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2026 MGMA APP, Staffing and Access

Data Report

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Executive Summary

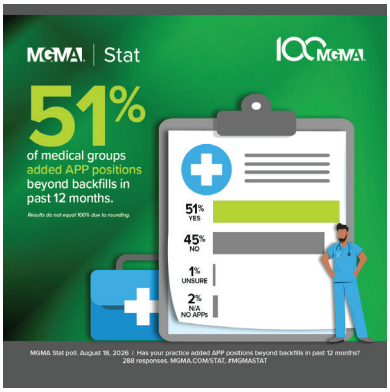
MEASURING WHAT CHANGES WHEN YOUR CARE TEAM GETS BIGGER

Advanced practice provider (APP) deployment, support staffing and new access benchmarks show why headcount alone cannot tell you whether added capacity is working.

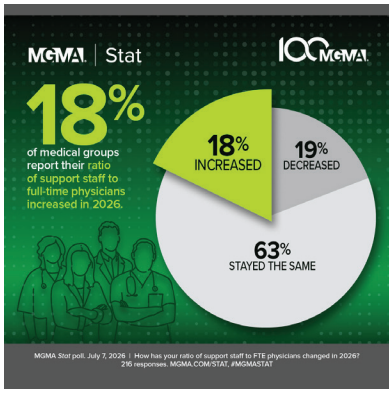
At the monthly close, three practice leaders can all point to the same line: operating cost is higher. What happened on the revenue side — and how much cash actually arrived — is where their stories separate.

A practice leader can approve another APP hire, hold a staffing ratio steady and still not know whether patients got in sooner or whether the full care team became more productive. Those are different operating questions, but they belong in the same review: what did the staffing decision change? Our **initial Financials and Operations data report** shows what the practice spent and what was left over financially; this report asks what the staffing decision changed.

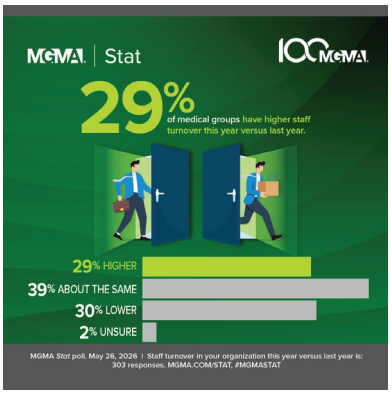
Current pulse: MGMA Stat on staffing and access



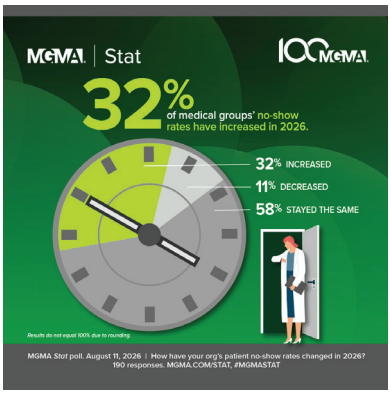
51%
added net-new APP positions beyond backfills in the past 12 months



63%
said support staff per physician was unchanged in 2026



69%
reported staff turnover was the same or lower in 2026 vs. 2025



32%
reported higher patient no-show rates in 2026

WHAT THE BENCHMARKS SAY

- **APP deployment is concentrated at the poles.** About 37% of single-specialty practices reported no physician/APP mix, while 51% reported 0.41 or more APPs per physician. But recent MGMA Stat polling shows this is still moving: 51% of groups said they added net-new APP roles, not just backfills, in the prior 12 months.[1]
- **A larger APP team can make physician-level revenue look much stronger without producing the same gain for the full provider team.** In the highest APP-ratio cohort, revenue per physician was 47% higher than in no-mix practices, but operating spread was only 6% higher and the amount remaining after APP compensation was lower. Just as the companion report notes, revenue growth alone is an incomplete scorecard.
- **More staff does not automatically solve workload or access.** Support staffing rose over five years, yet one in four leaders with flat or rising staffing ratios still described staffing as inadequate or marginally adequate. New access benchmarks now give groups a way to test whether staffing choices actually shortened waits, protected same-day capacity or reduced missed visits.[2]

