MEDICARE ECONOMIC INDEX (MEI)

TECHNICAL ADVISORY PANEL MEETING

Wednesday, July 11, 2012

9:02 a.m.

Centers for Medicare& Medicaid Services
7500 Security Boulevard
Room C-114
Baltimore, Maryland

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PANEL MEMBERS PRESENT ON THE CONFERENCE CALL LINE:

Ernst Berndt, Chair
MIT Sloan School of Management

Bob Berenson
Urban Institute

Kathryn Kobe
Economic Consulting Services

Kirk Gillis
American Medical Association

Zach Dyckman
Dyckman & Associates

ALSO PRESENT AT CMS OACT:

Bruce Steinwald
HCDI PROJECT SUBJECT MATTER CONSULTANT

Rick Foster, CMS Office of the Actuary

John Poisal, CSM Office of the Actuary

Steve Heffler, Director,
CMS National Health Statistics Group

Heidi Oumarou, CMS Office of the Actuary

Hudson Osgood, CMS Office of the Actuary

Mary Carol Barron, CMS Office of the Actuary

A G E N D A

P R O C E E D I N G S

(9:02 a.m.)

KIM: Good morning. My name is Kim and I will be your conference moderator today. Welcome to the Medicare Economic Index Technical Advisory Panel. All lines have been muted to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question at that time, press pound 7-1 on your telephone keypad. If you would like to withdraw your question, press pound 7-2.

I will turn the call over to Mr. Hudson Osgood. Sir, please go ahead.

INTRODUCTIONS AND ADMINISTRATIVE ACTIVITIES

MR. POISAL: Actually, this is John Poisal. I'm the Deputy Director of the National Health Statistics Group and the designated federal officer for the MEI Technical Advisory Panel so I'm going to steal the microphone from Hudson for just a few minutes.

I also want to echo the welcome everybody to today's discussion. This is our third and final meeting. It's a lecture style call, as was mentioned,

so we'll only be hearing throughout the day the people that are at our table as well as our panelists. I just was going to briefly introduce everybody instead of asking folks to sort of speak over each other potentially on the phone as they introduce themselves, if that's okay.

Our panelists include our panel chair, Dr. Ernie Berndt; Dr. Bob Berenson; Dr. Kurt Gillis; Kathryn Kobe and Dr. Zack Dyckman.

We also have several folks in the room here at CMS that I'll briefly introduce. Once more, my name is John Poisal. We also have Steve Heffler, who is the Director of the National Health Statistics Group. We have Hudson Osgood, Heidi Oumarou and Mary Carol Barron all of whom are on the MEI team. We also have Bruce Steinwald who is going to be assisting the panel with writing their final, technical report.

As the panelists speak throughout the day, at least for the first few times as we sort of learn voices, because this is being recorded and transcriptions are being recorded and will be made available, we are going to ask everybody to identify

themselves. Again, at least the first few times that you speak, if that's okay.

Just a gentle reminder to our panelists that today is the day that we do need to wrap up in public during the public meeting all of our findings and recommendations, so we are optimistic that the way the meetings have gone, the first two meetings, and as collaboratively and professionally as everybody has worked together, we think we're in an excellent position to be able to meet that goal by the end of today.

As a final mention, the charter -- our panel's charter is set to expire in late September. We've gotten some interests from the public in terms of when things might be published. We are hoping to publish the items from the various meetings on an ongoing basis and hope to have things going up throughout the rest of the summer and into the fall, which will include copies of the final findings and recommendations at some point.

So with that, I'd like to turn it back over to Dr. Ernie Berndt and turn the meeting over to Dr.

Berndt.

DR. BERNDT: Can you folks hear me?

MS. OUMAROU: Yes.

MR. POISAL: Yup.

MR. OSGOOD: Yes.

DR. BERNDT: This is Ernie Berndt. Welcome to all of you. At the outset, special thanks to the TAP teams at CMS. You've put together and impressive number of documents in a very short period of time. They were very detailed, thorough and careful and I thank you for that. And also special thanks for making this meeting possible without my having to travel down to Baltimore this morning.

MR. POISAL: Very good.

DR. BERNDT: It's a pleasure to get up at six o'clock rather than four o'clock.

REVIEW FOLLOW-UP ISSUES FROM JUNE 25TH MEETING

DR. BERNDT: All right. We've got a number of documents that have been distributed ahead of time. As I look at the agenda, for the first 90 minutes there's six different documents to go through, so about 15 minutes on each, although we might run over a little

bit into the draft language part of the agenda.

John, do you want to -- who do you want to lead us through the Physician Wages and Salary discussion?

PHYSICIAN COMPENSATION

MR. POISAL: Well, I guess it's sort of a -- we can just open the phone lines, so to speak, to the rest of the panelists. I hope everybody had an opportunity to read through some of the background documentation that we sent around last week. In each of these we tried to include some of the options that the panelists discussed or that we felt might help make for an informed finding or recommendation and sort of open it up to the panelists to make any thoughts or reactions available.

DR. BERNDT: Well, why don't I begin.

My understanding of -- given the original mandating legislation, CMS used as its proxy for physician wages and salaries the economy-wide average hourly earnings as a proxy for a physician's wages and salaries. And that was in part because the mandating language, as I understand it, talked about general

wages and salaries.

One can make the argument that since we are trying to measure actual physician office expenses it makes more sense to use a measure that's more closely approximates the occupational wages earned by physicians. In that spirit, as I understand it, CMS has put together two potential options. One is the employment cost index wages and salaries for all workers in the private industry. The second, which is quite general, and I gather a very, very small proportion with 0.4 percent of folks in that sample are physicians, whereas another alternative would be the employment cost index wages and salaries for professional and related private industry of which about four percent, I gather, are physicians.

Physicians are defined rather broadly. In the memo sent to us on page three it lists about a dozen different types of physicians from chiropractors, the various types of dentists and facial surgeons, oral surgeons, orthodontists, optometrists, anesthesiologists, family and general practitioners, physicians and surgeons all others, psychiatrists,

various others.

On page five of that memo, the four quarter moving average change in average hour earnings are ending in two different employment costs indices are what's the demographics and the recommendation that CMS came up with is on the bottom of page five.

The Office of the Actuary believes there's enough flexibility in the original statute that the proxy used for a physician compensation wages and salaries is different from that which is currently used, given the panel's discussion at this point, we would be comfortable using the ECI for wages and salaries especially when related to private industry. And that if, in fact, legal folks determine that this does not satisfy the legal requirements of "general earnings," quote-unquote they'd also be comfortable using the ECI from wages and salaries for all workers in private industry as a proxy.

Are there any comments from the panel?

DR. DYCKMAN: This is Zack. I think at the last meeting I think perhaps said something in favor of or certainly preferred the ECI for professional related

and private industry. But as I look again at the guidance in 1972, talking about general earnings levels, I'm thinking that perhaps the ECI for all workers may be more consistent with that. You know, it cleans up the issue relating or -- you know, it's not influenced significantly by changes in mix, although it is to some extent because presumably the weight's changed as employment changes among the various groups.

But I think I may prefer now, only because it appears to be more consistent with the general earnings levels, the ECI for wages and salaries of all workers. Not a strong preference, but sort of a weak preference for that.

DR. BERNDT: Zack, do you have -- like what sort of led you to the conclusion that it's more consistent with the original '72 legislation? Can you point to any wording there?

DR. DYCKMAN: Well, I'm pointing to the word actually in the first paragraph here, which I recall, also, from my -- I don't know if I recalled it from my involvement or I recall it from my review of documents relating to my involvement. Initially the secretary

will be expected to base the proposed economic indexes on presently available information on changes in expenses of practice, which is not what we're talking about now, and general earnings levels.

So I'm focusing on general earnings levels which to me is societal wide. But, again, it's a weak preference. I mean, the professional and related is a pretty wide index also, but I have -- I think in order to be most consistent with general earnings levels, a broader index should be considered. But, again, it's -- I don't have a strong preference on that.

MS. KOBE: This is Kathryn. I sort of am in the opposite position from where he is in that it seems to me if we're going to make any change at all we should change to an index that's better reflective of the educational levels and the training levels of the group of people we're talking about.
So I'm certainly thinking more about the professional and related index as being the better proxy for that.

But I do -- I mean, I recognize that we have to be in compliance with the legislation so I did have a question about how it was going to be determined if

this would satisfy the, quote-unquote, "legal requirement of general earnings."

DR. BERNDT: Did CMS folks consult with legal at all about this matter?

MR. POISAL: Other than having consulted previously just that there was some flexibility, we would anticipate that to the degree you all make a formal recommendation that would express a preference for one or multiple ECI's that we could pursue further getting guidance from our legal folks here specific to those recommendations.

MR. FOSTER: This is Rick Foster. I just wanted to add, this is not a formal statutory requirement. This is in the conference report, so it sort of helps inform what's in the law itself but it also notes that the -- this is expected to be an initial basis. We've used the initial for, what, four years or whatever?

I think our general counsel would say we would have the flexibility to use a professional ECI as opposed to a general ECI so I don't think that would be a stumbling block. But as John said, with a specific

recommendation, we would approach them just to make sure.

DR. BERNDT: As I recall our discussion from our last meeting, Zack you sort of raised the point that if physicians unilaterally raised their rates, and we had a cost index that was heavily weighted by physicians, that would be sort of perversely indigenous, if I recall your discussion on this. My impression here is that in terms of the professional and related private industry that physicians are only about four percent as a sample, so I don't think that's a major concern.

Have I articulated your concern from the last meeting properly, Zack?

DR. DYCKMAN: Yes, definitely.

DR. BERNDT: After Rick's comments and realizing that this came from the report, certainly not part of the legislation and also the term "initially," if I focus on the term "initially," I think I withdraw my preference and I probably would agree with Kathryn that it probably makes more sense to compare them to other professional workers.

Bob Berenson, you have any comments?

DR. BERENSON: Oh, I agree with that. I would go with professional.

DR. BERNDT: I do as well, so can I take it that we have a consensus that we take as our proxy for physician, wages and salaries, the employment cost index for professional related private industry?

MS. KOBE: That's my vote, too.

DR. DYCKMAN: Yes.

DR. GILLIS: This is Kurt Gillis. I would vote for that, too. I do think that -- should we have some discussion of the choice between AHE's versus ECI's and whether that's -- one or the other is appropriate? I thought at the last meeting we brought up the potential -- or another potential average hourly earnings index that might be more specific to professional workers.

DR. BERNDT: Could you remind us what that discussion was, Kurt?

DR. GILLIS: Well, I'm not sure. In my notes somewhere I had something about --

MS. KOBE: I think that the current average

hourly earnings is the production worker one and we were talking about the fact that they have a much broader index now that includes more of the supervisory personnel as well, but I'm not sure if anyone looked at the difference between those two measures.

DR. GILLIS: I did see that there is a professional and business services AHE on the BLF website. I guess my point would be that if we're talking about what the average worker is making, wouldn't we want to account for ages and skill mix or occupation mix rather than, you know, having a fixed -- using a fixed occupation mix index?

PARTICIPANT: Presumably the weights have changes in the ECI as employment weights change, correct?

MS. KOBE: That's correct.

DR. BERNDT: And the ETI, as I understand it, includes fringe benefits where as the AHE does not, is that correct?

MS. KOBE: There's a separate benefit index and I do think we need to just circle back around and double-check what benefits index we would be using for

this group.

DR. BERNDT: I think our discussion in our last meeting was whatever we used or this one, we'd want to be consistent with the same occupational category for fringe benefits. Am I right on that?

MS. KOBE: The fringe benefits indexes tend to be a little bit more aggregated than the individual wage index because they're in the ACI. I think they're using an appropriate one at the moment, but we need to double-check that.

MS. OUMAROU: Also in terms of the benefit indexes --

DR. BERNDT: Who's this talking?

MS. OUMAROU: -- although they're more aggregated from -- oh, I'm sorry. This is Heidi Oumarou.

Although they're more aggregated in terms of what BLS publishes, we can actually disentangle if there's a compensation series and a wage ECI we can disentangle a benefits series, so even if there's not a professional-related benefit, we have a way to come up with a benefit series for that.

MS. KOBE: So at the moment you're using total non-farm benefits, is that correct? I mean, you're using the ECI index for benefits --

MS. OUMAROU: Yes.

MS. KOBE: -- but for the total private non-farm?

MS. OUMAROU: I think its total private. Yeah.

MS. KOBE: Okay. But you're saying you could check and see a benefits index for the professional and technical related, or whatever index we're talking about here, could be constructed?

MS. OUMAROU: That's right. Any ECI that has a compensation and a wage category, we can construct a benefit index from that.

DR. BERNDT: Well, have we reached consensus? Well, I guess we have a couple of issues. One, an ECI versus AHE.

DR. GILLIS: Kurt Gillis, again. I was under the impression that there was -- that the ECI didn't attract changes in occupation mix. If that's not true, then I withdraw that concern.

MR. POISAL: I think that's right. I mean, the skill mix is held constant for a very long time in the ECI whereas it varies within the AHE's. If you're looking for just a pure wage change, where you ignore skill mix, the ECI is where you would want to lean. If you want to include the wage rate change on top of the skill mix changes, then I think we -- you lean back towards the AHE's.

MR. OSGOOD: Hi, this is Hudson Osgood. Just to comment about how often they re-weight the ECI. So the current ECI's are based on employment counts from the 2002 Occupational Employment Statistic Survey information. Prior to the 2002 based-data, it was last re-based before that in 1990. So there is a re-weight, if you will, but it's a rather significant amount of time between re-weightings.

MS. FOSTER: This is Rick, again. What I remember from the prior meetings was that there was a pretty broad interest by the panel in moving to the ECI, away from the AHE on purpose, in part to match what was already being used for the benefits side but in part because I thought you had a preference not to

have changes in the skill mix included.

So I just wanted to remind you of that. We don't actually care much one way or the other. We just want you all to come up with your best recommendation.

DR. BERNDT: In the context of trying some of the other categories to sort of keep our proxy as close as possible to actual expenses; I think I have a preference to the ECI, both for the wage and salary component and for the benefits part for professional and related. But like the other panelists, I'm not -- this is not one of which I have a strong preference. But that would be my vote.

DR. DYCKMAN: This is Zack again. I would prefer the ECI, too.

MS. KOBE: This is Kathryn. I tend to prefer ECI over AHE just because you have a much clearer understanding of what's going on in the index. So I would lean towards the ECI.

DR. BERENSON: This is Bob. You've all convinced me. I'll go with the ECI.

DR. BERNDT: Shall we -- CMS, folks, are you content to move on to the next item on the agenda?

MR. HEFFLER: This is Steve Heffler. I just wanted to, before we do that, just verify, I think I heard three separate recommendations and I just wanted to double-check that this is where you're coming down? One is that the panel would prefer to use an ECI over an AHE? The second that the panel would prefer to use an ECI for professional related, and the third that the benefit series that's used should match that ECI that's used for the wages and salaries. Is that right, Ernie?

DR. BERNDT: That was my understanding.

MR. HEFFLER: I think one of our plans is when we get to the afternoon and we're actually going through the draft language on the recommendations is to have some language for you guys to look at, so we'll pull something together as the meeting's going on and have something we can present later and put all that in words.

DR. BERNDT: But, yes, I think those were the three distinct recommendations.

All right. Let's carry on, then. Thank you.

Our next item is non-physician compensation. And there was a memo on classification of expenses

related to non-physician payroll. Currently what we're using is data from the PPIS.

MS. OUMAROU: This is Heidi again. If you want, I can summarize the document for everybody, if that's easier.

DR. BERNDT: You'd do that for me, Heidi?

NON-PHYSICIAN COMPENSATION

MS. OUMAROU: Sure. So basically under the current method, we estimate the non-physician compensation weight, which is 19.2 percent based on the PPIS data. And then we use secondary data sources to estimate the wage benefit split and then we also use the CPS employment counts and the OES wage information to estimate the desegregation of the wages into four categories: P&T, Management, Clerical and Services, and at the last meeting the panel had questioned whether or not there should be a health specific category underneath the non-physician wages and benefits rather than just the current for non-health related categories. We proposed two options.

One would be to use the CPS and OES data that we currently use to estimate those four categories and

to use that information to estimate another possible two categories underneath non-physician wages so there would be an additional health-related professional and technical category and possibly a health-related service category in addition to the non-health related professional and technical and non-health related services.

The weights under the current professional and technical wages are about six percent and the weight under the current services category is about two percent. When we looked at the health-specific occupations within each of those, the health-related P&T accounted for the majority of that six percent with 5.2 percent being health-related professional and technical worker. And under the services category, the majority of that weight, 1.6 percent of the 1.8 percent, was health-related workers.

We could then, instead of having just four categories, we would have six categories with two health-related additional categories proxied by an appropriate ECI such as the ECI for hospital workers or the ECI for health care and social assistance.

The second option that we have proposed is to use the AMA PPIS data to come up with a non-physician compensation weight, split that between wages and benefits using a secondary data source and then also rely on the AMA data to estimate a health category underneath -- in addition to the non-health categories because we have a specific -- the PPI collects specific data on the independent billers and the clinical staff that do not bill independently.

So under that option, the weight for the health-related wages would be 6.5 percent of that 13.8 percent, and then the non-health wages would be 7.2 percent. And then we would use the CPS and OES date to break out the non-health wages into the four categories, non-health categories that we currently have.

DR. BERNDT: Heidi, when you said -- this is Ernie Berndt, sorry. When you said using the PPIS data, this, again, is the PPIS data for just solo practices?

MS. OUMAROU: Yes.

MR. POISAL: For the self-employed physicians?

MS. OUMAROU: Yes.

DR. BERNDT: Right. Whereas the ECI represents -- or option one would represent a bit more of the -- a more heterogeneous mix?

MS. OUMAROU: Correct. It would be reflective of CPS employment and OES data, which would include more than just self-employed physicians.

DR. BERNDT: If I look on page three for your final recommendation, you have a preference for the second, as I recall. And the rationale, can you help? The last few words are, "Minimize the reliance and alternative data sources." What did you have in mind there?

MS. OUMAROU: I think that basically the approach was that since we have data from the PPIS survey specific to health-related non-physician workers and non-health non-physician workers that we could rely on that and it would be more consistent with all of the other main weights that we derive for the MEI from that survey. I guess that would be in terms of the consistency and not relying on an alternative source. We would rely on the PPIS data which is where we derive

our main weights for the main categories from, so it -- I guess that's what that meant.

DR. BERNDT: Thank you. Panel members, do you have any reactions?

MS. KOBE: This is Kathryn. I'm still a bit confused between option one and option two, I'm sorry, about how we're getting to these different weights. We've got the health-related wages in option two are about 6.5 percent. And if I look up top in option one and add health-related ENT and health-related services, you get, you know, 6.7 or 8, I guess. It's 6.8. What causes the weights diversions to be slightly different? I think I missed that part?

MS. OUMAROU: Well, we have a dollar value from the PPIS survey for the independent billers and for the clinical staff that cannot bill independently. And so to come up with a option two, health-related wages, that 6.5 percent, we basically take the percentage of that level relative to the total non-physician costs reported in the PPIS data to come up with that 6.5 percent.

In option one, we're making an assumption

where we just take the total non-physician wages weight from the PPIS data and we use a secondary data source, that being the CPS and OES and then we classify the occupations into buckets, basically. In this document there's a table with the occupations that we've put in the P&T and the health service workers. And so any difference that there is between the employment counts and the OES for those occupations relative to the sample in the PPIS would be, I assume, driving that difference.

MS. KOBE: Okay. And then could you just explain a little bit about the difference between the ECI for hospitals and the ECI for health care and social assistance?

MS. OUMAROU: Sure. The ECI for health care and social assistance is the more aggregate index and it would include the ECI for hospitals, skilled nurse -- not skilled nursing, but nursing facilities and then I think there's one other category under that. So it's more of a broad level.

DR. BERNDT: Does it include social workers?

MS. OUMAROU: It does. And then the hospital

ECI is specific to the hospital industry and the occupational mix of the hospital industry and so it would be more highly skilled.

MR. HEFFLER: Hey, this is Steve Heffler. Heidi, this is a question for you just on the difference between a hospital and healthcare and social system. Is the healthcare and social assistance NAICS 62; is it everything under NAICS 62?

MS. OUMAROU: No. NAICS 62, I think, is education and health so it's one under that.

MR. HEFFLER: One under that, okay.

MS. OUMAROU: Yes.

MR. HEFFLER: So it's one under everything in NAICS 62 and then the hospital would be NAICS 622 or something like that. It's a subset of the broader.

MS. OUMAROU: That's right.

MR. HEFLER: Just from a NAICS classification standpoint, there is a lot more in the healthcare and social assistance then pure healthcare and more highly skilled workers like we would expect to see in a hospital setting.

MS. KOBE: What was the rationale in

presenting these two options between using the hospitals in one and using healthcare and social assistance in two? I understand the weights are slightly different and possibly the workers involved are slightly different, but I'm trying to understand the concept here.

MS. OUMAROU: I think that we were just thinking that the occupations that are in the P&T classification require more education than those that are in the service industry and so we thought maybe a more -- that the hospital ECI for the P&T type workers would be a little more reflective of the level of education and skill that's required for those occupations. And the service occupations generally, aids and assistants, require less education and would be more reflective of sort of a general, overall healthcare and social assistance; a little less skilled.

DR. GILLIS: Hi, this is Kurt Gillis. There's not an ECI for physician's offices, correct?

MS. OUMAROU: There is not.

DR. GILLIS: I was looking yesterday and I

didn't see it. It went right from this broad category to hospital and nursing facility but --

MS. OUMAROU: That's correct. There is not.

MR. POISAL: Wouldn't that have made things easier?

DR. GILLIS: Right.

MR. POISAL: We would love to have one.

DR. DYCKMAN: This is Zack. Do we know the weight of hospitals in the healthcare and social systems ECI?

MS. OUMAROU: Not off the top of my head. I'd have to look at it.

DR. BERNDT: Again, remember the context here. We're looking at non-physician payroll expenses for office practices. I guess the question is to the extent that these folks who work in physician offices could instead be employed at the hospital or more generally in healthcare and social assistance, what's the best proxy, I guess, is what we're asking, both for the ECI and for the weight?

MS. KOBE: This is Kathryn. On this list of occupations that's on the non-physician payroll expense

on the first page of this document, which of those is being covered by this healthcare and social assistance index?

MS. OUMAROU: All of the occupations listed on both the health service and the P&T would be covered within that.

MS. KOBE: You're saying "a," "b," and "c," are all being covered with the weight for that index?

MS. OUMAROU: I'm sorry. "A," "b," and "c." Oh, I see. You're looking at the question. Okay. It's just "b," and "c."

MS. KOBE: "B," and "c," together is being covered by that healthcare and social assistance index?

MS. OUMAROU: Well, those types of occupations would be reflected in the healthcare and social assistance. Those are the questions from the AMA PPIS survey and so basically the way we came up with that option two weight was to take the "b" and "c" levels and add them together to get that 6.5 percent of the total. And then the "a" is just everything else that's non-health related.

