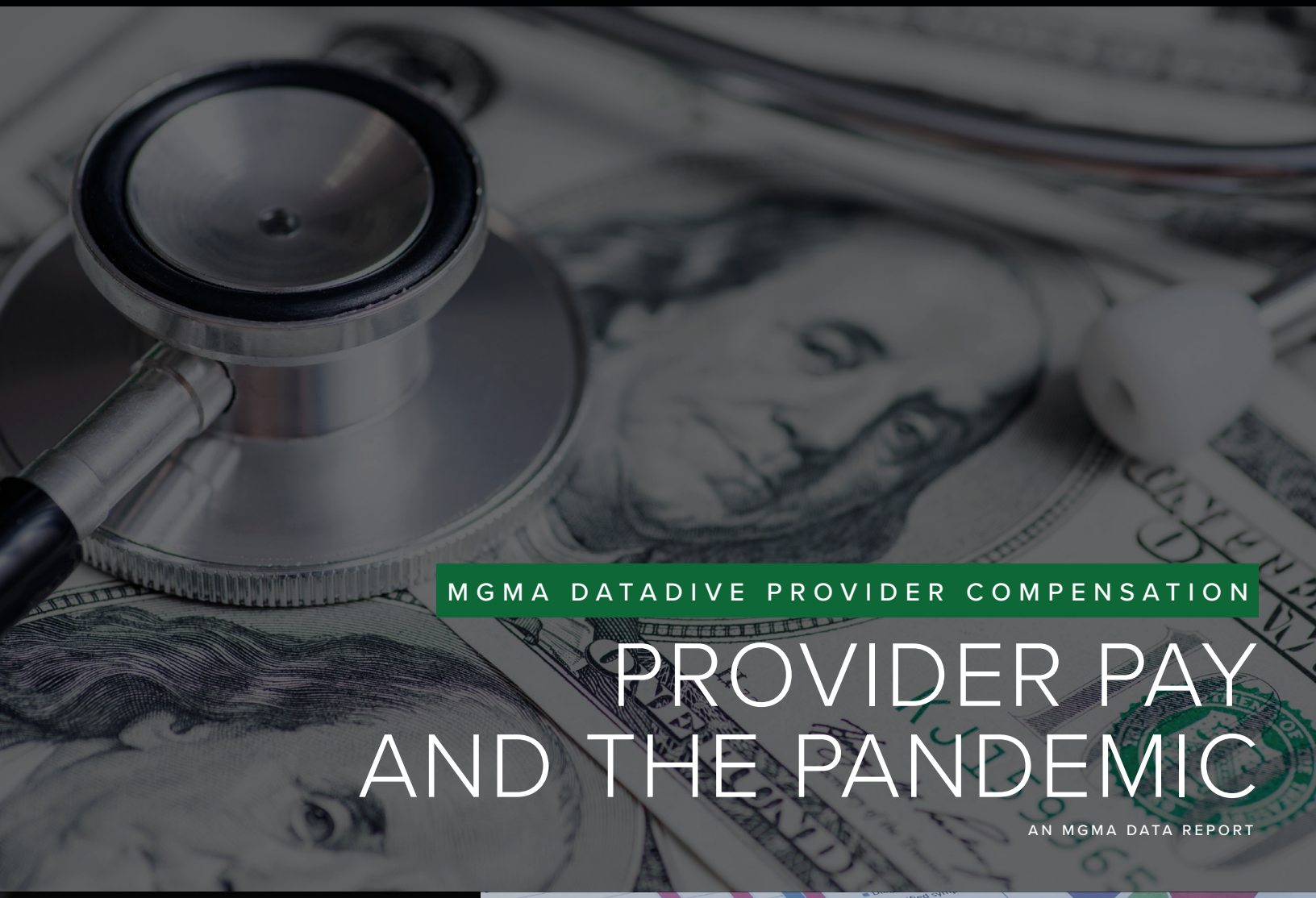
MAY 2021



MGMA DATADIVE PROVIDER COMPENSATION

PROVIDER PAY AND THE PANDEMIC

AN MGMA DATA REPORT

MGMA®

Table of Contents

ABOUT MGMA

Founded in 1926, the Medical Group Management Association (MGMA) is the nation's largest association focused on the business of medical practice management. MGMA consists of 15,000 group medical practices ranging from small, private medical practices to large national health systems, representing more than 350,000 physicians. MGMA helps nearly 60,000 medical practice leaders and the healthcare community solve the business challenges of running practices so that they can focus on providing outstanding patient care. Specifically, MGMA helps its members innovate and improve profitability and financial sustainability, and it provides the gold standard on industry benchmarks such as physician compensation. The association also advocates extensively on its members' behalf on national regulatory and policy issues.

mgma.com

Introduction

It took a once-in-a-lifetime public health crisis to slow down America's physicians.

Even with the COVID-19 pandemic shuttering some practices and capping elective procedures for significant portions of the past year, the *2021 MGMA Provider Compensation and Production* report — reflecting data from more than 185,000 providers across more than 6,700 organizations — finds **compensation for most physician specialties was either flat or increased slightly during 2020 versus 2019 levels**.

2.6% **Increase in primary care physician total compensation, 2019 to 2020**

1.25% **Increase in advanced practice provider (APP) total compensation, 2019 to 2020**

Those numbers may not immediately reflect the pain felt by practices that were forced to respond in the face of crisis. Data from specialist physicians for the report point to what most of us already know: 2020 took a major toll on a broad range of healthcare providers whose deference to safety and science in weeks (and sometimes months) of shutdown orders strained the ability to serve their patients in an industry in which access was already a major concern:

-1.91% **Change in median total compensation for specialist physicians, 2019 to 2020**

-0.89% **Change in median total compensation for surgical specialists, 2019 to 2020**

-1.29% **Change in median total compensation for nonsurgical specialists, 2019 to 2020**

This report offers a closer look at the data within ***2021 MGMA DataDive Provider Compensation***, so that we can learn more crucial lessons from 2020 and position today's medical practices for continued recovery and sustainable success.

We know all too well that the pandemic isn't over...

Visit the MGMA COVID-19 Recovery Center for the latest tools, content and insights for leading throughout the coming months.

