's any detailed questions in some of the specific underlying, I have additional charts in a PDF.

So our three main questions to the panel, which we had brought up in the first meeting:

What does the approach discussed above including the data used and the sensitivity with the results imply about the MFP measure currently used to adjust the MEI?

Are there other measures of physician office MFP that the panel is aware of that could provide further context for this issue?

Are there alternative scenarios that the panel would like to see regarding the current physician office MFP methodology to better understand the sensitivity of these estimates?

Dr. Berndt provided a few suggestions. If you don't mind if I put them right up there.

Ok. So the first one -- do you want to speak to these?

>> Dr. Ernie Berndt: Go ahead.

>> Molly Knight: Ok.

The first comment was, he wanted to feel we were examining more directly the composition of the non-physician labor, becoming increasingly -- [inaudible]. So that is something we did a little bit with the OES data. We do realize more analysis could be done.

Then, do some consulting firms have physician office MFP

estimates?

And the third, I didn't quite understand this one. If you could explain that. I wasn't sure if it was the first one.

>> Dr. Ernie Berndt: You mean number three?

>> Molly Knight: Yes.

>> Dr. Ernie Berndt: I was concerned about non-physician labor and wondering if from BLS we could get any data on hours and number of people employed as and compensation data for several sub occupations within non-physician labor, mainly, nursing, clerical, lab technician. The previous presentation that you made broke it down a little bit into, I think, managerial service --

>> Hudson Osgood: Clerical.

>> Dr. Ernie Berndt: Clerical, etc. Something like that. What I was wondering is if you made an analogous data on the non-physician labor, would that give you some different numbers or not?

>> Molly Knight: Ok.

>> Dr. Ernie Berndt: As opposed to using just production.

>> Molly Knight: This scenario, the hours data is not available. The OES data, employment average on the earnings. They have the hours but I've never seen -- do they have actual hours?

>> Heidi Oumarou: In what?

>> Molly Knight: The OSE data?

>> Heidi Oumarou: I don't think so.

>> Molly Knight: The CPS might have some data we can pull in that might not be -- that might be able to work where we can pull some occupations by physician industry. It's a little cumbersome trying to pull it. But that could be someplace we could look.

>> Dr. Ernie Berndt: The other thing Molly mentioned earlier, the way I'm familiar with most multi-factor productivity calculations, it's done in a difference rather than a division

sort of format. You see growth in output minus growth in inputs, not growth in output divided by growth in inputs. If the percentage changes are small, the numbers are very close to each other. But ever since going back to solo and others, it's usually done in differences. She and her --

>> Molly Knight: Bridget.

>> Dr. Ernie Berndt: We did the calculations on one day's notice, which was quite impressive. And the numbers were virtually the same.

>> Kathryn Kobe: Molly, I assume from your comment just now that you haven't ever looked to see if the CPS sort of indicates that there's tradeoff between -- over time that there's been a tradeoff between physician hours and the hours of the other types of workers.

>> Molly Knight: In this scenario, we choose the self-employed versus the all physicians. There were some slight differences. But we didn't go into look at separating the physicians from the non-physicians using the data for this project. We could definitely do that. And then seeing how that tracks with the data as well.

Just comparing to see, if they work less than 48 hours on average compared to the physicians which were working 40, 50 hours a week.

>> Kathryn Kobe: Ok. That's sort of what you described.

>> Steve Heffler: Related to that question, can you go back to the chart of the contribution effect dates. So you get that big drop in the last decade, physician labor. How much of that is weight verses how much is the actual change? They were both contributing?

>> Dr. Ernie Berndt: This is a decade in which residence hours are restricted.

>> Molly Knight: The other thing contributing was employment counts, average per week and the average work weeks.

I think we have the additional charts.

John, do you have them?

>> John Poisal: Kurt, just for you, I still left my daughter's picture in the background.

[Laughter]

>> Molly Knight: Do you have the additional chart PDF?

>> John Poisal: Can you look in the new folder?

>> Molly Knight: The new folder? Oh, Ok.

Here's some additional charts. One of the things -- we can go through all of them if you would like. But physician output, output deflator, and output quantities. These are the physician input shares.

>> Dr. Ernie Berndt: I was quite struck by --

>> Molly Knight: This was one of the points you had?

>> Steve Heffler: Right so the share went from 43 to only about a third of the inputs.

>> Dr. Ernie Berndt: Yeah. Actually, I think it was 29%.

>> Molly Knight: Yeah. This is the average.

>> Steve Heffler: And then the quantities. Part of that share is what's going on with the quantities over that period.

>> Molly Knight: The physician piece, no. Well, I mean –

>> [Inaudible]

>> Steve Heffler: Yeah. So there you go. Go back. You can see the counts. Counts have the biggest.

>> Molly Knight: There's been a slowing in the number of physicians. These are total, increase in the 90's.

>> Dr. Kurt Gillis: I'm not sure I follow everything, but. Does it take into account the hour differential for self-employed and employee positions? Employees typically work --

>> Molly Knight: You mean employed physicians versus non-physician employed? In the current baseline method we pulled the CPS data which would be all physicians, self-employed and employed. And that second scenario we just pulled the self-employed.

I believe that they actually did work more.

>> Dr. Kurt Gillis: Ok.

>> Dr. Ernie Berndt: Do you want to put up the questions at some point again?

>> Molly Knight: Yeah. Yeah.

>> Dr. Ernie Berndt: These are the shares. Quite striking, by the way. If you take a look at the blue on top, that's physician labor share. So it goes up from 29 --

>> John Poisal: That's –

>> Dr. Ernie Berndt: The most recent.

>> John Poisal: Yeah, the most recent to the left.

>> Dr. Ernie Berndt: Back in the future.

>> Molly Knight: So then you can see -- [inaudible]. Then, again, this might be the issue that we were looking, with the physicians being in that now non-physician measure more. That could be what we're seeing here. It's difficult.

>> Dr. Ernie Berndt: So beginning with number one. First of all, I think there's a presentation like this is somewhat misleading in a sense that it's all there. It doesn't look like there's that much work. But having done these things, I can assure you there's an awful lot of work behind this. Congratulate the team for doing that.

It seems to me, as before, there are some worries about proxy measure and so on. This is probably as good as you're getting. It is somewhat reassuring that two things happen. One is estimates are reasonably robust. And two, they're not that wildly different from the rest of the economy. I suspect different from the rest of the economy. They had some explaining to do.

>> Kathryn Kobe: Well, in 1991 to 2000 period, there was a pretty big difference.

>> Dr. Ernie Berndt: Right. And there are some stories to tell.

>> Dr. Zachary Dyckman: The data is problematic.

>> Kathryn Kobe: So you think that's a data problem?

>> Dr. Zachary Dyckman: When you have like a 4% reduction in physician output,

when there is no intuitive explanation for that, the data show it, the data you're using as proxy show it, but it's hard to have a lot of confidence in that.

>> Kathryn Kobe: So you think that differential is indicative of a problem with the data as opposed --

>> Dr. Zachary Dyckman: During the 1990's, yes. Things were happening. As I indicated before, Managed Care was introduced. That introduced different -- reimbursements were changed. Reimbursement is an important measure of output. A lot was happening then which made one suspicious about whether the numbers you see were actually correct.

But in the last decade I think it's been more stability. Both of the data and what was happen in the world. I'm more confident that that data is a lot better.

>> Kathryn Kobe: I must say this result surprised me because you're thinking this as being a pretty labor-intensive industry and given how much MFP is seemingly driven by technology change, it's a surprise to me that it came out that close together. So that's one reason I was looking at the two different time periods, because you don't want to leave something in place that's coincidentally measuring the same thing in one time period but might be very different in another time period.

I think your explanation about there being a lot more data problems, that might not be accurately reflected in the differential, is helpful to understanding that.

>> Rick Foster: I was also going to ask the same question. In the 1990's, we had the widespread introduction of Managed Care. Far and away the biggest impact of that was that the private insurance companies were able to negotiate or impose much tighter restrictions on pay rates to physicians and other providers during that period.

I haven't mathematically tried to figure out in a situation like that where reimbursement rates are constrained, then how would that end up impacting productivity measurement?

You get a supply and demand effect. Maybe you also get an income

effect, but then how either of those or both affect productivity measurements, I don't know. But I figured you would.

>> Dr. Ernie Berndt: That's just the logic. If it really tightened up on reimbursement, probably would mean reduced revenues.

>> Rick Foster: Right.

>> Dr. Errnie Berndt: So it showed up on a lower PCE expenditures. How it would affect the deflator depends on how well the BLS captures that.

>> Rick Foster: In a case like this – well, for Managed Care I'm not sure. If it was straight fee-for-service, it would be picked up pretty well.

Dr. Ernie Berndt: Yeah.

>> Dr. Zachary Dyckman: What Managed Care did in addition to changing reimbursement was looking at how data – how claims were reported and excluding, in terms of medical necessity, in terms of alleged bundling and software to compensate or to try to detect bundling -- unbundling, rather, unbundling of services, there was a lot going on that didn't relate directly to payment rates. But what claims review and what services were covered were not. That, I don't think, would be accounted for by BLS measures of reimbursement, price measures.

>> Kathryn Kobe: BLS is using -- I called the BLS analyst the other day about this because I was interested in what the underlying concept was here. They are still collecting CPT's. When the office is introduced, they'll collect the CPT by payer. Then they will press the same CPT, the same payer, until they change the sample, which is every five years or so.

>> Dr. Ernie Berndt: So it probably would not capture what Zach was talking about –

>> Kathryn Kobe: No.

>> Dr. Ernie Berndt: Which was hassles with paying claims.

>> Kathryn Kobe: They also wouldn't capture if -- for example, you used to go once to the doctor's office, and now they require you come back twice for the same purpose.

They wouldn't capture that either.

>> Dr. Ernie Berndt: Right.

>> Rick Foster: I think the conventional wisdom is that out of the so-called Managed Care impact, the biggest aspect by a pretty big margin was the payment rate negotiations.

>> Dr. Ernie Berndt: Yeah.

>> Rick Foster: But there was also the utilization management aspect that you're talking about. But I think it was a smaller -- based on this stuff.

>> Dr. Ernie Berndt: So suppose that logic is right, Rick, that would mean that the revenues went down, that the deflator probably didn't capture it. So that probably meant that productivity grew down.

>> Dr. Zachary Dyckman: That's right. You could get negative productivity --

>> Dr. Ernie Berndt: From that.

>> Dr. Zachary Dyckman: With no fewer services, perhaps more fewer services than provided.

>> Dr. Ernie Berndt: Right. But the way you would measure would go down.

>> Rick Foster: So what we saw in the 1990's, in terms of measurement, might be something of an artifact stemming from the Managed Care revolution.

>> Dr. Ernie Berndt: Yeah.

>> Steve Heffler: This chart right here actually shows the pieces. Blue is the revenue, the red is the price, and the green becomes the residual which shows up as the output.

You actually do -- in the data you see a price effect, between the 80's and the 90's. That's your payment rate. I think that did show. Also much lower overall inflations. That's kind of mixed up in there as well.

>> Rick Foster: Right.

>> Steve Heffler: But you do get a reduction in quantity, too, which would be utilization stuff. So they're both kind of showing up in the data. But it’s mixed up, and they know

exactly what's causing – what's causing what.

>> Rick Foster: There's also a bigger picture issue here. I think Molly mentioned this right up front. Just remind me if I'm remembering this wrong.

In the morning we talked about the price indexes to use for the -- basically physicians wage increases and so forth. And there was a tendency to prefer an economy-wide measure for various reasons. If you're going to adjust that basically for productivity, then does it make sense to use an economy-wide productivity measure?

>> Dr. Ernie Berndt: That's why I was asking the conceptual question.

>> Rick Foster: Right. And then the issue becomes, it's fun and interesting to measure or try to measure physician-specific productivity, but that's more to see sort of how it compares out of general interest. And you wouldn't necessarily want to do an economy-wide wage increase and a physician-specific productivity growth. I think.

>> John Poisal: That's worth emphasizing, too, Rick, that at no point was that physician-specific measure ever thought about as a means of adjusting payments. This literally is just for that basis of comparison. In this case, anyway, to the extent there might be others.

But for purposes of this discussion and what was done back in 2006, 2007, it's for illustrative purposes to try to say here's our best guess as to what's going on in physician offices relative to economy-wide. So that's right.

