MEDICARE ECONOMIC INDEX (MEI)

TECHNICAL ADVISORY PANEL MEETING

Monday, May 21, 2012

9:05 a.m.

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

Diversified Reporting Services, Inc.
(202) 467-9200

PANEL MEMBERS PRESENT:

Ernst Berndt, Chair
MIT Sloan School of Management

Bob Berenson
Urban Institute

Kathryn Kobe
Economic Consulting Services

Kurt Gillis
American Medical Association

Zach Dyckman
Dyckman & Associates

ALSO PRESENT:

Bruce Steinwald
Bruce Steinwald Consulting

Rick Foster, Office of the Actuary, CMS

John Poisal, Office of the Actuary, CMS

Steve Heffler, Director,
National Health Statistics Group

Heidi Oumarou, Office of the Actuary, CMS

Hudson Osgood, Office of the Actuary, CMS

Mary Carol Barron, Office of the Actuary, CMS

Mollie Knight, Office of the Actuary, CMS

Mark Freeland, Office of the Actuary, CMS

Sandy Marks, public commenter

A G E N D A

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P R O C E E D I N G S

(9:05 a.m.)

INTRODUCTIONS AND ADMINISTRATIVE ACTIVITIES

MR. POISAL: I think we can probably get started. It is 9:05. A little bit later than we thought. I think the weather and some other things have conspired to push us back just a few minutes, although I do not anticipate we would need even the whole time to get to 9:30 for your portion, Rick.

I just want to welcome everybody to the first meeting of the MEI Technical Advisory Panel. It has been a long road to get here, but we are really tickled with the five panelists that agreed to help us out and analyze the MEI from a technical perspective.

We feel like we have a pretty multi-disciplinary view, and when we get through the process, walk out with something we all feel that much more confident in and is able to do its job.

To let everybody know, unfortunately, Ernie Berndt, who is the Panel Chair, missed his flight this morning. Apparently, by roughly 120 seconds, is what he shared with me at 7:04 this morning.

He was hoping to catch an 8:45 flight, which would put him in Baltimore in time to get here around 10:30 or 11:00. He was flying stand-by for that. If that fell through, he was thinking he could catch another flight that would get to Dulles, and the expectation there is it is going to take longer to get from Dulles to here than it probably take to get from Boston to there.

We are not sure when Dr. Berndt will be able to join us, but we are hopeful he will still be able to get here and participate for most of the day.

Why don't we go around the table and do some introductions, self introductions.

I am John Poisal. I am the Deputy Director of the National Health Statistics Group in the Office of the Actuary here at CMS. I have the responsibility for managing and directing the work associated with the Medicare Market Baskets.

DR. BERENSON: Bob Berenson. I am an Institute Fellow at the Urban Institute, and I guess it is relevant to say that between 1998 and 2001, I was at CMS, at what was then called the Center for Health Plans and Providers, which was payment policy in the traditional Medicare program and contracting with Medicare, what are now called Medicare Advantage Plans.

I am a former practicing physician, general internist.

MR. STEINWALD: Bruce Steinwald. I am a subcontractor to HCDI, who is the facilitating organization for this meeting, taking notes and doing things of that nature.

My role is to be the substance expert. Basically what that means is I am responsible for trying to capture what you folks decide in your report.

I am going to be a principal author of your report. For that reason, my participation in your discussion will not be to

suggest anything but maybe to ask to clarify certain things.

I am sure you will eventually want me to write with clarity about what you decided, and in order to do that, I may have to ask you to clarify.

MS. KOBE: I am Kathryn Kobe. I am an economist with ECS. I used to work for Joel Popkin & Co. and I did some work for CMS in the past, including some work on the MEI.

DR. DYCKMAN: I am Zach Dyckman. I am an economist. I guess I'm here primarily because my second job a long time ago was with the Office of Research and Statistics of the Social Security Administration, and I had the responsibility of developing the MEI based on some guidance from the Senate Finance Committee.

Since then, I have worked with different Government agencies. Bob reminded me we worked together when he was with the Domestic Council, and I was in the new Executive Office Building and he may have been in the old Executive Office Building.

Since then, I have been primarily in private consulting, working mostly on provider payment issues for lots of health plans, CMS, MEDPAC, some other agencies. Almost all on provider payment issues.

DR. GILLIS: I am Kurt Gillis. I am an economist at the American Medical Association. I have been there about 20 years. I have spent most of that time working on Medicare payment issues. I am very familiar with the MEI. I have also worked on our practice

expense surveys in the past, and I have worked with some folks here at CMS to provide data for updating the practice expense RBUs.

MR. FOSTER: I am Rick Foster. I am the Chief Actuary for CMS. I have been in this position for about 17 years.

The Office of the Actuary has a broad range of responsibilities. We are perhaps better known for things like the Medicare Trustee's Report, making estimates of the financial implications of Medicare and Medicaid national health proposals.

One of our most important responsibilities are the Market Baskets, updating Medicare payments to virtually every category of provider.

I will tell you in a little more detail later on how much I appreciate all of your help in ensuring that the MEI is as best as it can possibly be for this purpose.

MR. HEFFLER: I am Steve Heffler. I am the Director of the National Health Statistics Group. Our group not only has responsibility for the Medicare Market Baskets but the national health expenditures, projections of those, other economic type things. We support the Office of the Actuary and CMS.

Prior to moving into management, I was involved with the Market Baskets and specifically with the MEI.

I have been involved with various folks in evaluating some of the data sources.

I just want to echo what Rick said, appreciate all the time

and effort that has gone into getting all the paperwork out. I think the hard part is done and now we start the actual evaluation.

Thank you all again.

MR. POISAL: I also wanted to ask our staff to introduce themselves.

MS. OUMAROU: I am Heidi Oumarou. I am with the Office of the Actuary. I have been here about six years now. (Inaudible.)

MS. KNIGHT: (Inaudible.)

MS. BARRON: (Inaudible.)

MR. POISAL: Mark is not on the MEI team but he is our historical expert. You should probably introduce yourself, too.

MR. FREELAND: Zach was the original developer of the MEI, and Dorothy Rice had her name on the memo. I'm not sure what she did. He was the one who implemented it. When Congress and AMA came with the hard questions, he was the one that wrote the economic analysis. (Inaudible.)

When we took MEI over, there was some congressional requests that we do some re-basing and make changes.

STAFF: (Inaudible.)

STAFF: (Inaudible.)

MR. POISAL: Very good. It sounds like we might be having some interference from some of the electrical devices. Anybody who does not need to have it on, if they wouldn't mind turning off their electrical devices. I think that will be helpful from a

transcription perspective.

Very quickly, I want to also thank the HCDI staff for helping us to get here, working with us so closely over the last couple of months to get ready for today.

Just some ground rules for the discussion. We have a few people here from the public that signed up to come and listen.

We also have folks on the line here who are going to participate or view the webinar. No video, which is probably good, because I was always told I had a face that was made for radio. No video, I am sorry. That is probably good.

(Laughter.)

MR. POISAL: The ground rules are that we are going to ask that the discussion just be limited to the table. We do have some time that is set aside at the end of the day, about 15 minutes, to the extent anybody has any further comments they want to share. You are welcome to do so at that time.

Just to reiterate, we are asking that the discussion and the dialogue be limited to the people at the table. Again, we will have about 15 minutes set aside at the end of the day to the extent anybody has any comments from the public, and depending on how many, we might ask you to keep it short, depending on how many people step up and would like to make any comments.

For those of us at the table, one of the things that we really want to make sure everybody understands is we really want

this to be an interactive discussion. We have some good advice from Bruce when we had spoke several weeks ago.

He made the point and we all definitely agreed and said this is something that we want to put out in front of everybody.

We don't want to spend a lot of time talking at you. We would really like to go over the material and then have a discussion and dialogue.

To the extent everybody can sort of help foster that, I think that would really get us to where we are hoping to go, and get us to the results we are hoping to get.

The last thing I was going to say before I invite Rick to make his opening comments was that I have been asked to administer the oath now that you are all special Government employees. Some of you were Government employees before.

Now that you are special Government employees, at some point today, and it will be after Dr. Berndt gets here, we will literally stand at the American Flag and take an oath to be good citizens and special Government employees.

To this day I can remember standing in one of the buildings over at SSA taking my oath. I am very happy we have had it printed out and sent to us. Even though I stayed at a Holiday Inn Express last night, in preparation for today, I couldn't remember the words. To have them in front of me will be helpful.

MR. DYCKMAN: Excuse me, John. I have worked for the

Government twice and I have never done that. Could I get a picture?

(Laughter.)

MR. POISAL: Yes, definitely.

Rick, if you would like to make your opening comments.

MR. FOSTER: Sure. I do have a question for you, John. Before everybody takes the oath, does that mean they can do like any old thing they feel like?

MR. POISAL: I think it does. We are going to hold you to your own moral standards.

(Laughter.)

OPENING REMARKS - RICK FOSTER

MR. FOSTER: I do want to thank everybody again for being willing to take your time and serve on the Panel, and on behalf of the Office of Actuary and on behalf of the providers and the public at large.

I think most of you have been involved in public service in one way or another at one time or another.

For those of us who have worked in the Government our entire careers, we are used to the concept that we are sort of taken for granted after a while, but when you step back and think about it, it is a very noble thing for you all to do on behalf of the process, and we very much appreciate that.

John alluded to the fact that we have an outstanding Panel, stellar qualifications, excellent experience. We could not have

asked for a better set of folks. I think your respective areas of expertise combine very, very well on behalf of this particular exercise.

You know, actuaries shouldn't be thrilled.

(Laughter.)

MR. FOSTER: I am thrilled you are here to help out and are enthusiastic about it.

You do have many other uses that you could be spending your time on. We just very much value and appreciate your contribution on behalf of helping us determine the best possible technical basis for the Medicare Economic Index.

Let me give you a little bit of background. Most of it is unnecessary background, but I will mention it anyway.

Probably everybody in the room and everybody in the country would agree that Medicare physician payments under current law are pretty much broken.

The sustainable growth rate system got off to kind of a bad start when it was first enacted. Kurt will understand this and maybe some of the rest of you are familiar with the early background as well.

The original proposal would have been wildly unstable. We recognized that in the Office of the Actuary, and we got Congress to make some technical changes that helped with the stability issue a lot, not 100 percent by any means.

Of course, the standard to which physician expenditures were held was a very tight one, which in practice hasn't worked very well.

For every one of the last ten years, Congress has had to override the operations of the SGR because of what would have happened otherwise. They will likely continue to do that.

We are facing roughly a 27 percent decrease in physician payments come January 1, in the absence of legislation to change it. Nobody thinks that is plausible. They will get changed again.

Maybe someday the SGR itself will get fixed in some more appropriate way.

In the meantime, we have this problem that the law doesn't work very well, and it is expensive to fix.

There have been suggestions from various quarters that a way to address the problem would be to sort of reinvent the MEI, to make the MEI something that it has not been in the past, but to do so in a way that would make the physician payment updates more reasonable.

There might be a lot of people who would like to see something like that happen, but our job in the Office of the Actuary and Government at large is to apply the law, even if the law is not so hot, and this is not.

We don't get the choice. We don't have the option of sort of finagling definitions to get around a law that is not working.

This is all in the way of background. In the charter for the Panel, it is laid out very specifically that your job is to look at the MEI, at the cost categories, the data underlying them, the prices that are used for estimating price increases in each of these categories, how all this fits together, and to help review an accessible approach for the Index, whether there are possible technical improvements, things like that.

I bet we could have a really fun discussion of how we should fix the SGR, and you may or may not be able to help yourselves in that respect. That isn't the purpose of this Panel.

It's not a bad idea to have another panel that would be policy oriented and not technically oriented to evaluate the SGR. That is not your immediate work.

(Inaudible.)

MR. FOSTER: You have all been selected for the Panel based on your expertise with the Index theory, with data, productivity measurement, all of the above, definition, practice costs, you name it.

That is my lecture on the background.

I will give you one more lecture and then we will get to a couple of presentations.

This isn't really a lecture. This is how I personally would like to see you all work. You all can work together any way you figure out, which is fine.

My suggestion is this, each of you have your own area of expertise. Each of you are a true expert in one or more categories. It might be a little tempting for one expert in one area to just go by what another expert in another area says. That would be natural and even sort of normal.

What I would recommend is that all of you engage actively on every aspect that you discuss, even if you are not the foremost expert in that area. You have a room full of experts, which is great.

If you all focus on each of the elements, if you all think about it, just from your own logical abilities, and you work to come to a consensus on what is the best approach, then based on past technical panelists for Medicare and Social Security, that is what has worked best, that everybody is involved in all the aspects that you look into.

That is just my two cents worth of advice. It goes without saying you will be objective about this process. We fully expect that and have no qualms whatsoever.

What I am really looking forward to most is the insight that you all will offer and your abilities and your discussions, your thoughts about what can we do to make this the most appropriate and best Index possible for the purpose for which it is designed.

I will stop lecturing at this point. I would just reiterate thank you all so much for everything that you will do on

our behalf and everything you have done to date. Thank you all.

MR. HEFFLER: Do any of the panelists have any questions or process issues?

(No response.)

MEI OVERVIEW

MR. POISAL: A few weeks ago, we had sent out to the panelists an overview that describes the Index, talks a little bit to the history, the underlying bases for the Index and the data we have used, some of the results, different evaluations that the Index has been subjected to over the years, et cetera.

I would ask that everybody go ahead and read through that and give it some thoughtful consideration in preparation for today.

What we thought we would do is just very briefly hit the high points of that document as a way of refreshing everyone's memory on the contents, speaking a little bit to what is the MEI and what is its role in updating payments.

At the end of the day, all of this is geared towards updating the Medicare physician fee schedule.

Rick pointed out there are things that are broken along the way, but ideally, what the Office of the Actuary is interested in is doing our best technical job to make sure that the way the fee schedule is updated would reflect the most appropriate technical work and basis.

The fee schedule itself, of course, everybody knows is just

a listing of fees that Medicare pays to physicians and other providers for Medicare.

It is updated annually by the SGR. Listening to you speak, Rick, sometimes I would think the SGR might be a four letter word instead of a three letter acronym.

What is the SGR? The SGR was born in Section 1848 of the Act. It establishes these yearly spending targets for Medicare payments for physician services. It was originally intended, as Rick alluded to, to sort of control the growth in aggregate Medicare expenditures for physician services.

It is a complicated formula, and this is really the easiest way and sort of the broadest way and lays it out in a way that I can sort of understand.

There are four kind of main components to help determine what those targets are on an annual basis.

The first is changes in Medicare fee for service enrollment. To the extent enrollment goes up, the target would move accordingly. That is intended to really reflect like an utilization or use measure.

The second component is changes in GDP. That is intended to pick up both utilization as well as intensity, and act in that way to influence the target levels.

The price piece, and that is where our focus is for this Panel, the price piece is the weighted average change in the MEI and

the clinical lab fee schedule update.

It is a weighted average of the two. The MEI reflects about 95 percent of that average. Again, that is the price measure that helps move the target.

Finally, to the extent there are applicable changes in law, those as well would help determine what that target is.

Where do we need your help? We solicited for nominations. We got some outstanding submissions from the public. We landed on five excellent representatives.

We are here to ask for your help in analyzing the technical aspects of this Index. When we think about where we really wanted you to focus, there are four main categories here as well.

The cost categories themselves, are they the right categories, do they really reflect what we need them to reflect.

The calculation of accurate cost weights. For each of the categories, there is a share, a cost share. Are those weights in the right place, are they calculated the right way, do they reflect expenditures shares at the national level.

The assignment of relevant price proxies, we are going to ask you to look at. We have to pick certain proxies that we use to measure price change for what physicians are incurring in terms of their costs, and are the ones we are choosing the right ones.

Finally, application of an appropriate measure of productivity. The Index has had a productivity adjustment built in

since its inception. It still does.

We would like for you to look at it critically and help us determine is this the right measure that we are using or are there things we should maybe consider that might be different.

Just briefly, to reiterate Rick's point, anything that goes sort of beyond the MEI itself, the technical aspects of the Index, sort of more towards Medicare physician payments, those types of things, really take us beyond the technical scope of our Panel and into matters of policy, and that sort of takes us beyond where we need for everybody here to go.

What is the MEI? It was born in Section 1842 of the Act and stated prevailing charges shouldn't exceed the level from the previous year except to the extent the Secretary finds on the basis of.

That is the role the MEI has served, to help justify and limit the extent to which payments would increase on a yearly basis.

The Index currently reflects a weighted average price change or weighted average annual price change for the various inputs that physicians need to purchase themselves in order for them to provide the services they provide. It is a fixed weighted price index, and again, it has this adjustment for productivity.

The productivity adjustment effectively converts the Index from an input price index to an output price index. That is sort of analogous to the CPI.

The Index has been around for a long time. The Index was required by Section 224 of the 1972 amendments to the Social Security Act. I was two years old at the time. President Nixon was in office. Zach was still working for the Government, but he hadn't taken the oath, so now we have to question the beginnings of the Index, I think.

(Laughter.)

MR. POISAL: The Index was first published in June of 1975 and effective that summer for services furnished after that date.

To pick on Zach again, we really are fortunate to be joined by Dr. Dyckman as one of the original architects of the Index. Zach is going to take us through in just a few minutes a brief walk down memory lane so we can go back and sort of examine the issues that were influential at the time.

Many Administrations later, the Index has gone through and been updated and revised many times over the years, in the 1980s, the 1990s. We analyzed the productivity adjustment in 2003. We will get into that a little more soon.

Revised in 2004 with a 2000 base year, and then we sort of come up to the current time. 2011 is the year in which the most recent version of the Index took effect, calendar year 2011, and it is in place for calendar year 2012 as well.

It is based on data from 2006, from a physician practice information survey. We are fortunate to have Kurt. Dr. Gillis is

going to walk us through a little bit of background with respect to that survey and the underlying data and the questions and so forth. We worked very closely, as Kurt had mentioned earlier, in setting up the weights.

Then we will focus on the four components that we walked through a few minutes ago, the categories, the weights, the proxies and the productivity adjustment.

Today's focus really is on those first two categories, the categories and the weights is where we are going to sort of ask everybody to narrow their focus, and we will address more fully the proxies and the productivity adjustment at a subsequent meeting.

Jumping into the cost categories, we really think of the Index as having three pieces, physician compensation piece as well as the practice expense piece.

Under the physician compensation, that is where we are capturing the physician wages and salaries as well as benefits. We only include data for self-employed physicians, but to the extent they have other physicians that work for them, their wages, salaries and benefits information is captured in this category as well.

Under the PE portion, practice expense portion, we have other sub-categories such as non-physician compensation, things like nurses or office managers or others that might be employed in the office.

Sort of general office expenses, professional liability

insurance, malpractice insurance, medical equipment, supplies and materials, and some other professional expenses that we also pick up.

One brief note about the current Index, the 2006 based Index that went into effect in calendar year 2011, we removed prescription drugs and separately billable supplies from the Index cost shares a couple of years ago when this was implemented for a few reasons.

One is neither is reimbursed on the physician fee schedule, so we felt it would be appropriate to remove those.

Additionally, for drugs, those were removed -- prescription drugs were removed from the calculation of the way the SGR was determined, and we felt we needed to be consistent with that as well.

Finally, the physician practice information survey or the PPIS, was detailed enough that it allowed us to accurately identify and determine the costs associated, and we were able to remove them as well.

All of those things sort of conspired for a change.

This is the Index. This is where me and my team live often, many hours. You will see this slide multiple times.

I draw your attention this first time to the left hand column, to the red writing. Those are all of the current cost categories that are found in the Index.

You will see physician compensation, practice expense, and then you can see the sub-categories that underlie those two main categories. We will be moving later this morning into a much more detailed analysis about how those were selected and determined and so forth when Heidi Oumarou walks us through how we sort of landed where we landed.

One of the other suggestions that we got from Bruce that we really appreciated and said you know what, that is a pretty good idea, let's make sure we do that, was to sort of be explicit about where can you help us. His recommendation was don't have everybody guess, ask where you need help. That is a great novel idea, let's do it.

These are the types of things. Periodically, you are going to see questions when we are showing the types of things we are showing and sharing information and data to say you don't have to necessarily speak to these, but these are the types of things that we would find helpful.

When you think about the cost categories and if you look back at those and really get under the hood on what they are and what they mean, do these categories represent or reflect 21st Century delivery of physician care, are they the right things.

Are there things that are missing that we really should be more mindful of and make certain we include the next time the Index is re-based and revised.

The second main component, as you might suspect, is highly related to the cost categories themselves, the category weights, or the shares of expenses that each category represents.

We use data primarily from the PPIS that Kurt was able to share with us to determine the primary cost weights, but there are levels underneath the aggregates that we needed to rely on some other sources to try to help us reach a final level of granularity for the Index.

We leaned quite a bit on some data from the Bureau of Economic Analysis in the input and output tables, which is also data we use very extensively in just about all the other Medicare Market Baskets.

We relied on some Census data, CPS, current population survey, some data from BLS, which we are a heavy user of BLS data with respect to the Market Baskets.

Employment costs for employee compensation survey as well as some IRS data, income data.

We will get into later how these data sources helped us to further disaggregate some of the higher levels from aggregate weights that we were originally provided.

Here is that slide again for a second time, drawing your attention to the right hand column in red, with the associated cost weights for each of the cost categories.

One of the things you might note is that the physician

compensation category, just over 48 percent, is less than half. If you followed the Index over the years, you probably noticed that when we re-based in calendar year 2011, this was a movement down from the 50 percent barrier.

It used to be that the physician compensation represented just over half of the Index's total weight, and now that figure has gone to just under half, while the practice expense piece has now exceeded the 50 percent barrier, is nearly 52.

We will go through those again in more detail and ask you to look critically at what those weights are and to the extent you have feedback, we will be eager to get it.

Some of the cost weight questions for you to consider, are the weights associated with those categories reasonable for national level weights. Should the weights themselves remain fixed year to year.

Are there other data sources that you might suggest to us would be an improvement over those that we used for the 2006 based Index that we implemented in 2011?

Are there concerns even with the use of using data for self-employed physicians?

I think Zach is going to mention a little bit about the history, about why we have self-employed physician data that has been underlying the Index for years.

To the extent data issues weren't really in the way, how

frequently should we be re-basing this Index?

I can tell you on the MEI as well as on the other Medicare Market Baskets, the cost shares themselves don't tend to move very much over four and five year periods, sometimes even longer, but as I mentioned, when we got to the cost weights, they can change, for instance, the physician compensation and PE weights, sort of flipping sides of the 50 percent barrier.

The third component is price proxies. We use a variety of different price proxies in the Index. We use producer price indices or PPIs. These measure price change at the intermediate or final stages of production.

These are really our preferred proxies for physician purchases, and really for just about all the Market Baskets generally speaking.

It just kind of reflects the product's first commercial transaction. That tends to be the one that seems most technically appropriate for our use.

Occasionally, we will lean on CPI, Consumer Price Indices. These, of course, measure changes of prices of final goods and services.

There are really two circumstances by which we would lean on a CPI. One would be there is no appropriate PPI for us to use. There is also situations where we might think this particular category is something that is probably purchased at a final point of

sale and used as an input for services, so if we find that is the case, we will lean on a CPI as our price measure.

In the MEI, we also use average hourly earnings. This is the price proxy that we assign to the physician wages and salaries. These are available for both production and non-supervisory workers in certain industries, but it is also applicable and available for the non-foreign business economies, so it is an economy wide measure.

It is just calculated by dividing first payrolls for wage and salaried by total hours, but what is important about this that we found is it reflects the shift in an employment mix.

To the extent things are moving around in the economy, the AHE is going to pick that up, both for certain industries as well as for the economy at large, and again, the non-foreign business economy.

The other proxies that we lean on here are employment cost indices for wages and salaries. These are a little bit different than AHEs. These measure the rate of change in employee wage rates per hour, but they are not impacted by changes in the employment mix, so it sort of holds that mix constant and just reflects the changes in the wage rates.

We use comparable ECIs for employee benefits, sort of the same kind of thing. These ECIs measure rates of change including cost for different benefits, including our Social Security taxes,

pensions, insurance benefits, et cetera. It is a whole myriad of things that are captured there. Again, this holds the mix constant, so it sort of focuses in on that per hour focus.

The slide once more, now drawing your attention to the middle column, the price proxies. As you examine that slide, you will see the AHE is assigned as the proxy for the wages and salaries there for physician compensation. Then we use an ECI for benefits, for the physician benefits' piece.

ECI wages and salaries are in the middle there. That is for a non-physician compensation. We break those into multiple categories based on the data sources we mentioned a few minutes ago, to try to make sure we can sort of disentangle what that composition looks like.

Then we have CPIs and PPIs there for the bottom half.

One thing that I would note for you and that we will be getting into a bit more down the road is our professional liability insurance category there, fourth from the bottom, the price proxy that we use there we refer to as the CMS professional liability for physician premiums.

We go through a process where we literally reach out to insurers and ask them to voluntarily submit their premium data for their physician professional liability insurance.

We will get more into detail there. That is sort of a stand-alone price proxy that is a little bit different than the ones

we use from other public sources.

Some of the price proxy questions we would be happy and eager for you to keep in mind as we focus on that at subsequent meetings, are the price proxies used in the Index appropriate? Are there others we really should be considering?

Are the proxies used for physician's earnings reasonable and consistent with congressional intent, and does the method used for determining the PLI price changes, does that seem reasonable?

Again, we will get into that a little bit more down the line about reaching out to these commercial insurers and applying our observations and calculations across the board for that measure for the Index.