Trends

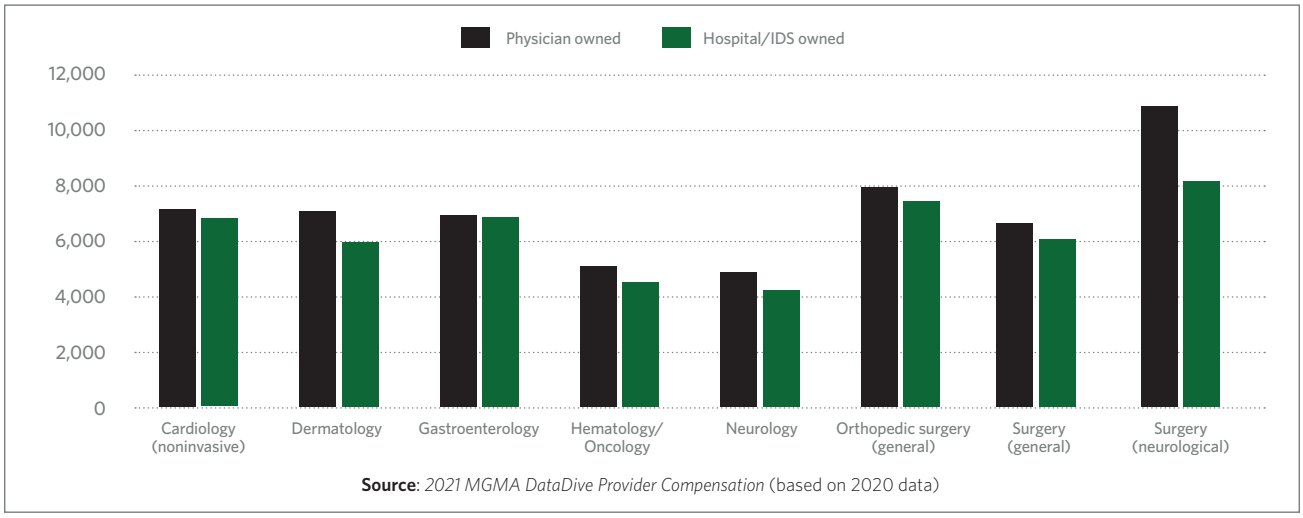
PHYSICIAN PRODUCTIVITY

KEY PRODUCTIVITY METRICS BY OWNERSHIP				
	Total encounters		Work RVUs	
	Physician owned	Hospital/IDS owned	Physician owned	Hospital/IDS owned
Primary care	3,243	2,653	4,653	4,280
Surgical specialist	1,801	1,864	7,914	6,502
Nonsurgical specialist	3,451	2,293	6,297	5,376

Physician-owned practices report higher levels of productivity for many specialties in total encounters and work RVUs (wRVUs) in the *2021 MGMA Provider Compensation and Production* report.

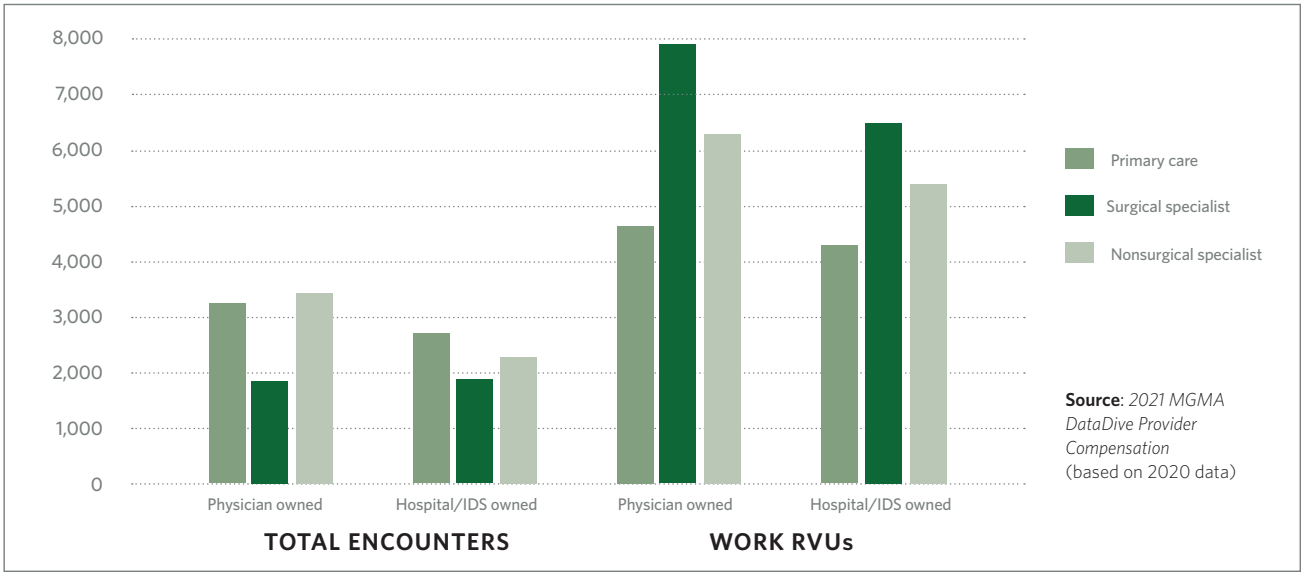
Total encounters reflect the number of direct provider-to-patient interactions regardless of setting, including televisits and e-visits. The wRVUs also quantify productivity and take into account the complexity of the visits.

WORK RVUs BY PRACTICE OWNERSHIP IN SELECTED SPECIALTIES



Source: *2021 MGMA DataDive Provider Compensation* (based on 2020 data)

PRODUCTIVY BY PRACTICE OWNERSHIP, BY SPECIALTY GROUPING



Source: *2021 MGMA DataDive Provider Compensation* (based on 2020 data)

These findings give deeper insight into similar findings derived from the *2020 MGMA Monthly Survey* launched in July 2020, which collected data at the provider level data and for the overall practice. By June 2020, volumes began to rebound. The *2020 Monthly Survey* data show **reported wRVUs stabilized after hitting their lowest levels in April, with sizable increases reported in May and June 2020 for all provider types.** Nonsurgical specialists reported the largest decrease and increase respectively.

