Medicare Economic Index (MEI) Technical Advisory Panel (TAP)
Meeting Summary Notes
May 21, 2012

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

Attendees

CMS	MEI TAP	HCDI
Rick Foster	Ernst Berndt (Chair)	**Jan Kelley-Adevor**
John Poisal	Bob Berenson	Jackie Scott
Steve Heffler	Zach Dyckman	Bruce Steinwald
Heidi Oumarou	Kathryn Kobe	Wendy Qin
Hudson Osgood	Kurt Gillis	Toya Via
Mollie Knight		
Mary Carol Barron		
Mark Freeland		

Introductions and Administrative Activities

The meeting opened with introductions of the Medicare Economic Index (MEI) panel members and other attendees.

John Poisal, Deputy Director of the National Health Statistics Group in the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS). John is responsible for managing and developing the work associated with the Medicare market baskets. **Bob Berenson,** Institute Fellow at Urban Institute. Bob worked at CMS from 1998 to 2001 in the Center for Health Plans and Providers. He is a former practicing physician in internal medicine. **Bruce Steinwald**, Subject Matter Expert from HCD International (contractor). Bruce is responsible for capturing the panel's decisions in a report that will be submitted to the U.S. Department of Health and Human Services, Secretary Kathleen Sebelius. **Kathryn Kobe**, Economist at Economic Consulting Services. Kathryn used to work for Joel Popkin & Company who worked with CMS on the MEI. **Zach Dyckman**, Economist at Dyckman & Associates. Zach's second job was in the Office of Research and Statistics at the Social Security Administration. He was responsible for developing the MEI based on guidance from the Senate Finance Committee. He has since worked primarily in private industry mainly focusing on provider payment issues. **Kurt Gillis**, Economist at the American Medical Association (AMA). Kurt has been with the AMA for approximately 20 years and has spent the majority of his tenure working on Medicare payment issues. He has also worked with CMS on the practice expense surveys in the past. **Rick Foster** serves as the Chief Actuary at CMS. The Office of the Actuary has a broad range of responsibilities including producing the annual Medicare Trustees Report. The Medicare market baskets are an important component of the Office of the Actuary, as well. Rick shared his appreciation for everyone's participation. **Steve Heffler** serves as the Director of the National Health Statistics Group (NHSG). NHSG is not only responsible for the market baskets, but is also responsible for estimating historical and projected national health expenditures. The group is located in the Office of the Actuary. Steve also expressed his appreciation for the participation of the panel members. **Mark Freeland** is an Economist in the Office of the Actuary and is an historical expert on MEI. **Heidi Oumarou**, **Mollie Knight**, **Mary Carol Barron**, and **Hudson Osgood**, introduced themselves as Economists working in the Office of the Actuary at CMS. The panel chair, Ernst Berndt, is a professor at the Massachusetts Institute of Technology. Ernie was delayed due to transportation difficulties, but joined the meeting later in the morning.

Opening Remarks

Mr. Poisal continued the meeting with the public meeting ground rules. Public and webcast attendees were asked to limit the discussion to the panelists and others at the table. All were informed that there would be fifteen minutes at the end of the meeting for questions and comments. Panel members were informed of the goal to have an interactive discussion. The intent of the CMS, Office of the Actuary was not to lecture, but rather to review the materials and to solicit a healthy dialogue. All panelists were encouraged to actively participate in the discussion. An announcement was made that all panelists would be required to take an oath later in the day.

Mr. Foster provided additional opening remarks to the panel and attendees regarding meeting objectives and expectations, panelist roles and responsibilities. He also stated that Medicare physician payments under current law are adversely affected by the Sustainable Growth Rate (SGR) system, which is used to update physician payment amounts from year to year. The original physician-update proposal would have been unstable so the CMS, Office of the Actuary requested Congress to make technical changes that helped with the stability issue. Each year, over the past 10 years, Congress has acted to override the provisions of the SGR to avoid payment reductions. There is an anticipated 27% decrease in physician payment rates coming on January 1st, 2013 in the absence of legislative change. In the meantime, the law doesn't work well and is expensive to fix. Mr. Foster mentioned that there have been many people over the years who have suggested that one way to help address the problem with the SGR is to re-invent the MEI in a way that will make the physician payment updates more reasonable. The Office of the Actuary has the responsibility of applying the law in its current state and thus, we do not have the option of changing definitions (of the MEI) to address any aspects of current law that may not be working as planned. Mr. Foster closed by thanking the panelists for their contributions to the process.

