



offered by **McMAI**

A photograph of two women in a bright office setting. The woman on the left has long blonde hair and is wearing glasses and a white button-down shirt. The woman on the right has dark curly hair and is wearing a tan blazer over a white top. They are both smiling and looking at a silver laptop held by the woman on the right. The background is a bright, out-of-focus office space with large windows.

**PRACTICE OPERATIONS
GLOSSARY
2024**

PRACTICE OPERATIONS GLOSSARY

This glossary is intended to serve as a reference guide when benchmarking against the MGMA data. Some benchmarks and filters denoted in this glossary are only available in the Custom Reports and Tools section of DataDive, which allows for the building of more comprehensive reports and graphs.



Additional DataDive resources can be found [here](#).

- VALUE BASED 3**
- TOTAL OPERATIONAL HOURS 4**
- PATIENT PORTAL 4**
- CALL CENTER 4**
- SCHEDULING 4**
- BILLING 5**
- TURNOVER & HIRE RATES 6**
- DEMOGRAPHIC/FILTER DEFINITIONS 7**
- GEOGRAPHIC SECTION 10**
- SUPPORT 13**

VALUE-BASED

30-Day Post-Operative Infection Rate

Any infection that occurs within 30 days of operation and may be related to the operation itself or the postoperative course.

To calculate:

- # of post-operative infections [in patients tied to value-based contracts] within 30 days of operation
- Total # of patients [tied to value-based contracts]

Covered Lives

The number of people (and their dependents) enrolled in a particular health insurance program.

Emergency Department (ED) Utilization

Patients who utilized the emergency department and is discharged from there.

To calculate:

- # of inpatient and/or outpatient ED admissions [for patients tied to value-based contracts]
- Total # of patients [tied to value-based contracts]

Hospital 30-Day Readmission Rate

Patients readmitted to the hospital within 30 days or less of being discharged from a previous hospital stay.

To calculate:

- # of patients [tied to value-based contracts] with hospital readmissions within 30 days
- Total # of patient hospital discharges [tied to value-based contracts]

Hospital Admission Rate

Patients admitted to the hospital for an extended stay.

To calculate:

- # of patient hospital admissions [tied to value-based contract]
- Total # of patients [tied to value-based contracts]

Value-Based Contracts

Contractual arrangements in which payment for providing healthcare goods and services is tied to terms that are based on clinical quality, patient outcomes, cost effectiveness and other specified measures of the appropriateness and effectiveness of the services rendered.

- **Commercial:** Private insurance excluding Medicare Advantage Programs.
- **Government:** May include CMS's Quality Payment Program (QPP), which includes the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).
- **Medicare Advantage:** Part of the Medicare Program, and may include Part A, B and D benefits, however, the benefits are instead offered through contracts with private insurers.

TOTAL OPERATIONAL HOURS

Hours of Operation

The days of the week and hours per day a practice is open to see patients.

PATIENT PORTAL

Patient Portal

An online platform where patients can perform administrative tasks associated with their care. Examples of these tasks include scheduling appointments, paying bills, accessing test results, communicating with providers and medical staff, viewing medical records, filling new prescriptions, and requesting prescription refills.

CALL CENTER

Inbound Call Abandonment Rate

The percentage of total inbound calls that were disconnected and/or not answered.

SCHEDULING

Appointment Time

A designated block of time spent providing patient care.

Cancellation Rate

The rate measuring appointments that were scheduled but cancelled by the patient, as a percent of total appointments. Rescheduled within 30 days after cancellation: the percentage of appointments that were rescheduled within 30 days of cancelling their patient's original appointments.

Established Patient

An individual who has previously received care from a provider in the same group practice, within the past three years.

Post Operative Visit

An appointment scheduled after an initial visit or performed procedure.

New Patient

An individual who has not previously received care from a provider in the same group practice, within the past three years.

No-Show Fee

The amount charged when a patient does not show for a scheduled appointment.

