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2026 MGMA Financials and Operations

Data Report



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Executive Summary

REVENUE MOVED UNEVENLY. COSTS TOOK MORE OF IT.

Five-year benchmarks show operating costs taking a larger share of the revenue dollar, while 2026 polling shows the squeeze continuing through uneven revenue growth and slower cash conversion.

At the monthly close, three practice leaders can all point to the same line: operating cost is higher. What happened on the revenue side — and how much cash actually arrived — is where their stories separate.

PRIMARY CARE

Growth, but less room

Revenue per physician rose 12.9% in 2025, but operating cost rose 27.4%.

NONSURGICAL

Contraction plus cash pressure

Revenue fell 5.2% while cost rose 7.3%; one-third of A/R was older than 120 days.

SURGICAL

A slow top line, higher pressure

Revenue rose 1.2%; operating-cost share reached 73.6% and loss after provider compensation deepened.

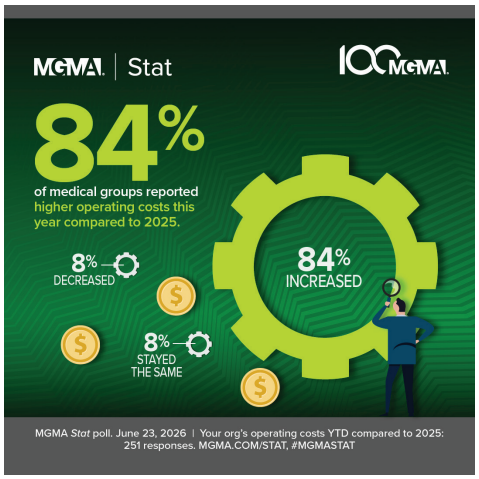
Different paths, same management problem: less room to absorb the next hire, technology renewal or slow-paying claim. That is the central story in data from nearly 4,000 medical groups and practices. This report follows the questions that show up in a real review: what came in, what operations consumed, what remained before provider compensation and where cash slowed down.

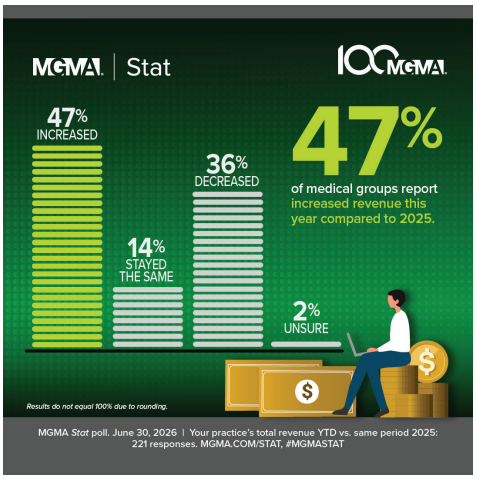
84%
reported higher operating costs YTD in 2026

47%
reported higher revenue YTD

36%
reported lower revenue YTD

Current pulse: MGMA Stat polls conducted June 23 and June 30, 2026.[1, 2]