So it's a separation between this is the AMA

question and then in terms of the ECI and the occupations reflected in the healthcare and social assistance, that would be for all occupations within healthcare and social assistance that are reflected in that.

MS. KOBE: Okay. I think I understand the concept at this point.

MS. OUMAROU: Okay.

MS. KOBE: I guess my only concern is that there's a lot of non-health care related occupations, I think, in that ECI and I'm not -- I don't have a clear understanding as to how well it matches up with these occupations that are listed in EMC on page one.

MR. HEFFLER: This is Steve Heffler. Kathryn, I don't know the specific answer to that and how they match but my guess is they don't match up all that well. That there are a lot of occupations in healthcare and social assistance that would not be captured by the types of services being provided by occupations in questions "b" and "c."

MS. KOBE: Is there a reason why for option two you decided to go with the more aggregated index

rather than the hospital index In question one it seems like the weight was more heavily weighted towards hospitals, you know, the hospital-type personnel when looking at this group of people. So I'm just wondering what the rationale was for picking the healthcare and social assistance index to represent those two groups when they were put together?

MS. OUMAROU: The rationale was basically since it was just one category we would go with the higher level aggregate, which would include everything, but it's not set in stone. It was just an option so that option can be changed if you feel it's more technically appropriate to use a different ECI.

DR. DYCKMAN: Can I ask about the possibility -- this is Zack -- about the possibility of an option 1a? I think you're saying that the hospital ECI is included in the healthcare and social assistance ECI, right?

MS. OUMAROU: That's correct.

DR. DYCKMAN: So in option one there's double counting of hospitals because it's likely a sizable proportion of healthcare and social assistance and it

has its own category in addition. What about if we have -- use the ECI of hospital and if there's a way to take out hospital from the healthcare and social assistance ones, so in essence that becomes healthcare and social assistance other than hospitals, we retain a lot of the types of occupations that we think would be applicable to physician offices as reflected in the hospital ECI but also include some other with a much smaller weight? Am I unclear or clear?

MR. HEFFLER: Zack, this is Steve. I think your comment is definitely clear. I'm not sure that we can do that. I don't think we can deal with it. We would publish data. And I'm not sure BLS could prepare that for us. If they did, it would be on some kind of unpublished, special run type basis. But I don't know of any instance where we've actually asked them to take a published index and pull a piece of it out and give us the remainder. So I don't know how feasible that is.

DR. DYCKMAN: Can't you just do it statistically? Can't CMS do it? For instance, if the hospital index goes up by percent in a year, and the --

well, if we know the weight --

MR. HEFFLER: We'd have to know the weight.

DR. DYCKMAN: Yeah. If you know the weight, you could do it, I think. If you don't know the weight, I agree.

DR. BERNDT: Can we make a recommendation that we go with option one but have TMS evaluate whether it would be feasible to do what you called 1a?

PARTICIPANT: I think that's somewhat attractive, but anybody else?

DR. BERENSON: This is Bob. I don't understand the attraction of the hospital ECI for physician offices? I don't know why we think that it's a good proxy. It's a different personnel mix, I would think.

MS. KOBE: I don't think that we think it's a particularly good proxy except that we're concerned that healthcare and social assistance is an even worse proxy.

PARTICIPANT: Why is that? Why do we think that's worse?

MS. KOBE: Because it has a whole lot of

social worker type people in there, probably -- I don't know. Does that also include like nursery schools and all of that? Does that all fit in under that category or does that go into education?

MS. OUMAROU: I don't think that that's included under that. That would be in the category above that, "Education and Health," NAICS 62.

PARTICIPANT: It would include things like home health aides?

MS. OUMAROU: Yes.

MS. KOBE: So I think the problem is that neither of these indexes is ideal but we're trying to decide which one would be more ideal than the other one.

DR. DYCKMAN: I agree.

DR. BERNDT: It's called the evil of two lessors.

DR. DYCKMAN: Just to throw one more thing in there, too. There was another recommendation about taking staffs who can bill independently and shifting the weight for them to the compensation, so that would kind of change the skill mix of the people that

remain -- if that was adopted, it would change the skill mix of the people that remain within the non-physician compensation category because that could have a bearing on what we decide to do here.

MS. KOBE: I think that's an important point.

Heidi, I'm looking at my NAICS's manual now. You're saying this is all 62 that we're talking about?

MS. OUMAROU: No. I don't know the NAICS number but NAICS 62 should be "Education and Health" and then there should be healthcare and social assistance under that NAICS 62. I'm not sure what NAICS it is.

MS. KOBE: Educational is NAICS 61. So you think this one is just Healthcare and Social Assistance?

MS. OUMAROU: I don't have my NAICS manual in front of me but --

MS. KOBE: Okay. Well, I'm looking at the NAICS manual and it's got Ambulatory Healthcare Services, which includes the offices of physicians.

MS. OUMAROU: Oh, yeah. 62 is Healthcare and Social Assistance. I'm sorry.

MS. KOBE: Hospitals, Nursing and Residential Care Facilities and then Social Assistance includes Child and Youth Services, Services for Elderly and Persons with Disabilities, Other Individual and Family Services, Community Food Services, Temporary Shelters, Emergency and Other Relief Services and Child Daycare Services and Educational and Rehabilitation Services.

So I would agree that, except for 624, this is probably a good match, but I don't know what the weight is for 624 relative to everything else.

MR. HEFFLER: This is Steve. We could probably, if we wanted to table this issue for now, look up a couple of these questions that have come up about relative sizes underneath of that. Maybe we could come back to that and that might help inform some of the discussion?

DR. BERNDT: Do we have any idea how much of a difference it would make if we take one of these options versus another? There's two things going on. There's a ECI index and the weights.

MR. POISAL: This is John. We did not run a sensitivity analysis to determine the degree to which

the results might change.

MS. KOBE: I think that Kurt's question is an important one in that as some of these people are going to be removed from this category, is that still a separate line item to be considered?

MR. POISAL: It is. This is John again. When we get to some of the draft recommendations and things you'll see one of the recommendations is to continue to research the appropriateness and viability of moving the clinicians who can bill Medicare independently out of the PE portion of the index and into the work portion. There are a few things, at least the way the recommendation currently reads, that we would need to research here to make that determination.

So maybe putting on the table a recommendation with respect to this issue that is contingent on the outcome of that recommendation is a possibility as well.

MS. KOBE: Currently the weight for that group of people is in this health-related wages group and specifically the Professional and Technical, is that correct?

MS. OUMAROU: Yes. The weight for the independent billers is within the P&T. Overall for the index it's about two and a half percent that would move between either the non-physician or the physician compensation weight. And then in terms of the break-out under P&T between health-related and non-health related, that would still basically hold, because in order to estimate the occupations that we put within that, we have to take out all physicians.

And the way that the occupations are classified there, we couldn't just take out independent billers. We don't have an estimate for that related to the CPS, employment counts and the OES data. So we removed all of those from our calculation because the majority of them would not be independent billers.

So that overall non-physician compensation weight of 19.2 would probably fall down to about, you know 16 and a half or 17 and then we would disaggregate under those categories. But it would show probably the same relative, you know, disaggregation with P&T being slightly a lower weight.

DR. BERNDT: We're running a little behind

schedule. How do you suggest we proceed?

John, do you want to make a --

MR. POISAL: Yeah. Why don't, per Steve's recommendation, why don't we see if we can table this discussion a bit for now and maybe we can pull some things together over lunch that helps to better inform. To the extent we can walk through before lunch some of the draft language and recommendations, findings and recommendations, rather, that that will help further inform as we have those discussions. Does that sound okay?

DR. BERNDT: Fine with me.

MS. KOBE: It sounds fine with me.

DR. BERNDT: Okay. Next item on the agenda -- is that okay with you, Zack and Bob?

PARTICIPANT: Yes.

PARTICIPANT: One of the items we could possibly check is the availability of hospital weight information within the larger ECI.

PARTICIPANT: Very good.

PARTICIPANT: That's fine with me.

DR. BERNDT: All right. Why don't we carry on

then with Fixed Capital Proxies?

Who at CMS would like to lead us through this discussion?

MR. OSGOOD: Dr. Berndt, this is Hudson Osgood. I'll walk us through the Fixed Capital Proxy overview.

DR. BERNDT: Thank you.

FIXED CAPITAL PROXIES

MR. OSGOOD: Again, to review the contents of some of the research that we did. To review, the Fixed Capital overall is about nine percent of the overall MEI expenses. And of that nine percent the majority is rent, so seven percent of that.

Historically, or what we did in the last MEI, is we used a CPI as a price proxy; the CPI for owner's equivalent rent of residencies. In the last meeting of the MEI, Technical Advisory Panel the Panel discussed the option of moving to a PPI instead of a CPI

So what we did was to review some of the options available for using a PPI price proxy. What we did is we looked into the individual -- well, we started with the commodity level for real estate

services and then looked within that for potential -- for some of the largest weights and what would be most applicable to a -- in this case, a physician's office expense proxy.

Within that, there is one primary category that's most relevant and that's -- at least on the commodity's side, non-residential real estate rents. Now if we want to jump ahead to page three, what you'll see is that the commodity, that had the largest commodity weighed or for non-residential real estate rents, for a PPI is leasers of non-residential buildings.

By the way, we'll skip around a few pages here. Going back to page two, you'll see now that when we look at that, you know, component with non-residential real estate rents, that is one option is to use that as an overall PPI. Now, within that, there are two major subcomponents, one is the office buildings, you know, commodity weight and that makes out to about 40 percent of non-residential real estate rents.

The other option is retail properties and that

makes up, again, almost an additional 40 percent.

So in conclusion, what we have, now going to page four, is that we believe that when, or if, the Panel decides to move with the PPI, they'd have -- that the three most what we believe to be viable options would be that the PPI for leasers of non-residential buildings, which, again, is the aggregate PPI, and within that PPI for leasers of non-residential buildings, again, that the two largest pieces, if you will, are the PPI for leasing a professional and other buildings. Again, your normal office and commercial space.

And then the other is leasing of shopping centers and retail stores, so something you might find more in a shopping center. We've charted those to make those available for the Panel's review.

Also now moving on to page five, we for comparison sake also wanted to give you the higher level PPI for leasers of non-residential buildings compared against what we used in the last MEI, which, again, was a CPI for owners equivalent's rent to, again, give you a comparison.

One issue that does stand out with the PPIs is that you do have a somewhat greater degree of volatility but, again, if it's in the Panel's interest that that volatility, even though it may be a slight issue, if the relevancy of having a PPI, you know, would offset that, that would, again, be a decision we would look for from you to decide, you know, which proxy we should use.

So in conclusion, one option, again, that the -- that may be the most viable is to use the -- if you, again, want to use a PPI is to use the higher level of the three proposed proxies. Again, the PPI for leasers of non-residential buildings.

DR. DYCKMAN: This is Zack. Relating to volatility, I'm pretty sure I know the answer to this question but I just want it clarified, I assume the PPI rental indices do factor in the length of leases? For instance, if the average lease is ten years and rentals in one year go down five percent, but they've been stable at zero for the previous nine years, then I assume the change would be minus .5 percent, not minus 5 percent for that year?

DR. BERNDT: I don't know how -- what the sample is on whether it's new leases or whether it's a weighted average of new and previously signed leases. Anyone at CMS know?

MR. OSGOOD: At this point, we don't have an answer, but it's, again, something that we can look into.

DR. BERNDT: I think conceptually a PPI makes more sense. I'm mindful of Bob Berenson's last meeting discussion where he said he used to have an office in a shopping center. So I think sort of having the aggregate of the non-residential buildings of both professional and other offices and shopping center retail makes some sense.

PARTICIPANT: I agree.

MS. KOBE: This is Kathryn. I think conceptually I think that the PPI is the better measure but this level of volatility does concern me. So I'd be very interested in the answer about the new lease disburses, how the old leases are handled as well.

DR. GILLIS: This is Kurt. I think this is a positive change, too, here moving towards something

that's reflective of what doctors are paying. But, you know, I am concerned about the volatility. I wonder if we can find out the sample size, too, that goes into the -- how many establishments they're surveying to come up with the number?

There was an issue before in the first summary document on this issue you raised concerns about representativeness of the EPI; whether it was geographically representative and also representative of the type of space, whether it might be large office buildings predominantly when doctors might not be in those buildings, so. You know, do we know much more about that now? Is that sort of the mix of office buildings that are in here?

MR. OSGOOD: At this point, no, we don't have any further information on that.

MR. POISAL: This is John. Maybe what we could do as well here is to see if we could do -- make a few phone calls and get at least some preliminary answers to these questions over lunch as well and see if we could help inform those questions and help inform a recommendation.

DR. BERNDT: At our June 25th meeting I believe we had someone from -- was it Bonnie from BLS?

MR. POISAL: Yes.

DR. BERNDT: You might want to give her a call.

MR. POISAL: Yes. That's exactly who we were thinking of

DR. BERNDT: All right. Any further discussions?

(No response)

DR. BERNDT: So I take it there's a -- the offsetting concerns we have are the conception. There's a preference for the PPI but there's a couple of implementation issues as well as concern about the greater volatility.

All right. Let's carry on. Next item, Other Professional Services.

OTHER PROFESSIONAL SERVICES

MR. POISAL: So we had constructed in this paper a couple of different alternatives for looking at other Professional Services. In both examples, we pull the weights from other services and other professional

expenses together, which brings a total combined weight of about 8.1 percent. And then in the two options effectively it's a question about how to proxy.

So in the first alternative we pulled some data and are able to break out the types of services that are purchased in physician's offices and break out -- or use, rather three different employment cost indices to proxy the various apportionments of the 8.1 percent. Specifically, the options would include using the ECI for professional scientific and technical services in ECI. This is all on page two, by the way, of your background packet in the highlighted grey area.

So the three sides again, professional, scientific and technical services; administrative and support and waste management; and remediation services and then services occupation.

Alternatively, under section two, we could pull data that would allow us to more specifically link to certain professional services that could be proxied with the various PPIs. Again, on the next page, you can sort of see the break-out of the things that we could go and pull.

One of the considerations with that second alternative is if we go to try to link to PPIs, those PPIs that are available to us to use would only represent about 3.1 percentage points of the 8.1 percentage points in that total professional services category.

So under alternative two, for the remaining roughly five percentage points, we would go and investigate and make a judgment about how to best proxy that remaining apportionment of the category either through other, more aggregated PPIs or potentially through ECIs as well.

DR. BERNDT: This is Ernie Berndt. Conceptually, the ECI would just be picking up the wage, salary and benefit component, just a labor component, if you will, of these services --

MR. POISAL: That is true.

DR. BERNDT: Whereas if I understand the PPI is they would include things other than labor to the extent they're supplies and things like that.

MR. POISAL: That's correct, Ernie. We do have a slight preference for alternative one here. To

address that point -- this is John, again, by the way. To address that point that Ernie made, you know, the labor costs tend to drive the large majority of the price pressures there. So while we would be sort of overlooking or not explicitly capturing some of the non-labor price changes, we did feel like this would still be an appropriate option to undertake, but ultimately defer to the Panel to make that judgment.

MS. KOBE: This is Kathryn. I mean, I think one of the conceptual problems we have here is if you used the ECIs and if they're really purchasing services from the types of industries listed in alternative two, that you're not capturing any productivity gains that are being made by those industries in those price proxies.

That may not be a major issue partly because, you know, there's the question about productivity gains in most of these industries anyway, but we are making an overall productivity adjustment later against the whole index.

So I guess that's not a major concern but it was one of the reasons that I asked about this question

to begin within my own mind.

I don't have a major objection to using ECI since that's the way it's done in the other indexes. That's my understanding from here. This is the way it's done in the other market baskets. Is that right?

MR. POISAL: For professional services, I'm trying to recall how we proxied them.

MR. HEFFLER: We don't use PPIs.

MR. POISAL: We don't use PPIs, right. We rely on some survey data that helps us to break some of these things out, but --

MR. HEFFLER: Weights, but on the --

MR POISAL: For the weights.

MR. HEFFLER: -- proxies we only use ECIs.

MR. POISAL: We do use ECI. That's right. We do have various break-outs of different types of professions that we pull together in the other market baskets; like for finance, legal, et cetera, Kathryn, so you're right.

(Simultaneous discussion.)

MS. KOBE: -- as the proxy price movement for them.

MR. POISAL: I'm sorry. Could you say that again?

MS. KOBE: As the proxy price change, you're using ECIs in those market baskets as well --

MR. POISAL: That's right.

MS. KOBE: -- is that correct?

MR. POISAL: Correct.

DR. GILLIS: Hi, this is Kurt again. Under option two, one of the things I would have expected to find, but maybe there's not a good -- there's not a BEA IO category for it, is billing services. That's one of the things that were really expected; the bigger parts of the other professional expense. It's not there. I wonder if it might be under some other category that's not as descriptive?

PARTICIPANT: That's heavily used by physician and probably not heavily used by almost everybody else. So it may not exist as a separate category.

DR. GILLIS: Right. It's in some broad, general category.

MS. OUMAROU: This is Heidi. I don't believe there is a NAICS code for billing services. They might

be under some of the finance categories, if I recall, Credit Intermediation.

DR. DYCKMAN: This is Zack. Conceptually I like alternative two for the reasons mentioned a few minutes ago that it includes the price of the services purchased both labor and non-labor rather than just the underlying labor components. But it probably adds a little complexity. If the complexity is not an issue, I would prefer alternative two, I think.

DR. BERNDT: This is Bernie. I agree with Zack.

MS. KOBE: I'm looking at the NAICS manual to answer the question about where our billing services come up. It looks like they're probably a portion of Other Accounting Services.

MS. OUMAROU: Yeah.

DR. DYCKMAN: I see a Business Support Services, too. That would be where it is, 56140.

DR. BERNDT: What's the weight on that? Can you tell?

DR. DYCKMAN: No. I'm working off of the original IO spreadsheet. So it's one of the top

categories. It's probably about the 15th category down in terms of weight in the IO table.

DR. BERNDT: Because that would make it quite a bit more than the 3.1 percent. That would add to that.

MS. KOBE: This is Kathryn. 5614, Business Support Services, appears to include document preparation, telephone calls, telemarketing bureaus, business service centers and private mail centers and collection agencies.

DR. BERNDT: Collection agency certainly is relevant.

MR. POISAL: Kathryn, this is John. What was under the other Accounting Services? Did that look more --

MS. KOBE: This industry comprises establishments except offices of CPAs engaged in providing accounting services, except tax return and payroll services. Business establishments may also provide tax return preparation for table services. It says, "Accountant accepts CPA offices, bookkeeper offices and billing offices are included as SMSP."

MR. HEFFLER: This is Steve. I think one of the issues we would have would be matching those specific categories up to a PPI so Zack you raised the question of complexity. You know, we can calculate indexes at very, very detailed level as long as we have cost weights that we can develop at that level and then price series that we can use at that level.

I'm not sure about whether there's a PPI for 5614. My guess is there would be, but when we pull together the IO data for the categories that fell under this, the ones that we listed in that table on the next to the last page, those were the only PPIs that we could identify to match those categories.

So I think this is about as detailed as we could get with the PPIs. The question is, that I would ask of all you, as far as the complexity standpoint if you think about being a user is, would it be helpful to have, you know, three percent of an eight percent weight where we're proxying those, you know -- that three percent in ten different categories where each weight isn't any more than six-tenths? You know, we can calculate it but presenting it becomes an issue.

We'd have to aggregate it. We'd have to explain it's blended. It might be a little bit difficult to replicate and so forth.

Clearly option one is much cleaner from a presentation and kind of an understandability standpoint even if conceptually it isn't reflecting some of the non-compensation costs.

So I just wanted to respond, Zack, to that question about complexity.

DR. DYCKMAN: Actually, by my question, I actually meant what you referred to in terms of presentation. I assumed you would have no difficulty in calculating it, but --

MR. HEFFLER: Right.

DR. DYCKMAN: This index, that's more complex.

MR. HEFFLER: Correct.

MS. KOBE: What sort of information do you have about actually which of these services the physician's are purchasing or you're just using the IO weights in order to come up with kind of this underlying alternative to sets of weights?

MR. HEFFLER: Yeah, the weights in there are

from the IO. Is that what you were asking?

MS. KOBE: Yes, that was my question. I'm sorry. I didn't have it worded very well.

MR. HEFFLER: Yeah. Those are pulled directly from IO but they're only the weights for which we could identify a PPI that we could match to it. So there's a lot of other categories from the IO that are part of that eight percent, but we didn't have a PPI to match.

Someone here quickly looked it up and there is not a PPI for 5614, so I was wrong on that.

MS. KOBE: Conceptually -- this is Kathryn -- I like alternative two, but I think reasonably as far as making it understandable and easily explainable, I think we almost have to go with option one and, you know, just consider this other option as, you know, data might change. But I understand your concerns about making alternative two conceptually clear to the people who are using the index.

DR. DYCKMAN: I would agree with that, too. Option one seems -- there's so much complexity in option two that I'm not sure it's worth it.

DR. BERNDT: Do we have a consensus, then,

that we reluctantly go with option one?

DR. DYCKMAN: Fine with me.

PARTICIPANT: I'm there.

DR. BERNDT: All right. The Panel reluctantly recommends --

(Laughter.)

DR. BERNDT: Okay. Anything else on "Other Professional Services"?

(No response)

DR. BERNDT: Okay. MFP Presentation. This is a PowerPoint presentation that's new and consists of five slides, as I recall.

Steve, do you want to take us through this?

MR. HEFFLER: Yes, I will.

MFP PRESENTATION

MR. HEFFLER: I hopefully won't butcher Molly's work too badly as I try to summarize this. Molly and Mike did a lot of research on the two issues that were raised at the last meeting that we wanted to follow back with you all on. There were two separate documents explaining these issues, but I'm just going to cover both of them in this one presentation.

I'm not going to walk through the memo. Just work off the slides. It's kind of a high level summary of what we found.

So the first issue was understanding a little better about how BLS computed the productivity gain, the multi-factor productivity gains for ambulatory healthcare services.

So on the second slide, there's a side-by-side comparison of the data that's used by BLS to calculate that series relative to the data that was used by -- that's the actuary. When we calculated the physician specific MFP estimates. I won't go over that right side of the table. Molly presented that in detail last time and you all asked a lot of questions about that, so I'll focus on the BLS method.

Of Ambulatory Health Care, physicians are about half of that, so by far the biggest piece and the major weight. And so they really influence a lot of the trends. So BLS follows the standard method for calculating MFP starting with real output and then identifying the separate inputs.

BLSU is BEAs estimate of gross output for the

industry Ambulatory Healthcare, and remember physicians is a subset of that. And then they deflate that by a price deflator to get real output. So conceptually it's consistent with how we do the physician measure. It's just at a different aggregation.

So that determines the real output. And when we get to the next slide you'll see that that -- and that's the numerator of the equation, the growth rate of those over the long history is actually very similar.

BLS then breaks the inputs down into the five pieces that are part of the CLEM methodology, capital labor, energy, materials and I think it's services or supplies.

