



Executive Summary Report

MGMA 2015

Cost and Revenue

Report

Based on 2014 survey data





MGMA 2015 Cost and Revenue Report

For more than 50 years, Medical Group Management Association (MGMA) has been the leader in benchmarking data for medical practices across the nation. The *MGMA 2015 Cost and Revenue Report* remains the premier source for cost and revenue data representing responses from 3,120 groups.

MGMA produced the following analyses to help industry members understand factors that influence cost and revenue measures and to provide insight into current industry trends. These analyses use the

median unless otherwise stated, and the report reflects data submitted by members and nonmembers for their organizations' 2014 fiscal year.

The results and conclusions outlined in this summary cover the following:

- Expenses
- Revenue
- Staffing
- A/R, Collections
- Operations

Expenses

Total Operating Cost

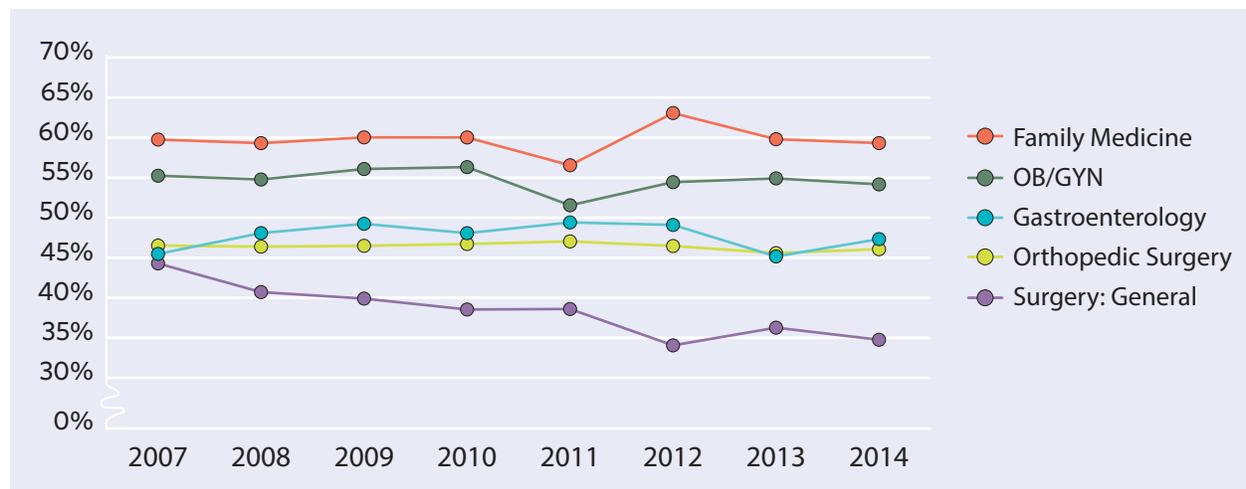
Total operating cost is composed of both support staff expenses and general operating expenses. For the physician-owned single specialties of family medicine, gastroenterology, OB/GYN, orthopedic surgery and general surgery, **total operating cost as a percentage of total medical revenue has experienced moderate fluctuations over the last eight years and minimal fluctuations in the last year.**

Physician-owned OB/GYN practices have experienced the most stability in their operating expenses over the last eight years, reporting **an increase of just 0.96% between 2007 and 2014.** In the last year, orthopedic surgery practices report steady growth with an increase of 8.03% in total operating cost and an increase of 10.34% in total medical revenue.

The long-term decrease in the overhead percent in **general surgery** is likely due to managing costs relative to production. Even though the revenue is relatively flat, operating costs are decreasing, which decreases the overhead expense.

Total Operating Cost as a Percentage of Total Medical Revenue

Trends for Select Physician-Owned Specialties



Total Cost

Total cost is inclusive of total operating cost (support staff expenses plus general operating expenses) and total provider cost (nonphysician provider and physician compensation and benefits).