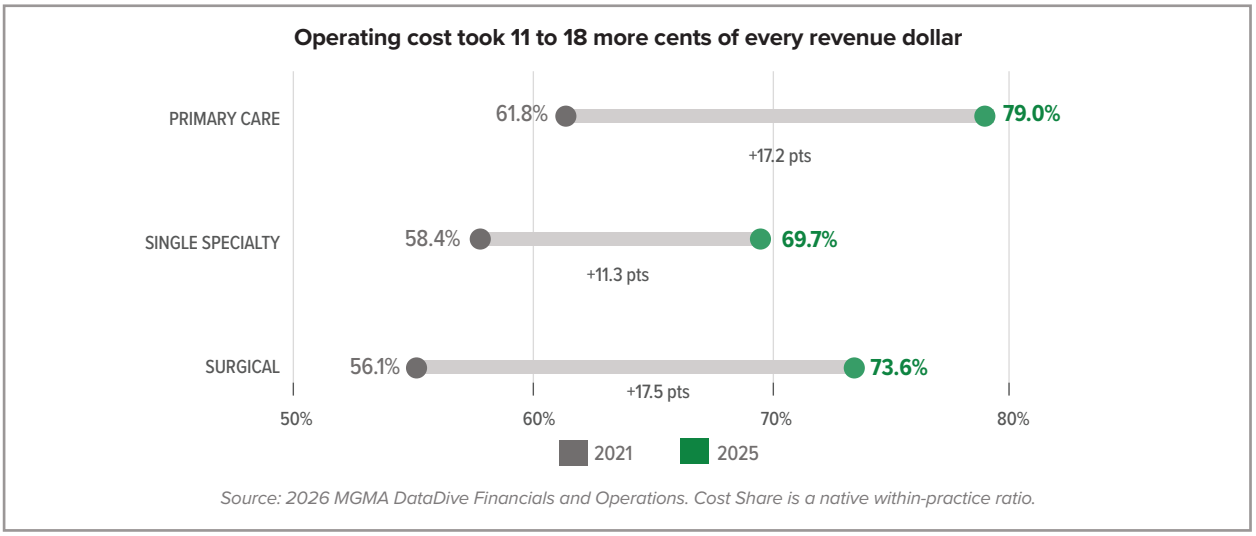




KEY TAKEAWAY

Costs are the predictable pressure. Revenue depends much more on volume, reimbursement, payer mix and provider capacity. Cash conversion determines how quickly that revenue becomes usable.

WHAT THE BENCHMARKS SAY



Source: 2026 MGMA DataDive Financials and Operations. Cost Share is a native within-practice ratio.

- Operating cost claimed 11 to 18 more cents of every revenue dollar in 2025 than it did in 2021 across the major views shown here. Cost share is simply the portion of a practice's own revenue used to run the practice before provider compensation.
- Operating cost per physician rose every year in the five-year window, from a 39% increase in surgical groups to a 79% increase in primary care. For budgeting, the higher cost base now looks more like a starting point than a one-year shock.
- Revenue remaining after operating cost — the operating spread — was flat to lower than in 2021. At the 25th percentile, all three major views were negative after operating and APP costs. The median alone does not show how little room exists in the lower part of the distribution.
- Practices still collected most of what contracts said they were owed, but more receivables aged past 120 days, charge-posting lag lengthened and bad debt remained well above 2021. Collecting the right amount eventually is not the same as having the cash on time.

Note on ownership

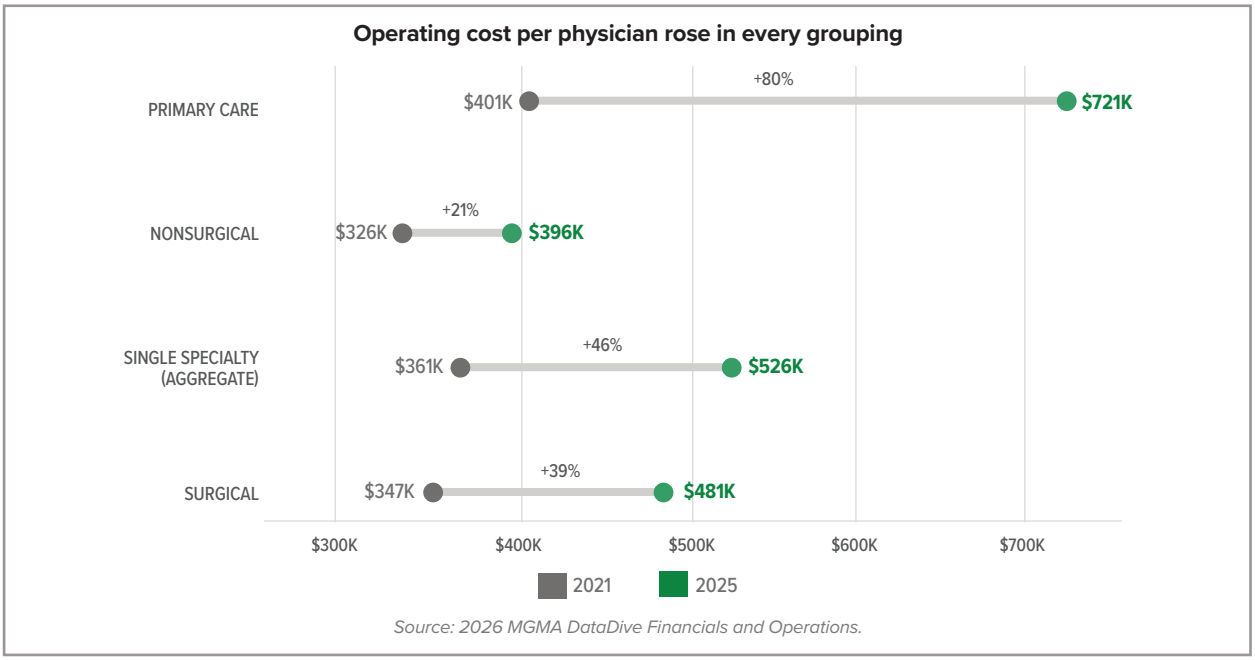
In a physician-owned group, the result flows directly into owner compensation and reinvestment. In a hospital- or system-owned group, the local site may be supported by the parent and may not carry every billing, IT, occupancy or administrative cost on its own ledger. The same number can lead to a different management decision.

