MGMA

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PRACTICE OPERATIONS SURVEY GLOSSARY

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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.

CUSTOM
REPORTS & TOOLS

Additional DataDive resources can be found here.

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]

Alternative Payment Model (APM)

A payment approach to paying for medical care that holds providers accountable for achieving specific quality performance goals in an efficient manner. In turn, group practices participating in an APM receive added incentive payments to achieve those goals. APMs can apply to a specific clinical condition, a care episode, or a patient population.

CMS Merit-based Incentive Payment System (MIPS)

Eligible clinicians are subject to upward, neutral, or downward payment adjustments based on performance in four performance categories: quality, cost, promoting interoperability (formerly advancing care information), and improvement activities.

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]

Generic Dispensing Rate (GDR)

The number of generic prescriptions filled divided by the total number of prescriptions filled.

Hierarchal Condition Category (HCC) Coding

A risk-adjustment model developed by the Centers for Medicare & Medicaid (CMS) to pay differentially based on disease burden and demographics. HCC relies on ICD-10 coding, which are grouped into categories and assigned a risk factor. There is weighting, or hierarchy, which assigns higher values to more serious conditions, in addition to demographic factors (such as age and gender). Two conditions in the same category are counted only once. Using the HCC model, the condition must be reported annually to be credited to that patient.

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]

Reimbursement Methodologies

Bundled Payment (may also be known as "episode-based payment"): A method of reimbursement where a single comprehensive payment covers all services related to an episode of care. If actual costs exceed the payment amount, the provider is accountable for the difference.

Full capitation (may also be known as "global capitation"): A method of reimbursement where providers may receive a fixed amount of money per patient over a defined period (such as per member per month) covering all health care services, such as primary care, hospitalizations, and specialist care. Providers are responsible for costs exceeding the fixed amount. However, they are also able to receive financial gains when costs are below the fixed amount.

Partial capitation: A method of reimbursement where providers may receive a fixed amount of money per patient over a defined period (such as per member per month) where a set of services, such as laboratory or primary care, may be covered. However, services provided outside of scope are reimbursed using fee-for-service.

Shared risk (may also be known as "upside and downside" or "two-sided") : A method of reimbursement where providers share in savings and in potential losses. When the actual cost of care exceeds the projected cost, the provider is accountable for the excess costs. However, when the actual cost of care is below the projected costs, the provider receives a percentage of the difference.

Shared savings (may also be known as "upside only" or "one-sided"): A method of reimbursement where providers share in savings but not risk. When the actual cost of care is below the projected costs, the provider receives a percentage of the difference. If costs exceed the projected cost, the provider is not responsible.

Risk Stratification of Patient Population

Segmenting patients into distinct groups of similar complexity (e.g., chronic care management patients and non-chronic care management patients) using objective and subjective data. By identifying and segmenting the patients that are most at-risk, practices may be able to provide them greater access and resources, which in turn could reduce costs and improve care.

Social Determinants of Health (SDOH)

Conditions in the environments where people are born, live, learn, work, and play that affect a wide range of health, functioning, and quality of life outcomes and risks. SDOH can be five key areas: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context

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), dieticians/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.

Billing Function Structure

The method by which a practice performs their medical billing operations and tasks. Combination of In-house and Outsourced: Some tasks of medical billing operations were performed inside the practice while others were performed by a third-party company. In-house: Medical billing operations were performed within a practice. Outsourced: Medical billing operations were performed by a third-party company. Other: Another method was used to perform medical billing operations.

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:

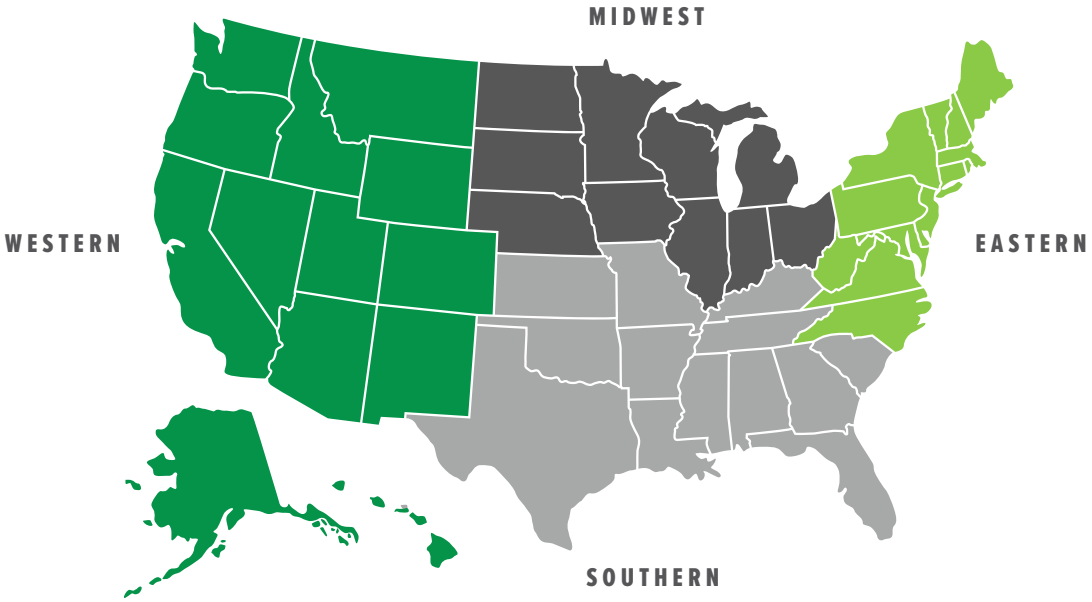
- Community Health Centers which serve a variety of underserved populations and areas;
- Migrant Health Centers which serve migrant and seasonal agricultural workers;
- Health Care for the Homeless Programs which reach out to homeless individuals and families and provide primary and preventive care and 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.

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

HHS Region 1:
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

HHS Region 2:
New Jersey
New York

HHS Region 3:
Delaware
District of Colombia
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

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.

Medical Records Storage System

The method in which the practice stored health/medical records for the majority of patients served by the practice.

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

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.

Total Medical Revenue

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.

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.

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

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