A fourth component is the MEI productivity adjustment. Here, as I mentioned earlier, the Index has included this productivity adjustment since its inception back in the 1970s.

The reason it is there is primarily it helps to remove double counting of productivity. If you think about it this way, when we apply economy wide wage growth or wage observations to the Index, those wage growth rates already include the productivity, and you also have the physician who will be productive in their production of providing services that he or she delivers.

To the extent they are productive themselves, they also generate that sort of self based productivity.

The application of an economy wide measure helps to remove

sort of that double counting of productivity.

We have always used an economy wide measure, largely because that is consistent with the use of economy wide wage measures that are the price proxies that are used for those components of the Index.

Notably, in 2003, we did change from a labor productivity adjustment that was applied to just the labor components of the Index to a multi-factor productivity measure that is now applied to all of the categories.

Finally, and I think it was the first time I met Kurt, but I guess it was back in 2006, the conference, and in 2007, the publication, but we had done a fairly recent evaluation of physicians as a group and their ability to be productive, and how that related to the economy as a whole.

We generally found that physicians were generally able to approximate that. We will be getting into this subject in subsequent meetings to go over it.

There were some links in some of the materials that we provided. The panelists will have those to look at when they are able.

The productivity adjustment questions we would ask you to keep in mind. One is it reasonable to continue to expect physicians to achieve an economy wide MFP and is it reasonable to continue to adjust the Index in that way.

Are there other measures that we should be considering that you guys feel might be more appropriate or a better approximation of what the Index should really reflect.

My second to last slide is just to say here's what it all equals over the last ten years. You have the Medicare Economic Index update factors there, just as a basis for comparison, the CPI.

You will see in some of the years, the MEI was higher and in some of the years, it was lower. The last couple of years, the updates have been below one percent with 0.6 percent being the most recent update.

This is sort of how everything has kind of come together with the categories and the weights and productivity adjustments and so forth, providing these MEI update factors over the last decade.

Finally, just a brief reminder about what today's focus is. We are really going to be concentrating on the categories and the weights. As you can imagine, they fit real nicely together. Then we will really get much more involved in the discussion of the price proxies and the fee adjustment as we get into our next meeting or meetings, as the case might be.

I think that is it for my part. I would invite any questions or clarifying questions about anything we just went over or things you might want to have in your arsenal before we start with our walk down memory lane with Dr. Dyckman.

DR. BERENSON: I have a question but it may be relevant to

Zach's presentation. There is a huge variation across practices, in the mix of capital and labor. That is going to increase, I expect.

I am sort of curious as to whether there has been any sort of creative thinking to be able to capture that. The main issue is -- let's just take a hypothetical, that all cardiologists are employed by hospitals. That is a bit of an exaggeration.

How do we get the representativeness of practices to represent that average if there is no other way to deal with the variations?

MR. POISAL: I think that is probably more germane to Kurt's presentation, when we get into the PPI and what it is and what we are not sort of planning to do in the future, at least at the moment.

Those are exactly the types of questions we think we should be discussing.

I would note in this regard, the MEI is like the other provider types, in that when we pull the Market Basket data together, it is always at the national level.

That is what those weights reflect, but we recognize definitely that different providers have different cost structures, but the goal has always been to try to get the best nationally representative one we have.

DR. BERENSON: That puts a high premium on getting the right representative.

MR. POISAL: Indeed, it does.

DR. GILLIS: One comment about one of your earlier slides. You could say right now the MEI doesn't have (Inaudible.)

MR. POISAL: Correct. It is good to not be completely irrelevant.

(Laughter.)

MS. KOBE: Is somebody's presentation going to cover why certain choices are made?

MR. POISAL: There will be. I know Dr. Dyckman is going to talk a little bit about sort of where we started.

MS. KOBE: That would be helpful to understand that.

MR. POISAL: Yes. To the extent we need to speak to price proxies because that will help inform the cost categories and cost weights' discussion, by all means, we should talk about those things.

I think Zach is going to speak to some of the beginning, and then we will move more -- we will talk about the underlying data with Kurt, and then Heidi is going to speak about how all that flowed into the current version of the Index, and why we have what we have.

MS. KOBE: Okay.

MR. POISAL: Very good. Zach?

HISTORY AND EARLY DEVELOPMENT OF THE MEI

DR. DYCKMAN: Good morning, everyone. I am Zach Dyckman,

as you probably know already.

I will be talking about the history and early development of the MEI. The MEI developed as a result of legislation in 1972 to develop some sort of an index to limit what may have been viewed as inappropriate growth in Medicare physician fees.

It is useful to understand what Medicare physician payments looked like in 1972, why did Congress feel the need, why did the Administration feel the need to implement an economic index to limit growth in Medicare physician fees.

For the Medicare fee for a particular procedure, it was the lowest of the submitted charge, the bill charge, the physician's customary charge, and that is what the particular physician charged in the previous year. I believe it was the median charge during the previous calendar year probably.

Even though a physician's charge might have been not very high compared to other charges, but they didn't want to immediately recognize very large increases in individual physician charges.

The third item was the prevailing charge of "peer physicians in a locality" and the prevailing charge was defined as the 75th percentile charge, if you were rating the charges from lowest to highest, the 75th percentile.

This methodology was not very different than many private insurance plans used or many Blue Cross/Blue Shield plans, some commercial. The Blue's tended to have the largest market share at

the time. Some of them used a variety of other fee schedules.

Sometimes there were income related fee schedules, if members had an income that did not exceed a certain level, it might have be $5,000 a year then or whatever, then there was a fee schedule applicable, but if not, and the patient's families' income was above that, then it was often based on a prevailing charge methodology, and there was a lot of variation.

A prevailing charge methodology tended to be the way the private insurance paid for health care, and when Medicare was developed, it sort of replicated what the private sector was doing in terms of physician payment.

Shortly after Medicare was implemented, it became obvious that for some physician services and for physician services in general, in the aggregate, there was relatively rapid inflation and unchecked inflation in Medicare physician fees.

It is important to realize that when you have most people covered by insurance, you don't have strong competitive market forces to hold down fees, hold down prices.

You didn't have market mechanisms to hold down charges at competitive levels, and Medicare fees were going up much more rapidly than general inflation, and the prevailing view in Government at the time and Congress was that we needed some sort of an index to limit growth in physician fees to reasonable or appropriate levels.

The legislation provided minimum or virtually no guidance at all. It required the development of an appropriate economic index to limit the growth of Medicare physician prevailing charge levels. That is what the legislation said.

The Senate Finance Committee report was written, which provided a lot more guidance. The prevailing charges should increase only to the extent justified by indexes reflecting changes in the operating expenses of physicians and in earnings levels. That is the charge.

Earnings levels should reflect general earnings levels in the overall economy.

Expense and earnings indices should be determined based on available data. They did not want the creation of new data which could be costly or certainly would delay the implementation of the Index, that reflects the experience of self-employed physicians.

I think there are a couple of good reasons why the focus was on self-employed physicians. First, there were hardly any other kind at the time. It was illegal for physicians to work for non-physicians in a number of states, and as a matter of reality, the overwhelming proportion of physicians were self-employed.

There were some hospital based physicians, pathologists, that were not. For the most part, for most specialties, hardly any physicians were not self-employed. There were some employed either in groups, small groups, larger groups, or individuals. They were

generally self-employed.

Over the long run and perhaps in the long run now with our efforts, we are supposed to seek the most refined indexes that can be developed.

It is of interest that the Senate Finance Committee language spoke about a limit to be applied to an aggregate increase in prevailing charges.

We will get to what that means or what it might have meant in a few minutes.

Rather than to every specific fee and every locality, it was intended to limit growth to the aggregate.

One thing I should have noted earlier when we talked about locality is there are carriers now, Medicare carriers, but I don't recall if there were 40 or 50 carriers at the time, and they each defined the peer group as they thought reasonable.

Many carriers would have prevailing charges by specialty. That was probably more typical. The specialty categories were not consistent. They could vary in terms of grouping and how specialties were defined.

At the time, physicians could self designate their specialty. That was quite common. You could become a specialist by calling yourself a specialist.

In terms of locality, there was no definition. It could be a municipal area, an SMSA. It could be state-wide. It varied by

area; even guidance, as I recall, from the federal government in terms of how carriers were to implement the rules regarding locality and peer group for physicians.

Next slide, please.

The task of developing an Economic -- Medicare Economic Index -- it wasn't called the Medicare Economic Index until later, just an Economic Index -- was given to the Office of Research and Statistics for the Social Security Administration, which administered Medicare at the time, and I was a -- actually, it was my father that did this. I didn't do it.

(Laughter.)

MR. DYCKMAN: I was a young economist. As Mark indicated, both was pretty correct. I had a background in labor economics, so I knew something about wages and productivity and employment and CPI and BLS data. I was not a health economist. There were very few health economists at the time. I sort of became a health economist a couple of years before this when I -- when Dorothy Rice, who some of you may know, hired me and called me a health economist.

(Laughter.)

MR. DYCKMAN: The initial recommendations from the Senate Finance Committee report was a 60 percent weight for physician earnings and a 40 percent weight for expenses. There were a couple of different data sources for those weights. One was IRS data and the Senate Finance Committee report recommended using IRS data, but

I looked at initial -- an early paper that I did and I recall now I had problems with use of IRS data because at the time, there was a relatively dramatic shift going on from self-employment to incorporation of physician practices and you didn't have random -- there wasn't random movement of physicians, but physicians who had the highest income tended to move to a corporation, and it made more sense economically for them to do that, and they had different expense income weights than those that were left behind as self-employed. So I sort of pushed against the use of IRS data.

The other data source, as I recall, was a survey done by a -- well, the trade magazine Medical Economics. They did an annual survey of income and expenses, and in general, the data suggested something very close to a 60/40 percent weight over the years. So that was implemented and actually stayed around for quite a while.

For earnings, the measure of proxy VAT I thought was most appropriate, and when I say "I," we didn't have panels. I had the responsibility of doing this and I did the best I could, you know, under the circumstances, and the index that I thought was most appropriate for earnings -- for broad based earnings was average hourly earnings of production and nonsupervisory workers.

I did consider weekly earnings rather than hourly earnings. In fact, I -- in looking at the issue paper I developed, I -- one was an option, weekly or hourly, but I gave stronger arguments for hourly, but weekly certainly was being considered. And there was no

discussion in the Senate Finance Committee report about any productivity adjustment and having some experience with wages and labor economics, I understood that wages included generally price change and productivity. So I thought it was appropriate to net out productivity, the productivity changes, and the one I selected was the output per manpower of employed nonfarm workers. Again, a broad measure of economy wide labor productivity. It wasn't multi-factor productivity. I don't know if that concept existed at the time. I still have no recollection of it.

MR. POISAL: Yeah, it did not.

MR. DYCKMAN: For expense weights, which is the 40 percent, the largest expense was salary and wages and I proposed use of nonsupervisory workers in finance, insurance, and real estate, which is a broad measure of sort of clerical/semiprofessional workers that physicians tended to hire. I remember being surprised initially that medical staff was not -- trained medical staff was not a major component of physician employees. The largest labor category and expense category for physicians was clerical, accounting, receptionist, and things like that.

For office space, we used the housing component of the CPI. There may -- I don't recall -- I didn't find a better measure. Maybe it existed, but this is what I selected. Auto expense tended to be a recognizable expense category. For that, the private transportation component of the CPI, and I think that was pretty

good.

Drugs and supplies, the drugs and pharmaceutical component of the wholesale price index, which is now the PPI, and for other expenses, we had to figure out -- I think about 1/3 of the 40 percent was miscellaneous other expenses, including malpractice insurance, by the way, and spent some time thinking about what's best and maybe because it was simple, but because I didn't have a much better -- any other better measure, I proposed use of the overall CPI.

Oh, this was in 1973. I believe I left the Office of Research and Statistics and went to another area within Health, Education, and Welfare sometime in late '74 or middle of '74 or so and I didn't -- I was not around for the final refinement and implementation of the MEI. I may have been consulted. I don't recall, but I wasn't involved on a daily basis certainly. I think Peter McMenamin may have been the one that had primary responsibility at the time.

The actual MEI -- and it was supposed to have been implemented for fiscal '74 -- it was not developed, agreed upon -- various constituencies that had an opinion gave their opinion and it took time and it was first implemented in July 1975 for fiscal '76. So there was a two year delay.

Average weekly earnings was used instead of average hourly earnings. I had a problem with average weekly earnings because it

reflected business cycle developments. If we were going into a recession, that could actually decline. If we're coming out of a recession, it could go up quite rapidly and my preference was, therefore, to use the hourly, but somehow weekly earnings was used instead.

Interesting, the -- all of the expense categories and BLS sources that I had recommended a couple years earlier were, in fact, used, and in fact, they were used for many years thereafter. I -- maybe the selection wasn't all that bad or once something got implemented, it was hard to change things, lethargy, but they continued.

In 1974 or '75, malpractice became a big issue and it's interesting, there's a lot of emotion regarding malpractice insurance. It was never a large expense category. I don't think it ever exceeded 5 percent and it may have been three percent at the time, but it was highly variable by specialty and highly variable by locality. So there was some physicians in certain localities that had very high and sharply rising malpractice costs and others didn't, but those that did felt, quite correctly, that the Medicare Economic Index didn't reflect their cost experience, and so quite appropriately, HCFA at the time or Social Security Administration did a survey of malpractice carriers and developed an index just of malpractice insurance. I think Ben Dutton did that. So that was the only change from the structure that was developed that I had

proposed in 1973.

And, in fact, this shows the early years. The MEI, it sort of was intended as a rolling index, so if in some year prevailing charges didn't go up as much as the Index, you could use what was left over from the previous year. So I'm showing the MEI growth. In 1976, it was 1.18 compared to the base year, which was fiscal '73, and you see the rates of inflation, which are considerably higher than exist today. So inflation was a real factor, and if the MEI had not been introduced, we -- instead of the sort of between sort of 6 and 8 percent that you tend to see for the annual percent change in the MEI, it might've been 10, 11, 12 percent because physician charges were going up quite rapidly.

Just to go back, some of the primary uses in the design and implementation of MEI, one is the limited data sources. In terms of weights, we have the IRS, which I -- you know, that could give you the aggregate weight between expense and income and I think over time, that became less and less reliable and it was less reliable when I looked -- it was becoming less reliable when I looked at it. So the magazine Medical Economics did their annual survey. They had a very low response rate, so there was concern about the accuracy of that. I believe shortly thereafter, I think 1974 may have been the first AMA survey of physician income and expenses and it may have been as a result of the MEI legislation because they felt there wasn't good data and they surveyed physicians, and Bureau

of Labor Statistics data that I used were not directly applicable to physician practices.

Now, Bob made a good point, and this was a concern of mine at the time and it remains a concern, perhaps even greater now than before, that physicians based on specialty, based on who they're employed by, have very, very different expense weights and one average may not reflect the actual weights and cost experience of very many physicians and it's highly variable and that's a concern, but at the time it was very clear that we were supposed to develop a single economic index, not specialty specific. There was concern about localities, but not -- certainly not specialty and, you know, that was our charge. But it was a concern to me then, as I recall.

The instructions and guidelines from the Senate Finance Committee report were to some extent limiting. They were -- you sort of were supposed -- I remember when I first took on that responsibility or was given that responsibility. The instruction was, "Well, here's your guidance." Well, I had some problems with some of the guidance.

The aggregate increase in prevailing charges, there were some suggestions that -- in fact, the Index was implemented as a cap when it was implemented in '76. If the Index was five percent and prevailing charges were -- had gone up by seven percent, it was limited to five percent. It was three percent. It actually went to five percent. No, no, no. I'm sorry. It was limited to what it

was, but there was some sense by some examples that if it varied among localities and specialties, you would apply a ratio. You would take the -- if the aggregate -- if the Chief Actuary, Mr. Foster, came out with an estimate of prevailing charge increases for the previous year and that was six percent and the Index was four percent, somehow you would take a ratio of four to six percent or 2/3 and allow 2/3 of the increase in prevailing and there was some confusion about that, and in fact, it was implemented as a cap, which I think is a better idea.

And as I indicated, the IRS physician tax return data, they were strong on that and I had a problem with that and I pushed back and we didn't use that, but we had to work within the existing Medicare payment methodology and that meant -- you know, right now we have the RBRVS system, which, you know, is somewhat of a reasonable structure in terms of resource costs. There's criticism of it, but it's a lot better than a charge based system, which -- where fees had more to do with economic -- relative economic aggressiveness of physicians with different specialties in different localities than anything else. So you had a lot of fee inequities by specialty, by locality, and that was incorporated in the methodology. That was -- in fact, prevailing charges that existed in 1973 tended to be a driving force or the primary force in terms of what fees were five and ten years later because the MEI sort of capped things. Generally charges were above the caps, and

whatever structure you had in '73 was retained and often it was not a rational structure. It just was the prevailing charge structure that existed based on the carrier's determination.

And something else to realize, at the time there was a concern about the impact on Medicare patients because physicians did not have to accept assignment and physicians could balance bill patients. The Medicare patient -- if a physician wanted, the Medicare patient -- the physician could say to the Medicare patient, "I don't accept Medicare fees. You get the payment from Medicare. My charge is $80 for the visit. You got to pay $80," and in fact, lots of physicians did that. Some physicians did that for some patients and not others. The higher income patients they would not accept assignment for. The lower income patients, they did, and whereas nationally the average might've been 60-70 percent in terms of assignment, there were a number of states where it was less than 50 percent. So if you were -- there was a concern if you were too restrictive in terms of the Medicare Economic Index, it could exacerbate the problem by pushing more physicians into not accepting assignment. So that was -- it was a concern and I remember discussions about that and that was a factor that was a consideration at the time.

I think that was the last slide, isn't it? Yeah.

Any questions or comments? Thank you.

MR. POISAL: Thank you. All right. Well, it looks like

there are no questions. Why don't we plan to take a 10 or 15 minute break?

(A brief recess was taken.)

MR. POISAL: I think we'll reconvene. Just to let everybody know, too, the eagle has landed. Zach is within drive -- or Zach -- Ernie is within driving distance of here and is apparently in route. So before we move on to any of the other -- or the next presentations, just questions?

STAFF: Yeah, actually, I had a question for you, Zach, about the productivity adjustment and the application of that to the earnings piece and I think my recollection on this is right, but it might not be, which is originally it was an annual -- it was the annual change --

MR. DYCKMAN: Yes.

STAFF: -- in productivity as opposed to the moving average and I don't know if -- was there any thought about the timing issues of relating changes in wages to changes in productivity, you know, given the relationship there or just if there was any background about just the issues of using annual data versus kind of longer run averages?

MR. DYCKMAN: I don't recall that.

STAFF: Okay.

MR. DYCKMAN: As I indicated, I had preferred the use of hourly data, which -- well, in terms of productivity, that was

always the -- it was the earnings --

STAFF: Per hour, right?

MR. DYCKMAN: -- that was -- I don't recall that, to be honest.

STAFF: Okay. Okay.

MR. DYCKMAN: We were looking at gross questions and that's more a refined question.

STAFF: Yeah. Yeah.

MR. DYCKMAN: Yeah.

STAFF: Okay. Thanks.

MR. FOSTER: I also had a question if you don't mind, but I was in and out of Medicare over the years before coming here to Chief Actuary, so I don't remember all the history as well as I might like to, but I know the MEI got started, as you described it, way back then as this limiting value for one of the -- the prevailing charge factor, and do I remember correctly that over the years, like when RBRVS came along and then the SGR and anything in between, that each time congress basically then referred to the same provision with the Economic Index as the indexing factor?

MR. DYCKMAN: Yeah, it was always part of it, and of course, as you indicated, increasingly it's become less important or practically irrelevant over the last 10 years or so in terms of setting fees, but it was always -- it appeared to be an essential component of it.

MS. KOBE: Am I correct in understanding that the original 60/40 split, that was a recommendation from the report or was that actually -- was that also a reflection of reality at that time or --

MR. DYCKMAN: It was a -- I think the report may have said assume that it's 60/40, and in fact, when we looked at data, it varied like between 58 and 62 percent.

MS. KOBE: Uh huh.

MR. DYCKMAN: So it was a reflection of reality based on the available data.

MS. KOBE: Uh huh.

MR. DYCKMAN: And going back to Bob's issue with specialty, highly variable by specialty, but, you know, we sort of sensed that, but we couldn't use that information anyway. So --

MS. KOBE: Right.

MR. DYCKMAN: -- so we didn't look into that further.

MR. STEINWALD: The fee schedule came in 1992. The RBRVS was 1992.

MR. POISAL: I think you're up. Would you like to sit here or would you prefer that I move your slides on your behalf?

MR. GILLIS: You can do it, but I thought I saw your page up there had a Blackhawk.

MR. POISAL: Oh, it did. Yes.

MR. GILLIS: Are you sure?

MR. POISAL: So --

(Laughter.)

MR. POISAL: Yeah. No, that's interesting. My -- but I told you we went to Chicago a couple of times and my family went with me the most recently and so we went to the Blackhawk store, and as a hockey family, I felt kind of obligated that we needed to go there, and my daughter, who doesn't play, was with us and she was nine years old, eight years old at the time and they had the goalie equipment from -- Nikolai Khabibulin's goalie equipment that was for sale and the pads -- his goalie pads are, you know, this big, and so I said, "Marisa, come stand behind these pads," and so I'll show you when we exit out of here, but, yes, that's --

(Laughter.)

MR. POISAL: -- she's got all the Chicago Blackhawk's --

MR. GILLIS: Oh, okay.

MR. POISAL: -- equipment and like hockey equipment does, her -- everything kind of -- we needed to go wash our hands quite a bit after we were done, but --

(Laughter.)

MR. POISAL: Anyway --

PHYSICIAN PRACTICE INFORMATION SURVEY

MR. GILLIS: Okay. John asked me to just provide a little background on the AMA's last practice expense survey and I wonder if that's the right word or whether I should call it the most recent practice expense survey by AMA and whether it really is the last

one.

So it was known as the Physician Practice Information Survey and it was jointly funded by CMS and the specialty societies and AMA and it was fielded in 2007-2008 and collected 2006 practice expense information. It was costly. I don't know exactly how much it was. I didn't end up finding out. It's somewhere around $2 million or a little more than $2 million. I don't know if that sounds right and, you know, that's just the direct cost to the contractor, not all the time that was spent on staff at CMS and AMA working on the survey.

The primary purpose was to update the practice expense per hour figures that were used in calculating the practice expense RVUs in the physician fee schedule and also to update the MEI weights.

We hadn't fielded a practice expense survey since 2001 and that was actually an abbreviated survey. It didn't have all of the expense detail. Our last full expense survey that has all the categories that are in the MEI was in 1999 and before that it was an annual survey. So you had this data from the late 1990s that was being used and the practice expense RVU methodology that was being used in the MEI and it was getting out of date. So that was the reason for getting together and going and doing another survey.

The physician sample was drawn from the AMA master file. That's a listing of all physicians in the U.S., including both members and non-members of the AMA. It was limited to nonfederal,

nonresident patient care physicians and patient care is at least 20 hours a week in patient care in a typical week and it was stratified by specialty. That was for the practice expense RVU part of it because we had to get an adequate number of respondents for each specialty and there were over -- I think there were over 50 specialties altogether.

MR. BERENSON: So that's specialty of self-employed physician?

MR. GILLIS: It's just a CMS specialty.

MR. BERENSON: No, but I mean when you say it's stratified by specialty, would it be just the physicians who were self-employed?

MR. GILLIS: No. Actually, this survey -- we surveyed both --

MR. BERENSON: Not just --

MR. GILLIS: -- self-employed and employees and non physician practitioners too.

MR. POISAL: But then what Kurt would send to us would be the data for the self-employed physicians.

MR. GILLIS: Yeah.

MR. POISAL: That's --

MR. BERENSON: So you were able to sort it by --

MR. POISAL: Right.

MR. BERENSON: -- who was self-employed and who wasn't.

So --

MR. POISAL: Right.

MR. GILLIS: Yeah.

MS. KOBE: What is your exact definition of self-employed in that circumstance or would --

MR. GILLIS: We just ask them if there's -- they had any ownership interest in the practice.

MS. KOBE: Okay.

MR. GILLIS: So it's a pretty broad question. It could mean that they are the sole owner or it could mean that they -- it's a corporation and they have some stock in it or something to that effect, but -- oh, and I guess I did mention that the other provider groups were also surveyed. I think there were nine other non physician provider groups.

We collected practice expense information, detailed hours, and some basic practice characteristics of practice size and setting and some special topics.

It was a multimode survey, so we collected data by telephone, by web, and fax. Twenty percent of the respondents were telephone respondents, 65 percent were by web/online, and 15 percent were fax and there was a small incentive payment of 50 or $75 depending on how they answered. If they went online, they got a little bit more. And these were both changes from our previous surveys, our SMS surveys, which were just telephone surveys and they

did not have an incentive payment.

Some of the other changes that were made, there were some new expense questions, and I'll get to those in a bit. There were some changes to the wording of the existing expense questions, especially the office expense question. Respondents were allowed to provide expenses at the individual, department or practice level. In the past, we just asked for expenses at the individual level. So if we're asking a doc in a group, it's -- the question is, "What's your share of the practice's total?" And on this survey, employee physicians were asked the expense questions. We hadn't done that before. Only self-employed physicians were asked expense questions in the past.

So then the actual questions up there, and again, these all correspond pretty much to the categories of the MEI and the new questions have the little stars. So payroll for staff who can bill independently, that was a new question in the survey. And these questions were added with, you know -- in our interactions with CMS going back and forth, especially the practice expense people, what they wanted to take out. That's one of the things that they wanted to be able to identify and take out. Separately billable medical expense, same thing, wanted to be able to exclude that if needed. Drug expense was a new question. That had been in medical supply expense and then we have separately billable drug expense and then we also asked about physician net income and benefits.