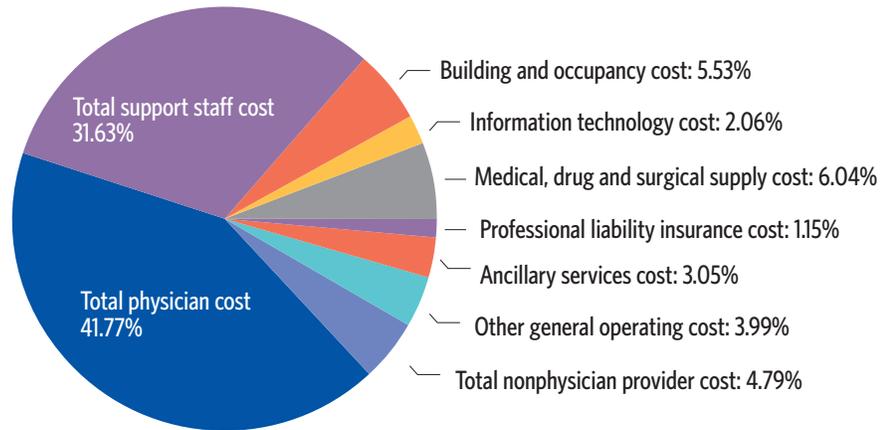
Practice ownership has a significant influence on expenses. Hospital/integrated delivery system (IDS)-owned medical groups are usually part of a larger health system that provides common services to its components. This cross subsidy is reflected in **information technology costs, which represent only 0.40% of total costs in hospital/IDS-owned multispecialty practices compared to 2.06% in physician-owned multispecialty groups.**

In a similar manner, ancillary services are generally consolidated in hospital/IDS-owned practices to gain economies of scale and better utilization. This is reflected in **ancillary services costs, which were 0.20% of total costs in hospital/IDS-owned multispecialty groups compared to 3.05% in physician-owned multispecialty practices.**

Other general operating costs include administrative supplies and services, furniture and equipment, promotion and marketing and billing purchased services. **Because hospital/IDS-owned practices tend to be part of a larger network, fixed costs may be spread out over more units of output, decreasing the cost per unit.**

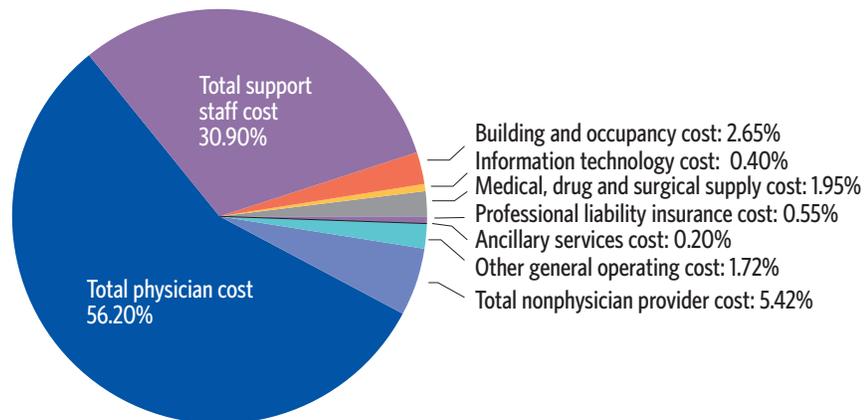
Percentage of Total Cost per FTE Physician by Category