So we'll start with the labor. They use data for production workers for the industry Ambulatory Healthcare to come up with their labor quantities but they supplement that with CPS data for proprietors and unpaid family workers, so time that's spent for both of those categories to come up with their quantity increase or number of hours. That is a difference from how we do the physician MFP, and particularly the

non-physician labor, where we do not reflect the hours that unpaid family workers contribute.

But, again, conceptually it's a number of hours that are labor hours. Similar there.

The capital, and you're going to see for one period, this ends up being probably the biggest difference in the two methods. Even though we're both using BEA data and we're both doing it at the level of ambulatory health care, because we do not have capital data for physician specific, is BLS, actually, goes sort of -- at a detailed asset level and gets data on investments at that level and develops their own measure of capital expenses to determine a capital share as well as the rate of growth of capital inputs.

So they do not use the published BEA quantity index for Ambulatory Healthcare, which is what we were using for the rate of growth of capital inputs. In one of the periods we look at, you'll see there's quite a major difference in the rate of growth in those.

So that's probably the biggest methodological difference between the two.

And then on the intermediate inputs, they get

into quite a lot of detail on energy, materials and these purchase services to identify the cost weights as well as the indexes, again, using BEA data. If you remember, we measure intermediate inputs as a residual. And that's actually one of the other things we looked into that you had asked us to look into.

So that is a difference in methodology but you're going to see that doesn't contribute the largest part of the difference between the two series.

So if we flip to the next page, which is a bar chart that just compares over the whole period 1988 to 2009, the average annual growth rates of the pieces and the total and then resulting from that why the MFP estimates are different.

So as I mentioned before, the growth and output quantities is pretty much identical between the two series. Again, that makes a lot of sense, because physicians is half of the overall industry.

The labor contribution over that period was so the weights and the quantities were actually similar both at 1.8. So you can see the two other categories here are the intermediate inputs and capital and those

are where some of the big differences are.

On the intermediate inputs, there's a six-tenths of a percentage point difference between the two methods. About half of that difference that we were able to disentangle was due to the rate of growth of the input quantities. Again, BLS is getting into a lot of detail doing energy separately from materials. Whereas, we're just doing it in aggregate. About half of the difference was due to the weight.

So that category there actually contributes, as we said, in the document about six-tenths of the one percentage point difference in MFP.

Capital input contribution is four-tenths higher for Ambulatory Health Care. And that's split evenly between the share that capital represents of this equation and the rate of growth of the capital inputs.

We did a little bit of digging into why that was the case. And, as I mentioned before, there is a different methodology that's implemented by BLS compared to what we implemented. It looks like BLS' methodology actually ends up producing assets that have

a longer useful life for this particular industry than what BEA has published that we used. And due to that, the greater growth of those inputs has tended to be higher. We still haven't disentangled all of these pieces to understand exactly why that was the case but that methodological difference appeared to be the major reason that we were getting a difference in the growth rate.

So just on this particular issue, we have roughly the same real output that we have for the BEA measure, intermediate inputs growing six-tenths faster, capital inputs growing four-tenths faster. Again, these are contributions. Because of that, the MFP growth is one percentage point lower under that particular industry.

So that's the major reason and sort of why the numbers look differently. I'm not sure how much this helps any recommendations or kind of conclusions you reached, but we just wanted to follow up on the question of why if you look at a published series at a different aggregation level do you get such a different rate of growth in MFP.

So I'll stop there before I move on to the next piece and ask if there's any questions on that?

DR. BERNDT: This is Ernie Berndt. My understanding is that because BLS BEA used a different way of computing capital stock, and actually look at actual investments, that probably more accurately picks up -- and that uses as a deflator of price adjustment for IT, which says that prices have really been falling quite a lot. As a result, a given amount of expenditure has a much larger quantity growth to it because the price has been falling. So that's probably what it's picking up. It's more of the IT stuff.

On the intermediate input side, my understanding is, particularly in the last couple of years, BLS has had a real big problem giving energy prices in part because spot prices are moving much more than contract prices and how they apportion that has been a big challenge for them. So I'm -- there's genuine uncertainty, I think, on both the capital and the intermediate services, especially the energy component, as to which measure is preferable.

It is somewhat striking how that -- however,

if you look at the 2001 to 2010 period, the numbers are very, very similar. Yet for the last slide that Steve had prepared, the big difference is what happened in the '90s.

MR. HEFFLER: Right. Although that particular sensitivity analysis really just isolates one effect, which is changes to the intermediate input approach as opposed to, you know, reflecting any types of changes in methodology for, you know, how we measure capital or some definitional things.

DR. BERNDT: Right.

PARTICIPANT: I think, as I recall, the 1990s measures related -- there were some issues relating to measurement of quantity and that related to managed care and change in indices used in the middle of the period.

MR. HEFFLER: Yeah. I think one thing as we've worked on this, although our sensitivity analysis for change in the intermediate inputs is going to show that it didn't change all that much.

One thing that I think we've learned is, there is just a lot of volatility. You can change a method

or a data source and because MFP is calculated as a residual, it doesn't take a lot to change the pieces a little and they add up and all of a sudden it's a really big change in a resulting MFP.

So that's really a concern. I think that's why there has been so many issues with how much to believe service sector productivity. It's a really difficult concept to measure. I think this highlights it.

As you said, Ernie, if there was a fix or there was an issue that was addressed with the energy prices and they looked very differently, that intermediate inputs might not grow as fast and all of a sudden the MFP measures look like they're similar. It's just hard to know.

But we wanted to present that background to you so you kind of understood why the results were different than what had been published at a higher level.

Then moving on to the next slide, Kathryn, you had raised an issue when we talked about the intermediate inputs about -- I think a good issue --

about we were deflating using the intermediate input part of the MEI, but we were excluding things like drugs because they weren't in the MEI even though they were in the real output that we were measuring for the physician sector.

So we did two things. One was we went in and made an adjustment and added the weight and the price change for things that we had excluded separately, particularly separately billable supplies and drugs, to see how much of an effect that had.

The other thing we did is instead of modeling intermediate inputs as a residual where we let the physician income share of expenses determine what the share of expenses that intermediate inputs were, we actually reversed that equation and came up with a share of expenses for intermediate inputs using some census data from the Business Expense and Service Annual survey and came up with some rates of growth for intermediate input, quantities using that data and then we let physician income be the residual to see what we would get if we made those changes.

So the last slide, which is a comparison, puts

all that together. And as you can see in most periods, it doesn't make a very large difference over the whole 83 to 2010 period, it's only about a tenth. The bar on the left is what we had presented last time. The middle bar here is the revised physician MFP based on those two changes I had mentioned.

You can see that in the latest ten-year period, it's only a tenth and making the change produces a slightly faster growth.

There are some offsetting things here. Incorporating the drugs and other supplies into the index actually tended to drive the MFP up higher. And that was because those types of goods tend to have faster price growth than the other goods that were in industry, which lowered the quantity growth which raised the MFP, or the quantity input growth, which raised the MFP.

The change to actually calculate intermediate inputs directly and not as a residual tended to pull MFP down lower. The most notable case of that is in that 1991 to 2000 period where the revised MFP was minus .7 instead of our baseline, which was minus .2.

It was very unique to that period and we weren't sure why that was occurring because we didn't see it in the others. So Molly had done a little digging and, you know, we're still trying to fully digest that, but, you know, at the end of the day, when you change the data source and we look at the rate of growth of the quantity of intermediate inputs from those census surveys, they just grow much, much faster over that period than what would be implied with our residual method.

And as a result of that, the share that intermediate expense is in is much higher under that method and the rate of growth is higher. So the faster that you have quantity growth, the lower -- of input quantity growth, the lower your MFP is going to be.

So it's very unique to that period. We don't know whether one is better than the other. I tend to think that we feel a lot better about having physician income in there and let intermediate inputs be the residual as opposed to let something like intermediate inputs tell us what the share of physicians are of total revenue. But we wanted to present to you what

the results of just doing things slightly differently were.

So I'll stop there. If there are any questions, I'll be glad to answer them.

MS. KOBE: This is Kathryn. I know this took a lot of work to look at these different options and I appreciate you doing it. I think it's informative in understanding the concepts underlying this physician MFP but obviously for the last ten-year period, it kind of gives us more confidence that none of these are really driving it in a recent time period. I think that was basically my concern that this was a very stable number for this recent time period and it looks to be pretty stable.

MR. HEFFLER: Yeah, we would agree. Definitely for the last ten years, that appears to be the case.

DR. BERNDT: And as I recall, the productivity adjustment is a ten-year moving average, isn't it?

MR. HEFFLER: Yes.

DR. BERNDT: So for current purposes, it looks easily robust.

MR. FOSTER: And this is also not the productivity adjustment we actually use in the MEI, of course, which is based on economy-wide productivity to match the economy-wide compensation with -- this is more of technical interest to get a better understanding of what's actually happening with physician practices.

DR. BERNDT: All right. Any further discussion on MFP?

(No response)

DR. BERNDT: I'm going to second what Kate said. So thank you very much for taking -- or your staff taking the extra time to do this.

MR. HEFFLER: You're welcome.

DR. BERNDT: Let's go on to the last presentation, which is the MGMA Cost Survey Overview. I thought was a very nice piece of research.

MS. OUMAROU: Sorry. We're just switching seats here so I can move the slides.

MGMA DATA PRESENTATION

MS. OUMAROU: This is Heidi. At the last -- well, over the last two meetings, we've touched a

little bit on the MGMA data as a possibility of using that for looking into the viability of using that data for establishing the cost weights for the MEI.

So we went ahead after the first meeting and got the data from MGMA. Since the last meeting, we've gone, based on your requests, and looked into more detail about some of the survey characteristics and then also some results in comparing the MGMA data to the PPIS data and the cost weights that we would get for the MEI based on those two surveys.

So basically this presentation has two parts. The first part is going to talk a little bit about the survey characteristics of the MGMA data. The areas where we have a comparison to the PPIS we'll compare that. And where we don't, we'll just report on what the MGMA data has shown.

Then the second part is comparing the cost weights that we get from the MGMA data to those that we got from the PPIS data.

One thing to note is that the PPIS data was for 2006. We did get the MGMA data for 2006 but because of government red tape and trying to install,

we were not able to actually get the data for 2006 because we had to get that off of a CD. Our IT people said it had to be tested and go through all -- so we compared the '06 to the '07. But as you'll see, the MGMA weights are very stable from year to year based on an analysis from 2007 to 2010.

So how do I -- oh, I have to use that.

DR. BERNDT: On slide to, Heidi, what does the acronym MSOPPMC mean?

MS. OUMAROU: MSOPPMC, hold on one second, means -- one second. I have to look it up.

PARTICIPANT: I bet you it was obvious when you prepared the slide?

MS. OUMAROU: Right, it was. I should have put it in there.

PARTICIPANT: I think it's Medical Service Organization and Physician Practice Management Company.

MS. OUMAROU: Yeah, you're right. I just found it.

PARTICIPANT: Would be my guess.

MS. OUMAROU: Management Service Organization and Physician Practice Management Company, and IPA,

which is not here, is also Independent Practice Association. So basically the definition is, "An entity organized to provide various forms of practice management and administrative support services to healthcare providers. The services include centralized billing and collection services, management information services and other components of the managed care infrastructure. MSOs do not actually deliver healthcare services. They can be jointly or solely owned and they're sponsored by physicians, hospitals or other parties.

"Some MSOs also purchase assets of affiliated physicians and enter into long-term management service arrangements with a provider network.

"PPMCs are publicly held or entrepreneurial directed enterprises that acquire total or partial ownership interest in physician organizations. PPMCs are a type of MSO, however, the motivations, goals, strategies and structures arising from their ownership character, development of growth and profits for their investors, not for the participating providers, differentiate them from other MSO models."

Does that answer the question?

(No response)

MS. OUMAROU: So the first difference between the MGMA cross survey data and the AMA data is the unit of observation for MGMA. The unit of observation is the medical group practice. The data is only reported for group practices consisting of three or more physicians. The practice ownership can include IDS, which there's a definition at the bottom of the slide. That's basically a network of organizations that provide, coordinate or arrange for the provision of a continuum of healthcare services at hospital owned. It can also be physician owned, government, MSO, PPMC or other.

For the AMA PPIS survey, the unit of observation is the self-employed physician or a physician able to report expenses at the individual level for the practice as a whole. There are no restrictions on the number of physicians in a practice eligible for inclusion in the PPIS.

Next for MGMA data, the data is reported in two ways. It's reported at the multi-specialty

practice level and then separately at the singles specialty practice level. They don't aggregate those two together to give an overall. The multi specialty practice for MGMA is defined as a medical practice that consists of physicians practicing in different specialists, but they have to include at least one primary care specialty. The single specialty is defined as a medical practice that focuses the clinical work on one specialty. It can be primary care, non-surgical or surgical specialties.

Also just to note, in the MGMA data, the -- in the sample, anyway, for the multi specialty and single specialty, the number of IDS or hospital-owned facilities ranges from 50 to 60 percent of the sample. And then physician owned practices account for about 30 to 40 percent of the sample. So they're geared -- their sample is geared more toward hospital-owned facilities.

For legal organization, the MGMA data is geared toward not for profit corporations. LLCs, partnerships and sole proprietorships do not constitute a majority of the companies reporting on MGMA so you

can see not for profit is about 37 to 41 percent for either multi specialty or single specialty. And then professional corporations or associations is about 30 percent of the sample.

DR. BERNDT: I was struck how similar these were.

MS. OUMARON: This is MGMA only.

DR. BERNDT: Right.

MS. OUMARON: The next thing that we looked at was the specialty representativeness and using December 2006 Medicare physician and other practitioner registry by specialty, it shows that based on the total number of specialties, excluding the non-physician practitioners, the AMA data represent about 97.5 percent of all physician specialties and the MGMA data represent about 60 percent of the specialties. So the AMA data is --

DR. BERNDT: Do you have any idea, Heidi, as to whether the -- how important are the 40 percent of physician specialties that are not in the MGMA? I mean, is it just -- are there many very small specialties or -- how to think of that?

MS. OUMAROU: Let me see here. I think I have a table. Some of the specialties that are not included -- I don't have a number but I can give you the types of things; colon and rectal surgery, dermatology, emergency medicine, endocrinology, medical oncology, nephrology, psychiatry, rheumatology, spine surgery. So there is a handful of specialties that are not represented that are represented in the PPIS data but --

DR. BERNDT: Are they not represented because there's no classification for them or they just happened -- they didn't have any single specialty organization that participated and provided data?

MS. OUMAROU: I don't know the answer to that. All I know is from the data that I could get from what we bought, those were the specialties that had data recorded, so --

PARTICIPANT: This is John. I have a feeling it's a classification issue. That they just aggregated up into larger categories of some subspecialty.

PARTICIPANT: Why wouldn't they include dermatology or psychiatry?

PARTICIPANT: Well, there may not be many large psychiatric groups.

PARTICIPANT: Well, there are.

PARTICIPANT: Did you say that they did not list dermatology and psychiatry?

MS. OUMAROU: No, they didn't.

PARTICIPANT: I mean, that's not the data base that I worked with MGMA. With the work that I did I'm -- and I've got 14 --

MS. OUMAROU: At least the data that they had for costs was not reported for those specialties. They may have sampled them but in terms of what their data show for the single specialties, they didn't have that broken out.

PARTICIPANT: Remember the response rate to their sample was not all that high.

MS. OUMAROU: Right.

PARTICIPANT: So if you got a real response rate from one of these specialties they wouldn't be reporting any data.

MR. POISAL: This is, John. Kurt, are you able to inform any of this? Have you worked previously

with that data?

DR. GILLIS: No, I haven't. So, no.

DR. BERNDT: Okay. Carry on.

MS. OUMAROU: This compares -- Kurt, after the first meeting, had run some information showing the cost weight distributions for major categories for the PPIS by specialty. And so we used the information that he provided there to compare that to the MGMA data in terms of the percentage of specialties represented. And this table only includes a specialties in both MGMA and the PPIS survey, so you can see that the MGMA data is geared more toward primary care specialties with family practice, internal medicine, OBGYN, having relatively high percentages of the overall sample.

DR. BERNDT: And the PPIS is much, much heavier weighted towards surgeons.

MS. OUMAROU: Um-hmm.

PARTICIPANT: I think it's amazing there's so many plastic surgeons around.

MS. OUMAROU: So the primary care specialties account for about 31 percent of the AMA specialties and they account for about 55 percent of the MGMA

specialties. And then overall, primary care specialties accounted for about 23 percent of all physician specialties.

So both of these are skewed a little bit toward primary care, but MGMA --

DR. BERNDT: Bob and Zack, what's your impression about if we had the universe of MDs, which of these samples best approximates that distribution?

DR. DYCKMAN: Bob, you go first.

DR. BERENSON: I would say the AMA. I mean, we have some huge gaps here.

MS. KOBE: Heidi, this is Kathryn. On this table where you're comparing the specialties, how have you dealt with the specialties that are in the PPIS but not in the MGMA? Are they just -- as far as the percent, are they just left off this table?

MS. OUMAROU: Yes, they are. So the specialties that the PPIS collects that MGMA does not, are not included in these percentages.

PARTICIPANT: So some of the PPI shares would be considerably less than 100 percent here?

MS. OUMAROU: If -- yes. If we included the

other specialties that they collect. If we didn't do it based on only the MGMA specialties, then, yes, those numbers would not add to one unless we --

PARTICIPANT: I mean, I did -- I'm sorry.

MS. OUMAROU: Go ahead.

PARTICIPANT: I agree with that. I guess that I may have been premature. I mean, I'm concerned that the MGMA represents -- this leaves out some very important specialties but I'm now looking at the PPIS distributions and it does seem to me that there's for some reason under weighting going on here of the primary care specialties. MGMA may overweight. AMA, I think, underweights. Family medicine, internal medicine are far more as a percentage of practice than what's represented here. So I don't think either one seems to do the right job, I guess, if I had to say -- draw a conclusion.

DR. GILLIS: Hi, this is Kurt. If I could break in here?

The counts here for the PPIS are the raw counts of the number of respondents that were included in the tabulations that I sent to Walt. But the PPI

survey wasn't a simple, random sample. It was stratified by specialty. Given that we had to collect data for over 50 specialties, 42 physician specialties, we aimed for responses from about 100 -- complete responses from about 100 for each specialty.

So the results for PPIS when we calculate the shares or whatever for MEI are weighted to account for the different sampling proportions for each specialty.

So, yes, we don't have enough internal medicine physicians in here. It's not -- it's looked at this raw percentage but internal medicine physicians are weighted up within the calculations so that it's nationally representative.

PARTICIPANT: I got you. So you've over sampled some of the small specialties here?

DR. GILLIS: Right. Right. In fact, the numbers -- you know, in a simple, random sample, these figures by specialty would be much different than what we have here.

DR. BERNDT: That's reassuring.

MS. KOBE: And consequently as I understand what you're saying, this is not representative of what

AMA thinks is the universe of physicians, then?

DR. GILLIS: Right, it's not. No. Not the raw count.

MS. KOBE: Heidi, do we know if MGMA does weight against some sort of overall sample of physicians or do they just use whoever answers the survey?

MS. OUMAROU: They only report it for the single specialties. They only report it by specialty, so they don't weight those up. For multi-specialty, I'm not sure how they do their weighting.

MS. KOBE: Okay. Thank you.

DR. BERNDT: Does the same consideration apply to the next slide, Kurt, in terms of the geographical? Oh, I guess that's only MGMA. Never mind.

MS. OUMAROU: Yeah. On the next slide, this shows the geographic representativeness of the MGMA data. And this is by HHS region. For regions 1 through 10, we have the states and areas that are included in each of those regions. And then we have that compared to universe counts. The universe counts are based on the AMA physician counts for these states

and areas.

You can see that for regions 1, 2 -- some of the regions or the MGMA are just completely underrepresented in some major areas such as New York, Massachusetts, California. That includes some of the largest physician communities are under reported.

In general, the MGMA single specialty, anyway, accounts for about 1.7 percent of the total U.S. physician population. There are ten states that account for over half of all physicians in the U.S.; California, New York, Texas, Florida, Pennsylvania, Illinois, Ohio, Massachusetts, New Jersey and Michigan.

For the MGMA single specialty samples, those states account for about 37 percent of their sample.

DR. BERNDT: Just to make sure I understand this slide, Heidi, if you had included -- is this universe the AMA universe of single specialties or does it also include multi-specialty?

MS. OUMAROU: This universe is for -- there's physician counts from the AMA so it would include multi-specialty, single specialty.

DR. BERNDT: Okay. I got it.

MR. STEINWALD: From their master file.

MS. OUMAROU: From their master file, yeah.

There's some geographic representative issues with MGMA data.

So now we get into the survey results and where we compare the MGMA data to the PPIS data and we put the MGMA data into -- tried to as best as we could put the data into similar buckets as the PPIS data and the MEI cost categories.

We took the single specialty data from the MGMA, which is reported basically by specialty, and we weighted that together based on the same method that we used when doing the weighting of the non-MD specialties from the AMA survey during the original rebasing of the market basket, so we used the physician counts from CMS and we basically weighted the specialties up to get an overall, single specialty mean.

And so column one shows the 2006 cost weights from the MEI based on the PPIS self-employed physicians. And then column two shows the MGMA cost weights for 2007 from the weighted single specialties.

The third column shows the MGMA

multi-specialty median cost weights. The mean cost weights --

DR. BERNDT: Is there any reason why in one column you have "median" and the other you have "means"?

MS. OUMAROU: Yeah. The multi-specialty mean data was -- seemed very skewed and so it just -- I put "median" in here because it seemed more realistic. I could add in the mean. I mean, the compensation weight was much lower. It was like 30 something, so --

PARTICIPANT: So the mean was even lower than the median for multi-specialty?

MS. OUMAROU: Yeah. And that multi-specialty data only includes primary care specialties, if you remember, correctly. They don't include any -- it has to have a primary care specialty. It could have another type of specialty but it has to at least have primary care whereas the single specialty is everybody. It can be multi-specialty, surgical, non-surgical.

So the fourth column shows the difference between the 2006 PPIS weights or the current MEI weights and the MGMA single specialty mean weights.

You can see that the biggest difference is, in terms of that comparison, would be for the non-physician compensation, which is higher in the MGMA data than in the PPIS data, about 9 percent higher.

The office expenses is lower in the MGMA data. The PLI is also lower in the MGMA data. And is there another category here?

And then the other difference that we saw was that the split between the physician compensation wages and benefits, the benefit weight in the MGMA data was a little bit higher and that was something that we had discussed at previous meetings with the PPIS data; the benefit, physician benefit. Expenditures seemed to be not representative of the defined contributions. And so this seems to be that that would support that idea that the benefits weight should be a little bit higher for physician --

PARTICIPANT: I would assume that the MGMA multi-specialty groups are much larger than the MGMA single specialty groups, so to the extent that there are differences between the MGMA single and multi specialty, it may reflect, to some extent, size, maybe

to a large extent size, and that also would reflect differences between the PPIS and the MGMA multi-specialty. So some of this might be reflecting an average size group of five or ten compared to 15 or 20 docs, and that could be the reason why we're seeing some differences.

PARTICIPANT: Well, it's sort of complicated because mean versus median.

