

ABOUT THIS REPORT

The State of Outpatient Clinic Finances 2026 is Sorso's annual research report on the financial condition of U.S. outpatient healthcare practices. It covers reimbursement trends, revenue cycle benchmarks, cost pressures, PE acquisition activity, and the 2026–2027 outlook. Every figure is traced to a primary source: CMS rules and fact sheets, MGMA benchmarking surveys, AMA workforce and practice-ownership research, KFF Medicaid surveys, PitchBook/LevinPro M&A data, and published reports from specialty associations (APTA, AAD, ADA HPI, AmSpa, UCA, AAOS, and others).

• SORSO RESEARCH · REPORT 2026-01

The State of Outpatient Clinic Finances 2026

What outpatient clinic owners are actually facing, by the numbers. Ten chapters. Forty-four primary sources.

Written by Stanislav Sukhinin, CFA, Founder of Sorso · Published April 2026 · ~12,000 words · 14 charts · 44 sources

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\$33.40

CY 2026 Medicare PFS conversion factor
CMS

73%

of finance leaders say denials are rising
EXPERIAN HEALTH

11.1%

average YoY operating cost increase in 2025
MGMA STAT

5.7%

office-based physician EBITDA margin (2024)
MCKINSEY

\$190B

global healthcare PE deal value in 2025
BAIN

Ten chapters. One operating picture.

Every figure in this report traces back to a publicly verifiable source. Where credible sources disagree, we cite the range rather than pick a side.

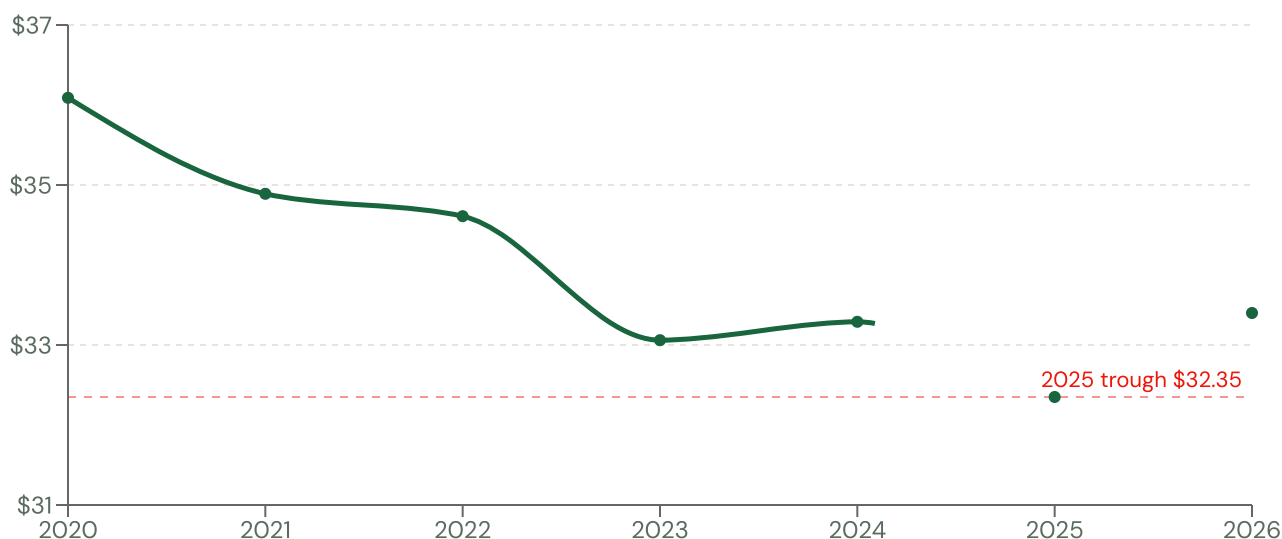
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03 Operating Costs	04 Practice Margins
05 PE & Consolidation Activity	06 Technology Adoption
07 Regulatory Burden	08 Workforce Trends
09 Specialty-Specific Insights	10 2026–2027 Outlook

On October 31, 2025, CMS published the CY 2026 Medicare Physician Fee Schedule final rule (CMS-1832-F)¹. The final conversion factor for non-qualifying APM clinicians is **\$33.40 — a +3.26% increase** from the CY 2025 value of \$32.35². Qualifying APM participants get \$33.57, a 3.77% increase. The update combines a statutorily required 2.50% increase, a 0.49% adjustment for finalized work–RVU changes, and a 0.25%–0.75% APM–tier update.

For physical therapy and other outpatient specialties living off Medicare Part B, this is the first scheduled fee increase since CY 2021⁴. APTA frames it as a pay bump that ends a five-year freeze; in absolute terms, the 2026 conversion factor still sits below the 2020 value of \$36.09.

Medicare Physician Fee Schedule Conversion Factor, 2020–2026

First fee schedule increase in five years — +3.26% to \$33.40 for non-APM clinicians in CY 2026



Source: CMS Physician Fee Schedule Final Rules (CY 2020–CY 2026, CMS-1832-F); APTA & AMA reporting.

Hospital-affiliated outpatient departments fared similarly under the CY 2026 OPPS final rule, with payment rates increasing **+2.6%** over CY 2025³.

Commercial reimbursement: the 196% / 230% question

Commercial payer benchmarking diverges sharply by methodology. Milliman's 2025 commercial reimbursement benchmark places commercial rates at approximately **196% of Medicare FFS** nationally⁵. Other transparency datasets cite figures closer to **230% of Medicare**, with markup varying dramatically by specialty (Urban Institute). For practices negotiating contracts, the right comparison isn't a single national multiplier but the specialty- and CPT-level rate sheet relative to Medicare allowed amounts.

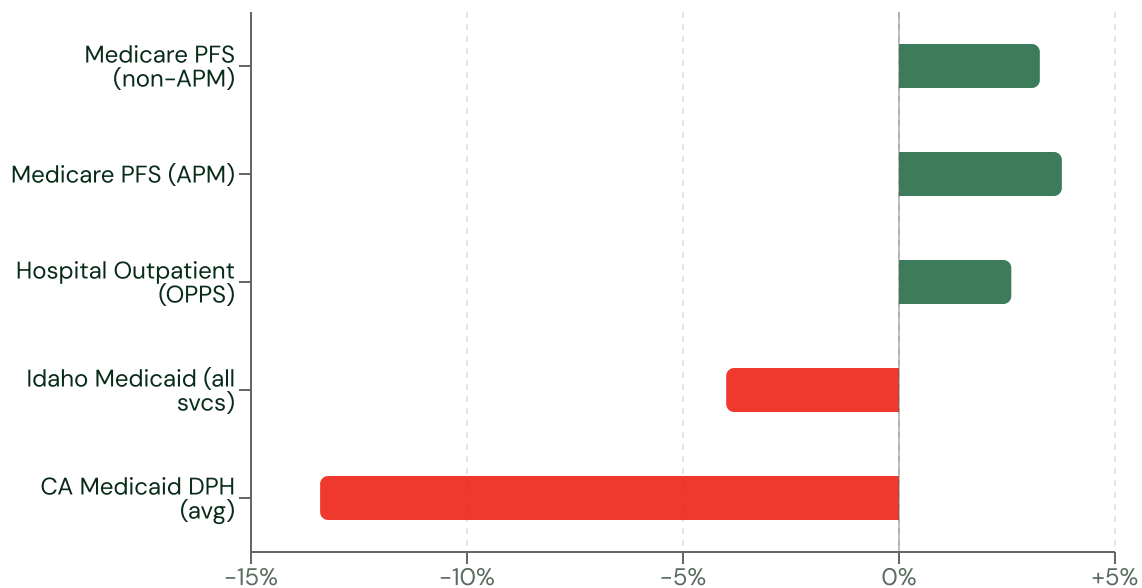
State Medicaid moves both directions in FY 2026

KFF's 50-State Medicaid Budget Survey shows the federal-level optimism doesn't hold uniformly. Twenty-three states implemented FFS rate increases for at least one outpatient behavioral-health provider type in FY 2025; only **14**

states are planning behavioral-health rate increases in FY 2026⁶. Idaho announced across-the-board **4% reductions** for all provider types and services effective September 1, 2025. California's Designated Public Hospitals saw an average **13.4% rate decrease** in FY 2025; non-DPH DRG hospitals received 4.8% base-rate increases.