>> Rick Foster: Yeah. And one other interesting thing, for me, anyway. This goes back to something you mentioned, about the fact that you tend to think of physician services as being very labor intensive as is with most of healthcare. And other things being equal, you might expect the productivity not to be so high.

And physicians traditionally, whenever we measure the productivity levels for physicians and other providers, physicians are the ones that stand out. All the other providers, inpatient hospital, conventional wisdom for home health, and so forth,

the productivity is essentially pretty close to zero.

>> Dr. Ernie Berndt: It seems like an orchestra.

>> Rick Foster: Like an orchestra?

>> Dr. Ernie Berndt: Like music.

>> John Poisal: Right.

>> Dr. Ernie Berndt: Very little productivity.

>> Rick Foster: Yeah, exactly. As Mark Freeland likes to say, eyeball-to-eyeball services.

>> Dr. Zachary Dyckman: Unless you decrease the size of the orchestra. Then you'll get productivity.

>> Rick Foster: Right. Whereas, physicians, one way or the other, seem to break the mold on this. And whether it's because of the use of physician assistants and nurse practitioners and so forth or other steps like bringing in more energy in other services that enhance productivity and not take as much labor time, I don't know. But they're the outlier on productivity which all the studies suggest.

>> Dr. Ernie Berndt: Well, talk to Manage Care folks and say we monitor how many patients you see an hour. That's got to go up. It used to be three. Now it's got to be four or five.

>> Bruce Steinwald: It is true that the stock -- the labor supply of the extenders is increasing much more rapidly than physician labor. Nurse practitioners for a while were increasing nearly 10% per year. Those people are deployed in a lot of different ways, but some are in physicians' offices.

The MRI's and so forth, you know, during the last decade, hardly any cardiologists had their own MRI's. At the end of the decade, hardly any cardiologists didn't have an MRI. That would show up, I'm sure, as a productivity increase, a major one.

By end of the decade, cardiologists, I think one-third of their

Managed Care revenues were from imaging, not basic physician services, but the imaging.

>> Dr. Ernie Berndt: If you think of mental health services, you have a fair bit of substitution away from psychiatrist's time toward drugs, which would show up as physician productivity.

>> Kathryn Kobe: In the long run, I think the issue about whether you're quality adjusting this -- obviously now it's not quality adjusted at all. When you start talking about the fact that physicians are going from seeing three patients an hour to five, a lot of people are going to perceive that as being worse quality.

>> Dr. Ernie Berndt: Declining quality.

>> Kathryn Kobe: In fact, I have people who complain about the fact that their doctor doesn't talk to them anymore. I mean, really, though, if the real outcome is how healthy you are, that doesn't matter whether your doctor talks to you an awful lot, as long as they can give you the things that cure you. I think that's part of the issue that ultimately comes into this measure, is what concept do really want for your output measure and whether you could quality adjust it to indicate what's going on there.

>> Dr. Zachary Dyckman: If health status is a measure of quality, then you get into what's the nature of the contribution of medical care to health status.

>> Kathryn Kobe: Right.

>> Dr. Zachary Dyckman: In terms of – not saying zero. What proportion? 20%, 30%, 40%, 50%? Is it Mayor Bloomberg reducing the size of the cup of soda that you can get? It's a lot of things.

>> Kathryn Kobe: Or is it -- amongst the different groups, is it the hospital that's contributing more to that or the physician contributing more to that?

There is way more questions than there's answers in that concept.

>> Dr. Ernie Berndt: Certainly in the hospital setting the whole movement toward endoscopy and so on, surgeries, enormously cut back on the hours of surgery hours.

>> Kathryn Kobe: Right. It's been a huge change. Right.

>> Rick Foster: Also, with our last technical panel for Medicare cost projections, we had some fun and interesting and long-winded debates about resource-based versus outcomes-based productivity.

The bottom line is always, what are we trying to do? In this particular case, we're trying to figure out what's the best way to set the payments for services for Medicare? In which case the basis for payment, which is largely, to date, resource-based, ends up being the driving element.

>> Dr. Ernie Berndt: If we go to value based pricing, we're in trouble.

[Laughter]

>> Rick Foster: We might need a different measure. We isn't there yet.

>> Dr. Ernie Berndt: Any thoughts on questions two and three or other ones on one?

Bob, you mentioned a law firm you were talking to the other day. Are there law firms -- consulting firms in terms of selling practices that really look at number two?

>> Dr. Zachary Dyckman: I think they look at RVU's because it's available now.

>> Dr. Ernie Berndt: Are there studies that you've seen that do that?

>> Dr. Zachary Dyckman: I've just seen a lot more reporting of RVU's by group practice association. And I've seen reference to reimbursement of physicians by RVU's. I don't know when someone considers purchasing in physician practice whether they look at RVU's or look at compensation, revenue or what. I think they still look at revenues.

>> Steve Heffler: I actually had some discussions with a few folks in the past about the terminology, or the term "productivity," and how that means something different in the physician community than it does in the BOS measurement world. When you say RVU's, that's what I think. There are reports out there that say, like, physician productivity went up 8% last year. What it is it's counts of RVU's.

>> Dr. Zachary Dyckman: Yes.

>> Steve Heffler: They call that productivity. That's not how we're looking at it. We want the output, but we also need to know what the inputs are. It's the net effect of the two. So we struggle with that at times in making sure when you talk about productivity adjustment in the MEI's, talking about being consistent with the BOS definition and clearly distinct from physician community world which is thinking number of RVU's, number of RVU's, number of RVU's as being the measure of productivity. That's really for us a measure of output.

>> Dr. Zachary Dyckman: Yes.

>> Steve Heffler: In this formulation.

>> Dr. Zachary Dyckman: They're using it for a different purpose.

>> Steve Heffler: For very different purposes.

>> Dr. Zachary Dyckman: For revenue.

>> Steve Heffler: Yeah.

>> Dr. Robert Berenson: And one other confounder is that RVU increases can lead to coding changes.

>> Dr. Ernie Berndt: So you have the coding consultants who probably are very productive.

[Laughter]

>> Dr. Robert Berenson: And co-create the services. So you have to factor that in.

>> Steve Heffler: Allison Rosen is one of the people I was talking to about this. She said one of her goals --she works with a lot of physicians -- trying to translate the new terminology. They have a hard time hearing, like, "productivity" and physician industry was negative or gone up .5 or .1 when they think, no, it didn't, I was up four, five, how can you say that? It's really trying to bridge the gap there in terminology.

>> Dr. Kurt Gillis: Did we decide to look more at the BLS study that was published, values, on I think slide three?

>> Molly Knight: AHC?

>> Dr Kurt Gillis: Yeah.

>> Molly Knight: There wasn't initial data, but we can contact them to see if we can get additional information. Probably specific --

>> Dr. Kurt Gillis: Yeah. Output. Don't even worry about it.

>> Dr. Ernie Berndt: I think there's -- in the ER volume that Dave and I edited that has a couple of chapters by BLS folks on this -- this morning Bonnie was here. I don't know if she's still here or not. There she is. Yeah.

>> Bonnie Murphy: Asking about productivity?

[Laughter]

>> John Poisal: Don't you have a Mike Harper hotline?

>> Bonnie Murphy: That's not me.

>> Steve Heffler: We talked about data measurements issues earlier. This is one of the concerns we've had with the numbers that come out in the articles from BOS. Molly kind of quickly went over and said she didn't want to answer questions about backcasting, PPI's and going backwards, trying to extend this back. There are clearly price-measurement issues from the mid 90's back. That's one of the things that worried us here, is that they're reporting, you know, minus three for 90 to 95. How much of that is just a purely, like, price-measurement issue as opposed to related to a trend? We tend to, when we look at the service sector productivity, put more weight on stuff from mid to late 90's on.

>> Dr. Ernie Berndt: Yeah. I would think that's probably a wise thing to do.

>> Molly Knight: Simplicity, just the Consumer Price Index for physician services, compared to the PPI, I tried to backcast. It was crazy. Unreal.

>> Steve, on that backcasting that Charlie Fisher did, he only use the PPI I think from 1998 onward when it started. When he backcasted,, if I remember correctly, he actually did it three separate ways. He did Medicare, Medicaid, and private health insurance.

And when he did private health insurance, he actually had data from sources that gave him the net revenues, you know, after all the discounts. And so I think he did about as good as you could do in figuring out, you know, what actually happened under Managed Care. But we could go back in the article and he goes over that in detail.

>> Kathryn Kobe: When you were doing the updates to Fisher's original work, have you looked to see if there's any way of getting around some of the weaknesses that Dr. Newhouse was pointing out in his article?

>> Molly Knight: One of them was the backcasting, is the one. And then the other one was the intermediate inputs, the Scenario B.

>> Dr. Ernie Berndt: The fixed capital.

>> Molly Knight: Right. And then the other was the non-physician compensation piece which was Scenario A.

The non-physician, if I remember correctly, his concern, I believe, was with like the hospitals and that whole issue that we've been discussing with physicians work for hospitals and how one of them picked up, the way the physician office measures was done, so that sort of thing.

>> Kathryn Kobe: Was it his article where he made the comment that 15% of physicians' time was for hospital visits?

>> Molly Knight: I think he might.

>> Kathryn Kobe: I think that was part of the capital he was a bit concerned about.

>> Molly Knight: Right. I'll look it up in the break.

>> Dr. Ernie Berndt: I remember reading that and was struck, though, Kathryn. I doubt the typical physician spends 15% of her or his time these days in the hospital.

>> Kathryn Kobe: Yeah. I would think that's unlikely.

>> Dr. Ernie Berndt: That's why we have hospitals. Because they don't do that.

>> Dr. Zachary Dyckman: Hospitals are physicians.

>> Dr. Ernie Berndt: Right. But they're not -- you're right.

>> Dr. Zachary Dyckman: Length of stay is much less than it used to be. Many more things are done on an outpatient basis.

>> Molly Knight: From what I can see, he just discusses the office-based physicians are about 75% of all patient care physicians. So does not account some attending physicians -- [inaudible] -- Medicare.

>> Kathryn Kobe: Ok.

>> Molly Knight: There could be more in here.

>> Dr. Robert Berenson: So 32% of physicians in a two-year period don't bill for place of service in the hospital.

>> Dr. Ernie Berndt: Say that once again, please.

>> Dr. Robert Berenson: According to the Fisher work, 32% of physicians do not have as place of service the hospital for any of their service claims over a two-year period. So you do have some decremented hospital services because things are moving outpatient, but we now have concentrated physicians in the hospital and many physicians never setting foot in a hospital. So it's moving out.

>> Dr. Ernie Berndt: Any thoughts on number three? I guess looking forward at the scenario, a panel like this meets four, five years from now again, my guess is a hot topic will be what was the effect of IT on productivity? So to the extent coming here, you can take a look at IT more carefully, that may be a scenario to plan for.

>> Molly Knight: Yeah. And in the current methodology it realized taking information from ambulatory healthcare and then applying that to physician offices, in looking at the capital issues raised by Kurt and some other data source, that perhaps could help us narrow down maybe more specific depreciation estimates and then IT under that.

>> Bruce Steinwald: You wouldn't want an outcome basis.

>> Dr. Ernie Berndt: Yeah, outcome. If you could. Yeah.

>> Bruce Steinwald: You said five years.

>> Kathryn Kobe: Can I go back to something that Rick said earlier? This is

something I thought about both ways. I come out both ways as I think about it so the comment on one hand and the other hand. But the concept here is because we're using general economy proxies, should we, for the price movements, should we also be using general economy MFP? Except that we're weighting proxies by a very specific physician input distribution, which I think tends to make it look more like a physician-specific situation and therefore you probably should be considering using a physician-specific multi-factor productivity measure.

I guess when Rick made that comment, I thought, well, maybe we ought to discuss that just a little bit as to whether -- obviously there's a lot of measurement issues right now. But I'm not saying we should throw out the general one and go to a physician-specific one. But if we had more surety about the measurement of a physician-specific MFP, work people think that's a better idea, conceptually?

>> Dr. Zachary Dyckman: One factor I think was the view if physicians are more productive, let them keep it.

>> Kathryn Kobe: Right.

>> Dr. Zachary Dyckman: If they're less productive, then their compensations would reflect that. So by using the general one, that captures that. I don't know -- that was -- my recollection was that was a factor in the decision making process at the time.