It was a big survey, over 7,000 total respondents, almost 6,000 physician respondents. Just a 12 percent response rate. The response rate to the 1999 survey was 42 percent, just to give you an idea of how it changed, and in 1990, it was over 60 percent.

MR. POISAL: Do you know why that has fallen to the degree it has?

MR. GILLIS: It's just gotten a lot tougher to --

MR. POISAL: Get their time?

MR. GILLIS: -- get their time and get them to answer --

MR. POISAL: Uh huh.

MR. GILLIS: -- financial questions especially.

MR. POISAL: Uh huh. Uh huh.

MR. GILLIS: And 39 percent of the physicians were employees. So then as far as what we did for the MEI tabulations, just simply calculated mean expenses, net income and benefits, means for all of those different categories, and here, even though we had a broader group of people, we limited the tabulations to the self-employed physicians and those who provided their expense information at the individual level. So that was consistent with what we had done in the past on our older surveys.

And then one of the first ones we did for John was in May 2009. We had about 2,400 total respondents and about 1,700 that answered all of the questions, all of the relevant questions.

So then looking at how things changed between this survey

and our -- the last complete survey that we did, looking at the means between these two years, 1998 and 2006, office expense more than doubled. It's up 120 percent and I've got the annual average in the right hand side there. Non physician payroll was up 47 percent. Medical supply expense increased 81 percent. Other expense only increased 5 percent. Net income increased 18 percent or 2 percent annual average and PLI premiums increased 91 percent.

Now, of the big increases, the PLI increase makes sense. We know that this was during a period when PLI premiums were increasing rapidly and I didn't go back to check to see if it matched up with what was in the MEI, but that makes sense. The office expense increase I think is harder to explain and I'm sure that it has partly to do with the change to the office expense question, and I really wish I had made this a slide after the fact, but --

STAFF: I have a slide or two --

MR. GILLIS: Do you have a slide?

STAFF: -- with the full question --

MR. GILLIS: Oh.

STAFF: -- if you want to pull it up, John, if you want it.

MR. GILLIS: Because the best I can do is, like, a show and tell.

(Laughter.)

MR. GILLIS: This is in the overview document that we got

from John and it has all the questions and I've highlighted -- this is the office expense question. I've highlighted all the new stuff and about -- you know, several things were added. So in the past we asked about rent, mortgage interest, depreciation, utilities, and telephone, and to that was added, as far as things to include, office equipment, office supplies, maintenance, refrigeration, storage, security, janitorial, other office computer systems. So it's just a lot more detailed. These things may have been going into office expense before anyway. You know, they are sort of office related items, maybe not.

Oh, great, here it is. So we've got the old question on the top --

MR. POISAL: Yeah.

MR. GILLIS: -- and the new question on the bottom with all that extra stuff.

MR. POISAL: The highlighted, yeah.

MR. GILLIS: Now, some of those things like maintenance and -- I'm not sure what storage -- maintenance, security, and janitorial, if they were contract services, they would've been in other before. So, you know, that may explain why other only went up by 5 percent --

MR. POISAL: Uh huh.

MR. GILLIS: -- and office went up by a lot more. That's about as far as we can go, I think, in understanding what happened

to office expense, and as far as why the question changed, you had asked me that and --

MR. POISAL: Yeah. If we had any background on why that --

MR. GILLIS: Yeah.

MR. POISAL: -- was the case.

MR. GILLIS: Now, this was six years ago when we were working on this, but I asked and the response I got was that it was just a back and forth working with --

MR. POISAL: Okay.

MR. GILLIS: -- with, you know, with you here at CMS and especially the practice expense people at CMS.

MR. POISAL: Okay.

MR. GILLIS: Exactly how much of it came from us and how --

MR. POISAL: Uh huh.

MR. GILLIS: -- much of it came from you guys, I don't know.

MR. POISAL: Fair enough. Thanks.

MR. GILLIS: But that was the big change. Other than that, the other questions didn't change much. I don't know if you have those, but --

MR. POISAL: I think it was just this one.

STAFF: Not a slide, sorry, just that.

MR. POISAL: Yeah, just that one.

MR. GILLIS: Just that slide. Yeah, that's the big one as

far as changes in wording.

MR. POISAL: Okay.

MR. GILLIS: And then I guess we can go on to the next one unless there's -- we haven't conducted a practice expense survey since the PPI survey and we don't have any current plans to do another one, as far as I know. So that really brings up the question of what happens --

MR. POISAL: Right.

MR. GILLIS: -- next?

MR. POISAL: I was going to say other than that, we have all that we need.

(Laughter)

MR. POISAL: Okay.

MR. BERENSON: So can I ask a question? How do you deal in the instructions with sources of revenue and expenses unrelated to patient care that may be in the practice, like clinical trials or selling products or things like that, whether -- are they supposed to include all of that as practice expense?

MR. GILLIS: I think we tried to exclude things that aren't -- sources of revenue that aren't related to --

MR. BERENSON: So the -- and the

MR. GILLIS: -- the medical practice.

MR. BERENSON: -- expenses related to those sources of revenue?

MR. GILLIS: The expenses I think would be harder I mean if --

MR. BERENSON: Yeah.

MR. GILLIS: -- you know, depending on how --

MR. BERENSON: Do you have any sense as to how significant that is? Do you know how much that represents -

MR. GILLIS: No.

MR. BERENSON: -- sources of revenues?

MR. GILLIS: So some examples of --

MR. BERENSON: So, like, mounting clinical trials, getting --

MR. GILLIS: Yeah.

MR. BERENSON: -- paid to do a clinical trial or --

MR. GILLIS: Yeah.

MR. BERENSON: -- selling products, whether it's eyeglasses or dermatologic products or whatever, which happens in some specialties, but not most. There probably are other examples. I'm just not sure what they are.

MR. GILLIS: No.

MR. BERENSON: Okay.

MR. GILLIS: And I think that's a real problem when you're doing this is trying to capture or trying to figure out if there are ancillary services in a practice and how much -- I guess you'd like to separate that as much as you can from -- you want to get at what

does it cost to provide the services of this particular, you know, specialty.

MR. BERENSON: Yeah.

MR. GILLIS: And that --

MR. BERENSON: I mean you could even get at, you know, services that are sort of generally covered by insurance and then cosmetic services, for example, and do you want to separate those out or include those, I guess would be an example of service. I could argue either way that that should be in the practice expense and it should be considered or not, but my hunch is that it's not all that significant in an aggregate sense. Where it's broad view specialties it might be, but I don't know that.

MR. GILLIS: Or in bigger practices it might be.

MR. BERENSON: Yeah.

MS. KOBE: In your stratification, did you find that certain specialties were better about responding than others and --

MR. GILLIS: Uh huh.

MS. KOBE: -- did you -- I assume you weighted then accordingly --

MR. GILLIS: Yeah. Yeah, we did weight --

MS. KOBE: -- back to -- you weighted back to some concept of the self-employed physicians or you weighted back to your total?

MR. GILLIS: Well, we constructed a special set of weights just for the MEI run and it was by specialty and practice size also

had an influence on response rates, so physicians in the smaller practices were more likely to respond. You can imagine they know more of the details about the --

MS. KOBE: Right.

MR. GILLIS: -- financial details especially about the practice. So we weighted for that and of course for specialty. So --

MS. KOBE: So the final weights that were used for the MEI were weighting according to the distribution of self-employed physicians or according to the overall distribution?

MR. GILLIS: To self-employed physicians because it was limited to just -- to just self-employed physicians, yeah.

MR. POISAL: So, like, the weights assigned to each responding physician. If you were to tabulate those up, I think that that would reflect the population of self-employed physicians. Is that what you mean, Kathryn?

MS. KOBE: Right. I mean I guess my question is I don't know whether the master file itself identifies whether you're self-employed or not.

MR. GILLIS: No.

MS. KOBE: It doesn't?

MR. GILLIS: No, it doesn't.

MS. KOBE: So you're dependent on asking the question and then I guess if you're trying to weight back to kind of the

distribution in the master file, you don't really know for sure whether you're self-employed --

MR. GILLIS: That's true. Right.

MS. KOBE: -- whether you got a more -- a better response rate from your self-employed versus you're not self-employed. Does that --

MR. GILLIS: Uh huh.

MS. KOBE: -- is that accurate?

MR. GILLIS: That's accurate.

MS. KOBE: Okay. Thanks.

MR. POISAL: So it's weighted back up to be representative of all physicians?

MR. GILLIS: Yeah.

MR. POISAL: Right. Okay.

MR. GILLIS: But that's a good point. We don't have population numbers on the self-employed, just overall. So I'm not sure -- I can't remember what was done there.

MS. KOBE: Okay. Thanks.

MR. GILLIS: I can try and find out.

MS. KOBE: I think that's going to be a question we'll have, but I'm not sure how important it is.

MR. DYCKMAN: Couple of questions. Did you retain any specialty specific data or did you develop any statistics relating to specialists, such as income expense weight and then within

expenses, the distribution of expenses?

MR. GILLIS: Well, we had that, but we didn't -- we just summed up what were all specialties, you know, to calculate the means, but that information is there.

MR. DYCKMAN: And it could still be pulled out?

MR. GILLIS: Uh huh.

MR. BERENSON: I mean for the practice expense issue, you -- for CMS, you needed to do that by the CPT code, right? I mean they ultimately need to allocate practice expenses, so you need to have specialty specific information for that, not maybe for the MEI.

MR. GILLIS: Right.

MR. BERENSON: But so you had the raw data for that purpose.

MR. FOSTER: Ernie, I'm sorry to report, but we started without you.

MR. BERNDT: My apologies.

MR. FOSTER: It is very good to see you. Thanks for -- sorry for the hassles you had getting here.

MR. BERNDT: Carry on.

(Laughter.)

MR. FOSTER: Well, Kurt Gillis had just made a presentation about the AMA survey data and we also had John's opening --

MR. BERNDT: I think I've seen both those presentations.

MR. FOSTER: -- summary. Right. And then Zach Dyckman's presentation on kind of the original development and we were finishing up with a few questions for Kurt, and I had one question for you.

Now, depending on what the panel ultimately decides to recommend in terms of data sources and so forth, if there were a continuing need for the AMA survey and if CMS, despite federal budget difficulties, such as they are, managed to come through with the financial support as we have in the past, do you have a sense that the AMA would be interested or would say, "Never darken our doorway again"?

MR. GILLIS: I don't know. I don't know. Someone had -- if you don't mind taking a comment from the -- from another AMA representative --

STAFF: Just it'd probably depend how much of the cost the government is willing to put up. I mean I imagine we'd be happy to do the analysis of the data, but, you know, it depends how much the government is going to pay.

MR. GILLIS: One thing, this last survey was -- part of what made it so difficult is that we were trying to collect all of this -- the practice expense per hour part of it that made it difficult. That just -- you know, we had to add the questions. The scale of the survey had to be huge. If it was just about updating the MEI weights, you wouldn't need as big a survey. You'd just need

one national number --

MR. FOSTER: Right.

MR. GILLIS: -- or set of numbers. So it means you don't have to ask about hours. So I don't think it would be as big an undertaking as the PPI survey was.

MR. FOSTER: Okay. So if we got together with the Center for Medicare and talked further with Sandy and try to figure out what could be feasible --

MR. POISAL: And pass around a hat today --

(Laughter.)

MR. POISAL: -- before we finish.

MR. BERENSON: And for the fee schedule, you need lots of more. I mean you need detail that you don't need for the MEI, you know, and you need some --

MR. FOSTER: Right.

MR. BERENSON: -- source for that too.

MR. FOSTER: Right.

MR. BERENSON: So --

MR. FOSTER: Yeah.

MS. KOBE: Now, were the 1,712 responses, that was what was actually used to calculate the weights; is that correct?

MR. GILLIS: Well, we did another run. I'm not sure what John ended up using.

STAFF: We did not use the 1,712. We used the 2,400.

MR. GILLIS: Okay.

STAFF: We just wanted to compare to see if there was a big difference between those that answered all --

MS. KOBE: Okay.

STAFF: -- and not, but there wasn't.

MR. FOSTER: Okay.

MR. POISAL: Okay.

MR. FOSTER: What's next, John?

MR. POISAL: Well, I think Heidi's up. And I'll flip for you, Heidi.

MS. OUMAROU: Okay.

MR. POISAL: And Kurt, I'll show you real quick. So that's Marisa using Nikolai Khabibulin's goalie equipment.

(Laughter.)

MR. POISAL: But I don't think Ernie flew from Boston and you from Chicago to see that, so we'll get back to this. So --

MEI CATEGORIES AND WEIGHTS

MS. OUMAROU: So does everybody have a copy of these slides already? They're getting passed around.

So, so far this morning John's given an overview of all of the different facets of the MEI, sort of a broader level, and then Zach gave the background and sort of the statutory guidance that was given of the congressional intent and then we heard from Kurt about the AMA survey data that we used as the main basis for establishing

our cost weights, but my presentation is going to be getting into more of the nuts and bolts of how we came up with the exact numbers and the categories, and so as I'm going through the slides, if you guys have questions, please stop along the way and ask them instead of holding till the end because sometimes you might write something down and then not remember. So we can just clarify as we go if you have something that isn't clear.

Okay. So as Kurt had mentioned, he talked about the Physician Practice Information Survey, which we used as the main data source to establish our cost weights for the 2006 based index, which is the current version of the index, and there are certain advantages and disadvantages to this survey. Some of the advantages, and this is a big one, is that currently it's the only data available on -- limited to self-employed physicians or physician owned practice expenses. It's representative of the American physician community and contained -- and I don't know if this is correct, but that's what we thought because you said it was more than 50, but --

MR. GILLIS: That sounds about right, yeah. Oh, no.

MS. OUMAROU: -- 42 specialties --

MR. GILLIS: Physician specialties.

MS. OUMAROU: -- medical -- physician specialties and 10 nonmedical specialties, non M.D. It's geographically representative. And another advantage somewhat is that it's

consistent with other offices within CMS that use this data such as for the RVUs. And then there -- disadvantages of this data is that -- or the big disadvantage is that it's not collected on a regular basis. It's not an annual survey. This particular survey, you know, was slightly different, like Kurt had said, from surveys that they had collected in the past, though basically comparable over time and it's unknown when or if the survey will be fielded again. So --

MR. BERNDT: Perhaps, and this is just because I wasn't here, but what is the evidence suggesting that this is representative?

MS. OUMAROU: I asked Kurt and he said it was.

(Laughter.)

MR. GILLIS: We did look at response rates by, you know, geographic area, by rural/urban breakout, and for the most part, yes, I mean we put -- when we were developing the weights, we looked at all of those things to see did any of the -- any factors affect response to the survey, and for the most part, you know, no. AMA membership affected response to the survey and practice size affected response to the survey. Those were the two big things.

MR. BERNDT: So you just did a -- sort of a regression to see whether certain characteristics were correlated with whether there was a response?

MR. GILLIS: Right.

MR. BERNDT: Okay.

MR. GILLIS: Yeah, like a probit regression of response, you know, against all that stuff.

MR. BERNDT: Okay.

MR. DYCKMAN: Just relating to response rates, I'm curious did you tend or look at whether you got a better response rate with lower income than higher income physicians?

MR. GILLIS: No, we didn't look at that.

MR. DYCKMAN: Because I had done work in the past relating to physician income and in terms of the medical economics data, and perhaps the AMA data also, I tended to think that perhaps higher income physicians that were sort of at the -- you know, you don't -- you have perhaps a log-normal distribution or some type of skewed distribution, less likely to make semi-publicly available information about their income and their business, and so I just wondered if perhaps you would have that.

MS. KOBE: Does your master file identify their income?

MR. GILLIS: No, it's --

MR. DYCKMAN: It's one of your questions.

MR. GILLIS: -- on the survey.

MS. KOBE: So the only information you have about it is from the people who've actually responded, right?

MR. GILLIS: Yeah.

MS. KOBE: Yeah.

MR. DYCKMAN: Yeah.

MR. BERNDT: A second question if I may, and again, you may have discussed this earlier, what does it mean to be self-employed? That is to say if I'm -- am I actually an employee or what if I'm a contractor?

MR. GILLIS: It's whether you have an ownership interest in your practice. That's what -- that's how we asked the question.

MR. BERNDT: Okay. Any ownership?

MR. GILLIS: Right. There is a separate independent contractor category. They're not considered self-employed when we do the tabulations and --

MR. BERNDT: I guess the reason I asked both these questions is that it's my observation that over the last half a dozen years, there's been a -- quite a trend where physicians are selling their practices to hospitals, to the physician groups, et cetera, and so I'm curious to what extent this data will -- it's obviously six years old, but to what extent it would capture that sort of a -- effects in such a trend.

MR. GILLIS: It would be nice to do another survey.

MR. BERNDT: Well, I've gotten emails, you know, I'm not a physician, saying, "We want to buy your practice." Are there consulting firms out there that specialize in providing support to physicians selling their practice, et cetera, that would be another source -- alternative source of data?

MR. GILLIS: I don't know.

MR. BERNDT: I mean I'm thinking of Huron and some of these big consulting firms, perhaps somebody you know. Len, do you?

STAFF: No, I don't have any. I want to ask a question. So to the extent that a physician practice was sold and the physician retained a partial ownership interest in the --

MR. BERNDT: It would still --

STAFF: -- answer to that question --

MR. BERNDT: Yeah.

STAFF: -- it would still be considered self-employed, as I understand it; is that right, Kurt?

MR. GILLIS: Uh huh.

MR. BERNDT: Got it. Thank you. Sorry.

MS. OUMAROU: No. Thank you. So next slide.

Some other data sources that we considered. One was data from the MGMA, which is the Medical Group Management Association. They have a cost survey which provides data on medical practice expense, revenue, operational, and output indicators for single specialty and multispecialty group practices, but, again, those are for group practices and not self-employed physicians.

Also, CMS has raised concerns with the sample size and representativeness of this data. The sample size represents only about 1 percent of the physician practices nationwide and there is some indication that there was disproportionate sample sizes for

each state, so -- on even response rates and not necessarily geographically representative, and it's also unclear how the physician income and benefits of the owner, which are major considerations in terms of the MEI, are reported on the survey and how we could, you know, parse those out. So those were the main reasons why we don't believe that we can use information from this survey.

Another data source that exists is the Census Bureau Services annual survey. This is annual data reported on NAICS-basis and while these data have more detail than some other data sources on compensation and practice expenses, they don't distinguish between physician and non physician compensation. It is just sort of lumped together, and then there is the problem again of trying to come up with a net income piece for the physician practice -- a physician owner. So getting that physician compensation piece from this data, we would have to use possibly a secondary data source, but it's unclear what we could use that would match up with that data to come up with that.

MR. DYCKMAN: I have a question about the MGMA, the third point relating to physician income and benefits of the owner.

MS. OUMAROU: Uh huh.

MR. DYCKMAN: Was there a problem in how the MGMA survey -- the questions they asked they didn't get to the information or how it may have been reported?

MS. OUMAROU: No, it's just we didn't look at it in a lot of detail, but it's just how it's asked and reported, I suppose. So we're not sure exactly how that net income piece is reported on or how we would isolate just that --

MR. DYCKMAN: Is it largely in terms of, say, retirement contribution because that's -- that could be a big category?

MS. OUMAROU: Possibly, but I mean it's --

MR. DYCKMAN: Yeah. Okay.

MS. OUMAROU: -- even a broader level than that for us that we got. So --

MR. DYCKMAN: Okay.

MR. POISAL: It just wasn't clear how we would parcel that out. We didn't have sort of the level of detail and access to somebody like Kurt too to help us work through the specifics, but it became an issue of, you know, how would we tease these things out in a way that would line up the way we needed to for MEI purposes.

MR. DYCKMAN: So I know they conduct an annual survey and --

MR. POISAL: Uh huh.

MR. DYCKMAN: -- that would be great, but --

MR. POISAL: Right.

MR. DYCKMAN: -- if you could rely on it.

MR. POISAL: Right.

MS. OUMAROU: Uh huh. And then we also looked at the

Census Bureau Services annual survey data to try to maybe see if we could compare components of that with just certain components of the practice expense portion, so limiting basically the expenses from that FAS data to the practice expenses from the PPIS data, but there was some difficulty in those comparisons as well just based on the way the questions were phrased or the way the categories were sort of put together.

One example was the expense data for lease and rental payments on the SAS is for all equipment, while the AMA practice expense collected the data separately for medical equipment and office equipment. So you could put them together, but they're just not lined up one-to-one.

MS. KOBE: Do you know what kind of coverage the SAS data has as far as --

MS. OUMAROU: I think it's done at the NAICS level, so it would be --

MS. KOBE: So it's all physicians who are --

MS. OUMAROU: At least --

MS. KOBE: -- all physician --

MS. OUMAROU: Yeah.

MS. KOBE: Okay.

MR. POISAL: It was broader than that, wasn't it?

STAFF: Yeah, it's done at -- conditions and then the SAS would be sort of kind of benchmarked to the economic census --

MS. KOBE: Right.

STAFF: -- to get sort of a master file, you know, and then -- I'm not sure, but we could look up how they stratify. We're not sure --

MS. OUMAROU: Yeah.

STAFF: -- if they do the level of stratification that the AMA does.

MS. KOBE: Right. Okay.

MS. OUMAROU: This --

STAFF: We do use the service annual survey on the national health expenditure accounts --

MS. OUMAROU: Uh huh.

STAFF: -- and consider it a pretty good sample when you're looking at things in the top line. So I think that the coverage is pretty good, but when you start getting into the newly detailed categories like some of this, I think there probably are some questions about how representative it is and how accurate the information is being recorded on a year-to-year basis and so forth. So I think it's pretty good at the top level and we use it in other places.

MS. KOBE: Okay.

MS. OUMAROU: Yeah. I mean this question is from the survey. It says, "Survey coverage, the report covers all domestic locations operated by your company and its subsidiaries primarily

engaged in independent practice of general or specialized medicine, except psychiatry or psychoanalysis or surgery. The industry comprises locations of how the practitioners who have earned the degree of M.D., Doctor of Medicine, or D.O., Doctor of Osteopathy. The practitioners operate private or group practices in their own offices, e.g., centers, clinics or in the facilities of others, such as hospitals or HMO medical centers." So it's pretty comprehensive.

MS. KOBE: Okay. Thanks.

MS. OUMAROU: Uh huh. So this is a similar slide to what John had in his presentation, but I cut out the middle, which was the price proxy since we're focusing today on the categories and the weights. The red highlighted font is basically the categories that we got directly from the data from the PPIS. So basically all of the main categories were derived from that data. Physician compensation, like John said, is slightly less than half of the index, and then the practice expense, which is the other major component, is slightly more than half at 51 percent.

And then underneath physician compensation, the weight is in salaries and the benefits also came directly from data on the PPIS. We did have to make one assumption in terms of the employed physician region benefit split, which I'll get into. But for the net income and the benefits of the owners, we got that specifically broken out on the survey, the non physician compensation weight and expense, mean expense, of looking directly from the survey.

The office expense total of that 20 percent came directly from the survey. PLI, medical equipment, medical measures and supplies and other professional expenses. So in terms -- and also total expenses was derived from the AMA PPIS survey.

So again, that is our main source. And all of our major cost categories came from that data. And the secondary data sources were just sort of to break those other categories into more detail.

MR. BERNDT: Where would things like medical journals be in this classification scheme?

MS. OUMAROU: Medical journals?

MR. BERNDT: Yes.

MR. POISAL: Like subscriptions?

MR. BERNDT: Yes.

MR. GILLIS: Should be in the other professional expense.

MS. OUMAROU: Other professional expense.

MR. BERNDT: Okay.

MS. OUMAROU: Well, I guess this is basically what I just said. But just to reiterate again, the expense data that AMA provided to us was limited and edited down to just include those self-employed physicians and physicians who reported expenses at the individual level.

So it wasn't the same sample that was used for the PE yesterday, aligned to our needs. And also just to reiterate that the total expenses were directly from the AMA survey.

Can we go to the next slide?

So now, in terms of going through all of these categories, I'm just going to go through each of the pieces and specifically say how we came up with the detail underneath. And if you guys again have questions on our methods, just stop me and ask. Next slide.

So for the physician compensation piece, which is 48.266 percent, because we're so sure of our numbers out to the third decimal, again this accounts for slightly less than half of the index and is derived from the 2006 data.

We only use the mean expenses from data that, you know, were the self-employed or respondents who reported at the individual level. And we also included the data from certain non-M.D. specialties. As Kurt mentioned, during the survey they collected data for ten non-M.D. specialties, but we only included the data from five of them because, based on the CMS definition of the way certain specialties are paid, these ones were the ones that we felt were really -- that we could include in this.

So we include the data for optometrists, oral surgeons, podiatrists, chiropractors, and then we also included radiation oncologists, but only a portion of them because some of them are considered M.D. specialties and a certain proportion are considered non-M.D. specialties. So we only -- we only included a portion of the radiation oncologists.

The expenses from the M.D. specialties and the non-M.D.

specialties were weighted together based on physician counts, and that was based on the Medicare physician and other practitioner registry.

And then the total weight of that 48.2665 is basically the sum of the mean physician net income, which was the physician compensation for self-employed physicians, plus the office's other employed physicians' compensation, which was another question that was asked on the AMA survey. So we combine those two pieces together to get total compensation.

Any questions?