How to read the data

- Benchmark figures are medians from the 2026 MGMA DataDive Financials and Operations dataset, representing 2025 performance and nearly 4,000 medical groups and practices.
- The main trend window is 2021 to 2025. Annual medians come from independently reporting organizations, so use five-year direction, within-practice ratios and current-year distributions more heavily than any single one-year change.
- Operating spread is revenue after operating cost and before provider compensation. Net income or loss is measured after provider compensation and, unless stated otherwise, before financial support.
- Ownership comparisons reflect different reporting units: physician-owned groups usually report whole organizations; hospital- and system-owned respondents often report practice sites. MGMA Stat and outside industry findings are current context, not part of the DataDive benchmark dataset.
- "Single specialty" is the aggregate of all single-specialty practices; primary care, nonsurgical and surgical are the mutually exclusive slices within it. The aggregate is used where a broader view is useful, while the slices are used where the contrast is the story.

1. REVENUE MOVED DIFFERENTLY. COSTS ROSE IN EVERY GROUPING.

Total medical revenue per FTE physician is the practice's medical revenue divided by physician FTE. Total operating cost per FTE physician is the operating expense supporting that physician, before provider compensation in the sequence used here. Read the two together. Primary care is the clearest example of growth without much new breathing room: over five years, revenue per physician rose 45% while operating cost rose 80%.



Source: 2026 MGMA DataDive Financials and Operations.

The five-year picture matters more than any one-year swing. Primary care operating cost rose from $401,425 to $721,084 per physician. Single-specialty cost rose from $361,384 to $526,167. Surgical cost rose from $346,767 to $480,734, and nonsurgical cost from $326,494 to $396,338. Practices did not absorb one bad budget year; they built on a higher cost base year after year.

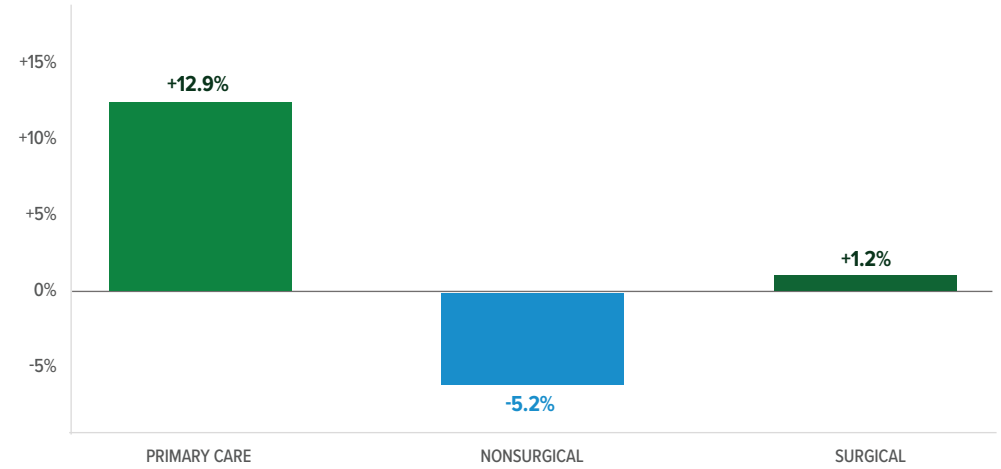
> **What this looks like in the practice**
>
> A full schedule can coexist with a tight budget. Revenue may be up, but the next scheduler, authorization specialist, benefits renewal or EHR project still has to fit inside the smaller share left after operations.

Primary care also shows why the 2025 surge should not be read as a simple price effect. Revenue per physician rose 12.9%, wRVUs per physician rose 7.8%, and support staffing reached 4.42 per physician. More work and more team capacity helped lift the top line, but operating cost rose faster. That is consistent with growth that required more infrastructure, not a reimbursement windfall.

The split is the year's real shape. Revenue moved three different directions at once — primary care grew 12.9%, surgical groups held nearly flat at 1.2%, and nonsurgical practices contracted 5.2% — while the cost line climbed for all of them.

REVENUE SPLIT THREE WAYS IN 2025

Change in median total medical revenue per FTE physician, 2024-2025 | decline in blue



Source: 2026 MGMA DataDive Financials and Operations. Changes are differences in annual medians; the decline is shown in blue.