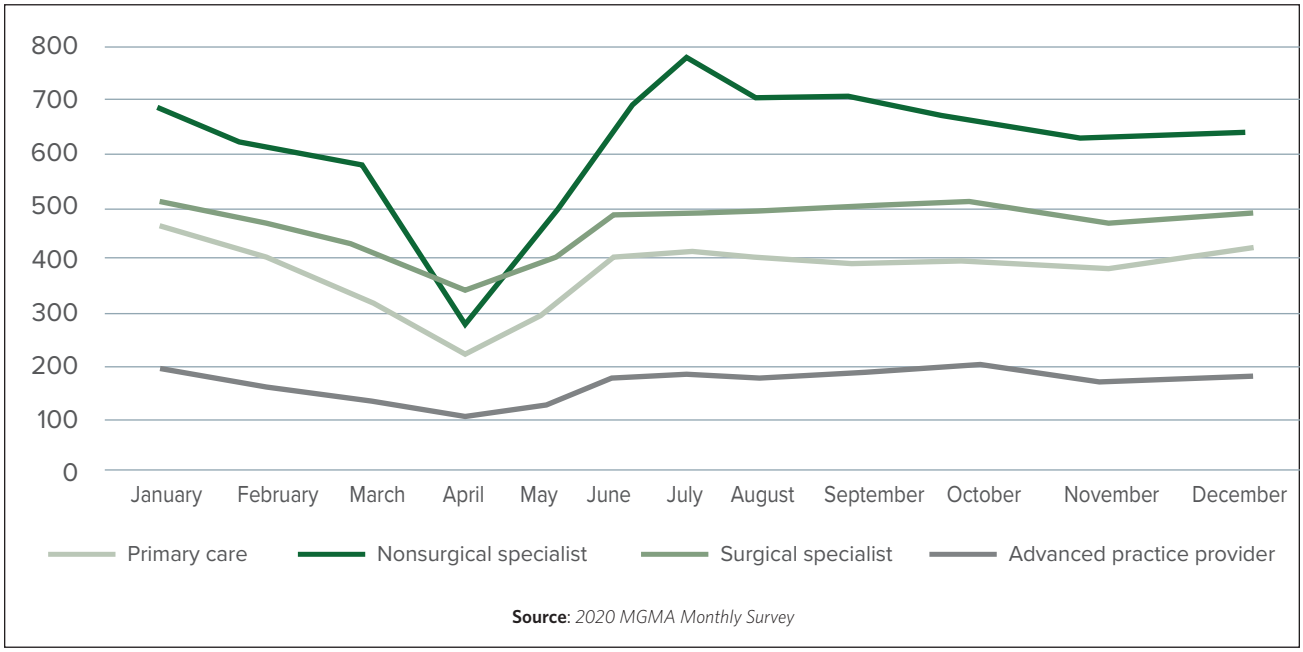
Whereas less than half (49%) of respondents to a June 2020 MGMA *Stat* poll saw patient volumes return to more than 75% of pre-pandemic levels, **the *2020 Monthly Survey* data find wRVUs after June 2020 being near or above reported levels for February and March 2020.**

PRODUCTIVITY VARIATION BY OWNERSHIP: HOW MUCH HIGHER/LOWER WERE KEY METRICS FOR PHYSICIANS IN HOSPITAL-/IDS-OWNED PRACTICES VERSUS THOSE IN PHYSICIAN-OWNED PRACTICES?

	Total encounters	wRVUs
Cardiology: Invasive	+203	+491
Cardiology (invasive-interventional)	-200	-3,431
Cardiology (noninvasive)	-393	-323
Dermatology	+366	-1,137
Family medicine (without OB)	-334	-514
Gastroenterology	-1,066	-69
Hematology/Oncology	-38	-577
Hospitalist (internal medicine)	+68	+245
Internal medicine (general)	-592	-197
Neurology	-770	-599
Obstetrics/Gynecology (general)	-609	-761
Orthopedic surgery (general)	-749	-556
Pediatrics (general)	-196	-94
Psychiatry (general)	-211	-144
Pulmonary medicine (general)	-1,250	-5
Surgery (general)	-481	-660
Surgery (neurological)	-201	-2,636
Urgent care	-284	-793
Primary care	-590	-373
Surgical specialist	+63	-1,412
Nonsurgical specialist	-1,158	-921

Source: *2021 MGMA DataDive Provider Compensation* (based on 2020 data)

2020 MONTHLY WORK RVUs FOR FULL-TIME, ACTIVELY EMPLOYED PHYSICIANS AND APPs



Source: *2020 MGMA Monthly Survey*

PROVIDER COMPENSATION

Primary care physician total compensation increased by 2.6% between 2019 and 2020. Advanced practice providers (APPs) also experienced a slight increase (1.25%) in compensation during the same period.

Over the past five years, total compensation for physicians and APPs has increased at rates ranging from 3% to 10%.

Overall, compensation for most physician specialties remained flat or saw a moderate increase between 2019 and 2020. **Most specialties experienced a decrease in productivity in 2020.**

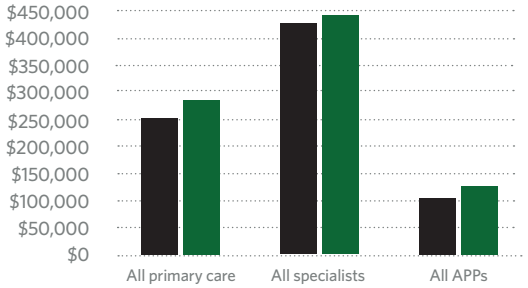
As reflected in MGMA's recent data report, ***Quantifying COVID-19: Measuring the Pandemic's Impact on Medical Practices***, specialist physicians saw steep decrease in compensation during the onset of the pandemic and extending through summer 2020. The suspension of surgeries and elective procedures, along with a decrease in referrals, negatively impacted specialist volumes and subsequent compensation.

MGMA DATADIVE USERS ENJOY EXCLUSIVE ACCESS TO THE *QUANTIFYING COVID-19* REPORT

APP COMPENSATION

Advanced practice provider compensation, for the most part, also remained flat or saw a moderate increase between 2018 and 2019, amounting to steady increases over the past 5 years.