PARTICIPANT: That too.

PARTICIPANT: It appears that the MGMA has greater non-physician personnel and lower percent office expenses, daily economies on both, probably.

PARTICIPANT: Heidi, is the MGMA data expensive or is it readily available?

MS. OUMAROU: It is not expensive.

PARTICIPANT: Good.

MS. OUMAROU: It's relatively easily available in terms of purchasing it.

DR. BERNDT: All right. Carry on.

MS. OUMAROU: So I'm going to go through the four categories that had the biggest differences. For non-physician compensation, the weight for the MGMA

data is about 9 to 13 percent higher than the PPIS data. And some reasons for the differences could be that the MGMA data is predominantly representative of primary care specialties, which tend to have higher non-physician compensation costs. The MGMA sample reflects practices with only greater than three physicians and larger group practices may be more likely to have a larger amount of administrative staff.

The MGMA ownership types has more IDS than hospital-owned practices and may tend to hire more administrative and billing staff than single-owned practices.

The MGMA data included expenses for contract labor costs in the non-physician compensation while the PPIS data did not.

PARTICIPANT: Can you explain your last point about contract labor costs?

MS. OUMAROU: Sure. The MGMA data has a line for contract labor and those are included in the amount that they collect for non-physician compensation, so that's just how the question is asked. On the AMA PPIS survey, the contract labor costs are not collected

under the non-physician compensation.

DR. BERNDT: What do we mean by contract labor?

PARTICIPANT: Yeah. That's what I was asking.

MS. OUMAROU: Let me see the question here.

PARTICIPANT: Would that be something like accounting services?

PARTICIPAN: Was it a lab technician?

PARTICIPANT: Heidi is looking it up.

PARTICIPANT: Okay.

PARTICIPANT: I would think it would be accounting services and billing services, legal services.

MS. KOBE: I'm looking at these percent numbers that are on the comparison of the PPIS self-employed with the MGMA one. Would the PPIS self-employed in that case have been weighted according to the master file weights or they've just been weighted by who happened to respond to the survey?

MS. OUMAROU: No. They're weighted by master files.

DR. GILLIS: The PPIS results were weighted

according to the master file, representative of the general physician population.

MS. KOBE: Okay. Thank you.

MS. OUMAROU: So in terms of the contracted support staff, the definition on the MGMA question is contracted support staff represent all of the staff hired on a contract basis not employed by any of the legal entities that comprise the medical practice.

PARTICIPANT: Would that include physicians?

MS. OUMAROU: It does include physicians but -- so in that physician compensation cost they do include contracted physicians but that's a separate line item.

So under their definition for physician compensation, it's compensation for shareholders, partners, associates on salary, employed physicians, contract physicians, locum tenants -- I don't know what that is -- residents and fellows, compensation for full time and part time physicians, salaries, bonuses, incentive payments, research, contract revenue, honoraria, profit distributions. So, yeah.

PARTICIPANT: Both obtaining our physicians

that work on a contract basis, in essence, usually short-term?

MS. OUMAROU: And then they also collect physician cost for the employed physicians and those include the contract labor, too; the non-physician providers.

MR. HEFFLER: This is Steve. I want to ask Heidi a question back on the contract labor issues. So under the MGMA survey if they hire someone to do accounting services for them, they report that and we presented that as a non-physician compensation. Under the MEI and the AMA survey, they're picked up in like other professional services --

MS. OUMAROU: Right.

MR. HEFFLER: -- as other expenses, something like that. So it's not whether they're included or not, it's just where they're classified.

PARTICIPANT: Definition.

MR. HEFFLER: Right.

MS. OUMAROU: Offense expense, this was a question that we had at the last meeting from a member of the public. So the question was from Michael

Kitchell and he specifically asked, the weighting of the practice expense is 10.2 percent for rent and utilities, and 19.1 percent for wages. This is in mark contrast to MGMA data and so he asked us to reconcile these.

So in terms of the office expenses when we look at the comparison, the MGMA weight is about five or six percent lower than the PPIS data show. And the fixed capital component, which is the rent, is also about three percent lower. Some reasons for those differences could be because some of the higher rent geographic areas, such as New York and California, are underrepresented in the MGMA survey and that the larger group practices have lower relative fixed costs. There could be other reasons for that, but it does show that the rent and the office expense weight is lower in MGMA.

MS. KOBE: How does the MGMA determine who answers that survey? Do they send it to everybody who is a member, or something like that, and just take whoever sends it back, or do they have a survey sampling concept?

MS. OUMAROU: I'm not sure. I know that they do only send it to their members but I'm not sure as in terms of responses how that works.

If there's no other questions --

MS. KOBE: Do you have any feel from other information as to how representative this single specialty concept is compared to multi specialties compared to what the universe looks like?

MS. OUMAROU: No, I don't.

If there's no other questions, I'll go to the next slide.

Looking at the physician compensation wage benefits split, the MGMA data show the wage benefits split to be about 8713 for the physician compensation while the PPIS data showed a 919 split. This is a list of what the MGMA includes in their benefits, the definition of their benefits. So you can see here that this definition is pretty robust. It includes payroll and unemployment insurance, health, disability, life insurance. It does include the defined benefits and contributions.

And the definition on the question from the

PPIS survey wasn't as clear and didn't specifically request the defined benefit contribution so that might be a reason for the difference. We would probably want to make sure that, like we said last time, that the weight for the benefits for the physician compensation was consistent with the price proxy and the expenses that were included with that.

And then --

PARTICIPANT: I'm looking at a relatively recent MGMA report and it's pretty clear that they send it to all their members. There's no stratified sample approach.

MS. KOBE: Okay. Thank you.

PARTICIPANT: The 2010, 2011, survey they indicated they sent it to some non-member groups too, but that might have been different from earlier.

MS. OUMAROU: The last category that showed some pretty substantial differences was the professional liability insurance category with the weight from MGMA being about two percent lower than the PPIS data.

We are pretty -- we feel pretty confident in

that the PPIS data on PLI and the weight that comes out of that, but some reasons for the lower weight in the MGMA data could be because it's overly represented by primary care specialties, which tend to have lower overall PLI costs than surgical specialties. It's not geographically representative and many of the states with higher PLI costs are underrepresented. So that's an issue with the data.

And then this slide just shows for the major cost categories. The blue is physician compensation. The red is non-physician compensation. Green, office expense less all other services, because we moved that down into one category. And then professional liability expenses.

It just shows over time from 2007 to 2010 that the MGMA cost weights are pretty stable over time. They're not very volatile, so we can extract the comparison from 2007 to 2006 without too much concern, I think.

Finally, just in conclusion, some considerations that we would want to take into account in terms of the use of the MGMA data for purposes of

the MEI, using this data would represent a change from using self-employed data only. The MGMA data is not geographically or specialty representative. The data is more reflective of primary care specialties and surgical specialties.

And moving to using this data to estimate the MEI cost weights would be inconsistent with the data that's used to estimate the RVUs and the gypsies, which those two, RVUs and gypsies are benchmarked to the MEI weights for physician work, PE and PLI.

DR. BERNDT: Could you remind me what the GCPI acronym is?

MS. OUMAROU: Geographic Practice Cost Indices.

DR. BERNDT: Got it. Thank you.

MS. OUMAROU: You're welcome.

That's it.

DR. BERNDT: I guess my take on this is that this -- the real compositional change that we think is occurring amongst the organization of physician practices bears close watching just to make sure that our sample remains representative of what's actually

happening. I guess we'll readdress that later on today when we talk about possibly commissioning AMA to do another survey joint with CMS at some point in time.

Panel members, do you have any other thoughts?

MS. KOBE: I can see some advantages to having a regular survey, like the MGMA does, but I have some serious concerns about the distributional differences here both geographically and across the specialties. I mean, it's hard enough to have one index, but if -- you know, reflective of this very wide range of specialties to being with, that have very different cost structures. But I don't think we would want to be leaving out a large percentage of specialties. I think that would be a concern if you were doing cost weights.

So while I think the MGMA results are interesting, I'd want to know a whole lot more about them and whether they could be re-weighted in some way to better reflect the -- which seems to be the population out there.

DR. BERENSON: This is Bob. I would agree with that. The only thing I'd throw in is that whether the response rates and distribution is improving with

time. I use their -- the reason I was surprised is that I use a different survey which is their compensation and productivity survey, which has 110 specialties represented and probably a much higher response.

The question is whether since 2005 or '06, whenever you had it, whether they're getting much higher responses to their cost survey. But given -- if it's not changed, then I think there are disabling problems of representativeness.

DR. BERNDT: Zack, do you have any thoughts? Kurt?

DR. DYCKMAN: I recall from the first meeting that -- and Kurt could respond to this -- that there was some concerns about whether another AMA survey could be successful; if you would get sufficient participation. Am I correct?

DR. GILLIS: Yeah. I mean, the response rate has gone down dramatically since they started doing -- AMA started doing that survey. And it gets more difficult every year and more expensive, but a survey that would just focus on collecting weights for the MEI

could be a lot -- a much trimmer ship, you know. It could be a lot smaller in terms of the number of questions and even the number of respondents that you'd need, because they wouldn't have to go out and get complete expense information for every specialty.

You know, we could just do another random sample. So, you know, it's hard to say how it would turn out. A simpler survey but, you know, in times that are still really tough to collect the information.

DR. DYCKMAN: In the last AMA survey, did you compensate physicians at all for responding?

DR. GILLIS: Yeah. There was a small payment of 50 dollars to 75 dollars depending on how they answered the survey. But I think they're accustomed to getting paid quite a bit more than that, you know.

PARTICIPANT: It's not a market wage.

DR. GILLIS: Well, even for doing surveys.

DR. BERNDT: Okay. Any more comments, thoughts on MMA and PPIS?

PARTICIPANT: Just that if we do try to obtain data from a new AMA survey, that wouldn't preclude us from using available data from MGMA as a cross-check or

to fill in in areas where the AMA survey data may have some issues or problems? Would that be correct?

DR. BERNDT: That sounds very reasonable and I guess the other thing I'd add to it is, is Bob reminds us that there are some other MGMA surveys that they do that we're not looking at.

MR. POISAL: Ernie, if it's okay with you --

PARTICIPANT: And I don't think those are particularly relevant. I mean, they're interesting, but I don't think -- I mean, the work that I've done suggests that on compensation, the MGMA work is relatively in the middle of the pack in terms of the whole range of compensation surveys but I don't think that helps us with our activity.

DR. BERNDT: Thank you.

MR. POISAL: Ernie, this is John. If it's okay with you, maybe we could take a five-minute break. We did run a little bit long in terms of the first portion of the morning, but maybe take a quick five-minute break and then come back and start to go through some of the draft findings and recommendations?

DR. BERNDT: Sounds good to me.

MR. POISAL: All right. By our clock here it's almost 11:25, so we'll reconvene at 11:30.

DR. BERNDT: Okay.

(A brief recess was taken.)

MR. POISAL: We're back at full speed.

REVIEW DRAFT LANGUAGE ON PANEL'S FINDINGS AND RECOMMENDATIONS

MR. POISAL: So, Ernie, we thought we would pull up on the webinar for all to see the draft recommendations. Again, the panelists should feel free to edit, augment, and change in any way you all see fit. The goal really is to derive language that everybody feels as though they can endorse.

Ernie, do you want to walk us through each one and you can tell us when we're ready to move on to the next?

Like I said, we'll still plan to break at noon for a 30-minute lunch, so we'll just get our feet wet here and see how much progress we can make.

DR. BERNDT: Okay. The first recommendation or finding is to do the overall index itself. And I guess I'll read -- although (interruption to audio) the

panel's inclusive (interruption to audio) construct, (interruption to audio) and monitoring the MEI as a 6 point index as (interruption to audio) given the lack of evidence as a significant substitution (interruption to audio) categories over time as well as expectation (interruption to audio) as on physician expenses.

So (interruption to audio) this is a -- keep up the good work but keep your eyes and ears to the ground.

PARTICIPANT: (Interruption to audio) index. If they do change at some point (interruption to audio).

DR. BERNDT: (interruption to audio) change index. It's a (interruption to audio) occasional (interruption to audio).

PARTICIPANT: Someone seeing this might interpret that as the points never change.

DR. BERNDT: Good point. Do we (interruption to audio) using 2000 --

MR. HEFFLER: Hey, Ernie, this is Steve. Can you hold on for a second?

Is anyone else having phone issues as far as

the voices cutting out and crackling?

DR. BERNDT: I'm not.

MR. HEFFLER: Okay. I think we have a slight issue on our end. We're hearing about every third word or so. If you can just give us a minute. Let's see if we can try to troubleshoot this.

(Discussion about microphones)

MR. HEFFLER: Okay. We tried a couple of things. Ernie, would you mind rambling some words together and let's see if you crackle or not?

DR. BERNDT: Okay. I think Zack or (interruption to audio) what was it, Zack, that we want to change the wording of fixed weight because it now gives -- or it could give a reader the impression that it was a perpetually fixed weight, which is not the case.

PARTICIPANT: Perhaps the best way to do that is do it within the finding and then it occurred to me perhaps making a footnote right at fixed weight is something like (interruption to audio) revised every several years, most recent revision in weights occurred in 2006, something like that.

DR. BERNDT: That's fine with me. Does the CMS new day, are they comfortable with recommendations concerning -- containing footnotes?

MR. FOSTER: I'm sure that can be worked out in some way or another.

DR. BERNDET: Okay. The only other change I would suggest, as I look at it, is at the very end it says, "Physician expenses." I think it's typically really they mean "Physician office expenses," don't we?

MR POISAL: Yeah, that's a good point, Ernie. Thank you.

DR. BERNDT: Why don't you draft that footnote right now and just drop it here, John, so right after fixed rate index. Zack, do you want to take your poetic use and run with it?

DR. DYCKMAN: I'd prefer someone else do it but I'll try.

(Laughter.)

DR. DYCKMAN: Fixed rates are revised in several years, or periodically may suggest more frequent. New sentence. The most recent (interruption to audio) weights are based on a 2006 survey. We want

to indicate that we expect to revise that on occasion also.

DR. BERNDT: Yes. Current weights are based on a 2006 survey and are expected to be updated sometime in the next few years. Is that too vague?

PARTICIPANT: Maybe too specific to CMS.

(Laughter)

DR. GILLIS: It's actually 2007-2008 survey.

(Simultaneous conversation.)

DR. BERNDT: 2006 data but, you're right.

PARTICIPANT: When were they actually updated? In 2008?

MS. OUMAROU: No, in --

PARTICIPANT: The survey was conducted in 2007 and 2008. They weren't actually updated until the 2011 final rule, I believe. Is that right, John?

MR. POISAL: That's correct.

MS. KOBE: I think to construct -- the point concerning wages however they balance, I think we want to have 2006 indicated in there as some -- in some way.

PARTICIPANT: How about something like "Current weights are -- cost weights are revised

periodically. Current weights are based on 2006 expense data?

PARTICIPANT: That's pretty good.

MS. KOBE: I think that sounds good.

MS. OUMAROU: Can we see this?

PARTICIPANT: Collected in --

DR. BERNDT: 2007-08, that's fine.

DR. GILLIS: And could it just be a period after that closed paren?

DR. BERNDT: Yeah.

PARTICIPANT: These rates are expected --

DR. GILLIS: I'm wondering if the rest of it is necessary, because at the beginning it says they are updated periodically.

PARTICIPANT: Right.

DR. BERNDT: Okay. Any other revisions to first paragraph finding 1.1?

(No response)

DR. BERNDT: What is the difference, by the way, that CMS interprets the finding from a recommendation?

MR. FOSTER: A finding is more like a

conclusion that the existing practice is okay to you or you agree with something that's being done. Whereas a recommendation is a specific change.

DR. BERNDT: Okay. Thank you.

All right. Recommendation 2.1. The panel recommends that the CMS Office of the Actuary research whether using self-employed physician data for the ME cost weights continues to be the most appropriate approach. In particular, the Panel notes that in recent years there's been a shift from smaller to larger physician owned practices as well as from physician owned practices toward hospital-owned practices.

However, it is unclear whether adequate data are available to reflect a shift in the MEI or whether the cost structure for employed physicians would be materially different than that 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 aspect of

this research.

Zack, I think last time we met you contributed to the wording of this. I think CMS staff have worked on it a bit. Are you comfortable with this?

DR DYCKMAN: I'm comfortable with it.

MS. KOBE: Do we want to make the obvious comment that in considering any changes, though, we want to make sure that, you know, that we have a representative sample including geographically and specialty, I guess, is my question? I'm not sure that whether this is the appropriate place to mention that or not.

DR. BERNDT: How about adding to the last sentence, "Accordingly, consideration of the availability and viability of specialty and geographically representative expense data"?

PARTICIPANT: Sure.

MS. KOBE: I think it would be helpful to kind of cover what our concerns were.

MR. OSGOOD: Ernie, would you remind repeating that?

DR. BERNDT: Take your cursor and pull it to

the right, right after "Viability of."

MR. OSGOOD: Okay.

DR. BERNDT: "Of specialty and geographically -- specialty and geographically representative."

PARTICIPANT: You can do it, Lindsey.

(Laughter)

DR. BERNDT: There we go. Are you comfortable with that, Kathryn?

MS. KOBE: I think that probably -- at least makes clear that we were concerned about that issue in analyzing data sources, so, yes.

DR. BERNDT: Bob? Kurt?

DR. GILLIS: Well, it's kind of a picky point. I'm wondering if the sentence beginning with, "In particular," are we really convinced that we know these are facts that physicians have been moving from smaller to larger practices? I hear lots of anecdotal reports about -- and I'm sure it's happening to physicians, hospitals buying physician practices, but we don't have the -- do we have a nationally representative survey that really demonstrates that, say, over the last four

or five years this is really happening?

PARTICIPANT: I guess we can say the Panel notes that apparently.

PARTICIPANT: No, there is data that says that --

PARTICIPANT: I think there is data but we can support that. We're not being quantitative here. I think there's no question.

DR. GILLIS: All right. That's fine, then. Thank you.

DR. BERENSON: I mean, instead of "has been," we might want to say there is or there's a trend towards -- in other words, we don't want to suggest that there's some finality to it. There is a continuing trend towards smaller to larger. I think we have data to support that, or I would have it.

DR. BERNDT: Giving trend toward --

DR. BERENSON: There is a current trend or a continuing trend toward involving a shift from smaller to larger owned practices as well as from physician owned towards hospital-owned practices. I think that is true.

DR. BERNDT: Do you say, "involving a shift?"

DR. BERENSON: Yeah. I mean, the language is a little awkward as a continuing -- yeah, I don't think we need the word "shift" in there. There's a continuing trend towards larger.

DR. BERNDT: Okay. Kurt, do you have any?

DR. GILLIS: No. Not beyond that.

DR. BERNDT: That was number 2.1. Let's try 2.2 before lunch.

(Laughter)

DR. BERNDT: The Panel recommends that the Office of the Actuary scan for and research additional data sources that may allow for more frequent updates to the MEI's cost categories and their respective weights. Such data sources could include, but are not limited to, the following: IMGMA cost survey, Bureau of the Census survey, Annual survey, including the possibility of adding questions to the survey pending feasibility of CMS survey possibly conducted jointly with the American Medical Association that focuses exclusively on physician expenses as they relate to the MEI. Assuming such a survey would likely have lower

administrative costs relative to past joint studies.

Do we need that last parenthesis in there? I guess for balanced budget reasons we probably do?

(Laughter)

DR. BERNDT: Do we want to add --

MS. KOBE: I think feasibility reflects the budgetary issues.

DR. BERNDT: Okay.

PARTICIPANT: So I have an idea that this, I think, is the right time to talk about -- I don't know if we can do it all before lunch. But and this is the right context, because we're simply talking about exploring possibilities but I keep hearing, I don't think the MGA data is going to work, at least currently.

And the earlier discussions we've been having about the uncertainties around the AMA survey and physician's reluctance, I guess what I briefly alluded to in the first meeting we had was the possibility, and here's how I would describe it, as getting a sample of practices and actually working with them to produce cost reports. Whether it's 100 or 200, I mean, I don't

know that, but actually get real good data from a sample of practices on an ongoing basis as a basis for getting cost data.

And the model that I have in mind, which is qualitative research and not the kind of quantitative data we need for this is the Center for Studying Health System Change, which 15 years ago or longer decided to pick 12 communities that met criteria for being broadly representative of sort of urban MSAs and studied the hell out of those 12 communities. And actually say very useful things about trends in health system change, even though they don't go to a couple of 100 urban MSAs.

So instead of surveying -- they're really concentrating. I guess the question I would ask is, could we do something comparable and even more quantitative by getting cost reports by working with a small number of practices but getting real good data?

MR. BERNDT: You want to put that forward in a wording?

PARTICIPANT: Well, I want to kick it around first and see. I mean, this is -- I'm not basically a

methods person and I'm just not sure that there weren't be some disabling problem with that, but I want to at least see if people think it's deserving of consideration to add to this list.

DR. BERNDT: I think it's an option that's worth keeping open.

MS. KOBE: I think it's an option to consider but I would still be concerned about whether we have specialty and geographic representation if it's going to be just a very small group.

PARTICIPANT: Oh, absolutely.

MS. KOBE: I think talking about trends in a more general sense, studying a small group might be helpful but I don't know that we know enough about how distributions across specialties in a geographic region are different that would allow us to kind of narrow down -- allow us to use data that doesn't cover every specialty.

PARTICIPANT: Well, I think we would know how to be able to -- using the AMA master file or other sources know what the geographic distribution of practices are and by specialty. I guess to me the

problem would be is potential bias of which practices get selected to actually provide the cost reports. I think we could deal with the representative issue.

Again, it's easy for me to say that. But I think we'd have to think through those kinds of issues. I mean, do we sort of send letters randomly to practices or do we actually try to select practices that would actually be cooperative and produce it, in which case you do have potential bias? I mean, I can see issues. And at this point I'm not recommending it. I actually don't see the alternative to doing something like this.

PARTICIPANT: How about some wording like that would say, "CMS, or an organization with whom it contracts, periodically mount a survey -- I think it's more than a survey. I think it's actually -- I mean, there's a lot of companies -- sort of comments on it.

MEDPAC has actually recommended for a couple of years that because ambulatory surgical centers don't submit cost reports that there should be some sampling of ASCs to get cost reports from a sample; ASCs, not from all of them, as a way of getting cost data.

So I'm suggesting something comparable here. So it's not a survey, I guess is the point I'm making. It's a sample to get actual cost reports.

PARTICIPANT: Yeah. You're talking about a --

PARTICIPANT: Selecting a group of physician practices and surveying this same group, the same practices, on a periodic basis every two years.

PARTICIPANT: Yeah, that's right. But, again, I'm suggesting -- I mean, the survey suggests that some doc is sitting down and answering questions. I'm actually thinking that they're following guidance to produce a report, a cost report, is what I'm suggesting. So in a sense it's not really a survey.

PARTICIPANT: Given the statistical validity or better statistical validity to following the same group, because if it's a small survey and you conduct a new survey each time, you're introducing variability there. I think you could gain seeing how individual practices change over time.

