datadive

BETTER PERFORMERS

AN MGMA DATA REPORT - DECEMBER 2023

KEYS TO MEDICAL PRACTICE EXCELLENCE IN 2024

Inspiring healthcare excellence.℠

MGMA®

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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.

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Introduction

Operating a successful medical group is always a formidable challenge, but many organizations stand above the rest despite the post-pandemic hurdles of tight staffing, rising expenses, new technologies and surging demand for care.

Each year, MGMA evaluates thousands of organizations with data from across three industry-leading surveys — Compensation and Production, Cost and Revenue, and Practice Operations — to assess their performance on key metrics in four categories:

OPERATIONS	• Less than the median for percentage of total A/R over 120 days • Less than the median for days adjusted FFS charges in A/R • Greater than the median for adjusted FFS collection percent
PROFITABILITY	• Less than the median for total operating cost per work RVU • Less than the median for total cost per total RVU • Less than the median for total operating cost as a percent of total medical revenue • Greater than the median for total medical revenue after operating cost per physician
PRODUCTIVITY	• Greater than the median for total medical revenue per physician • Greater than the median for total medical revenue per staff • Greater than the median for work RVUs per staff • Greater than the median for provider work RVUs for at least 66% of providers; **-or-** • Anesthesia practices: greater than the median for ASA units for at least 66% of providers
VALUE	• Practice reports on quality metrics; **and** • Practice qualifies for Better Performer status in at least one other category

* Participation across all three surveys (*Compensation and Production*, *Cost and Revenue*, and *Practice Operations*) is required to be considered for Better Performer status across all categories. Learn more about participating in the surveys.

In total, MGMA evaluated 4,003 organizations, with 956 being deemed a Better Performer in at least one of the four categories.

In this report, we take a closer look at the benchmarks of top-performing organizations — with expert commentary from MGMA consultants and our best real-time data from MGMA Stat polling — to go beyond chronicling the year that was and provide a clear expectation of what 2024 will hold for medical groups, their leaders and the industry at large.

Better Performer benchmarks

ACCOUNTS RECEIVABLE (A/R)

For the fourth consecutive year, Better Performer practices report collecting more A/R in the first 30 days compared to all practices. Likewise, Better Performer practices report less outstanding A/R in the 120+ days bucket.

BY THE NUMBERS

MGMA Better Performers by category:

- Operations: 340
- Profitability: 515
- Productivity: 201
- Value: 273

MGMA Better Performers by number of qualifying categories:

- One category: 612
- Two categories: 315
- Three categories: 29

PERCENTAGE DIFFERENCE BETWEEN BETTER PERFORMERS AND ALL PRACTICES*

	Primary care practices	Nonsurgical specialty practices	Surgical specialty practices	Multispecialty practices
0-30 days in A/R	6.74%	4.96%	5.32%	8.09%
120 or more days in A/R	-5.34%	-4.82%	-5.26%	-7.28%

* Mean reported Source: *2023 MGMA DataDive Better Performers*

It is notable that the gap between Better Performer benchmarks and the mean shrunk for primary care specialties on both ends of the A/R buckets, as well as for the first-30-days bucket for surgical specialties and multispecialty practices versus 2021 levels; however, surgical specialty and multispecialty Better Performer practices saw a larger percentage difference in 2022 for the 120+ days bucket than the previous year — so while the difficulty of collecting balances due as pronounced in an inflation-heavy environment of higher consumer expenses, the top-performing medical groups found ways to limit A/R aging that many other organizations did not.

EXPERT INSIGHTS FROM MGMA CONSULTING:

"Much of my consulting in 2023 focused on helping practices improve revenue cycle performance. MGMA surveys show that Better Performer practices collect between 5% to 8% more revenue in the first 30 days and lower A/R over 120 days between 4% and 7% by implementing proven operational strategies coupled with expanded use of technology. Some examples include working from a written financial policy, eligibility and verification process verbally shared with each patient, making payment expectations clear, improved point of service collections, credit card on file, electronic statements and easy electronic payment methods. I have also provided coding and documentation analysis to ensure practices are maximizing revenue through correct coding, capturing all billable services accurately, that supports medical necessity. Implementing these types of improvements will put practices in a strong position as we begin a new year."

TRACY BIRD, FACMPE, CPC, CPMA, CEMC, CPC-I

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PRACTICE REVENUE AND EXPENSES

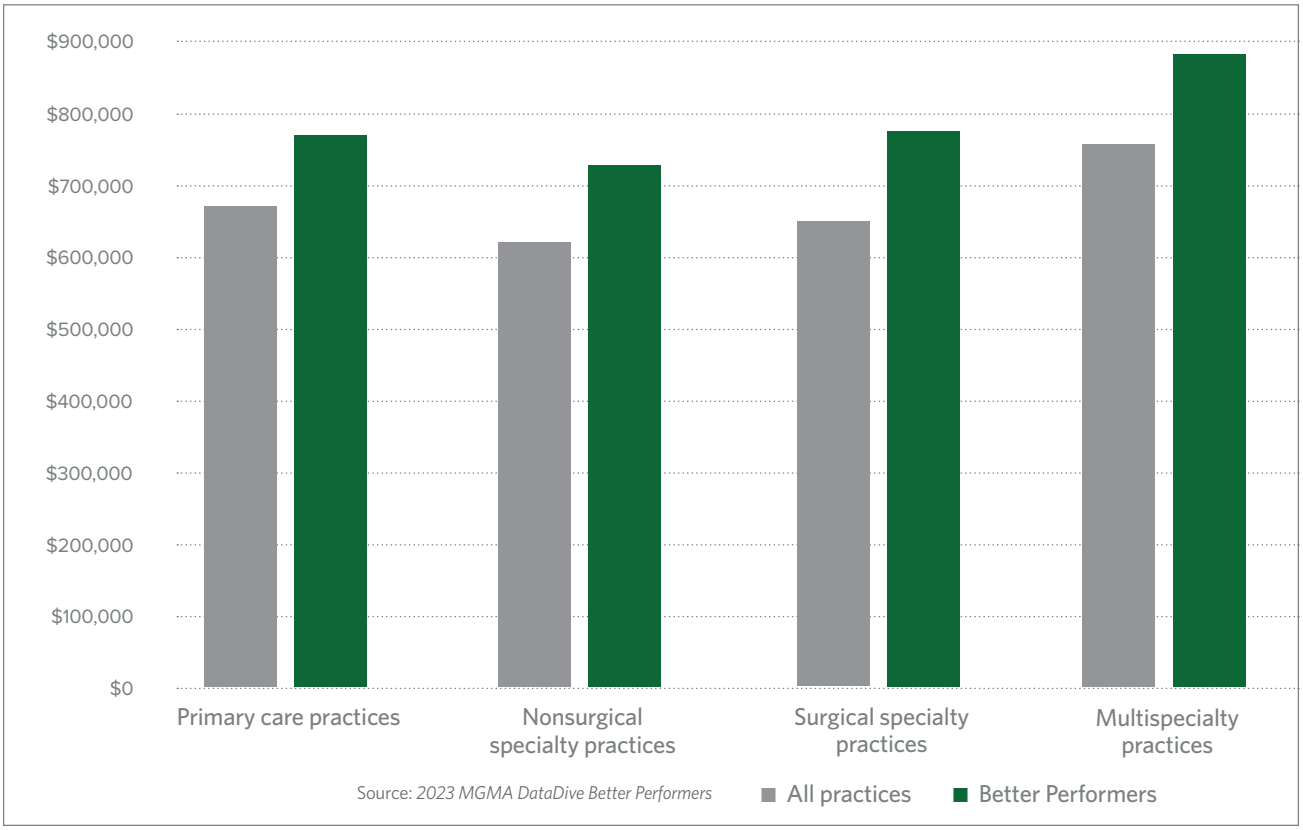
Across the board, MGMA Better Performer practices reported earning more in total medical revenue compared to all practices. The differences are staggering, as Better Performers report nearly $100,000 or more in medical revenue compared to their counterparts.