Payer Rate Changes Heading Into 2026

Federal rate increases are real, but selected state Medicaid programs moved in the opposite direction



Source: CMS CY 2026 PFS & OPPS final rules; KFF 50-State Medicaid Budget Survey FY 2025–2026.

Meanwhile, Medicare Advantage enrollment surpassed **35 million beneficiaries** in early 2026, covering more than half of all eligible Medicare beneficiaries⁷. Plan exits compounded the problem: roughly **2.9 million enrollees** were forced to switch plans heading into 2026 due to insurer market exits, pulling billing staff into a wave of eligibility re-checks and contract overhauls in Q1.

WHAT THIS MEANS FOR CLINIC OWNERS

The headline 3.26% PFS bump is real, but it doesn't stop rate pressure from other directions. Three actions matter most heading into 2026:

- Map your top 25 commercial contracts to a Medicare–relative multiple. If a payer pays you 1.4x Medicare for your highest– volume CPT codes while the Milliman benchmark sits at 1.96x, that’s the conversation worth having.
- Re–verify Medicare Advantage eligibility for every patient seen in Q1 2026. Plan–exit churn means coverage changes you didn’t cause but will eat denial rework.
- If you operate in a state with announced Medicaid cuts (Idaho, California DPH), model the revenue impact at the location level — not the practice average. The hit is rarely evenly distributed.

HEADLINE STATISTIC

73%

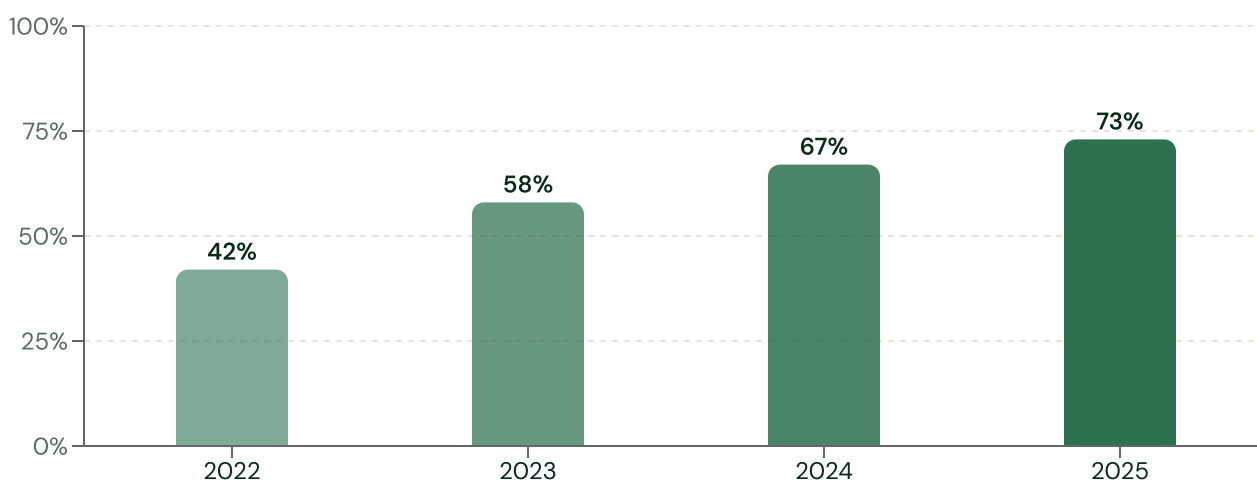
of healthcare finance leaders say claims denials are increasing across payers in 2024 — up from 42% in 2022. Three in four CFOs are watching the same line move the wrong direction.

Source: AAPC Knowledge Center, “Claims Denials Are on the Rise” (citing 2024 healthcare finance leader survey)⁹.

Experian Health’s third annual *State of Claims* survey (250 healthcare revenue cycle leaders) found that **41% of providers** now report denial rates of 10% or higher — up year–over–year since the survey first ran in 2022⁸. **54%** say claim errors are increasing; **68%** say submitting clean claims is more challenging than a year ago. The top driver of denial growth: missing or inaccurate claim data (cited by **50%** of respondents, up four points year–over–year).

Share of Healthcare Finance Leaders Reporting Denials Are Increasing

From 42% in 2022 to 73% in 2024 — the steepest sustained climb in any modern revenue-cycle benchmark



Source: AAPC, "Claims Denials Are on the Rise" (2024 survey); Experian Health State of Claims 2025.

Staffing is part of the story: **43%** of organizations report insufficient staffing in claims operations⁸. Industry studies show first-pass denial rates now exceeding 10% at a large share of organizations⁹. More than half of U.S. healthcare organizations report denial rates exceeding 10% in MGMA's 2024 benchmarking.

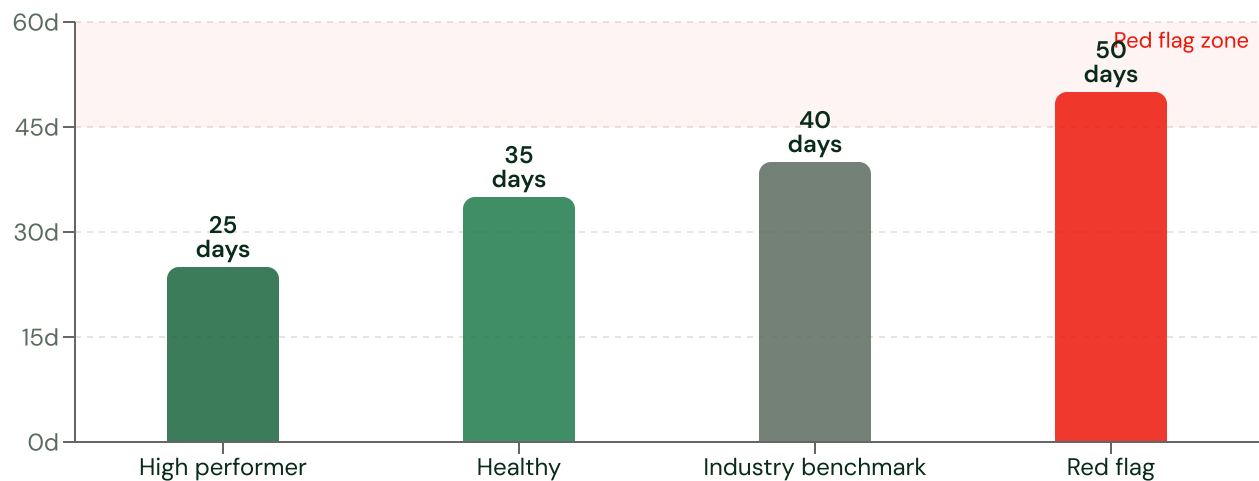
The bottom-line cost: **hospitals lose an average of roughly 5% of net revenue to denials**. For a \$5M outpatient specialty practice, that's roughly \$250K annually disappearing into the denial machine, before counting the staff-time cost of working appeals.

Days in A/R: the 25/40/45 rule

Industry rules of thumb set clear performance bands for A/R management. High performers stay at or below **25 days in A/R**; the healthy benchmark sits in the 30–40 day range; the industry benchmark is under 40 days; and crossing **45–50 days** is the red flag indicating bottlenecks. As a rule of thumb, under **15%** of total A/R should sit in the 90+ day bucket.