>> Kathryn Kobe: Ok.

>> Dr. Kurt Gillis: Didn't the Senate language go back to talk about the tying physician earnings to general earnings levels? And physician's earnings are going to keep up with the general earnings levels. If there's a difference in productivity, if they're not as productive as people in the general economy are, then chances are their income isn't going to keep up with the average earner income.

>> Dr. Zachary Dyckman: Not everyone is so consistent. You're right. There's an inconsistency there.

>> Dr. Ernie Berndt: Another rationale for focusing the physician office specific is that if

you want to have a reimbursement scheme that mimics a competitive market, then you would want to have growth in output prices being equal to both in input prices minus productivity. So you want to bring that explicitly in. That's different from the fairness argument.

>> Dr. Zachary Dyckman: Yes. If you wanted a competitive market for healthcare services, we'd start all over.

[Laughter]

>> Dr. Ernie Berndt: I guess resulting goes if you have constant markup. So a fixed markup.

>> John Poisal: We got some feedback from the webinar participants, and they're asking if we can kind of generally elevate. I guess we've got some -- microphones are hanging from the ceiling, but we've also got some wireless microphones. Maybe we could position them in a bit better place just to be better heard on the webcast.

>> Rick Foster: These are for conference room participants?

>> John Poisal: No. This is for -- we had people that signed up for an actual webinar as well, external, public attendees.

>> Dr. Ernie Berndt: Any other –

>> Steve Heffler: Could I just follow up? Take the scenario where you've -- you're clear on the volume side, as physicians produce services, they get paid for every one of those. That's what happens on the quantity side. So we're talking about the unit price side now. So if you had a price index where the wages, benefits and so forth were not physician-specific, they were more economy-wide -- I don't know about the one using now but different. You weighted everything based on the physician distribution. That gave you a measure of some normative input price index, Rich, kind of what you were getting at. Or you don't apply to MFP adjustment. So that becomes your input price. And MFP adjustment converts it to the output price. You're now going to combine with your volume, and that's going to determine your total revenue.

So conceptually, if you have the normative input price, what is the right MFP measure? Is it the productivity of the physician that went to produce the outputs that are the quantities that get paid or is it the normative MFP measure that's consistent with the normative input price measure to give you an appropriate normative output price measure?

I think that's kind of the question conceptually that you're raising. It's something we've talked about internally before and why we brought up the issue of using weight issues, economy-wide MFP. Just think about that scenario.

>> Dr. Ernie Berndt: I think what you would like to do is have a measure that preserves the economy identity. The economy identity being value, output, revenues being equal to participating factors, the factors of production.

>> Steve Heffler: The identity being revenues equal --

>> Dr. Ernie Berndt: Costs.

>> Steve Heffler: Price times the amount of services you're providing?

>> Dr. Ernie Berndt: Yes. Say that once again just to make sure.

>> Steve Heffler: If you think about revenue -- think about it this way. Think about revenue as price times the number of units of services.

>> Dr. Ernie Berndt: Price times quantity.

>> Steve Heffler: Price times quantity. So leave the q's aside. Think of price. Then price can be the cost per unit of service and any profit that you make. That's going to determine your sort of total price.

So pulling profit out of that, we're not going to worry about whether profits are going up and down or whether you focus on the costs of unit per service. Within that cost per unit of service, or in this case it's really the price per unit service, that's an output price which is the identity of that is your input price plus your MFP. So that's kind of the -- how I think about the identity. It's revenue times price per unit of service times number of unit of service times price per unit of service is function of your input services

and your MFP. I don't know if that's --

>> Dr. Ernie Berndt: I get it.

>> Steve Heffler: So within that output price per unit of service, you have input price and then MFP. Do those conceptually have to be on the same basis?

>> Dr. Ernie Berndt: I would have thought so in order to preserve the economy.

>> Steve Heffler: Right. So if you have physician-specific MFP but an economy-wide input price measure, your identity is --

>> Kathryn Kobe: You don't have necessarily an economy-wide input measure.

>> Steve Heffler: We have a physician-specific weights --

>> Kathryn Kobe: Applied to – right. which is --

>> Dr. Ernie Berndt: Improvised. Another hybrid.

>> Kathryn Kobe: Right.

>> Steve Heffler: It is a hybrid.

>> Kathryn Kobe: You have a hybrid measure.

>> Steve Heffler: We have economy-wide price changes weighted together based on physician-specific inputs.

>> Kathryn Kobe: So the question becomes, how good are your proxies?

>> Dr. Ernie Berndt: Physician-specific prices.

>> Kathryn Kobe: For measuring physician-specific prices? If they're good, then what you've got is a physician-specific index. If they're not so good, then you've got a mush. I think that is the question --

>> Dr. Ernie Berndt: This is analogous to the BLS trying to publish a senior citizens price index.

[Laughter]

Remember that?

>> Kathryn Kobe: Yes. I do remember that. It's come up several times.

>> Dr. Ernie Berndt: They use a consumer expenditure survey to weight senior

citizens' budgets composition but they use the economy-wide prices.

>> Kathryn Kobe: And look at economy-wide purchase patterns.

>> Dr. Ernie Berndt: Yeah. Rather than looking at what are the prices paid by senior citizens.

>> Bruce Steinwald: That didn't work very well.

>> Dr. Ernie Berndt: Pardon?

>> Bruce Steinwald: Didn't work very well.

>> Dr. Ernie Berndt: Depends who you talk to. AARP.

Any other questions for Molly?

Thank you very much. And, again, thanks for the extra work over the weekend.

>> Molly Knight: Bridget bailed me out. Was on my way. Running into errors. I think I got it.

>> Dr. Ernie Berndt: John, do -- should we head back to topics we didn't discuss this morning?

>> John Poisal: I defer to you, Ernie, and the panelists. You have that option. We know we wanted to spend a bit of time at the latter stages of the afternoon speaking about potential recommendations and findings. Whatever you all determine is most appropriate is certainly ok with us.

>> Dr. Ernie Berndt: I guess -- how does the panel want to proceed? We have two options. One -- there are three documents that we didn't get to this morning -- classification expenses related to payroll, contract services with other professional expenses, and then fixed capital proxies. Although I think we did talk a little bit about the fixed capital proxies, did we not?

>> Steve Heffler: Yes, we did.

>> Dr. Ernie Berndt: The second option is to ask Rick to give us the three sentences that are going to be part of the first recommendation.

>> Rick Foster: I think we have such three sentences, although maybe you have to introduce the edits yet.

>> Steve Heffler: We have not introduced the edits yet. We will do that after the break if that's ok. We need to answer a question. And then we can get it in the computer.

>> Dr. Ernie Berndt: Ok. All right. So why don't we start with the technical paper.

Technical Advisory Panel question.

One, classification of expenses related to payroll for clinical staff that can bill independently.

John, do you want to talk to this?

>> John Poisal: Yeah. So we can briefly mention we've looked at that. And currently the way those clinical staff are incorporated into the indexes that they reside in the PE-to-practice expense piece. Kurt had raised an issue about that potentially might be inconsistent with the way they're handled when the RVU's are set for individual -- for the individual codes. So we are investigating.

Historically they have been in the PE piece and not in the work piece. But we're going back and we're going to examine this and make certain that we're doing this appropriately, technically. And to the degree we feel like we should be consistent, we thought we would become consistent.

So I think that was kind of the major, if I recall, the major finding or the major outcome of that. It's in CMS's court to go back and do a bit more investigating here about where those people should be captured and categorized.

>> Bruce Steinwald: I'm retaining something -- I heard -- repeating something I heard someone else say, so verify. Something like 50% of the individuals who are entitled to bill Medicare are not physicians. 10% of the billings come from those 50%.

The up side of that is --

>> Dr. Ernie Berndt: You talking psychologists?

>> Bruce Steinwald: No, no. These are -- for the most part these are people who can

bill independently but typically don't. The physician bills. The physician's assistant provides the service. They get 100% of the fee that way. If the physician assistant bills independently, they get a portion.

>> Dr. Robert Berenson: 85%.

>> Dr. Kurt Gillis: One thing I was wondering, is whether there was some sort of statutory definition of “physician” and would that limit us any way?

>> John Poisal: There is a statutory definition of “physician.” I don't know if we have that in our book. We reference it.

>> Dr. Kurt Gillis: I'm wondering if, you know, nurse practitioners, physical therapists, physician assistants. They have all become big specialties in Medicare.

>> Dr. Ernie Berndt: Chiropractor?

>> Dr. Kurt Gillis: Yeah, also. But I think they are listed. They might be listed --

>> John Poisal: We have things that are individually listed. I think that's what we asked when you ran the data for us. Then we ran through the contractor that had pulled the data. I'm drawing a blank at the moment who that was. But we had pulled the data from the PPIS associated with all of those specialty types that were listed by CMS as being a physician, treating it as like a physician service.

Do you have it, Heidi?

>> Heidi Oumarou: Yes. 1861-R of the Act, definition of the term for physician. When used in connection with the performance of functions or actions, an individual is legally authorized to perform means the following: A doctor of medicine or osteopathy; or, two, a doctor of dental surgery or of dental medicine; three, a doctor of podiatric – I cannot say that word -- podiatry medicine, a doctor of optometry, or a chiropractor.”

>> John Poisal: That's what we used.

>> Dr. Ernie Berndt: Not a nurse practitioner?

>> Heidi Oumarou: That's not listed here.

>> Dr. Kurt Gillis: That’s not listed.

>> Dr. Robert Berenson: Not physical therapy.

>> John Poisal: Right. So this is all part of the investigation.

>> Dr. Kurt Gillis: Ok.

>> John Poisal: There's a few moving parts here that we need to make sure we're consistent with. That might be one of your recommendations to consider, investigate this further.

>> Dr. Ernie Berndt: You want to sort of take -- put it on your to-do list to put together a draft recommendation on that?

>> Dr. Kurt Gillis: Ok.

>> Dr. Robert Berenson: But I think Bruce's is, and Bruce's point is the right one, which is that they can bill independently but they are actually providing services incident to a physician and are part of practice expenses. They are not billing independently. I think is for the most part.

>> Dr. Kurt Gillis: We had a question on the survey about that, too. Among respondents with non-physician staff who can bill independently, 70% answered yes to the question, do these individuals spend 100% of their time -- as physician extenders or independent billers. So that doesn't answer the question.

>> John Poisal: I think you had shared the 70% figure with us earlier as well. Ok.

>> Dr. Kurt Gillis: They're acting more like physicians.

>> John Poisal: Right. In the MEI as it stands today, they are in the practice expense which is where they had traditionally and historically been. But we will move forward and derive an understanding here to ensure that they are either where they should be or if there is a good technical reason to think we should maybe make a tweak to the index to account for that.

>> Kathryn Kobe: If they're billing separately, how are those rates being escalated?

>> John Poisal: I don't think you get the same rate. The physician fee schedule, I think, accommodates rates different from physicians to non-physicians.

>> Dr. Zachary Dyckman: Depends on -- well, podiatrists are physicians, nurse practitioners, I think there's a discount.

>> Dr. Kurt Gillis: 15% discount.

>> Dr. Zachary Dyckman: Yeah.

>> Kathryn Kobe: But they're all on the physician fee schedule, controlled by the MEI anyway. Right?

>> John Poisal: Right.

>> Kathryn Kobe: So these are all conceptually -- should be all measured somehow.

>> John Poisal: And they are. The issue isn't whether or not these people are included in the index. The real issue here is where are they classified? So when we have the weights associated with the different components, presently we have a work weight that's 48.266% and the PE weight that's 52%. Right now they're in the PE. I think when we looked at the costs, it would roughly be about two percentage points.

>> Heidi Oumarou: Two and a half.

>> John Poisal: Two and a half percentage points of weight. So if we were to make a determination that, indeed, maybe these costs should be -- if they're performing the services of a physician, maybe we should capture them in the work component and therefore proxy these costs by the different price proxies associated with that component versus where they are currently captured in the PE and proxied by those pieces.

>> Dr. Robert Berenson: That would change the weights also.

>> John Poisal: That's right.

>> Dr. Ernie Berndt: And the deflators.

>> John Poisal: Right.

>> Kathryn Kobe: Perfect.

>> John Poisal: The impact of the deflator.

>> Heidi Oumarou: And it would change possibly payment because the RVU's --

>> John Poisal: Correct. The RVU's are benchmarked or have been historically benchmarked to what the MEI weights are. So that could have downstream impacts as well.