No-Show Rate

The rate measuring appointments that were scheduled but patients did not show up for their scheduled time, as a percent of total appointments.

Preventive Care Visit

Typically, a yearly appointment intended to prevent illness and detect health concerns early before symptoms are noticeable.

Same-Day Appointments

The total number of appointment slots per day that are scheduled for same-day patients to accommodate for last-minute appointment requests.

Third Next Available Appointment

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.

Throughput/Total Cycle Time

The number of minutes between when a patient arrives at the practice and when they leave the practice including time spent waiting in the waiting area, exam room and checkout time.

Unfilled Appointment Slot

Total appointment slots that were not filled by a scheduled patient visit or purposely unscheduled per day.

Wait Time

The average time spent by a patient before receiving care in the waiting area or exam room.

BILLING

Charge-Posting Lag Time

The number of days between when a patient was seen (date of service) and when the claim was posted for third-party payment.

Claim

A written request for payment submitted to a third-party for services rendered to patients by providers.

Patient Encounter

An instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient's condition, where the provider exercises clinical judgment that may or may not be billable.

Payer Contract

An agreement that outlines the terms and conditions under which a payer promises to pay the practice or specific provider for medically necessary services it provides patients.

TURNOVER & HIRE RATES

Advanced Practice Provider (APP) *Also referred to as: Advanced practice practitioners, nonphysician providers (NPPs), physician extenders, mid-levels, etc.*

Advanced practice providers are specially trained and licensed providers who can provide medical care and billable services. Examples of advanced practice providers include audiologists, certified registered nurse anesthetists (CRNAs), dietitians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, and surgeon assistants.

Note: Residents are not considered advanced practice providers in the MGMA data sets.

Ancillary Support Staff

Staff who perform support duties for the ancillary services provided by the practice, including clinical laboratory, radiology and imaging, and other medical support services.

Business Operations Support Staff

Staff who perform the business functions of the practice, including general administration, patient accounting, general accounting, managed care administration, information technology, housekeeping, maintenance, and security.

Clinical Support Staff

Staff who perform the clinical support duties of the practice including registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, and nurse's aides who assist clinical services.

Front Office Support Staff

Staff who perform the front office duties of the practice, including medical reception, secretarial functions, transcription, medical records, and other administrative support.

Hire Rate

The number of individuals hired for a given position, divided by the total number of positions within a practice.

Turnover Rate

The number of individuals who left a given position, divided by the total number of positions within a practice.

DEMOGRAPHIC/FILTER DEFINITIONS

Accountable Care Organization (ACO)

A group of coordinated health care providers who form a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for their population of patients. The ACO is accountable to patients and the third-party payer for the quality, appropriateness, and efficiency of the care provided.

Demographic Classification

Metropolitan Area (50,000 or More): The county in which the practice is located is defined as a metropolitan (metro) county by the Office of Management and Budget (OMB), based on recent Census Bureau data.

Nonmetropolitan Area (49,999 or Fewer): The county in which the practice is located is defined as a nonmetropolitan (nonmetro) county by the Office of Management and Budget (OMB), based on recent Census Bureau data.

Federally Qualified Health Center (FQHC)

A reimbursement designation that refers to several health programs funded under Section 330 of the Public Health Service Act of the US Federal Government. These 330 grantees in the Health Center Program include:

- Community Health Centers which serve a variety of underserved populations and areas;
- Migrant Health Centers which serve migrant and seasonal agricultural workers;
- Health Care for the Homeless Programs which reach out to homeless individuals and families and provide primary and preventive care and substance abuse services; and
- Public Housing Primary Care Programs that serve residents of public housing and are located in or adjacent to the communities they serve.

FQHCs are community-based organizations that provide comprehensive primary and preventive health, oral, and mental health/substance abuse services to persons in all stages of the life cycle, regardless of their ability to pay.