MR. BERNDT: Is there a lot of variability in this data? That is to say, would standard deviation be really very high?

MS. OUMAROU: For the M.D. specialties, we only got one set of mean expense data. So the AMA had already weighted those together. And then for the non-M.D. specialties, there was variation in terms of their relative mean expenses. But we weighted those together, and when we compared basically the distribution for the five non-M.D. specialties and the distribution for the M.D. specialties, there were differences but it wasn't as extreme as if you looked at a certain specialty like radiation oncologists.

MR. GILLIS: We did ask that question on staff: Who can bill independently? And in a way, you can think of them as more like another physician. And I'm wondering if they don't really -- do they belong in the work, too? I'm just (inaudible).

I'm not saying it does, but --

MS. OUMAROU: Yes.

MR. GILLIS: -- or even some of the other non-physician specialties that weren't included.

MS. OUMAROU: Uh huh. I'm not sure. Hold on one second. I'm going to look behind this survey and see what we did. And I think for that billed independently, that was a subset of the non-physician compensation group.

MR. GILLIS: Right.

MS. OUMAROU: So yes, we wouldn't have included them in the physician compensation. But possibly we could consider it.

MR. BERENSON: So are you calculating this at the hourly level or at the weekly level? Or how do you deal with part-time --

MS. OUMAROU: It's at the mean expense level for however the survey was collected. So I guess it's at the annual.

MR. POISAL: Yes. It would be the annual. I think so. Right?

MR. BERENSON: And also, if you have a 50 percent physician, are you -- how do you calculate the annual? A full-time equivalence? Is that how this is working or -- do you see what I'm asking about?

MR. POISAL: So how did we get to the 48 percent of the total cost being attributable to the physician weighted salary?

MR. BERENSON: Yes. Yes.

MR. POISAL: So Kurt sent us a total -- documentation that had total mean expenses for the physicians that made it through the filters, of the individuals that made it through the filters. And then for each of these main categories, there was a mean associated with it such that if you added them all up, you got to the total.

So when we looked at the physicians' wages and salaries, physicians' benefits, and then the employed physicians' wages and salaries and employed physicians' benefits, those four means together equaled the 48.2 percent of the total.

MR. BERNDT: So it's based on actual expenditures for that physician were he or she half-time, part-time, whatever?

MR. BERENSON: Nobody has to extrapolate.

MR. BERNDT: It's not just --

MR. DYCKMAN: But if you're dealing with ratios, then it should be okay.

MR. BERNDT: Right.

MR. DYCKMAN: If you're trying to get the full-time equivalents, it's not because it's biased.

MR. BERNDT: Right.

MR. POISAL: I described that accurately. Right? Yes, that looks exceptionally familiar to me.

(Laughter.)

MR. GILLIS: I can pass it around if you want.

MR. DYCKMAN: That would be fine.

MR. GILLIS: Just to show you exactly what -- exactly what was provided.

(Pause)

MR. POISAL: Any other follow-up questions before we move on?

(No response.)

MR. POISAL: Okay.

MS. OUMAROU: And then also, in terms of that handout that was just handed out with the total mean expenses for the M.D. aggregated, we got that similar information for the non-M.D. specialties, so the levels.

So then, continuing on, how we then decided to get into physician compensation between wages and benefits, for physician compensation basically it's the net income for the self-employed physicians, plus the employed physician payroll. And the wages and salaries accounted for 92 percent of the compensation based on those mean expenses from the PPIS data.

And then we added in -- for the employed physicians, we estimated the wages and salaries to account for 86 percent of compensation. And this ratio is based on a weighted average of IRS Statistics of Income data for physicians in outreach and care centers. So these would be the split between wages and salaries and benefits from (inaudible).

And then for benefits for the self-employed physicians, the

benefits again were directly from the PPIS survey data, and the benefits counted for 8 percent of compensation for the self-employed physicians. And for the employed physicians, we used that same data source from the Statistics of Income, and 14 percent.

MR. BERNDT: Is that because the denominator is very different or because the numerator is very different?

MR. FOSTER: I'm guessing the denominator, but it's a guess.

MS. OUMAROU: Yes.

MR. BERNDT: So employed physicians basically earn less? Is that what you're saying?

MR. FOSTER: I would expect that, but I don't remember if Kurt --

MR. GILLIS: Yes. Yes, in the past, when we had data, that's what happened.

MR. BERENSON: What's the rough split between self-employed and employed physicians in the survey?

MR. DYCKMAN: I'm sorry?

MR. BERENSON: The split between self-employed and employed?

MS. OUMAROU: In terms of the compensation piece and the levels, self-employed accounted for about 84 percent of the total compensation.

MR. DYCKMAN: Is that what you're asking, Bob?

MR. BERENSON: Yes.

MR. DYCKMAN: Okay. There it is. I missed it.

MS. OUMAROU: Yes.

MR. DYCKMAN: Where would -- say for self-employed physicians, where would the contributions towards retirement be? Would that be a benefit or would that be in wage and salary?

MR. GILLIS: I'd have to look at the original question to be sure. I think it would be in benefit, but --

MR. BERNDT: Then that seems like a pretty small partition.

MR. DYCKMAN: I would think so. I would think so.

MS. OUMAROU: That 92 percent also, if you look at the Statistics of Income data for sole proprietors, on that data it also shows that there's like a 91 percent report for salary versus (inaudible) that's on that survey.

MS. KOBE: Doesn't the SOI data show the contributions for retirement separately? And how were you including that in there when you were making this calculation?

(Pause)

MS. OUMAROU: For these splits, we just used data from table 2 which just has salaries and wages and benefits. And the benefits equals the employee benefits program plus pension and profit-sharing plans. So I think a different table does list out details on the defined contributions and all, but that's not what we used.

MS. KOBE: I was thinking of the pension and profit-sharing line item when I was asking the question. Okay. Thanks.

MS. OUMAROU: Okay. You're welcome.

MR. GILLIS: And I gave the wrong response to Zach's question. Deferred compensation is included in net income.

MR. BERNDT: Oh, in income? Okay.

MR. DYCKMAN: But not wages or --

MS. OUMAROU: So not in the benefits.

MR. BERNDT: That makes sense.

MR. GILLIS: Yes.

MS. OUMAROU: And then lastly, just as a check for the employed physicians split, we also looked at BEA data for wage and salaries accrual share compensation for ambulatory health care services, which isn't exactly (inaudible) of physicians. But that had 81 percent, so slightly lower. Next slide.

So unless there's any other questions, I was going to move on to practice expense.

So for practice expense, that accounts for about 51.7 percent of the MEI. And the first large component under practice expense is the non-physician compensation piece. Again, this is taken from the mean expense level on the PPIS data and includes the independent billers. We can go to the next slide.

We broke the non-physician compensation piece into wages and benefits first, using the BLS employment cost for employee

compensation survey for 2006 for NAICS 62. And that split basically gave us 13.7 percent for non-physician wages and 5.4 percent for non-physician benefits.

The survey provides the wages and salaries as a percent of total compensation, and the wages and salaries for that year were 71.8 percent.

MR. BERNDT: It's striking that I don't think the ratio of benefits to wages for the non-physician as opposed to the physician category -- well, any thoughts as to how we should interpret that?

MR. GILLIS: Well, underneath, is it partly the deferred compensation or --

MR. DYCKMAN: It's (inaudible), and also you're dealing with a much lower level of income. So things like health insurance, which might be -- could be 20 percent of the cost of the (inaudible) but only 4 or 5 percent of a higher income.

MS. OUMAROU: Okay. Next slide, please. Now, we also further broke down the non-physician wages into different subcategories. We used the 2006 BLS occupational employment survey for the mean hourly wage, and CES employment counts for NAICS 6211 from the Census Bureau.

And this chart shows the comparison between -- this is basically the same methodology we used in 2000, which was the version of the index prior to the most recent one, which is 2006.

And the four categories were professional and technical

workers, managers, clerical workers, and service workers. And the big shift from 2000 to 2006 were that the management share declined and the service workers increased. The other two categories also had some changes, but not as drastic.

The main reasons, especially for the manager shift, was that the occupational classification used by the Census Bureau was different. That was used in 2000. For the 2000 -- and a lot of the occupations that were classified as managers in that occupational classification were things like first line supervisors for different areas that weren't considered management any more.

So one example would be maybe -- I don't have it listed out here; I probably should have -- but like managers of supervisory workers in a particular industry versus -- would have been -- would have shown up in the 2006 classification in that industry.

So let's say a service worker manager. It would have shown up in service workers for a service occupational classification under the standard occupational classification, whereas in 2000 it showed up in management. And then also just there was a shift in the employment counts for those categories from those (inaudible).

MR. BERNDT: Where would a nurse practitioner show up in that? Would that be the professional category?

MS. OUMAROU: I have to look and see. I have a detailed listing of all of the occupations here. I'd have to find --

MR. FOSTER: You can pick the professional category. Heidi

will track it down for you.

MS. OUMAROU: Yes. Can I find out --

MR. FOSTER: Later we'll look it up.

MS. OUMAROU: All right. Next slide.

So the next major category that we split out into more detail was the office expense category. And you can see the categories, ten categories, underneath the office expenses and the weights associated with each of those relative to the 20 percent of the total of office expenses for the whole index.

So we disaggregated the office expense cost weight into ten more categories using the 2002 Year of Economic Analysis benchmark input/output data for NAICS 621A00. That's their aggregation, and includes offices of physicians, dentists, and other health practitioners.

Our reasons for disaggregating this category were several. First and foremost, in prior regulations or proposed regulations, we had gotten comments specifically requesting for the MEI to better reflect cost base by physicians that are running a practice. And so we thought this was one area where we could break the cost into more detail and improve the index.

Also, it would allow us a higher level of precision in the price proxies that we could map to that category, and better capture the price pressures of those inputs used; and also, to interpret the broader scope of that 2006 PPIS survey question for office expenses,

which included more items than had been included in the past. Next slide.

And here's the slide that we saw when Kurt was talking. And this just compares the office expense question from the 1998 SMS AMA Socioeconomic Monitoring Survey question on office expenses. At that time, the question asked for office expenses as defined as rent, mortgage interest, depreciation on medical buildings, utilities, and telephones.

And then in the 2006 survey, the question was expanded to include those red -- those categories that are in red font. So there were some additional costs that would have been included that wouldn't have been included in the 1998 question -- non-medical equipment, non-medical supplies, maintenance, refrigeration, storage, security, janitorial, and other office computer systems, including information management and electronic medical record systems.

So to answer your questions on professional.

STAFF: (Inaudible.)

MR. GILLIS: Thank you.

MS. OUMAROU: Then office expense detailed cost categories. And we, like we said, were matched to BEA input/output data as closely as possible to those categories that were in the question, the 2006 office expense question.

We basically took the input/output table in its entirety

and went through each line item and mapped where we thought every expense would go, so -- to all of the questions in the PPIS survey. So when we estimated the office expense, it was just inclusive of those categories that matched best to that data. And that was our denominator from the IO, was those categories only. And so, you know, we excluded the categories that would have been hopefully captured in the other questions.

And then we calculated the relative share of each category as a percentage of the total office expense IO data level. Then we aged that 2002 data forward to 2006 using the price proxies, associated price proxies, for each of those categories. And then we came up with the ratios and applied that to the 20 percent to come up with the cost weights underlying that office expense category.

Any questions?

MR. BERNDT: Go ahead.

MS. OUMAROU: No, go ahead.

MR. BERNDT: Somebody else?

MS. OUMAROU: No.

MR. BERNDT: We spoke about this a little bit on the phone, but I wanted just to make sure I got my arms around it. For physician practice purchase of physician administered drugs, for example, or oncology, chemotherapy, where does this show up in the accounting here? Is that -- I know it's separately billable.

MR. GILLIS: Yes.

MR. BERNDT: But I would think that the IO data would have it in that.

MS. OUMAROU: We excluded drug costs.

MR. POISAL: Right. We would have excluded drug costs. When we were -- when we were -- Heidi, you should answer on that.

MS. OUMAROU: Oh, no. It's okay. For this purpose here, we would have excluded any of the drug related costs that were reported on the IO. And that IO is basically by NAICS also, so --

MR. BERNDT: So we've captured from the -- okay. Thank you.

MS. OUMAROU: You're welcome.

MR. GILLIS: We really tried to limit it to the office expense --

MS. OUMAROU: Yes.

MR. GILLIS: -- in the (inaudible) that are in the IO data.

MS. OUMAROU: Yes. And I didn't make copies of it, but we have all of the NAICS categories under that and where we sort of assigned the category, the NAICS category, to in terms of the AMA. You could add a survey question. So we could share that.

MR. DYCKMAN: Kurt, isn't it correct that in your presentation, you indicated that drug purchases were excluded from everything, were not included in any expense category? Or am I incorrect?

MR. GILLIS: No. There was an expense question on drugs.

I think John mentioned that drugs were entirely excluded from the MEI.

MR. POISAL: Correct.

MR. DYCKMAN: Yes. All right.

MS. OUMAROU: The data were captured on the survey, the drug expenses.

MR. DYCKMAN: Right. But there were --

MS. OUMAROU: Then there were also separately billable drugs, a line item for that. But for our purposes, we excluded all of the expenses related to drugs for the reasons John mentioned.

MR. DYCKMAN: And from revenue as well?

MS. OUMAROU: Yes.

MR. POISAL: I know we have a slide that shows that mapping. So we will be certain to have --

MS. OUMAROU: Well, we have --

MR. POISAL: -- that in our freer discussion today, too.

MR. DYCKMAN: Thank you.

MS. OUMAROU: Yes. And we have the mapping of what NAICS categories we assigned to the different office expense categories. But we also have a handout that we can give (inaudible) that shows all of the categories and where we thought they would go, not just office expense. And (inaudible), we could make a copy.

MR. GILLIS: Do you want to go into that more in detail later, or --

MR. POISAL: Defer to you guys.

MS. OUMAROU: Maybe later we can discuss more in the afternoon when we have the discussion portion because we have some slides that we made related to that, if that's okay with everybody.

MR. GILLIS: I guess just one question for now, if I could.

MS. OUMAROU: Yes.

MR. GILLIS: Is what other alternatives might have been considered? And maybe (inaudible) or -- this is the only alternative, but --

MS. OUMAROU: Right.

MR. GILLIS: -- just think about just trying to get a number for rent and say, okay, rent is what we really want to get out of there because -- you know, and that's probably the biggest piece of it. And rent affects geographic adjustment, and that's important to get to the right number for the match. Or was it just there weren't really any alternatives and this is what we had to turn to.

MS. OUMAROU: We didn't actually look at too many other data sources for this breakout because we rely on this data for most of the other market baskets for the breakout. And then also, when we look at the results that we got compared -- and we sort of aggregated the categories for what we got for fixed capital, utilities, telephone, it gave us a weight that was somewhat in line with what we had seen in the 2000 data. So we thought this was

giving us a pretty good indication.

MR. POISAL: And we do rely on that data source very heavily. But part of the discussion should be to the extent you are aware of maybe other data sources that we might be able to tap into for varying purposes. That would be very much appreciated.

MR. BERNDT: Obviously, your 2007 IO tables, when they become available.

MS. OUMAROU: Right.

MR. POISAL: Yes, indeed.

MS. OUMAROU: Any other questions?

MR. POISAL: Next slide?

MS. OUMAROU: Yes. So again, this is just the table with those office expenses broken down and the weights underlying them for fixed capital, which would basically be the quote unquote "rent" component. It accounts for 8.9, or basically 9 percent of that 20 percent, so a little less than half.

Other services, which would have the janitorial and -- what else was in that question? Maintenance. Storage -- no, storage probably isn't in there. Security. Janitorial. That would be in there.

MR. BERNDT: How about advertising?

MR. POISAL: That's -- is that under --

MS. OUMAROU: Advertising I think was in the other professional expense question

MR. POISAL: Yes. I think it's in other professional. Okay.

MS. OUMAROU: So it wouldn't be in this office expense. Next slide.

And then just the remaining categories of the index under practice expense -- PLI, the medical equipment, the medical materials and supplies, and the other professional expenses accounted for -- you can go to the next slide -- about 12.5 percent of the index in total. And all of those costs were from the levels from the PPIS survey data. So we didn't use secondary data sources to break those out any more. Next slide.

This chart -- sorry for the smallish font -- compares the 2000 cost shares or expense shares to the 2006 expense shares, with the 2006 shares being the first column of numbers and the 2000 being the second. And you can see that the compensation declined, the compensation share declined, since 2000, from 52.5 down to 48.3, and the practice expense, obviously, the opposite. It increased to now it's about 52 percent, and it used to be about 47-1/2.

The non-physician compensation weight is slightly higher, 18.6 to 19.2. The office expense weight you can see went from 12.2 up to 20, and that is a reflection partly of the additional costs that are included in that, and partly, possibly, an increase in the other components that were included in the prior question.

The professional liability insurance weight increased

slightly from 3.9 to 4.3. Medical equipment is slightly lower. The drugs and supplies line, because now we're excluding drugs altogether, is lower, but that materials and supplies weight also declined, from 2.3 to about 1.8. And you can see the drugs used to account for about 2 percent, and now there's no weight in there.

MS. KOBE: Was the benefits question asked differently? That seems like an awfully large differential between those two years. I was wondering if you had looked into that.

MS. OUMAROU: We did look into it, and I don't think I --

MR. GILLIS: We didn't have a benefits question on their prior survey.

MS. KOBE: Okay. So it was being estimated from a secondary source.

MR. GILLIS: Right. That's right.

MS. OUMAROU: Yes. In the 2000 index, benefits -- the compensation was broken into wages and salaries and benefits based on the ratio for 1996, updated to 2000 in the ECI for Private Employees' wages and salaries benefits.

MR. BERENSON: Can I have just a couple of -- one element that goes into these categories? What goes into rubber and plastics? Do you have that listed?

MS. OUMAROU: Let's see here.

MR. BERENSON: I see there's a separate category for materials and supplies, so I'm just wondering what goes into which.

MS. OUMAROU: Right. For rubber and plastics, we included expenses that were captured in NAICS 326, which is things like plastic packaging materials and unlaminated film, unlaminated plastics, profile sheet (inaudible).

MR. GILLIS: Latex gloves?

MR. BERENSON: But I've got it in supply.

MR. GILLIS: Like, trash cans, too, we had in there.

MR. BERENSON: Oh, okay.

MR. GILLIS: I mean, literally, that's literally the level of detail that you get to, is to try to capture all those things. And that's why you have small weight --

MR. BERENSON: That's from medical supplies.

MR. GILLIS: Right. It would be --

MS. OUMAROU: For anything -- yes, anything that would have -- we would have been able to designate as mainly being a medical supply, if it was listed as a NAICS category, we would have excluded that.

MR. BERENSON: And where does sort of property and casualty insurance go in this scheme? You know, fire insurance and liability insurance and all of that stuff?

MS. OUMAROU: Well, liability insurance --

MR. BERENSON: Not professional liability. General liability.

MS. OUMAROU: Oh, okay. I'm not sure. I'd have to look.

MR. BERENSON: I don't need it now. I'm just sort of -- I mean, so -- but you've got something somewhere that can tell me where everybody is located?

MS. OUMAROU: Yes. Uh huh.

MR. BERENSON: Okay. That's fine.

MR. DYCKMAN: Bob, I'm envisioning your question about, to a physician's office, what do you spend on rubber and plastics.

MR. BERENSON: I know. And I assume that's not out of the questions.

(Laughter.)

MR. FOSTER: Regular trash cans, but not for the hazardous waste trash.

MR. BERENSON: That's exactly right. You know, a syringe goes over here, but something goes over there.

MR. FOSTER: A paper cup goes over there.

STAFF: I have a follow-up on your question, just to make sure that we're answering it clearly so you know -- so I think it's basically a data source change, and that the new survey in 2006 actually asked physicians to split their compensation between income and benefits.

Prior to that, we were using essentially an economy wide split for all -- I think it was all private -- what was it you said, all private workers in that split before. There's always concern, I guess, in a lot of ways. We try to (inaudible) here that other data

sources -- we just try to apply (inaudible) what it was, and we didn't feel that it was all that bad. But again, it wasn't specifically physician specific.

That had always been an issue that we had some concern with that we were -- we were basically saying that the split compensation for physicians looked like all other workers in the economy, and we weren't sure that was (inaudible).

So this new data clearly has been updated, and it looks different. And that could be in part by the way the questions are asked compared to the way the questions from other surveys -- in part just because there's a different split.

MR. FOSTER: Yes. I want go back to Ernie's denominator issue, the relative level of wages and salaries, in effect earned net income, versus the benefit cost.

MR. BERNDT: I guess (inaudible) back to your point was where we stuck the retirement benefits and so on now.

MR. DYCKMAN: Yes. I'm not sure about that. Yes. I don't know if it's included in that four percent.

MR. BERNDT: Right.

MS. OUMAROU: So these last two slides are just questions for the panel's consideration. And we have forwarded you guys these questions previously. And then they -- some of them have been mentioned previously today.

In John's presentation, for data sources, are there other

sources that could be used that would be an improvement, or were those used in the 2006 index? Are there concerns with using only self-employed physician data?

Can the panel consider the reliability of the AMA PPIS data design, particularly the sample design? Respondents to the survey by type of specialty. Credibility of the contractor used to conduct the survey. This was actually a question that we got during comment response, so we put the specifics in here.

Can the panel give guidance regarding ways to adjust the 2006 data forward to a more recent year to appropriately reflect increases in practice expense and physician compensation? And then for the cost categories, do the cost categories that we have here seem reasonable? Do they reflect categories that would be important to a physician and reflect 21st century delivery of physician care?

Are there any categories that you think that we're missing that we should have? Do you all believe that the MEI accounts for the costs related to regulations or requirements that physicians must comply with, such as the physician quality reporting initiative and the electronic health records initiative?

And then in terms of the cost weights, are the weights associated with categories reasonable. Can you all discuss the appropriateness of the breakout of the detailed categories under office expenses, particularly the weight for office rent?

And given the cost data limitations, how regularly would

you recommend the index be re-based or possibly changed to another type of index that's not a fixed price index, given that we already have data issues?

MR. POISAL: Well, it is just past 12:00. Before we finally break, are there any questions that we should discuss prior to getting something to eat?

I always know the most dangerous place in America is between a person and the time to break for lunch, so I hesitate to even ask that question. But I'll put it out there anyway.

(No response.)

MR. POISAL: Okay.

(Whereupon, at 12:03 p.m., a luncheon recess was taken.)

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

(The panel members were duly sworn.)

MR. POISAL: Your pay just got frozen for another two years.

(Laughter.)

PANEL DISCUSSION

MR. POISAL: Welcome to the government.

Okay. So the afternoon part of the agenda is about discussing what we have kind of covered so far and addressing additional follow-up questions with the focus remaining on the categories themselves and their respective cost weights and cost shares.

So, Ernie, it's up to you how you'd like to proceed with respect to the dialogue.

DR. BERNDT: Do any of the panel members want to open up with some questions or comments?

(No response.)

DR. BERNDT: I was given ahead of time here on the back of the agenda, draft agenda, some questions which I suppose we can use as an organizing device. The first question would be: can the panel consider the reliability of the AMA PPIS data design?

Some commenters have questioned the representativeness of the survey. Particularly, they would like to hear about the sample design, number of respondents to the survey by type of specialty,

and the credibility of the contactor used to conduct the survey.

I presume you addressed some of that this morning before I got here.

DR. GILLIS: Yeah, I think we went over some of that. It was stratified by specialty. So it wasn't a random sample, and we did check for nonresponses using a number of variables that were on our sample frame and master file, location and AMA membership, practice size.

There's not a lot of information on the master file we can use, but what was there, pretty much everything. There was very little impact on response rates, except for AMA membership and our practice size, and there were differences by specialty. So those were the things that we --

DR. BERNDT: How about age or gender?

DR. GILLIS: Age and gender did not have a significant effect on response rates.

MR. DYCKMAN: Within specialty or among specialties, do you recall a variation in response rates? Was it very significant?

DR. GILLIS: Yeah, it was pretty significant. If I remember right, one specialty that was so small we had to take everyone off the master file and sample them, osteopathic manipulative -- I can't even say it -- manipulative therapy.

MR. POISAL: That's why no one goes into it.

DR. GILLIS: Okay. They had a pretty high response rate,

and I think it might have been around 50 -- I'm just guessing from memory -- but it was high, 50 percent or so, and other specialties, much lower response rates. So there was variation between specialties.

DR. BERENSON: That became a controversy in the new practice expenses, I believe. The cardiologists had a very low response rate and took a big whack on the practice expenses, and that was one of the arguments they used, was their low response rate. I seem to remember down around one or two percent or something like that.

DR. GILLIS: I can't remember exactly for cardiology.

MS. KOBE: Sue said it was practice size and AMA membership, and actually more AMA members would respond to the survey than non-AMA members.

DR. GILLIS: Yeah, right.

MS. KOBE: But your master file incorporates all physicians as far as you are able to capture them?

DR. GILLIS: Uh huh.

MS. KOBE: And how much difference was there between size of specialty as far as the response rates were concerned?

DR. GILLIS: So by practice size?

MS. KOBE: Practice size, yes. I'm sorry.

DR. GILLIS: That I'd have to find for you. I don't remember.

DR. BERNDT: It's bracketed, isn't it?

DR. GILLIS: What's that?

DR. BERNDT: It's bracketed, isn't it, on AMA receipts?

DR. GILLIS: Yeah, that's categorical, practice size. I don't think it was a huge difference, but that's something I can look up and get back to everyone with.