INCREASE IN MEDIAN TOTAL COMPENSATION, 2016 TO 2020



Sources: 2017 and 2021 *MGMA DataDive Provider Compensation* (based on 2016 and 2020 data)

TRENDS IN MEDIAN TOTAL COMPENSATION

	Change, 2019-2020	Change, 2018-2020
Primary care physicians	2.60%	5.27%
Surgical specialists	-0.89%	-4.81%
Nonsurgical specialists	-1.29%	-2.92%
APPs	1.25%	3.41%

COMPENSATION AND PRODUCTIVITY BY SPECIALTY

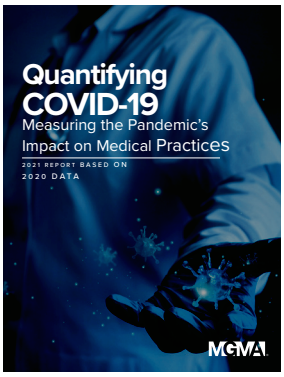
Specialty	2019-2020 change in median total compensation	2019-2020 change in median wRVUs
Cardiology (invasive)	2.61%	-5.45%
Family medicine (without OB)	3.94%	-11.10%
Gastroenterology	0.67%	-13.70%
Hospitalist (internal medicine)	0.14%	-6.79%
Internal Medicine (general)	2.73%	-10.93%
Neurology	1.44%	-11.68%
Obstetrics/Gynecology (general)	0.35%	-7.24%
Orthopedic surgery (general)	1.67%	-11.65%
Pediatrics (general)	6.00%	-11.76%
Surgery (general)	0.40%	-11.19%
Urology	0.12%	-11.89%

INCREASE IN MEDIAN TOTAL COMPENSATION, NP AND PA

	2019-2020 change (1 year)	2016-2020 change (5 years)
Nurse practitioner (NP)		
NP (surgical)	1.00%	7.33%
NP (primary care)	1.66%	5.69%
NP (nonsurgical/nonprimary care)	1.88%	6.12%
Physician assistant (PA)		
PA (surgical)	-4.26%	3.85%
PA (primary care)	0.53%	3.33%
PA (nonsurgical/nonprimary care)	1.39%	10.00%

6 keys to medical practices' recovery amid the pandemic

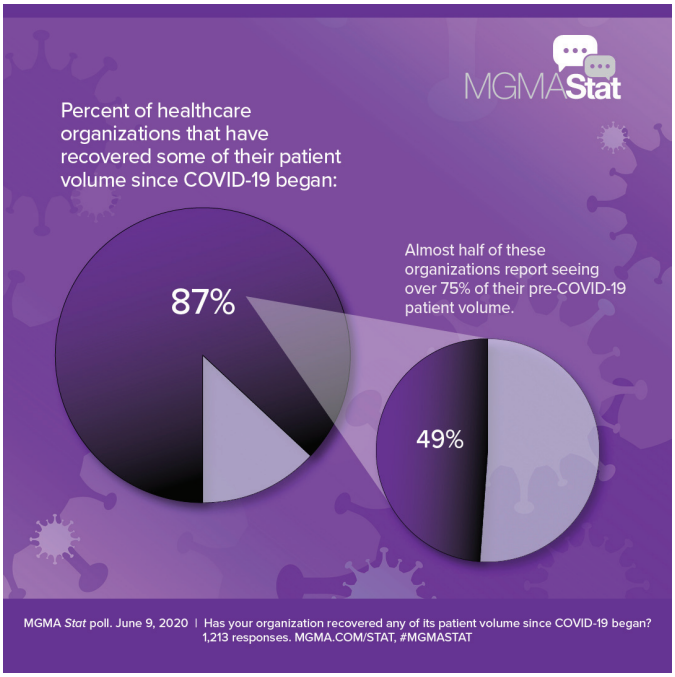
During an April 28 webinar, MGMA's Andrew Swanson, MPA, CMPE, vice president of industry insights, and Meghan Wong, MS, director of data solutions, detailed the findings of MGMA's monthly survey throughout 2020 and insights from interviews with practice leaders on how they responded and innovated to sustain financial viability and work back to pre-pandemic levels of volume and revenues. Here are 6 key takeaways from their presentation:



1 Patients came back for care in summer 2020 after safety worries, deferred visits

Despite the catastrophic drop in patient volumes and revenues in March and April 2020, the MGMA monthly survey found that many practices quickly restored productivity, with some reporting RVUs in July 2020 at the same level or even higher than January and February 2020 levels.

The survey data help confirm a June 2020 MGMA *Stat* poll that found **87% of healthcare leaders reported that their practices had recovered some patient volumes since the pandemic's start, with nearly half of those recovering back to more than 75% of their pre-COVID-19 patient volume.**