PARTICIPANT: I agree with you. I would go back to the same practices and then what you've got is the potential of bias about how you selected the

practices. I'm not so concerned that we couldn't get representative small practices, geographically dispersed practices, primary care practices, and neurosurgery practices. That I think we could do. I don't know what the end would be here, but the ones that are eager, willing and capable of providing this information may be somewhat unrepresentative, although we could probably find that out.

PARTICIPANT: They also come into play. Whereby surveying them and working with them you're going to change their behavior.

PARTICIPANT: Well, that's exactly the concern.

PARTICIPANT: But we're only asking them to report cost data. It's not like we're telling them how to be more efficient or something like that. But Rick has been wanting to say something, right?

MR. FOSTER: Well, I was going to say something earlier about the nature of your design. You're talking about a cost report based scientific sample of stratified, random representative, et cetera. I'm assuming as part of this there would be like a

contractual agreement of some kind where CMS or whoever we pay these outfits money to do a really good job. And they'd be subject to audit if we felt like it.

Now, having said all that, I think what I'd suggest is why don't we try drafting a fourth option along those lines over lunch for you all to think about.

PARTICIPANT: What's your immediate reaction to this, Rick?

MR. FOSTER: I like the idea in general. I think to do it right, because of what Kathryn mentioned a minute ago about the broad based representativeness of it, it's like what Kurt and AMA already try to do except we take it like a big step further, a really big expensive step, and get much better data as a result. So, you know, given the money that's leveraged out of this, it's probably worth doing.

PARTICIPANT: Well, the other thing, and the reason I'll bring this up now is my initial idea around this had nothing to do with the MEI. It actually had to do with providing an alternative source of information for constructing work RBUs in the physician

fee schedule rather than relying on self-interested estimates by specialty societies, which is the way it works.

MR. FOSTER: Which has been a problem, yeah.

PARTICIPANT: It would actually be to go collect time data from practices. It seems to me, if you're in those practices and collecting time data, you could also be collecting this cost data. I actually think it could be leveraged so that it becomes an approach for actually getting much better data for constructing RBUs.

PARTICIPANT: I agree yet I'm a little worried about, does that go outside the domain of our charge?

PARTICIPANT: I don't think we write this down here that we would do that. I do think ultimately if this became a good idea, CMS would have to figure out how to leverage it and how to finance it and could possibly find a joint effort with the folks in Medicare management to do something. That's not within our charge. I agree with you.

So that's sort of an aside in parenthesis as a way to perhaps solve a couple of problems. But for now

I would be more than happy to take up Rick's suggestion to have some draft language over lunch.

MS. KOBE: I think that's a good idea. I mean, conceptually I don't see any reason not to include it as something that they look at.

PARTICIPANT: Yeah. That's all I'm recommending at this point.

MR. FOSTER: That's the point. I mean, it might turn out to be hopelessly expensive, but on the other hand, it might turn out to be not that expensive and worth it.

PARTICIPANT: I assume we're not suggesting that this would replace any other survey or be -- or this would be the main source of information? I think we still would need other data but this would add, well, depth and better understanding and things like that.

PARTICIPANT: Well, consistent with feasibility and resources, sure, but if we're not going to be able to get an AMA survey and if the MGMA data is flawed, I'm not sure what else we got. Now, if it comes down to, you know, does CMS spend money to do a

broad survey and pay doctors lots more to fill it out, versus what I recommended, then there's a choice of which one would be sort of give you the best result. And that's a choice that would be made. I'd love to have both sources of information if it was possible, but it's not like we've got an ongoing stream of the routine survey information.

So I'm suggesting this primarily as a gap filler because we don't have anything else.

PARTICIPANT: Just one thing to add. I don't want to hold off on lunch, but timing is important here, too. The weights have been updated about every six years and it seems like it just happened. But like if AMA were to do another survey or to pursue one of these other options, an AMA survey would take quite a bit of time, lead time, to get -- you know, decide on funding, put together a survey, pick a contractor, et cetera.

So, I mean, we're not very far away from the point where we'd have to start working on it and some of these other options, too. The need to start on this is pretty immediate if you want to keep to that

schedule of about every six years.

MR. FOSTER: For option three, that would be, I think, a point with that in, in view of the startup time that should be considered in the near future. Option four is a longer term possible big improvement over what we've been able to do to date and that would take a longer time to, if nothing else, even go through and get a new what would still look like a survey in some respects, getting that approved.

MS. KOBE: I mean, the top of this "For more frequent updates" but right now we're talking about -- and I think we all agree that you need to keep on at least the six year schedule because a lot of changes are going on. So I guess the timing probably is important to express as far as the expectation that the weights are going to be updated, maybe not on a fixed schedule but some concept that it doesn't get worse than it is right now.

DR. BERNDT: Shall we take a break now?

MR. POISAL: Yeah, Ernie, if it's okay. It seems like there's a fair amount of legwork that we require to do here between now and the end of lunch, so

if it's okay with you, maybe we would reconvene at 1:00?

DR. BERNDT: Okay. Kim, shall I hang up and call back in or how do you suggest we proceed?

KIM: You can just leave your phone off the hook or you can just -- if you want to mute your phone, but just leave it off the hook, because if you hang up, I'll have to conference you back in. I mean, do you want me to do that? I can do that. It's up to you.

DR. BERNDT: I have a hand -- I have a wireless here, so I'm worried the battery's going to give out.

KIM: Okay. So I'll call you back.

DR. BERNDT: Okay.

KIM: So I'll call you back at one o'clock.

DR. BERNDT: At 857-350-3826.

KIM: And let me repeat it; 857-350-3826.

DR. BERNDT: Thank you.

KIM: You're welcome.

Does anybody else need for me to call them back?

MS. KOBE: I'll just put mine on mute.

Thanks, Kim.

KIM: You're welcome.

PARTICIPANT: I'll do the same.

KIM: You're welcome.

MR. STEINWALD: Well, my batteries gave out years ago but it has nothing to do with the phone.

(Laughter)

MR. POISAL: Very good. Okay. Thanks, everyone. We'll reconvene at 1:00. Thank you.

(Whereupon, at 12:06 p.m., a luncheon recess was taken.)

A F T E R N O O N S E S S I O N

MEI OVERVIEW

MR. POISAL: I think what we'll do and just to give you a little bit of background about how we envision the afternoon unfolding, pending Erie's hope to get approval.

REVIEW DRAFT LANGUAGE ON PANEL'S FINDINGS AND RECOMMENDATIONS ASSOCIATED WITH FOLLOW-UP ISSUES

MR. STEINWALD: The reason for this is that it's implicit in your conversation about the lack of concern for lack of a data source, but it's never stated. So the first sentence would be, "The panel is concerned about the absence of a reliable, ongoing source of data for maintaining the MEI."

And then "accordingly," comma, and proceed from there. Here it is.

DR. BERNDT: Can you read that once again? "The panel is concerned"?

MR. STEINWALD: Hudson is typing it.

Something like that. Thank you.

MS. KOBE: I think that's a very helpful phrase to put on there because I do think that those

reflect our concerns here.

MR. FOSTER: You might clarify for maintaining the MEI cost point.

MR. STEINWALD: Well, since the next sentence covers it so I didn't think it was --

MR. FOSTER: Okay.

DR. BERNDT: Bullet number three, why don't we just go down and systematically? Any comments about the first paragraph in the first bullet?

PARTICIPANTS: No.

DR. BERNDT: Okay. Second bullet?

In the third bullet, it sets the word "the" before "lead time." "We note that the lead time to conceive the...administered." I guess, right, okay.

MR. POISAL: Kurt, does that get to your point?

DR. GILLIS: Yeah, I think so.

MR. POISAL: Okay.

MS. KOBE: Do we need the first phrase in the parentheses? Didn't we decide that was kind of colored by (interruption to audio)?

MR. HEFFLER: Right, the phrase that begins

"assuming such a survey"?

DR. BERNDT: Right. Just delete that.

MR. HEFFLER: Oh, through the semicolon is going to come out. So we need a period and a capital there.

DR. BERNDT: To be in force, "alternatively and again pending feasibility, CMS could obtain more robust data by means of detailed formal cost reports"?

I'm comfortable with the rest of it. How about other panel members?

DR. BERENSON: This is Bob.

I guess I would leave open the question of whether it needs to be a random sample or whether it could conceivably be a purposes, purposeful, purposes, whatever the word is, sample, recognizing that that might create some bias, but it might also be much more feasible and get better data. So I would rather use the word "representative," "scientifically sound, representative sample," rather than "random sample."

DR. BERNDT: "Scientifically sound, representative sample."

DR. BERENSON: Yeah. I mean, "random" might

be the way to go, but it might not be, I guess. I wouldn't prejudge that.

MR. FOSTER: What was the wording you had, Bob?

DR. BERNDT: "Scientifically sound" --

DR. BERENSON: "Scientifically sound, representative sample."

PARTICIPANT: I'm not sure I know what "scientifically sound" means in this --

DR. BERENSON: Well, I was just building on "scientific," which didn't work for -- I mean, I'd be happy to have "representative" without the "scientifically sound."

PARTICIPANT: Do you want to just take out the word "random"?

DR. BERNDT: Yes, and replace it with "representative."

DR. BERENSON: Again, in my model it may not be perfectly appropriate, but the health system chain sample of 12 communities was not random, but it was representative or at least, yes, it was -- I mean at least it was -- a whole bunch of criteria were used to

try to determine that they were representative of the whole country, but they clearly weren't random. That is the point I'm trying to communicate.

PARTICIPANT: You can be both stratified and random, right?

MR. FOSTER: Yeah, we threw the word "random" in there to avoid --

DR. BERNDT: Random.

MR. FOSTER: -- the potential vices that you talked about, Bob.

DR. BERENSON: Yes. No, I understand.

MR. FOSTER: But I agree. There --

DR. BERENSON: Well, are you happy with "representative"?

MR. FOSTER: Yeah, I think that's good.

MS. KOBE: What about "statistically" in place of "scientifically" or "methodologically sound"?

DR. BERENSON: Yeah, that's right. I think that's right.

DR. BERNDT: That's better.

DR. BERENSON: "Methodologically sound, representative sample" would work for me.

PARTICIPANT: "Statistically methodologically" as well?

DR. BERENSON: I don't think you have to say "statistically" if you say "methodologically."

PARTICIPANT: Why don't we just -- "statistically," replace it with "methodologically"?

DR. BERNDT: Good. Kurt, Kathryn, any comment?

MS. KOBE: I think that covers what we're looking for, yes.

DR. BERNDT: Kurt?

DR. GILLIS: Well, we just want to get this next sentence that's needed. Such a sample, how specific do we have to get here? I mean, we want to point out that needs to be representative of specialties, types of practice, geographically, but we did say "representative" up above.

DR. BERNDT: I think that's right.

DR. GILLIS: You know, how detailed, specific do we have to be?

PARTICIPANT: I think "methodologically sound" covers the next sentence. So why don't we delete the

next sentence?

DR. BERNDT: Okay. Bob, do you have any further comments?

DR. BERENSON: No.

DR. BERNDT: Zack?

DR. GILLIS: I was worried about when you said, "This approach would address many of the traditional concerns with voluntary surveys." Well, this is a voluntary survey, too, except it's more -- we're demanding more of the practices.

PARTICIPANT: We're paying them.

DR. GILLIS: Yes, okay.

PARTICIPANT: We might even be auditing them.

DR. BERNDT: Yeah. Okay. Any further comments from any of the panel on 3. -- on 2.2 I guess it is? Well, wait.

PARTICIPANT: Let's take 3.

DR. BERNDT: Okay. Let's go on to Section 3, Input Cost Categories and Weights. How about "the panel would recommend certain refinements and continued monitoring as noted below"?

PARTICIPANT: I assume there's reference to

monitoring below, right?

DR. BERNDT: I believe there was and said we should define certain things.

MR. HEFFLER: Ernie, does that change address?

DR. BERNDT: Yep.

MR. HEFFLER: Okay.

DR. BERNDT: Kathryn, I think this was -- was this your point or was this Bob's point? I forgot.

MS. KOBE: I think we had a general discussion about this, and I think it was a point that I made at one point.

PARTICIPANT: Well, it is fairly specific, if I could break in, about what CMS should do. I'm wondering if we need to be that specific here also or whether it could give CMS more latitude here to decide on what to do. It seems like there aren't other possible approaches going back to, say, the approach we used with the 2000-based MEI, or an approach similar to what's used for employees' positions be used for the self-employed?

There might be several approaches. It seems very specific unless we think that's definitely what we

want to do here.

MS. KOBE: I have no objections to giving CMS latitude to consider what the best approach is for resolving this potential issue. So I --

DR. BERNDT: How about saying in the sentence two, "specifically, OACT should consider estimating"? That gives it some leeway.

PARTICIPANT: We definitely agree with making the change. It's just whether or not it ought to be this specific approach.

DR. BERNDT: And I guess the word "reclassify" should now be "reclassifying."

MR. HEFFLER: One possible option if you wanted to make it broad would be to say something like, "Specifically, OACT should determine an appropriate method to ensure that physicians' retirement benefits are appropriately classified in the physician benefit cost weight," just something really generally like that. I don't know if that gives us too much latitude or if that's what you were thinking, Kurt, but that would be one way to just kind of revise this so it's not as detailed.

PARTICIPANT: Are there other items besides benefits that are not included currently that might be -- we might want to include?

As it is right now we just have basically insurance in there. There was a whole long list of different things that were included in benefits.

DR. BERNDT: Right, like motor vehicle expenses.

MR. HEFFLER: One other way to word this would be just OACT should determine the cost weights in a way that aligns the wage and benefit split consistent with the definitions in the ECI. That's really what we're talking about here.

PARTICIPANT: Yeah.

DR. BERNDT: I like that. Can you state that once again?

MR. HEFFLER: That OACT should revise the or should insure that the -- to determine. Let's see. Should determine cost weights for wages and benefits are consistent -- and benefits are consistent with -- let me kind of look at that.

Are consistent with the definitions in the

employment cost index.

PARTICIPANT: Determine whether.

MR. HEFFLER: Yeah. Should determine -- I see what you're saying. "should determine the cost weights so they are" -- that's what I was missing -- "to ensure they are" or something like that, yeah.

PARTICIPANT: We are.

MR. HEFFLER: Yeah, sorry.

MR. FOSTER: And then you want a "for example" and then mention this specific issue? Because this issue is actually kind of important.

MR. HEFFLER: Yeah. Would that be okay with the panel if we then said, "For example," and then went into the discussion about the benefits issue?

PARTICIPANT: It works.

MS. KOBE: I think that works.

MR. FOSTER: And we can fine tune the grammar there to make that work.

DR. BERNDT: Okay. Any other comments on 3.1?

(No response.)

DR. BERNDT: Three, point, two.

PARTICIPANT: I had some thoughts about the

general idea of essentially considering the fact they can bill as if they were physicians. I mean, in many cases nurse practitioners and others, if they're in the employ of the physician or they're part of the practice, their revenue is based on salary generally, I would assume, and I don't know that we should consider them in the physician category. I think perhaps they should still be considered as professional staff.

MR. STEINWALD: I think you should remove the word "can" because you want to exclude those that do bill independently, right?

PARTICIPANT: Right.

MR. STEINWALD: Not those that are entitled to by state law, right?

MR. POISAL: I don't know if the data are available in that way that we could distinguish. The survey question asks, I think, can you bill. For those who can, costs associated with those who can bill independently as opposed to those who do, but I could be wrong about that.

MR. STEINWALD: Well, you know, this is a MEDPAC finding. I think I mentioned before that half

the people who can bill Medicare are non-physicians, but only ten percent of the billings are actually billed by those people. So the vast majority of them are still being billed incident to physician services and then being billed by the physician with the nurse practitioner or whomever, as Zach stated, are likely to be absorbed by the practice. So, therefore, you wouldn't want to exclude them.

PARTICIPANT: And even those nurse practitioners, the ten percent that are billing I would assume a large proportion, perhaps most of them, are billing independent of the physician practice.

MR. STEINWALD: I think that's logical.

PARTICIPANT: So we're essentially probably not collecting any data for them.

MS. KOBE: What would really be the practical result of this change? I mean, you're simply moving the weight from one section to another section, correct? But are we actually proposing taking these people out of the weight altogether or just moving the weight around?

MR. POISAL: I think the practical result

would be that you are proxying these few percentage points that are attributable to these clinicians. You'd be proxying by a different price proxy if you moved them from the non-physician compensation to physician compensation.

And then in addition, and we're still researching here, but there are considerations with respect to the way the RVUs, the relative value units, are computed for purposes of the actual payments, and they tend to be linked to the MEI. So a change in the MEI weights could result in a change to the RVU distribution.

MS. KOBE: So the reality is this might have more of an impact on RVUs than it does on the MEI itself.

MR. POISAL: If the price proxies are generally the same, that's true.

PARTICIPANT: Right.

MR. POISAL: But I think one of the points here, and, Kurt, you should jump in at any time because I think you composed this language, but you know, leaving this open to further research where we can go

and examine the definitions of physicians and examine, you know, potential issues associated with the RVU methodology, et cetera, I think sort of covers some of the places where we might want to be careful and, you know, invest the time to make an appropriate decision here.

DR. GILLIS: You know, I think this is going to be a growing issue. The numbers of physician assistants and nurse practitioners are growing, and they may play a larger role in providing physician services in the future. They already have a pretty big role right now, and I guess it's a question of if they're doing physician work, should they be counted in the physician -- that's how we would refer to it under the physician fee schedule -- you know, should they be counted in the physician compensation part of the MEI.

And it is probably more important, not so much the impact that it has directly on the MEI, but the impact that it has on the pools of relative value units under the fee schedule and the geographic practice cost indexes related to that.

MS. KOBE: Do we really want to say then that

we want to have them consider moving it or do we want to say we want them to consider what the appropriate method of handling this issue is?

DR. GILLIS: Well, there is some of that in there. I mean, they are supposed to be looking for consistency between how this category of labor is treated in the MEI and the practice extent to RVU methodology, but, yeah, maybe that's more -- did you have some language in mind?

MS. KOBE: I don't know. Maybe "the panel recommends that OACT evaluate the appropriate method of" --

PARTICIPANT: "By supplying"?

MS. KOBE: -- "giving these people MEIs"? I don't know.

DR. GILLIS: Okay. Something like that.

MS. KOBE: That's not very good.

DR. BERNDT: How about "the panel recommends that OACT evaluate the appropriate classifications of those expenses associated with" -- "of those expenses," delete the word "moving." "Can bill" or "will bill"?

MS. KOBE: The question is "can bill."

MS. OUMAROU: Conceptually we want to be "those who do bill."

DR. BERNDT: Yeah.

MS. OUMAROU: Whether that's possible or not could be part of the evaluation, but I think the question has to do with the people who actually are billing

DR. GILLIS: Actually, I mean, even if they don't bill independently, if they are providing the services incident to or they're just providing part of the physician service, I mean, it's still physician work. Now it's still doing what physicians do.

MS. OUMAROU: Okay. That's a good point.

DR. GILLIS: So shouldn't it be considered part of this encounter face?

DR. BERNDT: And then do we want the "from none"? I don't think the "from" and "to" make as much sense now.

PARTICIPANT: Ernie, do you have your telephone on a relatively low volume? Sometimes it's hard to hear you.

DR. BERNDT: This better?

PARTICIPANT: Yes.

DR. BERNDT: Okay. It was my microphone. I have a speaker phone -- not a speaker phone. I have a headset on.

MR. POISAL: So, Ernie, were you suggesting just ending the recommendation at the word "independently"?

DR. BERNDT: Yes.

PARTICIPANT: And delete the next sentence.

DR. BERNDT: Right. Now, I would not say now in deciding whether to make this change say "among the factors that CMS should consider in evaluating the allocation" --

PARTICIPANT: Besides that, they should be good.

DR. BERNDT: Fine. That's very concise.

"Among the factors that CMS should consider are." That would make this change and say "to make changes."

Any further comments to Recommendation 3.2? Zack?

DR. DYCKMAN: Should we have a bullet here

that brings in this topic of whether you should only try to consider people who can bill, who do bill independently or those who can? I don't know how to state that, but is that an issue?

MS. KOBE: Well, it may be something they should consider. So you're suggesting putting that as a bullet point.

DR. DYCKMAN: Un-huh.

MS. OUMAROU: This is Heidi. I just wanted to make one point with regard to that.

The question on the survey asks who can bill independently. So in terms of those who do bill independently, we have to estimate that, I guess, a different way. So that would be a concern.

PARTICIPANT: How about something, "the extent to which those who can bill independently actually do so"?

PARTICIPANT: That sounds good.

PARTICIPANT: You've got to look at claims.

DR. GILLIS: And then maybe delete the "regardless of whether they bill for them independently" in a previous bullet.

DR. BERNDT: Yep. Any other comments on 3.2? Bob, Zack, Kathryn, Kurt?

PARTICIPANTS: No.

MS. KOBE: I think it looks good.

DR. BERNDT: All right. Let's carry on to 3.2, Office Expenses.

MR. POISAL: So what we did here over lunch was to derive some language that's a little bit different than what was delivered to each of you yesterday or previously, to try to reflect what we think the consensus was from the morning. We have done that in various places, and you'll note as we move further in some cases we added recommendations. So the numbering may be off a bit as we move into the price proxy section, at any rate.

So this is the language that was developed today for your consideration.

DR. BERNDT: The types of professional services purchased by physician offices?

MR. HEFFLER: This is Steve.

Just to clarify, this recommendation is just for the classification part, the weighting. We had a

discussion earlier this morning about how we actually proxy these.

DR. BERNDT: Right.

MR. HEFFLER: So what it should be later on. I don't know if it's best to jump to that now.

MR. POISAL: We could do that.

MR. HEFFLER: Or to go in order.

MR. POISAL: Because we do have -- I mean, we don't have a separate price recommendation at the moment, but that last sentence could be teased out and dropped into the price proxy section associated with this.

DR. BERNDT: Which used to be Recommendation 4.3. You're right.

MR. HEFFLER: So you're saying, John, we do not have written --

MR. POISAL: Correct. Right now we do not have a recommendation that's a separate price proxy recommendation which would be associated with the new professional services cost category. We just included it in as the last sentence there in the recommendation, that the price change associated with this would be

proxy by an appropriate blend. We could take that out and then make a separate recommendation under the price proxy section that would be associated with this category, categorization, to blend or to develop an appropriate blend of ECIs to move that category.

Does that make sense?

DR. BERNDT: But keep that sentence, the last sentence beginning with "price changes." Revise it slightly: "price changes associated with the professional services category."

MR. POISAL: Right. And then we make that a stand-alone recommendation.

DR. BERNDT: Fine. What about the benefits for that? Do we want to say anything about them rather than just the --

MS. KOBE: Aren't they using compensation?

DR. BERNDT: Right.

MR. POISAL: That's right, Kathryn.

Does that look okay?

DR. BERNDT: Yep.

MS. KOBE: Yes.

PARTICIPANT: Yes.

DR. BERNDT: Okay. Let's go back then to Recommendation 3.4. That's, yeah, the next one now.

