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MANAGEMENT AND STAFF COMPENSATION

AN MGMA DATA REPORT | JUNE 2023

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MGMA DATADIVE MANAGEMENT AND STAFF COMPENSATION
provides key compensation benchmarks for job titles throughout a medical group practice, from the C-suite to the front desk. **Learn more about this industry-leading data set.**

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ABOUT MGMA

Founded in 1926, the Medical Group Management Association (MGMA) is the nation's largest association focused on the business of medical practice management. MGMA consists of 15,000 group medical practices ranging from small, private medical practices to large national health systems, representing more than 350,000 physicians. MGMA helps nearly 60,000 medical practice leaders and the healthcare community solve the business challenges of running practices so that they can focus on providing outstanding patient care. Specifically, MGMA helps its members innovate and improve profitability and financial sustainability, and it provides the gold standard on industry benchmarks such as physician compensation. The association also advocates extensively on its members' behalf on national regulatory and policy issues. **mgma.com**

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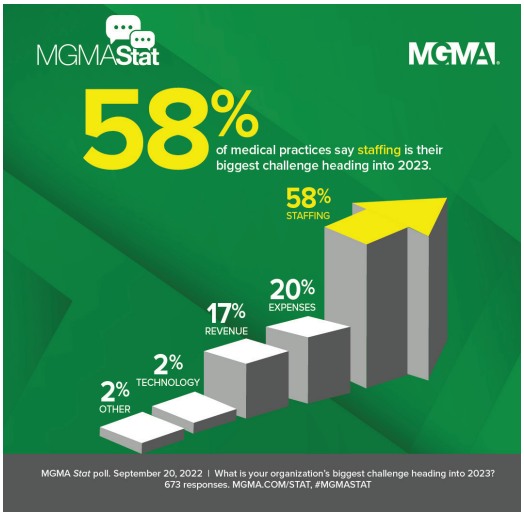
INTRODUCTION

The surge keeping medical group leaders up at night no longer has anything to do with COVID-19 — it's in the expense line of their budget.

The latest ***MGMA DataDive Management and Staff Compensation*** data set shows double-digit percentage gains in payroll for certain clinical and nursing staff positions from 2021 to 2022. Even as inflationary growth has lost steam in 2023, the increased labor expenses for medical group practices are continuing an upward path.



Staffing was easily ranked as the top challenge for medical group leaders in 2023 before the start of this year, and findings from this report and other MGMA research suggest the need for continued monitoring of labor market trends and efforts to boost recruitment and retention strategies for clinical and clerical support roles throughout provider organizations.

While the public health emergency around COVID-19 is over, **medical group leaders face the ongoing pressure to handle growing patient demand for care in the face of historic difficulties in staffing medical practices and the financial squeeze of stagnating reimbursement and ballooning prices for supplies to operate their businesses effectively.**

This data report highlights key trends in total compensation for a wide array of management, nursing and clinical assistant roles, with benchmarks pulled directly from the ***2023 MGMA DataDive Management and Staff Compensation*** **report, which includes data on more than 157,000 management and staff positions from more than 2,940 organizations**.

KEY TAKEAWAYS

- **All nursing positions saw an average 8.5% jump in median total compensation from 2021 to 2022**, fueling a 19.37% five-year increase since 2018.
- **Five-year compensation trends were even higher for certified nursing assistants (27.67%) and medical assistants (23.06%)**.
- **Median hourly rate compensation grew $2.14 for MAs from 2021 to 2022**, while **registered nurses (RNs) and triage nurses saw hourly rates climb $5.80 and $5.70, respectively**, for the same period.
- As many RNs exited the industry during the COVID-19 years, **RNs with 21 or more years of experience earned about $27,500 more than their early-career counterparts** with five years or less experience.
- New polling by MGMA suggests recruitment and retention strategies for MAs and nursing roles remain top challenges, though the financial pressures on medical groups have **limited efforts to invest in expanded employee benefits in the past year** beyond salary and wage increases to remain competitive.
- Broadening how medical groups recruit workers can yield improvements, but **efforts to formalize diversity programs have not gained significant traction** during the COVID-19 pandemic and the labor crisis in healthcare.

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DATA TRENDS

CLINICAL AND NURSING STAFF COMPENSATION

All five of the main clinical and nursing staff positions reported in the M*GMA DataDive Management and Staff Compensation* data set saw 5% or higher gains in median total compensation from 2021 to 2022, with certified nursing assistant (10.59%) and licensed practical nurse (LPN) rating highest (18.70%) in the one-year upticks.

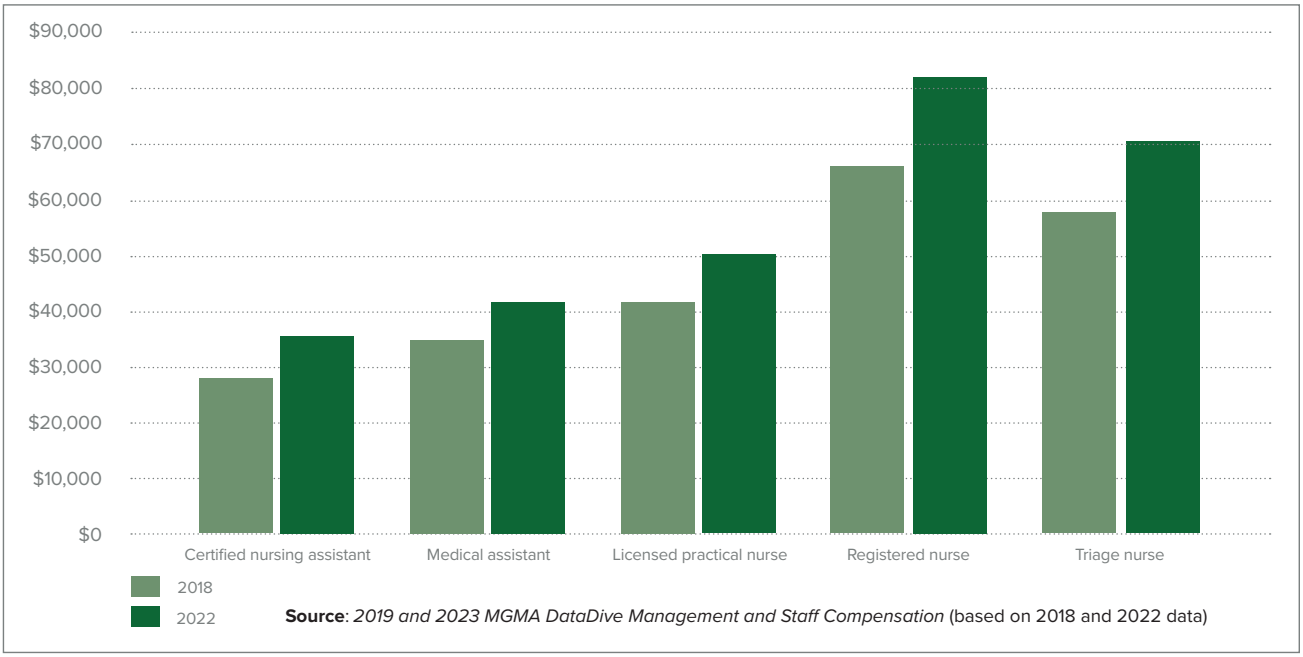
The one-year compensation growth for registered nurses (RNs) actually outpacted its change in 2021 (4.81%), while LPN compensation — which grew 6.67% in 2021 — surged 18.70% in 2022.