MS. KOBE: It might be helpful to know it. I guess there does seem to be this trend in getting into larger groups or at least I hear this anecdotally. Do you see that in your master file as a change that can be observed in the master file or have you not seen that?

DR. GILLIS: I haven't tried to look at that to see if there's a trend in the master file towards more physicians being --

MS. KOBE: Right.

DR. BERNDT: There's a category of variables as I recall by sole practice versus what, one or two, isn't it?

And then there's above a certain threshold. I forgot. So you could probably observe it rather coarsely.

One thing we might consider is trying to get in touch with some of the human resource consulting firms, the Hurons, et cetera, that provide support and consulting services to potential purchasers of practices so you might get some idea on what they see in terms of the composition of expenses and things like that.

MS. KOBE: Did you look at expenses by practice size when

you were looking at -- I mean, I know what was given to CMS was a very aggregated file.

DR. GILLIS: Right. We looked geographically by region of the country, but I don't think we looked at by practice size.

MS. KOBE: I mean, I guess if the distribution of expenses is the same it doesn't really matter that much.

DR. GILLIS: Right.

MS. KOBE: But it's a question that comes to mind.

MR. DYCKMAN: Given the move from small practices to larger groups, often single specialty groups, in some cases multi-specialty but larger groups, and the fact that there's an organization that is doing annual surveys and like think of MGMA. I know you indicated you had some problems with some aspects of the data, but they are getting it from the accounting systems. They're getting it from, you know, not individual physicians.

I'm thinking or I'm wondering whether in the long term that might be a better, more regular, more periodic source of data if you can address some of the issues that you have because I think they have a set methodology and they do get responses. So they publish data, and it's annual.

MS. KOBE: have you ever discussed with the Census Bureau adding more detail to their questionnaire in order to better fulfill your -- sometimes that would work, but not all the times. I know the Census Bureau is not always helpful on that.

MR. HEFFLER: We have talked with them in general about that, not just on issues related to indexes, but other data collection. Money is an issue, and then their resources to actually process it, follow, all that type of stuff. And there's also a lot of concern any time we go to one of these other government sources collecting data. There's a concern that asking for this additional detail will affect response rates and the other pieces of the survey that are much more critical to a broader age.

MS. KOBE: Right.

MR. HEFFLER: So the more detail we get into when we ask about that, the less success we've had. We have had some instances where we've been able to add a question here or there or to ask them to change how they ask a question to try to get at something better.

Like an example was on the service annual survey, they used to ask for spending, and this was just spending so not expense date, but spending by payer. So how much does Medicare pay? How much does private insurance pay? They would ask it in percentages. What percentage of your revenue comes from Medicare? What percentage comes from private?

We were really concerned about the data because it tended to be very stable over time, and which meant that all three payers were on a year-to-year basis a lot of times moving at the same rate, which we knew wasn't true. We had them actually change the question to ask for levels of spending. How much revenue did you get from

Medicare? How much revenue do you get from private? Chaos, we created chaos with the survey because, one, their systems weren't always up to date to get at that and, two, they looked nothing like the percentages they were collecting before, and so we didn't know what was really true, the percentages or whether they just made up a number and put it in there.

So that's been sort of an example of some of the issues we've had when we've tried to get better, more detailed data, and specifically on expense questions, there's been some changes at Census, too, right, on how they collect some of the expense data? There used to be different surveys and now they're merging them all into the service annual survey and going out on a regular basis.

So there might be some opportunities there if we could ask the right questions even to get maybe some of the broader categories, like not get into as much detail, and that might be a way as a check against some of these other surveys at a more aggregated data level, not like at the IO level.

MS. KOBE: Right.

MR. HEFFLER: But the equipment level or the compensation level, things like that.

MS. KOBE: Well, it seems like you might be able to get them to split out the office equipment from the medical equipment or something like that, but I understanding having, you know, dealt with Census a few times myself that they have their own concerns.

MR. HEFFLER: Right.

MS. KOBE: And that's rightly so, but it does seem like if somebody is already collecting some of this information it would be helpful if everybody just went to the physicians one time and asked them for the information instead of three or four different groups asking for the same information.

What kind of responses do you get from your members about filling this in? Is it just because it's a lot of questions and a lot of very detailed financial information?

DR. GILLIS: You know, I don't know if we have follow-up to Niki (phonetic), why they don't do it. It was a long survey initially. It probably took -- well, it was supposed to be 25 minutes, but there's no way it took 25 minutes or, you know, I think in many cases it was just difficult to get them get the contact. They just don't want to do the survey, period.

MS. KOBE: Well, you can understand this is not primarily what they're signed up to do to allocate everything into these little categories, but I don't see how you get an accurate index if you don't have at least broad categories nailed down pretty sufficiently to the group we're trying to measure. So since you've got to use one piece surveys, instruments, I don't know of any other source you could use with this.

DR. BERNDT: Do the Blues have a research arm?

MS. KOBE: I don't know.

DR. BERNDT: I thought they did.

MR. DYCKMAN: The Blues do have a research arm, but they would not typically have access to physician data. They're concerned with what they pay, not necessarily with what it cost physicians to provide services, and they rely on RBRVS to the extent the individual plans are interested in that. You know, they'll replicate RBRVS or come close to it.

DR. BERNDT: Because you would think since the Blues are sort of -- well, they're buying information practices. United is as well, I think.

MR. DYCKMAN: So I don't think they're buying like hospitals are buying.

DR. BERNDT: No, right, yeah.

DR. BERENSON: So my question, maybe it picks up a little what Zach was getting at, the administrative data. In the predecessors to this survey, and this used to be done like annually or something like that, did anybody ever look at checking sort of the validity of the responses against the equivalent of cost reports actually going into some places and you getting actual cost data --

DR. GILLIS: No.

DR. BERENSON: -- and seeing how that works, or we don't really know?

DR. GILLIS: No.

DR. BERENSON: So I guess there's a tradeoff between

getting larger numbers during the survey and smaller numbers actually getting real data as an alternative, which I think we might want to consider, and then trying to figure out how you go from that relatively small universe where you're getting pretty accurate data to what we're supposed to be doing here is representing physicians broadly, and that's where I defer to the statistically minded.

MR. DYCKMAN: No, there are a couple of things that you've said, Bob, throughout the day that lead me into a certain direction and yet there are tremendous dangers in moving in that direction. You know, we have small sample size problems, but there is tremendous variability in nature of expenses and expense weight by specialty, by specialty and by hospital ownership or, you know, salaries or self-employed.

And you know, we're mixing radiology practices with millions of dollars' worth of equipment, with psychiatrists and others that have virtually none and sometime almost no staff or no support staff, and we're computing an average.

Now, statistically that introduces variability questions even in getting a mean figure for everyone, but one could ask how meaningful is an economic index that treats practices that have very, very sizable capital expenditures versus others that have very, very small, almost no capital expenditures.

And yet once you decide to go in that direction, you have the same issues we have now, that we have for each specialty that

you're trying to do it with, and then, you know, to the extent there are difference in specialty by specialty and the resulting indices produce different numbers. There are potentially political problems, and so forth.

So I'm wondering if whether this is a -- as I ask the question whether this isn't a congressional intent type question and we should stay out of it and just work within the charge that we have, just looking at the overall MEI for all specialties, or we should suggest that perhaps it should be done for different specialty categories, perhaps not individual specialties, but the specialty categories.

There is no answer there. There's only a question.

DR. BERENSON: And I understand. I mean, it's one thing to want to suggest having different MEIs for different categories of specialties, and it's another thing to develop a methodology which groups specialties into a few categories and then aggregates those samples into an overall MEI.

MR. DYCKMAN: Which theoretically that is what's being done now, except you don't have categories of specialties.

DR. BERENSON: No, I understand, but what I'm suggesting is, is there a way to actually go into a large enough sample of four or five or seven categories of specialties and actually getting administrative data and then moving that up to some aggregate rather than relying on a survey, is I guess what I'm saying.

Is it manageable? Is it statistically valid to actually go and the equivalent of cost reports, I guess, for a relatively small number of practices representing different categories of specialties and having that be the way you get the data, I guess is what I'm putting on the table.

What I'm thinking about is MEDPAC made a recommendation on getting a check of time data for calculating work, for helping calculate work in the RBRVS system, which is instead of relying on surveys of specialists on how long it takes them to do a colonoscopy, to actually go to a number of practices and find out how long it takes to do time and use that as sort of the basis for establishing work, which gets at real data rather than from administrative databases or special collection efforts, whether it's time-motion studies or something.

So I can see a similar kind of argument to be used here. Instead of sending this out to thousands of docs and not knowing what you're getting back, go to X number of practices, collect the cost data and have a method for extrapolating to making an aggregate MEI. You know, that's what I'm perhaps suggesting.

MS. KOBE: It's still probably needed really a good sized sample because of the large number of specialties we've got here. But I think we all are agreed that we're seeing a change from the old system to a new system that is not maybe fully established yet, but it's going to make these 2006 eights highly suspect probably in

a relatively short period of time.

Now, whether it's suspect for a good reason or a bad reason, I'm not sure that's clear. It's just any time your industry is changing along the lines this one seems to be changing, you're going to ask that question as to whether these old weights could possibly still be valid.

So I do think we have to think about the possibilities of finding weights that are going to be more up to date than this within a relatively short period of time.

DR. BERNDT: Do we have any idea as to the effects of the 2009 legislation in terms of electronic medical records and offering incentives to physician practices, as to how that would change composition of expenses?

MS. KOBE: I was wondering that myself. I haven't seen any information about that.

DR. BERNDT: We do know that it's the larger group practices that are much more likely to adopt electronic medical records. That I've seen some information on.

MS. KOBE: I can say from my own doctors they're almost all going to electronic medical records within the last two years. So obviously the change is moving down into relatively small practices to a certain extent, but I think it -- do you have any information about what percentage of your members have gone in that direction?

DR. GILLIS: Well, what we have is from the PPI survey.

MS. KOBE: Oh, uh huh.

DR. GILLIS: So, again, we're going back to 2007-2008. At least this question is just asked currently. It's not like any expense question that we are asking for the prior year. So it's more like 2007-2008.

Forty-five percent of the respondents had EHR either fully or partially, and the mean acquisition cost was 31,000 and the mean annual operating cost was 5,000. That' what we got.

MR. FOSTER: I think CMS has some perhaps later data on that, on some aspects of the incidence of EHR adoption. We can see what we've got and give it to you.

MS. KOBE: I think it would be interesting to see if that number has changed a lot. If nothing else, it may have changed the distribution of what your capital expenses are, although after you've depreciated it --

DR. BERNDT: It probably might affect non-physician compensation as well.

MS. KOBE: Yeah, that's probably true. Your distribution of who your workers are is likely to be quite a bit different.

DR. GILLIS: Did we complete all of the first questions? I mean, there was one question about the survey contractor that I --

DR. BERNDT: Yes, or the credibility of the contractor used to conduct the survey.

DR. GILLIS: Okay.

DR. BERNDT: Anything you want to say about that?

DR. GILLIS: Well, I'll just say that Gallup was the original contractor, and they fielded the survey in 2007, and it didn't work out well. They just didn't think they could complete the survey at the amount that they were promised to receive for this survey. So we contracted with a different firm, DMR Kinetic, a smaller firm in Missouri, but they had done these practice expense surveys in the past with specialty societies. So they had some experience, and they were actually pretty successful in not only wrapping up the work that Gallup had done, but getting the whole thing completed.

DR. BERNDT: There are firms that sort of specialize in trying to get cost structures of different parts of the health care sector. What's the name of the one that does the pharmacies who's now doing actual acquisition costs for CMS?

MR. HEFFLER: Is it VeriSpan (phonetic)?

DR. BERNDT: No, not VeriSpan. It's -- they've done it for a lot of states and now they're doing it for the feds.

MR. DYCKMAN: Myers & Stauffer.

DR. BERNDT: Yeah, Myers & Stauffer. I don't know if they do physician practices. Do you?

MR. DYCKMAN: I haven't seen any surveys of physicians that they've done. In general it has been only the feds. That are interested in what it costs physicians --

DR. BERNDT: Right.

MR. DYCKMAN: -- to provide medical services. The states aren't too concerned or almost anybody else.

DR. BERNDT: Where at the pharmacy level, the states do because of Medicaid.

MR. DYCKMAN: right.

DR. BERNDT: Anything further you want to say about that?

Did someone ask you the obvious question of just how costly is it to do something like this?

DR. GILLIS: Oh, yeah. In my presentation at the beginning I tried to ask and didn't get an answer. So I think Bob said roughly two million or a little over $2 million.

DR. BERNDT: And how many responses, 2,800?

DR. GILLIS: Oh, altogether over 7,000.

DR. BERNDT: Oh, 7,000.

DR. GILLIS: Right.

DR. BERNDT: So what is that, 300 a head?

MR. DYCKMAN: I think one thing we can anticipate that the trend you've seen of lower and lower response rates will likely continue, and you can't assume that you can even maintain 12 percent. Some of the factors that operate to have reduced the response rates probably are continuing to operate.

DR. BERNDT: That's been the experience across a lot of federal agencies, at Census, at BLS, lower response rates.

MS. KOBE: He also pointed out that it was the smaller practices that tended to respond to the questionnaire, and as these groups combined to become bigger practices, probably each individual physician has less and less feel for what the underlying numbers are.

You're a sole practitioner and running your practice. You have a very good idea of what it's costing you, where in a group practice that's a little less certain.

DR. BERNDT: I guess more generally, is CMS under the legislation from 2009 mandated to take a look at what happens to office expenses as each becomes more prevalent? Is there any congressional mandate on that? Do you know?

MR. FOSTER: Not that I'm aware of. I can't think of any.

MR. HEFFLER: We also have talked the issue about the variation by specialty and then this trend over time away from smaller practices to larger practices. If you had to prioritize thinking about data collection going forward, if you had to put one above the other and make cuts, what's your sense of what's more important than the other?

MS. KOBE: I think that would depend a little bit on what his findings were about what the distribution looks like. If the distribution over different office sizes is pretty similar within a specialty, it would be less concerned about it, but if there's a big variation, then I think then you'd have to re-weigh in your mind

which ones of those --

DR. BERNDT: How easy would it be, Kurt, to do a big of a decomposition by specialty in terms of cost?

DR. GILLIS: By specialty.

DR. BERNDT: Yeah.

DR. GILLIS: Okay. I can add that in. By specialty and practice size or just by specialty?

MS. KOBE: I think the impression is about both, but --

DR. GILLIS: Okay.

DR. BERNDT: Yeah, and the point is Kathryn is saying that there if there isn't much of a difference don't worry about it.

MS. KOBE: Don't worry about it, right.

DR. BERNDT: But if there is a big difference, then we should be aware of the significance of trends.

DR. GILLIS: Differences in expenses.

DR. BERNDT: Yeah.

DR. GILLIS: By specialty.

DR. BERNDT: Yeah.

DR. GILLIS: Well, there certainly are big differences.

MR. POISAL: But the cost structures, I guess, is what we'd be looking most closely at, right?

MS. KOBE: I think you're looking at the distributions.

DR. GILLIS: Okay. So you want the DTL --

DR. BERNDT: Not line by line.

DR. GILLIS: No. Right.

DR. BERNDT: But perhaps by major category or something like that.

MS. KOBE: I think for one reason we're concerned about the heavy capital, specialties with heavy capital intensity versus those that aren't, but --

DR. BERNDT: By the way, where do taxes fit in expenses here? I didn't see them anywhere.

MS. KOBE: I don't know that.

MR. HEFFLER: I'm sure that they're someplace.

MS. KOBE: They're typically in other professional expenses.

DR. GILLIS: Net income is after expenses but before taxes. So personal income taxes are not counted in here, but other types of taxes --

DR. BERNDT: Schedule C things?

MR. DYCKMAN: No, Schedule C income taxes would not be included, but sales tax. Well, sales tax might be included in the purchase price. Employee taxes are included in employee fringe benefits. Everyone else is large.

DR. BERNDT: I guess if it's a partnership or something like this there's partnership.

MR. DYCKMAN: But that's income taxes.

DR. BERNDT: Yeah.

MR. DYCKMAN: I think it's all after that.

DR. BERNDT: No, before or after income taxes?

DR. GILLIS: net income is after expenses, before taxes.

DR. BERNDT: Before taxes. Okay.

MS. KOBE: Property taxes would be included in there, payments. Well, if they're just granting, they're obviously going to include the property taxes. If they have their own, I assume they would add that.

Do you ask them to add that in?

DR. GILLIS: No, and I don't know if property taxes are included.

DR. BERNDT: Is that in the implicit owner's rent? Is that where it would show up?

MS. KOBE: It would be in their rental costs for certain. So if they're renting, it would show up in the rent cost, but if they own their building, it's a little less clear how it's defined.

DR. BERNDT: But they were using a price index based on owner occupied, wasn't it? Yeah.

MS. KOBE: I think so.

DR. BERNDT: Yeah, fixed capital, the CPI for owners' equivalent rent.

MR. DYCKMAN: S you're thinking about the weights.

MS. KOBE: I'm thinking about the weights, correct, and he's -- I agree that the prices proxy includes the property taxes.

MR. DYCKMAN: I would assume that a practice that is filling out a form that asks for information about rental or ownership costs would include the taxes.

MS. KOBE: Include the taxes. I would think so, too.

MR. DYCKMAN: If you made it explicit or not.

MS. KOBE: But we're economists. So that's the way we think about things.

MR. DYCKMAN: Everyone has their burden.

(Laughter.)

MS. KOBE: I think more of a question is the question about the retirement benefits or costs.

DR. BERNDT: Yeah.

MS. KOBE: I think there's a bigger question about that because we all have the feeling that the weights don't look quite right there.

MR. DYCKMAN: Yeah, the four percent would not appear to include the full return and contributions.

MR. FOSTER: Are you talking about payroll taxes primarily or are you talking about also supplemental pension cost centered and premiums for that?

MR. DYCKMAN: Well, I think we're thinking in terms of the physician compensation distribution. Wasn't that four percent part of that?

MS. KOBE: that was the benefits part of it, and of course

to a certain extent being that most of the retirement payments are coming out of their own wage stream, you know, it may be more a question of allocation than anything else, and since benefits and wages and salaries have really been moving up at almost the same rate lately, it doesn't make a big difference as far as the rate of change, but there have certainly been times in which that hasn't been true.

MR. HEFFLER: The question was please include all income -- this is for the wages and salaries -- please include all income from fees, salaries, retainers, bonuses, deferred compensation, other forms of monetary compensation.

MR. DYCKMAN: So it's in the wages and salaries.

MR. HEFFLER: It's in the next income, right. And then the benefit says, "Provide the dollar value of benefits, health insurance, dental, life insurance, etc., received from your medical practice."

MR. DYCKMAN: Okay. That would suggest that it's in the wages and salaries --

MR. HEFFLER: It's in wages and salaries.

MR. DYCKMAN: -- and not in the benefits.

MS. KOBE: right.

DR. BERNDT: I think that's probably right.

MR. HEFFLER: So the question asked for net income, which is what we would call physician compensation, and then there's a

separate question that asks for benefits, and then that's what we backed out from it, and the difference ends up wages and salaries. But methodologically?

DR. GILLIS: Is that enough of a problem that you think it needs to be changed?

MR. DYCKMAN: I don't think so. I'm just wondering where it went. I saw the four percent, and initially I think we thought that that might have included the pensions, but now it is clear that it does not, and it's reasonable even though that there's any issue there.

MR. HEFFLER: The bigger issue when we get to the price proxy.

MR. POISAL: What's the appropriate way to move that?

DR. BERNDT: Right.

MR. HEFFLER: ECI benefits are included in net earnings.

(Simultaneous conversation.)

MS. KOBE: In the last few years it doesn't make much difference, but in some years there's been a big difference between those two.

DR. BERNDT: In the '80s and '90s, in particular.

MS. KOBE: Yeah.

MR. FOSTER: I'd kind of like to ask the question that maybe is a very simple answer, maybe not, but I don't know. I'm not that much of a student of index theory, but I know we've got a

couple of experts in the room, and in terms of the fixed rate index like we've been using ever since day one, in general terms that has its limitations compared to like a chain rated index or some of the other categories, but when there are data limitations of the type we've got where currently at least there's only a periodic availability of the data in the detail that we need, and given that the weights don't seem to change dramatically year by year, would you all consider or think that a fixed rate index is perfectly suitable for this application or should we be thinking about something different in terms of the index itself?

I'm looking primarily at earning and capital.

MS. KOBE: Well, now to move to a different type of weighting system, moving away from a fixed weight system, you really would have to have pretty consistent method of collecting all of the expenditure data. I mean, we are struggling to even figure out how you could collect the most up to date information for our fixed rate index right now. So it doesn't seem to me that that would be your first priority especially since you're not seeing huge changes in your index components.

I mean, that's just my personal opinion. That --

DR. BERNDT: Why would you be concerned about it if two things were happening? One is the weights were changing, and two, the components of the weights had prices that were moving at different rates.

MR. DYCKMAN: Dramatically different.

DR. BERNDT: Dramatically different rates, and it looks like the former is not there, and we don't know much about the latter.

DR. GILLIS: Well, malpractice premiums did go up a lot in that last site. It would have been an exact year's worth.

DR. BERNDT: Yeah.

DR. GILLIS: But you would know better than anyone, but correct me if I'm wrong. If you have a Laspeyres index, the weights are fixed whenever you're calculating the price change from the base year to an out year.

DR. BERNDT: yeah.

DR. GILLIS: But any year-to-year changes where the first year is not the base year, the weights effectively change.

DR. BERNDT: Right.

DR. GILLIS: So if you have a category like PLI where the prices are going up a lot, the weight, the actual weight for that calculating MEI in that year will increase if, you know, PI has gone up by 50 percent. You are accounting for the price changes, the differential price changes that occur.

MR. DYCKMAN: It's not really a fixed weight. It's almost like semi-fixed, and you're assuming that will be incorrect if people are buying more practice or less malpractice insurance, but if they're buying the same volume, the same quantity, the same

dollar amount of insurance, you're already accounting for that by allowing the weights to change to reflect price changes.

DR. BERNDT: You can think of the year-to-year weights as ratios of your T plus one to the base year T.

MR. DYCKMAN: Yes.

MS. KOBE: I mean, one advantage to using a fixed weight index also is because you pretty much have to use -- I mean, you have to develop a year-to-year rate of change. In order to get an accurate one, you would need there to be changing every year to get new weights or you'd have to use a fixed rate index or you'd have to be -- you'd have to be doing the change every year.

So I think you would buy yourself a lot of trouble that you might not need. There's no obvious reason to think that you would need to change to that, given what we know so far about how this index works, I think.

DR. BERNDT: So I guess part of the answer to your question, Rick, is that part of what Kurt's going to do is to check to see whether weights are highly variable across practice size and specialty. If they are and if we see trends in those things happen, then we may want to revisit that. But at this point it seems like at least at the pre-aggregate level, the weights are pretty steady.

Am I basically --

MS. KOBE: yeah, I think that's true.

MR. FOSTER: So under the present circumstances, something

like a chain weight might be what I characterize as gilding in the dandelion.

DR. BERNDT: Do you have another?

This is the sort of cost categories. Are there any panel thoughts on how adequate that is? Are these too aggregated, too disaggregated? Any missing?

DR. BERENSON: Well, I guess my response is that all other services and all other products is -- I'm sorry -- other professional expenses are rather sort of large compared to rubber and plastics.

DR. BERNDT: Yeah.

DR. BERENSON: And I'm wondering if there are, especially with EHRs, are there some new categories that we could pull out of all other and track specifically. I just don't know what's in those categories. But one of them is 3.6 and the other one is 4.5 percent, and I just wonder whether we could do a little more granularity in those two categories.

I don't know. It may be they all represent lots of really small things.

DR. BERNDT: Let's see.

MS. OUMAROU: I'm sorry. I can tell you some of the things that are included in the other professional expenses: legal, marketing, accounting, billing, office management services, professional association memberships, maintenance, certification or

licensure, journals, and continuing education, professional PAR upkeep (phonetic), and appreciation of I believe cars, and any other professional expenses not included above.

DR. BERNDT: Not recalling the order, was that in alphabetical order or was that numerical order?

MS. OUMAROU: That's just the order of how they appear in the AMA question.

DR. BERNDT: Okay. Do you have any sense which was largest?

MS. OUMAROU: I don't, but I would imagine billing is probably pretty big.

DR. BERENSON: So that's billing outside of personnel, which are separately accounted for. It's billing. It's what, hardware or what?

DR. BERNDT: ADP and software?

MR. POISAL: Bob, this is what comes under other services category. These are the IO categories that we met to this particular category.

DR. BERENSON: What is on the right hand side?

MR. POISAL: Those are the IO expenditures.

DR. BERENSON: Okay. That's the --okay.

MS. OUMAROU: 2002.

DR. BERENSON: Okay. So that says services to buildings and dwellings is the biggest, and truck transportation is second

largest.

MR. DYCKMAN: Truck transportation for a physician.

MS. KOBE: Well, that's the IO table. It's allocated out. So the list that you gave us, the billing, et cetera, is that in all other services or that's in other professional services?

MR. POISAL: That was other professional.

MS. KOBE: Oh, okay. Do we know what's in all other services?

MR. POISAL: That's this.

MS. OUMAROU: This is all other services. It's not all other professional services.

MR. POISAL: Right.

MR. OUMAROU: This, you can hand this around. I think you guys might have gotten this. This handout right here will show what office expenses, each of the categories and then we assign to that, and then this second handout that I'll pass around will show all of the IO categories and where we inputted those, whether it was office expense or another category.

DR. BERENSON: So tell me again what the last column represents, those numbers.