TOTAL MEDICAL REVENUE PER FULL-TIME-EQUIVALENT (FTE) PHYSICIAN

	Primary care practices	Nonsurgical specialty practices	Surgical specialty practices	Multispecialty practices
Better Performers	$769,939	$721,364	$777,028	$879,121
All practices	$667,995	$623,811	$648,024	$747,637
Difference	**$101,944**	**$97,553**	**$129,004**	**$131,484**

Source: *2023 MGMA DataDive Better Performers*

TOTAL MEDICAL REVENUE PER FTE PHYSICIAN, BETTER PERFORMERS AND ALL PRACTICES



This year's benchmarks find primary care, surgical specialty and multispecialty practices — Better Performer or not — having increased their total medical revenue per FTE physician sizably over 2021 levels:

- **Primary care practices**: Better Performers up 10.8% versus 2021, all practices up 10% versus 2021
- **Surgical specialty practices**: Better Performers up 4.1% versus 2021, all practices up 2% versus 2021
- **Multispecialty practices**: Better Performers up 8.9% versus 2021, all practices up 6.7% versus 2021

As noted in David N. Gans' article in this report, median total medical revenue per FTE physician saw a rebound in 2021 and 2022 after the pandemic-impacted decrease in 2020. These revenue gains align with significantly higher productivity numbers. [MGMA members can read a detailed analysis of the changes in productivity and staffing per FTE physician in the January 2024 issue of ***MGMA Connection***.]

TOTAL OPERATING COST PER FTE PHYSICIAN				
	Primary care practices	Nonsurgical specialty practices	Surgical specialty practices	Multispecialty practices
Better Performers	$414,830	$349,450	$350,290	$502,937
All practices	$443,682	$348,947	$370,920	$532,794
Difference	**-$28,852**	**$503**	**-$20,630**	**-$29,857**

Source: *2023 MGMA DataDive Better Performers*

The broader impacts of inflation and rising expenses were felt by all practices, as measured by total operating cost — which includes support staff and general expenses, such as information technology, medical and surgical supply, building occupancy, furniture and equipment, etc. — per FTE physician:

- **Primary care**: Better Performers' costs were up 10.6% versus 2021, all practices' costs were up 10.5%.
- **Nonsurgical specialty**: Better Performers' costs were up 7.0% versus 2021, all practices were up 10.1%.
- **Surgical specialty**: Better Performers' costs were up 8.1% versus 2021, all practices were up 7.0%.
- **Multispecialty**: Better Performers' costs were up 3.5% versus 2021, all practices were up 8.1%.

Overall, Better Performer practices report higher profits (revenue after expenses) than their counterparts.

TOTAL MEDICAL REVENUE AFTER OPERATING COST PER FTE PHYSICIAN				
	Primary care practices	Nonsurgical specialty practices	Surgical specialty practices	Multispecialty practices
Better Performers	$347,578	$406,280	$413,088	$404,993
All practices	$230,018	$259,792	$268,209	$240,875
Difference	**$87,238**	**$146,488**	**$144,879**	**$164,118**

Source: *2023 MGMA DataDive Better Performers*

These benchmarks show practices of all specialty types, despite facing a rough year, worked to improve their profitability in 2022:

- **Primary care**: Better Performers' profitability rose 7.4% versus 2021, while all practices were up 2.7%.
- **Nonsurgical specialty**: Better Performers rose 4.1% versus 2021, all practices were almost unchanged.
- **Surgical specialty**: Better Performers rose 10.2% versus 2021, all practices were up 5.4%.
- **Multispecialty**: Better Performers rose 13.7% versus 2021, all practices were up 16.8%..

EXPERT INSIGHTS FROM MGMA CONSULTING:

"Better-performing practices report earning more than $100,000 in annual revenue more than peers. This takes work in focusing on both efficiency in managing expenses and focus on maximizing revenue. The practice paycheck comes from payers, and consistently negotiating rates, value-based elements and decreasing administrative burden must be part of the strategic plan to achieve such results. We are observing more practices than ever going to the table and working with payers to create creative arrangements that work for all involved. We are also seeing practices decline participating in value-based programs that are administratively burdensome where 'the juice is not worth the squeeze.'"

DORAL DAVIS-JACOBSEN, MBA, FACMPE

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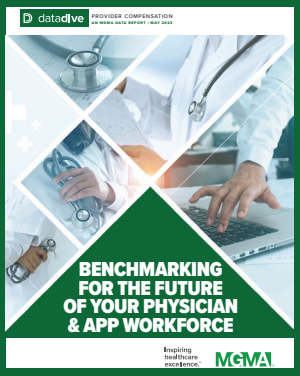
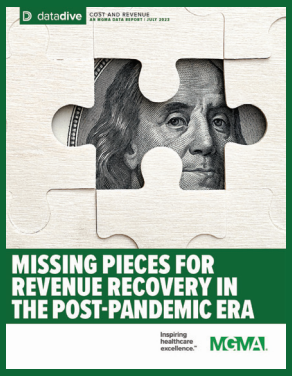
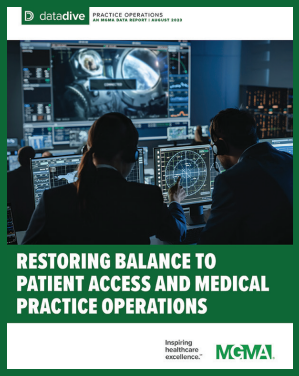


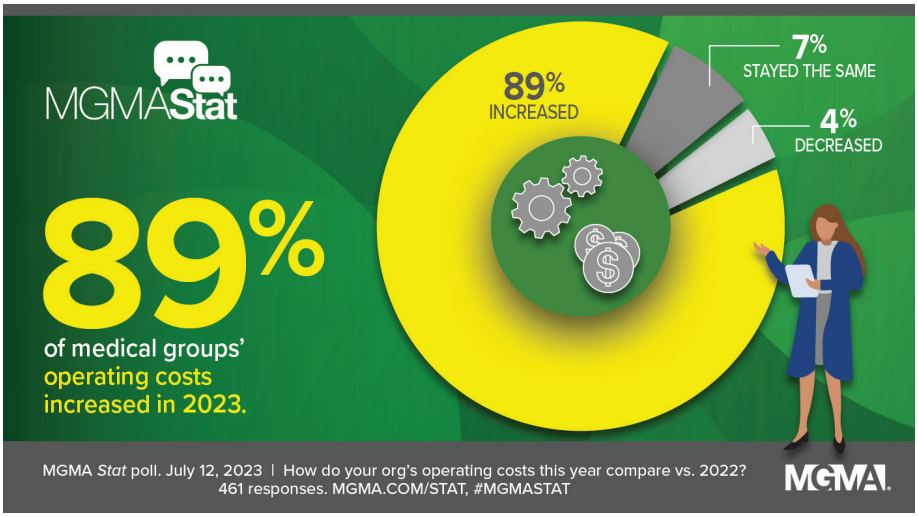




DISCOVER EVEN MORE FROM THE 2023 MGMA DATADIVE SURVEYS

Each MGMA DataDive survey release in 2023 included a special data report highlighting major benchmarks, trends and expert insights from frontline medical practice leaders. For a deeper dive into each survey report's findings, download *Bencmarking for the Future of Your Physician & APP Workforce*, *Flexible Strategies for Medical Groups in a Strong Labor Market*, *Missing Pieces for Revenue Recovery in the Post-Pandemic Era*, and *Restoring Balance to Patient Access and Medical Practice Operations*.