Days in A/R — MGMA Performance Bands

Crossing 45–50 days is the standard signal that the revenue cycle is bottlenecking



Source: MGMA, "Finding the right revenue cycle benchmarks" and 2025 Financials and Operations Data Report.

Administrative cost avoidance: \$258B and counting

The 2025 CAQH Index (released February 2026) reports that U.S. healthcare avoided **\$258 billion** in administrative costs in 2024 through electronic transactions and improved data exchange — a **17% increase** in cost avoidance year-over-year¹¹. CAQH measures a 9% reduction in medical administrative spend and a 4% reduction in dental. Fully automated administrative workflows save **70 minutes per patient visit** on average, and CAQH estimates **\$20 billion** in additional savings remains available via further automation.

WHAT THIS MEANS FOR CLINIC OWNERS

The denial trend is a paid-staff and payer-contract problem before it's a software problem. Three diagnostics worth running this quarter:

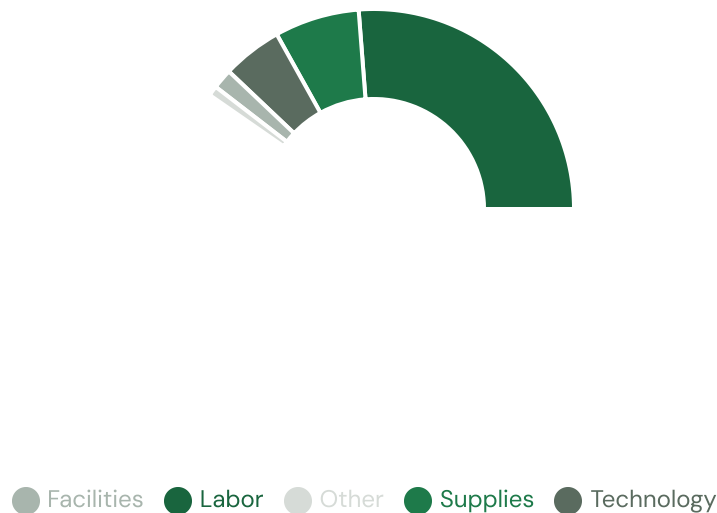
- Compute your first-pass denial rate by payer, not in aggregate. Denial rates vary wildly by payer — some run 4%, others 25%.

- Pull your A/R aging report and compute the percentage in 90+ days. If it's above 15%, you're sitting on recoverable cash that gets harder to collect every week.
- If your billing team flags "missing or inaccurate claim data" as the top denial driver, the fix usually lives upstream — in front-desk eligibility checks and provider documentation, not in the billing software itself.

On June 10, 2025, MGMA Stat polled medical group leaders on year-over-year operating costs. **Ninety percent** reported costs were higher than at the same point in 2024, with the average year-to-date increase reaching **11.1%**¹². Labor was the largest cost driver for **65%** of respondents; supplies (17%), technology (12%), facilities (4%), and other (2%) split the remainder.

Largest Operating Cost Increase Cited by Medical Group Leaders, 2025

Two-thirds of leaders point to labor — everything else is a rounding error by comparison



Source: MGMA Stat poll, June 10, 2025 — "Medical practice operating costs are still rising in 2025."

Industry-standard practice overhead has long sat near **60% of practice revenue**, with billing/RCM cost benchmarks around **5% of collections**. Both numbers are now under pressure: when a single line (labor) grows faster than

total revenue, the overhead ratio creeps upward even if every other expense holds flat.

Wages: the BLS baseline

The most current BLS data (May 2024 OEWS release) puts the median annual wage for medical assistants at **\$44,200**, with the 90th percentile above \$57,830¹³. BLS projects medical assistant employment to grow **12% between 2024 and 2034** — much faster than average. Across all healthcare practitioner and technical occupations, the median annual wage was **\$83,090** in May 2024.

Selected Healthcare Wages \u2014 BLS OEWS May 2024			
ROLE	MEDIAN (ANNUAL)	90TH %ILE	NOTES
Medical assistants	\$44,200	>\$57,830	Projected +12% growth, 2024–2034
Healthcare practitioners (overall)	\$83,090	—	Aggregate of practitioner & technical

Source: BLS Occupational Outlook Handbook (May 2024 OEWS release)¹³.

Real estate: the buildout you can’t avoid

CBRE’s 2025 U.S. Healthcare Real Estate Outlook reports a Q2 2024 record triple-net asking rent of **\$24.86/sq ft** (national average) for medical offices¹⁴. Buildout cost is the sleeper expense: medical build-outs can exceed **\$150–200/sq ft** due to specialized plumbing and HVAC. CBRE forecasts rent growth of 1.4–1.8% over the next two years and projects vacancy will fall below 9.5% — both of which constrain landlord concessions on new leases.

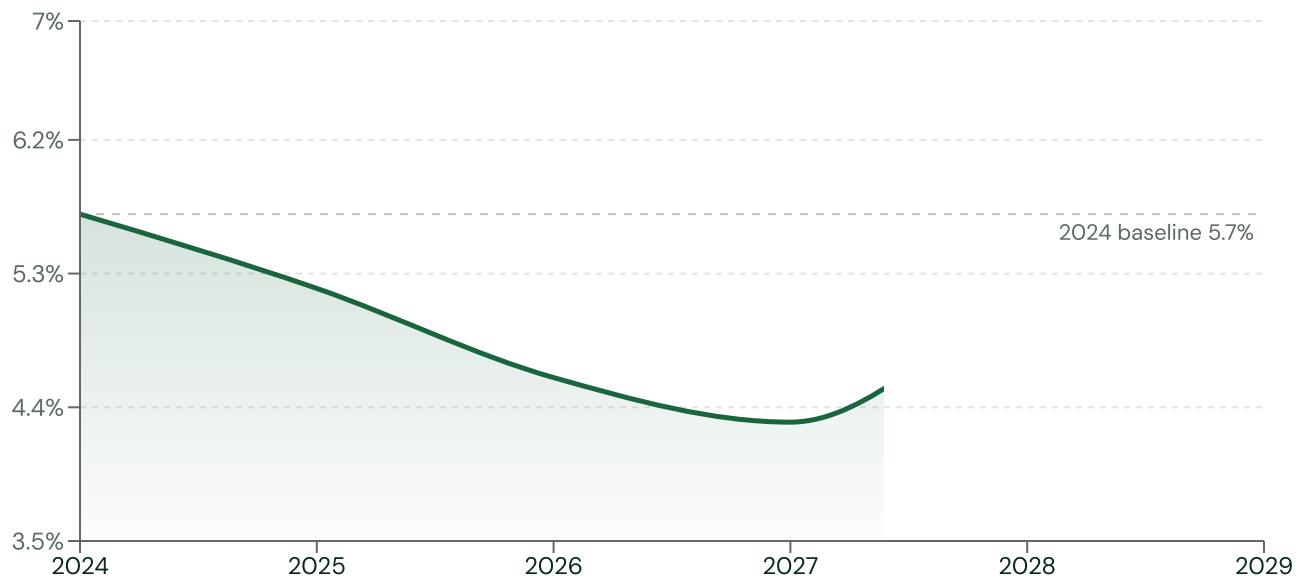
If your YTD operating cost increase is well above 11.1%, the gap is almost always staffing-driven. Practical actions:

- Compute revenue per FTE by role, location, and provider. A front-desk team that grew faster than visit volume is the first place to look.
- Re-bid your medical office lease 12 months before renewal. Vacancy below 9.5% means landlords have leverage, but tenants negotiating early still capture concessions on TI dollars and free rent.
- Benchmark your overhead-as-a-percent-of-revenue against the ~60% MGMA standard. Crossing 65% is the warning track.