Revenue alone is an incomplete scorecard because practices have limited room to simply raise price. In February, 80% of medical group leaders said Medicare reimbursement was below the cost to deliver care.[6] The commercial side is not reliably keeping up either: an Aug. 25 MGMA Stat poll found only 29% had secured their most recent commercial payer rate increase within the past year, while 50% said their last increase was three or more years ago.[11]

The 2026 pulse shows the same split narrowing rather than resolving. A year earlier, 56% of groups reported higher year-to-date revenue and 30% lower — a 26-point gap between gainers and decliners. By mid-2026 that gap was 11 points, and half of practices reported flat or falling revenue.[2]

The comments explain the split in terms a practice would recognize. Groups with higher revenue most often described more visits, cases and encounters, frequently paired with added providers or expanded capacity, along with contract renegotiations, stronger payer mix and new services. Flat-revenue groups described more volume but less payment per service, more Medicare exposure, denials and prior-authorization friction. Declining-revenue groups most often pointed to lower volume, physician departures or retirements that were not fully backfilled, and stagnant reimbursement.[2]

80%

say Medicare reimbursement is below the cost to deliver care (Feb. 2026)

50%

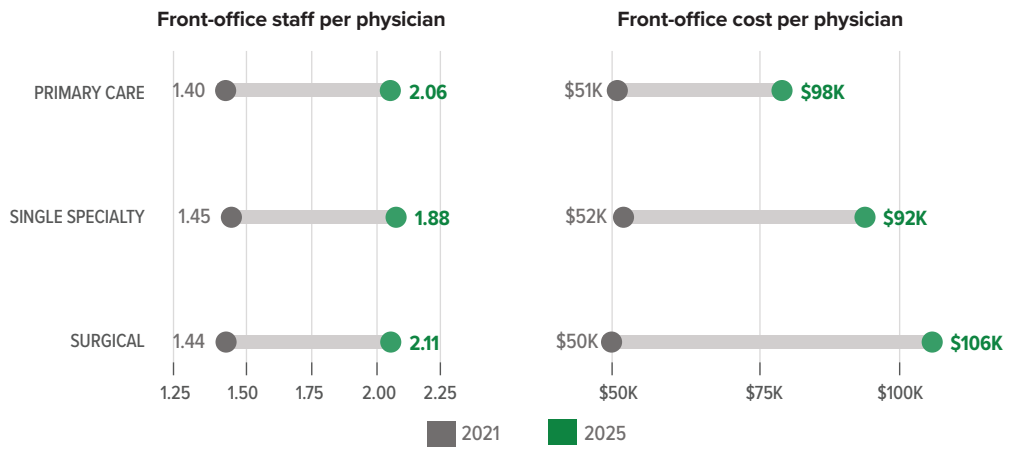
say their last commercial payer rate increase was 3+ years ago (Aug. 2026)

Current reimbursement context: MGMA Stat polls, Feb. 24 and Aug. 25, 2026.

2. COST GROWTH IS MOSTLY A PEOPLE-AND-WORKFLOW STORY

The expense story is not every line rising at the same rate. The broadest increase is in support staffing, especially the front office. Front-office staff per FTE physician counts the people doing work such as scheduling, registration and authorization; front-office cost per physician shows what that staffing costs. Those are lines a practice manager recognizes immediately: another scheduler for call volume, an authorization specialist for payer rules, overtime during vacancies, benefits above budget and contracted labor when a position stays open.

The front-office line grew through both headcount and cost



Source: 2026 MGMA DataDive Financials and Operations.

$300.7K
primary care support-staff cost per physician

$227.7K
single-specialty support-staff cost per physician

$200.8K
surgical support-staff cost per physician

Support-staff cost consumed roughly 30% to 34% of revenue at the median practice. The **2026 Management and Staff Compensation data** show base-pay growth cooling in many roles, but that does not conflict with these Financials and Operations results. Total staff cost also reflects headcount, benefits, overtime and contracted labor. A practice can hold raises down and still spend more because it employs more people or pays more to keep work covered.

Current polling makes the cost pressure concrete. In June, 84% of medical groups reported **higher operating costs**; among those reporting an increase, the average was about 11%, and labor-related costs were the most common explanation.[1]

The share reporting higher costs has eased from 90% in 2025, 92% in 2024 and 95% in 2023. What has not eased much is the size of the increase where it lands: reported jumps have stayed in roughly the 10% to 12.5% range across those years. The share is easing; the magnitude is not.[1]

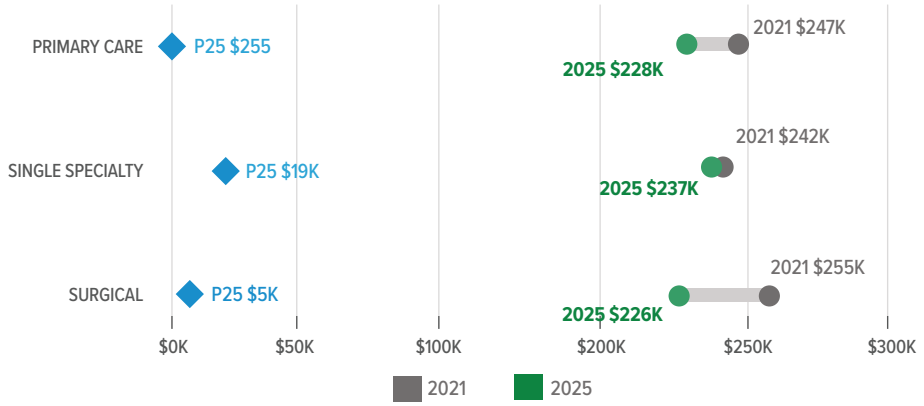
The work itself is heavier, too. In March, 45% of leaders named eligibility and prior authorization as the most time-consuming phone work, and 31% named scheduling. A stable headcount can still cost more when each patient requires more touches, more portal switching and more rework.[4]