LOOKING AHEAD:



Even as the pace of inflation has subsided in 2023, it's a good bet to see the trends around higher operating costs reflected in the upcoming 2024 MGMA DataDive survey reports, given that about nine in 10 medical groups reported operating cost increases, per a July 2023 MGMA *Stat* poll.

EXPERT INSIGHTS FROM MGMA CONSULTING:

"Strategic planning is our No. 1 focus for next year. 2023 was the year we came out of the pandemic and a harsh reminder that we've spent the last three years reactively attacking any issues that arise within our practices or hospital systems. The biggest need going into 2024 for my clients and what we've been focusing on nationwide is developing individualized strategic plans that encompass financial management, staffing strategies, compliance/risk reduction, operational excellence, and revenue cycle optimization.

Developing a strategic plan around these areas and protecting time throughout the year dedicated to these defined and unified goals is how we structure our return to proactive management and prevention of negative outcomes like revenue leakage, data breaches and rising costs. Organizations that prioritize strategic planning and protect the time to implement associated activities have been able to not only survive the pandemic but to thrive afterward."

SHAWNTEA "TAYA" GORDON, MBA, FACMPE, CMOM

CHIEF REVENUE CYCLE OFFICER, H4 TECHNOLOGY, AND MGMA CONSULTANT, OMAHA, NEB.

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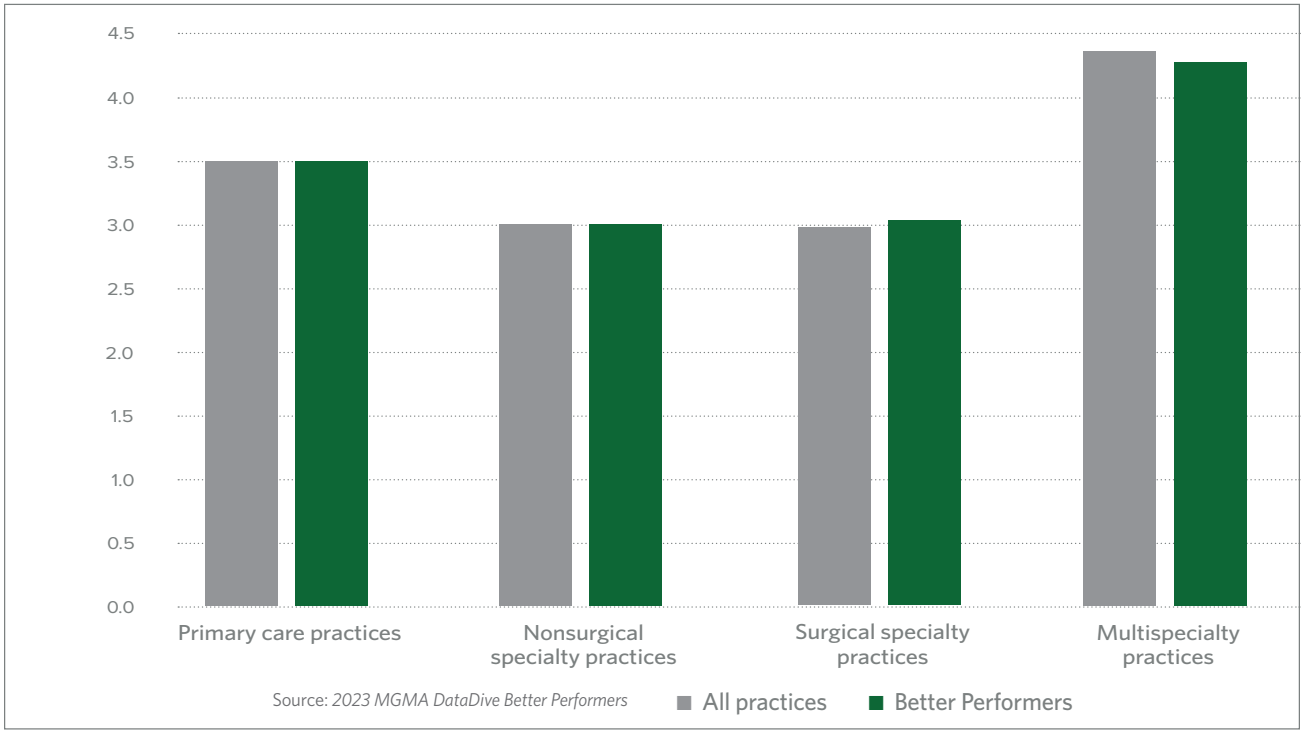
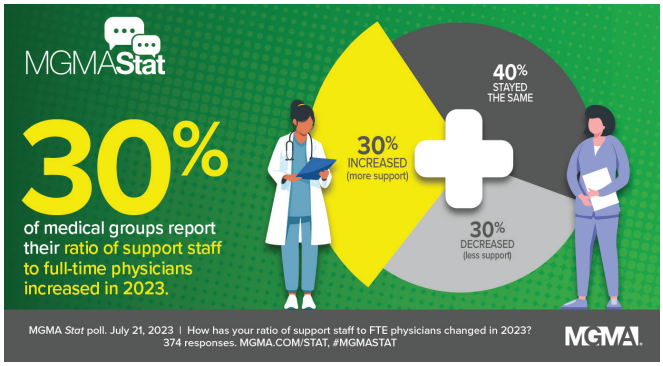
STAFFING
TOTAL SUPPORT STAFF PER FTE PHYSICIAN





As difficult as hiring and retention have been for medical group practices in the post-pandemic era, there is little variance when it comes to support staffing models. In general, Better Performer practices report similar staffing ratios compared to all responding practices. This aligns with the results of a July 2023 MGMA *Stat* poll that found that only 30% of medical groups reported their ratio of support staff to full-time physicians increased in 2023.

EXPERT INSIGHTS FROM MGMA CONSULTING:

"Each of the categories for MGMA's Better Performer practices are driven by people. All the tech and automations in the world won't eliminate the need for people in your practice. The biggest challenge with staffing isn't turnover or people who 'don't want to work' — it is ignoring the role of culture in staff performance. Employee engagement and staff performance are driven by two things: skilled leaders and systems that optimize people performance. Practices that measure leadership competencies and provide leadership training have higher levels of employee engagement. Optimizing systems starts with analyzing your processes for each step of the lifecycle of the employee. Is your interview process effective? Do employees know how their success is measured? Does your practice prioritize people management through regular discussions with team members, individual goal setting and action-oriented feedback? Practices that prioritize their people strategy are not only surviving, but they are also thriving."