Full Time Equivalent (FTE)

A measure based upon the number of actual hours worked regardless of whether it's spent in clinical or nonclinical activities. A 1.0 FTE provider works the number of hours the practice considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. Regardless of the number of hours worked, a provider cannot be counted as more than 1.0 FTE.

Legal Organization

Business Corporation: A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders need not be licensed in the profession practiced by the corporation.

Limited Liability Company (LLC): A legal entity that is a hybrid between a corporation and a partnership, because it provides limited liability to owners like a corporation while passing profits and losses through to owners like a partnership.

Not-for-profit Corporation/Foundation: An organization that has obtained special exemption under Section 501(c) of the Internal Revenue Service code that qualifies the organization to be exempt from federal income taxes. To qualify as a tax exempt organization, a practice or faculty practice plan would have to provide evidence of a charitable, educational, or research purpose.

Partnership: An unincorporated organization where two or more individuals have agreed that they will share profits, losses, assets, and liabilities, although not necessarily on an equal basis. The partnership agreement may or may not be formalized in writing.

Professional Corporation/Association: A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders must be licensed in the profession practiced by the organization.

Sole Proprietorship: An organization with a single owner who is responsible for all profit, losses, assets, and liabilities.

Number of FTE Physicians

The practice's full-time-equivalent (FTE) physician count. For further detail on FTE, see Full-Time Equivalent above.

Organization Ownership

Hospital/IDS Owned:

- **Hospital:** A hospital is an inpatient facility that admits patients for overnight stays, incurs nursing care costs, and generates bed-day revenues.
- **Integrated Health System or Integrated Delivery System (IDS):** A network of organizations that provide or coordinate and arrange for the provision of a continuum of health care services to consumers and is willing to be held clinically and fiscally responsible for the outcomes and the health status of the populations served. Generally consisting of hospitals, physician groups, health plans, home health agencies, hospices, skilled nursing facilities, or other provider entities, these networks may be built through “virtual” integration processes encompassing contractual arrangements and strategic alliances as well as through direct ownership.
- **Management Services Organization (MSO):** An entity organized to provide various forms of practice management and administrative support services to health care providers. These services may include centralized billing and collections services, management information services, and other components of the managed care infrastructure. MSOs do not actually deliver health care services. MSOs may be jointly or solely owned and sponsored by physicians, hospitals, or other parties. Some MSOs also purchase assets of affiliated physicians and enter into long-term management service arrangements with a provider network. Some expand their ownership base by involving outside investors to help capitalize the development of such practice infrastructure.
- **Physician Practice Management Company (PPMC):** Publicly held or entrepreneurial directed enterprises that acquire total or partial ownership interests in physician organizations. PPMCs are a type of MSO, however their motivations, goals, strategies, and structures arising from their unequivocal ownership character – development of growth and profits for their investors, not for participating providers – differentiate them from other MSO models.

Physician Owned:

- **Advanced Practice Providers:** Any advanced practice provider (e.g. nurse practitioners, physical therapists, etc.) duly licensed and qualified under the law of jurisdiction in which treatment is received.
- **Physicians:** Any Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Other Majority Owner:

- **Insurance Company or Health Maintenance Organization (HMO):** An insurance company that accepts responsibility for providing and delivering a predetermined set of comprehensive health maintenance and treatment services to a voluntarily enrolled population for a negotiated and fixed periodic premium. An organization that indemnifies an insured party against a specified loss in report for premiums and paid as stipulated by a contract.
- **Government:** A governmental organization at the federal, state, or local level. Government funding is not enough criterion. Government ownership is the key factor. An example would be a medical clinic at a federal, state, or county correctional facility.
- **Private Investor(s):** A company or individual that takes their own money and uses it to fund another organization. Some investors have the option to invest passively, which means they give their funding and play no further role, while others have a more significant role in the organization.
- **University or Medical School:** An institution of higher learning with teaching and research facilities comprising undergraduate, graduate and professional schools. A medical school is an institution that trains physicians and awards medical and osteopathic degrees.