This report stops at the cost implication. Later in 2026, a companion APP, Staffing and Access report examines where staff are deployed, turnover by role, and whether added team capacity is showing up in access.

3. THE SPREAD DID NOT KEEP PACE

Revenue after operating cost — the operating spread — is what remains after running the practice and before provider compensation. It is not net income. For an independent group, this is the pool that still has to support physician compensation; for an employed site, it helps show how much of that obligation the local operation covers.

Median operating spread was flat to lower; the bottom quarter had almost no room



Source: 2026 MGMA DataDive Financials and Operations. P25 is the 25th-percentile 2025 result.

At the median, operating spread was flat to lower than in 2021: $227,894 per physician in primary care, $236,983 in single-specialty practices and $226,206 in surgical groups. The more important warning sits below the median. At the 25th percentile — the point where one quarter of reporting practices performed lower — primary care had just $255 per physician before APP costs; single specialty had $18,721 and surgical $4,507.

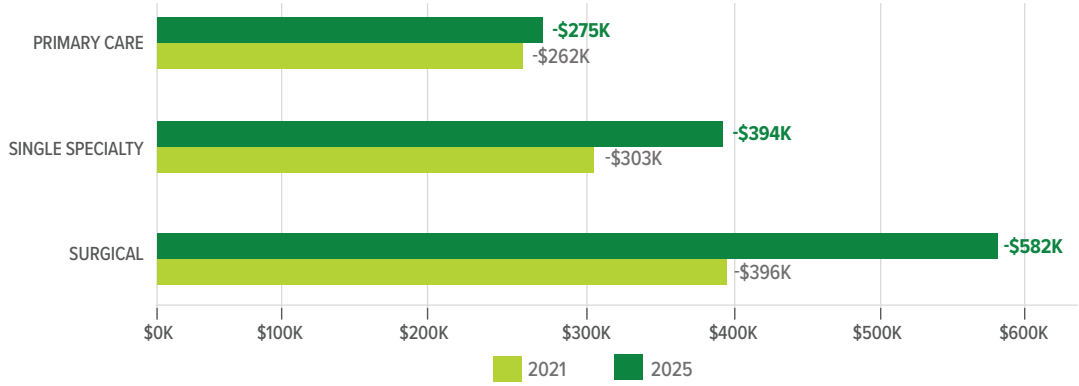
> **After APP costs, the bottom quarter was negative**
>
> At least one quarter of primary care and surgical specialties (as well as the single-specialty aggregate) spent more on operations and APPs than they collected before physician compensation. The 25th-percentile results were -$127,765, -$204,278, and -$150,448 per physician, respectively.

That is the risk hidden by a median. A practice can benchmark near the middle overall while a service line, location or payer contract has almost no room for a vacancy, a denial spike or a slower-than-planned provider ramp.

4. AFTER PROVIDER COMPENSATION, OWNERSHIP CHANGES THE MEANING

Net income or loss here is measured after provider compensation and before financial support. In a physician-owned group, a result near zero can be intentional because owners take earnings through compensation. A deep negative means compensation and local economics have moved apart. In a hospital- or system-owned group, a negative local result may be part of the parent organization's planned investment in the employed network.

Loss after provider compensation deepened, especially in surgical groups



Source: 2026 MGMA DataDive Financials and Operations. Figures exclude financial support.

SINGLE SPECIALTY

-$244K vs. -$413K

Median loss per physician after provider compensation: physician-owned versus hospital-/system-owned.

SURGICAL

-$435K vs. -$597K

Median loss per physician after provider compensation: physician-owned versus hospital-/system-owned.

SYSTEM SUPPORT

$436K to $559K

Median support per physician where hospital-/system-owned groups reported it; respondent sets differ from the loss benchmark.

The surgical decline is also the dataset's most consistent: the median loss after provider compensation deepened every year since 2021, from $396,270 to $582,290 per physician. Industry context points in the same direction, though the measures are not interchangeable: Kaufman Hall reported median investment or subsidy of $315,358 per physician FTE in Q4 2025 among employed physician enterprises.[7]

Same benchmark, different decision

Independent groups should ask whether compensation formulas still fit local revenue and cost. Employed enterprises should separate site performance from enterprise support, then identify which costs and decisions the site can actually control.