>> Kathryn Kobe: Ok.

>> Dr. Kurt Gillis: And the gypsies.

>> Heidi Oumarou: And the gypsies.

>> John Poisal: And some other things that certainly we haven't thought of.

>> Dr. Ernie Berndt: Any other comments, thoughts, on this expense classification issue?

So, Kurt, you'll draft a recommendation for us?

>> Dr. Kurt Gillis: Yes. I'll talk with John.

>> Dr. Ernie Berndt: Great. Thank you.

The last one then, contract services within other professional expenses and all other services cost weights.

John, you want to fill us in on this one?

>> John Poisal: I was actually going to ask Molly if she wouldn't mind speaking to that. That was –

>> Dr. Ernie Berndt: Brian?

>> John Poisal: Yeah. That was one of the things that we pulled together towards the end of trying to furnish all of the documentation to each of you.

Do you mind speaking to that briefly? And maybe we could even give you a microphone or put that -- it's wireless, so.

>> Rick Foster: Or just come up here.

>> John Poisal: Or come up here.

>> Molly Knight: So this question was from Kurt, a concern. It was in regards to -- thank you. I don't wear heels very often. Usually in flip-flops.

So in the MEI currently we had a category of other services. And

then there was this other professional expense category as well that came directly from the PPIS. So when they developed -- the gypsies, they had actually asked for our assistance, the contractor. We gave them an underlying category of names and expenses to which they could determine and calculate a weight for this purchase service index.

And the idea was based on comments from the physician industry that said we now have this residual of expenses that we now outsource but are geographically not being adjusted because they're in this all other category, not geographically adjusting. That's the way the current method was.

So we acclimated an analysis and provided them underlying data. So they came up with a percentage of the MEI which was actually a total percentage of 8.095 percentage points that were all other services or other professional services. They then deemed about five percentage points of them to be adjusted for locality.

So I think Kurt's question was, can we do – it wasn't exactly clear in the write-up exactly where they go the underlying data. But they got it from us. He suggested that we put aggregate MEI, perhaps break these categories out into something more specific and then proxy them.

So we just provided a suggestion here. Using underlying data, we created three additional categories here. One was professional, scientific, and technical. And then administrative, support base management, and residual all of other.

We chose those aggregations based on the fact that that's most of the underlying services, 54 and 56. There wasn't an appropriate ECI for that.

We certainly can do that if that's what the panel recommends. That was basically it.

>> John Poisal: So that last page, if you're looking -- the last page is the present construction of the MEI with the two highlighted pieces. And then pulling those highlighted pieces together and breaking out differently results in the three highlighted

on the page before.

>> Dr. Kurt Gillis: Ok. And I brought this up because we think there are these other professional services in -- other contract services that are included in the other professional expense category. So things like billing services, accounting, legal, contract services. I didn't really expect all of it to be -- somehow I guess the gypsy people decided only part of that would be geographically adjusted.

>> John Poisal: That's right.

>> Dr. Kurt Gillis: We wouldn't expect all of the other professional expense to be these contract services. Do you know how they came up with –

>> John Poisal: That become a policy, a matter of policy as opposed to a matter of technical interpretation. I'm sure somebody would be happy to go into that.

>> Molly Knight: You mean how they came up with the labor-related?

>> John Poisal: Is that what you mean, how they came up with what proportions?

>> Dr. Kurt Gillis: Yeah. What share. 4.5%.

>> John Poisal: Similar to methodologies that we've used but not identical if I recall in some cases. Right?

>> Molly Knight: I think they did two different ways and they ended up with ours. We produced the same number. So I think in the end it ended up being the same number.

Basically as we do with the market baskets, there's a labor-related share for, like, the hospital. So we go through the detailed categories and deem whether or not this is something that’s labor intensive, volatile in the labor market. She they did the same here.

So for most of the services they deemed to be in the local market which I think could probably provide more detail but things like marketing. It was on a national marketing firm for physician offices. Accounting, I believe they included because of the local accountant. Some things they didn't because in that all other professional expenses there were some just random things like banking, which is just the fees that

they --- sort of things like that.

>> John Poisal: It's the two. Is it labor-intensive and are those costs likely to vary or be influenced by the local labor market?

So as Molly mentioned, in some of the other market basket we've conducted surveys and things to try to find out, like, what percentage of advertising, legal, or accounting fees are you purchasing from organizations that would be sort of headquartered in your local labor market?

And in some cases things tended to be purchased locally. And in other cases, they tended to purchase from like a national-based vendor where the price is the price.

>> Kathryn Kobe: But aren't you still ignoring the potential for productivity in these industries in that if you're buying accounting services from somebody to the extent that they are a productive accountant, perhaps, then it's not going to be the wages that they're paying, their accountants that you're paying, as your price?

Is my question not making sense?

>> John Poisal: Can you try one more time?

>> Kathryn Kobe: Your price proxy here is a wage index.

>> John Poisal: For what's presently in the MEI or what's --

>> Kathryn Kobe: I guess -- it is currently being proxied, I guess, by an ECI as well. But at least the all other services is.

>> John Poisal: Right.

>> Kathryn Kobe: But if you're purchasing that from a services company, their wage increase may not be paying the fee what you were paying as price increase. That may not be what they're purchasing at.

>> John Poisal: That's true.

>> Kathryn Kobe: I mean, you may not have any other option. But we don't have a price for legal services, I guess. We need to have Bonnie get that.

>> Bonnie Murphy: We have a PPI for legal services.

>> John Poisal: I think this encompasses so many things. I mean, if I recall the question correctly, it was in some respects a catchall for everything that was left over, that wasn't explicitly asked for in other questions which would be inclusive of -- even though I do think it did specifically reference some of these things. But it was also -- I remember having conversations or two about this three or four years ago about, you know, while there were certain and specific things, maybe the interpretation of the question was, and any other costs that weren't specified or asked for.

So that does make it a bit difficult to kind of whittle down to some of the other finer level possible proxies that maybe could be aggregated to something similar to what we were speaking to earlier about paper, plastics and so forth.

But your point is well taken. That proxy may not reflect a price change associated with legal fees that they were paying. But we would hope it would be a decent proxy in the end for all of those.

>> Molly Knight: These are just ones we picked.

>> Kathryn Kobe: Right. There's just an underlying assumption which may or may not be a problem.

>> Molly Knight: Sure.

>> Kathryn Kobe: It's like any other price proxy issues as well.

>> Steve Heffler: That's actually an assumption that’s consistent in all of our market baskets. The assumption is you're buying some kind of labor type service, what the underlying price of that labor service should look like, the underlying, cost drivers associated with that.

>> Molly Knight: There's a substitution issue, too. Some of these staff could employ them or they could hire the service. So if we employed them, you would definitely proxy ECI for some of these wages.

>> Kathryn Kobe: Right. That's true.

>> Molly Knight: So that's something to be considered.

>> Steve Heffler: It is an assumption.

>> Kathryn Kobe: Ok.

>> Dr. Ernie Berndt: Can I ask a technical question?

When Molly presented MFP numbers, they were in tenths of a percent, 1.1, 1.3, etc, etc. Here we sort of got shares to hundreds of a percent and when we're multiplying all sorts of things to gather a bunch of small numbers. Are you carrying out lots of digits? Are you rounding at the very end? How are you doing that?

>> Molly Knight: We have three decimal places for the weights. When we do the actual calculation of MEI, I've used as many as the program software will allow us, which is 13.

>> Dr. Ernie Berndt: Gotcha. Good. Then you round off.

>> Molly Knight: Yeah. Then we round off, which we actually had questions from the industry about whether or not we had rounded and we gave them the number down to the 13th decimal.

>> Dr. Ernie Berndt: Good. Because sometimes --

>> Molly Knight: It can make a difference.

>> Dr. Ernie Berndt: Especially using Excel, because Excel truncates.

>> Molly Knight: Right.

>> Dr. Zachary Dyckman: We're not asking about reliability to the 13th decimal.

>> Dr. Ernie Berndt: Right.

[Laughter]

>> John Poisal: That's a much longer answer.

>> Molly Knight: We have many check programs, let's just say that, to make sure they sum up correctly.

>> Dr. Ernie Berndt: Thank you.

>> Molly Knight: Is there any other questions?

>> Dr. Ernie Berndt: So to bring this one to a close, is there going to be recommendation on this one or is it just --

>> John Poisal: I think that's up to you all to think about. Maybe you can revisit that. We can take a short break here shortly.

>> Dr. Ernie Berndt: Right. Did we finish up the fixed capital? I think we did. But I'm not sure. This morning?

>> John Poisal: I know we talked about it in the presentation.

>> Hudson Osgood: Yeah. Dr. Berndt, we discussed the majority of the fixed capital during the course of the presentation. The write-up does include more detail on the highest level CPI that we use, the CPI for housing as well as one level down in terms of the pre-subcomponents and one level down from the shelter subcomponent within housing. Again, on the equivalent as discussed before, 60% of the normalized weight of the CPIU for housing.

One -- in the fixed capital proxy write-up, under the section for non-residential lease proxies --

>> Dr. Ernie Berndt: Yes.

>> Hudson Osgood: We did chart two additional proxies that weren't included in the main body of the price proxy presentation. So on Page 5 of the fixed capital proxy write-up, what we did is we charted -- we went two – well, one level below lessors of non-residential buildings and showed the two largest subcomponents. First was the leasing of professional office buildings. So to break out the more pure element of office buildings or professional office space. And then the other proxy that we charted was leasing of shopping centers and retail stores in the event that the panel -- they believe that perhaps that could be another possible alternate proxy for fixed capital.

What we've seen is that there this is quite a bit more volatility in the possible alternate proxies. So, again, we leave it to the discretion of the panel to decide whether or not they want us to look into additional possible alternate proxies or if they

feel this information is suitable.

>> Dr. Ernie Berndt: Do you know, is this PPI sort of a spot rate or based on lengths of contracts that are three, four, five-year contracts when you're leasing?

Where I'm going with the question is, I think the spot market probably is considered more volatile in a long-term contract market. And I'm not sure whether these different price measures are measuring contracts in different length.

>> John Poisal: Bonnie might be able to help us with that.

>> Bonnie Murphy: We measure average rent for occupied square foot.

>> Dr. Ernie Berndt: Ok. So it's a weighted average.

>> Bonnie Murphy: Right.

>> Dr. Ernie Berndt: Essentially.

>> Bonnie Murphy: It's occupied square feet.

>> John Poisal: Occupied square feet.

>> Dr. Zachary Dyckman: So suppose the average lease is five years and there are price changes for new leases, it would have a 20% weight. The new lease rate.

>> Dr. Ernie Berndt: Right.

>> Bonnie Murphy: If I understood what you said. The average --

>> Dr. Zachary Dyckman: Suppose 20% of leases come up in a particular year and there's a 10% increase for that year. You wouldn't say that prices went up 10%, that housing prices or lease prices went up 10% that year. You'd have to consider all the other stability of existing leases.

>> Bonnie Murphy: Right.

>> Kathryn Kobe: Most existing leases have escalators in them. That's all taken into account. Right?

>> Bonnie Murphy: Yes.

>> Dr. Ernie Berndt: That would be captured I would think. Right?

>> Bonnie Murphy: That's right.

>> Kathryn Kobe: And what's the -- what is the kind of the base of buildings that are available for which rents might be collected for?

When you're choosing your sample, what are you choosing your sample from? What base of types of buildings?

>> Bonnie Murphy: There's different indexes. We have indexes for retail buildings. Different indexes for professional and office buildings. We take a national sample.

Is that what you're asking?

>> Kathryn Kobe: Right.

>> Bonnie Murphy: Yeah.

>> Kathryn Kobe: Ok.

>> Bonnie Murphy: So two indexes. One we mentioned was retail shopping centers. That's a separate index. And then professional and office buildings is the separate index as well.

>> Kathryn Kobe: So those are the two. Then they make up the non-residential --

>> Bonnie Murphy: I believe there's five lower indexes.

>> Hudson Osgood: Yes. Bonnie's correct. On Page 4, at the bottom on Table 4, the list of the four primary components of lessors of non-residential buildings.

>> Dr. Ernie Berndt: Kurt, from the EMA occasional survey, do you ever ask questions on what type of space do you practice in?