All right. How do you display things? Do you publish them or the word "display" I guess is --

PARTICIPANT: Report

MS. OUMAROU: Display. We have web tables.

DR. BERNDT: "Recommends that OACT construct and publish"? You display them other ways.

MR. POISAL: Yeah, I mean, it's basically in what we publish on our website about what the actual categories are, yeah, and in the Federal Register. That's right. I mean, when we go and we publish, you know, for all of the market baskets, when we show sort of what the top line number is, we always also show the underlying cost categories themselves and the detail associated with each.

So the question, I guess, would be, you know, would we have this aggregated cost category that would reflect the underlying components that are listed explicitly here, but for purposes of display only show that aggregated number, not necessarily displaying the Federal Register on our webpage the pieces that

underlie.

I mean, you know, I think at a minimum when we discuss and we propose changes to the various indexes and it goes through public comment we would obviously articulate for transparency purposes that this is what we would be doing, but I guess it would be up to you all in your sort of general discretion as to what you think we should do following, you know, sort of the rulemaking process when we would establish this type of category and how it would be maintained.

MR. HEFFLER: Kurt, this is Steve. I wanted to ask you a question.

I mean, one of the reasons for recommending this is the people that are affected by this when they see it, they're just not clear what we mean by rubber and plastic, so what we mean by chemical and so forth. For those people that aren't clear, where are they going to to see this information? Are they getting it out of rules? Are they getting it off the web? Are they getting it in other reports?

Do you have a sense of where most of the users are getting information?

DR. GILLIS: I would guess from the rules, you know, the MEI table that is published in the final rule each year or people are looking at detail right now. Is that what you're saying?

MR. HEFFLER: Right.

DR. GILLIS: For that, I mean, personally I don't think that detail is needed there. Where I selfishly would like to see the detail is still up on the market basket webpage. I think it's still useful to see everything, all of the detail there, and it's probably not where most people are finding this information, although I could be wrong.

DR. BERNDT: Is this micromanaging CMS too much or just sort of allow a little flexibility here?

DR. GILLIS: Well, it's just a suggestion. You know, the webpage has -- the market basket webpage is more of a -- you know, it has the technical documents, and for somebody who wants to delve into it more deeply, they could go there.

MR. POISAL: So would you propose then, Kurt, that, or suggest rather, that for Federal Register publication purposes --

DR. BERNDT: How about something like "the panel recommends that OACT instruct and make available"? That gives you a lot of flexibility, doesn't it?

PARTICIPANT: I think it would.

DR. GILLIS: Yeah, fine.

MR. POISAL: I mean, I would personally still be interested in your collective view regarding the level of detail that we show and where we show it. I mean, I hear Kurt saying that he would prefer to see that level of detail. We would have sort of a category and then underneath of it the subcategories are rubber and plastics, chemicals, products and paper, but I think this came up in part because, you know, people look at this and think that that's an index that doesn't reflect the costs, and to continue to show it somewhere might, you know, continue to elicit that type of reaction to the index.

I mean, I think, again, just to quickly reiterate, we definitely would have to discuss at this level of detail any potential change if we were to go to the public with a proposal to change the index as we

go through rulemaking, but once the index is finalized, assuming this sort of made it through that process, would it be appropriate to just show the aggregated category for rule publication purposes, but maintain the finer level detail on the website?

I mean, I guess I think that's where Kurt's kind of suggesting we go.

MS. OUMAROU: This is Heidi.

I just wanted to point out in general when we have a blended price proxy in other market baskets, when we propose and finalize the re-basing and revision will give the detail of the weights associated with the blend, and then the specific public series that we use.

So you can always go to that to construct the index if you want, but on the web tables normally when we have a blended index for a category, we just call it blended index, and do it like a one line of what that is. But I'm not saying that we couldn't. I'm just saying normally that's the way that we handle it.

MS. KOBE: It seems like just the detail is available at to how the index is calculated. That would be sufficient. I mean, it could be made

available. I mean, it's clear that it's available.

I've noted somehow it's written up when you're changing the index. It certainly makes clear how that's done. I think part of the confusion is what's actually being included in the category. So I think verbally you can explain in some rational way which expenses this actually covers, then the detail of the indexes is going to be -- you know, people aren't going to think too much about the details of which indexes are being used to proxy those things.

I think part of the problem is you don't know exactly, you know. Is this, you know, patient gowns or rubber gloves or, you know, I guess it's all of those things, but --

MR. HEFFLER: What if, in the interest of trying to resolve this, what if we just instead of saying "construct and make available," what if we just left it very vague like "the panel recommends that OACT present more aggregated cost categories under the office expense cost category"?

And then we can decide where that's the most appropriate. If it's on the web; if it's not on the

web we don't put it on the web. If it is on the web, we do. If it's in the rule we do. If it isn't in the rule, we don't. Then that way we're getting the recommendation, which is some of these costs just at times may not be all that clear, and so present them in ways that make it clear.

But it's just basically you make a recommendation that you should present it in different ways, but you have to calculate it the right way. Would that suffice for our purposes?

PARTICIPANT: I agree with that.

MS. KOBE: I wouldn't have any objections to that.

DR. BERNDT: Sounds good to me. So change "construct and display" to "present."

MR. HEFFLER: And we can work on where the most appropriate place to present the right level of detail is because it might depend.

DR. BERNDT: Good. Any further comments on 3.4?

PARTICIPANT: It's a minor thing, but what this will leave out is postage as the smallest category

that remains in office expense, and I wonder if that's -- should that be grouped with the others or can it be renamed? Or it's kind of shipping, I guess. That's the other thing paid for.

Is it small enough it can just be combined with other stuff? I'm assuming the reason you didn't is because maybe it's not another product.

PARTICIPANT: That's what the weight was supposed to express. It's an obvious expense to most physician practices.

MR. OSGOOD: This is Hudson. The postage weight is 0.9 percent.

PARTICIPANT: So it is .9 percent. Is it .09 or 0.9?

MR. OSGOOD: The weight is 0.9 percent.

PARTICIPANT: I would leave it.

MS. KOBE: I don't think people question postage like they do some of these other things.

PARTICIPANT: Right.

PARTICIPANT: Okay. So maybe we'll leave it as it is.

MR. STEINWALD: Very good.

DR. BERNDT: Okay. Prescription drugs. This is Finding 3.5.

MR. POISAL: Three, point, two.

DR. BERNDT: Well, no, we just had 3.4 above. So we've got to renumber.

MR. POISAL: Yeah. The way we did these, Ernie, was we kept the findings within their own sort of numbering convention, and the recommendations within their own numbering convention. So we had recommendations in between findings.

DR. BERNDT: Oh, I see.

MR. POISAL: If that makes sense.

DR. BERNDT: Fair enough.

MR. POISAL: Anything to make this more complicated, right?

PARTICIPANT: It looks like tables and figures.

MR. POISAL: Right, like tables and figures, right.

PARTICIPANT: Or exhibits.

DR. BERNDT: Yes, I guess I'm still surprised by our finding because I would have thought that for

certain practices, like my ophthalmologist putting me in red drops after my exam so my dilated pupils undulate quickly and things like that, which he tells me costs $75 each time he does it.

MR. POISAL: Kurt, do you want to speak to this a little bit?

MS. KOBE: That's simply negligible. I mean, we indicate why we were coming to this conclusion --

DR. BERNDT: Yes, right.

MS. KOBE: -- and if it changed, it could be reevaluated.

DR. BERNDT: Yeah.

DR. GILLIS: Yeah. No, I don't have any comment about them. I mean, we came up with the estimate. It was fairly small and, you know, would have resulted in a weight of a quarter of a percent or something, which isn't even worth putting into the index. So it may be that the reason for the difference between Medicare policy and the PPIS result was either because of a misinterpretation of the question or it could be that Medicare payment policy is different than, you know, prior payment policy.

One of the drugs that it's not separately payable is the antigens that go into allergy testing, from what I see, and maybe that's more important in the private population than it is in the Medicare population.

I think it's fine as it is.

PARTICIPANT: I'm wondering whether in the last sentence you need the phrase where it says it's based primarily on concerns regarding the relevance of the information found in the PPIS. Delete that and just go straight to the comparatively negligible costs associated with these drugs. I think we're relying on that. We found that virtually, you know, it hardly ever occurs or it's just a tiny percentage of the cost.

Isn't that the reason we're doing this?

MS. KOBE: I think that's the reason we made the recommendation. I would agree with that.

DR. GILLIS: Yeah, that's a good point.

DR. BERNDT: What happens with vaccinations in pediatricians' offices? Is it separately billable or not?

PARTICIPANT: I think they are.

DR. BERNDT: Okay.

PARTICIPANT: Drugs are.

PARTICIPANT: Yeah, I think so.

PARTICIPANT: Put it this way. I just had a pneumonia vaccination, and it's billable.

PARTICIPANT: Oh, it's absolutely billable. It includes the cost of the vaccine. In fact, there's capitated organizations who separately pay fee for service for vaccinations because of the direct costs of the vaccine that can be changing with time. So, yes, they are billable, reimbursable items.

DR. BERNDT: Okay.

PARTICIPANT: Maybe not the drops for your eye dilation, however, for $75.00

PARTICIPANT: Time to start your practice up again, Bob?

DR. BERENSON: I don't know. I gave it up because I couldn't do that.

(Laughter.)

DR. BERNDT: So how do you want to pick up Zack's suggestion on the wording of the last sentence?

MS. KOBE: I think we suggest delete from

"concerns" down to --

PARTICIPANT: "The comparatively negligible cost."

MS. KOBE: Right. I think that's what we can still see. To save primarily on the comparatively negligible cost.

PARTICIPANT: Got it.

(Simultaneous conversation.)

PARTICIPANT: "The findings to continue," "the findings and resulting recommendation to continue"?

DR. BERNDT: Yeah.

PARTICIPANT: Because that becomes a recommendation.

PARTICIPANT: Well, remember it's only a recommendation if you're recommending a change. Otherwise it's a finding. At least that's how we started out.

MR. STEINWALD: Do you want to say "on their comparatively negligible costs"?

PARTICIPANT: Yeah.

PARTICIPANT: And then did you decide based on what Bruce just said to take back out the "and as a

result of the recommendation" part?

PARTICIPANT: I think it reads a little funny if you do that, but if there are rules, there are rules.

(Laughter.)

DR. BERNDT: Okay. Any further comments on Finding 3.2?

(No response.)

DR. BERNDT: All right. Price Proxies, do you want to say again "and certain refinements and monitoring?

(No response.)

DR. BERNDT: Okay. Any further comments on 4.1?

MS. KOBE: No, that's fine.

DR. BERNDT: Okay. Physician's own time.

MR. POISAL: So this is where we effectively torpedo the numbering for the rest or for a large part of what goes on. So I think where we landed this morning and what we then reflected here in the document are three bullet points associated with the physician's own time.

So just a quick heads up that this is where the numbering becomes a bit different than what you had originally.

DR. BERNDT: Okay. I think that's true. I think this is what was it Rick or was it Steve said this morning that there was one of three? There were three different things. This is the first.

MR. POISAL: Right.

MR. HEFFLER: Right.

DR. BERNDT: Can you put up 4.2? You've got a split infinitive there, which my high school grammar teacher said I should never do. So "this change would be determined not to meet" rather than "to not meet."

MS. KOBE: If it doesn't meet the general earning threshold or, I guess, legal concept, is it to make a change really?

PARTICIPANT: I think we preferred it, yeah. This morning I initially thought that the general earnings phrase would preclude us from making a change, and then it was pointed out to me correctly that the sentence started with "initially." I mean how binding is the general earnings phrase and do we have

to include it?

MR. HEFFLER: I think our conclusion was that -- we talked about this last time, that we think there's flexibility, and it's not that binding, but until we go forward with a proposal to use something that is like professional and related, we're not sure that the decision is going to be, yeah, that's still within the spirit of it.

So I think this was kind of written. They just provided the flexibility that if it's determined that it's not in the spirit of it, there is an ECI that is broader than something that's just professional and related services.

So it would still meet the idea of general earnings, but it wouldn't be an average hourly earnings. It would be an ECI.

PARTICIPANT: Okay.

MR. HEFFLER: So we think it would be okay, but you know, as Rick said earlier, we had to go through that process of verifying it if we decided to move in that direction.

PARTICIPANT: I think there are two related

issues. One is whether it's consistent with general earnings, and two, does it have to be consistent with general earnings because of the word "initially"? But I'm find with this.

PARTICIPANT: I'm fine with this.

MS. KOBE: I'm fine with this.

DR. GILLIS: Same here.

DR. BERNDT: Settled. Next.

(Laughter.)

DR. BERNDT: On the same conceptual basis, should we say that it is consistent with?

With the basis says, yeah.

PARTICIPANT: I don't think we need "basis," yeah.

DR. BERNDT: Good. Anyone have any further comments?

MS. KOBE: It looks okay to me.

DR. GILLIS: Right. I think it's pretty clear what it means.

DR. BERNDT: Kurt, Bob, Zack?

DR. GILLIS: Fine.

DR. BERENSON: Fine.

DR. DYCKMAN: Fine.

DR. BERNDT: Fine it is. Okay. Recommendation, not "recommendation," and I think it's number 4.4, isn't it?

MS. OUMAROU: Yes.

PARTICIPANT: Yes.

DR. GILLIS: Well, then the one above it should be 4.3. I think it was numbered 4.4. Oh, okay. Sorry. Wrong.

MR. POISAL: So this brings us back to part of the discussion that we had this morning with respect to the non-physician comp. I think we had done a little bit of homework.

MS. OUMAROU: Yeah, we looked at lunchtime to try and answer the question about the components and the weighting for the ECI series, and Hudson is pulling up the tables now.

Okay. So there are two tables here. Sorry for that XLS. I couldn't get it out of there, but the top ones show the CPS employment counts, which I called over to BLS, and they weren't sure how they weight. So they had to check with somebody, but I read the

Handbook of Methods, and in terms of the industry weighting I believe they use the CPS -- I'm sorry -- the CES employment counts, and then they benchmark to the QCEW, which CES -- that shouldn't say CPS. I'm sorry -- CES Employment Council also benchmarked, too, and then assuming that to be the case, the hospital NAICS 6.2.2 would account for 30.7 percent of the NAICS 62 health care and social assistance. So that was the question about how much hospitals compose of that overall ECI for health care and social assistance.

And then the second table shows the OES employment counts, and I didn't pull out each occupational category, but the two health related occupational categories, 29-000 which are health care practitioner and technical occupations, and then occupation category 31-0000, health care support occupations.

And then in terms of how OEC displays the data industry by occupations, they don't have the detailed data on the occupational mix for NAICS 62. So I used the weighting from above to basically pull in the three digit NAICS code, which is the level of detail that

they have to come up with that 62.

So for NAICS 62, health care and social assistance, the health care practitioners and technical occupations would be 32 percent, and the service worker or less skilled would be 19 percent, and then for NAICS 6.2.1.1, which is offices of physicians, that mix is 41 to 14, and then the other available ECI was NAICS 6.2.2, which was the ECI for hospitals, and that composition shows a 51-13 split.

So I don't know if that helps inform a decision on where we were going with the recommendation for this.

DR. BERNDT: Can we go back to the recommendation?

Thank you, by the way, Heidi.

MS. OUMAROU: Sure.

MR. HEFFLER: So on the first source to be determined issue, the two options were, one, to use -- Option 1 was to use the OES and CPS data, and Option 2 was the AMA survey data.

So that's probably the first decision to make.

DR. BERNDT: That said Option 1(a), didn't he.

MR. HEFFLER: Yeah.

DR. BERNDT: Is that the second decision you're talking about?

MR. HEFFLER: That would be the second decision, I think. 1(a) would be the second.

MR. POISAL: That's right. That was a price proxy decision, how to proxy the weight, not how to apportion the cost.

PARTICIPANT: Got it.

DR. BERNDT: So the decision is OES, slash --

PARTICIPANT: CPS.

PARTICIPANT: Are we allowed to take out the serials from this morning?

MS. OUMAROU: Yes.

MR. POISAL: As Kathryn pointed out, from a weighting perspective, either method gets you pretty close to the other method. They're slightly different, a slightly different weight, but pretty close.

MS. KOBE: I concur because I would have thought you would assess EMS' preferred method. I don't see a problem with using the entire set of

weights.

PARTICIPANT: Yeah, I think that I'm with Kathryn. I think I'll defer to -- I don't have strong views. So I defer to EMS preferences

DR. GILLIS: Yeah, I mean, the same here. It seems like you mentioned that the second approach was a little simpler. Delta is about the same.

DR. BERNDT: So why don't we take the second one? And what did you call them? Rely directly on the --

MS. OUMAROU: PPIS.

PARTICIPANT: PPIS.

DR. BERNDT: Yeah. Do we want to make it very clear on Zack's point to estimate the health related non-physician compensation cost weight?

PARTICIPANT: Yeah, we had weight it there.

DR. BERNDT: Yeah.

MR. FOSTER: Hudson is the fastest typist you ever saw --

(Laughter.)

MR. FOSTER: -- before correcting for any typos.

DR. BERNDT: And, Zack, do you want to take a stab at what's your 1(a) wording was here for this second proxy to be determined?

MS. KOBE: I think we only have one proxy if we do it according to two, but we have to decide about it.

PARTICIPANT: If you feel that two was simpler, than my 1(a), I'm fine with it. You get caught up in these things. But in 1(a) you have to -- while it's feasible if you have the weight, and you do because you were able to say that the hospital weight was like 30 percent -- you're creating a variant of an index that doesn't exist now, essentially a new index.

I think I was fussier in the morning than I am in the --

(Laughter.)

PARTICIPANT: Lunch must have been good.

PARTICIPANT: Yeah, we tried to wear you out, Zack.

MS. KOBE: Well, let me play devil's advocate for a minute because I was more worried about the price proxy. I'm a little less worried about after I've

looked at the weight. So I appreciate you taking the time to look them up, and that the social assistance is only about 15 percent. So I'm less concerned about that than I was this morning.

But there's still an issue that like 75 percent of this six and a half percent here seems to be on professional workers, and I'm not sure that really that is implicit in the health care and social assistance events, and it's in the hospital index right over weight, the importance of those types of workers.

PARTICIPANT: Well, how do you know they're professional?

MS. KOBE: Well, just because up here at the top when we were looking at the other set of workers, I mean, Option 1 says that 5.2 percent of the total was professional and technical as opposed to 1.6 percent that were in the health related service occupations. EMS and OES distribution, but it's probably not very far off, but that indicates that there's a heavy weight here on the professional and technical staff, and if you go back and look at the list of people who are listed on the first page, 78(c) and 78(b), it's all

practitioners, nurse practitioners, physician's assistants, clinical personnel, lab technicians. There's not a lot of people in there like general aides and that sort of thing that you're seeing in nursing homes.

DR. DYCKMAN: Would hospital, the ECI be a better side track to that?

MS. KOBE: Well, that's my question, is whether we want to consider whether the hospital one comes a little closer to representing that set of workers than does this broader index, and I don't have a really good answer to that question. I'm just posing it.

DR. DYCKMAN: Are you coming closer to my position, which was to use the hospital but not to double count hospital in the broader health care and social assistance? In other words, to take that 30 percent out.

MS. KOBE: I mean, I think there's some logic to that. I'm not sure without looking at the underlying data. We have no way of knowing whether we're making a big deal out of nothing because both of

these indexes might move similarly. I don't know.

MR. POISAL: Zach, this is John.

To move back towards the 1(a) suggestion on price proxies would potentially move us a bit away from the Option 2 determination of the cost weights. If you look in the background paper under Option 2, when we leaned on the PPIS, we generated the health related wages' weight of 6.5 percent based on the clinical staff who could and could not bill Medicare independently.

So if we wanted to move to an issue where we had two or if you all felt like moving towards an issue or a situation where we use two price proxies, we would have to break apart that 6.5 percent to distinguish two different categories that would then be proxied by the respective proxies.

Does that make sense?

MS. KOBE: I'm not sure of that. I mean we only asked for hospitals. It's bound to show that there is nonprofessional workers being included in the hospital index, I would assume. There must be service workers in there, too. At the hospital --

MR. HEFFLER: Oh, yes, absolutely.

MS. KOBE: Contrary to what we've said here.

DR. DYCKMAN: Particularly that I see that 65 percent of it relates to ambulatory health services and hospitals. And a nursing residential may be relevant also because it includes some aides and you have, you know, semi-skilled or semi-professional people in offices.

Actually I think that the health care and social assistance is a better index than I thought it was. I think it's a better fit than I thought it might have been this morning.

MR. HEFFLER: Hey, Zack, this is Steve. Just a slightly different look on this.

On the top part of the table that's on the screen, you know, one of the questions was how much do these sort of non-health occupations contribute to the overall health care and social assistant, and that's only 15 percent. So I think it's sort of what you're basing that decision on, which is maybe it isn't as skewed towards those occupations as we might have thought.

DR. DYCKMAN: Right.

MR. HEFFLER: I would say if you look at the bottom part of the table, however, our only two choices of ECIs are NAICS 62 or NAICS 6.2.2, which is the hospital.

But we do have the occupational employment counts for physician offices, which is 6.2.1.1. I think looking at that you might conclude that the hospital actually looks a little more like the professional, at least the health type occupations that are reflected in the physician's office than maybe the broader health care and social assistance.

I mean the support occupation is almost identical as a percentage, and while it's a little higher in the health care than the 6.2.1.1, you know, at least it's approaching, you know, half as opposed to only a third of it is made up of that.

So I don't know. I mean, when I looked at this, I got kind of a mixed feel like, yeah, NAICS 62 isn't so bad because 6.2.4 is a small piece, but I don't know that the health care occupations, which is kind of what Kathryn was referring to, are really

reflected in that NAICS 62 in the right proportions for what physicians' offices -- kind of the makeup of physicians' offices.

MS. KOBE: In looking at the bottom half of this table, my feel is that the hospitals are a little bit closer and so the correct proportion of the professional and technical case workers through the service workers, and that's the more general index.

DR. DYCKMAN: Right. I don't feel strongly about it.

John, are you saying that this would make life simpler and the reporting of this simpler if we used Option 2, which is the health care and social statistics?

MR. POISAL: I think it does, yep. Well, I think it does to have one category, one cost category associated with health related workers who are employed in physician's offices, as opposed to --

MR. HEFFLER: But I think -- this is Steve. I'm sorry.

I think what I hear Kathryn saying is that Option 2(a), which is have one category but use NAICS

6.2.2 --

PARTICIPANT: Right.

MR. HEFFLER: -- the ECI for that instead of 6.2.

MS. KOBE: That is what I'm saying.

DR. DYCKMAN: That's why I think we have a consensus, and I'm using 6.2.2.

PARTICIPANT: Yeah, I would agree with that, too.

PARTICIPANT: It's a bit of a toss-up, but it seems like the hospital proxy is a little better than the --

DR. BERNDT: What is the 6.2.2 hospitals? Go back to the recommendation, John? Or the hospital ECI?