MEI Overview

Mr. Poisal provided an overview of the MEI Mr. Poisal shared that the MEI is an important component of the annual update to the Medicare physician fee schedule (PFS). The PFS is a listing of the fees that Medicare pays physicians and other providers for services to Medicare beneficiaries. In recent years the fee schedule has been updated annually by the SGR. The SGR was born in Section 1848 of the Social Security Act and it establishes targets for aggregate Medicare payments for physician services.

The MEI was established in Section 1842 of the Act. The MEI has helped justify and limit the extent that payments would increase annually. The index was published June of 1975 and Zach Dyckman (panel member) was one of the original architects. The most recent version of the index is based on data from 2006 and was implemented in the calendar year 2011 update. The MEI comprises several cost categories covering physician compensation and practice expenses. Physician compensation is composed of physician wages and salaries and benefits for self-employed physicians. If these physicians have other employed physicians that work for them, their wages are included, as well.

Practice Expenses (PE) include non-physician expenses such as those associated with employing nurses, office managers, and others. This broad category also includes expenses for malpractice insurance, medical equipment, supplies, materials, and other professional expenses.

The cost category weights found in the MEI are primarily derived from data from the AMA's Physician Practice Information Survey (PPIS). In addition, data from the Bureau of Economic Analysis's (input and output tables) are incorporated, as well as data from the Census Bureau's Current Population Survey (CPS), data from the Bureau of Labor Statistics' Employment Cost for Employee Compensation Survey. Finally data from the Internal Revenue Service's Statistics of Income were used. All of these secondary sources are helpful in estimating finer levels of granularity to the MEI.

History and Early Development of the MEI

Dr. Dykman provided an overview of the history and early development of the MEI as an original architect. He stated that the MEI was developed in 1972 to limit inappropriate growth in Medicare physician fees. The goal was to seek the most refined index that could be developed. Congress decided there was a need for an index to limit growth in physician fees. The focus was on self-employed physicians as they represented the vast majority of the industry. It was illegal for physicians to work for non-physicians in many states. They were employed either individually, in small groups, or in large groups.

Some of the concerns regarding the implementation of the MEI were (1) many of Medicare's insurance carriers had numerous specialty categories affecting fees, (2) physicians could self-designate their specialties, and (3) there was no definition of locality. Physicians had very different expense weights based on their specialty and location. Despite this variability at the time, the charge was to create one economic index. When the index was implemented in 1976, it was implemented as a cap on prevailing physician fees.

Physician Practice Information Survey

Mr. Gillis provided information on the most recent PPIS, which was jointly funded by CMS, specialty societies, and the AMA. The direct cost was about $2 million, (not including some labor costs). The PPIS was fielded in 2007/2008 and collected data on 2006 practice expense information. The primary purposes were to update data used in calculating practice expense relative value units (RVUs) in the physician fee schedule and to update the MEI's cost category weights. The AMA has not fielded a practice expense survey since then.

The physician sample was drawn from the AMA Master file, which is a listing of all physicians in the US (both members and non-members of the AMA). It was limited to non-federal, non-resident physicians who provided patient care for at least 20 hours a week. The physician sample was stratified by specialty (there were approximately 50 specialties). There were nine other non-physician provider groups included, as well.

The survey collected practice expenses, detailed hours, and basic practice characteristics (such as practice size and setting). The survey was conducted by telephone (20%), web (65%) and fax (15%). There was a small incentive payment of $50-$75 depending on how the physician took the survey. The previous AMA surveys were only conducted via telephone and did not offer an incentive payment. New expense questions were added, existing expense questions were re-worded, and respondents were allowed to provide expenses at the individual, department, or practice level. The new questions added focused on payroll staff who can bill independently, separately-billable medical supply expenses, separately-billable drug expenses, and physician net income and benefits.

The survey response rate was 12%. The response rate to the 1999 survey was 42%, down from over 60% in 1990. The cause of the decreased rate of response is due to the difficulty of the physicians finding time to take the survey especially with the finance questions.

The MEI tabulations were simply calculations of mean expenses, net income, and benefits. Even though there was a broader group of survey respondents, the tabulations used in the MEI were limited to self-employed physicians who provided expense information at the individual level.

Mr. Gillis shared the following information regarding the PPIS results. Between the 1998 and 2006 surveys, the costs associated with the Office Expenses question increased by 120% (10% annually), non-physician payroll increased 47% (5% annually), medical supply expenses increased 81% (8% annually), other expenses increased 81% (1% annually), net income increased 18% (2% annually), and Professional Liability Insurance premiums increased 91% (8% annually). The rapid increase on the Office Expenses question may have been due, in part, to the change in the wording of the question. In the past, this question sought costs associated with rent,

mortgage interest, depreciation, utilities and telephone. Most recently, the question was refined, seeking to also capture costs associated with office equipment, office supplies, maintenance, refrigeration, storage, security, janitorial, and other office computer systems. These costs may have been captured by the Office Expenses question previously, but that cannot be confirmed. Also possible is that costs associated with maintenance, security, and janitorial services may have been contracted services captured in other expenses (perhaps explaining why this category experienced annual average growth of only 1%.