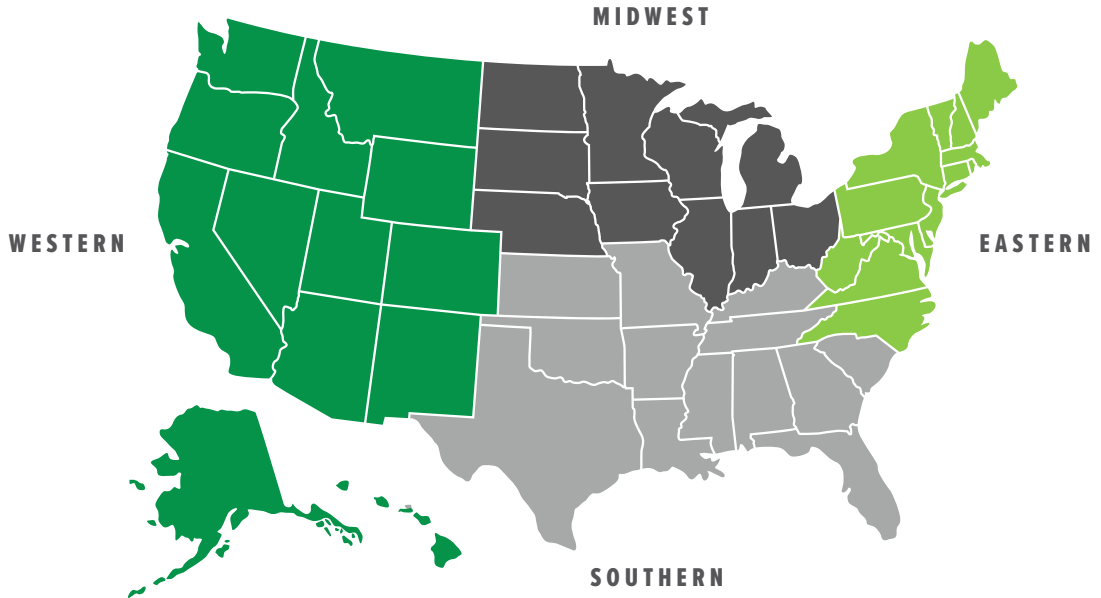
Patient Centered Medical Home (PCMH) 

A care delivery model where patient treatment and care is coordinated through their primary care provider to ensure they receive high quality care when care is necessary. The objective is collaboration between the patient and physicians with care delivered in a way the patient can understand. PCMHs seek to improve the quality, effectiveness, and efficiency of the care delivered while focusing on meeting patient needs first.

Rural Health Clinic (RHC)

A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is to improve access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and advanced practice providers (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50% of the time with an advanced practice provider. RHCs may also provide other healthcare services such as mental health or vision services, but reimbursement for those services may not be based on their allowable cost.

GEOGRAPHIC SECTION



Western Section:

Alaska
 Arizona
 California
 Colorado
 Hawaii
 Idaho
 Montana
 Nevada
 New Mexico
 Oregon
 Utah
 Washington
 Wyoming

Midwest Section:

Illinois
 Indiana
 Iowa
 Michigan
 Minnesota
 Nebraska
 North Dakota
 Ohio
 South Dakota
 Wisconsin

Eastern Section:

Connecticut
 Delaware
 District of Columbia
 Maine
 Maryland
 Massachusetts
 New Hampshire
 New Jersey
 New York
 North Carolina
 Pennsylvania
 Rhode Island
 Vermont
 Virginia
 West Virginia

Southern Section:

Alabama
 Arkansas
 Florida
 Georgia
 Kansas
 Kentucky
 Louisiana
 Mississippi
 Missouri
 Oklahoma
 South Carolina
 Tennessee
 Texas