A useful ownership comparison: about $58 per work RVU

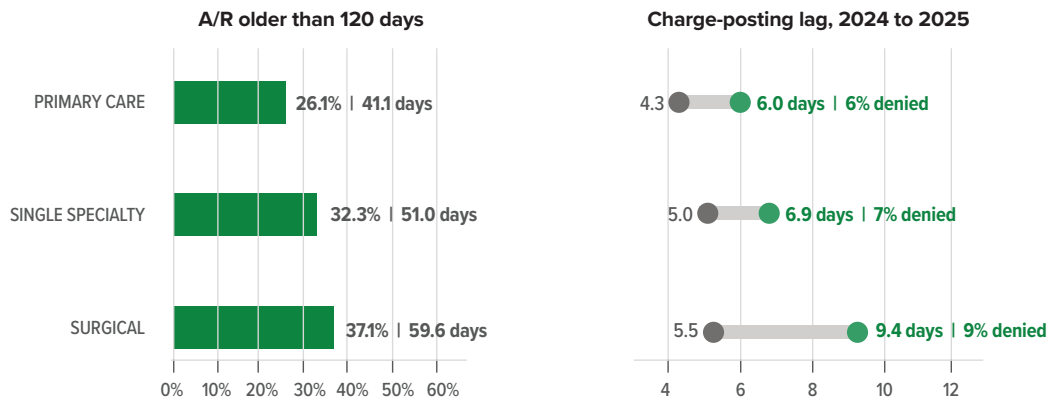
Cost per work RVU divides operating expense by units of physician work. Physician-owned single-specialty groups reported $804,498 in operating cost per physician versus $507,086 for hospital-/system-owned sites, but the per-work-RVU medians were nearly identical: $58.36 and $58.09. The per-physician gap reflects throughput and what sits on each ledger, not a simple efficiency verdict.

Independent groups generally report whole organizations. Hospital- and system-owned respondents often report practice sites, while billing, IT, occupancy or administrative functions may sit on the parent ledger. Use cost per work RVU and cost as a share of revenue before treating cost per physician as an ownership scorecard.

5. COLLECTIONS HELD. CASH MOVED MORE SLOWLY.

Adjusted collection rate asks whether the practice collected what contracts said it was owed after contractual adjustments. Those rates remained between 93% and 96% across the major groupings, so the revenue cycle did not broadly collapse in 2025. The strain appeared in time: more receivables sat in the oldest bucket, and claims took longer to leave the practice.

The front of the revenue cycle held; the back end aged



Source: 2026 MGMA DataDive Financials and Operations. Posting-lag measures have two collection years of history.

An accurate claim can still be a slow claim. Charge-posting lag counts the days from the service until the charge is posted or released into billing — time added before the payer can do anything. The median reached 6.0 days in primary care, 6.9 days in single-specialty practices and 9.4 days in surgical groups. Denial rates did not worsen in parallel, so the operational question is not only whether a claim is clean, but how much time is added before submission and after it returns for work.

MGMA Stat **shows the same mixed picture** in real time. In July 2026, 43% of leaders said days in A/R were about the same as a year earlier, 32% said they were higher and 22% reported improvement. Leaders whose A/R worsened cited payer delays, downcoding, medical-record requests, prepayment audits and long appeals, as well as internal vacancies, credentialing problems and system transitions.[5]

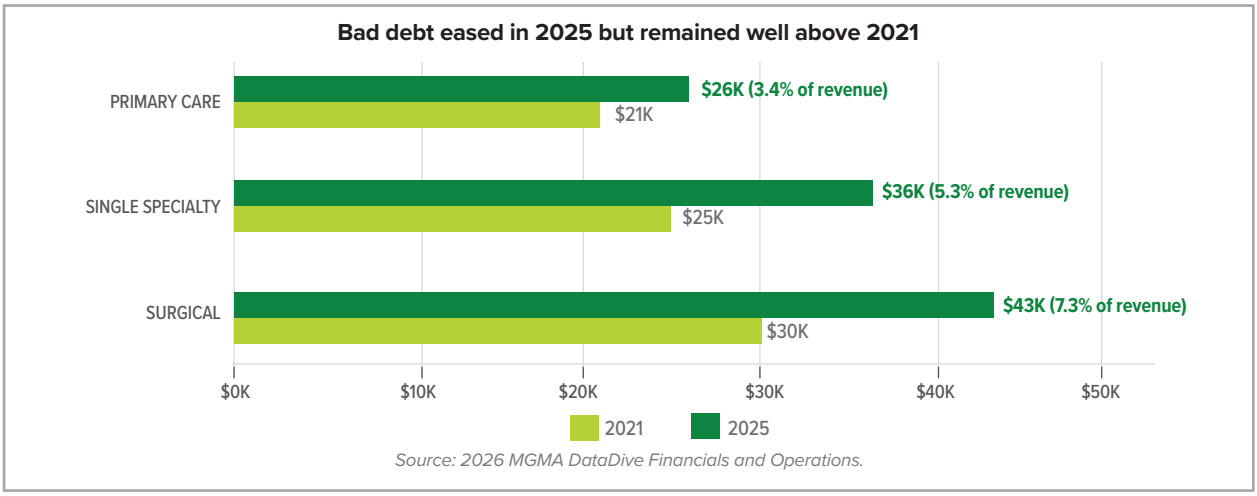
"About the same" was not the same as "nothing changed." Practices with flat days in A/R described clean claims, next-day submission, experienced billing staff, consistent denial follow-up and stronger time-of-service collections — deployed simply to offset payer delays, documentation requests and larger patient balances. One respondent kept insurance A/R within 28 days while self-pay balances pushed the overall figure to 32. A stable headline number can conceal improvement in one part of the cycle and deterioration in another.[5]