Mrs. Oumarou then presented on the MEI's various cost categories and cost weights. The AMA PPIS survey was the main data source that was used to construct the major cost categories for the rebasing of the MEI to a 2006 base year. The sample was edited by the AMA to only include respondents that were self-employed physicians. This survey is currently the only data source available for self-employed physician expenses. It is unknown when another PPIS survey will be fielded. Other potential data sources were discussed such us the Medical Group Management Association's survey and the Census Bureau's Services Annual Survey (SAS) but there were limitations to these data that prevented them from being viable data sources for the MEI cost weight construction. There were several minutes of discussion among the panel members inquiring about the details of the representativeness of the data and the definition of self-employed physician. Dr. Gillis from the AMA answered these questions.

The major cost weights that are obtained directly from the AMA PPIS mean expenses were total expenses, physician wages & salaries (net income), physician benefits, employed physician payroll, non-physician compensation, office expenses, professional liability insurance (PLI), medical equipment, medical supplies, and other professional expenses.

There are two major components of the MEI: Physician Compensation and Practice Expense (PE). The 2006-based MEI reported the weight for physician compensation to be 48.266% and a 51.734 %-weight for Practice Expenses.

The physician compensation cost weight is the sum of both self-employed net income & benefits and employed physician wages & benefits. The wage and benefit split for employed physician compensation was based on data from the IRS Statistics of Income for physician and outpatient care centers. The self-employed wage and benefit split was based on the levels reported on the AMA survey. Several panel members questioned the wage and benefit split that was reported based on the AMA data and believed that the weight for benefits of about 8% seemed low. Ms. Kobe questioned where retirement benefits or defined contributions were likely reported by the physician owner and CMS agreed to look into the issue in more detail before the second meeting.

The non-physician compensation costs were split between wages and benefits using the Employer Cost for Employee Compensation statistics for North American Industrial Classification System 62, Healthcare and Social Assistance. The non-physician wages were further disaggregated into 4 occupational groupings based on CPS employment counts and Occupational Employment Statistics' mean annual salary. These were the same four occupational breakouts used in the previous 2000-based MEI. The four categories were Professional and Technical Workers, Managers, Clerical Workers, and Service Workers. Mrs. Oumarou noted a significant shift from 2000 to 2006 in that the management share declined and the service workers share increased. The other two categories also experienced changing shares, but not to the same degree.

Next the Office Expenses categories of the MEI were discussed. In the 2006 survey, the PPIS question related to office expenses was expanded to include additional costs that were not included in the 1998 version of the question. These costs included non-medical equipment, non-medical supplies, maintenance, refrigeration, storage, security, janitorial, and other office computer systems, including information management and electronic medical record systems. Ms. Oumarou explained how the BEA I/O data was used to disaggregate the

office expense costs into the sub-aggregate categories. There was discussion among the panel regarding the exclusion of drug expenses from the MEI, which CMS agreed to follow-up on prior to the next meeting.

The remaining category weights for 2006 were compared to the weights from 2000, including Medical Equipment, Medical Supplies, and PLI.

Questions related to the cost weights were posed to the panel members.

Lunch Break

The Oath of Allegiance was taken by all five MEI TAP members.

Panel Discussion of Physician Practice Information Survey –continued

The panel considered the reliability of the AMA survey, particularly in the sample design, the number of respondents by type or by specialty, and the credibility of the contractor who conducted the survey. The survey was stratified by specialty, it was not a random sample, and it was checked for non-response using sample frame and master file information (location, practice size, AMA membership, etc.). Age and gender did not have a significant effect on response rates. There was a significant difference, however, in response rates by specialty. Some specialties had a response rate as high as 50% with others much lower.

The panel posed additional questions to Dr. Gillis about the survey. They asked if there appears to be a trend towards providers moving into large groups? Dr. Gillis indicated that data from the Medical Group Management Association (MGMA) might be able to inform that as they do annual surveys and they obtain their data from county systems, not individual physicians. It was suggested that in the long-term, the MGMA data might be a good periodic source of data if issues surrounding that data can be addressed. That survey has a set methodology and they get responses.