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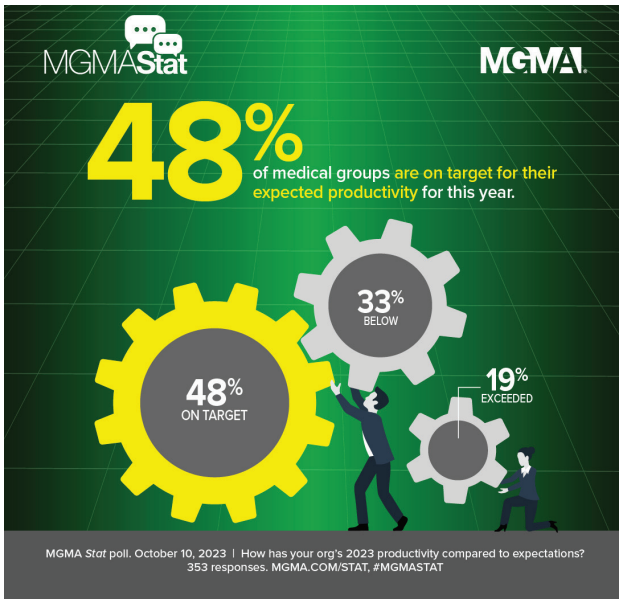
PHYSICIAN COMPENSATION

DIFFERENCE BETWEEN BETTER PERFORMERS AND ALL PRACTICES	Total compensation	Work RVUs
Primary care physicians		
Family Medicine (without OB)	8.24%	10.33%
Hospitalist: Internal Medicine	-0.44%	17.76%
Internal Medicine: General	-0.12%	9.48%
Obstetric/Gynecology: General	2.25%	12.39%
Pediatrics: General	4.22%	-2.09%
Nonsurgical specialty physicians		
Cardiology: Invasive-Interventional	1.24%	1.24%
Cardiology: Noninvasive	13.22%	19.39%
Dermatology	10.49%	5.80%
Emergency Medicine	39.07%	13.11%
Gastroenterology	19.15%	23.61%
Hematology/Oncology	31.00%	26.93%
Neurology	11.19%	11.81%
Pulmonary Medicine: General	19.82%	6.71%
Radiology: Diagnostic	43.07%	31.91%
Surgical specialty physicians		
Orthopedic Surgery: General	1.95%	5.10%
Otorhinolaryngology	-0.89%	9.86%
Surgery: General	0.67%	13.44%
Surgery: Neurological	7.68%	33.57%
Urology	10.47%	19.64%

Source: *2023 MGMA DataDive Provider Compensation* data)

In most instances, physicians in Better Performer practices earn more in total compensation and achieve higher productivity versus physicians in all practices.



LOOKING AHEAD:

One-third of medical groups reported the were behind on their expected productivty, per an October 2023 MGMA *Stat* poll, while almost half were on target and another 19% were exceeding goals. Many medical group leaders noted in the poll that staffing shortages this past year were a major factor in these results.

EXPERT INSIGHTS FROM MGMA CONSULTING:

"Engaging in candid conversations about physician compensation isn't just a best practice; it's vital to retaining physicians and reducing turnover. After all, physicians are no different from anyone else — they want to understand their compensation and know it's fair. Physician compensation methodologies vary widely, and compensation plans are often cumbersome and complex for administrators to administer, let alone explain.

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Provider compensation data, the predominant source for establishing physician compensation, is expensive, requires training to interpret effectively, and is not easily accessible to physicians. A lack of transparency and open communication with physicians regarding compensation can lead to mistrust and misunderstanding with employers. Don't assume that 'no news is good news' when you're not hearing from your physicians. Make it a priority to check in routinely. Physicians have identified two-way communication as one of their top priorities and expectations from healthcare leaders. Employing these strategies distinguishes highly effective leaders and organizations!"

PRACTICE OPERATIONS

A number of benchmarks within the MGMA DataDive Practice Operations data set offer clear comparisons as to what specific workflows are setting MGMA Better Performers apart from their counterparts.

DIFFERENCE IN SAME-DAY APPOINTMENTS AS PERCENTAGE OF TOTAL APPOINTMENTS, BETTER PERFORMERS AND ALL PRACTICES	
Primary care practices	**0.00%**
Nonsurgical specialty practices	**-1.00%**
Surgical specialty practices	**0.00%**

Source: *2023 MGMA DataDive Practice Operations*

DIFFERENCE IN THIRD-NEXT-AVAILABLE APPOINTMENT, IN DAYS, BETTER PERFORMERS AND ALL PRACTICES		
Specialty type	New patient	Established
Primary care practices	**0.0**	**-0.65**
Nonsurgical specialty practices	**1.65**	**-3.90**
Surgical specialty practices	**1.25**	**-2.00**

For example: Better Performer practices of all specialty types reported lower time to third-next-available appointment for established patients versus all practices, showing they are excelling in a key patient access metric at a time when staffing shortages often lead to empty appointment slots when patients, eager to see a provider, consider shopping for another practice as a matter of convenience.

MGMA Better Performers also set themselves apart in their lower no-show and appointment cancellation rates relative to all practices: Better Performer practices of all specialty types reported 2% lower appointment cancellation rates than all practices, and no-show rates were 0.75% to 2% lower among Better Performers versus all practices.

DIFFERENCE IN NO-SHOW RATES AND APPOINTMENT CANCELLATION RATES, BETTER PERFORMERS AND ALL PRACTICES		
	No-show	Cancellation
Primary care practices	**-0.75%**	**-2.00%**
Nonsurgical specialty practices	**-2.00%**	**-2.00%**
Surgical specialty practices	**-1.00%**	**-2.00%**

Source: *2023 MGMA DataDive Practice Operations*

KNOW YOUR KPIs

Third-next-available appointment (TNAA) is the number of business days from the start of each day to the third open appointment. This does not count days when the office is closed for business; however, days where the provider is unavailable due to vacation, administrative time, sick leave, etc., should be included in the count. Appointment slots reserved for same-day appointments should not be included the count for third-next-available appointment.

Keep in mind: This performance was achieved without a significant difference in the operational hours of Better Performers or a significantly higher rate of same-day appointments available. In fact, the latest benchmarks from MGMA surveys show that Better Performers did not report more same-day appointments available than all practices, and Better Performers also reported being open five fewer hours each week (excluding weekends) compared to all practices. This, in general, is one hour per day less — or being open eight hours a day compared to the all-practice median of nine hours each day.

DIFFERENCE IN HOUR OPEN PER WEEK (EXCLUDING WEEKENDS), BETTER PERFORMERS AND ALL PRACTICES	
Primary care practices	**-5**
Nonsurgical specialty practices	**-5**
Surgical specialty practices	**-5**