>> Dr. Kurt Gillis: One year I think -- one year we asked about square footage of space. That's the only thing we got into in terms of characteristics of the office space. Always ask for office expense, but.

>> Dr. Ernie Berndt: Any thoughts from the panel on which of these proxies is most appropriate and is volatility good or bad?

[Laughter]

That is to say, is that what the real world is like or not?

I guess I'm a little uneasy about using any CPI here simply because

the rental market and asset market for houses is so different, I think, than from offices. So I guess my prior would to be to try and use one of the PPI's rather than a CPI. But I don't have a strong opinion.

>> Kathryn Kobe: Well, we know that the CPI for Owner's Equivalent Rent doesn't even accurately -- well, I wouldn't say accurately or inaccurately. It does not fully reflect the types of housing that owner-occupied housing says. So you have to really question whether that is the best index for using for something that isn't even related to owner-occupied housing.

I see that this other index -- this is a four quarter moving average, this chart on Page 6?

>> Hudson Osgood: Yes. Those are all the same used in the presentation.

>> Kathryn Kobe: It is a quite volatile series here it looks like, the PPI.

>> Dr. Ernie Berndt: I think the real world is pretty volatile.

>> Kathryn Kobe: Conceptually, one would think that's a little closer given that I'm not that sure that many physicians practice out of their house anymore, do they?

>> Dr. Ernie Berndt: Well, go to New York and that's where all the psychiatrists are.

[Laughter]

>> Dr. Zachary Dyckman: I don't know if they're in their homes. They're in apartments where other people live next door.

>> Dr. Robert Berenson: And they've all opted out of Medicare anyway. It doesn't matter.

>> Dr. Zachary Dyckman: That's true.

>> Kathryn Kobe: Do we have any information about where physicians practice? You're saying we never ask that question? The AMA may have to ask that question. We don't really know what the answer to that question is.

>> Dr. Kurt Gillis: We have the zip code.

>> Kathryn Kobe: Well, I thought about, well, you have their addresses, you could look

them up.

[Laughter]

I'm not sure that's an efficient use of their time.

>> John Poisal: Let us know when you wrap that up.

[Laughter]

>> Kathryn Kobe: On Google maps you could look at the front door of their building. But you can't look at their private garden though.

>> Bruce Steinwald: You have to go there.

>> Dr. Ernie Berndt: So if we're going to, for both the reasons I suggested and the reasons Kathryn suggested, go away from the CPI, what would you recommend? Which of the PPI's? We have some plotted on Pages 5 and 6. Again, these are growth rates not levels.

>> Dr. Zachary Dyckman: Well, suppose you changed with PPI index, when would -- you start – would you take the last year and set that at 100% and look at changes from 2011 or 2012?

>> Dr. Ernie Berndt: When would you go back?

>> Dr. Zachary Dyckman: I'm wondering if levels would be relevant. It's just going forward it would be the percent change. Right?

>> Dr. Ernie Berndt: Depending on the weight, too. The weight that would be assigned, cost share, would be on the reflective level. Right?

>> Dr. Zachary Dyckman: The weight would be the weight you're using now.

>> John Poisal: Right. I don't think we have any additional data that would permit the change of the weight. Of my God, we would be picking up the rate of change in price only.

>> Dr. Ernie Berndt: And right now you're using lessors of non-residential buildings?

>> John Poisal: No. It's the Owner's Equivalent Rent.

>> Dr. Ernie Berndt: Oh, Owner's Equivalent Rent.

>> John Poisal: Yup.

>> Dr. Zachary Dyckman: I apologize for forgetting what was said earlier, but the Owner's Equivalent Rent is based on questions to owners about what they would rent?

>> Dr. Ernie Berndt: Yes.

>> Kathryn Kobe: No. The prices aren't collected that way. The weight in the CPI is collected that way. But the prices come from a set of houses that are rented.

>> Dr. Zachary Dyckman: Yes. Now I recall that.

>> Kathryn Kobe: Rental units.

>> Dr. Ernie Berndt: Thank you.

>> Dr. Zachary Dyckman: Yes.

>> Dr. Ernie Berndt: I guess in the future at some point to help us choose amongst these, perhaps for the various graphs that you've plotted out, might be useful to have means and standard deviations or something like that so that we have some idea of how much -- since you end up being a 10-year moving average on MEI productivity.

>> John Poisal: From a technical perspective, what strikes you as most appropriate?

>> Dr. Ernie Berndt: I would have thought the PPI for something like professional and office buildings.

>> Dr. Zachary Dyckman: If you think about where physicians rent, that makes the most sense. And yet when one looks at the volatility, one has some concerns.

>> Dr. Ernie Berndt: Right.

>> Dr. Robert Berenson: I actually rented a nice shopping center, myself, for 12 years. My practiced moved to a professional building. The lessors of non-residential buildings, the dominant weight is the professional office building. But -- so you could capture that. And yet I think it probably makes more sense to do professional and office buildings.

It would be nice to get some real world information. But if you don't have that, I would, I don't know -- I don't know whether we want volatility or not want volatility. It's been argued both ways.

>> Dr. Zachary Dyckman: Would non-residential buildings include just -- would it include warehouses?

>> Dr. Ernie Berndt: Take a look on the bottom of Page 4, Table 4. It says leasing of manufacturing and industrial buildings. I would think warehouses would come under that, but I'm not sure.

>> Dr. Zachary Dyckman: I was afraid to ask about manufacturing.

>> Dr. Ernie Berndt: Yeah.

>> Dr. Zachary Dyckman: I would not be comfortable using the definition then.

>> Dr. Robert Berenson: I think we're probably best off using professional.

>> Dr. Ernie Berndt: Office buildings?

>> Dr. Robert Berenson: Office buildings, I think.

>> Dr. Kurt Gillis: Would it help to learn more about exactly what types of buildings are being included there? Size.

>> Dr. Ernie Berndt: Law firms, consulting firms, tax preparation.

>> Steve Heffler: This is the direction that you're going. Something this particular family of mix. We can certainly spend more time between now and the next meeting, doing more research, so you have more data points with which to make recommendations. If that would be helpful. You might need some help from colleagues from DC. We can look into that.

>> Kathryn Kobe: The PPI is -- the CPI is looking very much at urban areas. But I don't think the PPI – no. She's shaking her head no.

>> Bonnie Murphy: National sample.

>> Kathryn Kobe: PPI would be a national sample. So it would not necessarily be just the urban areas. I think that gets to some of the questions we're having about where physicians practice, I think.

>> Dr. Ernie Berndt: Almost on time.

>> John Poisal: Almost. We did have one other write-up.

>> Dr. Ernie Berndt: Which one was that?

>> John Poisal: Physician compensation. Time about what was captured in the wage and salaries and benefits. I recall that was one of the ones we talked about pretty early on in the first meeting.

This had to do with where certain components of compensation were categorized and captured.

>> Kathryn Kobe: So we take from this that we think the retirement benefits, which I think was the question from last time, is actually in wages and salaries as opposed to benefits.

>> John Poisal: That is true for the physician piece.

>> Kathryn Kobe: And that the benefits index, of course, the retirement is in the benefits index as opposed to being in the wage index, as I understand it. So we possibly have a bit of a mismatch there. I'm not sure that we can do anything about it, so.

>> Dr. Kurt Gillis: A split was 15% benefits for employed physicians, right? From SOI. That's what's used.

>> John Poisal: Right. That became how we broke it out.

>> Dr. Kurt Gillis: So one option would be to use something closer to that. Not using the AMA PPIS questions.

Is that what was done in the 2000-based MEI? Was it also from SOI? To get the income benefits?

>> Molly Knight: [Inaudible]

>> John Poisal: Say that again, Molly.

>> Molly Knight: It was done using EECI -- we used it for the two-based MEI. I believe we used the ECI data, the ECE data split out.

>> John Poisal: We grew it from the previous mark, as I recall. Right? Aged the data forward? Mary Carroll might have that, too.

>> Molly Knight: I have to double-check. For the 2000 base index we did not have a full AMA survey. We only had portions. So I think John is right about that. Would have assumed the split of something sort of what was coming in the ECE data which is somewhere around 80/20 or something.

>> Steve Heffler: That was like an economy line. Right?

>> Heidi Oumarou: For 2000 we used the overall ECI for private employees for wage, salary, and benefit.

>> Steve Heffler: Small private employees?

>> Heidi Oumarou: Yeah. And we inflated the 96 SMS level to 2000 using the growth in those same proxies.

>> John Poisal: Proxy. Right.

>> Steve Heffler: It does seem clear that the proxy we are using has pensions in the benefit and are weight as pensions and the salaries. Right?

>> Heidi Oumarou: Right. For 2006.

>> Steve Heffler: 2006. Right.

>> Heidi Oumarou: So we could do what Kurt is saying and take that compensation, those two together, and then use the split from SOI or ECI.

>> Steve Heffler: That could be a recommendation.

>> Kathryn Kobe: Re-weight the proxy is what you're saying?

>> Steve Heffler: A general recommendation could be CMS should ensure that the wages and benefit categories in the MEI are –

>> Dr. Ernie Berndt: Are consistent.

>> Steve Heffler: -- consistent with the weights and the proxies for the use of different data whether economy-wide or income data to ensure that that's the case. Whatever. But that's --

>> Dr. Ernie Berndt: One good, long sentence.

[Laughter]

>> Steve Heffler: Yeah.

>> Dr. Zachary Dyckman: But then you need a second recommendation.

>> John Poisal: About how to do it. Right?

>> Dr. Zachary Dyckman: No. If it's consistent, it could be consistent either way. Inclusive or exclusive.

>> John Poisal: Right.

>> Heidi Oumarou: It would be harder to be exclusive. We'd want to make it consistent with the proxy.

>> John Poisal: Yeah.

>> Kathryn Kobe: We decided that the other one was already correct. I mean that's why we asked that question because the ratios were different. So the other one.

>> John Poisal: The non-physician piece you mean?

>> Kathryn Kobe: Right. That one already seemed to match.

>> Dr. Ernie Berndt: Any other questions on physician and non-physician compensation, benefits? Wages and salaries?

Why don't we take a 15-minute break.

>> John Poisal: Excellent.

[A break was taken at 2:46 p.m.]

>> Dr. Ernie Berndt: So the remaining agenda has three parts to it, I think. I'm going to ask the audience if there's anyone who later will want to make any public statements so that I can prepare. Do we have anyone doing that?

>> John Poisal: Do you know if any of your colleagues were anticipating speaking?

>> Dr. Kurt Gillis: I'm sure they'd like to. I'm not sure if they're coming back in time.

>> John Poisal: Ok.

>> Dr. Ernie Berndt: Ok. Secondly, there's some logistical issues. In particular, Steve and John have indicated that from their perspective it is permissible for our third meeting to be held via conference call rather than in person here. That being the case,

I'd like to ask the panel what their preference would be. This is the meeting we're talking about on July 11. Which is what day of the week? Wednesday I think. Isn't it?

>> Heidi Oumarou: Wednesday.

>> Dr. Ernie Berndt: Wednesday.

Any thoughts?

>> Dr. Robert Berenson: Any guesses as to whether we have to go all day or part day or what would we need to be accomplishing?

>> John Poisal: I think that would likely sort of sit in your court, to the extent we discuss possible findings and recommendations today, and then we here can provide you with any additional information try to record and get to you. I don't know that there's a maximum or minimum amount of time.

>> Dr. Robert Berenson: We're mostly going to get to then recommendations, basically, and not suggest any new areas of research.

>> John Poisal: That's correct.

>> Dr. Robert Berenson: So that should go faster, I would think, which I think the conference call might work pretty well.

>> Bruce Steinwald: One question, though. It will be very beneficial for everyone to be able to see the recommendation. So do you have the capability of webcasting it?

>> Dr. Ernie Berndt: WebEx?

>> John Poisal: I guess we could do a webinar where we have a live sort of typed-up living document as we progress through? Is that – do you think that's right?

>> Hudson Osgood: Yeah. One person, the webcast moderator, would have the ability on the fly to make changes on the screen. Are you speaking about the WebEx like having an interactive webinar where people can also themselves make changes to the document on the screen?

>> Bruce Steinwald: No. I didn't have that in mind. I had in mind that each of the five panel members would be able to see a draft recommendation.

>> Hudson Osgood: Yes.

>> Bruce Steinwald: And then if one of them wanted to suggest a change, then one of you guys would make the change provided that the other four would agree to it.