CHANGES IN MEDIAN TOTAL COMPENSATION

	2021-2022 change	Five-year change (2018-2022)
Certified nursing assistant	10.59%	27.67%
Medical assistant	7.09%	23.06%
Nursing positions	**8.50%**	**19.37%**
Licensed practical nurse	18.70%	24.87%
Registered nurse	5.02%	21.84%
Triage nurse	5.34%	16.86%

Sources: *2019-2023 MGMA DataDive Management and Staff Compensation* (based on 2018-2022 data)

INCREASE IN MEDIAN TOTAL COMPENSATION FOR CLINICAL STAFF AND NURSES, 2018 TO 2022



Source: *2019 and 2023 MGMA DataDive Management and Staff Compensation* (based on 2018 and 2022 data)

INCREASE IN MEDIAN HOURLY RATE COMPENSATION

	2021-2022 change	Four-year change (2019-2022)
Certified nursing assistant	$1.90	$2.49
Medical assistant	$2.14	$3.67
Licensed practical nurse	$1.29	$2.84
Registered nurse	$5.80	$7.46
Triage nurse	$5.72	$8.06

Source: *2020-2023 MGMA DataDive Management and Staff Compensation* (based on 2019-2022 data)

Hourly rates for clinical and nursing staff also continued to increase year over year, keeping pace with the annual total compensation increases. The rate growth seen in 2022 accounted for half or more of the total growth seen compared to pre-pandemic benchmarks from 2019.

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MANAGEMENT COMPENSATION

Management positions at every level saw some degree of compensation growth over the past year.

HOW EXPERIENCE AND EDUCATION MATTER

Management and staff positions with more tenured experience report higher rates of compensation than their counterparts who are newer to the position.

Nurses with decades of experience have become highly in demand after many veteran workers exited the industry during the pandemic or shifted to roles in clinical trials or training.

CHANGES IN MEDIAN TOTAL COMPENSATION FOR MANAGERS

	2021-2022 change	Five-year change (2018-2022)
Executive management positions	8.99%	10.16%
Senior management positions	2.35%	15.38%
General management positions	3.88%	12.86%
Supervisors	4.52%	4.91%

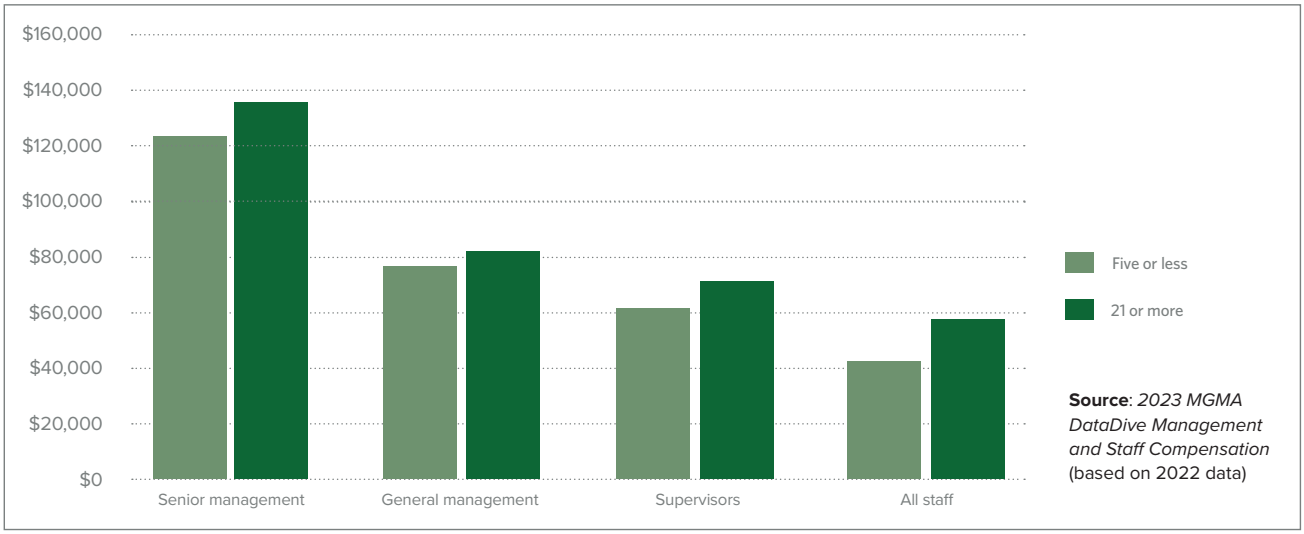
Source: *2019-2023 MGMA DataDive Management and Staff Compensation* (based on 2018-2022 data)

DIFFERENCE IN MEDIAN TOTAL COMPENSATION BETWEEN "FIVE OR LESS" AND "21 OR MORE" YEARS OF EXPERIENCE

Senior management positions	$11,867
General management positions	$5,498
Supervisors	$9,578
All staff	$14,336
Medical assistant	$8,871
Licensed practical nurse	$6,944
Registered nurse	$27,564

Source: *2023 MGMA DataDive Management and Staff Compensation* (based on 2022 data)

MEDIAN COMPENSATION BY YEARS OF EXPERIENCE



Source: *2023 MGMA DataDive Management and Staff Compensation* (based on 2022 data)

DIFFERENCE IN MEDIAN TOTAL COMPENSATION BY EDUCATION LEVEL

	Difference between high school diploma and bachelor's degree	Difference between bachelor's and master's degree
Executive management positions	—	$16,798
Senior management positions	—	$11,973
General management positions	$14,589	$4,540
Supervisors	$4,726	$7,671
All staff	$9,407	$10,657
Registered nurse	$13,311	—

Source: *2023 MGMA DataDive Management and Staff Compensation* (based on 2022 data)

Formal education level can also affect compensation rates. Management and staff positions with a bachelor's degree report more in total compensation than their counterparts with a high school diploma. Likewise, management and staff positions with a master's degree report even greater compensation than their counterparts with a bachelor's degree.

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REGIONAL DIFFERENCES

Compensation is reported as the highest in the west and east regions of the United States. Compensation is consistently reported as the lowest in the southern region.