Multispecialty, Physician-Owned Practices



Percentage of Total Cost per FTE Physician by Category

Multispecialty, Hospital/IDS-Owned Practices



Revenue

Total Medical Revenue

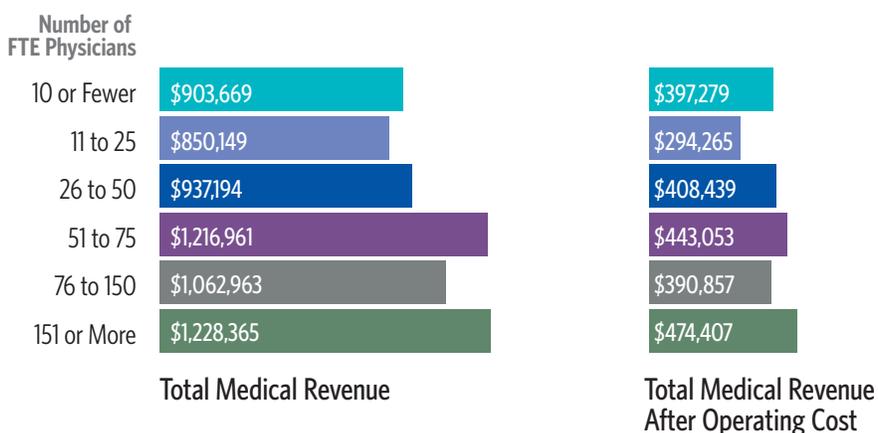
In general, **as the size of a practice increases, revenue increases**. As practices grow in size and production units increase, those larger practices have **better opportunities to decrease costs as they become more spread out**.

Larger practices are also more apt to include medical and surgical subspecialties that can be supported by the practice's larger base of primary care physicians. Subspecialty services have greater complexity and generate greater amounts of revenue per full-time equivalent (FTE) physician. This is reflected in the data provided by **physician-owned multispecialty groups where medical groups with 151 or more FTE physicians report the greatest total medical revenue per FTE physician (\$1,228,365) and greatest total medical revenue after operating cost per FTE physician (\$474,407) of any size category reporting**.

Revenue by Size of Practice

per FTE Physician

Multispecialty,
Physician-Owned
Practices



Staffing

Total Support Staff

Total support staff includes personnel in business operations, front office, clinical and ancillary support.

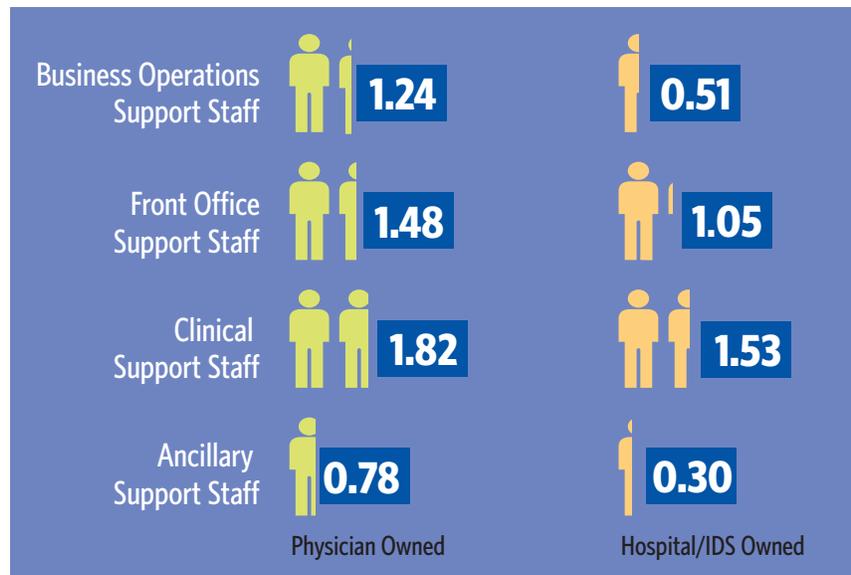
Physician-owned multispecialty practices with primary and specialty care report having 2.11 more total support staff per FTE physician than their hospital/IDS-owned counterparts.

The most notable difference in support staff between physician-owned and hospital/IDS-owned practices is for business operations and ancillary services. **Physician-owned multispecialty with primary and specialty care practices report a median of 0.73 more business operations staff per FTE physician than hospital/IDS-owned groups.** This is largely due to hospital/IDS-owned practices utilizing centralizing billing and collections, administration, accounting and IT, which are part of business operations support staff.