Source: *2023 MGMA DataDive Practice Operations*

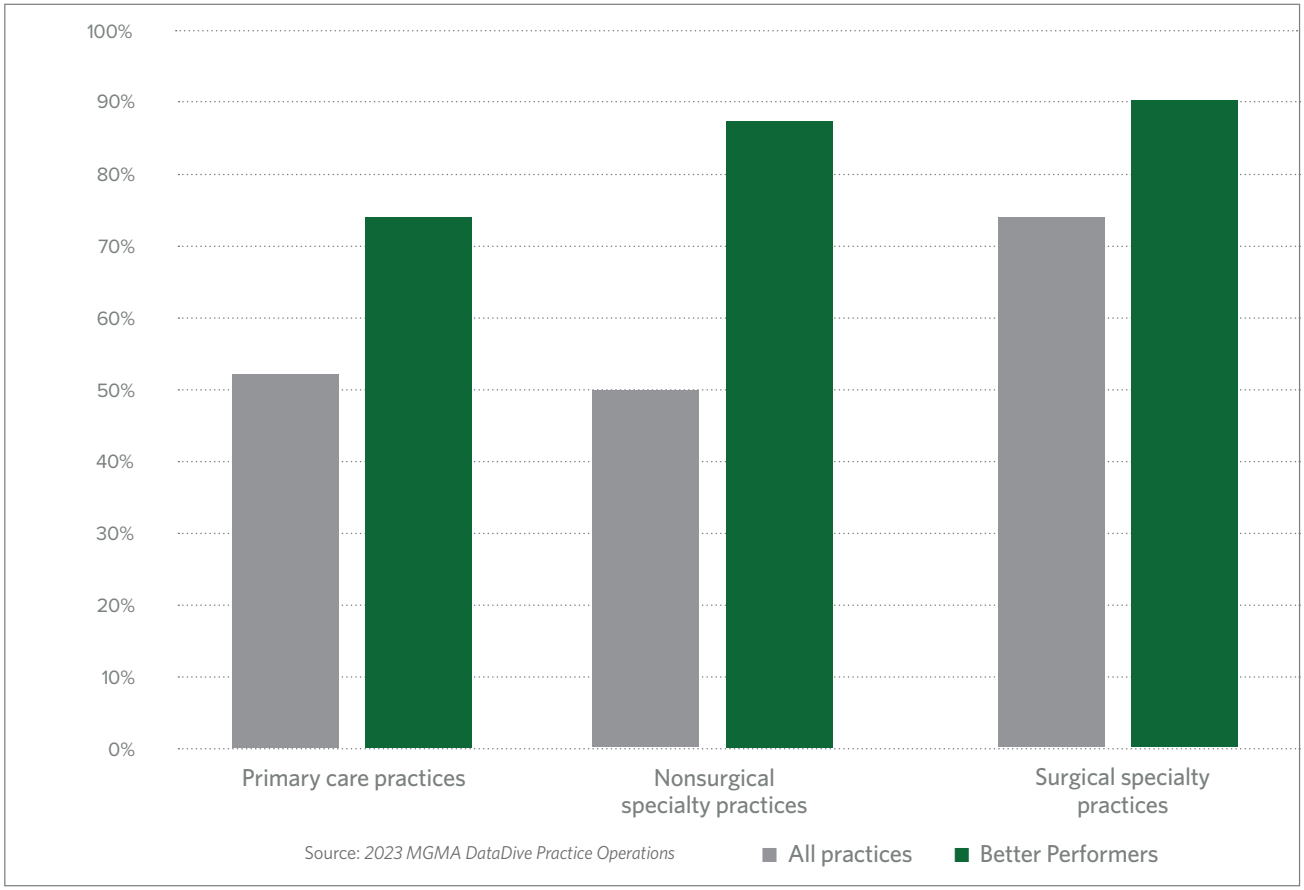
CLAIMS AND COLLECTIONS

Another key workflow where MGMA Better Performer organizations set themselves apart is in collection of copayments: Broken out by specialty type, these practices' copayment collection rate at time of service are 16% to 36.5% than all practices.

DIFFERENCE IN PERCENTAGE OF COPAYMENTS COLLECTED AT TIME OF SERVICE, BETTER PERFORMERS AND ALL PRACTICES	
Primary care practices	**21.00%**
Nonsurgical specialty practices	**36.50%**
Surgical specialty practices	**16.00%**

Source: *2023 MGMA DataDive Practice Operations*

PERCENTAGE OF COPAYMENTS COLLECTED AT TIME OF SERVICE



DIFFERENCE IN CHARGE POSTING AND CLAIMS BENCHMARKS, BETTER PERFORMERS AND ALL PRACTICES		
Specialty type	**Percent of claims denied on first submission**	**Charge-posting lag time (in days)**
Primary care practices	**-1.50%**	**-0.60**
Nonsurgical specialty practices	**-3.00%**	**-1.00**
Surgical specialty practices	**-5.00%**	**0.60**

Source: *2023 MGMA DataDive Practice Operations*

Better Performers also report a lower percentage of claims denied on first submission compared to their counterparts. For the most part, Better Performer organizations also report a shorter charge posting lag time for third-party payment.

FROM DATA TO ACTION: THE CRUCIAL ROLE OF HEALTHCARE BENCHMARKING IN OPERATIONAL SUCCESS

ADRIANNA SMELL
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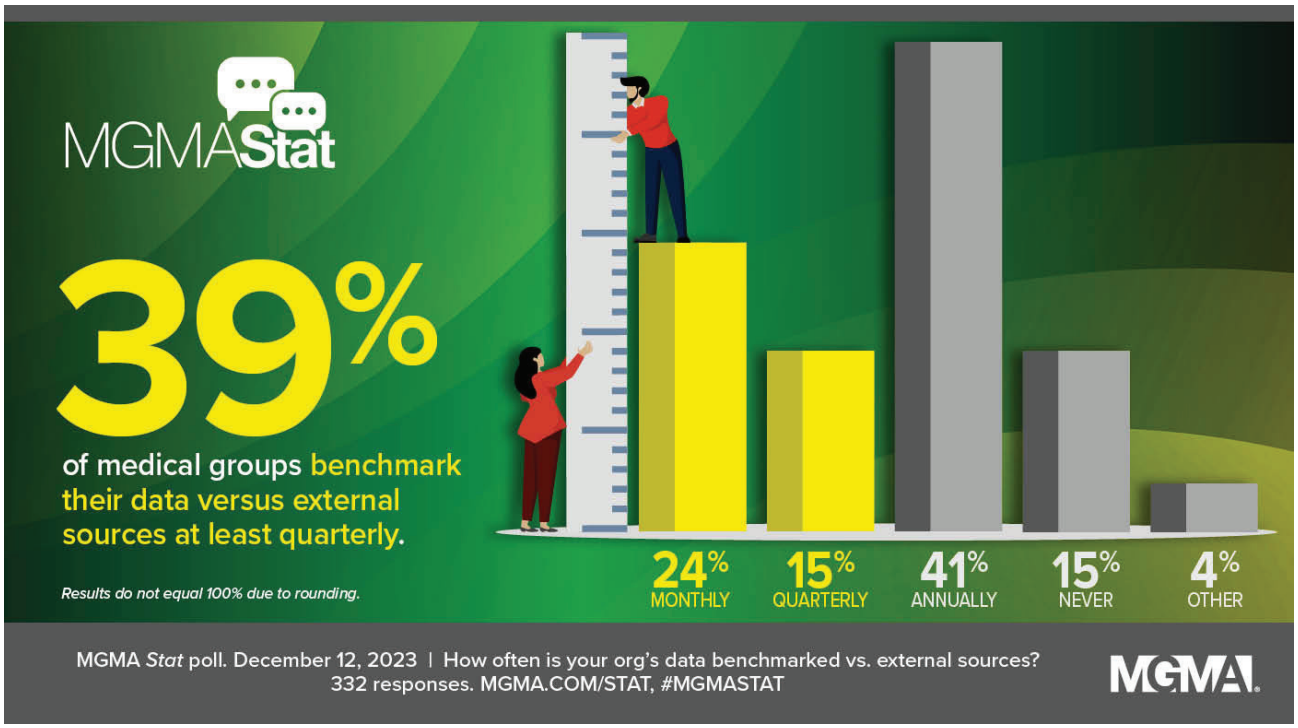
Benchmarking is vital to healthcare organizations as it identifies operational issues, presents solutions to these issues and highlights successful procedures within practices. Ultimately, healthcare benchmarking aims to improve efficiency, quality of care, outcomes and the patient experience.

Benchmarking became a defining feature of healthcare in the 1990s, although the earliest outcomes comparisons (i.e., mortality in hospitals) date back to the 17th century. Today, it continues to measure and compare clinical outcomes across organizations, as well as foster peer support and the use of best practices.[1]

MGMA polls from 2019 showed that most healthcare leaders have used benchmarking data to improve their operations (84%)[2] and address business issues (82%)[3] in areas such as productivity, financials, human resources and patient access.



Although healthcare leaders are using benchmarking to improve their operations, it might come as a surprise that they aren't doing so more often. A Dec. 12, 2023, MGMA *Stat* poll found that **most medical group leaders (41%) benchmark their organization's data versus external data annually, compared to nearly one in four (24%) who are benchmarking at least monthly and another 15% benchmarking quarterly**. Another 15% noted they never benchmark versus external sources, and 4% responded "other" — most of whom noted they benchmark every two to three years. The poll had 332 applicable responses.

WHY BENCHMARK?

Benchmarking is crucial in helping healthcare leaders make optimal strategic choices, reducing risk in decision-making and justifying their actions or inactions. In other words, "If you don't measure it, you can't manage it. If you don't value it, you won't change it."[4]

Benchmarking facilitates organizational growth and development by improving operations, boosting efficiency, and reducing operating costs. It also enables leaders to compare with competitors across multiple metrics, identify and adopt effective practices from high-performing organizations and eliminate unnecessary costs by streamlining positions, activities, policies and procedures that were previously ineffective.