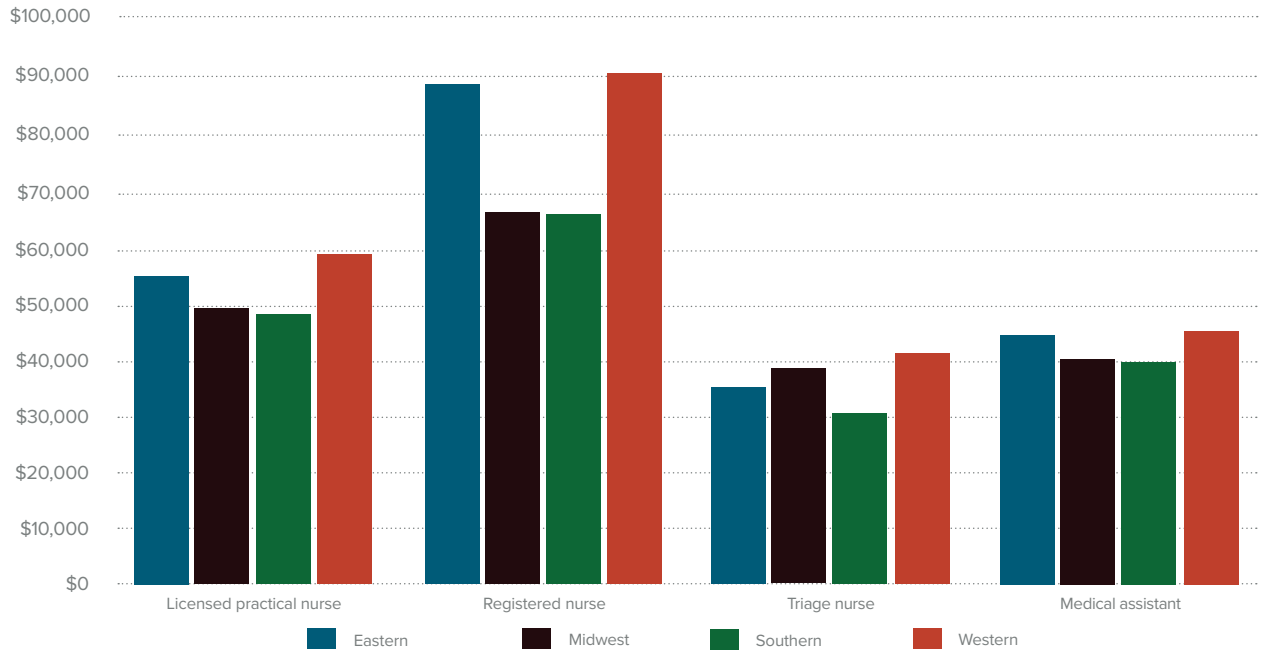
COMPENSATION DIFFERENCE FOR MANAGEMENT POSITIONS BETWEEN HIGHEST- AND LOWEST-PAYING REGIONS	
Executive management	$97,623 (East versus South)
Senior management	$25,217 (West versus South)
General management	$23,370 (West versus South)
Supervisors	$11,117 (West versus South)
All staff	$13,204 (East versus South)

Source: *2023 MGMA DataDive Management and Staff Compensation* (based on 2022 data)

COMPENSATION DIFFERENCE FOR NURSE POSITIONS BETWEEN WESTERN AND SOUTHERN REGIONS	
Certified nursing assistant	$11,203
Medical assistant	$5,189
Licensed practical nurse	$11,257
Registered nurse	$23,677

Source: *2023 MGMA DataDive Management and Staff Compensation* (based on 2022 data)

MEDIAN COMPENSATION BY REGION FOR CLINCAL AND NURSE POSITIONS



Source: *2023 MGMA DataDive Management and Staff Compensation* (based on 2022 data)

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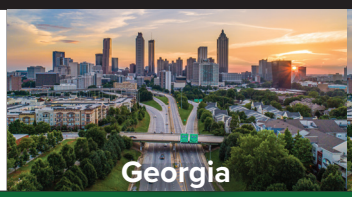
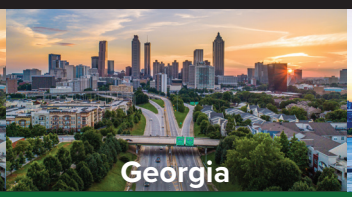
Compensation can range dramatically by state, and the differences between the highest and lowest paying states are substantial for management-level positions.

TOP 5 STATES FOR TOTAL COMPENSATION BY POSITION, MANAGERS

	Executive management	Senior management	General management
Highest-paying			
#2			
#3			
#4			
#5			
Lowest-paying			
DIFFERENCE BETWEEN HIGHEST- AND LOWEST-PAYING STATES			
	$203,533	$116,720	$69,461

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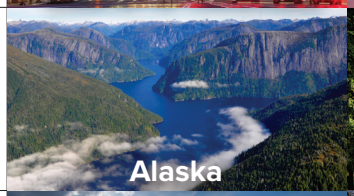
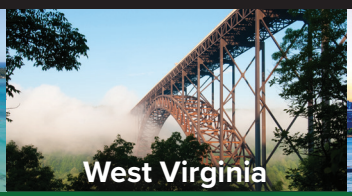
Nursing and clinical positions also experience gaps in compensation rates between the highest- and lowest-paying states.

TOP 5 STATES FOR TOTAL COMPENSATION BY POSITION, CLINICAL AND NURSES

	Medical assistant	Licensed practical nurse	Registered nurse
Highest-paying	 Wisconsin	 Washington	 District of Columbia
#2	 Washington	 District of Columbia	 Maryland
#3	 District of Columbia	 Maryland	 Washington
#4	 Alaska	 Massachusetts	 New York
#5	 New Hampshire	 Colorado	 Arizona
Lowest-paying	 Hawaii	 West Virginia	 New Jersey
DIFFERENCE BETWEEN HIGHEST- AND LOWEST-PAYING STATES			
	$69,293	**$35,502**	**$55,751**

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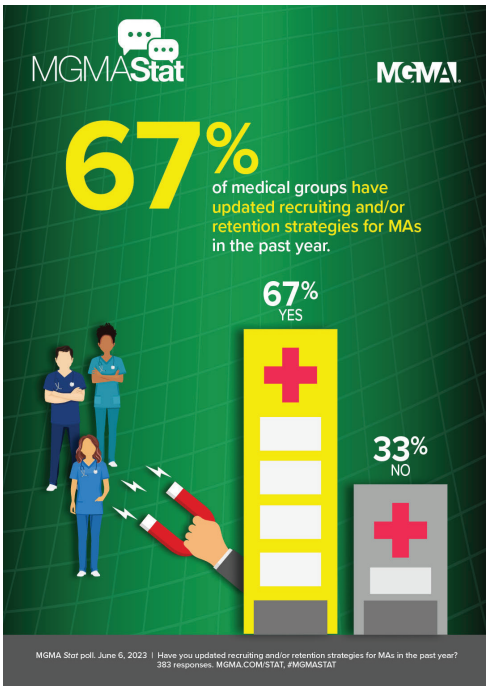
SHIFTING STRATEGIES TO IMPROVE MEDICAL ASSISTANT RECRUITMENT AND RETENTION

It's no secret that hiring medical assistants (MAs) following The Great Resignation has been a challenge, affecting almost all practices, and that MAs have been among the toughest non-physician roles to hire in recent years, according to past MGMA *Stat* polls.



So, what's the secret to improving recruitment and hiring strategies for medical groups to get talented candidates on board and stay there for the long term? That's what a June 6, 2023, MGMA *Stat* poll sought to find out.

About two-thirds of medical group leaders (67%) report they updated recruiting and retention strategies for MAs in the past year, versus 33% that did not. The poll had 383 applicable responses.

Among the one-third of practice leaders who responded "no," MGMA asked if they were having difficulty hiring or retaining MAs. Many of these respondents pointed to an extreme scarcity of applicants for the open jobs they've posted. As for those not reporting such difficulty, they were asked which factors drove their success.