>> Hudson Osgood: Yes. We can do that.

>> Dr. Ernie Berndt: Zach?

>> Dr. Zachary Dyckman: I think that's fine.

>> Dr. Ernie Berndt: Kurt?

>> Dr. Kurt Gillis: I'm indifferent.

>> Dr. Ernie Berndt: Kathryn?

>> Kathryn Kobe: It can be done either way. In some ways I think when you're agreeing on recommendations, it's easier if everyone is in the same room. But I think it can be done either way, so that's fine with me.

>> Dr. Ernie Berndt: I have a preference for not traveling.

>> Kathryn Kobe: Understood, since I don't have to do the traveling and you do.

>> Dr. Ernie Berndt: Having gotten up at 4:00 this morning.

>> Bruce Steinwald: What if I got you tickets to a ballgame?

[Laughter]

>> John Poisal: Only if the Red Sox are in town. Right?

>> Dr. Ernie Berndt: So why don't we plan on a conference call then if that's all right.

>> John Poisal: Ok. We will start all of that in motion and assume, keep our fingers crossed, it all goes well. But I don't anticipate any problems. We'll move forward with that understanding.

>> Dr. Ernie Berndt: One other matter before we get to the panel recommendations.

There was -- from the public, there was a letter sent in from a Ms. Padulla -- I forgot her first name – who's a representative of the American Psychological Association, I believe. She, in her letter to us, raised a policy issue which I think is somewhat outside the scope of our consideration, but let me just mention what

it was.

And the reason I'm mentioning it even though I think it's out of scope is that I think it just highlights the importance that we attached to doing things as best we can as a technical committee because it does have important repercussions, and the particular repercussions that she was referring to was, as best I understand -- correct me if I'm wrong -- was that by going to an index here that sort of split out -- from the intermediate inputs that split out capital and other inputs, those particular providers who were very labor-intensive and very little capital-intensive essentially took a hit in their payment because of the overall neutrality and the reweighting, and that in particular she was representing psychologists that are pretty labor-intensive sort of operations that would take a bit of a hit. She wanted us to know that.

So I've asked John to distribute her letter to the panel members so they can read that. I think, technically speaking, it's sort of outside the scope of our consideration.

>> John Poisal: I think we would agree with that, but we'll distribute it so that everybody has the materials that were sent.

>> Dr. Ernie Berndt: Ok.

>> Bruce Steinwald: But taking a hit or not taking a hit is really an empirical matter, isn't it? You wouldn't automatically take a hit just because --

>> Dr. Ernie Berndt: Well, if you are less capital-intensive, in the way I think it was done, we would now be rewarding more -- overall budget neutrality would be putting a higher expenditure towards capital-intensive --

>> John Poisal: Those with higher practice expenses make out better under the current system if the weights shift in a way that practice expenses weighted more heavily. So in the case of the psychologists, their practice expenses are less. Their labor pieces are a bit more -- more eyeball-to-eyeball.

>> Dr. Zachary Dyckman: You're talking about the RVU's.

>> John Poisal: Right, an RVI issue which connect to the MEI.

>> Dr. Zachary Dyckman: 90% or 95% versus 50%.

>> John Poisal: Right. That's right.

>> Dr. Ernie Berndt: I miscast that a bit. My apologies.

>> Dr. Zachary Dyckman: I just wanted to clarify.

>> Dr. Robert Berenson: We don't have real jurisdiction over that.

>> John Poisal: That's right.

>> Dr. Ernie Berndt: Any other logistical, other issues, before we get on with recommendations?

Rick and Steve have done us a favor and drafted the first one.

The panel recommends that CMS research, whether using self-employed physician data or the MEI cost weights, continues to be the most appropriate approach. In particular, the panel notes that in recent years there has been a shift toward physicians operating as employees -- do we want to add and in larger group practices?

>> Dr. Zachary Dyckman: Sure.

>> Dr. Ernie Berndt: Instead of in a self-employed status. However, it is unclear whether adequate data are available to reflect the shift in the MEI or whether the cost structure for employed physicians would be materially different than for self-employed physicians. Accordingly, consideration of the availability and viability of expense data for physicians in larger practices and physicians employed by hospitals and other business entities would be an important --

>> John Poisal: I beg your pardon, Ernie. Sorry. I was trying – I had to page down. I wanted to fix this. Sorry.

>> Dr. Ernie Berndt: Would be an important aspect of this research.

Any comments, edits, reactions?

>> Rick Foster: We can fine-tune this a little bit just for readability. Steve, Bruce, and I

put this together in the middle of all the other discussions.

>> Dr. Ernie Berndt: Right.

>> Dr. Zachary Dyckman: My recollection is that what drove this was at least in part the movement of physicians from physician group practices owned by physicians to hospital-owned practices and hospital-affiliated. And perhaps hospitals should be in the first part in addition.

>> Dr. Ernie Berndt: Ok.

>> Dr. Zachary Dyckman: I don't know if it was largely from smaller group to larger group as much as from physician-owned group practices to hospital-owned group practices.

>> Dr. Ernie Berndt: Point well taken.

>> Dr. Robert Berenson: I think that's right.

>> Dr. Ernie Berndt: You want to suggest some re-wording, Zach?

>> Rick Foster: I was going to say we can take your comment and go ahead and fix it.

>> Dr. Ernie Berndt: Ok. Fine.

>> Dr. Zachary Dyckman: Ok.

>> Dr. Ernie Berndt: Why don’t we just leave it that way and then deal with it on the conference call?

>> Rick Foster: No. We'll go ahead and make that change for you. As a group, editing the specific language probably will not be the best to use of your time.

>> Dr. Zachary Dyckman: This may not be very hard. Shift towards physicians operating –

>> Dr. Robert Berenson: As hospital employees.

>> Dr. Ernie Berndt: As operating?

>> Dr. Zachary Dyckman: Currently. They’re in physician-owned practices.

>> Dr. Robert Berenson: From physicians and physician-owned practice to --

>> Dr. Zachary Dyckman: To hospital-owned practices. Maybe something as simple

as that.

>> Dr. Robert Berenson: Yeah.

>> Dr. Ernie Berndt: So a shift from --

>> Dr. Robert Berenson: Physician-owned practices to hospital-owned practices. Isn't that really what we're talking about?

>> Dr. Ernie Berndt: Ok.

>> Dr. Zachary Dyckman: Yes. We do have data for larger group practices.

>> Dr. Robert Berenson: Yeah.

>> Dr. Ernie Berndt: We don't have from onesies-twosies into.

>> Dr. Zachary Dyckman: I mean we have tens.

>> Dr. Ernie Berndt: Right. Yeah.

>> Dr. Zachary Dyckman: It's not the size of the group. It's the --

>> Dr. Ernie Berndt: Right.

>> John Poisal: We still want to preserve the larger group practice aspect of this? Because it could be -- in addition to just moving -- move -- the transition to hospital-based physicians but also the onesies and twosies getting together --

>> Dr. Zachary Dyckman: I think that's largely happened already.

>> Steve Heffler: The issue was, is that reflective in the self-employment data?

>> Rick Foster: Which it should be.

>> Dr. Robert Berenson: That's what I was going to say. It should be reflective.

>> Rick Foster: I think this is a self-employment to employment issue. Whereas you point out, most of the employment's pretty much within hospitals.

>> John Poisal: So delete from cursor to period?

>> Dr. Robert Berenson: I think that's right.

>> Dr. Zachary Dyckman: I think so.

>> Dr. Ernie Berndt: Yup.

>> Dr. Robert Berenson: I guess the other comment I would make is do we want to

say it's unclear whether? I think we know more. There are no data available. Right? Do we want to be more definitive or not?

>> Rick Foster: How thoroughly have we actually researched that ourselves already? I didn't get the sense we really exhausted.

>> John Poisal: I think we can continue to scour and prove what we probably already know, but all the same.

>> Dr. Ernie Berndt: Any other comments for the first recommendation?

>> Steve Heffler: Can I just ask a point of clarification. I want to make sure I understand. Part of what's going to follow here is looking more into the MGMA data. I thought part of the imaging MGMA issue was its reflective of these larger specialty groups which we don't think are being captured adequately in the PPIS data for just pulling the self-employed. Am I mistaken in that? I might be mixing issues up here.

>> Kathryn Kobe: I think we were concerned that the MGMA data didn't reflect the onesie and twosies.

>> Dr. Ernie Berndt: That, too.

>> Steve Heffler: Right. But is the inverse of that a concern or not? That the MGMA data doesn't reflect the local or larger MGMA data is capturing?

>> Dr. Zachary Dyckman: Kurt?

>> Dr. Kurt Gillis: We got responses from people in larger groups, but they were definitely under representative in the survey.

>> Steve Heffler: Ok.

>> Dr. Kurt Gillis: The people most likely responded were in the smaller practices.

>> Steve Heffler: So that's probably separate. That should be a separate issue from this.

>> Dr. Zachary Dyckman: Well, maybe from physicians in smaller practices to larger group practices and then the physician-owned to hospital-owned. And then the rest I think sort of works out ok. You refer to both in the second.

>> Steve Heffler: Right.

>> Dr. Robert Berenson: I'm happy then with – it is unclear. I think the issues on MGMA will be representative as an example size, but that's not a lot different from what we have. It's worth looking into.

>> John Poisal: Does that read ok?

>> Dr. Robert Berenson: Yeah, I think so. Yeah.

>> Dr. Zachary Dyckman: I think so.

>> Dr. Ernie Berndt: How about deleted the first practice through smaller and larger practices. Improve our word productivity.

[Laughter]

>> Rick Foster: The output just went down.

[Laughter]

>> Dr. Robert Berenson: The outcome went up.

>> Rick Foster: And it took us longer.

>> Dr. Ernie Berndt: Ok. Cost weight issues. OACT should research -- is the word "should" what I'm uncomfortable with? Is it encouraged to?

>> Steve Heffler: Just as a clarification, these weren't really written to be like recommendations. They were more of some of these to do's. Some of these are things that seemed like you guys had evolved as a force. So however you want to approach this. I think in that case it should be we will research because we got asked to do it.

>> Dr. Ernie Berndt: Ok. And I guess I would go a step further. Even if the MGMA presents a representativeness problem, does it make any difference?

For office expenses, Option 2 is preferred, calculate at detailed level but show at aggregate level. Right? Option 2 is the one on the --

>> Dr. Robert Berenson: If I could just go back on number one. You might want to look at the report from MedPAC where we deal with some of the representativeness issues of the MGMA.

>> John Poisal: Ok.

>> Dr. Ernie Berndt: Is that publicly available?

>> Dr. Robert Berenson: It's on their website, yes, 2010 publication has a contractor report. If you go to their website and go to year and then contractor report you will find it.

>> John Poisal: A 2010 report, you said?

>> Dr. Robert Berenson: A 2010 report, I'm pretty sure. It's from – it's a contractor report. It was prepared by the Urban Institute and MGMA actually, as the contractor. It's the last one in the contractor reports for 2010.

>> Dr. Ernie Berndt: Prepared by Urban Institute. Yeah.

>> Rick Foster: This is more like an outline at this point rather than a final recommendation.

>> Dr. Ernie Berndt: For office expenses, option 2 is preferred.

For independent clinicians, Kurt will draft a recommendation concerning classification issues. Is that what it is? I forgot what the --

>> Dr. Kurt Gillis: The people who can bill independently. Whether payroll should go into it.

>> Dr. Ernie Berndt: Regarding – independent. Right. Ok.

For wages/benefits, the distribution of retirement expenses should be -- was it classification? I guess "distribution" is the right word.

>> Kathryn Kobe: The distribution, I think. It's conceivably a weight issue.

>> Dr. Ernie Berndt: Distribution is the right word. The retirement expenses should be consistent with the benefit proxy. Yeah.

And finally, Electronic Health Records and IT.

>> Steve Heffler: Was there any to do's or inclusions? We were brainstorming a little bit.

>> Dr. Ernie Berndt: No. Just starting to look at it, because next time --

>> Steve Heffler: A common issue down the pike.

>> Kathryn Kobe: I think we were debating what might be potentially appropriate proxies at one point.

>> Dr. Ernie Berndt: We were talking about software at one point.

>> Kathryn Kobe: Right. When we were talking about – I mean, we were talking about the proxies that are associated with the machinery.