DR. BERNDT: Those are new hours.

DR. BERENSON: Those are in dollars? Those are dollars?

MS. OUMAROU: Those are dollars.

DR. BERENSON: Those are dollars.

MR. POISAL: So if you think about it this way, when you look at all the categories under office expenses, the subheading there represents the sub grouping within the index. So under office expenses we have utilities, and so we go out to the IO data, and we say, "Okay. Which categories here that match up with physician as best we can would flow into a utilities type of a definition?"

And so we pull all of these particular categories from the IO data, and then we aggregate their spending in that right hand column so that total utility spending is twenty-three, eighty-four, four, and we replicate that for each of the subgroups on the office expenses, and then that gives us a relative proportion of these things that we then use to distribute the 20.033 percent rate that we got from Kurt that says, okay, well, of the 20.033 percent, X percent can be associated with utilities. X percent we associate with paper, rubber and plastics, et cetera.

Notably things like computer systems and things I think we said were under the removable capital weight, and I think there was some impression during the comment periods that that tended to look low, that weighty.

DR. BERNDT: It's on the third page of this handout, removable capital.

MS. KOBE: But the IM table is from 2002, right?

MR. POISAL: Right.

MS. KOBE: So --

MR. POISAL: But we age it forward to 2006 using the proxies.

MS. KOBE: Proxies.

MR. POISAL: Right.

MS. KOBE: Which if the base is -- if the base distribution is not up to date, it means that you're -- I mean, that's a good reason why your computer weight might be too low, although while the prices have been going down, the quantities have not.

DR. BERNDT: Gone up.

MS. KOBE: Are not being captured as going up.

MR. POISAL: And that kind of gets to your question, Ernie, about the 2009 requirement and so on, that if there were requirements that forced physicians or encouraged physicians to make, you know, costlier investments in those types of things, to the extent that's not picked up in the data source that we're using, we would miss that.

Now, it becomes important to us in that if it changes the structure of costs.

MS. KOBE: Right.

MR. POISAL: Which it may have.

MS. KOBE: A ten-year difference could, I think, a difference as far -- especially since there's been, you know, sort of a policy push to get people to change over to electronic medical

records.

DR. BERNDT: I think I heard last week that the 2007 IO tables will be out in October. I'm not sure about that.

MS. KOBE: I haven't seen an announcement, but that would be about the right timing.

DR. BERNDT: DEA Advisory Committee, I think that was stated.

MR. DYCKMAN: I'm going to ask a question about a basic, what used to be a simple expense, and now you have to look around for it, and it probably has component parts, and that is auto expense.

MR. POISAL: That is under other professional, if I'm not mistaken.

Heidi.

MS. OUMAROU: Just the professional upkeep and depreciation.

MR. POISAL: Okay. So you --

MS. OUMAROU: -- auto is in there.

MR. DYCKMAN: Where would that be in the tables?

MR. HEFFLER: This is office expense.

MS. OUMAROU: This is an office expense. It's just in that other professional expense, the bottom category.

MR. DYCKMAN: Okay, and that's broken down. The categories are upkeep or --

MS. OUMAROU: What's written in the question related to automobiles is just professional car upkeep and depreciation, not comment anyway.

MR. DYCKMAN: What about gasoline?

MS. OUMAROU: It's not specifically in any of these questions. So I'm not sure where it would be captured.

DR. BERNDT: What would what we call automobile expenses be for a typical physician practice?

MR. DYCKMAN: they used to have bigger cars and more costly cars in order to their practice revenue, I think so.

DR. BERNDT: I see.

MR. DYCKMAN: And I think as the tax laws changed and other things have changed, I think it's gotten smaller, somewhat smaller. But it used to be it was like five percent. It was a big expense, you know.

DR. BERNDT: Is that when they made home visits?

MR. DYCKMAN: That's when they allegedly made home visits.

(Laughter.)

MR. DYCKMAN: Or --

DR. BERENSON: Traveled around hospitals.

MR. DYCKMAN: -- somehow there may have been more reportable expenses.

DR. BERNDT: I see.

MR. DYCKMAN: But I think it's much lower now probably,

but, yeah, the auto insurance which appears somewhere, and you have the depreciation, and you have repairs which is in some phraseology used, and oil and gas might be in some other expense category.

MS. OUMAROU: Right.

MR. DYCKMAN: Petroleum refineries I see. I don't know what --

MR. POISAL: That's our world, Zach. This is where we live.

DR. BERNDT: Somewhat of a conceptual question. Back to this separately billable that's sort of excluded completely, to the extent that that was a source of practice income, that would now show up still here in our income statement, wouldn't it?

MR. DYCKMAN: What do you mean by "separately billable"?

DR. BERNDT: Drugs.

MR. DYCKMAN: Oh, yes.

DR. BERNDT: To the extent that that contributed to office practice income, that would show -- it wouldn't be excluded in the income part here.

MR. DYCKMAN: I assume it's -- yeah, it should be out of both numerator and the denominator.

DR. BERNDT: Right, but --

MR. DYCKMAN: So it should be out of the -- it should be out of the income.

MR. POISAL: I don't think it is.

MS. KOBE: They'd have to subtract it out.

MR. FOSTER: You're talking about for determining net income?

DR. BERNDT: Yeah, yeah, yeah. I was trying -- are those consistent is what I'm trying to get at.

MR. FOSTER: Yeah, that's good.

MS. KOBE: What type of professional services are billed separately?

DR. GILLIS: Separately?

MS. KOBE: They said that certain types of professional services could be billed separately as well as the drugs. I was just asking for what is an example of the type of professional services.

MR. DYCKMAN: Cosmetic.

DR. BERNDT: Lab tests.

MR. FOSTER: Yeah, hydrology. Do any of you remember --

MS. OUMAROU: Are you talking -- I'm sorry. Just to clarify, are you talking about what would be something that could be an example of a separately billable supply or a drug or are you talking about the question that was on the survey related to the independent billings?

MS. KOBE: The independent billings.

MR. DYCKMAN: Like nurse practitioners or physician assistants, which they may be billing under the -- they're often

billing under the practice.

DR. BERNDT: Right.

MR. DYCKMAN: Presumably if they're independent and receive the revenue based on their billings, either a percent or their expenses shouldn't be included in the practice expenses. If the practice is billing for them and they receive a salary, then they should be included.

MS. KOBE: How are those people being handled in here in your rates?

MS. OUMAROU: Currently they're in the weight in the non-physician compensation.

MS. KOBE: okay.

MR. HEFFLER: Can I clarify? I'm not even sure of the answer. It's the issue about the separately billable drug. When we got the data, they were not in the numerator. We used that for the MEI. They're not in the numerator or the denominator, right?

MS. OUMAROU: Right. We --

MR. HEFFLER: The net income piece is reduced by the -- it doesn't include --

MS. OUMAROU: The net income piece is not reduced by anything. You take the net income piece as a -- it's in the numerator. If we were going to in that income percentage, it would be in the numerator and the denominator would be the total expenses, which would be the aggregate of everything that we included.

So we would take out the expenses related to those items that we included not in that income --

MR. HEFFLER: So they're considered separately.

MS. OUMAROU: Separately billable supplies which we had a dollar mean expense for, and then also the adjust. So those would be excluded.

MR. HEFFLER: So they were excluded from both.

MS. OUMAROU: From both. And the expenses would just be the sum of what we included in each piece. So it's not a separate number that we got for expenses.

DR. BERNDT: So when dialysis got bundled this year -- was it this year?

MR. POISAL: Uh huh. 2011.

PARTICIPANT: 2012.

DR. BERNDT: It used to be separately billable, but now it's bundled. How would we handle that consistently over time?

DR. BERENSON: That's not a physician --

MR. DYCKMAN: You're talking about the --

DR. BERNDT: Yeah.

MS. OUMAROU: Well, the market basket would include whatever would be classified as the services included within that bundle. So we would figure out what expenses are included in the bundle and then create a set of weights based on that definition.

DR. BERNDT: Okay.

MR. FOSTER: Yeah, which we've done.

MS. OUMAROU: Right.

MR. FOSTER: So Mary Kate's is on your responsibility, yours?

MS. OUMAROU: Yeah.

MR. FOSTER: Okay.

MR. POISAL: Heidi is on the market basket. Mary Kate is on other ESI --

MR. FOSTER: That answers the question. Anyway, it's not related.

MS. OUMAROU: Yeah.

MR. POISAL: I think they have to have an endocrinologist, right? Isn't that --

MS. OUMAROU: We have cost data for it.

MR. POISAL: Yeah, you have cost data, but from the physician perspective it's different.

DR. BERENSON: There's a dialysis code for the nephrologist.

MR. POISAL: Nephrologist.

DR. BERENSON: That's professional service.

MR. HEFFLER: Make sure I'm not confusing this issue or confusing myself. So there are expenses associated with separately billable drugs. They are pulled out of the MEI.

DR. BERNDT: Right.

MR. HEFFLER: Is your question whether there's income generated from separately billable drugs?

DR. BERNDT: Yes.

MR. HEFFLER: That shows up in the net income.

DR. BERNDT: Right. That's my question.

MR. HEFFLER: And I think the issue is --

DR. BERNDT: No is what I hear you saying.

MR. HEFFLER: I think the issue is yes.

MS. OUMAROU: Yes.

MR. HEFFLER: Because the only way we can get income is to take total income as reported, total expenses as reported and subtract them. We do not know income from separately billable expenses.

MR. FOSTER: That's right.

MR. HEFFLER: I think that's what -- is that what you were trying to get at?

Yeah. So if they make half their money on separately billable drugs, we are clearly overstating the income share in here.

DR. BERNDT: So you can take a look to see where oncologists and a few other specialties that derive a fair bit of their income from injectables, from infusion?

MR. FOSTER: Yeah, specialties that used to derive a fair share of their income from.

DR. BERNDT: Right.

MR. HEFFLER: Is that right?

DR. GILLIS: Yeah, that's right.

MR. HEFFLER: I just wanted to make sure.

MS. OUMAROU: Yeah.

MR. POISAL: We shouldn't align that from the way the survey is collected.

MR. HEFFLER: No.

MR. POISAL: We just don't -- we didn't ask it that way. So it's a limitation.

DR. BERNDT: But I wonder --

MR. POISAL: Yeah, it's a limitation of the data.

DR. GILLIS: With the changes to drug pricing going to every sales prices, I don't know if there are really big markups now.

MR. POISAL: Right, right.

DR. BERNDT: There's some that suggest that the markups are a lot smaller now.

MR. FOSTER: We're paying what, average sales --

DR. BERNDT: Yeah. It's going to be AWP minus --

MR. FOSTER: That's way smaller than the APW.

DR. BERNDT: Right.

MR. DYCKMAN: But you still have the dollars there in the revenue. I mean, the profit is far less, but the expenses could be sizable for oncologists.

DR. BERNDT: Yeah, yeah, especially with some of the newer drugs.

DR. BERENSON: So my question that remains, this was very helpful to see what's in here, and there's not too many that I would suggest need to be pulled out as a separate category now that I see it, but I didn't see what INO for medical equipment, medical instruments and equipment, and that strikes me as very low. At least there's some very high capital equipment now like MRI machines and things like that.

Just sort of surprised. I assume that's where that would go. And I'm curious what the item is under "instruments and equipment."

MR. GILLIS: But this is "office expense."

DR. BERENSON: I know "office expense," but we're talking about an office expense.

DR. BERNDT: This is "non-medical," right. This is not right.

MR. POISAL: Oh, "non-medical."

MS. KOBE: You can put capital as the "non-medical" and then there's "medical equipment" further down on the right hand column.

DR. BERENSON: I got "medical equipment," right?

STAFF: "Medical equipment" was collected on the survey and then marked.

DR. BERENSON: I'm talking about a cardiology practice that I heard about recently that has a PET scan, an MRI scan and a CT scan all as equipment in their office.

MR. POISAL: That would fall under the "Medical Equipment and Supplies."

MR. BERENSON: Right. Well, as opposed to --

MR. POISAL: That's not part of what the bio maps do. That actually comes -- that weight is developed -- falls right out of the PPIS data. It's only those subcategories under I.

DR. BERENSON: So I guess -- so you'd be asking directly, then, if -- and what is it that they -- let's say it is major equipment. Is it amortization and depreciation? What is it that gets reported because I'm just surprised that it's only two percent overall?

MR. GILLIS: Yeah. It's supposed to be taxable so it should be depreciation and maintenance and -- I can give you the exact wording.

STAFF: It's in your overview.

MR. GILLIS: It's in your overview document on page 17.

"Expenses for depreciation, maintenance contracts, leases, rental of medical equipment used in the diagnosis of treatment of patients include the 2006 tax deductible portion of the purchase price over replacement value of medical equipment if not leased."

So we're trying to get them to record the purchase price.

STAFF: Yeah. Specifically say, do not do this.

MR. GILLIS: Please don't.

(Laughter)

MR. DYCKMAN: But I think what you're saying is that in the aggregate for all physicians, the expense weight for medical equipment is two percent?

DR. BERENSON: Yeah.

MR. DYCKMAN: But it might be 15, 20 percent for some practices.

DR. BERENSON: No, I understand. I mean, I'm surprised that it averages out to that little.

STAFF: Well, that also means you could partially because it's one single year in time. Like you were saying, it costs -- it would just be for whatever spending you have.

MR. DYCKMAN: And if you go to a general internist, there's not a whole lot of equipment there that's very costly or purchased on medical.

DR. BERENSON: If the practice purchased a machine with a ten-year life for a million dollars, it's not going to all be expensed in one year. It's going to be --

MR. STEINWALD: So that's why 100,000 is expensed.

MR. DYCKMAN: 100,000 is more than two percent.

(Laughter)

STAFF: But it's also only for those people who responded

to the survey, too, so it has to be one of those respondents who made that. It's not a universe.

MR. BERENSON: Well, actually that's Zach's point there. Some practices are very non-capital intensive or equipment intensive and others are quite.

STAFF: Right. But then also --

DR. BERENSON: I'm just surprised that it averages out to that little, but I understand the part about you're only expensing the one year of the ten year life. I understand that.

DR. BERNDT: Does the American Dental Association do a similar thing to your survey?

MR. GILLIS: I don't know.

DR. BERNDT: Mark, do you know?

STAFF: Well, they used to. They used to do one every two years, I think.

STAFF: We talked to them but I don't think they've --

DR. BERNDT: It might be useful just to hear the comparison test --

STAFF: Right.

DR. BERNDT: -- to make sure the numbers are --

STAFF: Now, I think they just put a couple of articles on the survey; acquisitions of equipment and made references on that. So at least we could track that. I don't know exactly what their intent is.

DR. BERENSON: Are the instructions to the survey respondents to -- or something like this, medical equipment where it asks for a depreciation, maintenance contracts to go find out what it is or are they supposed to make an educated guess as they're filling this thing out?

MR. GILLIS: They're encouraged to fill out a worksheet prior to the survey. You know, hopefully get all this information --

DR. BERENSON: Oh, so they are. Okay. So they are encouraged to actually try to get the real information?

MR. GILLIS: Um-hmm.

MR. BERENSON: Okay.

MR. FOSTER: But the worksheet also takes 25 years.

(Laughter)

DR. BERNDT: Any other thoughts on cost categories?

MR. GILLIS: We solicited some input from physicians. We've already touched on several of these so I brought along something to hand out but I think I could probably just read from it.

We talked about electronic health records. Right now that is in the "office expense" category. As I mentioned we were getting about half of the physicians using EHR in 2007.

DR. BERNDT: If I remember that question, it was sort of, are you using -- it didn't go into detail as to -- for example, if

you did web prescribing and that's all you did, that would still qualify saying you're --

MR. GILLIS: Oh, yeah.

That seems to be one potential thing to break out. Like I said, it would be in "office expense" right now. How much it would be, it might be a major category but -- and these "outside contract services," we mentioned "billing services" and "legal accounting services," and they would be in the other professional expenses down at the bottom, 4 1/2 percent.

DR. BERNDT: To the extent that it used to be done in-house that would have been moved then from "clerical wages," perhaps to "other professional expenses."

MR. GILLIS: Right.

You know, with the geographic adjusters you have kind of a mirror for, you know, something similar; an index that's a practice box and the gypsies -- I don't know if anyone is familiar with the gypsies -- but there was a -- what is it, this year's or last year's pole where part of "other expenses" was split out as a wage for purchase services. So they broke out part of that to recognize these as a billing and other professional services. I think that's been done on the gypsy side.

MR. POISAL: Sometimes some of the feedback we get from the public through rule making is literally, you know, like it sounds like some of the questions are, "We don't see these expenses in the

MEI expenses," when they actually are there. It's just not always broken out the way somebody who doesn't, you know, work with the MEI on a regular basis, or maybe even somebody who does, would readily identify exactly where that is. It strikes me that maybe some of that -- maybe some of those points are more not are they included and we want to make sure these expenses are being picked up kind of a question, but maybe a question more for the price proxy discussion. Just thinking out loud.

MR. GILLIS: For each of these you'd need a weight and a price process.

MR. POISAL: Right. We would need a weight, right. But to the extent you've got several things captured under "other professional expenses," and we currently use the CPI for all items less food and energy, you know. I'm not really sure what the detail would permit, but it's worth raising and speaking to.

MR. GILLIS: And then whenever the drugs were taken out entirely, but there are drugs that are not separately payable. We had I think it was about $6,000 in drugs that are not separately payable. I'm wondering if that's not just another input to "medical practice" like anything else, equipment or staff? Does that really actually still belong in there?

MR. DYCKMAN: Not too long ago.

MR. GILLIS: Well, the argument in the room was that drugs are paid for under essentially being a system and not paid for under

Medicare.

MR. DYCKMAN: But if they're not -- you're saying they're not. You're talking about drugs that are not separately billable?

MR. GILLIS: Right.

MR. DYCKMAN: As part of this practice give the patient -- some patients some drugs --

DR. BERENSON: A flu shot.

MR. DYCKMAN: Right. And not bill for it. Something that they don't bill for. So it should be like any other expense.

MR. GILLIS: Yeah. I would think so.

DR. BERNDT: Right now we're saying it's included because we did not make an explicit reduction for that type of drug. Is that your question?

MR. GILLIS: Well, right now they're being excluded entirely.

DR. BERNDT: So before --

STAFF: It's my understanding that all drugs are paid outside. At least that's the information that we received from the policy staff.

DR. BERENSON: Right.

DR. BERNDT: EPO isn't paid separately any more for dialysis.

STAFF: But it's not paid under --

MR. DYCKMAN: But that maybe under the "facility."

MR. GILLIS: Well, I guess are there drugs that -- I mean, from the survey results, there are. They tell us that there are something like $26,000 for total drug expense and 20,000 were separately payable so there's 6,000 that's not separately payable. What is that stuff?

DR. BERNDT: Yeah.

MR. GILLIS: Is it stuff that they just have to purchase to run the practice or --

STAFF: Maybe in 2006 it was different. I could follow-up on that.

DR. BERNDT: Yeah.

STAFF: I specifically asked the question when we were making this decision to -- a person that very specific question, are any drugs paid for in the efficiency schedule and the response is, no.

So maybe there was a change from 2006 to when I asked the question or maybe the answer was incorrect. So we can follow-up.

MR. GILLIS: It's not so much whether they're paid for but did they just have to buy them just to practice? I have no idea what these things would be.

STAFF: Well, they can also --

DR. BERNDT: I can guess. I can guess some practice wants to have some epinephrine around in case anybody has an anaphylactic reaction. You just have to have or maybe --

STAFF: Maybe their patients are not under Medicare.

DR. BERENSON: Contrast agents would not be separately billed for.

STAFF: If it was direct expense it would be in the EE column, so it's really -- it would be a drug that would not be separately billed but would be in the indirect expense, right? That would be the only kind of drug that would really account for. So even if a drug is not separately billable, if it's billable as part of the direct practice expense, it's essentially billable.

DR. BERENSON: So contrast would go there.

STAFF: That's right.

MR. POISAL: We didn't distinguish those different types of drugs when we broke down the categories from the PPIS, correct?

MR. GILLIS: Right.

MR. POISAL: And we're just talking about drugs but there's also nebulizers and things like that. Is that treated the same way?

MR. BERNDT: Well, the drug for the nebulizer would be billed separately. That's a supply; equipment.

MR. POISAL: That's an office expense?

MR. GILLIS: Would that be part of equipment, then?

DR. BERENSON: Medical materials and supplies.

MR. FOSTER: Yeah. But are those customarily used in physician's offices or individual beneficiaries?

DR. BERENSON: No, no. I mean, they would be used in the

office.

MR. FOSTER: Okay.

DR. BERENSON: For some of them not many offices, but the one for a pulmonary doctor, nebulize a patient in the office that had an asthmatic attack. I think would bill that but maybe -- I don't know. It's a small amount.

MR. FOSTER: So the big picture on this is the -- that I think I'm hearing is the -- there are several places where we might be able to refine or fine tune exactly what's in or excluded from the cost category for the future AMA survey. I'm not hearing that there are major deficiencies in terms of what we have for the movement.

DR. BERNDT: With a possible caveat in terms of the standard to which the IT equipment is separated out.

MR. FOSTER: Right. Yeah. I'm trying to keep an eye on the big picture.

DR. BERNDT: Yeah.

MR. FOSTER: But we've got several areas where we, if possible, I'd like to refine them like for drugs that are routine supplies maybe should go back into if they can, in fact, be identified. The question there opens the context.

DR. BERNDT: I'm thinking, for example, ophthalmologists, drugs that they put in the outset for dilating.

DR. BERENSON: That's true.

MR. POISAL: Rick, are you aware if there were any special treatment of certain types of drugs when these drugs were made from the list calculation?

MR. FOSTER: No. They're all physician administered drugs. In terms of doing the calculations for the physician related expenses and so forth, I believe those are the ones that were, in fact, separately billable.

MR. POISAL: Well, we can investigate a little bit further and then see about if there are other opportunities to get better data that might allow us to --

MR. FOSTER: Yeah. Hopefully we've all been keeping track of this in terms of several key areas where we might be able to refine this and find what we want to include and possibly refine what we can get and include that. So that's actually pretty helpful.

Now, most of you sound kind of at the margin in terms of not being way off base, possibly in your DEHR. I don't know what to make of the capital question given that that's an existing longstanding variation across specialties. And we have a single MEI. I'd have to think about that some more. It seems like we're stuck with that.

DR. BERNDT: Unless Congress goes the other way, right?

MR. FOSTER: Yeah.

DR. BERENSON: I mean, I just would observe that I don't

think that these sort of categories of chemicals, paper, rubber and plastics are particularly meaningful unless the price indexes varied significantly and it's worth keeping them separate because when you add all that up and you're a lot less than sort of a couple of other categories which are "other." I mean, I'm not sure -- I guess I would question the advantage of having those as separate items, which sort of looks stupid.

(Laughter)

MR. DYCKMAN: Well, for the moment, it's two categories and you're going in the other direction.

(Laughter)

MR. FOSTER: So the point is we can consolidate some of these lesser categories?

DR. BERENSON: I think so. And maybe break full IT or something else that has a little more meat to it. But it is -- to the point that they're not included, they are included, they're just in categories you might not recognize. I mean, that's the key.

MR. HEFFLER: Can I ask a question related to that, which is, you can see when Heidi was giving the presentation that the broad categories, this was a purposeful decision of why specifically with the survey questions but every survey can ask a question in a different way, so someone could look at these and say, well, that's not an office expense to me, that's a professional expense. And someone else could say, well, that's not a medical supply, that's

this or whatever it is. How important do you think it is for the data to align to the survey versus be clear to those who see the ultimate product or ultimately see a table like this or who are affected by this and they say, well, where are my costs? Where are the things that I am experiencing in the terms that I typically experience them? Because where we do have probably more flexibility, you know -- we can collapse some of these specific categories into a broader category. I mean, if we felt like the price -- where we really have the most flexibility is how we aggregate things because that doesn't affect what the ultimate index is but it effects how it's reported and what it looks like and the clarity that comes from how people can identify what's in a category to the subcategory.

So I'm curious what the panel's thoughts on that? What's the pros and cons of aligning to the actual survey questions versus presenting an index that might make a little more intuitive sense to someone about where their actual expenditures are?

MR. FOSTER: Look less stupid.

(Laughter)

DR. BERENSON: One of the problem is you kind of -- I mean, it would be lovely to have sort of a line item for ITH, then, except the personnel are going to be somewhere else. They're not going to have --

MR. HEFFLER: That's exactly right.

DR. BERENSON: And so I don't know that you can have a functional -- I mean, I guess it's -- that would be sorting everything along functional lines, and that would be very different from what you've got here. I'm not sure you want to do that.

MR. MR. HEFFLER: Health care informational systems costs of doing -- for physician practices, hospitals. Maybe you should -- if you want to get answers on a survey, your questions have to be able to align to get the cost so the physician can find it. There's a lot of research but we wouldn't have a chance. If we can get what the health care financial management suggests in the big practices, then they should be able to look it up and should do that. It's both gratuitous and it's a good number.

DR. BERNDT: Aren't there widely used software programs designed for physician practices so that they would have their own classification scheme that one could --

MR. DYCKMAN: I know there are but I don't know they'd go into this level with them. It's primarily for tax purposes and for efficiency in operating the practice. You know, for that purposes, it's likely to look very different than this.

I'd like to go back to something. I'm thinking about the one category that we've identified where, one, the weight appears to be increasing, and, two, there's a lot of provider noise about it, and that's EHR. It's a combination. It's less a combination of rapid price change for that category but just buying more of it as

you're introducing it and perhaps expanding the capability of EHR.