- In many cases, the respondents' organizations mostly use nurses and have little need to recruit or retain MAs. Other respondents in college towns that can hire a lot of pre-med students in their gap year report good hiring but a decent amount of turnover every May and June.
- Others pointed to strong organizational culture and team atmospheres that make employees want to stay.

WHAT'S WORKING IN RECRUITMENT AND RETENTION

The range of strategies being used to recruit and retain MAs is as varied as the task has been difficult in recent years. As one practice leader told MGMA: "First we completed a new market analysis to see our position in the market with pay. We have brought our pay scale more in line with the study results. We have made our referral program more robust. We are requiring our management to be more proactive with performance feedback to our new hires, as well as ensuring all 90-day reviews are completed. We feel good communication, true interest in the employee well-being and competitive pay are the core for retaining employees in this competitive market."

Some of the most common responses from other respondents to the poll included:

- Increased compensation (including equity pay adjustments) and bonus incentives
- Increased use of sign-on bonuses tied to a one- or two-year commitment
- Efforts to match outside offer letters and not requiring certification for some candidates with experience
- Engaging outside agencies to build a larger pool of candidates
- Expanding advertising of open jobs, as well and broadening a practice's presence at local job fairs and making offers on the spot
- Increased collaboration with nearby MA school programs, as well as apprenticeship programs and outreach to high school students to encourage them to consider work as MAs

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- Implementation of in-house training and certification programs, often alongside cross-training efforts
- Creating career ladders within the organization with tuition support
- More part-time positions for workers who prefer to not work full time
- Transitioning mostly administrative duties off MAs' plates.

BUILDING MA TRAINING CAPACITY

One of the biggest obstacles to hiring MAs during the post-pandemic labor market has been the scarcity of training capacity for new MAs to join the workforce. As detailed in the July 2022 *MGMA Connection* magazine, Cone Health in North Carolina invested in its own training program to pick up where the nearby community colleges and technical schools were unable to keep pace with the demand for certified MAs (CMAs).

Similar programs have shown positive results in recent months. According to *Community College Daily*, the Alamo Colleges District — a network of community colleges in San Antonio, Texas — partnered with the College of Health Care Professions to build an "earn-and-learn" MA program catering to working adults who sought flexible and evening class schedules to become CMAs. The program is funded for the next four years via a 1/8-cent sales tax that helps pay for workforce development in the area, according to *Diverse Education*.

TRAINING MAs FOR NEW TECHNOLOGIES

Even though the long-term future of telehealth is uncertain, as the industry shifts beyond the COVID-19 public health emergency, the vast expansion of virtual care delivery is still an important topic for healthcare leaders looking ahead to future workforce training and development strategies.

A recent report by the University of Washington (UW) Center for Health and Workforce Studies suggests that MAs using telehealth during the pandemic were capable of the transition but could have benefited from more education and training on virtual care services, as reported by *mHealth Intelligence*.

The study also noted telehealth training alongside the other elements of evolving MA roles as the industry shifts, especially in the primary care space: "The most common roles that surveyed physicians reported MAs could take on with proper training included those related to population health: management of patients with chronic health conditions such as diabetes, identifying patients in need of preventive screening and EHR data extraction for managing patient panels," the UW report read.

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NURSE RECRUITMENT AND HIRING AFTER THE GREAT RESIGNATION STILL A MAJOR CHALLENGE

Across an industry inundated with big claims about AI and machine learning, the healthcare world has another standout when it comes to eye-catching headlines: Nursing shortages.

Depending on which study you're reading, there is a troubling to apocalyptic share of nurses prepared to call it quits on their clinical careers after the COVID-19 pandemic and rising burnout:

- Nearly 800,000 registered nurses (RNs) plan to leave the field by 2027 after almost 100,000 left during the COVID-19 pandemic, according to an April 2023 analysis by the National Council of State Boards of Nursing (NCSBN).
- A report from staffing company AMN Healthcare (PDF) suggested about 3 in 10 RNs were likely to leave their career due to the pandemic, while 18% said it's likely they would retire from nursing due to the pandemic. This report was additionally worrisome for healthcare leaders, as it found that younger nurses reported lower satisfaction, mental health and well-being compared to older nurses.
- Staffing agency ConnectRN says the share of nurses who are thinking of leaving the profession is closer to half, per a November 2022 report.

To better understand these shocking estimates, a May 23, 2023, MGMA *Stat* poll asked medical group leaders how their nurse recruiting and hiring efforts have changed in the past year. The bad news is that it largely confirms the gloomy reports referenced earlier: **The majority (46%) reported their efforts worsened this past year, while only 17% said they saw their efforts improve and another 37% reported it stayed the same.** The poll had 360 applicable responses.

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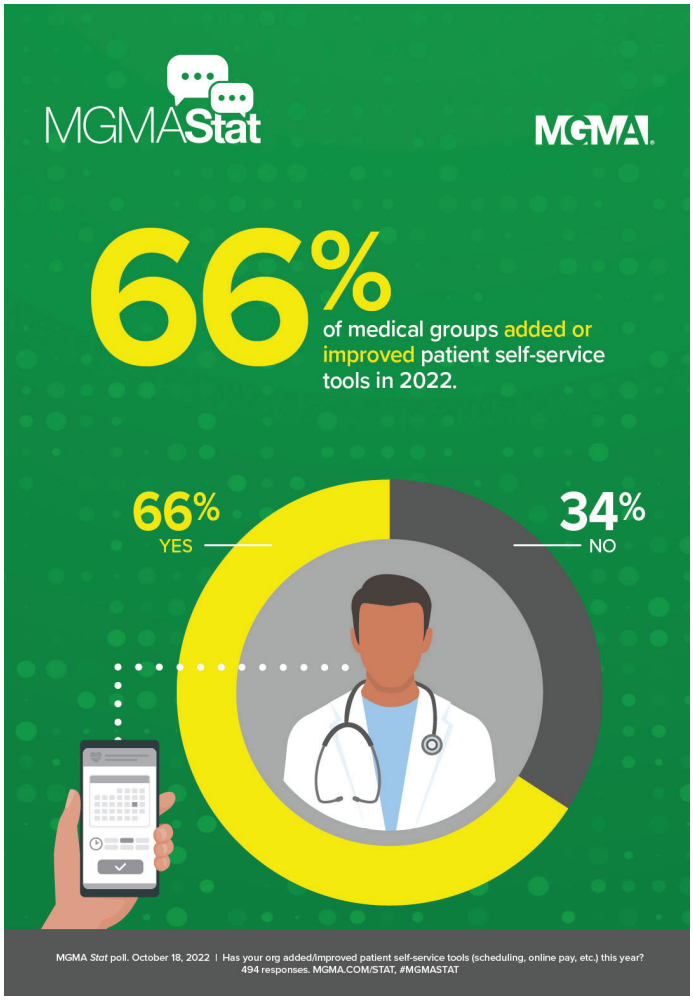
SUCCESSES AND CHALLENGES

Medical groups, health systems and hospitals all have shifted gears in their recruitment and retention strategies for an array of healthcare positions amid the pandemic and subsequent staffing shortages. An Aug. 16, 2022, MGMA *Stat* poll found that most medical groups had planned 3% to 5% merit or cost-of-living increases in support staff wages for 2023 to remain competitive, with a similar amount seen in a December 2021 poll.