The most useful diagnostic in those responses is to ask who controls the delay. Slow adjudication, downcoding, records requests and appeal processing sit with the payer; a practice can track them by payer, escalate recurring problems and bring payer-level aging reports into contract discussions. Registration accuracy, unsigned encounters, charge-posting lag, denial follow-up and patient collections are more directly under practice control — and the practices that improved cited staffing changes, stronger denial management, faster note closure, better front-end collections and new billing technology rather than any single fix.[5]

What to inspect first

Break posting lag and 120-plus-day A/R by payer, service line and location. Then identify whether the delay belongs to the local practice, the central business office, payer contracting or an interface team. A site cannot fix a handoff it does not own.

Patient balances and bad debt moved the pressure downstream



Bad debt here is fee-for-service balances written off as uncollectible, shown relative to revenue. It eased in 2025 but remained roughly 40% to 45% above its 2021 level. At the median surgical practice, bad debt equaled 7.3% of revenue. The measure does not identify the cause, but it tells leaders how much revenue is making it through care delivery and billing without ultimately becoming cash.

62%	10.5%	$1,886
co-payments collected at time of service	other patient-due balances collected at time of service	average 2025 deductible among covered workers with a deductible

Nonsurgical practices carry the sharpest version of the strain: the lowest adjusted collection rate of any grouping (93.0%), A/R of $287,468 per physician — up 10.0% in a single year against falling revenue — and a third of receivables aged past 120 days.

Hospital- and system-owned groups reported higher 2025 bad-debt medians than physician-owned groups across the three groupings. Use that as a prompt to inspect payer mix, patient mix, write-off policy and the reporting unit — not as proof that ownership caused the difference.

The predictable dollar remains easier to collect than the complicated dollar. At the median single-specialty practice, 62% of co-payments were collected at the time of service, compared with only 10.5% of other patient-due balances. A known co-payment can be requested at check-in; a deductible or coinsurance balance may depend on adjudication, benefit design and an estimate staff may not fully trust. KFF found that 34% of covered workers were in plans with a single-coverage deductible of at least $2,000 in 2025.[8]

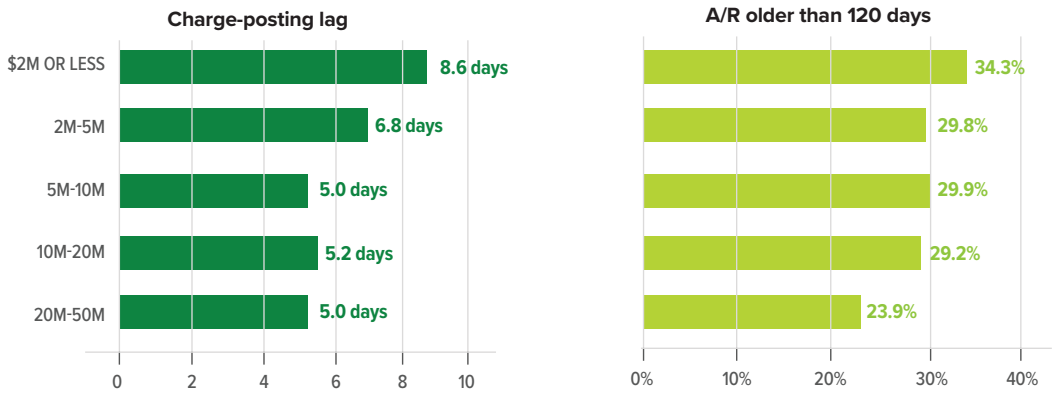
The affordability pressure extends beyond employer coverage. Among 2026 ACA Marketplace plan selections, the average deductible rose 37% — from $2,759 to $3,786 — and 32% of medical groups reported higher patient no-shows in 2026, with leaders citing patient cost concerns. The no-show result will be explored in our companion access report, but it matters financially because revenue can be lost before a claim is ever created.[9, 10]

The practical response is not simply to demand more at checkout. It is to verify coverage earlier, improve estimates, explain patient responsibility, offer clear payment options and make the handoff from the visit to patient billing consistent.