A question was posed generally about possibly obtaining physician data from the Census Bureau. In response, CMS indicated that they have approached them in the past; however, money and resources are issues that need to be addressed further. Dr. Gillis shared that physicians typically express concern if the survey instruments ask for additional detail. This, in turn, may affect response rates and other critical pieces of the survey. There might be other opportunities for information on expense data related to equipment or compensation. For instance, BlueCross has a research arm, but they would not typically have access to physician data. They are concerned with what they pay, not costs for the physicians.

Dr. Gillis explained that the issue of a small sample size is a problem because of the tremendous variability in expenses and expense weights by specialty. For example, on one end of the spectrum you have oncology practices with millions of dollars of equipment versus the other end of the spectrum where you have psychology practices with virtually no equipment. It was suggested that the panel look at individual specialty types, but may need to develop a different methodology. Different MEIs for different specialty categories would need to be aggregated into one for the entire MEI. Is it manageable or cost-effective? It was pointed out that MedPAC made a recommendation on getting objective time data for helping to calculate work in the Resource-based Relative Value Scale (RBRVS) system. Instead of relying on a survey of specialists to determine how long it takes to do colonoscopies (for example), they went to a number of practices and measured the timing themselves. This represents a real-time measurement and doesn't rely on administrative databases. A similar argument could be made for the MEI; instead of sending surveys to thousands of doctors, go to a few practices and collect the cost data and extrapolate them to making it an aggregate MEI.

With respect to electronic health records (EHR), there is an ongoing change from old systems that didn't utilize this technology to new systems that likely will, but that is not fully established yet (making 2006 data somewhat suspect). We have to ask if the weights are possibly valid with regard to this particular expense. PPIS data show that 45% of respondents had EHR systems either fully or partially in place. The mean acquisition cost was $31,000 and mean annual operation cost was $5,000. CMS may have some data on EHR adoption. Recent adoption of EHR systems may have changed the distribution of capital expenses and affect non-physician compensation.

Dr. Gillis pointed out that Gallup was the original survey contractor that fielded the survey in 2007. Due to some contract issues with Gallup, the AMA contracted with a Missouri based firm, DMR Kinetic. They had relevant experience and were successful in wrapping up the work. They found that smaller practices had a higher response rate as compared to larger practices. The bigger the practice, the more removed the physician was from the underlying numbers. The panel acknowledged concern regarding heavy capital expenditures in certain specialties.

The panel also asked, where do taxes fit into expenses in the PPIS? Dr. Gillis noted that net income is after expenses, but before taxes. Property taxes would be included in payments. The price proxy includes the property tax. More of a question is on the physician's retirement costs. After a brief discussion, it was suggested those costs are in the wages & salaries category.

The question of index theory was posed. In terms of a fixed-weight index, it has some limitations. There is only periodic availability of data, and given the weights don't change dramatically, would a fixed-weight index be suitable or should we think about something different? To move to a different type of weighting system, one would need to have a consistent method of collecting data. This particular issue doesn't seem to be a major priority since there is not a large difference in weights over time. It was suggested that the panel check to find out if the cost category weights tend to be variable across practice size and specialty, if there is a difference, then the panel could investigate further.

The panel and CMS staff contemplated and discussed adequate cost categories. The weights associated with All Other Services and Other Professional Expenses are large. The question was asked, could we pull out EHR from All Other Services? Other Professional Expenses includes maintenance, journals, marketing, and depreciation of cars, legal, billing costs, among others. Billing is probably the largest. Truck transportation is the second largest.

Costs associated with computer systems are captured under Movable Capital. The panel discussed automobile expenses, drugs and income expenses, and more specifically, separately-billable drugs and lab tests belonging to other professional services billed separately. A panel member asked if income is generated from separately-billable drugs. We do not know what proportion of income may or may not be from separately-billable expenses. If providers make half of their money on separately-billable drugs, we may be overstating the income share. It was also noted that the practice expense portion of the index includes those non-physician staff who can bill independently.

The panel noted that the weight for Medical Equipment seems low and asked why is that? It is an aggregate weight and it represents equipment costs for one year (thus making the timing of the reported purchase important). It was noted that the American Dental Association used to do a similar survey every two years. The respondents to the PPIS are encouraged to fill out a worksheet with details of the purchase prior to completing the survey.

Drugs were taken out of the MEI entirely in the 2006-based index, but there may be drugs that are not separately-billable that physicians still purchase. The question was asked, do those costs belong in the MEI?