Beyond higher salaries, efforts throughout The Great Resignation to recruit and retain nurses have included taking burdens off staff through more patient self-service tools, updating job descriptions to better reflect the work to be done and adding or expanding employee benefits.



WHAT'S WORKING

According to the May 23 poll respondents:

- Improvements in recruiting efforts have been aided by the decline in travel nurse compensation as COVID-19 caseloads ebbed, nurses opting to leave the hospital setting for private practice models and broader labor market shifts. "Systems are starting to say 'no' to exorbitant traveler mark-up," one practice leader told MGMA, which has allowed for some market stabilization.
- Multiple groups reported examining and redesigning their care teams to change the mix of RNs and licensed practical nurses (LPNs) and reassess how the knowledge and skills of their nursing staff are used.
- Embracing flexibility to allow part-time job sharing for nurse staff who want it, which makes scheduling more flexible and, in some instances, results in some full-time benefit costs decreasing.
- Taking a fresh look at compensation, benefits and bonuses led to recruiting new hires, in addition to increased efforts around student recruitment.
- More creative incentives reported by poll respondents included expanded employee appreciation events outside the office, such as picnics, food truck events and trips to amusement and water parks.

As medical practice leaders told MGMA in the past year, medical assistants (MAs) were often the most-difficult role to recruit in the pandemic era. However, organizations that invested in developing their own internal MA training and development programs to supplement staffing needs are now seeing return on those investments. Developing career paths and building tiers for nursing staff also showed results for some groups.

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WHERE CHALLENGES REMAIN

Among practice leaders who said the success of their efforts remained the same this past year, most cited a continued lack of worker availability and intense competition from hospitals and larger systems in terms of signing and starting bonuses. “Hospitals and specialists can pay more than private practice primary care,” one respondent told us.

While keeping pace with hospitals on incentives has proven a tough task, one practice leader told MGMA that basing sign-on bonuses to longer commitments (two years, for example) has produced positive results.

For the majority of practice leaders reporting worsening outcomes since last year, increasing compensation expectations were a frequent challenge, as well as just getting candidates in for an interview. “I have had no response and candidates have ghosted us and not shown up for interviews that have been set up,” one practice leader told MGMA. “Absolutely the most frustrated I have ever been in my career!” Candidate interest in flexible scheduling and aversion to non-day shift work also were common responses from practice leaders.

TRACKING NURSE JOB GROWTH

- **RNs**: The Bureau of Labor Statistics (BLS) *Occupational Outlook Handbook* estimated there were about 3.13 million employed RNs nationwide in 2021, and that the position would grow at a rate of 6% through 2031, or roughly 195,400 new RN roles.
- **LPNs and licensed vocational nurses (LVNs)**: LPN and LVN job growth is estimated at 6% through 2031 per the BLS *Occupational Outlook Handbook*, resulting in about 41,300 new jobs in that period.
- **Nurse anesthetists, nurse midwives and nurse practitioners (NPs)**: The BLS expects faster-than-normal growth (40%) in nurse anesthetist, nurse midwife and NP jobs through 2031, with an estimated 118,600 new jobs to be added in that period. jobs through 2031, with an estimated 118,600 new jobs to be added in that period.

THERE’S A BOTTLENECK, THOUGH

While the demand for more nurses is obvious, it takes nursing schools to bring those new professionals into the field, and the past few years have not been kind to those looking to hire a new generation of nurses.

The American Association of Colleges of Nursing (AACN) 2021-2022 report on nursing program enrollment and graduations found that “U.S. nursing schools turned away 91,938 qualified applications from baccalaureate and graduate nursing programs in 2021 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors and budget constraints,” with **faculty shortages often ranked as the top reason for qualified applicants not making it into a program**.

The same report pointed to many faculty in nursing schools approaching retirement age, with about one third of existing nursing faculty “expected to retire by 2025.” Faculty shortages are also exacerbated by increasing compensation to pull teachers back into clinical settings, as well as declining enrollment in master’s and doctoral programs in nursing that produce the nurse educator workforce.

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BIDDING WAR: WHY PRIVATE PRACTICES ARE STRUGGLING TO RETAIN NURSING STAFF

While the United States and global economies have largely recovered from the financial crises spurred by the COVID-19 pandemic, the aftereffects of the pandemic are still being felt. Despite supply chain snarls, the nation went on a post-lockdown buying spree, which depleted inventory levels and increased demand for products and services, which resulted in the highest jump in inflation rates in 40 years.

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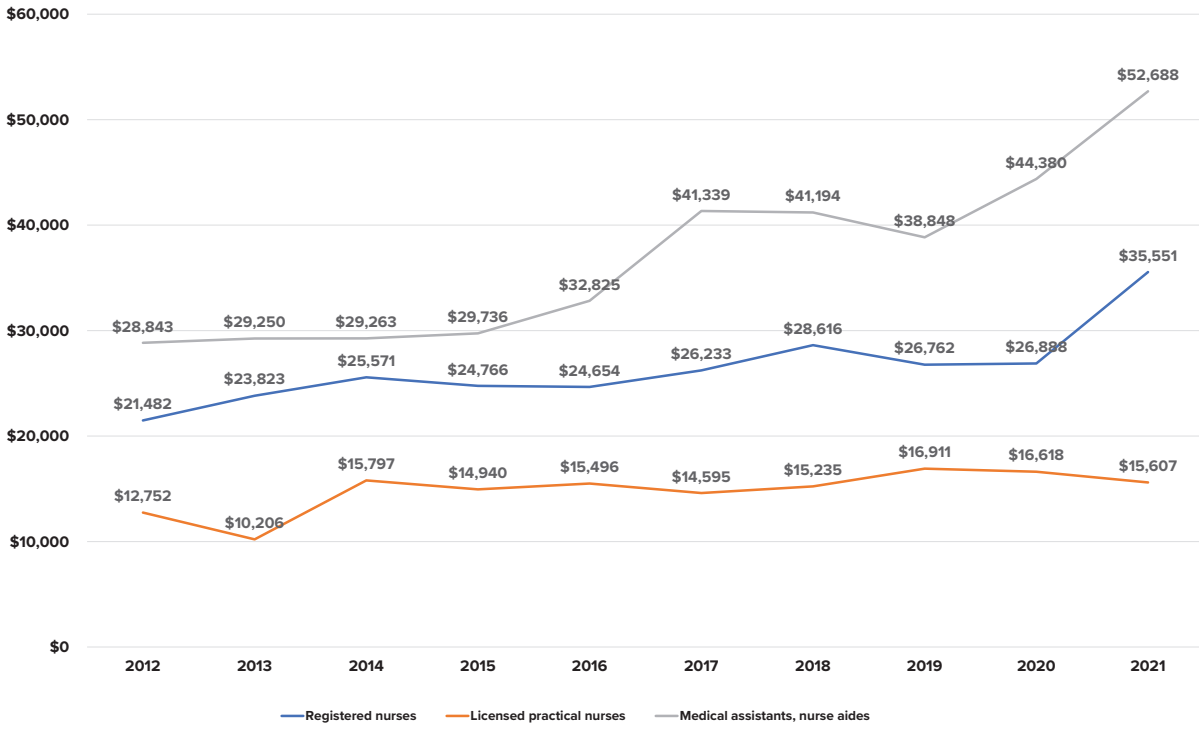
The economic forces that affected the country also impacted physicians and hospitals. Medical groups substantially recovered from the loss of revenue and increased costs in 2020; however, many of the problems that practices experienced in 2019 and 2020 are continuing, especially their ability to recruit and retain staff at a wage scale that competes with businesses inside and out of healthcare.