Okay. Do you --

PARTICIPANT: Do we want to provide a rationale in there based on the finding that the hospital distribution was similar to --

PARTICIPANT: -- which is reasonably close in terms of employee mix --

PARTICIPANT: Yeah.

PARTICIPANT: -- to physician office

practices, something like that?

PARTICIPANT: Something like that.

MS. KOBE: I think that's a good addition because then if something else that was a closer match between available and the question, then it was a good idea to move to something else.

DR. BERNDT: Is reasonably close to what?

PARTICIPANT: Occupational mix.

PARTICIPANT: Occupational mix for physician offices.

DR. BERNDT: Yes.

PARTICIPANT: Fred, I don't have an audience when I'm editing.

(Laughter.)

MR. POISAL: I'm just glad it's Hudson and not me. You recall how much I loved Word at the end of last meeting. So we picked Matt for a reason.

PARTICIPANT: I think which has an occupational mix that is maybe reasonably close.

DR. BERNDT: Right. Yes, I agree.

Okay. Any more comments on 4.4?

(No response.)

DR. BERNDT: Next, Office Expenses, 4.5.

MR. OSGOOD: Hey, this is Hudson.

Just we had the opportunity to speak with Bonnie Murphy at BLS over lunch. She had some feedback on some questions that were brought up earlier this morning.

Zack, both you, Zack, and Kathryn, just to go back and to answer those, Zack, you were wondering about potential weights or spreading that was going on in terms of incorporating increases in leasing expense.

After speaking with BLS, it was explained to us that BLS captures the entire increase in expenses in the month where they occur, and so they aren't spread at all or distributed. So, again, everything is captured in the month of its occurrence.

Also, the --

DR. BERNDT: Wait a minute. Let me make sure I understand that. So suppose I sign a three-year lease and we're now sampling it month 18 inside that three-year lease. Is it the rent I'm paying in month 18 or am I completely excluded because it's not -- I'm not a new lease?

MR. HEFFLER: It's the rent you're paying in month 18, and if your agreement says that on the 19th month you have a ten percent increase in your leasing cost, BLS would capture a ten percent increase in that month.

DR. BERNDT: Great, good. I think that's what we want; isn't that right? Because I think Zack's worry was some leases may be quite long, and wanted to make sure that we were getting a sample of a currently or contemporaneous rents actually paid; is that right, Zack?

DR. DYCKMAN: I think my concern was almost the reverse. My concern was that if there's volatility in rental markets and rents in one three-month period go up substantially, that, you know, they could go up or down by eight, ten percent. I didn't think that -- and most people are not exposed to that. So their rent will remain the same. I didn't think it was appropriate to use an eight, ten percent figure, but to consider that only one-third of the people are exposed to that and two-thirds have a zero percent rent change.

MS. KOBE: I think the question is Bonnie

explained who is being asked this question. I mean, are we going to the building management and say, "Who" -- or are you going to specific renter and saying, "What's your rent this month?" because if they have a long-term rent, then, you know, it might change and the rest of the months it's going to be unchanged, which I think is what Zach and I think should be going on.

But if they're asking, you know, the question to a building manager, "What kind of rent are you charging to your tenants?" that's not what we want to be picking up.

PARTICIPANT: Right.

MR. HEFFLER: My understanding is they're going to the building owner, and they are getting price quotes for leases that they have in that building regardless of whether it's old, new, it changes hands or not. It's for that space.

Basically they're sampling square footage, and so across all their quotes they would have a whole mix of people that are staying, people that are coming, people that are leaving, but that once someone is in their sample, that space is in the sample regardless of

who's in and out.

So it's not just all new people, and it is kind of a mix of all types and lengths of leases. That was one thing we did find out, was the only thing they really keep constant is the square footage.

MR. POISAL: Occupied square footage is what they keep constant, yep. And to the extent they are escalator clauses in multi-month or multi-year leases, those are included as well.

PARTICIPANT: I'm comfortable with your understanding.

MS. KOBE: Yes, I like the way they're doing it. It sounds like that's a reasonable approach for them to take. So that conceptually seems like the right methodology to use. I don't think it answers why the index is quite this volatile, but I am comfortable with that concept.

PARTICIPANT: Again, it's how you show the data. Well, I thought that rents would be more volatile than this if it was, you know, at the point in time. So you know, in fact, rentals are volatile. You know, the scale is -- on the negative side, it's only

up to about one and a half percent or down to two percent. So it's not as volatile as perhaps it looks.

You know, if you increase the scale a bit, it wouldn't appear so volatile.

DR. BERNDT: Okay. Do we have consensus then that this is the conceptually appropriate transaction?

MR. OSGOOD: I'm sorry, Ernie. This is Hudson. I don't mean to interrupt, but there's one other data point we might want to mention.

We were able to pull a figure looking to try to remove some of the volatility. I'll put it up on the screen now. This is just the second quarter, you know, from each year for the four quarter moving average. So the same measure we were using in the other charts that we've talked about today but just again looking at the second quarter to see if that removes some of the cyclicality that may have been causing some of the volatility and then previous figures that we were reviewing and it's -- you know, it may be a bit more stable.

But another point, too, is that when we were also having our discussion with Bonnie Murphy at BLS is

that her opinion, she didn't -- I mean, obviously the index does have some volatility but in her opinion, it wasn't too volatile. So that was also the opinion expressed by BLS.

DR. BERNDT: Somebody asked this morning, I believe, how large a sample was it. Did you happen to have the chance to ask her that?

MR. OSGOOD: Yes. So they don't have the detail of the PTI for professional offices or retail space but the higher, more general category, the PPI for non-residential buildings, she said that sample size was around 800 and that includes urban and rural, you know, large and small, you know, everything, she said.

MR. STEINWALD: And just to clarify that, if you ask them what the sample size is, they would tell you they can't give that out. What that number is is like the number of quotes. So they can go to one building, giant building that has a hundred different square footage leasing by tenants and get a hundred price quotes. So it's one sample but 100 items. The 800 number is the number of items they quote and one of

the reasons they don't give the sample sizes out, I guess, because it's not that large and they're worried about confidentiality issues.

MR. STEINWALD: Could be one big building.

MR. OSGOOD: Yeah. She assured us that she actually felt like it was pretty representative of a bunch of different geographical areas, urban and rural, which she said, and I guess is the point we should have maybe taken into consideration, is that the CPI, owner's equivalent rent, doesn't go to rural areas. It is only in urban areas. So that wasn't a concern. So even though it could be a lot of large buildings that have a lot of quotes in them, they tended to think it was at least picking up some urban/rural leases.

MR. PARK: The PPI, in general, drives -- my experience with it is that they tend not to get more than five or six item quotes from any single establishment.

MS. KOBE: I think there are serious questions with continuing using the PPI because the match there, I think, is very poor. So I think I'm more comfortable with this one, given the background information.

DR. BERNDT: Why don't we change the wording then?

DR. GILLIS: Did we have the discussion at the last meeting about whether that broader PPI was better than the office, the subcomponent for office buildings?

MR. PARK: I thought that was Bob Barron's point because he used to rent in a retail mall.

DR. BERENSON: Yeah. But I don't know how typical that was. It just struck me as that was an appropriate index.

DR. BERNDT: How about the last two sentences? Do we still want them?

MR. PARK: At a minimum, I would delete the concerns and perhaps substitute the word "noted also the volatility in the index which is greater." I would maybe take out "much," yeah.

DR. BERNDT: Outweighed our volatility concerns? Present tense? Is there consensus?

MR. PARK: Bob, did you ever rent in a self-service storage or mini-warehouse?

DR. BERENSON: No, but I lived there. That's PPI.

PARTICIPANT: That's right. That's where I was going.

MR. POISAL: One question that comes to mind for me. Should the recommendation include -- guidance isn't the right word but a recommendation for OAC to continue to monitor that volatility?

MS. KOBE: Well, I think that --

PARTICIPANT: Although the panel noted the volatility which is greater than the CPI for owners' equivalent rent of residence, and merits further monitoring or which merits --

PARTICIPANT: Ongoing monitoring or --

PARTICIPANT: Yeah. And merits ongoing --

PARTICIPANT: And then in the last sentence, we don't want to overdo the concerns, we should say outweighs any volatility concerns rather than our volatility concerns.

PARTICIPANT: Or maybe do we need the last sentence now?

PARTICIPANT: Yeah. That's true. Ongoing monitoring.

PARTICIPANT: Yeah. Let's delete it.

DR. BERNDT: Okay. Consensus reached. Kurt?

MR. STEINWALD: Yeah. The only other thing I was thinking is whether, in terms of monitoring, whether CMS would continue to look for alternatives for non-residential rents.

DR. BERNDT: Monitoring and evaluation of alternatives?

MR. STEINWALD: Yes. That works.

MS. KOBE: I think that would be good because then if something came forward that says, you know, 80 percent of physicians get their rent and office buildings and, you know, ten percent of them rent in residential buildings or retail properties, that would give you a better idea of how to do things. So I think that's a good thing to add to it.

DR. BERNDT: Add an evaluation of alternatives. Instead of saying and merits, we should say that merits? Okay. Kathryn, are you happy with that?

MS. KOBE: I am happy with that.

DR. BERNDT: Zack?

DR. DYCKMAN: Yeah. I'm just wondering about

"than" and "and." The panel noted the volatility in the index that merits ongoing -- I mean, disregard the phrase in the middle.

DR. BERNDT: Yeah.

DR. DYCKMAN: Or maybe a new sentence.

PARTICIPANT: Would "and" work better than "that?"

DR. DYCKMAN: I think so but I'm not crazy about and either. Maybe a new sentence. Just merits ongoing monitoring and evaluation of alternatives.

DR. BERNDT: Bob?

DR. BERENSON: Yep.

DR. BERNDT: Kurt?

DR. GILLIS: Yes.

DR. BERNDT: Okay. Let's go. Next.

MS. KOBE: I use this in findings, given that essentially you're saying we think that it can be changed?

MR. HEFFLER: When we were pulling this together from the last meeting, we didn't know that the panel had enough information nor did we that there was a specific index that would be recommended to be

changed to. So we thought maybe splitting it apart to say we don't think what you're doing is maybe that representative, that's a finding, and then the recommendation was the research and find something that's more appropriate.

MS. KOBE: Okay. I understand.

MR. HEFFLER: But, I mean, there's some semantics to it. I mean, it could easily be kept in mind.

PARTICIPANT: Based on findings are numbered separately from recommendations?

PARTICIPANT: Yes.

PARTICIPANT: You do that later but it may be helpful to do it later.

DR. BERNDT: Okay. Anything more on 4.2?

(No response.)

DR. BERNDT: Okay. 4.7.

MS. KOBE: I think it should say that the panel thinks it does work and it isn't working, not wasn't working. The panel believes it isn't working?

PARTICIPANT: It believes it is. Present tense.

MS. KOBE: And since we're talking about information technology expenses, should it say including hardware, software, and e-services? Some of these are designed services.

PARTICIPANT: Yeah.

PARTICIPANT: Although would that go into another category?

MS. KOBE: That's a good point. That may be true, that it would end up in that other professional services part.

PARTICIPANT: Typically, the way BEA puts it out as information and communications technology rather than just information technology. That's very minor.

DR. BERNDT: Zack, anything else?

DR. DYCKMAN: I don't think it's communications, plural. It may just be communication. I'm not sure.

DR. BERNDT: I think you're right. Bob?

DR. BERENSON: Yes, it's fine with me.

DR. BERNDT: Kathryn?

MS. KOBE: Yeah. It's fine with me.

DR. BERNDT: Kurt?

DR. GILLIS: Yes, me, too.

DR. BERNDT: All right. Next one. Anyone have any changes or edits?

MS. KOBE: It looks okay to me.

PARTICIPANT: The background document has more detail, right? It had actually three ECIs, four -- this new category.

DR. GILLIS: That's right.

PARTICIPANT: You were saying if we don't want to be that specific.

PARTICIPANT: Right.

MS. KOBE: I think we're saying an appropriate rent, presumably that would be taken into account in determining what to do.

DR. BERNDT: And the selection of these folks. Indexes that reflect -- I guess it's --

MR. POISAL: It's the blend.

DR. BERNDT: Oh, you're right. Selective knowledge.

PARTICIPANT: Did we have a specific recommendation this morning?

PARTICIPANT: There were two alternatives, I

think.

MS. KOBE: There were two alternatives. I mean, the recommendation was whether to go this way or to go on PPI. Now there are three specific sub-indexes that are used here, all compensation documents, potential scientific and technical, administrative, and all --

DR. BERNDT: This is where we had the discussion on labor-only versus labor and other inputs that we decided for pragmatic reasons --

MS. KOBE: We had decided to go with the labor-only indexes.

DR. BERNDT: Right. Okay.

MS. KOBE: I did think this recommendation is what we decided this morning. The only thing it doesn't have in it was the length of the indexes that were presented in the examples but we do have the word "appropriate" in there. So I think that once we agreed to appropriate, then it's going to be matched against the services.

MR. HEFFLER: The sister recommendation to this is the one about the weights. Would it be helpful

in that recommendation to be more specific about the data sources used to determine the weights because then that will basically feed into what's appropriate? I don't know that we did that. We just said that we should combine the category of professional services, but these weights here, are these OES weights?

MS. OUMAROU: No. This is IO weights.

MR. HEFFLER: These are IO weights.

MS. OUMAROU: Yeah.

MR. HEFFLER: So would that be helpful, Kathryn, if, in the weighting recommendation, we said this should be combined and blended by IO, using the IO?

MS. KOBE: When we were doing the weighting, I assumed that it would continue to be done the way it's already done. I mean, we were just saying put the two categories you've already got and put them together and I assumed that the weights would be however they were being distributed in the separate categories but I suppose it doesn't -- I wasn't trying to be that explicit on that weighting, unless there's a question about how you go about doing that. If there is a

question, then we should provide a recommendation on it. If there isn't a question, then we would assume they follow the current methodology, just put the two categories together.

MR. HEFFLER: Right now, the two categories, which is the roughly 8.1 percent, are weighted by the ECI for service occupations is 3.6, and the CPI U-all items is the remainder, 4.5. So we don't actually have an occupational breakout like we're going to move to under this recommendation. So I think it would be helpful to be a little clearer that it's not just about combining two weights. It's about combining two weights and then splitting them in a different way than we're currently doing.

MS. KOBE: Okay. Then maybe we better make that more clear. I mean, where's the underlying weight? Where's the 8.1 weight come from? Is that out of the survey instrument and then it's split apart by the IO or is that how it would be done?

MR. HEFFLER: No. That's not -- all other services doesn't come out of the survey.

MS. OUMAROU: The all other or the other

professional expenses comes from the survey, so that 4.51 percent weight in the current index, but the all other services is determined from the IO breakout because the only aggregate we get from the PPIS data is office expense.

MS. KOBE: Okay. So we've got tons of mixes. We've got a mix in determining weight, as well, then? The overall weight is being determined currently by IOO rating and currently by the survey. The distribution within that is going to be determined by IO, correct?

MS. OUMAROU: Right.

MR. HEFFLER: Right. On the screen is the current recommendation for the weight which just says combine the two categories which is the first step. The second step is splitting that into occupational and then the third -- the last recommendation says use an appropriate occupational blend. So are we missing anything in there or does that cover everything the way it's currently written?

MS. KOBE: I mean, the way it's written does not tell you how to produce the weight that the

individual price proxies would be applied to. I mean, I'm correct in thinking that the 2.5 million and the 3.05 and the 2.45, that's being determined by some other method than your usual method, right?

MR. HEFFLER: That is correct.

MS. KOBE: Those haven't been predetermined. Those are coming off the IO table.

MR. HEFFLER: That is correct. Right.

MS. KOBE: We would have comments about the details to be -- wait for the details to be determined in the most -- using the most appropriate weights or something like -- the most appropriate data, something like that. I mean, we want to provide enough flexibility for an improved set of data.

MR. HEFFLER: Right. I think maybe if we did add a clause just at the end of this recommendation, 3.3, you know, it's Step 1 is combining them into one category and then Step 2 is and disaggregate them into appropriate occupational categories and that's very broad, doesn't say which data source and we're using appropriate in both places and it gives flexibility.

MS. KOBE: Okay. I don't have an objection to

that.

PARTICIPANT: Do we want to say ECI occupational categories?

MR. HEFFLER: I think the other recommendation says use ECIs.

MS. KOBE: Could use a lot of different data sources and then, depending on which ECIs, that's not the -- now ultimately you're going to have to have it in this occupational category that match what the ECI Index boxes are but you wouldn't necessarily want --

MR. POISAL: Could this second part of this be a period after the second closed paren there and just say the panel further recommends that this new category be disaggregated according to appropriate occupational categories?

MS. KOBE: We can just say it's appropriate occupational categories consistent with the price proxies or something like that. Make it clear what we meant by that.

DR. BERNDT: I like the consistent with the price proxies.

PARTICIPANT: Probably need a cost before the

price proxies.

DR. BERNDT: Yeah.

PARTICIPANT: With the associated or something like that.

MS. KOBE: I can live with that wording.

DR. GILLIS: What we're trying to do here, though, is really identify what kinds of occupations are being counted in this category. I mean, regardless of whether we've got a good -- I guess we have to have a good price proxy for it but that's not the primary thing, right? I mean, --

MS. KOBE: Right. I don't think what we're saying here is that you have to use anything related to the ECI to determine how to do the SOA, but eventually you've got to do the SOA into categories that match the price proxies.

DR. GILLIS: That you have a price proxy for. Yeah.

MS. KOBE: Right.

DR. BERNDT: Would relevant be better than associated? Associated is a little bit weaker.

Any further comments? Let me just go around

the horn. Zack?

DR. DYCKMAN: Fine.

DR. BERNDT: Bob?

DR. BERENSON: Fine.

DR. BERNDT: Kurt?

DR. GILLIS: Yes, it's good as is.

DR. BERNDT: Kathryn?

MS. KOBE: It's fine.

DR. BERNDT: Okay. Let's carry on. This is the weak side of what we've just been talking about. Sounds okay to me.

MS. KOBE: It sounds okay to me.

DR. GILLIS: Same here.

PARTICIPANT: Minor suggested change in the -- well, about the fourth line from the bottom where it says would be influenced, maybe are influenced.

DR. BERNDT: Yeah.

MS. KOBE: Yep.

PARTICIPANT: Fine with it.

PARTICIPANT: Yeah. I'm fine with this.

MS. KOBE: It sounds okay to me.

DR. GILLIS: Same here.

PARTICIPANT: If I may suggest a change about the fourth line from the bottom where it says "would be influenced," maybe "are influenced."

MS. KOBE: Yes.

DR. GILLIS: Yes.

PARTICIPANT: Fine with it.

PARTICIPANT: Yes, I'm fine with this.

DR. BERNDT: Okay. Section 5. The double counting we're trying to avoid.

PARTICIPANT: Do we want to indicate that we considered or looked at various measures of physician productivity or we don't need to do that?

MS. KOBE: I think we can recommend monitoring of physician productivity. If there comes to be a time when there appears to be a big deviation between these two, then I think it might need to be revisited.

DR. GILLIS: That's a good point.

MR. FOSTER: Right, but all that comes up in the next one, I believe.

DR. BERNDT: Okay. Let's go to that.

DR. GILLIS: I think the previous finding is fine. This one, however, I'm not sure about the part

that seems to be indicating that the overall is more appropriate or is the appropriate measure to use and not physician productivity, and the rationale being that economy-wide, earnings are included in the Index, but economy-wide earnings are only half of the Index.

The other half is specific to physician practices.

MS. KOBE: The economy-wide earnings is down to a set of professional and technical set of earnings anyway. I agree. I have a little problem. I'm not sure we came to an agreement on that last time.

I don't have any objection to continuing using this as the measure. I just think that if we get to a point where they diverge, the issue needs to be re-looked at to make sure there isn't a problem there.

DR. GILLIS: Right.

DR. BERNDT: What is your suggested wording change, Kathryn?

MS. KOBE: I would say the first sentence end with "appropriate."

DR. GILLIS: I guess I would go farther and ask whether it's necessary. We already have the

previous finding.

DR. BERNDT: Yes, it's redundant, isn't it?

PARTICIPANT: I'm not sure what we're trying to accomplish. What are we trying to accomplish with it?

MS. KOBE: The other thing I want to accomplish is that the physician productivity measure continue to be monitored in case you come to a situation -- what is physician productivity begins to fall behind significantly for the economy overall?

If that were to happen, then you are penalizing them significantly. They probably wouldn't be able to do too much about it. There could be technological factors, for example, that go into economy-wide --

PARTICIPANT: You're making the point that we don't want this. I was asking why would we have this in the first place.

MS. KOBE: Only because in the previous one, we didn't make any reference to monitoring, continuing to monitor the physician one.

PARTICIPANT: What about if we start the

finding from measures of growth. Now we're saying we're also interested in physician specific productivity.

MR. FOSTER: Could I interject just for a moment? The Finding 5.1 was intended to point out the productivity adjustment is needed and appropriate and the reasons for it.

Finding 5.2 was intended to say it's more appropriate to use an economy-wide measure of productivity than it is a physician measure, but the physician measure is of interest for various reasons.

That was organizationally based on the last discussion at the last meeting, how we put this together.

MS. KOBE: The last one does mention specifically the Index. Isn't that an endorsement of it?

PARTICIPANT: Finds that such an adjustment continues to be appropriate.

PARTICIPANT: It continues to be appropriate but you could have just said the same thing about measures of physician productivity and then gone on

with the rationale.

I now think maybe it's good to have a sentence in the next one which implies we could have picked a measure of physician productivity or economy-wide productivity and we think the economy-wide productivity is appropriate.

MS. KOBE: One of the reasons we think economy-wide is appropriate is because probably methodologically it's more sound in how it's put together at the moment, because of the data sources available, but also because we think it doesn't move dramatically differently from the physician productivity.

I think if all of us had been looking at that Index through the 1990s, we might not have been quite so confident in making this recommendation.

PARTICIPANT: Right.

PARTICIPANT: Okay. I agree.

MR. STEINWALD: You just used the word "recommendation." I think the latter part of this is a recommendation, not just a finding.

MS. KOBE: You're right; yes. This is still a

finding because at the moment we are not saying there is any reason to change it. It's just the rationale for not changing it may be different from what the rationale was.

MR. FOSTER: I've gotten a little confused now, Kathryn, by your earlier comments. Take a hypothetical situation where say a practice, physician productivity, was not increasing at all, and if we're still using a price proxy for physicians' contribution that is economy-wide, which reflects some level of economy-wide productivity growth, and we say oh, but the physician productivity is a lot different, it's zero, so we'll subtract out only zero, then we have given the physicians credit for economy-wide productivity gains when they haven't actually accomplished any.

MS. KOBE: Physicians are having to pay their staff based on kind of economy-wide wages. If they can't make use of that staff, then we are penalizing them for that by subtracting out the productivity.

You're weighting up the component based on their practice expenses.

I understand where you're coming from. We are talking about their own compensation. I understand the argument you're making, Rick. Once you start taking price proxies -- to what they are doing. It seems to me you're putting together a price index that reflects what you think a physician's input prices look like.