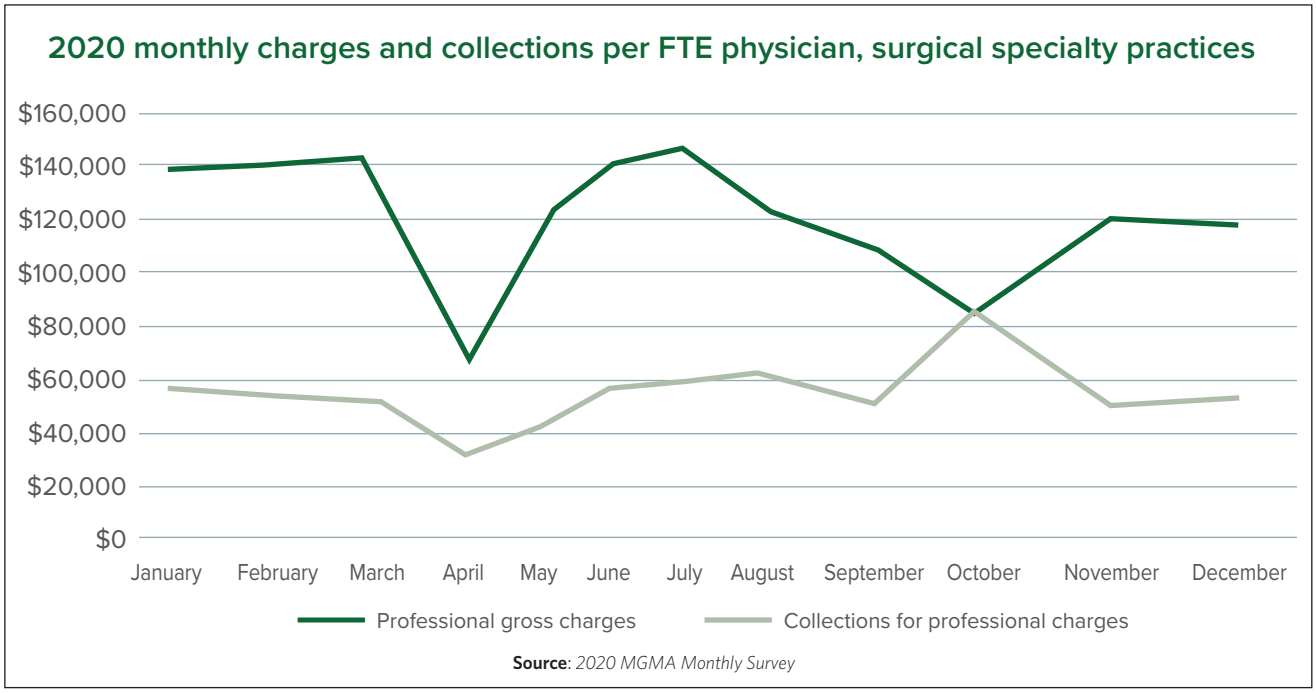
However, a poll of the more than 100 webinar attendees of when their volumes returned to pre-pandemic levels found that practice leaders were somewhat split as to whether it was June (26%), July (21%), August (17%) or September (36%). **"I think this data shows that, depending on where you are in the country, what type of practice you are operating … people had widely varying degrees of when volumes came back," Swanson said.**

In some cases, this was a matter of restrictions on elective surgeries being removed in certain states before others; however, attendees noted that patients with high-acuity care needs returned with worsened conditions after delaying care.

READ MORE ABOUT THE IMPACTS OF CANCELLED OR DELAYED CARE IN THE MGMA-HUMANA RESEARCH REPORT ON DEFERRED CARE, *NO TIME TO WASTE.*.

2 The recovery was short-lived due to the fall 2020 COVID-19 surge

Despite the boost for many practices throughout the summer months, the resurgence in COVID-19 infection rates in early fall 2020 took a toll on practices again, with surgical practices hit hard in September and October, and a leveling off for recovery in gross charges toward the end of the calendar year.



Source: *2020 MGMA Monthly Survey*

3 Telehealth surged, then ebbed, then grew again with new waves of COVID-19

While MGMA data pointed to nearly all medical practices embracing some form of telehealth in the early months of the pandemic, the 2020 monthly survey report found that providers did not report the vast majority of their wRVUs as coming from virtual care delivery.

As Swanson noted, data on primary care, nonsurgical specialists, surgical specialists and APPs showed a massive spike in telehealth wRVUs for March and April, but for some segments of the provider data, telehealth as a percentage of all wRVUs never rose above 50% — only to plunge in the summer months.

But toward the end of 2020, telehealth wRVUs began to pick up again as COVID-19 infection rates rose in many areas of the country. **"Perhaps what this tells us is that, as patients are coming through to the other side of the pandemic and they're reflecting on things they experienced, perhaps there is an ongoing place for telehealth visit volume at a significant degree," Swanson said.**

4 Slow periods for productivity were opportunities to catch up on collections

With fewer patients coming through the doors in person or virtually, the significant drop in volumes and claims to submit in the first half of 2020 provided medical practice leaders an opportunity to focus their staff members' attention to work through accounts. Interviews done for the report found multiple MGMA members reporting a redeployment of staff to do other tasks internally that might not have been done in busier times, such as **putting billing staff to work to look at back charges and addressing aging A/R to improve collections and avoid bad debts,** Swanson noted.

MGMA's survey data showed a decline in charge collections for primary care practices in August and September — likely a product of the significant drop in professional gross charges in the spring months that preceded.

5 Supply costs were up dramatically, but cuts elsewhere lowered overall spending

While the market for personal protective equipment (PPE) tightened dramatically throughout much of 2020 and prices for items such as masks, gloves, gowns and other protective gear surged, practice leaders more than made up for those increased costs by trimming total costs in other areas.

A poll of webinar attendees found a majority (54%) had an overall decrease in operating costs for 2020, compared to 23% whose costs rose and 23% whose costs stayed the same. For practices that accepted Paycheck Protection Program (PPP) loans, the need to retain those employees kept those staffing expenses on the books, whereas other practices that opted for furloughs and layoffs saw a lot of cost savings to account for dramatic loss of revenue in early 2020.

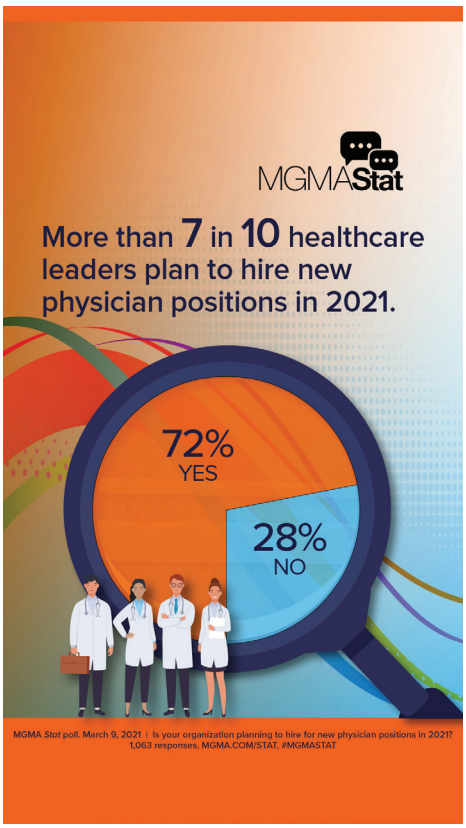
"It might be a bit counterintuitive, thinking about groups trying their best to stay afloat — that operating expenses would decrease and, in some instances, decrease significantly," Swanson said, but as the report notes, "decisions to cut spending elsewhere in the practice … likely mitigated the overall impact" of PPE price hikes.