>> John Poisal: That was one of the other write-ups now that I think about it. When we looked at the potential break some of the IT things into an IT-specific category, and then we thought further about what those proxies might be, we get noted in what we forwarded to all of you, that there could be some sort of serious concerns about those price proxies to the extent that they're hedonic in nature, and so that might be part of the reason we saw a negative price growth when we were looking at some of the things earlier. I think -- I'm not sure that that type of -- an index that's so heavily impacted by that type of work would be ideal for our purposes.

>> Dr. Ernie Berndt: I think the other point that I raised was that software ends up being a comparable expense to hardware. We would like to probably get some sort of software price index.

>> John Poisal: But I think that's where we left off with the IT, is that there were places where we thought we could break things out but there are concerns with the proxies.

>> Kathryn Kobe: About the price proxies. And it depends on whether people are buying that as business services which would be a different price proxy than if they're actually going out and buying computers. So I think those are still all issues that are related to the price proxies related to IT. I don't think we came up with any answer that we all agreed to on that.

>> Dr. Ernie Berndt: Speaking of proxy issues, then, for physician wages/benefits, use a non-health professional measure. Professional –what was it, professional and technical? I forgot. Just professional?

>> Steve Heffler: I thought there was a discussion of maybe exploring --

>> Dr. Ernie Berndt: Higher. Yeah. So let's leave it. For moveable capital, find an alternative --

>> Kathryn Kobe: There was an ECI measure we were discussing.

>> Dr. Zachary Dyckman: Professional and technical.

>> Kathryn Kobe: So should it say --

>> Steve Heffler: I thought it was professional and related was one of the options.

>> Dr. Zachary Dyckman: Well, why don't we do professional, technical, and other measures.

>> John Poisal: Other similar?

>> Kathryn Kobe: Aren't we talking about moving toward the ECI measure?

>> Dr. Zachary Dyckman: Yes.

>> Steve Heffler: Oh, yeah. It should be explicit.

>> Dr. Ernie Berndt: ECI rather than AHE.

>> Steve Heffler: Right.

>> Dr. Ernie Berndt: Got it.

For moveable capital find an alternative price measure as the current one isn't as relevant.

What is the current one again?

>> Hudson Osgood: The current price proxy for moveable capital is the PPI for machinery and equipment.

>> Dr. Ernie Berndt: Ok. This is the issue you were just raising, Kathryn.

>> Kathryn Kobe: Right.

>> Dr. Ernie Berndt: So that incorporates -- do we want to say, incorporating both hardware and software services? Keep it vague so that it could have both?

>> Kathryn Kobe: I think we want to consider broadening beyond maybe just a hardware-based index.

>> Dr. Ernie Berndt: Good.

>> John Poisal: Is that satisfactory?

>> Dr. Ernie Berndt: Excellent.

For fixed capital, move away from CPI, OACT will work with BLS to explore PPI possibilities. Good.

Sorry?

>> Bruce Steinwald: The four acronyms in a short space there.

>> John Poisal: Bruce, you worked in the government long enough to know that that's actually very efficient use of acronyms.

[Laughter]

That's very productive.

>> Dr. Zachary Dyckman: My first job was in Defense, and this is nothing.

>> Dr. Ernie Berndt: Product liability insurance, current measure seems reasonable.

Should we say current CMS measure seems reasonable?

>> Dr. Zachary Dyckman: Yeah.

>> John Poisal: I'm sorry. Which one were we on?

>> Dr. Ernie Berndt: Number 4. Current CMS measure.

>> Dr. Zachary Dyckman: Seems reasonable and exemplary.

[Laughter]

>> Dr. Ernie Berndt: Yeah.

For non-physician pay possibly use a blended health – professional technical? Is that what you mean by PT?

>> Steve Heffler: Yeah, P&T.

>> Dr. Ernie Berndt: Not pharmaceutical?

Laughter]

>> Steve Heffler: I wasn't sure how strongly you all felt about this, but that came up at some point when we had the discussion about RN's and other health occupations in

other market baskets we blended health specific, a common line of both.

>> Dr. Ernie Berndt: Yeah.

MFP issues. Change that to will?

>> Steve Heffler: We're supposed to do some more research. A technicality came up.

>> Dr. Ernie Berndt: OACT will explore improving the intermediate inputs estimates.

Is that the price, quantity, or both?

>> Molly Knight: The expenses that determines the quantities and the weights for both.

>> Dr. Ernie Berndt: Quantities and weights.

>> Molly Knight: But then I believe that Kathryn had raised an issue about the deflator and possibly putting back in the drugs and supplies.

>> Kathryn Kobe: Oh, I guess my question was whether the deflator that excludes those was necessarily appropriate for an intermediate inputs that does not -- so it was more matching the deflated to your concept.

>> Dr. Ernie Berndt: It is important that the accounting identity between the input prices and MFP measures be preserved, maintained -- fine.

>> John Poisal: Fine, take that away?

>> Dr. Ernie Berndt: That's fine. Good.

Other issues -- Any amendments to these before we open up to others?

>> Bruce Steinwald: At your first meeting you spent a considerable amount of time talking about the PPIS. I wondered at the time if you were going to consider suggesting to CMS that they arrange with the AMA to do a new survey or something along those lines.

Anyway, it never got to the point of looking like a draft recommendation. But I wondered.

>> Dr. Robert Berenson: We got that issue of where's the data coming from.

>> Dr. Zachary Dyckman: And lack of responses, difficulty in getting adequate

responses.

>> Dr. Kurt Gillis: Mm-hmm.

>> Dr. Ernie Berndt: I think first we need to discuss should CMS consider helping sponsor another update to that.

>> Kathryn Kobe: Well, isn't part of their looking into the MGMA data more -- I thought more in-depth was to decide whether that could possibly be used as an update mechanism or if they need to invest in a survey.

>> Dr. Ernie Berndt: Yeah. Can you pull that down a little bit so we can see number one?

You want a point c under 1 that would say, consider whether commissioning joint study with AMA is appropriate and feasible? Something like that?

>> Dr. Zachary Dyckman: I had thought in the top line there, "its representativeness" and perhaps usefulness for MEI purposes.

>> Dr. Ernie Berndt: Ok.

>> Dr. Zachary Dyckman: It's more than representative.

>> Dr. Ernie Berndt: And utility for --

>> Dr. Zachary Dyckman: And utility.

>> Dr. Ernie Berndt: Good.

And point c, you want to insert the word “whether” after consider?

There we go.

>> Rick Foster: Back on the multi-factor productivity. I thought I heard consensus for a while on the point that if you have an economy-wide measure of wage growth, then you should have an economy-wide measure of productivity. Subject to your concern, Kathryn, about is any damage done by having the hybrid nature with an economy-wide price but physician-specific cost categories.

>> Dr. Ernie Berndt: That was sort of in point 3 at the very bottom, isn't it?

>> Kathryn Kobe: It is in three.

>> Rick Foster: Yes, although --

>> Kathryn Kobe: It's not explicit.

>> Rick Foster: That would need to be flushed out for a reader to understand.

>> Dr. Ernie Berndt: Right.

>> Kathryn Kobe: I think the question still exists. I wasn't sure at the end of that discussion whether we were even giving any serious thought to moving away from the economy-wide measure. And part of this discussion was -- it's interesting to discuss physician-specific productivity and it does have an implication, but are we seriously considering moving away from economy-wide measure?

So then that question becomes a more important question than it does whether we're just considering it in sort of an intellectual way.

>> Rick Foster: Right. I guess my thought was that's useful to spell out, I think, because it amounts to a finding. Even if you're not recommending anything be done, it's significant to recognize that this current approach is appropriate. Do you see what I mean?

>> Kathryn Kobe: Right.

>> Dr. Ernie Berndt: Do you want to suggest some wording on that? Is that a separate bullet?

>> Rick Foster: Yeah. I can draft something up, and we can send it around to everybody.

>> Dr. Ernie Berndt: Good.

>> John Poisal: Say Rick will draft --

>> Steve Heffler: Say Rick will work all weekend to draft --

[Laughter]

>> Rick Foster: As long as I don't have to do anything until then.

>> Dr. Ernie Berndt: Based on direction from John and --

[Laughter]

>> John Poisal: Note that, right?

>> Dr. Ernie Berndt: Will draft a finding regarding economy versus physician-specific MFP.

>> John Poisal: Economy-wide.

>> Dr. Ernie Berndt: Versus.

>> John Poisal: Ok.

>> Dr. Ernie Berndt: Other issues that we've talked about, Bruce, in May?

>> Bruce Steinwald: Let me just see. Were you going to consider some consolidations? That was one of the things. Rubber and plastics.

>> John Poisal: That was in option two. That's here.

>> Bruce Steinwald: Ok. All right.

>> Rick Foster: I think, Ernie, you asked for a presentation the next time on the distribution of the MGMA data in the trend versus the AMA.

>> Dr. Ernie Berndt: Yeah. That's part of looking at --

>> John Poisal: But we should write. Let's add --

>> Rick Foster: To do's.

>> John Poisal: Right.

>> Rick Foster: A side-by-side comparison.

>> Bruce Steinwald: If I were you, I would make c its own. I don't think that's underneath MGMA.

>> Dr. Ernie Berndt: Yeah. I think that's right. Could 1c be a separate bullet, John?

>> Dr. Robert Berenson: It doesn't belong.

>> John Poisal: Pull it out as Number 2 in the cost weight?

>> Dr. Ernie Berndt: Yeah.

>> John Poisal: Yeah. Is that accurate there at least? I hate Word.

>> Dr. Zachary Dyckman: The way to do that is to go to 2, hit on that and then move.

>> John Poisal: Bring it down. Backspace that. And then hit 2?

>> Dr. Zachary Dyckman: Hit before the f in two and then hit enter. See, if you move that, it's retained.

>> John Poisal: Here?

>> Heidi Oumarou: No, no,no,no. C.

>> John Poisal: Oh, c?

>> Dr. Zachary Dyckman: It may change that –

>> John Poisal: Oh, that's the one you wanted to change.

>> Dr. Zachary Dyckman: Yeah.

>> Steve Heffler: Did you hit the left?

>> John Poisal: This one?

>> Steve Heffler: No. Keep going. There you go.

>> Dr. Ernie Berndt: The wonders of --

>> Kathryn Kobe: It depends on what version of Word you're using.

>> John Poisal: Oh man, I hate it.

>> Dr. Ernie Berndt: All right. Any additions?

>> Heidi Oumarou: I think you guys had talked about the other professional and other services broken down into more detail.

>> Dr. Ernie Berndt: I'm sorry? Can you –

>> Heidi Oumarou: The other professional fees and the other services, cost weight. You had talked a little bit.

>> Dr. Ernie Berndt: I think that's part of Kurt's memo. Isn't it?

>> Dr. Kurt Gillis: No. This is --

>> Kathryn Kobe: No. That's separate.

>> Dr. Kurt Gillis: Services.

>> Dr. Ernie Berndt: Where would you put that?

>> Kathryn Kobe: That's sort of a proxy -- I think that's sort of a proxy issue almost. Not exactly. It's more of a weight.

>> Heidi Oumarou: Yeah. It's sort of like the office expense thing in a different way. We're collapsing the office expense category whereas this would be sort of expanding the two existing price proxy and cost categories into three. I didn't know if – [Inaudible].

>> Dr. Ernie Berndt: Hockey time.

>> John Poisal: Yeah.

I thought I had saved -- I just wanted to make sure we covered all the issues from the last time. I thought I had saved the to do's from the last time. We should have -- all the things that we sent around since the last meeting were all to have addressed those. This is it. Right here. Just to make certain that we did in fact, cross the t's and dot the i's from meeting one.

>> Dr. Ernie Berndt: Is it possible to add questions to the SAS?

>> John Poisal: We were going to investigate that. I think we had termed that as one of the longer term things, but you could certainly make that part of your recommendations.

>> Dr. Ernie Berndt: Where would that be? With that MGMA thing? Would that be part of 1?

>> John Poisal: For cost weight purposes? I guess it would, yeah.

>> Dr. Ernie Berndt: So 1d. Consider whether adding questions to SAS.

>> Rick Foster: I got lost. You're talking about the services and the survey?

>> Dr. Ernie Berndt: Yeah.

>> Rick Foster: Which is unrelated to MGMA, right?