The argument that was posited was that, although there are many drugs that are separately-billable (and therefore not paid via the PFS), there may be other pharmaceuticals that physicians need to have on hand in order to furnish services. Should these expenses be treated like any other expenses? CMS indicated that all drugs are paid outside the physician pay schedule, however, they would investigate further and report back to the panel.

There are certain categories that may need to be fine tuned, but there are no major deficiencies. Ideas that were offered included Information Technology (IT) equipment being separated into its own category. Others included mentions of drugs (as routine supplies) being expressly included, and the Rubber and Plastics category being subsumed into another category. The panel noted that categories can be collapsed, but the real issue is how the data are aggregated. There was panel consensus to consider consolidating to fewer categories and to possibly break out IT.

It was noted that costs associated with EHRs were likely increasing due to rising adoption levels. It's likely less related to rapid price changes for that category and more related to buying more EHR capability as you're introducing it and perhaps expanding it. A panelist posed the question of the possibility to do a targeted survey just for EHR to get a sense of the extent of the increase? Perhaps one could reach out to providers to get total cost growth? Much of the EHR costs are personnel costs, for example a scribe. Consequently, there may be labor costs that show up as an expense, over and above the cost of hardware and software.

The panel further discussed appropriate breakouts for office expenses, particularly costs related to office rent. The following topics were addressed: Are we under the assumption that it's an annualized cost? Yes, it is equivalent to a rent share. The Fixed Capital category has two main components; "Leasing" and "Depreciation." The leasing piece was derived directly from the I/O data and that's based on NAICS 531, Real Estate; industries primarily engaged in renting or leasing real estate, others. Of the roughly nine percentage points of the MEI being attributable to Fixed Capital, about 7 percentage points are related to the leasing component. The other two percentage points are related to depreciation, estimated from the Census Bureau Service Annual Survey. CMS noted that beginning with 2007 data, SAS began publishing leasing expenses for fixed assets and moveable assets, separately. Using this data, fixed capital costs as percent of total costs are estimated to be about 6 percent.

Panelists expressed concern over the use of the Consumer Price Index for Owner's Equivalent Rent to proxy Fixed Capital cost weight. In particular, in the most recent years, concern was expressed that although asset prices may have fallen, rental rates may have actually gone up, in part because so many people are renting.

The panel suggested thinking about grouping categories together, such as Chemicals, Paper, Rubber and Plastics, each of which is less than one percent of the total market basket. Moreover, these may not be meaningful categories for physicians. Likewise for All Other Products. Perhaps a single category entitled Office Supplies and Products or Products and Supplies.

The panel discussed payroll tax in terms of cost weights and cost categories.

Public Comments

Sandy Marks from the AMA stated: It's good to pay some attention to how the information is presented because even though the economists are coming up with these ideas, it's practicing doctors and their societies who are looking at the information that comes out of it, and it just strikes them odd, for example, to see postage broken out as a new category when everybody has moved to E-mail, and there's no cost for electronic equipment. The PPIS, I believe, was conceived to update the practice expense relative values, and that's how it was designed.

We got 7,400 responses, of which only a fraction was used. So one can't look at the cost of that survey as necessarily the cost of what it would take to do a survey to update the MEI.

Closing:

Action items for next meeting:

1. Run PPIS mean expense data on specialty and practice size
2. CMS: look into any CMS data sources related to Electronic Health Records (could these sources provide guidance on what a more contemporary IT-related cost category weight would look like?)
3. Look into the various wage and salary definitions for the different data sources used for wage and benefit splits. That is; the definition of net income & benefits from PPIS, ECEC, and IRS SOI data.
4. CMS: Further investigate the MGMA data for income and expense breaks
5. Look into the issue of including non-separately-billable drug expenses in the index
6. Should staff that can bill independently be separated out from the non-physician compensation?
7. Can we collapse categories under the office expense questions?
8. What are the resulting cost weights if IT expenses were aggregated into a single category
9. Investigate the validity that the medical equipment cost weight fell slightly from 2000 to 2006. Do other data support this trend?
10. Can we discuss the proxies that were investigated for the fixed capital component of the MEI?

Ideas to explore (long term):

1. CMS and Panel Members: Are there consulting firms that could help inform some of these issues about purchasing individual physician practices?
2. Is there value in possibly conducting (or mandating) a smaller survey with targeted 'cost-report' type investigation.
3. CMS: Investigate the possibility of adding questions to the Census Bureau Services Annual Survey (SAS)

Panel Consensus:

1. A fixed weight index for the purposes of the MEI is appropriate given that there does not appear to be much substitution across categories and over time, and given the existing data source limitations on obtaining expense data.

Meeting Adjourned

The next MEI TAP meeting is scheduled for Monday, 6/25/2012.