McKinsey's 2026 outlook pegs office-based physician EBITDA margins at **5.7% in 2024**, with a near-term compression of 1–2 percentage points expected from 2025 to 2027 driven by the 2.83% Medicare fee schedule cut in 2025 and the impact of tariffs on medical supply costs¹⁵. Specialty-care revenue is projected to grow **4–5% annually** from 2024 to 2029, supported by ancillary services like diagnostics, imaging, and pharmacy. By 2029, McKinsey projects office-based physician EBITDA margins recovering to 6.1%.

Office-Based Physician EBITDA Margin Outlook, 2024–2029

Margins compress 1–2 points from 2025 to 2027 before recovering by 2029, per McKinsey



Source: McKinsey & Company, "What to expect in US healthcare in 2026 and beyond." 2025–2028 values modeled within McKinsey's cited 1–2pt compression range.

Deloitte's December 2025 outlook adds a related data point: more than two-thirds of U.S. healthcare leaders expect to outperform competitors heading into 2026, with rising policy uncertainty driving a focus on digital care, AI, and partnerships¹⁶. Industry-wide compression doesn't prevent individual operators from gaining share.

WHAT THIS MEANS FOR CLINIC OWNERS

The recovery McKinsey forecasts isn't evenly distributed. Practices that survive the 2026–2027 trough usually do so by:

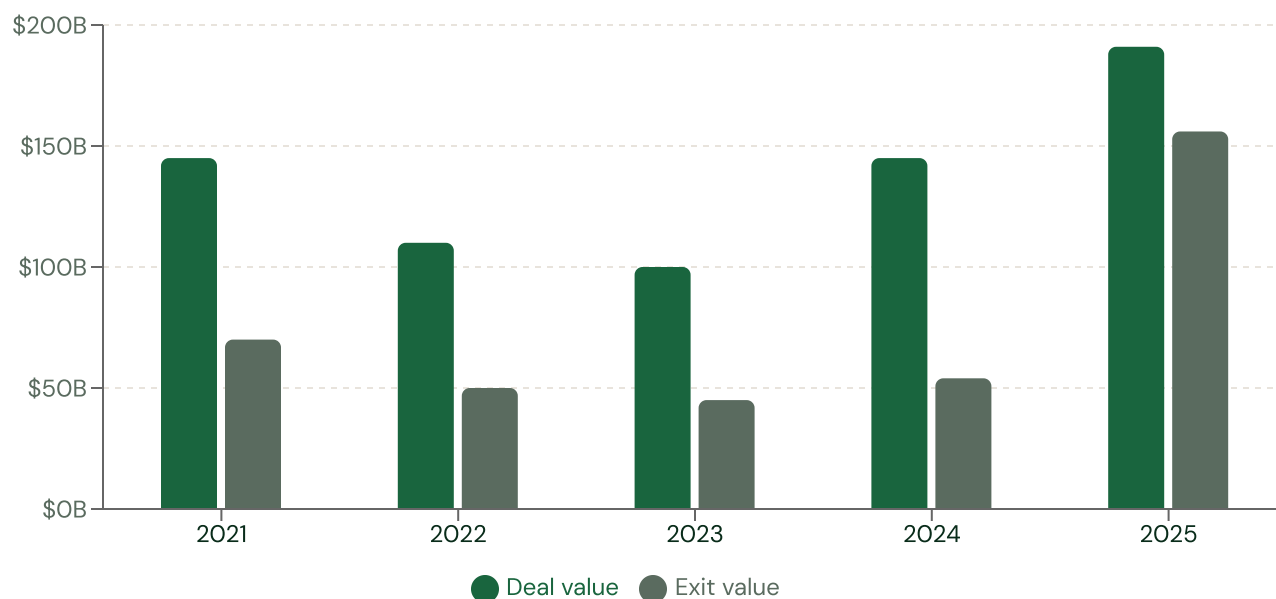
- Knowing their EBITDA margin by location and by service line, not just at the consolidated level. The line you cut to save 30 basis points is rarely the obvious one.
- Building ancillary revenue (imaging, pharmacy, in-office infusions, retail products in dental and med spa). McKinsey's 4–5% specialty-care growth is driven by these.
- Modeling a 2-point margin downside scenario before signing expansion debt. If you can't cover the new payment at a 4% margin, you don't have

the financing structure you think you have.

Bain & Company's Global Healthcare Private Equity Report 2026 placed 2025 global healthcare PE deal value at roughly **\$190–191 billion**, a record that surpassed the previous 2021 peak^{17 43}. Buyout volume reached **445 announced buyouts** — the second-most on record. Exit value rose to **~\$156 billion** versus \$54 billion in 2024. Deals over \$1B in North America rose from 14 in 2024 to 26 in 2025. Sponsor-to-sponsor deals topped 150 transactions worth approximately \$120 billion.

Global Healthcare Private Equity — Deal Value & Exit Value (\$B)

2025 set a record at ~\$190B in deal value — and exits nearly tripled to \$156B



Source: Bain & Company, "Global Healthcare Private Equity Report 2026." Pre-2024 values from Bain historical series.

PitchBook and LevinPro HC count **1,029 unique healthcare PE deals in 2025**: 151 buyouts, 664 add-on acquisitions, and 214 growth investments¹⁸. In Q1 2025, dental represented **61% of physician practice management activity** (roughly 105 PPM deals)¹⁹.

Median EV/EBITDA multiples for publicly traded healthcare services compressed to roughly **11.5x in 2025** from 14.5x in 2024 — a moderation that filters down into private practice valuations.

Practice valuation multiples in 2026

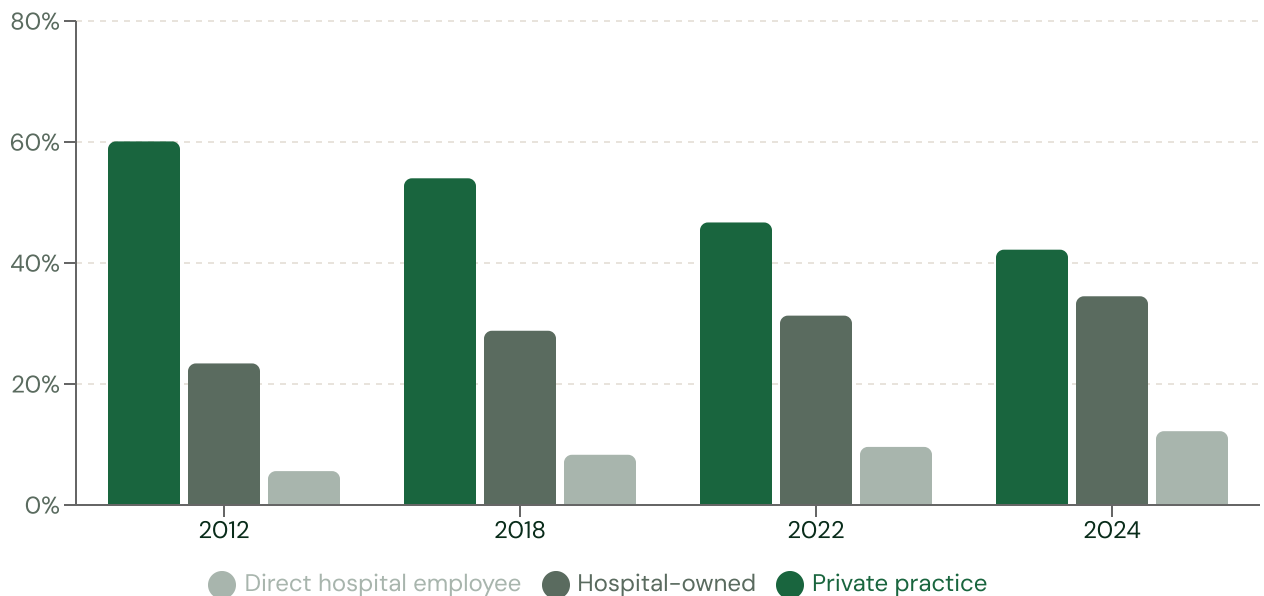
FOCUS Investment Banking and Sofer Advisors place the typical physician-practice EBITDA multiple in the **6x–12x** range, depending on size, specialty, and market^{20 44}. Platform deals command 3–5 turns higher than add-on deals. PE platforms generally consider practices above **\$5M EBITDA** platform-ready. Cardiology and ophthalmology remain the highest-valued specialties heading into 2026.