6 Staffing struggles persist due to quarantine, childcare and a tight labor market

Practice leaders interviewed for the report all pointed to the need to update staffing models to accommodate for potential employee quarantines if exposed to coronavirus, as well as updating staffing schedules due to family care needs after schools and daycare facilities closed during the pandemic.

These factors — paired with a tightening market for physicians, various types of APPs and staff — speak to a need for healthcare practice leaders, especially in human resource management, to rethink their long-term strategies.

With more than 70% of practice leaders planning to hire a new physician position in 2021 after a rash of unexpected physician retirements in 2020, **"an already tight and already difficult recruiting market is going to get even more tight,"** Swanson noted. To fill that gap, hiring APPs might be an alternative approach for practices looking to add providers as recovery continues: A November 2020 MGMA *Stat* poll found more than half of practice leaders expect to add new APPs this year. "I think this really points to [the need] to think more strategically about how to get ahead of this," Swanson added, such as getting workers performing tasks at the top of their licensure and building out pipeline/feeder systems in the community for bringing in new talent for certain clinical support staff positions. **"If your nursing staff is bouncing around practices in town or between the hospital or hospital systems … you've got to have a feeder system,"** Swanson implored.



Additionally, building more into the employee onboarding process is a crucial way to lay the groundwork for better retention as compensation and benefits become more competitive. Making those early days and weeks "memorable and extremely positive" to leave a lasting impact as a new employee integrates with your team might make the difference in keeping that person when an offer for better pay comes along, Swanson said.

Redefining fair market value under Stark Law

IMPACTS ON PHYSICIAN PRACTICES BASED ON NEW RULES AND THE 2021 MEDICARE PHYSICIAN FEE SCHEDULE

Physician practices face new compliance concerns after the Centers for Medicare & Medicaid Services (CMS) shared two major announcements in the latter part of 2020:

1. The 2021 Medicare Physician Fee Schedule (PFS)
2. New final rules under the Physician Self-Referral "Stark" Law and Anti-Kickback Statute (AKS).[1]

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These recent changes will have a wide-ranging impact on physicians and their transactions in 2021 and beyond. It is essential that the significance of these regulatory changes — a new definition of FMV, appropriate application of survey data, and decoupling of the volume and value standard — should not be overlooked. To complicate matters, the 2021 Medicare PFS will likewise refashion FMV for physician practices.

REDEFINING FMV

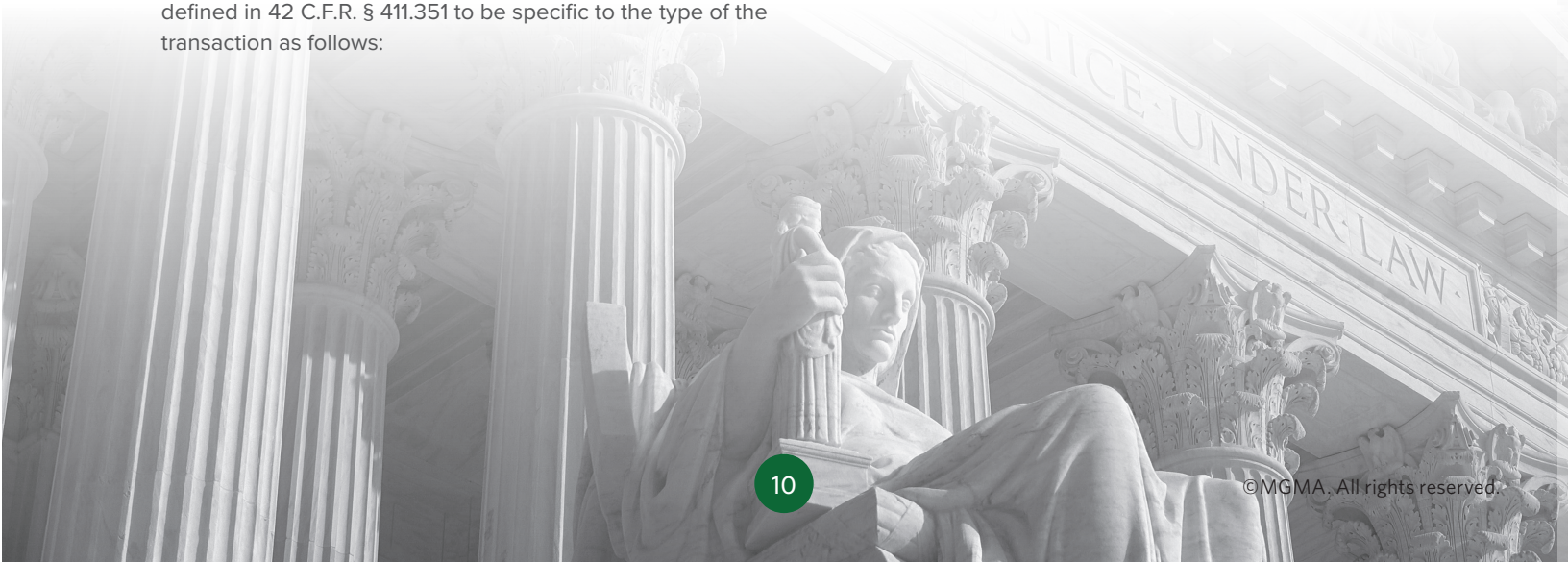
Determining whether compensation under a specific arrangement is within FMV is a requirement for many of the exceptions or safe harbors that may be used under the Stark Law or AKS. Understanding how FMV is defined is of utmost importance. However, for many physicians, health-care executives and healthcare valuators, the regulations have historically generated ambiguity surrounding FMV. In the new final rules, CMS has attempted to increase clarity around the definition of FMV, its application to survey data, as well as its relationship to the volume or value standard.