Hospital/IDS-owned practices also consolidate the laboratory and imaging ancillary services into a system-owned laboratory or imaging center or into the hospital, explaining why **physician-owned multispecialty with primary and specialty care practices report 0.48 more ancillary services staff per FTE physician than their hospital/IDS-owned counterparts.**

Support Staff per FTE Physician

Multispecialty with Primary and Specialty Care Practices



The Brookings Institution defines an accountable care organization (ACO) as “a group of health care providers who accept shared accountability for the cost and quality of care delivered to a population of patients.”¹

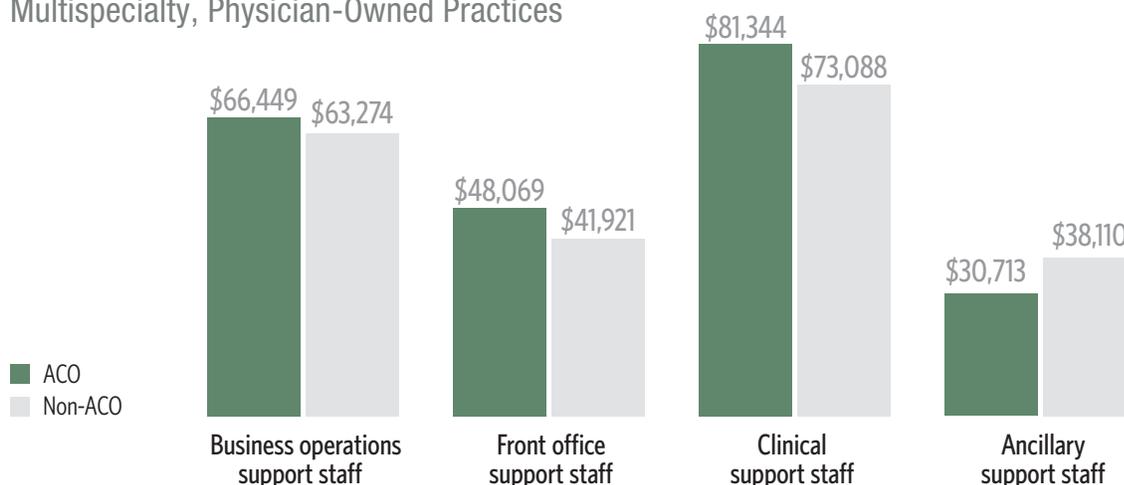
Physician-owned multispecialty groups that are part of an ACO report spending \$13,015 more on total support staff costs per FTE physician than multispecialty practices that were not part of an ACO. These same ACO practices reported spending 14.67% more on front office support staff and 11.30% more on clinical support staff than non-ACO physician-owned multispecialty groups.

Although physician-owned multispecialty ACO practices report spending more on total support staff costs, they report spending significantly less on general operating expenses. **Compared to their non-ACO counterparts, they report spending 12.18% less on total general operating costs per FTE physician.**

¹<http://www.brookings.edu/~media/research/files/papers/2014/11/19-aco-toolkit-primary-care/aco-toolkit--full-version-text.pdf>

Support Staff Cost per FTE Physician

Multispecialty, Physician-Owned Practices



A/R, Collections

Accounts Receivable

Better-performing practices are more efficient in tracking accounts receivable (A/R) and collecting payments than practices that did not meet the better-performer criteria. Days in A/R reflects the number of days of charges in the practice’s A/R balance, thus indicating how quickly the practice collects its fees.