The independent practice has shrunk by 18 points

AMA's 2024 Physician Practice Characteristics survey is the counterweight to all the deal activity above: only **35.4%** of physicians had an ownership stake in their practice in 2024 — down 18 points from 53.2% in 2012²¹. Just **42.2%** of physicians worked in private practice in 2024 (down from 60.1% in 2012). Hospital-owned practice share grew from 23.4% to **34.5%** over the same period; direct hospital employees more than doubled, from 5.6% to 12.2%. Physicians in PE-owned practices rose from 4.5% in 2022 to 6.5% in 2024.

Where U.S. Physicians Practice, 2012–2024 (% of physicians)

Private practice fell 18 points in 12 years; hospital-owned settings gained the bulk of that share



Source: AMA, "Physician Practice Characteristics in 2024" Policy Research Perspectives. Intermediate years interpolated from AMA biennial benchmark series.

Rural is the sharpest version of the same story. PAI–Avalere tracked a **43% decline in rural independent physicians** from January 2019 to January 2024 — from 21,956 to 12,467²². Roughly 9,500 independent rural physicians left that segment in five years.

WHAT THIS MEANS FOR CLINIC OWNERS

Whether you're considering a sale, a roll-up, or staying independent, the same data tells you what the buyer sees:

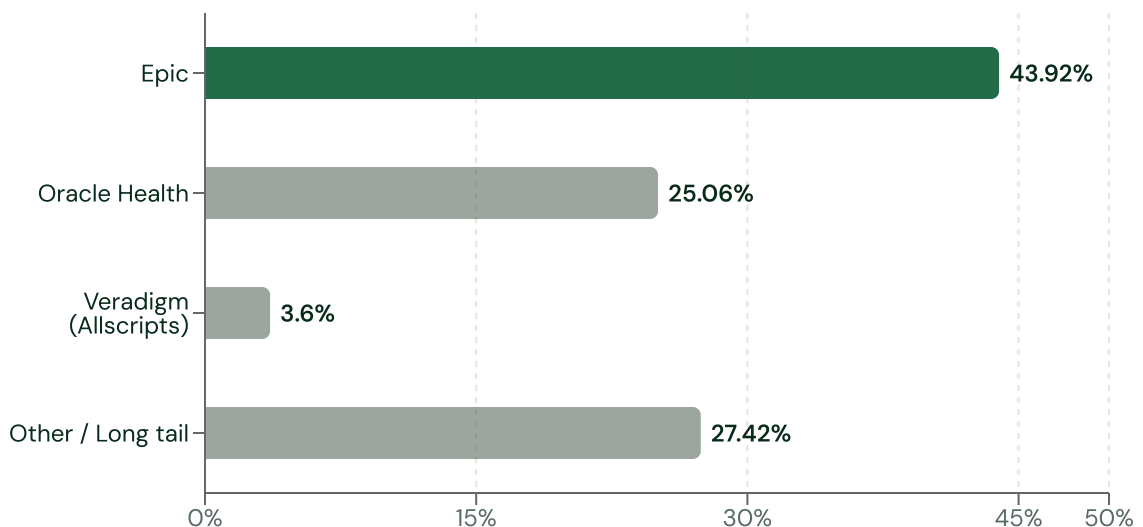
- If you're below \$5M EBITDA, you're an add-on, not a platform — and add-on multiples are 3–5 turns lower. Closing that gap usually means scaling past \$5M, not chasing efficiency at \$1.5M.
- Buyers underwrite 24 months of trailing financials. Cleaning up your books, eliminating one-time owner add-backs that can't be defended, and producing audit-ready statements adds real turns at the table.

- If you're not selling, the same analysis tells you what you'd need to fix to be sellable, which is usually the same thing you'd need to fix to run a better practice.

KLAS's 2025 acute care EHR report places Epic at roughly **42.3%** of acute-care hospital installations and Oracle Cerner at **22.9%**²³. In ambulatory, Epic sits at **43.92%** versus Oracle Health at 25.06%; Veradigm (Allscripts) holds about 3.6%. The 2024 net swing was decisive: Epic added **+176** acute-care multispecialty hospitals (its largest annual gain ever) while Oracle Health lost a net 74 hospitals. Epic took home roughly 70% of new hospital contracts in 2024.

Ambulatory EHR Market Share, 2025

Epic now controls more than 4 in 10 ambulatory installs — and won ~70% of new hospital contracts in 2024



Source: KLAS Research, "US Acute Care EHR Market Share 2025." Ambulatory shares per KLAS secondary coverage.

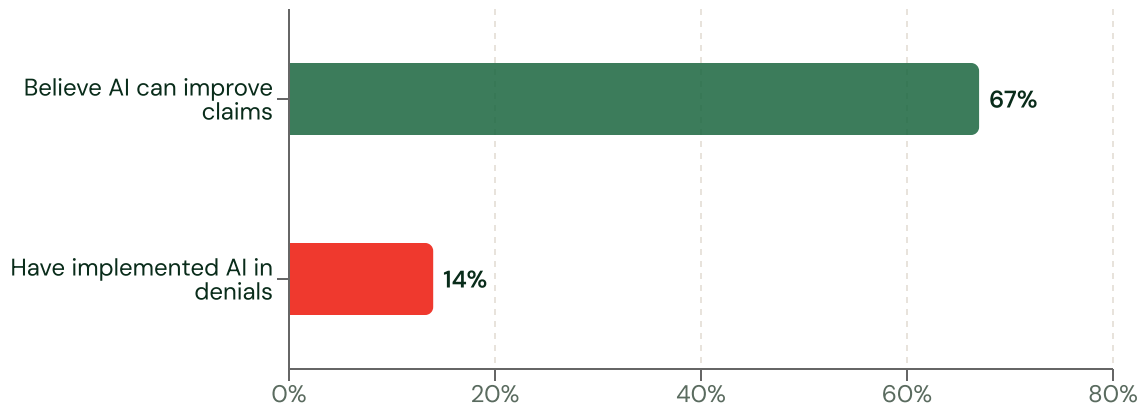
AI in revenue cycle: belief vs. implementation

The U.S. AI-powered medical billing market is projected to grow at a **~24% CAGR from 2025 to 2030**²⁴. But the Experian Health 2025 survey exposes the

biggest gap: **67% of healthcare organizations believe AI can improve claims**, while **only 14% have actually implemented AI tools in denial management**⁸.

Belief vs. Implementation: AI in Denial Management

A 53-point gap between conviction and adoption defines the 2026 RCM opportunity



Source: Experian Health, "State of Claims 2025" survey of 250 healthcare revenue cycle leaders.

Where AI does land, the savings potential is real but, so far, unevenly captured. Per McKinsey, **more than 10% of U.S. physicians** have already adopted ambient AI scribing solutions¹⁵.

Telehealth has stabilized — with one specialty exception

The medRxiv analysis of Medicare FFS E&M visits, 2019–2024, confirms what providers have observed: telehealth peaked at **41.0% of E&M visits in April 2020**, then stabilized at **5.7–7.0%** by 2023–2024²⁵. The exception: high-use specialties (behavioral health, psychiatry) where telehealth still represents **43.8% of E&M visits**. In Q4 2023, more than 12.6% of Medicare beneficiaries received a telehealth service.