>> Dr. Ernie Berndt: That's really different. You're right. You're right. Just make it a --

>> John Poisal: Yeah, but I'm not going to try to do like I did before.

[Laughter]

>> Rick Foster: That's a relief.

>> Steve Heffler: That other list there was the issue about the fixed weight versus alternative mixed formulations. Is that a finding?

>> Dr. Ernie Berndt: Which one is this?

>> Steve Heffler: The index is basically fine as a fixed weight price index as opposed to –

>> Dr. Ernie Berndt: Yeah. Right

>> Kathryn Kobe: I think we decided we didn't have enough data, and the weights didn't shift. But I'm not sure we've got a consensus agreement on that.

>> Dr. Robert Berenson: I'm easy.

[Laughter]

>> Dr. Ernie Berndt: Pardon?

>> Dr. Robert Berenson: I'm easy.

[Laughter]

Since I don't even know what you're talking about.

>> John Poisal: Yeah, we'll put -- I think we had had this marked in the e-mails that we had sent that we actually did have consensus, but if we should revisit, we certainly can do that.

>> Rick Foster: We need to include that someplace as a draft finding.

>> John Poisal: Right. This for purposes of not forgetting.

>> Kathryn Kobe: Does that belong at the top with the other potential finding?

>> Heidi Oumarou: Under recommendation?

>> John Poisal: I'm sorry?

>> Kathryn Kobe: I thought we had gotten relatively close on that one. So maybe it belongs up at the top where we have the wording. Its possible people want the wording.

>> Rick Foster: I think what we can do is reorganize this a bit. Take the specific things that are explicitly recommendations or findings, put them in one place, like your suggestion, and clarify some of these which are really recommendations and others which are to do things. Reorganize that, add the extra language that I'm going to do,

and send the whole works out to everybody. Make sure you're happy with it.

>> Kathryn Kobe: I think that would be helpful.

>> Steve Heffler: Can 7 come off then, the EHR IT thing? Are there any issues there we need to be looking into? Need to be writing around that?

>> Kathryn Kobe: I think the issues have sort of moved down into the proxy issues now.

>> Rick Foster: [Inaudible]

[Laughter]

>> Heidi Oumarou: You had the small issue of including the non-separately billable drugs. I think that was resolved on e-mail. But I wasn't sure.

>> Dr. Zachary Dyckman: I think we saw some statistics that drugs represent that almost nothing in terms of the costs.

>> John Poisal: You had raised some follow-up concerns.

>> Dr. Zachary Dyckman: I think it was something --

>> Dr. Kurt Gillis: Actually followed up just on Friday with the people in our work staff. We were able to actually take -- pick fixed codes that had those non-separate, legal drugs. They had a price. They had an amount. They were able to come up – the Medicare utilization data, come up with a dollar total for those. It was $184 million.

>> Dr. Robert Berenson: That's nothing.

[Laughter]

>> Dr. Kurt Gillis: Which is $80 billion in Medicare fees.

>> Bruce Steinwald: Spoken like a former CMS official.

>> John Poisal: So if we were going to put that on a per physician basis like we used to develop the weights that underline the index, would that basically kind of fade away?

>> Dr. Kurt Gillis: Yeah.

>> John Poisal: So we could put that issue to bed then?

>> Dr. Kurt Gillis: Yeah.

>> Dr. Ernie Berndt: So make this a finding?

>> John Poisal: We should make that a finding. Yeah.

>> Dr. Zachary Dyckman: It was something distributed over the last week or two that had showed weight. It was like zero. It might have been MGMA data or something. I don't recall. Unrelated to our discussion.

>> Heidi Oumarou: It was just a number from the survey. It was like when we included it, it ended up being like .8. But some of those expenses might not actually have been true non-separately billable drugs like you had mentioned. Didn't understand the question. But your number would be even lower.

>> Dr. Kurt Gillis: Less than a quarter of a percent.

>> John Poisal: Is that fair, Kurt, how that's written up?

>> Dr. Kurt Gillis: [Nodding]

>> John Poisal: Ok.

>> Steve Heffler: Sorry to keep doing this, but on Number 2, that's a longer term issue. The other issue isn't related to that because it's the survey data. The cost of the additional survey. It would be more targeted. I think you called that up, Bob. So for completeness, is that Number 2 just kind of a broad category, like you could turn that into recommendation of panel recommends that alternative data sources be investigated, examples could be, you know, SAS. Is that?

>> Dr. Ernie Berndt: Yeah.

>> Steve Heffler: Ok.

>> Dr. Ernie Berndt: Such as --

>> Rick Foster: In our organization of all of this, I think we can take all of Number 1, put it as -- under the new Number 2. I won't ask John to do that right now.

[Laughter]

>> Steve Heffler: Ask him to do track changes.

>> John Poisal: If it was in Excel, I could do it, no problem, Rick.

>> Dr. Ernie Berndt: Any others from the panel? From the public?

>> Kathryn Kobe: I'm not sure that we ever got the first one that she mentioned, the expansion of the other services issue. Did that one ever get added?

>> Dr. Kurt Gillis: For the contract services?

>> Kathryn Kobe: Right. I'm not sure that we ever kind of got to a point where we had made any decisions about that one.

>> Rick Foster: Can you screen down a little bit?

>> John Poisal: Sorry.

>> Rick Foster: That was different from Number 5?

>> Kathryn Kobe: Yeah, it was different from Number 5, because it had to do with the components of breaking them out further, the additional services, the purchase professional services.

And the other services?

>> Heidi Oumarou: Other services. Then other professional related.

>> Kathryn Kobe: Right. Other professional related costs. What the appropriate proxies would be and whether they should have separate weights broken down to the level they had them broken down.

>> Heidi Oumarou: And then there was some discussion about the proxy, like whether or not we should be using ECI or PPI.

>> Kathryn Kobe: Or consider PPI. Right. That's correct.

>> John Poisal: How should this read, Kathryn?

>> Kathryn Kobe: I think we needed to make a final decision about the level of detail where purchase professional services, as well as the appropriate -- as revisiting the appropriate proxies.

>> Dr. Ernie Berndt: Determine appropriate level of professional -- determine appropriate level of purchased professional services data and identify appropriate proxy?

>> Kathryn Kobe: Yeah. I think that's – I think that's -- that covers the questions that were being expressed.

>> John Poisal: So in terms of what was included and what was circulated, what additional information would we be pulling? Was this something for the panel to go back and think more about and then provide us that feedback?

>> Kathryn Kobe: I'm not sure the panel ever decided whether, A, the level of detail that was now being shown in the suggestion was the appropriate level of detail, and, B, whether the proxies were appropriate.

And we had the question about using ECI proxies yet there were PPI proxies available or perhaps the ECI is the best.

>> John Poisal: So should this be rephrased as maybe the panel will reconsider or the panel will opine?

>> Molly Knight: The PPI's available? Would that be helpful in making a decision?

>> Dr. Zachary Dyckman: I think you were – I think we sort of finished up with what we had. I don't think we could go any further at this point without some suggestions or some research.

>> Heidi Oumarou: So maybe provide some more research into other alternatives that we would break out the data, for example, if we had an amount for legal and there's a PPI for legal.

>> John Poisal: Ok.

>> Heidi Oumarou: We could run that and send it around. And then you guys could maybe discuss and recommend something.

>> Dr. Zachary Dyckman: Kathy, is that consistent?

>> Kathryn Kobe: Yeah. I think that's consistent with how far we've gotten.

>> John Poisal: Ok.

>> Steve Heffler: That's what you need from us, right? Additional -- you guys need something to react to, to determine what's appropriate level of proxy.

>> Kathryn Kobe: Yes. I think we haven't necessarily rejected the suggestion here.

>> Steve Heffler: Right. Right.

>> Kathryn Kobe: Just we're trying to decide if that was -- is the best.

>> Dr. Ernie Berndt: Any further comments from the panel, from the public?

Shall I just -- are there any folks listening in who would like to make a public comment?

>> John Poisal: I don't know that we have that capability anyway. I don't think. Do we, Hudson?

>> Hudson Osgood: They'll be able to on the webinar at least write a comment or a question.

>> John Poisal: Oh, on the webinar?

>> Hudson Osgood: So I guess I turn to Jan to see if perhaps anybody on the webinar has a question at this time.

>> Dr. Ernie Berndt: Were there some folks?

>> Kathryn Kobe: Yeah, but they're not here. They left so.

>> Bruce Steinwald: They lost their chance.

[Laughter]

>> Molly Knight: There's always a position to schedule a comment period.

>> Dr. Ernie Berndt: All right. Any other agenda items or shall we close it for the day and convene? You'll send out details of the time for the phone teleconference?

>> John Poisal: Yup. We'll pull all of that together.

>> Dr. Ernie Berndt: It will be one where it will be a WebEx format that someone at CMS will be in control, but panel members will be able to see the material on the screen on their own PC?

>> Hudson Osgood: Yes.

>> John Poisal: That's our understanding.

>> Dr. Ernie Berndt: Ok.

>> Rick Foster: And prior to that, we'll send out the better organized and worded version of this for all of you. It probably will be helpful even to just do an e-mail exchange, kind of comment back and forth to each other about any further additions or modifications.

>> John Poisal: Definitely.

>> You do have one question.

>> Jan Adevor: He wants to ask a question.

>> Rick Foster: Are they writing out the question?

>> Jan Adevor: Typing it out.

>> Dr. Zachary Dyckman: John, can you help him with that?

>> John Poisal: I was just going to say. As long as you don't need me to add numbers and move things around.

>> Jan Adevor: Ok. We have a hand raised.

Ok. Michael Kitchell asks, "The weighting of the practice expense shows 10.2% for the rent and utilities and 19.1% for wages. This is in marked contrast to the MGMA data. Please reconcile these."

>> Rick Foster: That's part of what we're doing with your suggestion. Right?

>> Dr. Ernie Berndt: Number 1. Yeah.

>> Rick Foster: I guess we can't respond immediately.

>> Jan Adevor: If you all just talk into the mic. They can hear you.

>> Rick Foster: That's not something we can do on the spot, but it will be done in preparation.

>> Dr. Ernie Berndt: What is the name of the person again?

>> Jan Adevor: Michael Kitchell.

>> Dr. Ernie Berndt: Mr. Kitchell, this is Ernie Berndt. We've received your query. And while we can't provide you with an on-the-spot response, staff members here at CMS have committed to make a presentation that will attempt to address the issue that you

raised.

>> Dr. Zachary Dyckman: I would guess that the MGMA data has a higher figure in the labor category and a lower figure for the rent, whatever category it is.

>> Rick Foster: Because the economy was stale?

>> Dr. Zachary Dyckman: I would think so. I'm just wondering which direction he was asking about. But that's my guess.

>> Dr. Ernie Berndt: Are there any other?

>> Jan Adevor: I'm still waiting for one person, Angela Jenson.

"I understand that additional information will be sent to those on the webinar. As a part of the information, will it include either a summary of today's meeting which will include synopses of findings, recommendations, additional research? It was difficult to figure out all the recommendations with the sound cutting out."

>> John Poisal: Yeah. The plan is that after each of the meetings that we post to the website that -- the dedicated space that's on the CMS website associated with this FACA panel, the presentations that are made, and then ultimately once the summary notes are pulled together and sort of edited to ensure consistency and completeness that that summary also will be posted to that website.

Timelines aren't definitive because a lot of work goes into all of these. We have some compliance issues and administrative issues that are associated with each of these. But ultimately all of these materials will be -- that I just mentioned -- will be posted on the website associated with this.

That site -- do we have that site's address listed in the Federal Register notices?

>> Hudson Osgood: The first Federal Register meeting notice, I believe the Federal Register meeting notice which announced the chartering of the panel, there's a website address there that has a copy of the panel's charter. There's additional information located at that web address. So, yes.

>> Steve Heffler: Can we, for all the people that have registered by webinar, can we send them a link?

>> Jan Adevor: Yes. That's not a problem.

>> Hudson Osgood: Thank you.

>> Dr. Ernie Berndt: Are there any other folks who want to submit?

>> Jan Adevor: I think that's it. Those are the only website ones.

>> Dr. Ernie Berndt: Well, on behalf of the panel, I thank the staff at the OACT for all of their hard work and rapid turnaround, under duress.

[Laughter]

I thank the fellow panel members as well. I look forward to seeing -- being with you on the phone.

[The meeting concluded at 4:00 p.m.]