MR. FOSTER: Right, exception with the distinction that we are purposely not using physicians' own wages and salaries and benefits based on the Senate Finance Committee language.

I'd have to think through. Maybe we can take a second to do this. For the physician part of it, Kurt, you started to mention -- the physician part of it, which is roughly half, I think it's pretty clear.

If you are using the economy-wide measure of compensation growth, then you take out an economy-wide measure of productivity, whatever actual productivity physicians generate, then they are rewarded for that through more payments for more services.

The part I'm less sure I understand is for the other half, where you would have the non-physician personnel, you have the other input costs, and all of

that is being proxied by any number of different price measures.

DR. BERNDT: A multi-factor productivity gross adjustment, if you look at the prices of all your inputs, you're using them more productively now, the ultimate price you get will reflect the multi-factor productivity growth over both your own inputs and those you purchase.

MR. FOSTER: Right. The question is for all the non-physician part of the inputs is the economy-wide productivity and appropriate adjustment, or should it be something more specific to those inputs.

That's the part I'm less sure that I understand.

DR. BERNDT: Okay. I think that's the right issue.

MR. FOSTER: You remember, Ernie, what was it, six or eight years ago, when we moved from labor productivity to multi-factor, and then you and the other people, and Kathryn, I think you were part of that, too, and recommended that the productivity adjustment be applied to the Index across the board,

whereas the labor part used to be applied only to the labor performance.

The question is, is the economy-wide multi-factor productivity still appropriate to apply to the non-physician part.

One could argue that the non-physician part maybe represents the economy at large more closely than the physician might, even though we have studies that suggest that the physician productivity is pretty similar.

I think that's the key question. Heidi, Steve, John, Hudson, Mark, anybody tell me if I'm getting this wrong. I think that's the issue.

MR. STEINWALD: Physicians are more productive than society at large. They get more income through -- they are billing more RVUs.

MR. FOSTER: But they're giving back the one percent.

MR. STEINWALD: Which they got in the first place for their half of the MEI because the economy generated that. That allowed wages and salaries to grow that much faster than otherwise. They're getting

back what we gave them.

I think all that part is consistent.

The other thought embodied in this is the comfort level of the economy-wide adjustment is largely based on the last ten years of experience that shows the productivity between physicians and the economy is pretty close.

This language near the end of that that implies we should continue to monitor that, if that proves not to be the case for some significant period of time, then you might consider changing the way the productivity adjustment is made.

MR. FOSTER: Right, that goes back to my example where say physician productivity was zero and then the economy was one percent, we give the physicians through the ECI the one percent, then we kick it out. So, so far they have nothing for improved productivity, and then they generate their own, which happens to be zero, so they don't get rewarded for it because they didn't generate any.

So, there is a big difference between the economy-wide and physician, and I think it doesn't

matter if we're still reimbursing them properly.

That's all on the physician side.

MR. POISAL: That gets a little bit back, Zack, at what you had covered in the first meeting when you went and looked at some of the issues that sort of surrounded the first, so to speak, of the MEI.

We talked about this double counting issue and the intention at the time was you remove the double counting because you have adjusted for the fact that you are updating portions of this by economy-wide measures, you take that out, and then to the extent the physician him or herself is more productive than the general economy, they keep that in terms of gains, and to the extent they are less, they don't.

PARTICIPANT: I was listening to all of this. I don't think we can capture all of that in here or if we could, we could write it up very quickly. We will probably go through several versions.

PARTICIPANT: I forgot who made the suggestion, but moving the first sentence from Finding 5.2, starting it with "Measures of growth" would be useful, don't you think?

PARTICIPANT: I think so. I don't think it's really necessary. Well, yeah, I agree with that.

PARTICIPANT: That's on the basis that in 5.1, you said the current measure is okay. Would you want to identify in 5.1 that the current measured based on economy-wide, et cetera, is okay?

PARTICIPANT: Sure. That's what 5.1 says already.

MS. KOBE: I think it's rewarding them through the RVUs is what I'm struggling with a little bit as opposed to just the Index itself.

PARTICIPANT: The RVUs is the intent to divide up the pie amongst physicians, not to reflect productivity changes.

DR. GILLIS: It sounds like we're making progress, but at the risk of interrupting that, I think part of the problem is we don't really have a clear definition of what the MEI is supposed to be.

Do we need a very specific, precise definition to be able to answer this question about which productivity adjustment is appropriate?

You could say it's an input price index, but

it's not really that. It is something like an input price index, change in input prices per unit of output, is that what it is, when you adjust by productivity?

PARTICIPANT: Yes. Think of it as input price growth minus multi-factor productivity growth equals what we're going to call "output price growth."

DR. GILLIS: Okay.

PARTICIPANT: If that's the case, should we be using physician productivity, output price growth for physicians for productivity growth for physicians?

MR. HEFFLER: I think at the bottom of Finding 5.2, that's sort of the issue, although it gets a little messy, as Kathryn said.

This really is not a physician input price index. The non-physician costs, things like professional liability, clearly are proxied by things specific to the Index, but most of the price series they are using in the non-physician costs are not specific to physician inputs.

They are things like PPI non-residential rent, ECI for compensation for the workers and they are weighted together based on the physician cost

structure, but half of the Index is not based on the weighted change of physician wages.

I think the point Ernie was making at the last meeting is if your input price index is based on a concept that is more of like an economy-wide price index, it is actually inappropriate to adjust that by an adjustment that isn't on that same basis.

Now you have an output price that is subtracting apples and oranges, the result of subtracting apples from oranges.

Kathryn has made a good point which is we don't really have a pure input pricing that is pure on either side, it has physician weights but it has economy-wide prices.

Since we are using economy-wide prices, it seems like, particularly for the physician compensation, that the issue of using economy-wide productivity is an important distinction to make sure there is a consistency.

The way it is written, there is kind of an accounting identity that is maintained for that.

MS. KOBE: It's possible they could not

meet --

PARTICIPANT: They could exceed it.

MS. KOBE: That's true. The weights are on both sides as well. I guess that's my concern. The MFP conceptually has weights in it as well.

PARTICIPANT: If you don't have purity, they can't.

PARTICIPANT: At this stage, we're not recommending the adoption of a physician multi-factor productivity measure. I think what we are doing is saying we want to keep on looking at it, and that's why I agree that the "measures of growth" sentence is a very useful starting point for Finding 5.2, and we are going to continue to look at that, both the measurement and even some of the conceptual issues now that are related to the measuring.

MS. KOBE: I agree with that. We don't have to because we're all comfortable with using the economy-wide index based on what we do know about the relationship.

PARTICIPANT: If we go back to 5.1 for a second, I would propose to stick in the "The Panel

reviewed the basis for the current economy-wide multi-factor productivity" so it's very clear what we are doing here.

DR. BERNDT: That sounds good.

PARTICIPANT: I think we are more comfortable taking out the first sentence in 5.2.

DR. BERNDT: Do we add to what would be the new first sentence after the semi-colon or before the semi-colon saying "Are of interest for the purpose of comparing the structure of price increases for physician services versus other sectors of the economy, and continued monitoring," something like that.

PARTICIPANT: Where are you?

DR. BERNDT: What used to be the second sentence, "Measures of." It would be a new sentence.

PARTICIPANT: We want to take out the first sentence before "Measures of," right?

DR. BERNDT: Correct.

PARTICIPANT: Let me do that so we get a better sense of how it looks. I agree with what you're proposing.

MR. FOSTER: In ACE, we make a lot of

arguments on input price indexes and the ability of that industry to do it. We want to make sure we can cross walk this industry with that.

If you take the physician -- that you cannot increase productivity, the cognitive ones, like the fee attribution, if you take out the economy-wide productivity for them and they can't increase RVUs per visit -- I think their real income has declined.

This is an aggregate one across all specialties, but in that case, they're not actually getting kind of the same -- they wouldn't be getting those economy-wide wage increases because we have taken those out.

Check me out here if this is right. Their reimbursement, because they can't increase RVUs, their real income, I believe is actually declining.

DR. BERNDT: Yes, it's important -- real income per RVU.

MR. FOSTER: Yes. They can't proliferate RVUs, like the other specialties. There is an issue of understanding how this plays out with physician specific productivity, I think.

DR. BERNDT: I have it at 3:30 on my clock. John, are you comfortable with after the word "monitoring" starting "However?"

MR. POISAL: I think we are okay with that, Ernie. What we were going to propose was that maybe we take a short five minute break, come back, have the public comment period and wrap up.

Is that okay with you?

PARTICIPANT: Are we done with this finding or are we going to continue working on this language?

MR. STEINWALD: It needs a little wordsmithing to make it clear that you are continuing to do what you are doing now, as opposed to making it sound like you're proposing something else.

PARTICIPANT: I don't understand the sentence that begins with "However."

PARTICIPANT: I don't either. I don't think it is appropriate given the previous sentence.

MR. POISAL: Ernie, I will defer to you. Would you prefer to address that now or address it following a quick break?

DR. BERNDT: Let's have a quick break. It's

been a long time.

MR. POISAL: Fair enough. Reconvene in five minutes.

(A brief recess was taken.)

DR. BERNDT: How comfortable are you with this now, Zack?

DR. DYCKMAN: But you need something at the end, and then it's mirror continued monitoring. "It is not being recommended for adoption at this time."

DR. BERNDT: Okay. A comma.

DR. BERENSON: Do we need the assess time? That implies that at some future time.

DR. BERNDT: Only because later on you said we need taking a look at it.

DR. BERENSON: Yeah. Okay. But, again, I don't think we should be -- all right. I'm not going to try to change anything

(Laughter.)

DR. BERNDT: I wore Zack down. Now, I'm wearing you down, Bob?

DR. BERENSON: I mean it's just hard, but I mean I'm already overtime here. And I don't have the

time to really engage, frankly. I mean I don't think the passive voice works anyway. We do not recommend. I mean it is not being recommended as -- we don't recommend its use now. How about that?

DR. BERNDT. Yeah. We do not recommend it, period. Yeah.

DR. BERENSON: Not at this time was the answer?

DR. BERNDT: Correct. That's where I'd come. I think I'm with Bob that conceptually, I'm not sure I'd ever want to do it.

DR. BERENSON: And that's where I was, and at this time suggest that we're quite open to it. And, again, I'd want to know about it and I'd maybe want to make a separate policy decision, but I don't think it should corrupt the MEI.

DR. BERNDT: Are you comfortable with this wording now, Bob?

DR. BERENSON: Yes, I am.

DR. BERNDT: How about you, Zack?

DR. DYCKMAN: I'm fine with it.

DR. BERNDT: Kathryn?

MS. KOBE: Um. Yeah. I guess I can live with the wording.

DR. BERNDT: It's late in the day. Kurt?

DR. GILLIS: Well, I'm okay with it up to, "We do not recommend its use. I would like to see at this time." I don't see how you can make a judgment about one or the other, again, without having a clear definition about what the MEI's supposed to be. I think that's the problem we're having. I think that's why it's so difficult to answer this question. So, I mean the drawback right now, I would recommend not using it right now because we're not sure about how it's measured.

We don't think that's a measurement of physician and MSP is refined enough to use it. That wouldn't mean that in the future, in my opinion, if a more refined measure were available in the future, that that would not be appropriate, but it might be appropriate. I'm sorry that causes problems.

DR. BERNDT: Do we want to compromise as to, say, WOPEE and merit continued monitoring to the end that we do not recommend its use, but to recommend

continued monitoring? Or does that open the door to wide, Bob?

DR. BERENSON: Pardon me?

MS. BARRON: Well, they're already saying that it merits continued monitoring.

DR. BERNDT: Well, I was going to say move that --

MS. BARRON: Oh. Okay.

DR. BERNDT: -- to the end of the sentence after, "We do not recommend its use, but do recommend continued monitoring."

DR. GILLIS: Yeah. That's sort of a compromise.

PARTICIPANT: "Do believe that continued monitoring is appropriate." Otherwise, it's a recommendation.

DR. BERNDT: Yeah. Yeah. That's better yet.

MR. STEINWALD: I'd say, "Do believe that continued monitoring is appropriate."

DR. BERNDT: Hello?

PARTICIPANT: You're still there. We're all still here.

DR. BERNDT: I had to switch phones, since my phone battery gave out on my other phone. I think you will need a professional editor for this paragraph.

(Laughter.)

MR. FOSTER: Or we happen to have on staff a Ph.D. in rhetoric and English literature who would be happy to take a look at the entire report before it is finalized.

PARTICIPANT: All right.

MR. FOSTER: She's going to kill me.

DR. BERNDT: All right. Do we want any further discussion on 5.2?

PARTICIPANT: Well, you have to take out the, "while," now, because there is no --

DR. BERNDT: Correct, correct.

PARTICIPANT: There's a long phrase.

DR. BERNDT: Yeah. You're right.

DR. GILLIS: Well, again, I don't agree with anything after, "appropriate." But I don't know if the four of you strongly think that that's --

MS. KOBE: What about the last sentence? Does the panel conclude it is appropriate that the

accounting identity be maintained as the current system approximates? But, if you reevaluated how the accounting identity was being determined or defined, would that answer your question?

DR. BERNDT: What you're saying, Kathryn, is in parentheses, "as the current version of the index approximates?"

MS. KOBE: Well that's what I think it means. I think that's what I'm hearing. And our concern is that we don't clearly agree on what the accounting identity really is here, or whether the proxy, or what the proxies are approximating. Although I think we're agreed that the current methodology is coming pretty close to approximating it one way or the other. But it really comes down to what is the accounting identity telling us, and what is the proxy measuring.

So if you got to a point where you had a major diversion between the two sets of measures, you could reevaluate it based on the accounting identity and make the appropriate decision as to what is the right thing to do.

DR. GILLIS: Okay. The sentence that begins

with, "Use of," is still somewhat vague to me. Can we eliminate that sentence and just go right to the --

PARTICIPANT: -- the final concludes?

DR. GILLIS: Yes.

PARTICIPANT: Yes.

DR. BERNDT: You know. At this point I wonder if track changes is helpful or makes it a little more confusing.

MR. OSGOOD: Okay. We can turn that off.

DR. BERNDT: I'd just like to read it rather than think of how it was. How about in that parentheses, to follow Kathryn's logic? In the final parentheses at the end of the paragraph, say, "as is approximated by the current version of the index, so it's clear that it's an approximation.

DR. GILLIS: Yeah. I think that would be fine, and then keeping the sentence that begins with, "Use of."

MR. HEFFLER: Could we combine the sentence that begins, "We do not" and the sentence that begins, "Use of" and say something like, "We do not recommend its use in the MEI because it would be introducing

consistencies, but do believe continued monitoring is appropriate?"

DR. GILLIS: I don't know what the inconsistencies that it's producing are.

DR. BERNDT: Input price costs minus productivity costs equals output of price.

PARTICIPANT: Kurt, are you saying that there are inconsistencies regardless of which index you use?

DR. GILLIS: I'm saying it's hard to say whether they're inconsistencies with one approach or another without knowing, specifically, what the MEI is supposed to be.

PARTICIPANT: I think there's a lack of purity and we're mixing things. You know. We're not dealing with apples or oranges, but a fruit out of necessity. And one could argue that one index is better than the other just from that perspective. So there are issues with the use of either index, I think.

PARTICIPANT: And I think that's what you're saying. Right? So --

MR. FOSTER: Let's go back for a second. And, Kurt, we can try and answer your question about what is

the MEI all about. Ever since it was created the MEI's been here from the other price indexes for updating Medicare payments. And the actual legislative language, it was exactly members that specifies an economic index.

Now, that was interpreted by the original designers way back when as in effect an output price index. Everywhere else in the world, it actually specifically says using input price index. That's not ideal for a lot of reasons, but the point is the MEI has been different from the start, the 40 years or whatever it's been based on an output price index.

That's where the accounting identity that Ernie mentions comes in, for input price growth minus the productivity and gives you other things being equal in the output price index. So that's for better or for worse, and admittedly Congress was a little vague in what they said, but it's been interpreted as an output price index all the way along. The whole point of 5.2 was to say that you should use in deriving an output price index, you should use consistent components.

If you have an economy-wide inputs, you should

use economy-wide productivity as an adjustment. If, at sometime in the future, we went to a physician's specific input, then we'd probably want to use a physician specific productivity measure, assuming one could be reliably enough calculated. Now, I don't know if that helps or not, but that's what the MEI is supposed to be about.

DR. KOBE: I think we have different -- I mean I think we're all saying that this is not -- these indexes are not pure right now. And what counts more is the weights or the price proxies. And, granted, the price proxies have in place of productivity that's built into them, but the way they're weighted together is not inconsequential when you're gearing it to economy wide MFP, which may have a completely different underlying weighting of the input.

And so I think it's that inconsistency that makes the answer to this not absolutely that clear. I think we're pretty much all in agreement that right now it appears to be a good approximation for what's going on, but I guess because we have this mix here, it's not quite as clear and online as perhaps it is in yours,

Rick. I mean that's what I'm reading.

MR. FOSTER: Right. That's what makes it difficult to come to a definitive statement that this is wrong and this is right.

DR. BERNDT: I agree with that.

MR. HEFFLER: This is Steve. I think from our perspective and maybe it's not as appropriate as we thought, I think we put more weight on the price proxy issue than we did the weighting issue. You know. If you go over the long history and sort of the initial rationale behind the MEI and the use of general earnings, it was sort of intended. So there wasn't 10 percent wage or 15 percent compensation increase is showing up in the payments every year because there was such an increase in the amount of outputs, which the physician controlled and which is on the RE side of it.

So for us, I mean, you could weight them together however you want, but the compensation piece, which is clearly the biggest piece in any type of index you're going to pull together, it's that proxy that really matters. And since we're using something that is reflective of economy-wide, we intended to include

that the input side of this is something that looks more like an economy wide price increase, even though it's weighted using physician weights.

Now, maybe that's over time has changed, or maybe that's not the right way to look at it, but I think that's kind of been part of our thinking behind this, and in that equation input, price minus MFP was output price, and the input price, although not clean, is actually more like something that looks like economy-wide.

MR. FOSTER: And it is an approximation, because of the reason that Kathryn mentions, because of the different rating.

DR. BERNDT: Where do you suggest -- how do you suggest we proceed from this point?

DR. GILLIS: I'll take myself out of it if the four of you agree. That's fine. I'll go along with what you do.

DR. BERNDT: Well, I guess it's the sentence of, "Use of physician specific productivity" that is causing Kurt some issues. Right?

DR. GILLIS: Right.

DR. BERNDT: I don't feel strongly either way. I don't have a problem eliminating that sentence and just going with, "The panel concludes." But I don't have a problem keeping that in either.

DR. KOBE: What if we change that sentence to read, "Use of the physician-specific productivity growth to adjust the economy-wide compensation growth in the NEI could introduce inconsistencies." And then say that, "The panel concludes that it is appropriates to continue to require the accounting identity between input price growth/output price growth, and productivity adjustments be maintained." And indicate that, you know, there's a time when it diverges, then it has to be reevaluated at that point.

DR. BERNDT: I'd change the word, "would."

DR. BERENSON: Changing one letter changes it dramatically, because you're not making it the statement that it does introduce inconsistencies or more inconsistencies than a physician productivity. I think it's a great idea.

DR. BERNDT: But change would to could? I'm comfortable with that. Kurt, does that help you sleep

better?

DR. GILLIS: Yes, that does. Yeah. Thank you.

DR. BERNDT: And do we need, "That is," maybe just, "The panel concludes"?

DR. BERENSON: Yeah.

PARTICIPANT: Kathryn, you're brilliant.

DR. KOBE: Well, I would not go that far. I'm still not absolutely certain what the answer to this is. I just know what the question is. Where we talked about it, I think, well, maybe that's true, but I'm not convinced one way or the other. It's because exactly what they're saying. We don't have clean indexes here. It's hard to determine where the error, what off-setting errors might be there.

DR. BERNDT: Bob, are you comfortable with this?

DR. BERENSON: I am comfortable with it, absolutely.

DR. BERNDT: All right. I think we've got consensus, then. John, Rick and Steve, are you comfortable with where we are ending up? We still have

to do public discussion, but I was wondering, before we can bring this to a tentative conclusion.

PARTICIPANT: Yeah. I think this is fine. I mean at our end of the conversation, our language might have varied a little bit, but we're not we're not the technical panel. You are, and I think you have a pretty good consensus on this and I think it's reasonable.

DR. BERNDT: Any further comments from the panel or from the folks at OACT or guests in the room?

PUBLIC COMMENT

DR. BERNDT: What is the procedure now for Hudson or Kimberly to opening it up to folks from the public? I think you said if someone wants to beef, they should press star 71. Was that it?

KIM: Yes, if you would like to ask a question at this time, press pound 71 on your telephone keypad. We'll pause for a moment to allow you to get online to ask your question. Again, then it's pound 71 on your telephone keypad. At this time, there are no calls in queue.

DR. BERNDT: And to remind you of weddings

when they say speak now or forever hold your peace.

(Laughter.)

DR. BERNDT: All right. Well, thank you very, very much, panel members. It's been a pleasure to work with you. I think we've made some constructive accomplishments, and thanks especially to the staff at the OACT for all the hard work.

FINALIZE ALL FINDINGS AND RECOMMENDATIONS

MR. POISAL: Ernie, as the designated federal officer, I wanted to echo your thanks. As you know, the work isn't completely done yet in that while we've got our set of formal findings and recommendations, we still do have to work together to produce sort of the underlying, complete written report that will document the data and the processes that underlie the findings and the recommendations.

But, as this is our last public meeting, again, I wanted to echo a thanks to all the panel members: Kathryn, Kurt, Zack and Bob; and, thank you, Ernie, for chairing. I also wanted to thank publicly the MEI team that's poured so much into this over the last several months, as well as the OACT leadership,

and then also the HCDI staff who have been all that we'd hoped that they would be too. So with that, I guess if there's nothing else, we can conclude.

DR. BERNDT: Can I ask what sort of a timetable we should expect to hear from Bruce?

MR. POISAL: I think we're going to get together with Bruce and HCDI and try do derive what we think is a reasonable turnaround time. We do have some guidelines that we are bound to, based on the fact that we're a FACA panel. So it won't linger for very long, but we'll put our heads together here and communicate all that back to the panel. And all the panelists will have opportunity to view and comment on the final written report.

PARTICIPANT: In draft.

MR. POISAL: In draft, right.

DR. BERNDT: If you could let us know roughly what schedule to expect this, we have Labor Day coming and classes starting, and things like that. That will be helpful.

MR. POISAL: We will do that.

MR. FOSTER: I would just like to echo what

John said. Thank you so much to the members of the technical panel for your commitment of time to this public service which is very valuable, and we really, really appreciate it. You all could have been doing many other things, many of which would have paid money. But it's enormously valuable to get this outside, independent input on what it is that we try to do under the law, and it's very much appreciated. Thanks, too, for our various transcribers and assistants, coordinators and so forth. We really appreciate it all.

DR. BERNDT: Thank you all.

DR. BERENSON: Take care. Bye-bye.

KIM: Thanks.

(Whereupon, at 4:10 p.m., the meeting was concluded.)

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