WHAT THIS MEANS FOR CLINIC OWNERS

The technology gap isn't about software cost — most clinics already pay for tools they're not using. Three practical moves:

- Audit how much of your existing EHR's automation you actually deploy (eligibility checks, denial worklists, payment posting). The 53-point belief-vs-adoption gap usually lives inside the platform you already own.
- If you're evaluating ambient scribing, model it as a provider-time investment, not an IT cost. The ROI math turns on documentation hours saved and chart-closure speed, not license fees.
- For behavioral health, telehealth is no longer a peripheral channel — it's the dominant E&M format. Treating it as a temporary fix in your scheduling and contracting processes leaves money on the table.

HEADLINE STATISTIC

39 / 13

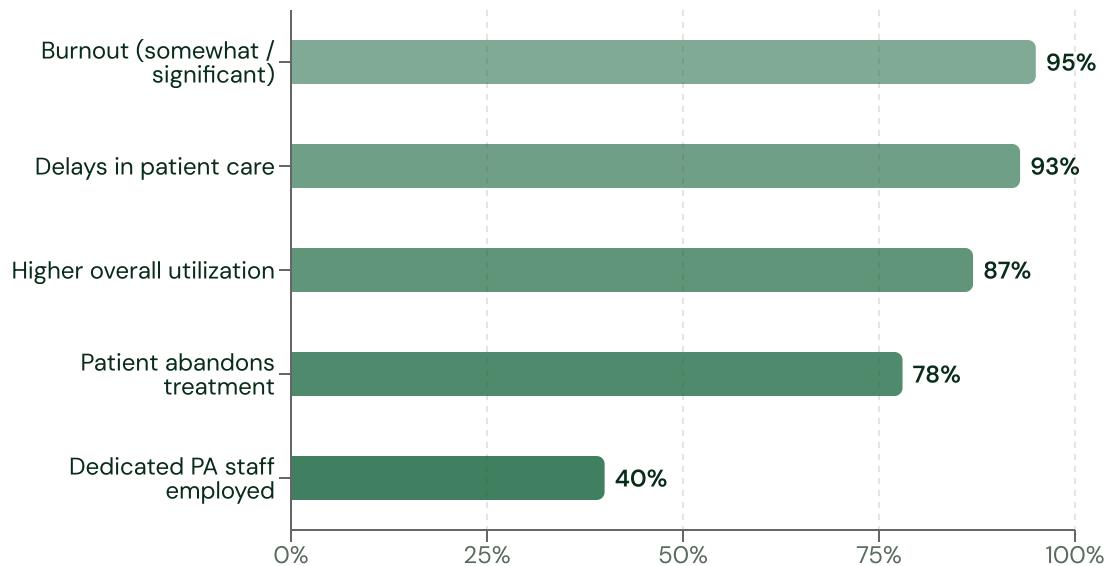
39 prior authorizations and 13 hours per physician per week — equivalent to 12+ hours of physician + staff time. National provider time spent on PA equals more than 100,000 full-time RNs annually.

Source: AMA, 2024 Prior Authorization Physician Survey²⁶.

The downstream effects are large and consistent across waves of the same survey:

Physician-Reported Effects of Prior Authorization

39 PAs and ~13 hours per physician per week — with downstream effects on patients, staffing, and morale



Source: AMA, "2024 Prior Authorization Physician Survey."

Ninety-five percent of physicians say PA somewhat or significantly increases physician burnout; **93%** say PA delays patient care; **87%** say it leads to higher overall healthcare resource utilization; and **78%** say PA often or sometimes results in patients abandoning recommended treatment²⁶. Forty percent of physicians employ staff exclusively for PA work, a line item that almost never appears in operating budgets as "regulatory cost."

MIPS: smaller practices pay the heaviest penalties

Per-physician MIPS compliance is estimated at **\$12,800 and 202 hours per year** (the most current published figure, JAMA Health Forum 2021)²⁷. The 2025 maximum penalty remains **-9% of Medicare payments**. Among practices receiving a penalty, the median expected solo- practitioner penalty is **-6.42%**; small practices sit at **-5.88%**; **13% of small practices** and **29% of solo practices** getting a penalty are receiving the maximum -9%.

RISK TO WATCH

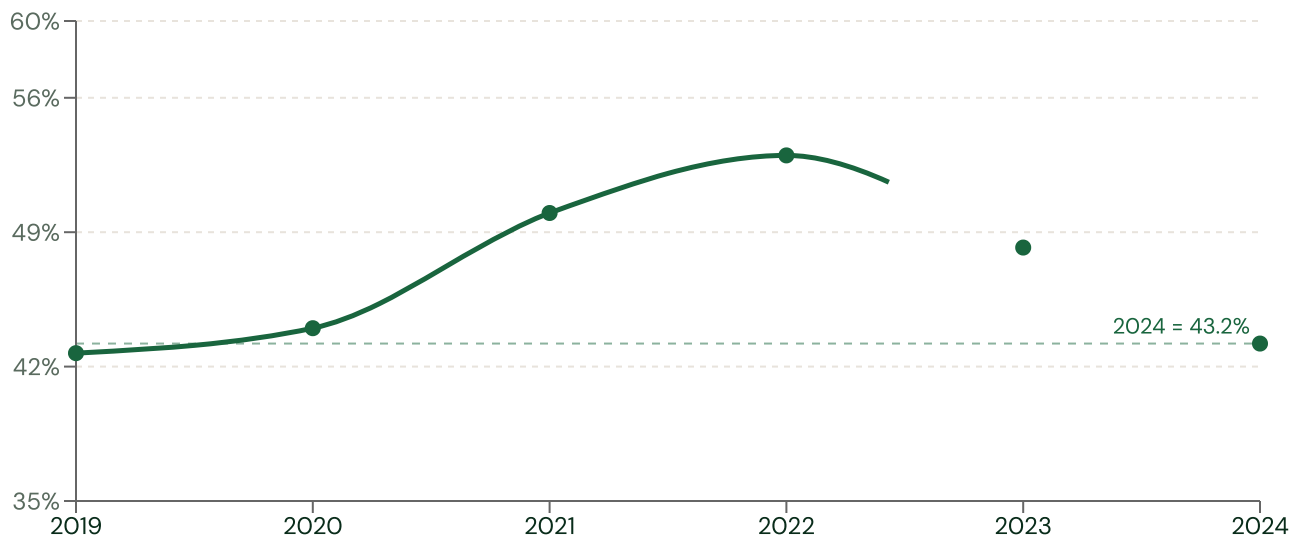
The accounting reality of regulatory burden is that it's hidden labor cost that never lands on the right line. To make it visible:

- Track PA staff time as a discrete cost center for one quarter. The number is usually 1.5–3x what owners estimate.
- For solo and 2–5 physician practices, MIPS exposure can exceed annual practice profit on a Medicare-heavy panel. Election decisions matter; defaulting into MIPS without a specialty-tuned reporting strategy is the most expensive option.
- Most denial- and PA-driven labor expansion is justified upstream by a low-friction front-desk process. Investments here usually pay back faster than back-office headcount.

The AMA Organizational Biopsy (2024 data, ~18,000 physicians across 43 states and 100+ health systems) found **43.2%** of physicians reporting at least one symptom of burnout — down from 48.2% in 2023 and 53% in 2022, the lowest level since before COVID-19²⁸. Medscape's 2025 survey reports a slightly higher figure of ~47% (still down from 49% the prior year, but above the 44% pre-pandemic baseline). Highest-burnout specialties in 2025: urology (54%), neurology (50%), nephrology (49%), endocrinology, family medicine, and radiology (all 46%).

Physician Burnout, AMA Organizational Biopsy 2019–2024

Down 10 points from the 2022 peak — the lowest reading since before COVID-19



Source: AMA, “U.S. physician burnout hits lowest rate since COVID-19” (~18,000 physicians across 43 states). Earlier years from AMA biennial Biopsy series.

For comparison: physician burnout in the short two-item survey sits at **39.5%** versus **24.6%** in the general working population. Improvement is real; the absolute level is still elevated.