FMV: Clarifying the definition by subject transaction

To minimize confusion, CMS redefined FMV in the Stark final rule[2] to be the value in an arm's-length transaction, consistent with the general market value of the subject transaction.[3] Furthermore, general market value is now defined in 42 C.F.R. § 411.351 to be specific to the type of the transaction as follows:

General market value means:

1. **Assets**. *With respect to the purchase of an asset, the price that an asset would bring on the date of acquisition of the asset as the result of bona fide bargaining between a well-informed buyer and seller that are not otherwise in a position to generate business for each other.*
2. **Compensation**. *With respect to compensation for services, the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other.*
3. **Rental of equipment or office space**. *With respect to the rental of equipment or the rental of office space (not taking into account its intended use and without adjustment to reflect any additional value the prospective lessee or lessor would attribute to the proximity to the lessor where the lessor is a potential source of referrals to the lessee)[4], the price that rental property would bring at the time the parties enter into the rental arrangement as the result of bona fide bargaining between a well-informed lessor and lessee that are not otherwise in a position to generate business for each other.*[5]



FMV is not linked to a particular survey percentile

In redefining FMV, CMS provided some useful commentary and insight into its thoughts on determining the FMV range for a transaction. Specifically, CMS highlights the need to evaluate general market value in the context of "the subject transaction" and not solely depend on the utilization of particular survey data or specific percentiles within the data for the determination of FMV.

Using survey data continues to have utility when determining FMV; however, the end value needs to be nuanced to the specific set of circumstances surrounding "the subject transaction." CMS' comments to this end, included the following:

> *...We continue to believe the fair market value of a transaction — and particularly, compensation for physician services — may not always align with published valuation data compilations, such as salary surveys. In other words, the rate of compensation set forth in a salary survey may not always be identical to the worth of a particular physician's services.*[6]

> *It is not CMS policy that salary surveys necessarily provide an accurate determination of fair market value in all cases. ... Consulting salary schedules or other hypothetical data is an appropriate starting point in the determination of fair market value, and in many cases, it may be all that is required. ... In our view, each compensation arrangement is different and must be evaluated based on its unique factors.*[7]

As an example, CMS indicated that securing a sought-after physician with a unique skill set may warrant a compensation level higher than typically expected for the specialty in the particular geographic area. On the flip side, hospitals that may be in a more tenuous economic state need not feel compelled to pay higher than financially prudent simply because salary surveys would suggest such a payment.

For these reasons, CMS declined to establish a bright line rule based on a particular survey percentile. Specifically, CMS' policy of determining appropriate compensation is not based on salary data at or below the 75th percentile, nor is it outside of FMV range for compensation set above the 75th percentile.[8]

Decoupling volume or value standard

Until now, the volume or value standard had not been separately defined within the regulations but linked to the determination of FMV. The final rule has now clarified that meeting the FMV requirement for an exception is separate and distinct from meeting the volume or value standard. In doing so, the rule has created a two-part mathematical formula used to determine if the volume or value standard has been met.

To address compensation terms between an entity furnishing designated health services (DHS) and a physician, with payments made either from a physician to the entity or to a physician from the entity, a two-part rule needs to be met:

1. When evaluating compensation from a physician (or immediate family member of the physician) to an entity furnishing [DHS], does the compensation formula vary by taking into account the volume or value of referrals to the entity and/or other business generated by the physician for the entity when calculating compensation?[9]
2. If referrals or other business generated by the physician is used in a compensation formula, does the physician's compensation increase or decrease based on a negative or positive correlate with the number or value of the physician's referrals to the entity?[10]

Should the answer be "yes" for the questions above, then the arrangement does not meet the volume or value standard. In this instance, if the arrangement fails to meet the volume or value standard, then "that determination is final."[11]

For more insight, CMS included some additional commentary on meeting the volume or value standard:

> *With respect to employed physicians, a productivity bonus will not take into account the volume or value of the physician's referrals solely because corresponding hospital services (that is, [DHS]) are billed each time the employed physician personally performs a service.*[12]

Important for physician practices entering into professional services agreements (PSAs), CMS' guidance "extends to compensation arrangements that do not rely on the exception for bona fide employment relationships [e.g., PSA] ... and under which a physician is paid using a unit-based compensation formula for his or her p ersonal performed services, provided that the compensation meets the conditions in the special rule [on unit-based compensation]."[13]

2021 MEDICARE PFS IMPACT ON FMV

The new Stark final rules took effect Jan. 19, 2021, amidst the backdrop of a significant PFS change first shared by CMS on Dec. 2, 2020,[14] and revised Dec. 27, 2020, by the Coronavirus Response and Relief Supplemental Appropriations Act 2021. Among the multiple changes under the 2021 Medicare PFS final rule, the following are some of the material ones that will have a potential impact on determining FMV:

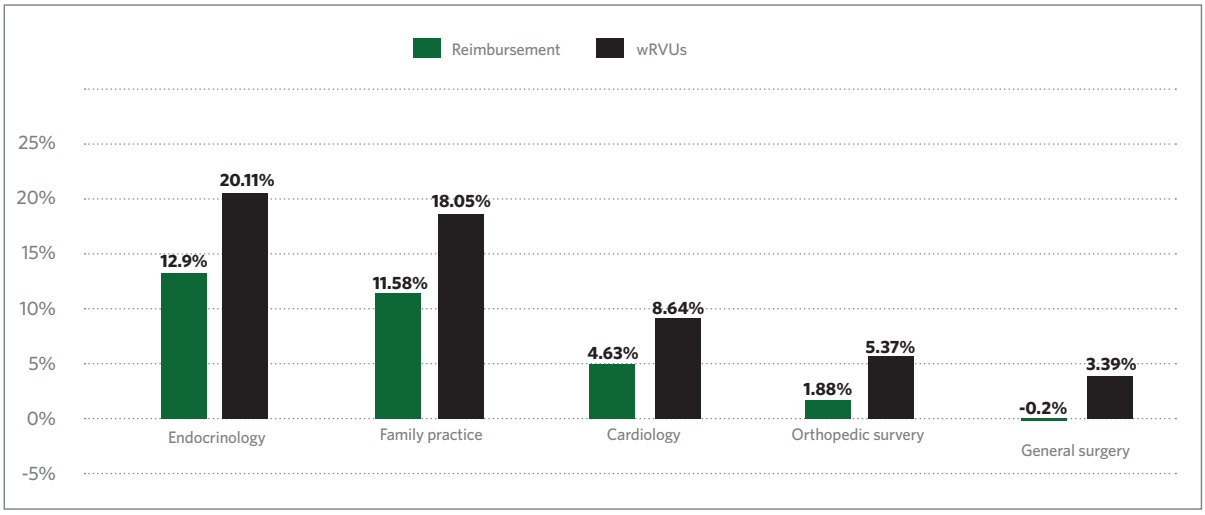
- wRVU values for office and other outpatient services E/M codes have increased by 7% to 13% amongst new patient office visit codes 99202-99205 and by 28% to 46% amongst established patient office visit codes 99212-99215.
- Add-on codes for incremental time spent with a patient based on their complexity have been introduced but not finalized to date.
- The Medicare conversion factor for 2021 is $34.89, which reflects a 3.3% decrease from the 2020 conversion factor.