Evidence of this problem was noted in the October 2022 Data Mine article, "COVID-19 recovery: The long road back to normal," which described the MGMA DataDive survey results for physician-owned multispecialty groups with primary and specialty care who experienced a 6.5% one-year increase in total support staff expense from $370,060 to $393,961 per full-time-equivalent (FTE) physician.[1]

Drilling down, much of the increase in staff costs can be attributed to the increase in the cost of nursing staff. Figure 1 displays how the cost per FTE physician for registered nurses (RNs), licensed practical nurses (LPNs), and medical assistants (MAs) has changed over the past 10 years. The graph shows how physician-owned multispecialty groups with primary and specialty care experienced a substantial increase in RN and MA costs.

FIGURE 1. 10-YEAR CHANGE (2012-2021) IN COST PER FTE PHYSICIAN FOR NURSING STAFF IN PHYSICIAN-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALTY CARE



Sources: *MGMA DataDive Cost and Revenue, 2013-2022* (based on 2012-2021 data)

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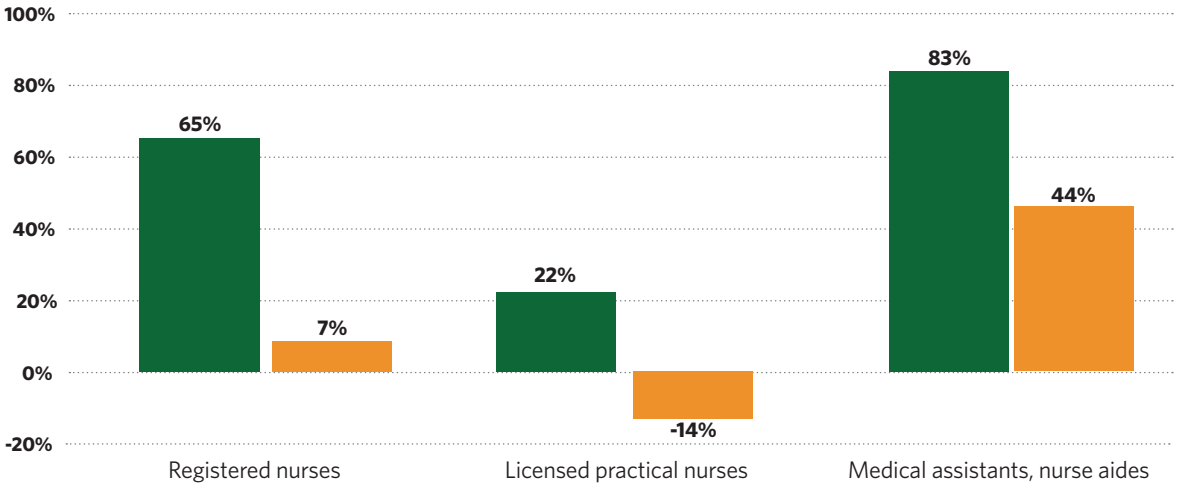
FIGURE 2. 10-YEAR PERCENT CHANGE (2012-2021) IN COST AND STAFFING PER FTE PHYSICIAN IN PHYSICIAN-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALTY CARE



Sources: *MGMA DataDive Cost and Revenue, 2013 and 2022* (based on 2012 and 2021 data)

Since total staff cost is a function of the number of staff members and their average compensation, Figure 2 shows the percent change in total cost along with the change in staffing levels. Examining the graph, it is apparent that the increase in cost of MAs is largely driven by an increase in the staffing level; however, while LPN costs have increased by 22% in the 10 years, their staffing level actually decreased 14%. Most importantly, physician-owned multispecialty groups with primary and specialty care saw their RN staffing cost per FTE physician surge by 65% despite only increasing their RN staffing levels by 7%.

While the *MGMA DataDive Cost and Revenue* records practice expenses revenue and staffing information, the *MGMA DataDive Management and Staff Compensation* publishes compensation and fringe benefit information for practice executives, managers, and staff members. Table 1 shows the median compensation paid by physician-owned and hospital-owned medical groups for their nursing staff during the three years of the COVID pandemic.

While physician-owned groups experienced substantial increases in the total costs of nursing staff, in the context of national inflation, their annual compensation increase did not keep up with the cost of living. The table shows that nurses working in hospital-owned medical groups had much greater annual increases in median compensation than their private practice peers. More importantly, nurses in hospital-owned practices have substantially greater compensation than similar nurses in private practice.

TABLE 1. COMPENSATION OF NURSING STAFF IN PHYSICIAN- AND HOSPITAL-OWNED MEDICAL GROUPS, 2019-2021

MEDIAN COMPENSATION FOR NURSING STAFF IN PHYSICIAN-OWNED MEDICAL GROUPS				
	2019	2020	2021	Percent change 2020-2021
Medical assistant	$35,718	$35,279	$36,823	4.4%
Licensed practical nurse	$45,341	$43,936	$45,238	3.0%
Registered nurse	$59,780	$60,237	$61,434	2.0%
MEDIAN COMPENSATION FOR NURSING STAFF IN HOSPITAL-OWNED MEDICAL GROUPS				
	2019	2020	2021	Percent change 2020-2021
Medical assistant	$36,173	$36,816	$39,416	7.1%
Licensed practical nurse	$42,988	$43,666	$47,222	8.1%
Registered nurse	$68,567	$67,113	$72,647	8.2%
COMPENSATION IN HOSPITAL-OWNED GROUPS AS A PERCENT OF COMPENSATION IN PHYSICIAN-OWNED GROUPS				
	2019	2020	2021	
Medical assistant	101%	104%	107%	
Licensed practical nurse	95%	99%	104%	
Registered nurse	115%	111%	118%	

Sources: *MGMA DataDive Management and Staff Compensation, 2020-2022* (based on 2019-2021 data)

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The differential in nursing compensation by group ownership in 2021 ranged from 4% for LPNs and 7% for MAs to a full 18% for RNs, whose median compensation in hospital-owned practices was $11,213 greater than RNs in physician-owned practice.

The difference in median compensation for nursing staff indicates a potential problem for physician-owned medical groups. It is widely reported that many nurses left the profession during the pandemic due to overwork and burnout, and that there is a national shortage of RNs and only a slightly lesser shortfall in LPNs and MAs. Even though much of nursing turnover occurred in inpatient facilities, the effect is felt industrywide, as it occurred alongside an increase in the demand for nurses due to the aging population and increased complexity of ambulatory care and inpatient services.