Turnover: stabilizing in medical practices, sticky in hospitals

MGMA’s 2025 Stat poll reports **70% of medical practices** say turnover is the same (35%) or lower (35%) than last year; 29% say it has increased. Front-office and medical-assistant roles remain the most cited turnover hotspots²⁹. The healthcare quits rate dropped to **2.2% in 2024** — the lowest since the 2018–2020 average of 2.0% — and held at ~2.0% in early 2025.

Hospital data is worse. The 2026 NSI National Health Care Retention & RN Staffing Report puts the national hospital turnover rate at **18.5%** (up nominally from 2024) and the RN turnover rate at **17.6%** — a 1.2 point increase year-over-year³⁰. Travel and contract nurses carry a steep premium over staff wages.

Compensation: keeping up with the survey, not with CPI

MGMA's 2025 Provider Compensation and Productivity Data Report (220,000+ physicians and APPs nationwide, 2024 data) shows annual compensation growth of **3.17%–5.57%** — roughly matching inflation. But over a 5-year window, median total compensation gains have **not kept pace with the 21.2% 5-year change in CPI**³¹. Surgical specialist signing bonuses now median **\$30,000**; starting bonuses median **\$38,750**. Primary care and surgical specialists in physician-owned practices were eclipsed by hospital/system-owned practices in median work RVUs after years of private-practice outperformance.

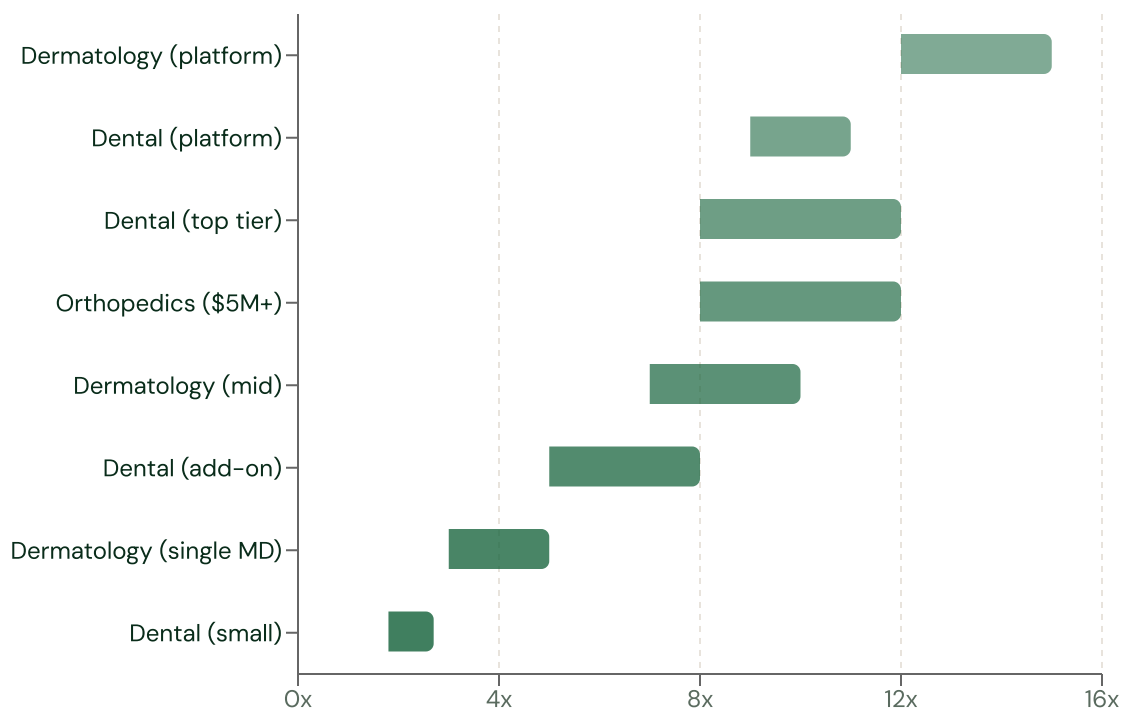
WHAT THIS MEANS FOR CLINIC OWNERS

The workforce dynamics in 2026 differ materially from 2022. Three things have changed:

- The marginal hire is harder, but the marginal departure is less likely. Retention investments — clear career paths, schedule control, modest wage compression at the top — outperform sign-on bonuses for already-stable practices.
- If you're benchmarking provider comp against MGMA's national medians, also pull regional cuts. The wRVU shift toward hospital-owned settings means the "market rate" for productive providers in your geography may be moving independently of the headline number.
- Travel and contract labor at a steep premium is a budgetary tell. If it's structural rather than episodic, the economics almost always favor hiring permanently — even at +10–15% over your standard wage.

2025–2026 EBITDA Multiples by Specialty & Deal Type

Platform deals consistently command 3–5 turns more than add-ons



Source: FOCUS Investment Banking specialty practice valuation reports (2025–2026); Physician Growth Partners; Sofer Advisors; TUSK Practice Sales.

Dental

DSO and PE buyers value dental practices on adjusted EBITDA³². 2025 valuation multiples: platform deals trade at **9–11x EBITDA**; add-ons at 5–8x; and smaller practices (under \$1M EBITDA) at 5–7x. The DSO regional cluster strategy — 3–10 offices within a defined radius for shared admin, staffing, and marketing — remains the dominant playbook. In Q1 2025, dental practice acquisitions accounted for **61% of physician-practice-management transactions**³³.

Physical Therapy

CY 2025's Medicare therapy threshold sat at **\$2,410** (PT and SLP combined), with the KX modifier required above the threshold³⁴. The CY 2026 PFS rule represents the first scheduled fee schedule increase in five years for PT — a real but partial offset to the prior cumulative cuts. Two CY 2025 changes matter operationally: 5 new caregiver-training CPT codes are billable without the

patient present, and general supervision is now allowed for PTAs/OTAs in private-practice outpatient settings.

Dermatology

2025 single-physician practice multiples sit at **3x–5x EBITDA**; larger practices fetch 7x–10x; large platforms reach **12–15x EBITDA**³⁵. There are now more than **35 sponsor-backed dermatology platforms** operating nationally. The landmark 2025 deal: Schweiger Dermatology’s acquisition of California Skin Institute, consolidating two of the largest regional players.

Medical Spa

The American Med Spa Association’s 2024 industry recap puts average annual med spa revenue at **\$1,398,833** in 2023 — up from \$1,307,587 in 2022³⁶. The U.S. industry grew from 8,899 locations in 2022 to **10,488 in 2023**. Owner outlook is positive: **84% of owners** expected revenue to rise in 2024, with **54% of those** expecting at least 10% growth.

U.S. Med Spa Locations

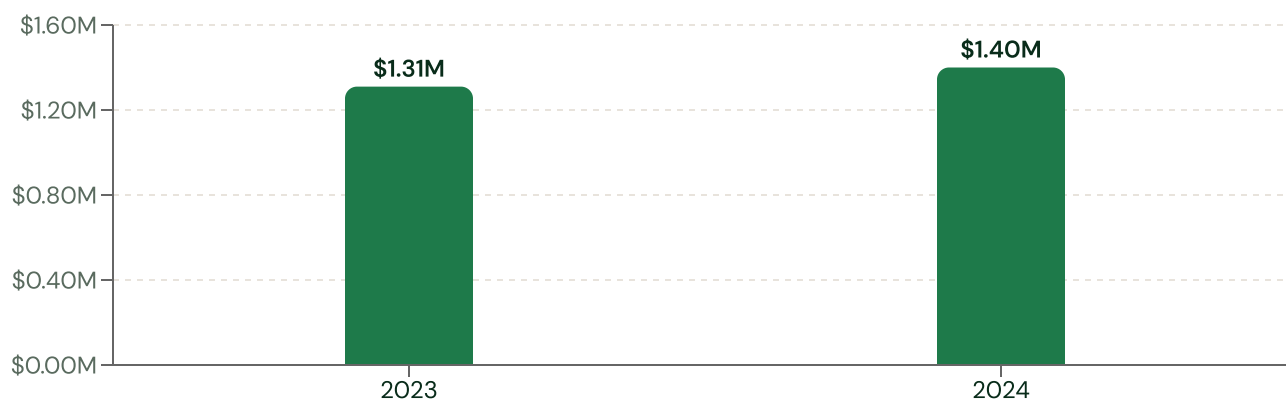
+18% growth in a single year



Source: AmericanMedSpa.org 2024 State of the Industry Recap.