6. SCALE SHOWS UP FIRST IN CASH CONVERSION

Scale is often discussed as physician headcount. For revenue-cycle work, total medical revenue may be the more useful peer-group measure because it better reflects the amount of business the billing operation has to process. Among single-specialty practices, larger-revenue groups released claims faster and kept less A/R in the 120-plus-day bucket.

Larger-revenue practices released claims faster and carried younger A/R



Source: 2026 MGMA DataDive Financials and Operations. Single-specialty practices grouped by total medical revenue.

The smallest practices posted charges in a median 8.6 days and carried 34.3% of A/R past 120 days. Practices in the $20 million to $50 million revenue band posted in 5.0 days and carried 24.0% that old. That does not prove scale caused the difference. Larger operations may have more specialized billing staff, automation, coverage and payer-specific work queues. The practical question is whether your peer group processes a similar amount of business.

Where the companion report picks up

Primary care's 2025 revenue and work rose alongside a larger support team, but physician-level measures do not describe the full care team. The companion APP, Staffing and Access report will examine APP ratios, provider-normalized economics, staffing by role, turnover and whether added capacity changed access.
Don't want to wait? Get MGMA DataDive access today.

YOUR OPERATING REVIEW IN FIVE NUMBERS

Measure	What it tells you	Question for the next review
Operating cost share	How much of each revenue dollar is committed to operations?	Which increases bought needed capacity, and which reflect rework?
Operating spread	What remains before physician compensation?	Where does the bottom quartile sit by site or service line?
Support-staff cost + workload	Whether labor cost matches the work being asked of the team.	Are authorizations, calls, messages or rework driving the increase?
Posting lag + 120+ A/R	How quickly completed work becomes usable cash.	Where is time added before submission and after payer response?
Patient balances + bad debt	How much revenue depends on affordability and front-end accuracy.	What can be estimated, explained and collected before checkout?

The message is not “cut every cost.” Some of the fastest-growing costs protect access, throughput and cash. The job is to separate capacity from rework: the employee who keeps a physician moving is different from the extra touch created by a broken authorization process, an interface failure or a payer rule no one owns.

Independent groups should use the data to protect owner economics and decide where reinvestment still pays. Hospital- and system-owned groups should separate local performance from enterprise support and assign the fix to the level that actually controls the work.

The 2025 benchmarks and the 2026 pulse point in the same direction. Costs remain the predictable pressure, revenue is increasingly uneven and slow cash conversion leaves less room for error. The goal is not the smallest expense line. It is to know what each cost is supposed to protect — and to see quickly when it does not.

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About MGMA

MGMA, a nonprofit membership association, is dedicated to advancing the business of healthcare. Throughout its 100-year history, the organization has supported more than 70,000 medical practice leaders nationwide through advocacy, education, data insights, and professional community. Representing more than 15,000 medical groups across all sizes and specialties, MGMA empowers practices — and the 350,000 physicians they support — to deliver exceptional patient care while thriving in an increasingly complex healthcare landscape.

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Selected Current Sources

1. *MGMA Stat, "Operating costs keep climbing for medical practices in 2026," June 24, 2026.*
2. *MGMA Stat, "Revenue growth narrows as costs climb: the 2026 squeeze on medical practices," July 2, 2026.*
3. *MGMA Stat, "Stable staff-to-physician ratios might conceal real strain in your practice," July 8, 2026.*
4. *MGMA Stat, "Phones are still a bottleneck costing medical practices time they cannot afford," March 2026.*
5. *MGMA Stat, "Days in A/R holds steady for most practices, but payer pressure persists in 2026," July 30, 2026.*
6. *MGMA Stat, "2026 Medicare reimbursement changes: Tracking what matters," Feb. 26, 2026.*
7. *Kaufman Hall, Physician Flash Report: Q1 2026 Metrics.*
8. *KFF, 2025 Employer Health Benefits Survey.*
9. *KFF, "What we know so far about 2026 ACA Marketplace enrollment, premiums, and deductibles," May 19, 2026.*
10. *MGMA Stat, "About 1 in 3 medical groups see higher no-shows in 2026 as patients face higher costs," Aug. 12, 2026.*
11. *MGMA Stat, "Most medical groups have gone years without a commercial payer rate increase," Aug. 26, 2026.*

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