Economists understand that the effect of high demand and scarcity of resources often results in a redistribution to the parts of the economy willing to pay the most. In effect, the national nursing shortage and the high demand for professional nurses could easily result in a "bidding war" among healthcare entities. For years, physician-owned practices were able to recruit and retain nurses with promises of a better working environment and regular scheduled hours. Unfortunately, **if the pay differential continues to diverge, the "deep pockets" of hospital systems may well overcome the attraction of working in a private practice.**

PHYSICIAN-OWNED PRACTICES ARE SEVERELY CONSTRAINED IN THEIR ABILITY TO MATCH THE COMPENSATION LEVELS OFFERED BY HEALTH SYSTEMS. AS INCREASED SALARY LEVELS RAISE OPERATING COSTS, A PRIVATE PHYSICIAN PRACTICE EITHER HAS TO INCREASE PRODUCTION OR REDUCE THE COMPENSATION OF ITS OWNING PHYSICIANS. IN PAST YEARS, NEW TECHNOLOGY ENABLED PRODUCTIVITY INCREASES THAT KEPT PACE WITH INCREASED OPERATING COSTS, BUT MEDICAL GROUPS COULD BE IN A SITUATION OF DIMINISHING INCREASES IN PRODUCTIVITY.

Physician-owned practices are severely constrained in their ability to match the compensation levels offered by health systems. Essentially, as increased salary levels raise operating costs, a private physician practice either has to increase production or reduce the compensation of its owning physicians. In past years, new technology enabled productivity increases that kept pace with increased operating costs, but medical groups could be in a situation of diminishing increases in productivity.

Physician-owned practices are experiencing many problems, but most executives are not prepared for having to substantially increase staff compensation — but they may have to if they want to survive. In a bidding war, there will be only one winner — the one with the most money to spend.

NOTE:

1. Gans D. "COVID-19 recovery: The long road back to normal." MGMA Connection. October 2022. Available from: mgma.com/dm-oct22.

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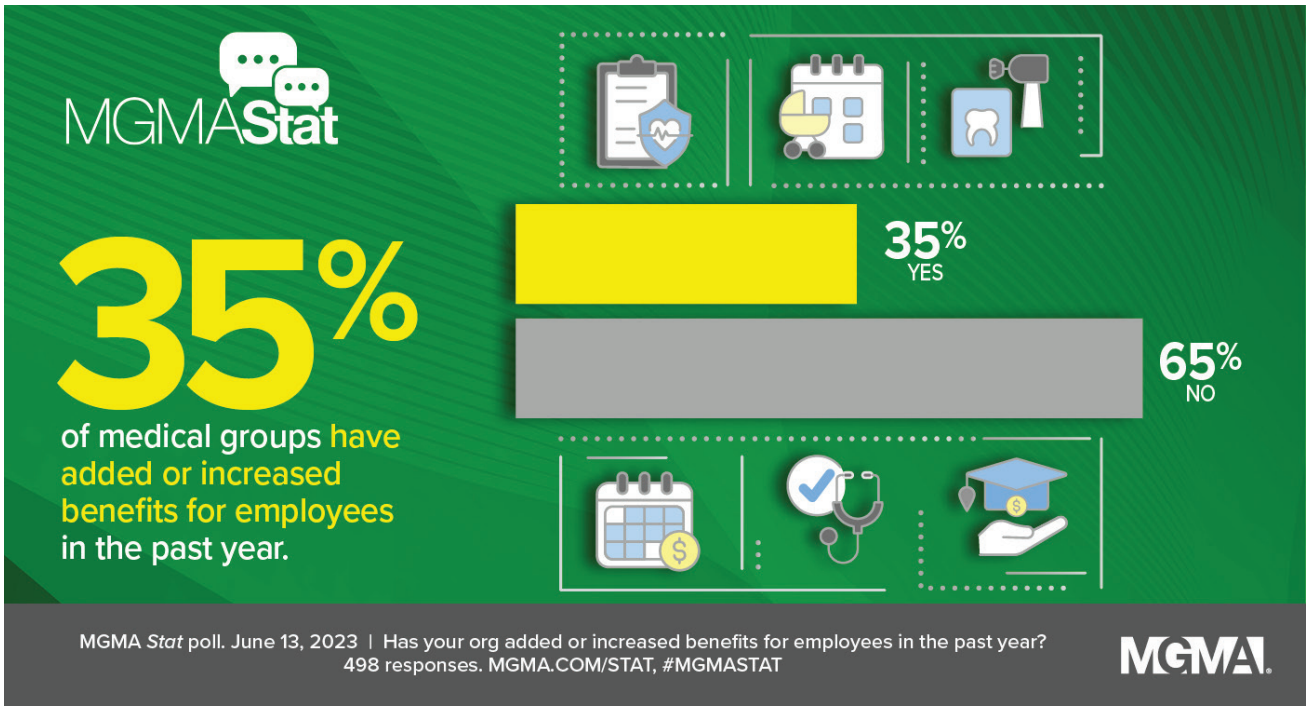
PACE OF EMPLOYEE BENEFIT ADDITIONS COOLS IN 2023

While competition for certain roles in medical group practices remains intense, fewer healthcare leaders say they are expanding or adding to their employee benefits as a tool to recruit and retain those workers.



A June 13, 2023, MGMA *Stat* poll found that **35% of medical groups added or increased benefits for employees in the past year**, while 65% reported "no." The poll had 498 applicable responses.

The poll results mark a 10-percentage-point shift from a similar MGMA *Stat* poll from May 31, 2022, which found nearly half (45%) of medical groups had made improvements or additions to the slate of benefits offered to employees. However, the latest poll shows the share of group practices working to boost their benefit offerings is still above levels noted in a June 8, 2021, poll that found only about one in four (26%) of groups were adding or expanding employee benefits.

Healthcare leaders are still on guard for potential turnover and losing out on talented candidates, as better wages and benefits were the top reason given for employee exits in a February 2, 2022, poll, well ahead of factors such as burnout, retirement or leaving the workforce. While sectors such as technology have seen sizable layoffs in the past year, demand for labor in ambulatory care remains high alongside the demands for care as practice leaders address lingering issues from the COVID-19 pandemic and The Great Resignation:

- Staffing was rated the biggest challenge for medical group leaders for a second year in a row last year.
- Improving patient access and scheduling — often in response to wait times getting worse due to lack of staffing — was rated the top patient experience priority for medical groups in a Dec. 13, 2022, MGMA *Stat* poll.
- Wage increases and various types of bonuses were frequently mentioned among healthcare leaders in MGMA's recent polling on MA recruitment and retention strategies (detailed earlier in this report).

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THE TOP CHANGES IN EMPLOYEE BENEFITS IN 2023

A larger majority of group practices reported not making updates or additions this year compared to 2022, and many of those leaders told MGMA that their efforts in this area have been put on hold after either greatly expanding benefits in the past two years or being in a financial situation in which hiring is frozen or headcounts are falling, and expanded offerings are not sustainable.

However, leaders at group practices that did not expand or add offerings told MGMA that they are considering making changes to:

- Employer contributions to 401(k) match
- Paid sick leave, wellness and mental health days
- Employee assistance programs (EAP)
- The tenure-based bands/tiers at which employees earn more paid time off
- Shifts of siloed time off buckets into a single bank usable for any purpose
- More health savings account (HAS) offerings
- Short- and long-term disability insurance plans
- New pet insurance and legal aid offerings.