Average Annual Med Spa Revenue (\$M)

\$1.31M (2023) → \$1.40M (2024)



Source: AmericanMedSpa.org 2024 State of the Industry Recap.

Mental & Behavioral Health

SAMHSA projects a U.S. shortage of approximately **31,000 FTE mental health practitioners by 2025**. HRSA's mental health counselor projections show demand growing from 128,600 (2022) to **203,140 (2037)** while supply is projected to decline³⁷. The addiction counselor gap is even wider: demand of 129,250 in 2022 versus shrinking supply of 92,160 by 2037, a shortfall of ~114,000. Geographic distribution is uneven — the nationwide average is 58.3 mental health workers per 10,000 residents; Georgia (36.4), Alabama (38.8), Texas (40.0), and Arkansas (40.3) are the most underserved. One reimbursement bright spot: clinical social workers projected a +4% increase in total Medicare allowed charges under CY 2025 PFS — the highest of any provider type.

Urgent Care

The U.S. urgent care market reached ~**\$34.34B in 2024**, with projected 8.6% CAGR for 2025–2030³⁸. Center count stands at roughly **14,000 locations**, with the post-pandemic CAGR slowing to ~3% versus the 7–8% pre-pandemic baseline. The operational reality beneath the growth: roughly **40% of provider**

time is not filled seeing patients in many markets³⁹, which is the single biggest lever for margin recovery.

Orthopedics

Practices with **\$5M+ EBITDA** are achieving 2–4 multiple turns higher than smaller add-ons; the PE platform sweet spot remains the **\$3M–\$10M EBITDA** band⁴⁰. Q1 2025 saw 10 PE acquisitions in orthopedics — tied with internal medicine for second place behind dental. PE-backed orthopedic platforms began entering “second bite” recapitalization transactions in 2025 (typical PE hold ~5 years), creating an anticipated wave of secondary deals through 2026.

OB/GYN

IBISWorld places industry revenue at **\$17.2B in 2026** with a 0.4% five-year CAGR — with revenue up **3.9% in 2026**⁴¹. Self-employed physicians earn ~9% more than employed peers. The reimbursement issue defining the next 24 months: obstetrics global maternity codes have remained largely unchanged for decades and do not adequately cover pregnancy/postpartum support or administrative work — a structural pricing problem rather than a collection problem.

Chiropractic

2026 industry revenue: **~\$24.0B**, growing about 2.2% over five years (2.6% in 2026), across roughly 66,061 chiropractic businesses⁴². The high-performer collection rate benchmark is **95%+**.

WHAT THIS MEANS FOR CLINIC OWNERS

Specialty benchmarks travel poorly. The same EBITDA margin looks like underperformance in dental and overperformance in urgent care. Three rules of thumb:

- Compare to the right peer set. If you're a single-physician dermatology practice, your relevant multiple is 3–5x — not the 12–15x platform figure that gets quoted in industry coverage.
- For high-utilization specialties (urgent care, PT), the margin lever is provider-time utilization, not pricing. Closing a 10-point utilization gap dwarfs most reimbursement upside.
- In specialties with strong cash-pay components (med spa, dermatologic cosmetic, dental), commercial denial rates matter less than retention and average ticket size. Track those, even if your accountant doesn't.

2026\20132027 Verifiable Forecasts

THEME	FORECAST	SOURCE
Margin compression	1–2 point EBITDA margin compression for office-based physicians from 2025 to 2027; recovery to 6.1% by 2029	McKinsey ¹⁵
PE activity	Cautiously optimistic 2026 outlook based on record 2025 deal volume, aging PE portfolios, and rebound in sponsor-to-sponsor exits	Bain ¹⁷
Specialty-care growth	4–5% annual revenue growth through 2029, supported by ancillary services demand	McKinsey ¹⁵
Care setting shift	Continued migration from acute hospital settings to ASCs and outpatient venues	McKinsey & Deloitte ^{15 16}
AI in billing	~23% CAGR (2025–2030) in U.S. AI-powered billing market	Medical Economics ²⁴
Ambient scribing	>10% physician adoption today, expected to scale further	McKinsey ¹⁵

WHAT THIS MEANS FOR CLINIC OWNERS

The 2026–2027 outlook for an outpatient clinic owner comes down to three honest questions:

- Can your practice absorb a 1–2 point margin compression for 18–24 months without breaking debt covenants or delaying owner distributions?
- If consolidation continues at the 2025 pace, what happens to your referral network, your payer leverage, and your provider recruitment if the largest specialty group within 30 miles of you sells?
- Of the technology investments in your 2026 budget, how many fall into the 67% “believe AI can help” bucket versus the 14% “have actually implemented” bucket?

M METHODOLOGY & SOURCES

How this report was assembled.

Every statistic in this report traces back to a publicly verifiable source. Government data (CMS, BLS, HRSA) and association primary research (AMA, MGMA, AAPC, APTA) are the primary citations. Vendor and consulting reports (Bain, McKinsey, Deloitte, KLAS, Experian Health, NSI) are reliable but represent paid research products and are cited by report name and date.

Where credible sources disagree — for example, commercial reimbursement at 196% (Milliman) versus 230% (Urban Institute) of Medicare — we present the range rather than choose a single number. Anything beyond CY 2026 is labeled as a projection by the issuing firm, not as fact. Survey statistics are paired with sample size and methodology where known.

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Sorso works exclusively with outpatient clinics. The benchmarks in this report are the same ones we apply in client engagements: payer-mix analysis, denial recovery, provider productivity, and EBITDA-level forecasting. If you want these benchmarks compared against your own numbers, the free assessment is the fastest way to start.

[LinkedIn →](#)

PUT THE REPORT TO WORK

Apply these benchmarks to your own numbers.

REVENUE CYCLE (CH. 2)

Days in A/R calculator

Compare your days in A/R to HFMA MAP Keys benchmark ranges.

[Open calculator →](#)

COSTS & MARGINS (CH. 3)

Overhead ratio calculator

Compare your overhead percentage to specialty benchmarks from MGMA, ADA, APTA, AAD.

[Open calculator →](#)

PE & VALUATION (CH. 5)

Practice valuation calculator

Estimate your practice value using published specialty transaction multiples.

[Open calculator →](#)

FULL-TIME VS FRACTIONAL (CH. 8)

CFO cost comparison

Side-by-side cost of full-time CFO vs fractional for your clinic size.

[Open calculator →](#)

SPECIALTY CONTEXT (CH. 9)

Specialty benchmark pages

Profit margin, overhead, A/R days, and payer mix broken out by specialty.

[See benchmarks →](#)

WORKFORCE (CH. 8)

Provider profitability calculator

See net contribution per provider after loaded cost and allocated overhead.

[Open calculator →](#)

DEEPER READING

Five questions worth opening before your next board meeting

CFO vs Controller: which role you actually need, and when

Med spa accounting: cash-pay margins and the deferred-revenue traps

Billing modifiers: the two-character codes that decide whether you get paid

Why claims get denied: the five categories every owner should know cold

Florida clinic finance: state tax, payer dynamics, and operating context

Healthy days in AR: the benchmark most clinics miss by 12–18 days

Free assessment →