A cursory review of the impact on physician wRVUs shows a potential significant increase for medical specialties and a potential decrease for procedure-based specialties. In terms of reimbursement, the 2021 Medicare PFS governs Medicare as well as those Medicaid and commercial plans that rely on the PFS for their own rates. Therefore, the reimbursement impact from the 2021 PFS will be contingent on the practice's payer mix and the extent to which the PFS is used to determine commercial and Medicaid rates.

In light of the 2021 Medicare PFS, physician practices will need to consider the following:

- Figure 1 illustrates the percentage change to wRVUs and Medicare reimbursement from 2020 Medicare PFS to 2021 Medicare PFS based on Medicare utilization data by CPT code, respectively for endocrinology, family medicine, cardiology, orthopedic surgery and general surgery specialties.[15] In all specialty categories, the percentage change to wRVU was greater than the percentage change to reimbursement. This variance could result in significant changes to physician compensation. Practices need to perform financial scenario analyses and pro formas to help them quantify the financial impact to the group as well as to physicians individually.
- Utilizing national surveys to support compensation as FMV will be more complicated in the coming years given the impact from the pandemic along with recent CMS commentary in the final rules.
  a. Current published 2020 surveys contain data from 2019, prior to the pandemic. Data from the pandemic will affect surveys published in 2021. The pandemic has injected a fair degree of variability into the data across regions as well as across specialties. Combining confounding factors with the 2021 Medicare PFS changes will make it more difficult for benchmarking purposes and the assurance that one is comparing apples to apples. As a result, it is recommended that physician practices normalize their data for comparison purposes and utilize multiple analyses to ensure all aspects have been considered.
  b. CMS reiterated that there is no bright-line threshold upon which practices may rely when determining FMV, both on the upper end of the range as well as the lower end of the range. Via the new FMV definition,

FIGURE 1. CHANGE TO wRVUs AND MEDICARE REIMBURSEMENT, 2020 MEDICARE PFS TO 2021 MEDICARE PFS



The new Stark Law rules also have impacts for distribution of Medicare ancillary revenues. For MGMA Government Affairs' analysis of this change, visit mgma.com/stark-ancillaries.

- the final rule places increased importance on the specific circumstances surrounding the subject transaction. As a result, utilizing survey percentiles solely as the measure of FMV may result in compensation being outside of FMV range.
- Contingent upon the economic impact from the 2021 Medicare PFS, physician practices must weigh their compensation arrangements in the context of their financial sustainability, compliance risk and need for provider retention. Open communication between practice leadership and the physician team will be crucial. The challenge will be to keep the conversation centered around the practice's ability to provide quality patient care, maintain profitability and reward physicians accordingly.

KEY TAKEAWAYS

Physician practices continue to operate in a complex regulatory environment. Establishing FMV will continue to be a critical step in meeting exceptions and navigating safe harbors under Stark and AKS. Therefore, the attempt to increase clarity in this definition is a welcomed aspect of the new final rules. However, it comes with the understanding that FMV should be determined based on the specific circumstances surrounding the subject transaction and not solely on survey data at specific percentiles.

Lastly, the change to the 2021 Medicare PFS poses an additional confounding factor when determining FMV. The significant changes to the wRVUs will complicate benchmarking analyses and will require normalization of the data to ensure the appropriate use of the surveys. Physician practices need to engage this issue as they set compensation arrangements for 2021.

NOTES

1. Key to the final rules are new exemptions and safe harbors associated with value-based care arrangements. However, given the scope of this article, value-based care arrangements will be reserved for discussion in the series' final article.
2. It is important to note that AKS and other regulatory agencies are not bound to utilize the definitions put forth under the Stark Law final rules. However, the rules do provide terminology and interpretive guidance.
3. 42 C.F.R. § 411.351.
4. Ibid.
5. Ibid.
6. FR Vol. 85, No. 232.
7. Ibid.
8. Ibid.
9. 42 CFR *§ 411.354(d)(2);* 42 CFR *§ 411.354(d)(3).*
10. 42 CFR *§ 411.354(d)(2);* 42 CFR *§ 411.354(d)(3).*
11. FR Vol. 85, No. 232.
12. Ibid.
13. Ibid.
14. CMS-1734-F.
15. This figure was based on Medicare claims utilization across specialties. The percentage change should not be used as a substitute for a specific physician coding/reimbursement analysis as these changes are sensitive to the coding distribution, payer mix, and case mix for the practice. Contingent upon the relative percentage use of outpatient E/M office visit codes, this impact could vary.

ADDITIONAL RESOURCES

MGMA DataDive

Access industry-leading benchmarking data to understand the past and present to propel your practice into the future.

MGMA *Stat* COVID-19 polls

Find the latest, real-time data on how healthcare leaders are responding to the pandemic, along with expert insights and best practices.

MGMA COVID-19 Recovery Center

Find MGMA's latest operational resources, tools and stories of success from across the healthcare industry.

MGMA Consulting

Leverage the industry leader in creating meaningful change in healthcare, one organization at a time.

MGMA COVID-19 Podcasts

Find all MGMA Insights and Executive Session podcasts from our ongoing COVID-19 series.

Save the date: Medical Practice Excellence: Leaders Conference

Join us Oct. 24-27 in San Diego, Calif., or Nov. 16-18 for our Digital Experience (DX).

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