As group practices continue to face challenges in recruitment and hiring for high-demand candidates, **several respondents to this poll noted that their benefit offerings expanded into areas around professional development for their workers, such as access to certifications, training or improved tuition reimbursement**. This focus reflects MGMA's polling on MA recruitment and retention strategies, which noted many healthcare leaders finding success by creating career ladder programs and other routes for clinical staff to grow with the organization.

FAMILY LEAVE AND REPRODUCTIVE HEALTH

One of the most common responses from healthcare leaders who added or expanded benefits this year were focused on maternity and paternity leave, especially as more states mandate or plan to implement paid family leave in 2024. Employers in states that enact paid family leave should pay close attention, as maternity and paternity leave often are implemented to offer fathers the same benefit as mothers.

According to the brokerage Newfront, **reproductive care and family planning benefits — including coverage for abortion-related medical expenses and infertility care — have been on the rise** as health reimbursement arrangements (HRAs) respond to the 2022 Supreme Court decision to overturn *Roe v. Wade*.

EVERYBODY LIKES TO SAVE

While the pace of inflationary growth has cooled significantly since the summer of 2022, most consumers are still paying much higher prices for everyday goods than they did in 2020, and many employers have responded by creating or using an **employee discount program** that offers perks on grocery items, recreational passes and more.

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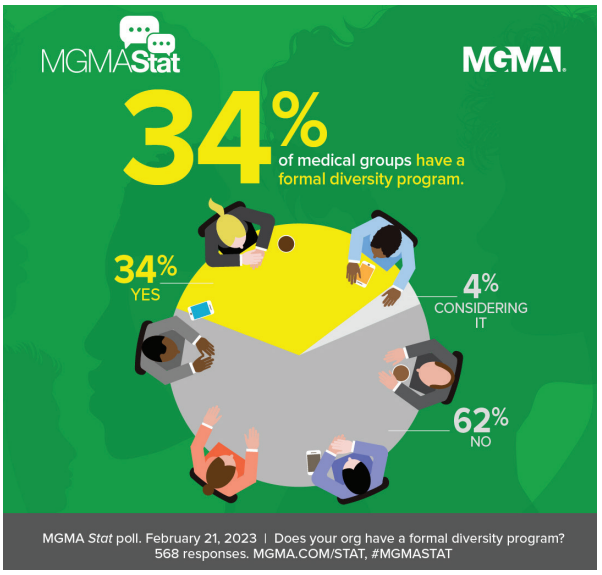
HEALTHCARE'S LABOR PAINS AND A STALLED DRIVE FOR DEI

Through new technologies and the natural trends in how people move, **we are increasingly connected to others and exposed to cultures, ideas and experiences that we may not be familiar with, requiring the capacity to approach this information with openness and curiosity rather than fear and antagonism**.

One of the popular approaches to building this emotional intelligence and awareness has been via diversity programs, which saw renewed focus since 2020 amid nationwide calls for social justice and a reckoning around cultural inequities.



Two and a half years after major protests in most major American cities and the emergence of a staffing shortage across several roles within healthcare provider organizations, the focus on diversity appears virtually unchanged: **A Feb. 21, 2023, MGMA *Stat* poll found that 34% of medical groups report having a formal diversity program**, compared to 62% that do not and 4% that are considering one.

These results show only a slight shift from a similar MGMA *Stat* poll from July 2021 that found 32% of medical practices had a formal diversity program at the time, with nearly two-thirds (64%) without and only 4% considering adding one.

The rationale for considering the implementation of a diversity program seems straightforward for many poll respondents: Some view it as a staff development initiative, while others see it as helpful "to serve our whole community," as one practice leader told MGMA. But those in the planning stages cited **two main reasons why they had not yet put a program in place: uncertainty on how to proceed, and staffing shortages and other high-priority challenges pushing the work off into the future.**

Among practice leaders with a formal diversity program, the sophistication of their efforts varied:

- A majority (53%) do not have specific metrics or goals tied to their programs.
- Another 4% were unsure.
- Just more than 4 in 10 (43%) of respondents said their organizations either had metrics or goals tied to diversity programs, or they were in the process of developing them.

Some of the most common efforts to measure success in healthcare provider organization diversity programs from the respondents were:

- Ensuring bilingual staff to serve communities in which a significant number of patients do not use English as their first language.
- Completion of DEI educational offerings/credit hours for a given quarter or period.
- Representation metrics among faculty and leadership positions in an academic medical center.
- Patient access and health equity improvement goals.

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THE ROLE OF DEI AMID AN EVOLVING LABOR MARKET

While several health systems are shedding payroll amid rising costs, the broader economy is witnessing rapid growth of several people-centric roles in the C-suite, according to LinkedIn News' Workforce Report: Chief diversity and inclusion officer (up 168.9%) and chief people officer (up 144.3%) are two of the three top C-suite positions for hiring grown from 2019 to 2022.

However, the most recent year showed that the percentage growth in hires largely favored the more generic "chief people officer" (32.9% growth from 2021 to 2022) versus "chief diversity and inclusion officer," which saw a 4.5% decline in hiring growth in the same period.

But healthcare providers typically struggle with turnover and intense competition for non-executive roles on the clinical team and at the front desk, as well as in revenue cycle management. Recent *Women in the Workplace* studies by McKiney underscore the issue across healthcare and other industries: Women are underrepresented at every job level, and senior management-level underrepresentation is not explained by a higher rate of women leaving the workforce than men.

Another report from the University of St. Augustine for Health Sciences combined data from the U.S. Census Bureau, Data USA, and the Association of American Medical Colleges to reveal (among other findings):

- Even though most nurse practitioners (NPs), physical therapists and occupational therapists are female, only 25% are non-white.
- Only 5% of physicians identify as Black or African American despite 13% of the population is Black.
- Only 6% of physicians identify as Hispanic whereas this group makes up 19% of the population.

This is where a diversity program can be a positive influence on efforts to attract and hire candidates from candidate pools that your existing efforts might miss.

Consider: A Press Ganey survey of more than 400,00 healthcare works from 2021 found that **valuing employees from different backgrounds was the No. 1 driver of engagement among nursing personnel, and that other DEI-related traits — such as demonstrating a commitment to workforce diversity, treating employees with respect, and valuing individuals with different backgrounds — also ranked highly in terms of influencing engagement.**

HOW TO APPROACH DEI WORK IN HEALTHCARE

A 2021 study by Deloitte on the state of DEI initiatives in healthcare found several encouraging signs from existing efforts, including leadership's respect of individual differences and willingness to fund DEI initiatives and connect them to the organization's strategic direction.

However, the results pointed to perceptions among DEI leaders that there are still differences in how some employees feel they are treated differently/unfairly — especially in terms of the recognition of their work's impact — based on traits such as gender, race and/or ethnicity. About three in four respondents in the Deloitte study also felt that accountability and meaningful measurement for DEI efforts were "lacking."

Four strategies for operationalizing DEI work and ensuring its sustainability emerged from the research:

- Making it an enterprise effort with the full C-suite involved
- Cultivating employee resource groups through executive sponsorship
- Making a serious effort around DEI goals in talent evaluation and leadership pipelines
- Measuring and leading with data about DEI goals.

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