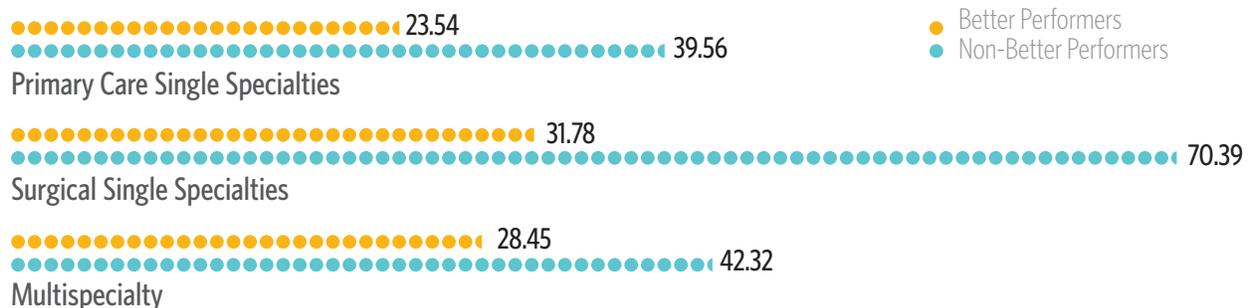
Practices participating in the Cost and Revenue Survey were deemed as a better-performing practice in the area of A/R if they met the following criteria:

- Less than the median for percentage of total A/R over 120 days;
- Greater than the median for adjusted fee-for-service (FFS) collection percentage; and
- Less than the median for months gross fee-for-service charges in A/R.

Data on practices that received a better-performer designation were published in the *MGMA 2015 Performance and Practices of Successful Medical Groups Report: Based on 2014 Survey Data*.

Better-performing practices report nearly half as many days gross FFS charges in A/R than practices that were not deemed as better-performing, regardless of specialty. The largest gap occurs in surgical single-specialty practices where better-performing practices report days in A/R just over a month, and non-better performing practices report over two months’ time. **In essence, better-performing practices are getting paid in half the time of other practices.**

Days Gross Fee-for-Service Charges in A/R



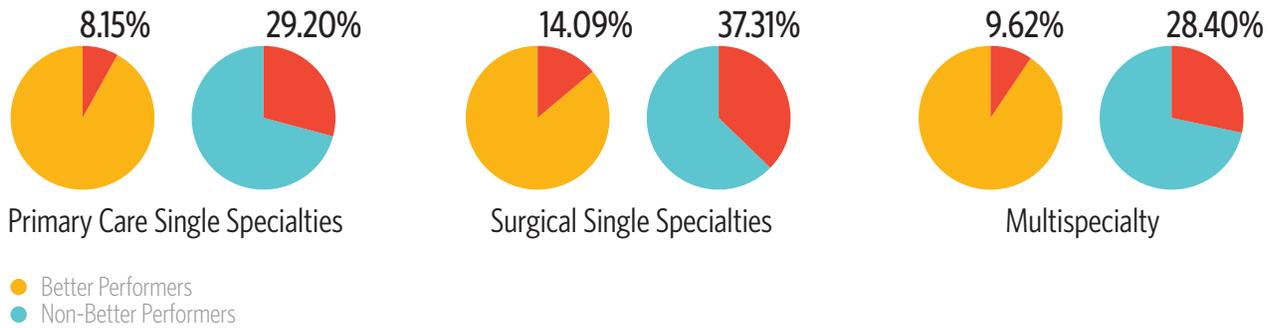
Better-performing practices take a variety of steps to improve financial processes and make patients’ bills easier to pay and understand.

Actions Taken to Make Bills Easier to Pay and Understand

Assisted patients in making financial arrangements	96.92%
Provided online billing and payment capabilities	96.92%
Provided counseling with onsite billing staff for patients	76.92%
Maintained convenient billing office hours	73.85%
Provided bilingual statements	67.69%
Provided face-to-face contact with accounting staff for patients	64.62%
Consolidated bills across payers	52.31%
Provided toll-free number for patient questions	46.15%

In addition to fewer days gross FFS charges in A/R, **better-performing practices also report that significantly lower percentages of their total A/R is over 120 days. Better-performing practices report nearly one-third the percentage reported by other practices.** By utilizing better processes and reducing the number of accounts that are allowed to age, the total outstanding A/R is less and balances are collected faster in better-performing practices.