Health and Human Services (HHS) Regions ^{D+}

HHS Region 1: Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	HHS Region 2: New Jersey New York	HHS Region 3: Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia	HHS Region 4: Alabama Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee	HHS Region 5: Illinois Indiana Michigan Minnesota Ohio Wisconsin
HHS Region 6: Arkansas Louisiana New Mexico Oklahoma Texas	HHS Region 7: Iowa Kansas Missouri Nebraska	HHS Region 8: Colorado Montana North Dakota South Dakota Utah Wyoming	HHS Region 9: Arizona California Hawaii Nevada	HHS Region 10: Alaska Idaho Oregon Washington

Total Medical Revenue ^{D+}

The sum of fee-for-service collections (revenue collected from patients and third-party payers for services provided to fee-for service, discounted fee-for-service, and non-capitated Medicare/Medicaid patients), capitation payments (gross capitation revenue minus purchased services for capitation payments), and other medical activity revenues.

- **Net Prepaid (Capitation/Sub-Capitation) Revenue:** Includes all capitation revenue received from Health Maintenance Organizations (HMOs), risk-sharing revenue, hospital/ utilization withholds, co-payments and revenue received from a benefits coordination and/or reinsurance recovery situation minus professional and medical services purchased from outside providers.
- **Net Other Patient Care/Medical Services Revenue:** Includes all revenue received from the sale of goods and services such as durable medical equipment rental, revenue from medical service contracts with nursing homes or ambulatory care centers, hospital reimbursements for direct patient care, and revenue from providing ancillary services on a fixed fee or percentage contract that are not billed as fee-for-service.
- **Other Medical Revenue:** Includes grants, honoraria, research contract revenues, government support payments, and educational subsidies plus the revenue from the sale of medical goods and services.
- **Total Department Revenue:** All revenue received by the department from patient care activities, net of all refunds, returned checks, contractual discounts and allowances, bad debts and write-offs. The sum of total fee-for-service (FFS) revenue, net prepaid (capitation/sub-capitation) revenue and net other patient care/medical services revenue equals total patient care revenue.
- **Total FFS Revenue:** Includes net collections (receipts) from patients who are self-insured, or reimbursements from a third-party insurer that compensates the department (practice plan) on a fee-for-service, or discounted fee-for service basis.

Minor Geographic Region

Northeast:

Connecticut
 Maine
 Massachusetts
 New Hampshire
 Rhode Island
 Vermont

North Atlantic:

New Jersey
 New York
 Pennsylvania

Northwest:

Idaho
 Oregon
 Washington
 Wyoming

Mid Atlantic:

Delaware
 District of Columbia
 Maryland
 Virginia
 West Virginia

Southeast:

Alabama
 Florida
 Georgia
 Mississippi
 North Carolina
 South Carolina
 Tennessee

Eastern Midwest:

Illinois
 Indiana
 Kentucky
 Michigan
 Ohio

Upper Midwest:

Iowa
 Minnesota
 Nebraska
 North Dakota
 South Dakota
 Wisconsin

Lower Midwest:

Arkansas
 Kansas
 Louisiana
 Missouri
 Oklahoma
 Texas

Rocky Mountain:

Arizona
 Colorado
 Montana
 Nevada
 New Mexico
 Utah

Pacific:

Alaska
 California
 Hawaii

SUPPORT

We are here for you, ensuring you get the absolute most out of your investment. Use the following, helpful resources any time you get stuck or have a question.

Mgma Datadive Resources

Within MGMA DataDive, select “Help” in the left navigation. This area links to a variety of resources including helpful guides, glossaries, survey demographics, best practices and FAQs. Visit mgma.com/datadiveresources

Online Help Community

Join an online support community of fellow MGMA DataDivers! Post questions, discuss insights, search archives and learn something new.

Visit mgma.com/datacommunity

Contact

We are here to make sure you get the most out of your investment. Your account manager is available to help answer your questions and accept feedback.

If you have questions about the MGMA benchmarks, please contact the MGMA Data Solutions department.

Call **877.275.6462**, ext. 1895, or email survey@mgma.com