Top-performing medical groups (such as those identified in the MGMA DataDive Better Performers data set) reach their goals because they "transform data into action"[5] and implement best practices based on key performance indicators (KPIs) and benchmarking against other medical groups. Better Performers review their benchmarking data regularly — every month, according to a 2022 interview with Martin Shehan.[6] Consistent, continual benchmarking can help organizations see the forest through the trees — showing change and consistency over time within individual practices, larger medical groups and entire specialties.

MGMA'S COMMITMENT TO BENCHMARKING

Providing expertly complied benchmarking data and statistics has been a defining feature of MGMA since its founding in 1926. MGMA has been at the forefront of helping medical groups make informed decisions through insights and benchmarks from industry-leading data analysis, reports, surveys, and more.

MGMA'S ANNUAL SURVEYS

For the past 97 years, MGMA has been leading the charge in providing medical practices with the data needed to identify, set and reach their organizational goals in areas such as productivity, financials, human resources and patient access.

Medical groups can contribute to industry-standard benchmarks by participating in MGMA's annual DataDive surveys (learn more here). The annual surveys open to all medical group practices on Jan. 1, 2024. Organizations that participate will receive complimentary access to the datasets they contribute and can upgrade their access to include more robust analysis tools (see the benefits guide for more information).

NOTES

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5. MGMA Staff Members. "Foundational benchmarks and KPIs for medical practice operations in 2023." MGMA. Feb. 14, 2023. Available from: https://www.mgma.com/kpis23.
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MGMA

SQUEEZED: HOW MEDICAL PRACTICES ARE BEING CRUSHED BY HIGHER COSTS AND STATIC PAYMENTS

The United States is experiencing a crisis as small businesses across the nation are being compelled to pay higher prices for raw materials while their labor costs have increased to record levels. Simultaneously, consumers are witnessing the cost of essential commodities such as lodging, fuel and food rising at a rate that outpaces any increase in wages.

DAVID N. GANS MSHA, FACMPE

RETIRED, FORMER SENIOR FELLOW, INDUSTRY AFFAIRS, MGMA

Adding to the complexity of the situation, the U.S. Bureau of Economic Analysis (BEA) has reported that certain mega-corporations are taking advantage of the nation's inflationary environment to raise prices substantially, resulting in record profits.[1]

These trends are not confined to a particular sector; they cut across all industries. However, medical group leaders face unique difficulty as their organizations are caught between the rock of set payments and the hard place of increased costs, demonstrated by the latest MGMA DataDive Cost and Revenue reporting 2022 financial performance. Figures 1 and 2 provide a four-year overview of the financial situation for physician- and hospital-owned multispecialty groups with primary and specialty care. The graphs clearly illustrate how median total medical revenue per full-time-equivalent (FTE) physician decreased between 2019 and 2020 due to the COVID-19 pandemic's restrictions on access and services. However, the graphs show a rebound in 2021 and 2022 as practices resumed normal operations.

FIGURE 1. REVENUE AND EXPENSE PER FTE PHYSICIAN IN PHYSICIAN-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALTY CARE

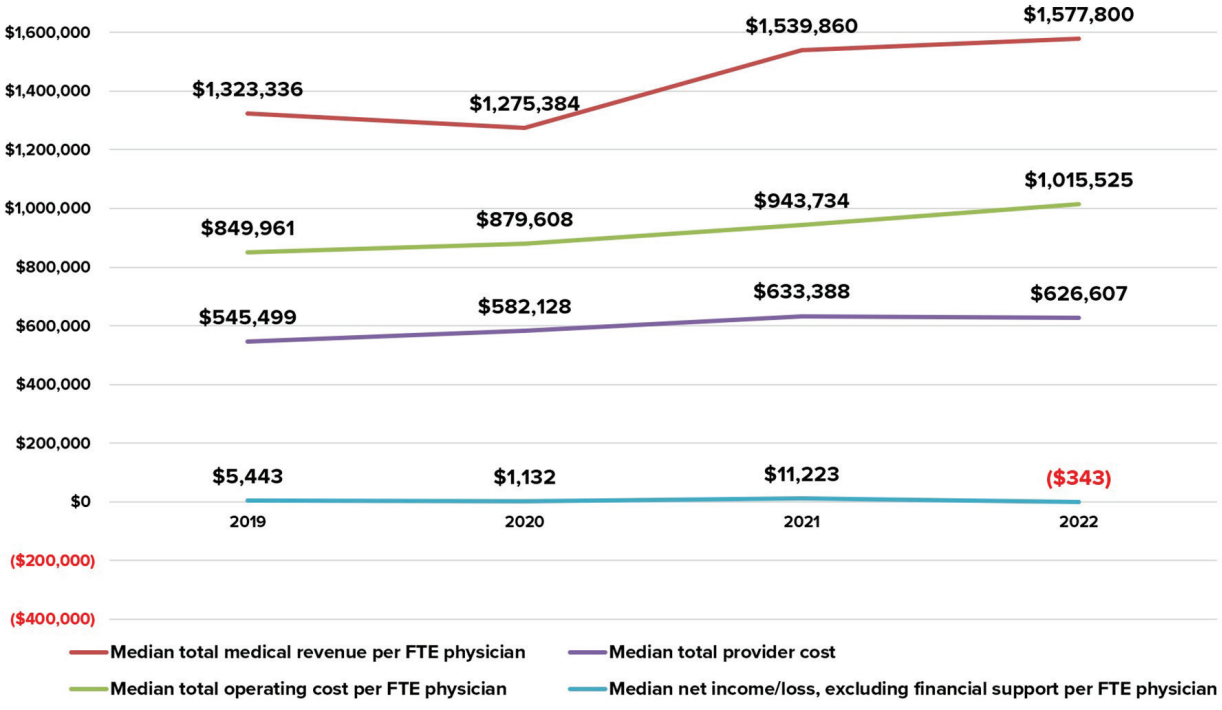
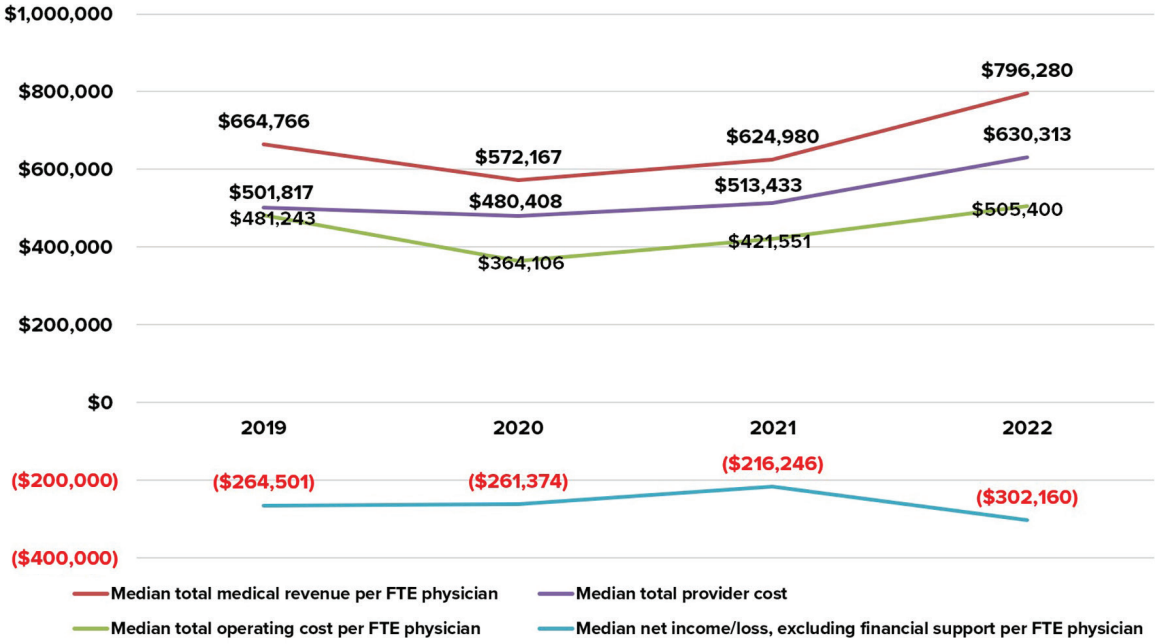