Percentage of Total A/R 120+ Days



Gross and Adjusted Fee-for-Service (FFS) Collection Percentage Trend

Despite the advent of insurance exchange products and bundled payment contracts that could result in greater contractual adjustments to FFS payments, **the gross FFS collections percentage has remained stable the past four years.** The slight erosion in the adjusted FFS collections percentage over the last two years may be a result of the increased number of high-deductible health plan contracts and the complexity associated with collecting the copays and deductibles from patients insured through a health insurance exchange.

Mean Gross and Adjusted Fee-for-Service Collection Percentages

Multispecialty, Physician-Owned Practices



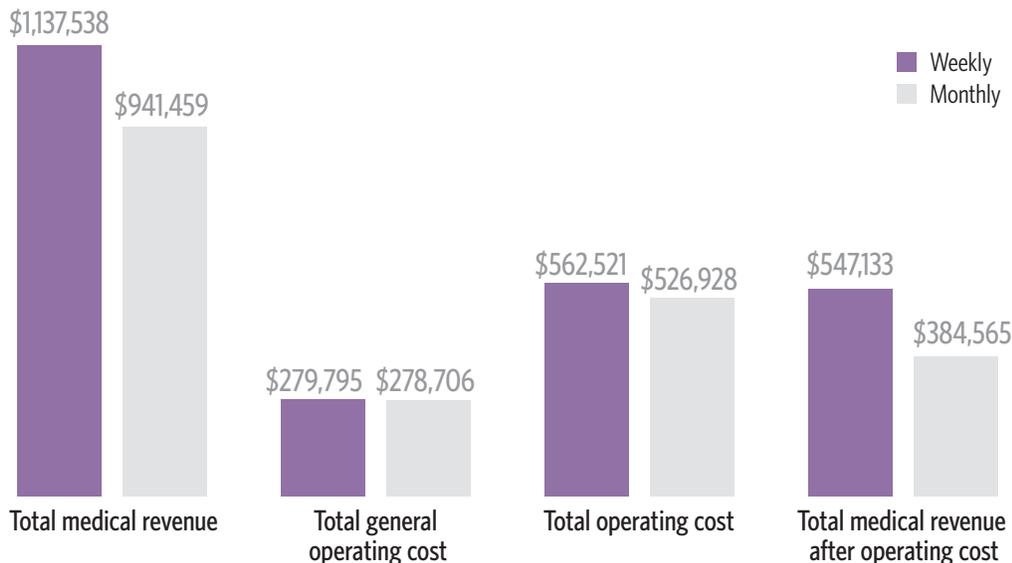
Operations

Physician–Administrator Team

More than 80% of practices responding to the Successful Groups Survey report a collaborative relationship between the lead physician and the administrator. Physician-owned practices where the lead physician and administrator meet more frequently report being more profitable. Those **practices where the lead physician and administrator meet weekly report earning 20.83% more in total medical revenue per FTE physician while spending only 6.75% more in total operating costs per FTE physician than practices where the physician and administrator meet monthly.**

Practice Performance by the Frequency the Lead Physician and Administrator Have a Regularly Scheduled Meeting

Physician-Owned Practices, per FTE Physician



Source: Special analysis of data from the MGMA 2015 Cost and Revenue Report and MGMA 2015 Performance and Practices of Successful Medical Groups Report

Practice costs and revenue are influenced by a variety of components. Understanding how to effectively benchmark data against various demographical and trend characteristics can be to a practice's advantage to assist in determining the overall health of a practice. The *MGMA 2015 Cost and Revenue Report: Based on 2014 Survey Data* allows for a wide range of additional analyses from those included within this executive summary.

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