In order -- we're not, evidently, going to do very frequent surveys. Is it possible to do a targeted survey just for EHR to try to get information for what extent it's increasing and then sort of tie those numbers back to some other numbers to put it in a quantitative perspective? Or we may just miss it if you don't do it, you know, every two or three years.

MR. FOSTER: That's a good question because from an administrative records, we ought to be able to find out with NCMS a fair amount of detail on the adoption of the technology and use of it. That number qualifies for meaningful use of incentive payments. In another couple of years, qualifies for the penalties for not having it and that sort of thing.

Now, I have no clue, however, in the context of the MEI or any of our other price indexes how we would use that as an external source of data and then work it into our existing surveys. I suspect that's a technical question to overcome, but I don't know how hard it is.

MR. POISAL: Yeah, I mean, I guess -- I think that wouldn't be all that straightforward. I mean, we could investigate and maybe brainstorm a bit on ways that that might be incorporated. When I hear you ask your question about that, Zach, I hear if you were able to reach out to providers and get total cost growth and EHR cost growth, and if that exceeds total then we could probably assume that

like the moveable capital rate which would include computers and software and things might need to be higher than the 1.353 that it is now wherein you just sort of proportionality distribute whatever more of a cost rate you would assign to moveable capital, you would just disproportionately take that away from all the other categories. Is that along the lines of what you're thinking?

MR. DYCKMAN: I think so. And maybe related to that is that the overall expense versus net income weight might change. Now, theoretically, one would assume that productivity also is enhanced as a result of that so that you have to factor that in to. That may be future productivity. It may not be in line with the expenses.

MR. POISAL: Right.

MR. DYCKMAN: But you would think that -- the hope is that the assumption that the government is making is that these are productivity enhancing activities. Every physician I've talked to said, right.

(Laughter)

DR. BERENSON: A coding enhancement.

DR. BERNDT: Pardon?

DR. BERENSON: A coding enhancement we got under productivity.

(Laughter)

DR. BERNDT: Another enhancement.

DR. BERENSON: Definitely enhancement.

MR. DYCKMAN: I think the way you define productivity it is included.

DR. BERENSON: A lot of the costs of EHRs are personnel costs. Now, you have a software maintenance person who's working the whole practice. The newest innovation I've heard about in primary care practice is actually have a third person in the room who's the scribe so the doctor doesn't have to spend an hour and a half at the end of the day entering everything. There's a third person who's doing the entering. That's a whole new FTE employee. That shows up somewhere else. So are you suggesting we would have sort of -- take the things that would be in other places and just assign that to EHR and somehow use that?

That's the problem. It's not the software and the hardware that's the issue. It is -- I think it's the labor costs that are really where this is showing up as expenses.

MR. DYCKMAN: I wasn't suggesting that. You're probably right.

DR. BERENSON: I think that's the issue.

MS. KOBE: Well, it certainly says something about what the price proxy looked like, because if the real costs is really a labor costs, then --

DR. BERNDT: Don't do it. Don't take the less PPI --

MS. KOBE: Right.

DR. BERNDT: -- computers and the software.

MS. KOBE: Right. You don't want that to be your price proxy because it's not accurate.

DR. BERENSON: Well, I mean, if you've accurately allocated all your personnel costs elsewhere, and it is okay because it's a small -- it's a small thing. It's less than -- which one did it go into?

MS. KOBE: It's just your software; your computer software.

DR. BERENSON: So it's a small item because I think this is consistent with my theory that it's mostly all labor costs associated. So that would show up in salary increases.

DR. BERNDT: So the last few minutes we've sort of gone into question three here; "Does the MEI account for the costs related to the regulations and requirements that physicians must comply with such as PQRI and EHRs." I think the answer is, we're not sure.

MR. POISAL: And that was a question we got from the public and in some regards I think some of that might be related to confusion in some respects about what the MEI really is supposed to do. So but there's a perception that the MEI is intended to be a cost index and people say, "Well, the MEI went up .6 percent in 2012 but my costs went up five percent. This is no where close." Other than repeatedly saying in the regulations that this is a price index, I'm not sure how to address it.

To the extent somebody would make this point to say the cost rates in the price index did they reflect these things, they do to the extent they were in place and got collected when the AMA reached out and surveyed, you know, their constituents.

I often wonder which way the public when questions like this come in whether it's an assumption that it's a cost index that's not being picked up or if it's a good understanding that, no, it did a weight to show these things. Yeah.

MR. HEFFLER: Kurt, do you have a sense of if you were to go field that survey today and not change any of the questions, if you asked a physician the report they're getting from the income from things like supplemental payments of surgery after new regulations or new mandates or incentive payments or all the things that aren't sort of a standard part of patient care, because there's a question that says, don't exclude -- don't include things that don't have to do with patient care. Do you have a sense of how physicians might report that data? I don't know, do you have a sense of whether a physician would think of that as being part of their income or whether it's sort of -

MR. DYCKMAN: Do you mean expense or income?

MR. HEFFLER: Well, I think they're going to report it as an expense, clearly.

MR. DYCKMAN: Yeah.

STAFF: I'm thinking on the income side.

MR. DYCKMAN: Where's the income coming from?

MR. HEFFLER: An incentive.

MR. DYCKMAN: Additional incentive?

MR. HEFFLER: Yeah, like an additional incentive.

MR. DYCKMAN: IMS health. I would assume so. I mean, it's revenue from practice, yeah.

MR. HEFFLER: Revenue from practice.

MR. DYCKMAN: Yeah.

MR. HEFFLER: Okay.

MR. GILLIS: Unless you want to exclude it for some reason.

MR. HEFFLER: But do you think then they would report it? Yeah, I was just curious because it's a little different animal than some of the other stuff we've dealt with in the past as far as how you might report revenue or income because it's a brand new requirement that's got an incentive payment associated or the, you know, we get three or four years down the road and there's a penalty, you know, how would these things actually be reported.

MS. KOBE: How are the incentive payments paid? Are they paid once when they implement it or what's the process for that?

MR. FOSTER: I'm trying to remember. I don't remember. I thought they could get paid for several years. You know, after three years, something like that. You'd have to ask Karen.

MR. STEINWALD: They're lump sum. They're not added on to their DRG payments. It's a lump sum. Yeah, they're standard lump

payments. I just don't remember how long or total amounts. I knew all that two years ago.

MS. KOBE: Well, presumably they're being given those payments to offset the upfront costs of the systems.

MR. STEINWALD: And that's a meaningful use criteria.

MR. FOSTER: Well, it gets a little complicated because Medicare incentives are one thing, Medicaid incentives are another. Some of the doctors qualify for both. It's a specialty all by itself.

DR. BERNDT: I think we're scheduled to have a break about now. All right.

(Off the record)

DR. BERNDT: Based on some discussions with some of you, I think we'll go and try to spend an hour or so continuing the discussion and then why don't we sort of ask ourselves where do we want to be? Do we want to have any recommendations today? Do we want to wait 'til the next meeting? What's the process that seems to be best going forward? Do that around 3:30. And then around 3:45 or so we'll have a public comments to the extent folks from the public like to be heard.

Okay. All right. Question number four; given the data source limitation CMS faces in obtaining a set of physician practice expenses, can a panel give guidance regarding ways to address the PPIS 2006 data upward to a more recent year to appropriately reflect

increase practice expense and physician's compensation?

Any thoughts on that? We've already touched on a little bit of stuff that Kurt's going to let us know about in terms of are there differences in cost categories, major cost categories, depending on size of practice and a specialty. To the extent that anybody can get some data on what's happening to size of practice data, that would be useful as well. We've also spent a bit of time talking about electronic health records.

Other than that, are there other parts that as you look at it should be -- are there other -- well, I guess it's really for the next meeting, the price proxies.

MR. POISAL: It is but what we mentioned this morning was if part of the discussion or if part of what would be helpful in discussing the costs categories and their weights could be informed by, you know, sort of forging into the price proxy piece, we could certainly do that. We'll go into much more detail in our next meeting, but if questions about the proxies would inform discussion about the categories and weights, we'd be very happy to discuss that now as well.

DR. BERNDT: Does the panel have any thoughts?

MR. DYCKMAN: Ernie, can you restate -- not restate, just repeat. I'm particularly interested in the last phrase of the question.

DR. BERNDT: Regarding ways to adjust the PPIS 2006 data

upward -- I presume forward -- to a more recent year, to appropriately reflect increases in practice expense and physician's compensation.

MR. DYCKMAN: Okay. I gather from that that you're talking about the overall expense versus income weights. You're not talking about individual categories, you're talking about expenses, how much have they gone up. It has gone up and income.

STAFF: Yeah. And almost partially that's split between the compensation and the practices.

MR. DYCKMAN: Yeah, the 48, 52 percent.

STAFF: Like 64 or 54.

DR. BERNDT: Any thoughts?

MS. KOBE: What is the problem with using the SOI data? I mean, they're still a lag time on that but -- and I haven't looked at this issue in any time recently, but I was -- if we're looking at overall net income from this industry, it seems like the SOI data can resend information. But obviously there's some problems with the SOI data and I'm assuming what those are.

STAFF: There is a lag.

DR. BERNDT: How long?

STAFF: The most recent data is 2009 today. And then that's really just for this first versions so then preparations that's like 2008. The preparations do include S-works, which connected to the result that they issued. I pulled the data and

presented this as receipts. It's been pretty steady, like 75 are those corporations and then the sole proprietors gone down a share and then hardships got increased. So if you combine the sole proprietors to the partnerships, the share like 96 to the most recent is pretty steady at like 5 percent. Sorry. Corporations are like -- we have a chart.

MS. KOBE: My memory on the SOI is for partnerships and I think for sole props don't they have -- probably it's just for partnerships. Partnerships ask what they get paid in income versus what -- I mean, there's a guaranteed payment to partners, correct?

STAFF: Yes. There's a guarantee to partners and then you have the compensation over service lines and corporation line. And then for --

MS. KOBE: Right. So there would be complications in kind of getting the pieces allocated out to get the distribution between these two.

That's the only source that I can think of that would give you that kind of rates.

STAFF: Some of them show up now as physician's office -- but this doesn't take into consideration --

MR. DYCKMAN: I would think the SOI data would be sensitive to any move tax type, tax changes, and the tax industry initiatives to respond to the changes. Now they're reported as part of the --

MS. KOBE: We've seen a big movement towards partnerships

because of the tax changes. I think almost all the service industries.

MR. DYCKMAN: That might be an issue, but in addition, you would be getting non-medical practice.

MS. KOBE: That's a good point.

MR. DYCKMAN: And that's I think increasing.

DR. BERNDT: What's your source?

MR. DYCKMAN: Oh, just a very poor source. Just visiting like some dermatologists and all the cosmetic stuff that excels.

DR. BERNDT: Clinical trials?

MR. DYCKMAN: No, I was thinking -- clinical trials is one. Selling all kinds of cosmetic products in some practices. There's a variety of things. Over the years maybe the costs of changes in payer behavior but physicians are more interpersonal than they were ten years ago and they're looking for more opportunities so you're getting difference sources of income.

DR. BERNDT: Talking to the investment analysts.

MR. DYCKMAN: Yes.

MS. KOBE: Maybe that's because they're declining from 60 down to 30.

MR. DYCKMAN: Now, we talked before about the MGMA data. That data may not be so good for some purposes but perhaps it might be acceptable for a -- just an income expense. I don't know if that data's problematic from that source.

I mean, any data has potential biases, particularly data where there's -- it's an altering response survey. But that's annual and they do report net income. They report means, certainly. Certainly a source, a good source, but it's a source.

MR. POISAL: And there's a disconnect. I'm sorry. There's a disconnect with this self-employed, I guess, there as well, right?

MR. DYCKMAN: It's not an issue.

MR. POISAL: Okay.

MR. DYCKMAN: I don't think it's an issue in terms of the incorporated practices. I don't think that complicates things for them. Generally it's incorporated.

DR. BERNDT: Do any of the professional societies run their own surveys like psychiatrists?

MR. POISAL: I think some of them have in the past, but I'd have to find out.

DR. BERNDT: Yeah.

MR. DYCKMAN: I think they've been for special purposes rather than on a continual basis.

DR. BERNDT: Any other thoughts on updating data to more recently than 2006?

MR. FOSTER: You mentioned earlier the new IO data is coming out.

DR. BERNDT: I think in October, yeah.

MR. FOSTER: Is that something that John or either of you

would just automatically pick up them and start using them?

MR. POISAL: I think we would absolutely as soon as we get it we would incorporate it into the index and see what the changes look like. To the extent there's a material change in what the index looks like, I think it proved to be material, we would probably want to -- assuming the data works out too that we'd want to consider proposing a rebase model.

MS. KOBE: There's no requirement as to how frequently this has to be given?

MR. POISAL: Correct.

STAFF: The IN --

PANEL MEMBER: You need to speak louder for this.

STAFF: The IN data doesn't have a net income survey, reverse operating surplus is certainly difficult to map out, but we could evaluate some of --

MR. FOSTER: Yeah. With a subsequent survey.

STAFF: Yeah. But that's a really not an option with that survey.

DR. BERNDT: Anything further?

I have a last question here which is, simply, we've talked about a little bit but we might want to just see where we summarize.

Can the panel discuss the appropriateness of the breakout of the detailed categories under "Office expenses," particularly the cost way for "Office rent"?

MR. POISAL: I think we started to go into that a bit.

DR. BERNDT: By way of summary, I am under the impression that that's sort of an annualized cost that assumes depreciation and things like that?

MR. POISAL: Do you want to walk us through how we arrived at that fixed capital basis?

STAFF: Yeah. In this context we had some questions specifically and then we asked that question about fixed capital. So I think John had a slide.

MR. POISAL: Let's see if I have that. Let me see if I can find it electronically.

Kurt had forwarded some questions that we wanted to try to have visuals ready. Kurt, in fact, I was going to invite you to go through some of those questions.

MR. GILLIS: I think we've talked about some of them already.

MR. POISAL: Yeah, I think we have, too.

MR. GILLIS: One was just the difficulty of actually assigning industries to a single expense category --

MR. POISAL: Right.

MR. GILLIS: -- when things like rubber and plastics simply apply to several different things. That was one of the observations. I guess it's something you just have to deal with in using the IO tables.

STAFF: I mean, provide some background on that. That data is based on the names and it's based on how the industry is primarily costs based on primary, like, products or service. And so you have a specific question about how those rubber and plastics how these inputs go to "Office supplies and equipment" and could there be some, you know, placed somewhere else?

Basically our response was for the most part we think it's pretty straightforward but there are some things maybe that could be but we think that's pretty minor. One of the things we realized is we had passed out all these expenses. We didn't get additional categories like all of the categories that were excluded. That sort of helped put some context behind it. For example, in your question here it says, medical equipment is "Supplies," and the slide before this there is a -- one more, one more -- yeah, just a few industries that -- and this is in that table -- that we would consider medical supplies. The concept of the latex gloves came up, I believe. Actually under the name definition they would actually fall under "Surgical supplies."

But to the extent that, like, a rubber plastic manufacturer also gave rubber gloves to you and sold them that they could possibly be in the "Rubber" things but it would be like a small, so that's sort of the answer to your question regarding that.

And then you also had it in context of the capital component. Say you had said about inputs to, you know,

construction. It's on the next slide. Basically, we went through the categories and things that were sort of -- there's some examples, sawmills, seat manufacturing, we consider them to be for office maintenance. The biggest piece was that non-residential, residential maintenance and repair, which is potentially -- to the extent that the lesser is the one who does the repair, it would not show up here because the physician didn't purchase it, but it could be represented in the real estate category, which is on the next slide. It would be likely that, you know, cost of repairing the building would be included in the rent is the idea.

Going to your specific question on the --

MR. POISAL: Rent.

STAFF: Rent share. So the fixed capital we had the two main components is "Leasing" and then "Depreciation." The leasing piece we got directly from the BIO data and that's "531, real estate; industries primarily engaged in renting or leasing real estate, others." And so the terms of the abatements in the MEI it's 9 percent; 7 percentage points is pretty much the leasing component as most provisions in the lease.

The other two percent was the depreciation and we estimated that based on the BEA -- I'm sorry, the Census Bureau. It's called the Business Expense Survey of 2002, which is sort of an emesis to service the annual survey. They used to do it -- they kind of got rid of the BS survey and now they use the SAS survey like quarterly

and annually, so it's sort of kind of the same concept in terms of methodology for surveying.

But one of the things we saw after you had posed the question as we were doing our analysis, we were looking at 2006, SAS data and they didn't have -- they had aggregate leasing but they didn't have a fixed capital leasing, but they just started publishing in '07. So that shows a weight of five percent, which the BUH shows the weight of 7 in 2002. So it does show a subtly different weight.

They do depreciation. They do not write that down on the SAS but if you assume an 80-20 split, which is what the BC split was, then you'll get something around six percent for 2007. They're just rough numbers. Again, this is just in '07. The trend look at the recent years. It seems to create consistent around six.

Now, one of the things about this survey, the SAS survey, which is not like the data we actually used for the index was the BES had more names data available so we were able to aggregate the Office of Commission, Office of Dentist and other practitioners, which is, you know, conceptually closer to the IOM and pick-ups the other non-specialties. The SAS data is only for 862117, so that is a little bit of a flaw.

The thing we did see relative to US instituting it is the dentists and other practitioners showed a slightly higher leasing rate than the 6211s but that was in '02. We don't have data for

'06.

DR. BERNDT: By leasing rates you mean leasing --

STAFF: As a percent of capital -- I mean, as a percent of total --

DR. BERNDT: Okay.

STAFF: We're just comparing there.

DR. BERNDT: Am I right that the leasing refers in the back of your mind to building and depreciations in equipment? Is that what you --

STAFF: This was just for the fixed capital, so this was --

DR. BERNDT: Yeah.

STAFF: -- so this was just for that -- factor one is just for buildings.

DR. BERNDT: Just for buildings.

STAFF: Right. And then the depreciation that we estimated was also we estimated that to be just for --

DR. BERNDT: So it's like rent versus ownership?

STAFF: Yes.

MR. POISAL: And that's all in the fixed capital 90 percentage point weight.

STAFF: So going forward, we could possibly now, since this data is now being published, we may use this data if that's something that the panel would like to recommend since it's now being published for 2007.

MS. KOBE: It's also 2007 business survey. Can I get your survey from the Census?

STAFF: No. I think they got rid of it and now the business expense survey is the SAS survey.

MS. KOBE: Is the SAS survey.

STAFF: Yeah.

MS. KOBE: Okay. So they're only doing it for a sample as opposed to for the universe?

STAFF: Yeah. And the businesses expense survey was in 2005 and was linked to the economic census, so I think -- my estimation is that '07 right now would be a sample because they had to finish the economic survey.

MS. KOBE: Did they finish the economic census?

STAFF: I'm not sure exactly. They've been phasing it in over time, so to the extent that the '07 economic census is completed, I believe, and we have a person upstairs who knows this better than me, that they benchmark those 2007 years to the economic census.

MS. KOBE: Okay.

STAFF: I'm not sure if the '07 data here is just the survey results or the benchmark results. We'd have to check on that.

MS. KOBE: Because I was going to say, you should already have some of the underlying data that's going to go into the IO

table. You have that if you check it or not.

DR. BERNDT: I know we're going to be talking about price indexes proxies next time. It strikes me that the one for fixed capital could be problematic in recent years because it's the CPI for "Owners equivalent rent." What's happening in the housing market, my understanding is, that asset prices have fallen because of the housing but that rental rates have actually gone up; in part because so many people are renting.

So you're going to get -- I think what you have in the back of our mind here is what we have in office rents rather than the residential. I don't know what proxy we could use that would be a better proxy than CPI for orders equivalent, which I think it was residential housing, which is quite different, I think.

Is there a commercial office index rate? I think there must be.

MS. KOBE: That's a really good one that I'm aware of but --

STAFF: Unless there's a non-residential building.

DR. BERNDT: Yeah. That might be better. But I think the FHA actually publishes one as well.

Other questions?

MR. POISAL: We looked at those issues. We'll be happy to sort of dig back through. When we rebased last, I think we looked at that as a possibility as well as other proxies.

DR. BERNDT: I think the last couple of years have been quite different, so maybe --

MR. DYCKMAN: In general, has the leasing index component been more or -- is one substantially more variable than the others over time? Is one more stable or they're both relatively stable?

MR. POISAL: I'm sorry. Are which stable?

MR. DYCKMAN: The two components; the depreciation component and the depreciation, whether they behave similarly or differently?

STAFF: Well, I mean, we just have these points in times but they don't change that much. Just based on the SAS data we have the aggregate depreciation and then we have this leasing and that's really what we gained in the survey. It really doesn't change; around 5 but it would be like 4.85, you know. It's just around there. It doesn't seem to change that much over the last several years. Now whether or not the lease housing prices and things may change a few things, but we kind of see that.

MR. POISAL: Kurt, any reactions to that?

MR. GILLIS: No. Could you forward the slides to me?

STAFF: Oh, didn't you get them?

MR. GILLIS: Oh, were they passed out?

MR. DYCKMAN: It's in the back of this.

MR. GILLIS: Okay.

MR. DYCKMAN: The last slide.

MR. GILLIS: Thank you.

DR. BERNDT: Any other thoughts about "Fixed capital"?

Are there questions, John?

MR. POISAL: Kurt, did we sort of hit on -- I remember when you had originally sent in your questions, you know, we said, we'll certainly try to make ourselves prepared to answer them, but did you have others that we haven't hit on that you shared or others that you've come across in the interim?

MS. KOBE: If you're saying the vast majority of these people are leasing offices, do they do their utilities separately. I guess I'm wondering if, usually -- lots of times utilities are included in their rent. Has that ever been --

STAFF: That question came up and people thought we were double counting, but since we took that leasing component from the IO, we should have only picked up the utility costs for the actual physicians. So we should be okay with that.

STAFF: We also have slide that Molly was talking about earlier and it just shows the distribution of the business receipts but also the physician's. So just pass it around.

DR. BERNDT: I guess related to our earlier discussion this morning, to the extent we're getting to larger group practices away from "onesies," "twosies," medical offices, I suspect, leasing will increase over time.

Regarding the distinction between fixed and removable

capital, if I have an x-ray machine, is that moveable or fixed?

STAFF: Medical equipment would be --

DR. BERNDT: Oh, that would be -- okay.

STAFF: That moveable capital should be in the IO.

DR. BERNDT: Okay.

STAFF: That would be -- if I remember correctly, it's like heating and air and things of that nature. It's not medical.

DR. BERNDT: Office furniture?

STAFF: Yes.

MR. DYCKMAN: Computers?

STAFF: Yes

MS. KOBE: Are the exam tables and that sort of thing considered to be medical equipment or is that general?

STAFF: I guess we never thought of it.

MS. KOBE: I don't think it probably makes a big difference.

DR. BERNDT: The chairs where they draw your blood?

(Laughter)

MR. HEFFLER: You don't have one of those in your basement?

(Laughter)

DR. BERNDT: Not yet.

MR. HEFFLER: They're really comfortable.

MR. POISAL: One of the things that has come up over the years, or at least in particular with the most recent rebasing,

where how some of the weights strike the public in some cases as being correct. I think we've touched on part of that in that it's not always clear what things are picked up and placed in what categories, but given that we've sort of talked about this a bit more -- my apologies for flipping back and forth -- but the fact that we've talked about this a bit more now and there seems to be a better understanding about where things sit, do those weights now look as though that they make sense? Does anything stand out at this point as it just doesn't sort of pass your own internal test of about what you might have thought prior to coming in today and learning a bit more about what things landed where?

MR. GILLIS: They haven't changed that much over time. I mean, this was -- the change this time around was bigger than what we normally would see. I think the last couple of rebasings it's been -- the changes have been pretty minor.

MR. STEINWALD: What happened to medical equipment? That's the one that surprises me.

MR. POISAL: Medical equipment.

MR. STEINWALD: It's in every practice but it just strikes me that with all that I hear about ancillary costs as a source of revenues and imaging equipment and all sorts of induction studies and this and that, to be at only two percent strikes me as low. That's all. It surprises me.

MR. POISAL: It's roughly the same as what it was.

MR. STEINWALD: Roughly the same.

MR. POISAL: Yeah. Down slightly.

DR. GILLIS: It is one of the harder questions for doctors to answer among the expense questions, and I don't know if that's just because they don't have it or if it's hard to come up with a figure for depreciation and leasing and maintenance and pull all that together and put a number on it.

DR. BERENSON: I would question whether -- I mean, that strikes me as one of the areas that I wonder how well they're doing on the survey.

MS. KOBE: It is surprising though. The number is the same, but it looks like it has gone down, which does not seem to --

DR. BERENSON: Oh, yeah.

MS. KOBE: -- to match what we would expect to have happened to that number, although I suppose the prices might have gone down.

DR. BERNDT: Is Medicare typically eligible for tax credits, equipment tax --

MR. DYCKMAN: To the extent any other equipment would be, that should be also.

DR. BERNDT: But it's not specially targeted.

MR. DYCKMAN: I don't think so. But you're right. It's hard to think of it going down --

DR. BERNDT: Yeah.

MR. DYCKMAN: -- over that six-year period. Some things are lower in cost perhaps, but there's new types of equipment.

MR. STEINWALD: I think the benefits, it doesn't look great to me, but over this time period generally more and more compensation has been in benefits.

DR. BERENSON: Just like alpha --

MR. STEINWALD: Right. That's one of them. That's the main one.

DR. BERENSON: We know about that.