FIGURE 2. REVENUE AND EXPENSE PER FTE PHYSICIAN IN HOSPITAL-/IDS-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALTY CARE



While revenues plummeted during the pandemic, physician-owned groups reported that median total operating cost per FTE physician increased substantially in 2020 and continued to surge, increasing 7.3% in 2021 and another 7.6% in 2022. The cumulative effect of operating costs increasing more rapidly than revenue is reflected in total provider cost per FTE physician [the sum of advanced practice provider (APP) and physician compensation and benefit costs], which decreased 1.1% in the past year from 2021 levels. Hospital-owned groups faced similar challenges, with median total operating cost per FTE physician surging by 15.8% in 2021 and another 19.9% in 2022.

Most importantly, the "bottom line" — measured as median net income/loss, excluding financial support per FTE physician — was nearly zero for physician-owned practices. This is because these entities operate as closed financial systems, where net profits are distributed as income to the physician owners. In contrast, hospital-owned practices reported a substantial loss to their parent health system. Figure 2 clearly shows this subsidy increased 39.7% in 2022 to $302,160 per FTE physician, demonstrating the cumulative effect of increased operating costs and static payments.

Note: the information in the two graphs should not be directly compared, since hospital-owned practices are components of larger health systems and share many expenses with their parent organization. Additionally,

TABLE 1. COST BREAKOUT

Physician-owned multispecialty groups with primary and specialty care	2019	2020	2021	2022
Median total support staff cost per FTE physician	$356,362	$370,060	$393,961	$395,539
Median total general operating cost per FTE physician	$429,718	$472,046	$515,011	$610,851
Hospital-/IDS-owned multispecialty groups with primary and specialty care	**2019**	**2020**	**2021**	**2022**
Median total support staff cost per FTE physician	$229,745	$194,310	$185,264	$260,729
Median total general operating cost per FTE physician	$219,534	$185,799	$214,027	$243,657

Sources: *2020, 2021, 2022* and *2023 MGMA DataDive Cost and Revenue*

FIGURE 3. 2022 PAYER MIX IN PHYSICIAN-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALITY CARE

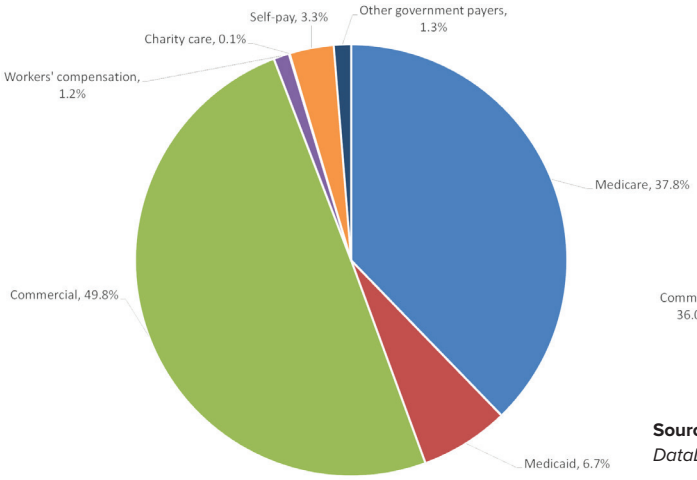
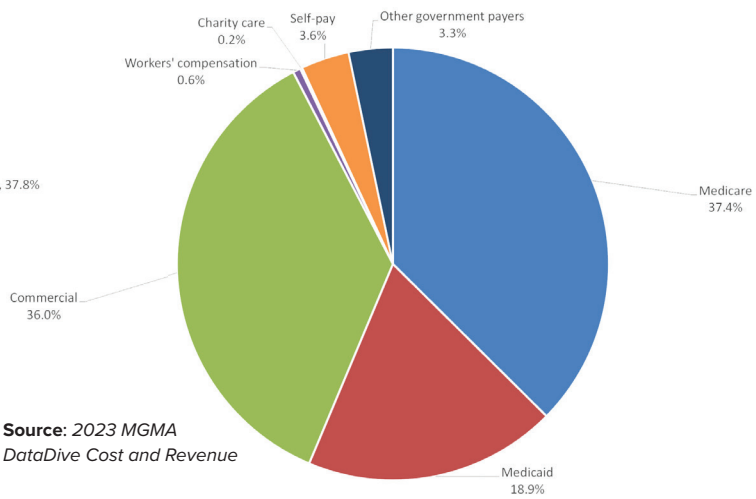


FIGURE 4. 2022 PAYER MIX IN HOSPITAL-/IDS-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALITY CARE



Source: *2023 MGMA DataDive Cost and Revenue*

substantial revenues that accrue in a private practice are not reflected on a hospital-owned practice's financial statements, which is described in the April 2022 *MGMA Connection* article, "Is employing physicians a smart strategy or a financial bubble?"[2]

Table 1 offers a detailed breakout of staff and operating costs over the past four years with a focus on the past two years as pandemic disruptions subsided. In 2022, physician-owned multispecialty groups with primary and specialty care were able to limit the increase in median total support staff costs per FTE physician to only a 0.4% increase; however, total median total operating staff costs per FTE physician surged by 18.6%. In contrast, hospital-owned practices experienced a substantial 40.7% increase in total support staff cost per FTE physician and a 13.8% increase in total operating cost per FTE physician. Compared to pre-pandemic 2019 benchmarks, physician-owned groups reported a rise of 11.0% in support staff costs per FTE physician and a staggering 42.2% increase in total operating costs per FTE physician.

The cost data conclusively show that practice staff and operating costs are increasing at rates exceeding inflation, posing a considerable challenge for healthcare providers who lack the flexibility available to traditional businesses in terms of redesigning products or raising prices to offset cost increases.

Figures 3 and 4 illustrate the problems that medical groups have with insurers fixing payments and how little control providers have in setting their prices. Medicare, the largest payer for hospital-owned practices and second largest payer for physician-owned multispecialty groups, sets specific payment rates for procedures, leaving practices with little room for negotiation. Medicaid, the state and federal program for residents with limited income, similarly establishes payment levels. While physician-owned practices typically have the option to limit the number of Medicaid patients, medical groups affiliated with a health system almost always have the broader policies of their parent for accepting Medicaid patients, which is reflected in how hospital practices report three times the level of Medicaid than physician-owned practices.

Commercial health insurers cover most Americans under 65 and represent 49.9% of charges in physician-owned and 36.0% of charges in hospital multispecialty groups with primary and specialty care. Leveraging their economic clout, commercial insurers employ complex payment methodologies that almost always specify the amount the

insurer will pay and usually limit the amount a provider can "balance bill" to patients. The insurance industry has been able to thrive under their system of limiting payments to hospitals and physicians to a predicted amount and then basing premiums on an actuarial estimate for the frequency of claims.

Essentially, only self-pay patients, constituting a small fraction of practice revenue, typically pay the full billed amount, and even they often pay less than the full charge.

Compounding the problem, practice leaders report they have little negotiating leverage when dealing with insurers. To highlight the scale of this issue, UnitedHealth Group, with annual revenue of $286 billion, is five times larger than the largest healthcare system, HCA, which reported annual revenue of $59 billion. In fact, each of the six largest insurers have annual revenues that surpass HCA's.[3,4] When even the largest healthcare provider lacks negotiating clout, private practices are at a distinct disadvantage. Fortunately, many smaller organizations may enjoy regional or local advantages that provide opportunities for negotiating payment.

The healthcare landscape is intricate and healthcare payment can be described as Byzantine in its complexity. What remains simple and evident, however, is that healthcare providers face significant challenges in managing their costs and maintaining their income as they are squeezed by our current environment of higher costs and static payments. ■

NOTES

1. U.S. Bureau of Economic Analysis (BEA). "Corporate Profits." U.S. Department of Commerce. Available from: https://bit.ly/48IKCWe.
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EXPERT INSIGHTS FROM MGMA CONSULTING:

"We will continue to see independent practices and entire medical groups merging into larger entities in 2024. Acquisitions and mergers often focus on operational processes, financial methodologies, and other observable aspects of business operations. The most successful ventures, start deeper. They begin by examining, discussing, and aligning the values and other unspoken aspects of the two organizational cultures. Beyond just the mission and vision statements on the wall, taking time to consider the tacit assumptions and underlying beliefs each culture holds is an effort that pays off as people come together to create a unified new organization."

KATIE LAWRENCE, MHA, CMPE

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BETTER PATIENT COMMUNICATION TO BALANCE YOUR APPROACH TO DETERRING NO-SHOW APPOINTMENTS

YURIY KOTLYAR
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Patients unexpectedly missing clinic appointments can lead to at least three negative outcomes: Patients may struggle to get another appointment and miss out on needed care. Clinicians may be frustrated at the gap in their schedules. And medical groups that don't get a handle on the problem will see the impact on their financial results.

Recent *MGMA DataDive* benchmarks show median appointment no-show rates of 5% to 7%.[1] The cost to healthcare providers from missed appointments is difficult to determine, but one widely cited estimate was a staggering $150 billion annually.[2]

Policies and procedures regarding no-shows can make a dent in the problem. Setting and enforcing a fee for missed appointments, requiring deposits and engaging in controlled overbooking are all tactics that can prevent no-shows or mitigate their impact. While they may be needed, these approaches work by delivering negative consequences to patients. Each one is a stick.

Medical groups also should find some carrots that impact no-shows. These approaches offer patients desired alternatives to ensure they fulfill their appointments or cancel with adequate time for another patient to fill the appointment. Telehealth options, flexible hours and transportation assistance all can reduce no-show appointments while providing a better patient experience.

Better patient communication offers the greatest opportunities to both reduce no-shows and enhance patient experience. Here are five ways to improve patient communication to prevent no-shows.

1. Optimize appointment reminders

To cut the number of no-show appointments, start by optimizing your reminder strategy.

- Remember that cancellations aren't the problem: No-shows are the problem. Your automated reminders should make it easy for patients to cancel and release the appointment slot.
- Ensure your reminders offer personalized messages that include the specific details of their appointment, such as date, time, location and the provider's name or service (e.g., MRI) being provided. With these details, the patient can determine, at a glance, whether they can come to the appointment or need to cancel and reschedule.
- Offer personal preference options to patients. These include the choice of channel (email, text message, phone call), language options and the ability to opt out of reminders.

2. Ensure operations support the reminder strategy

The next step is to ensure the contact center function has the workflows and capacity to support the patient reminder strategy.

For example, based on our clients' experience, **about 15% of appointment reminders generate a call to the contact center. Even when there is a frictionless way to cancel the appointment through a text message reminder, some of the patients who cancel might want to speak to someone to reschedule the appointment**.

The operational question is whether these patients will be able to get through to someone to cancel the original appointment and reschedule. If they cannot get through with a reasonable wait time, they are highly likely to become a no-show patient.

These calls must be accounted for in determining the right level of contact center capacity during evening hours. In weighing the costs of this capacity, consider the high value of preventing no-show appointments.

As noted above, your automated reminders should make it easy for patients to cancel appointments in advance. Your contact center function can operationalize this in two ways:

- First, develop a dedicated workflow to contact patients who have canceled appointments through an automated reminder but have not rebooked the appointments.
- Second, when you rebook these patients, also offer to add them to your waitlist and then actively work that list to fill appointment slots that free up on short notice.

Patients will be less reluctant to cancel in advance if they feel confident that they will be able to reschedule without too much difficulty. The operational response to achieve that is to have the call center open when your patients are most likely call to cancel or reschedule. Based on the accumulated statistics across our clients, most patients find out that they cannot come to the appointment during the evening hours and weekends.

If the contact center is closed during those hours and the patient is routed to the voicemail, there is a great chance that the voicemail will not be returned. Even if the voicemail is returned, in most cases, enough time will pass that the appointment would be a no-show.

Having the contact center function available on weekday evenings and the weekends allows patients to call and reschedule at the most convenient times for them; weekend hours help lower the call volume spike during the Monday peak hours.

"PATIENTS WILL BE LESS RELUCTANT TO CANCEL IN ADVANCE IF THEY FEEL CONFIDENT THAT THEY WILL BE ABLE TO RESCHEDULE WITHOUT TOO MUCH DIFFICULTY. THE OPERATIONAL RESPONSE TO ACHIEVE THAT IS TO HAVE THE CALL CENTER OPEN WHEN YOUR PATIENTS ARE MOST LIKELY CALL TO CANCEL OR RESCHEDULE."

3. Test, refine, repeat

Medical groups need a willingness to try a variety of methods, measure the results and choose the right ones for their patient populations to reduce no-shows.

Consider an A/B testing approach. A medical group can split up a patient population into two groups and then try two different methods for reducing no-shows, for example, by testing different ways to time pre-appointment reminders. In this example, Group A receives reminders 14 days and two days before their appointments, while Group B receives reminders 14 days, seven days and one day before their appointments. Different times of day for reminders also can be tested in this way.

Artificial intelligence (AI) tools can be used to analyze patient data for performance, as measured on the no-show rate and the rate at which patients who needed to reschedule eventually received needed care.

4. Follow the data

The same data analysis tools can surface insights on individual patients who require more effort to ensure they come to appointments. These may be individual patients who have a history of missing appointments or not following up on recommended care, or patients with certain chronic conditions or complex care plans. (This is not, however, a suggestion to base outreach on broad demographic categories, as this may cause legal issues.)

Asking patients for their communication preferences before or at their first appointment and periodically after that as long as they remain active patients also provides information that helps avoid no-shows.

5. Return the favor

Sometimes it's the clinician who is a no-show. Specialists who perform surgeries may be called away for an emergency procedure and unable to fulfill office appointments at short notice. Sometimes clinicians have family emergencies, feel ill or have other last-minute reasons to cancel appointments.

Medical groups need to do more than just notify patients that their appointments are canceled. Giving these patients some priority for appointments and actively reaching out to them to rebook builds trust and demonstrates that the provider and the medical group as a whole value the time of patients, too.

Conclusion

Medical groups need a multi-pronged strategy for reducing no-show appointments that balances sticks, such as no-show fees, with carrots that encourage patients via seamless options for cancelling and rescheduling. Over time, the focus on making patients a partner in avoiding no-show appointments helps patients get the care they need and builds loyalty for a long-term relationship.

Yuriy Kotlyar is co-founder and CEO of American Health Connection, Beverly Hills, Calif.

NOTES

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MGMA *Stat* helped give healthcare professionals a voice in 2023

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