MR. STEINWALD: And if you look at physician benefits as ten percent of wages and salaries and that's a reduction from, you know, a much higher percentage, and then look at the non-physician benefits, extremely high proportion.

MS. KOBE: But they said the original ten percent number had come from a completely different -- they had broken that out themselves.

MR. FOSTER: That was economy wide.

MS. KOBE: That was an economy wide number originally, and not a --

MR. FOSTER: Originally, yes.

MS. KOBE: -- not a physician specific number. And if all of their retirement is actually ending up in wages and solids (phonetic), which is what we suspect in this distribution here, it's a little bit more reasonable. But it does seem low.

DR. BERENSON: Health insurance is on the spouse.

MR. STEINWALD: Well, yeah.

MS. KOBE: Maybe they saw the insurer.

MR. STEINWALD: But you have not had pushback on that particular one? Okay.

DR. BERNDT: Do you float this by physician groups?

MR. POISAL: To the extent that it went out in the public in the rulemaking process and a proposed rule.

DR. BERNDT: Okay.

MR. POISAL: All of these figures were subjected to rulemaking, and a lot of the questions that we got were questions that were raised, you know, last year when we were re-basing and revising the index and had announced that we would be convening an MEI technical panel, and certain things that we got from the public were explicit about please have the panel consider. So those are reflected in the what we've covered so far.

MS. OUMAROU: A lot of the concern was maybe with the office expense breakdown. I really think that was the focus. We didn't receive very many comments about the drugs, which we talked about before.

STAFF: I don't think we received anything on that. They didn't receive any comments on the wage benefit, acquisitions and the loss regulations.

MR. POISAL: The biggest issues as I recall were just what

was related to the ITPs, you know, and the --

DR. BERENSON: Like where is the ITP.

MR. POISAL: Like where is it and, you know, if it costs thousands of dollars to install these new computer systems for recordkeeping purposes and EHR and things, and that's just not picked up, and then as we've said today, the things like rubber and plastics, we had gotten comments like, "I don't understand how rubber and plastics is a category but computer systems aren't."

MR. FOSTER: That was Bob's comments.

MR. POISAL: Yeah.

(Laughter.)

MR. POISAL: And we're sensitive to that, but this was, you know, our best attempt to reflect what the PPIS data picked up and how it picked it up, as well as to sort of balance the issue of the need to be brought enough and reflect an appropriate level of aggregation, but detailed enough to try to, you know, articulate what that cost structure really looks like and reflect it as best we can. So it's a balancing act here.

And to the extent maybe we aggregate up, again, and collapse some categories or the extent to which we rename some categories that Steve had mentioned a little while ago, you know, I think those are the types of things that would be in play from our perspective. We're going to get their feedback.

MR. HEFFLER: Kurt, I was going to ask you. You're going

to go back and do some runs off the data to look at different cuts. The wages and salaries and benefits, I don't know if you're planning on doing the detail that was like on the table like I'm handing out or whether you were just going to do it total, but that might be something that might shed a little more light on this wages/benefits, but if we can see it by the cuts that you're looking at, the specialty and size, because there could possibly, underline this, be some kind of weighting issue that is driving that down lower than what we might expect above and beyond the issue where the dollars were classified.

DR. GILLIS: Okay. I can plan.

MR. HEFFLER: So that might be helpful because that really does kind of front things. I was looking at the numbers, counting the trade, you know, over the last several years. The wages and the benefit have moved very similarly, but if you go back to the early 2000s, the benefits were probably two or three times as fast, and that can affect the total top line MEI.

Is that doable?

DR. GILLIS: Yeah.

MR. HEFFLER: Okay. Great.

MS. KOBE: Do you think it's possible that some of the benefits, for example if you are just buying health insurance for your whole company, some of the benefits just get rolled into the non-physician benefits, but you aren't necessarily allocating them

out?

PARTICIPANT: Could be.

MS. KOBE: It' shard to know. I think it's more likely the retirement issue, but that's the only other possibility that comes to mind, but it's there, but it's allocated to the wrong category.

MR. DYCKMAN: For the non-physician, what are the benefits for the non-physician?

MS. KOBE: They are down there about halfway.

MR. POISAL: Non-physician benefits --

MS. KOBE: They've got the 5.4 percent.

MR. DYCKMAN: It's about 40 percent, right?

MS. KOBE: The total wages and salaries for that group is 13.8. So that's a pretty high wage.

MR. DYCKMAN: I think there are accounting systems that put in things like sick leave and vacation time into that even though it's not an expense, and that might reflect that. It can be very high because of that.

In terms of the payroll taxes, I assume that would be included in that, but it does appear quite high, and it might include, you know, things like that where the vacation and sick leave, whereas that would not necessarily be included in the benefits of the physician.

MS. KOBE: That's true.

MS. OUMAROU: That non-physician split was based on

the -- yeah, that easy data. So that split was not from raw data.

MS. KOBE: Okay. So you've left a percent for ECEC, too.

MS. OUMAROU: It was just at the 8.62, that split, and we applied that toward non-physician compensation to get that split. So it's not like under the physician compensation where we had the two pieces for the net income and then the benefits question, which was only specifically for the health insurance, life insurance. So there might be -- I'm just saying the piece under non-physician isn't necessarily driving the definition. It's whatever that definition is.

MR. HEFFLER: Yeah.

MS. KOBE: Which subgroup from ECEC are you using?

MS. OUMAROU: NICK-62 (phonetic).

MS. KOBE: So that includes the physicians.

MS. OUMAROU: Yeah, that's the top level for health care and social assistance.

MR. HEFFLER: Yeah, that's actually a pretty foreign scope of physicians.

MS. OUMAROU: Right.

MR. HEFFLER: We've got everything in there, right?

MS. OUMAROU: Uh huh.

MR. HEFFLER: Hospitals, gold nursing, all social assistants, all types of workers' labs, yeah.

MS. KOBE: Well, then it brings up the ancient question of

physician member boards in those circumstances.

MR. DYCKMAN: Well, clearly, the definition is very different.

MS. KOBE: yeah.

DR. BERENSON: You're not talking about the same animal.

MS. KOBE: Absolutely.

STAFF: Well, we can go with the exhibit breakdown and see (inaudible).

DR. BERNDT: Yeah, if you could do that before the next meeting, that would be great.

MR. DYCKMAN: I know John had suggested we think about grouping things together, and I'm looking at chemicals, paper, rubber and plastics, each of which is less than one percent, and there may not be a meaningful category for physicians and also all other products, and perhaps call something office supplies and products or something, products and supplies, you know, with perhaps a two or three percent rate rather than break it out because you know, you're looking at chemicals and rubber and plastic, and it pretty much raises questions more than anything else.

MS. KOBE: Probably the prices on chemicals, rubber and plastics are more similar to paper. I guess part of it is the price structure.

MR. POISAL: That's true. It would be a consideration anyway.

MR. DYCKMAN: Yeah, but you could use the same price proxies.

MS. KOBE: Just the weight.

MR. POISAL: But just look at the weight.

MR. DYCKMAN: That's all.

MS. KOBE: We can do it that way.

DR. BERNDT: Do the computation disaggregated, but then we --

MR. DYCKMAN: Right, exactly.

STAFF: And just to clarify, those are some of the categories we have in the hospital market basket, and some of the reasons why we chose those is because the chemicals and rubber and places are not very friendly energy sensitive. So when energy prices and gas prices move, those tend to track. That's sort of why we kind of broke those out separately and proxied them. That was the idea.

STAFF: I think we decided to put paper because we had put rubber and plastics (inaudible). It had a little weight, but it didn't have that volatility. So we said we'll make our cutoff point higher.

(Laughter.)

DR. BERNDT: Any other thoughts on cost weights, cost categories?

MR. FOSTER: Just one other comment having to do with the

benefits relative as a share of total compensation between the physicians and everybody else, and I'll confess you know, I never figured out or I don't remember where the payroll taxes show up, but keep in mind that a fair chunk of physician wages and salaries would be above the Social Security wage base, whereas I would get most of the non-physician compensation is below the wage base and, therefore, subject to the full 6.2 percent.

But that would be one other factor, I think, causing some difference between the two sets.

MS. KOBE: Well, for self-employed, they might be paying that themselves, too. If we are thinking about this before taxes, are they, you know, including that as (inaudible) if they're paying it themselves?

MR. FOSTER: I'm trying to remember when I -- it has been a while since I've filled out a Schedule SE, but when you determine your net income from self-employment, that's what the payroll taxes get applied to, right? But it is subtracted as an expense.

MR. DYCKMAN: But you've asked the physicians -- you've defined for them what the benefits are, and I don't think payroll tax -- payroll taxes weren't part of that.

MR. FOSTER: This is what I don't remember. So in the AMA survey you mean we're not counting payroll taxes as part of benefits?

MS. OUMAROU: Right.

MR. FOSTER: But in the source for the non-physician we probably are?

MR. POISAL: It doesn't say payroll taxes.

DR. BERNDT: I thought it was non-physician.

MS. OUMAROU: On the back of this? It did not.

DR. BERNDT: For the -- no, no, no, no. I'm sorry.

MS. KOBE: Benefits does not. It doesn't specifically say to include your payroll taxes.

MR. FOSTER: In 2013 when we do this again, we'll be sure to specify it.

MS. KOBE: So it's possible that the payroll taxes will --

(Laughter.)

MS. KOBE: -- wages and salaries as well.

DR. BERNDT: I'm sorry. Say that again.

MS. KOBE: Where they're telling them how to define that, it says, "Provide the dollar value of your 2006 benefits (health insurance, dental, life insurance, etc.) received from your medical practice." That says nothing about payroll taxes and consequently it's likely that they would not have taken that out of there since wages and salaries. So that would be another explanation as to why this seems very small to us.

MR. DYCKMAN: Do you have the definition of wages and salaries on that page?

MS. KOBE: It says, "What was your net income from medical

practice? Please include all income from fees, salaries, retainers, bonuses, deferred compensation and other forms of monetary compensation, but not investment income from medical related enterprises independent from your medical practice. Please do not include benefits in this response."

MR. DYCKMAN: With no reference to payroll taxes.

MS. KOBE: So my guess would be if it is before taxes, then they would have just added -- I mean, they would have just kept it in their payroll taxes and their wages and salaries number.

MR. DYCKMAN: If it's before taxes.

MS. KOBE: That's probably an explanation as to why the differential is so strange, because the ECEC would definitely put payroll taxes on the benefits side.

MR. DYCKMAN: Yes.

DR. BERNDT: All right. Any other questions?

(No response.)

DR. BERNDT: Bruce suggested we might want to sort of think out loud for a few minutes as to what is our responsibility as a panel going forward. Should we be thinking about putting in the paper some specific recommendations or is it premature to do that?

I wasn't here at the opening instructions this morning. So what had you planned for us to be doing?

MR. POISAL: I thought by 3:30 we would have said the index looks great or something like that.

(Laughter.)

MR. POISAL: But that didn't work out. So, no, we weren't very explicit about sort of setting a specific goal for the day. You know, I think Rick, when he made his opening remarks, observed you as your panel, you operate as you see fit. So I think we defer to you about where you think we should be by the time we adjourn today.

To the extent you want to make recommendations or put things, you know, on the table to say these are things we're going to give some thought to between now and next time --

DR. BERNDT: Is it commonplace for technical advisory panels here to make explicit recommendations or not?

MR. POISAL: I think we'd like for that to be the case, and I think that that has been the history, and I think it's also okay for you to have considered things and to explicitly say we think the way this is done currently is a reasonable approach and should be continued, too. It sort of depends on the things that sort of rise to the threshold of your consideration and how strongly you feel about certain things.

But to have confirmation of things that you think are okay is helpful, too, and then to the extent you'd suggest changes.

MR. HEFFLER: I want to suggest that maybe just doing kind of a little wrap-up of the things that we promise to bring back or things we're going to look into and then things that -- I don't know

that they've been decided, but if we can get the list of those things, we can actually start on the wording even if it's in draft form of possible like recommendations or findings because I think our experience -- and you can tell me whether I'm crazy on this or not -- is it's one thing to sit around a table and talk about issues. It's very different when you see it actually written on paper to say, "We recommend this," or, "we have found this."

And it forces you to be explicit about what the finding is as opposed to just very general, and so the sooner you can start to get some of those things written down, I think the better chance you have when you get to the end of accomplishing sort of the overall goal on these various pieces. So I don't know if --

MR. FOSTER: Yeah, I would just add a couple of things to that. You know, this is an official Federal Advisory Committee Act panel, which means you have to follow certain rules. One of those rules is you have to make formal decisions at a public meeting like this one.

Now, you're also allowed to, you know, not at a public meeting like this one like draft findings and recommendations, draft other sections or whatever you might feel like putting down on paper, doing any background work or research that you want to or asking us to do anything on your behalf. You don't have to do all of that at a public meeting. You can do that kind of offline.

So just keep that in the back of your mind. At some point

you'll want to formally decide at one of these meetings, yes, we approve these findings and recommendations.

Now, the other thing I'd suggest is, I guess, consistent with what you were saying, Steve, one or more of you could start thinking about from today's meeting what are the areas of consensus. Do things look okay generally? Is there possible improvement by looking at this, this or this? And just start honing in on what you as a panel were trying to get consensus around.

Now, I wouldn't say you have to do that like right in the next, you know, ten minutes or something. That's the kind of thing that takes a certain amount of contemplation and probably looking at the record at the meeting.

And I don't know the timing on the transcripts, how long that might be. Will you be producing a formal transcript of the meeting?

THE REPORTER: I was told earlier today nine calendar days one coming out.

MR. FOSTER: Okay. Yeah, that sounds good.

DR. BERNDT: So that's what, the 30th?

MR. DYCKMAN: Steve, as a follow-up to what you've said, might it be useful for someone -- I don't know who's been taking notes. Maybe a few people were taking notes -- to sort of cull out the primary semi suggestions and proposals and also the suggestions not for future research, but for coming back to us with some

additional information like, you know, the specialties and the size and things like that.

And based on that either between now and the next meeting or perhaps some time at the next meeting, that should be distributed, and after it is distributed, we can comment and decide from that are there recommendations that we'd like to put forward.

MS. KOBE: From my own point of view, I think it would be helpful to discuss the price proxies before we make any final recommendation certainly about the cost weights, too. I see that everybody is wanting to kind of --

DR. BERNDT: I think that was planned for the next meeting, wasn't it?

MR. HEFFLER: Yeah.

DR. BERNDT: Post the price proxies and a (inaudible) adjustment.

MR. FOSTER: And even before that point, I mean, you've already -- there sounds to me like there's been some consensus already at this meeting about certain kinds of things that could be pursued further, and that's worth making a note of, and then you could possibly agree on those at the next meeting.

And you're right. Some of the other questions are going to depend on the proxy question.

MS. KOBE: Right. Okay.

DR. BERNDT: Bruce, do you have any recommendations you

want to lead off with?

MR. STEINWALD: Oh, no, and that's not my job. No, I think what you've decided is entirely reasonable, and I heard several times the point made that before getting to recommendations on the things we've already discussed it might be helpful to get to the discussion of the things that are still on the agenda to discuss, especially the price proxies.

MS. KOBE: I think the weights and the price proxies are very closely tied.

MR. STEINWALD: Yeah, yeah. That makes sense to me. So I don't think anyone should feel that they haven't accomplished something because there's no recommendation made today because you'll have ample opportunity to get there if that's where you want to go.

MR. HEFFLER: I was trying to keep tally as we were going through of places where there were "to do's" and then things where there was maybe some movement towards ideas. I would be glad to maybe just right now just take a couple minutes and go through them and you can tell me whether I heard them right or not.

MR. POISAL: Sure.

MR. HEFFLER: I don't know if you were planning on a better way.

I mean Kurt has gone around a couple of things on the PPI survey related to specialty and size.

DR. BERNDT: To some sort of aggregate, some of the cost categories, major cost categories, not line by line.

MR. HEFFLER: Okay. We were going to check into on the electronic health records and the data and availability for background on that.

I think at the very end there we said we would go back and look at the ECEC definitions and so forth.

Those were the three things I had as "to do's."

DR. BERNDT: "To do's."

MR. HEFFLER: Am I missing anything? Mary, Carol or Mollie, Hudson? Anything else?

STAFF: There was a couple questions on some alternative versus (inaudible). So maybe just pulling out some data on what's available.

MR. HEFFLER: Yeah.

DR. BERNDT: And the MGM.

MR. HEFFLER: I'm sorry. What was the --

DR. BERNDT: MGMA.

STAFF: I'll look into that data set.

MR. HEFFLER: Yeah, maybe we were going to do a little bit on some of the issues that got raised on the data source, right.

MR. DYCKMAN: Well, at the end we talked about possibly considering that as a source of the basic income-expense break.

MR. HEFFLER: Yeah. So maybe I would put that under ideas

for findings and recommendations --

MR. POISAL: Okay.

MR. HEFFLER: -- as opposed to an actual "to do."

MR. POISAL: Okay.

MR. HEFFLER: One of the things, Kathryn, you mentioned was the idea of whether we could go to Census and ask whether they could expand questions or add questions.

DR. BERNDT: To the SAS.

MR. HEFFLER: To the SAS.

Bob, I think you brought up a point about would there be some value in having a more focused, smaller survey effort to try to get specifically at certain specialty sizes and just try to target data collection as opposed to trying to do --

DR. BERENSON: It was actually a substitute for survey.

MR. HEFFLER: A substitute for survey, right, but a smaller, more focused cost reporting.

DR. BERENSON: And I haven't heard about what our alternative is. I mean what we're going to do. You know, there's an AMA gap, a survey gap.

MR. HEFFLER: Right.

DR. BERENSON: And I haven't heard, except for the possibility of the Census maybe doing it, and I don't know what else we've got. So I'm throwing that into the mix.

MR. HEFFLER: Sandy told me during the break she found $3

million sitting out by --

(Laughter.)

MR. HEFFLER: There was a general thought that there wasn't much we could do beyond doing a fixed weight and mix given the data limitations.

And then I had a bunch of issues just listed under, I guess, just the general weighting issues. Of course, we were talking about the physician wage benefit.

DR. BERNDT: Split.

MR. HEFFLER: Split and how that's actually --

DR. BERNDT: Compared to the non-physician.

MR. HEFFLER: Yep.

DR. BERNDT: Were there any "to do" items on that?

MR. FOSTER: Well, the definitional issues that we mentioned earlier.

DR. BERNDT: Yeah.

MR. HEFFLER: There was, I think, a general sentiment that some categories could be collapsed, and some maybe should be expanded, and the ones that I heard expanded were, Bob, you brought up the all other services and the other professional expenses.

DR. BERENSON: It depends on how the -- I'm not sure. I think HIT is the one that --

MR. HEFFLER: Right, and then related to that is whether the IT and the HR should be a separate category.

DR. BERENSON: That I don't see how you do it, but it's worth examining.

MR. HEFFLER: There was the issue of drugs and that are not separately billable but part of practicing and how they should --

DR. BERNDT: Had we identified them?

MR. HEFFLER: -- be reflected, right.

The issue about medical equipment and why that weight. I think there was agreement around the table here that it looked low, and it looked like it was going in the wrong direction relative to what intuition said.

The only other thing, I don't know how big a deal this was, but this issue of is there a problem with the definition of net income because it takes total revenue less expenses and calls that income, yet some of that income could come from things that don't have to do with actually practicing physician care, like the separately billables.

But I don't know how in the hell we would get at that, but I don't know if that was a big issue or not.

DR. BERNDT: That might just show up when you look at your -- you see it in certain specialties.

MR. HEFFLER: That's true, yeah.

MR. DYCKMAN: Hematology and oncology.

DR. BERNDT: Yeah. Neurology with MS strokes.

MR. HEFFLER: That's what I had. I may have missed

something along the way.

DR. BERNDT: I think I asked a few questions, and I don't know if they were "to do" items or not, but it is to say are there consulting firms that --

MR. HEFFLER: Yeah, you did.

DR. BERNDT: -- that offer services and might have some data available on purchasing physician practices.

MR. HEFFLER: Well, we could put that on the "to do's" and maybe we could spend some time between now and the next meeting seeing what we could find out.

DR. BERNDT: Right. And I guess do some of the professional organizations run their own surveys?

MR. FOSTER: And keep in mind that as you are thinking about what's a finding, what's a recommendation, what's just a discussion some of these issues we're not going to resolve within the time frame of the technical panel, but there's nothing whatsoever to suggest that you couldn't recommend pursue further the following issue.

MR. HEFFLER: Yeah.

DR. BERNDT: Anything else you can remember?

DR. GILLIS: I don't know about the issue of splitting out billing contract staff from the other expense category. I think that's --

MR. HEFFLER: Yeah, I missed that one. You raised that,

right.

DR. BERNDT: Any others?

MS. KOBE: I think there was some question about -- and maybe this is more for next time -- but you said you had already looked at some indexes on rentals and office rentals.

DR. BERNDT: Oh, yeah, right, yeah.

MS. KOBE: If you would just check which ones you've already looked at for the next time that might be helpful.

DR. BERNDT: Any others?

(No response.)

DR. BERNDT: Then I think our last item of business that's on the agenda is opening up for public comments.

PUBLIC COMMENTS

DR. BERENSON: Well, actually I did want to ask a process question. What are we committed to doing for future meetings? Do we have one meeting scheduled and one on hold? Is that what we've got?

MR. POISAL: We do. We have one meeting that's definitely booked on June 25th, and then I think at the end of the day it's ultimately up to you all to determine whether or not we utilize the third meeting that's scheduled for July 11th.

DR. BERENSON: And that, I mean, that's pretty much it?

MR. POISAL: Yes.

DR. BERENSON: We can do two or three meetings.

MR. POISAL: Correct.

DR. BERENSON: Or presumably we can do something on a call or something if we found a need to. Oh, no, this is a public meeting.

MR. POISAL: Right. It would have to be public.

DR. BERENSON: It can't be a call. Okay.

MR. FOSTER: Yeah, I mean, you can have offline research, discussions, whatever, but you can't make formal decisions except at this setting.

DR. BERNDT: Could you send it out to us?

MR. POISAL: I absolutely will, yep.

DR. BERNDT: Thank you.

And will there be many other things sent I would think?

MR. POISAL: I don't think we had anything that was targeted necessarily. We'd be happy to make available electronic versions of the documentation that was sent out if you'd like that, and to the extent other things come to you in your cab ride home or your drive home that you really didn't think at the time to ask but you really think that X, Y and Z might be helpful to you for the next meeting or for further sort of thinking about the issues we've discussed today, by all means let us know and we'll be happy to turn around what we can.

MR. FOSTER: As we and others produce the "to do" things, we'll send those out.

MR. POISAL: good.

MS. KOBE: The study that compared the productivity of physicians --

DR. BERNDT: Is that the Fisher study?

MR. POISAL: Yes.

MS. KOBE: The link to that is?

MR. POISAL: That's in the old one.

MS. KOBE: Yeah.

DR. BERNDT: That's what he told me.

MR. POISAL: That's right.

DR. BERNDT: All right. Let's open it up to the public for comments, and if you'd like to speak, could you first identify yourself and your affiliation? Yes.

MS. MARKS: Okay. Well, I spoke a little bit before. I'm Sandy Marks with the AMA, and I just wanted to thank you very much for convening this panel and for having this meeting, and I think it has been very useful.

I think the suggestions you've made going forward, I realize they're not formal recommendations yet, but they're certainly headed in the right direction.

And I think it's good to pay some attention to how the information is presented because even though you're economists coming up with these ideas, it's practicing docs 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.

So I think that's a good place to focus, and also I think we need to explore, you know, and maybe you want to explore -- I don't know -- but if there were to be another survey by the AMA, what would you need from it?

I mean, the PPIS, I believe, was conceived to update the practice expense relative value, and that's how it was designed, and you know, we got 7,400 responses that of which you used only a fraction. So you 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.

So I think that's something to think about on both of our ends, you know, what it would take from us, but what it is that you would really want. So maybe something for the panel to consider.

DR. BERNDT: Thank you.

Anyone else? What's that old phrase, speak now or forever --

MR. POISAL: Right.

(Laughter.)

MR. POISAL: Hold your piece until the next public meeting.

STAFF: I yield the balance of my time.

(Laughter.)

STAFF: Just a couple of data sorts of problems, data source that historically has been used. It's medical economics is one that you mentioned here. It was used some (inaudible), and I think at one time we actually used some. It wasn't really discussed today, and they just have meetings, but when they do -- at least they used to do this -- special surveys on topical things. So I have no idea, but they could have had a survey on movable equipment or IT or something, just something to know about, and also to look at trends because they have the net income and the costs.

And also on this medical group practice, I don't know if they have categories on there for IT or movable equipment, but if they did, it would just provide -- you could look at that and see if that squares with what we're getting here.

And on the IRS data, there's two sets of IRS data. There's the complete census, which the Office of Actuary used for the state estimates. Now, that actually has like a lot of physicians are into real estate and stuff. That actually has all of that income since you were talking, and for statistics of income, that's a sample. They certainly take out the kind of other industries like that, and there's probably some -- you know, it's not strictly kind of practice.

If you look at it on a year-to-year basis, the statistics of income sample has high sampling variability. If you look from year to year on it, there was usually a different kind of a way to

get shares, but there might be something there.

MR. POISAL: I'm just taking off my technician hat and putting my GFO hat back on. I want to thank everybody, the panelists --

DR. BERNDT: For showing up late.

MR. POISAL: -- for showing up late, but showing up all the same. So: and the valuable discussion we got out today.

DR. BERNDT: Thank you all.

MR. POISAL: Thank you all very much.

(Whereupon, at 3:55 p.m., the meeting was concluded.) * * * * *