KEY TAKEAWAY

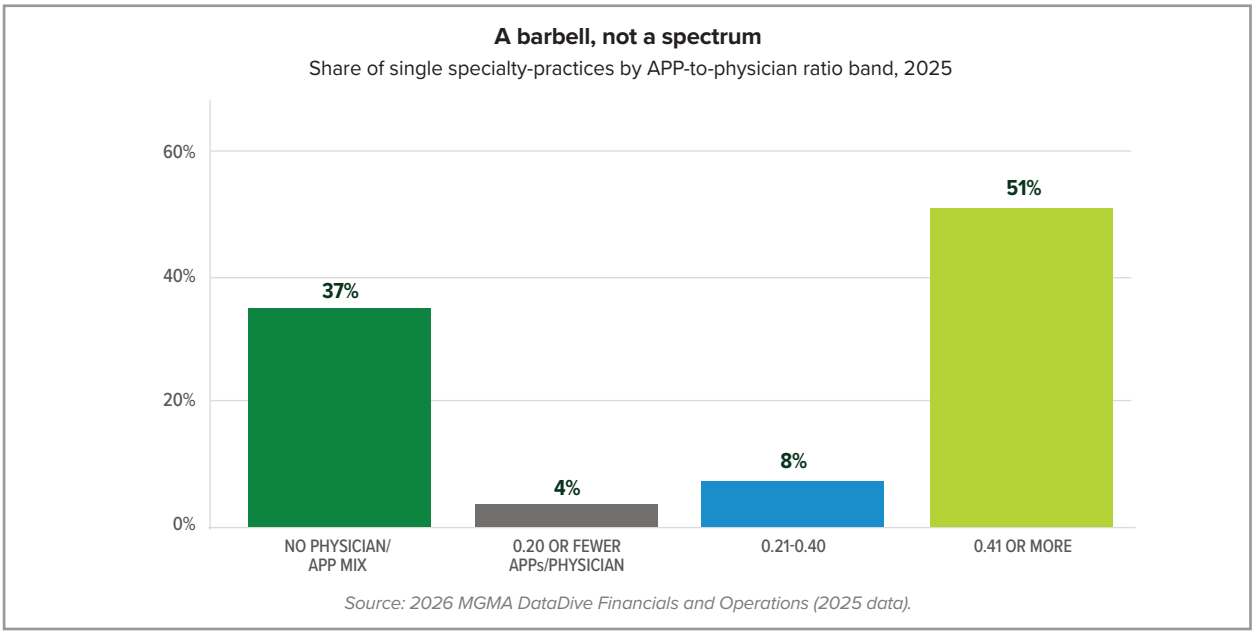
Every staffing decision should have a visible target. If the goal is access, measure access. If the goal is physician capacity, measure output across the whole provider team. If the goal is workflow relief, measure the queue or delay the new role is supposed to reduce.

How to read these benchmarks

- Figures are 2025 medians from the 2026 MGMA DataDive Financials and Operations dataset, representing nearly 4,000 medical groups and practices.
- APP-ratio comparisons describe associations across different organizations, not before-and-after results from changing models.
- Physician-owned groups generally report whole organizations, while hospital- and system-owned respondents often report individual sites. Ownership is context here; the companion Financials and Operations data report treats ownership economics in greater depth.
- Access and turnover measures are current-year baselines. MGMA Stat findings provide a 2026 pulse and are not blended with the DataDive benchmark dataset.

1. APP DEPLOYMENT IS EXPANDING BUT STILL POLARIZED.

APPs per FTE physician is the number of nurse practitioner (NP) and physician assistant (PA) FTEs relative to physician FTEs. It describes the care-team model; it is not a quality score and no ratio is automatically optimal. In 2025, the single-specialty aggregate shows that practices were concentrated at the ends in terms of APP utilization.



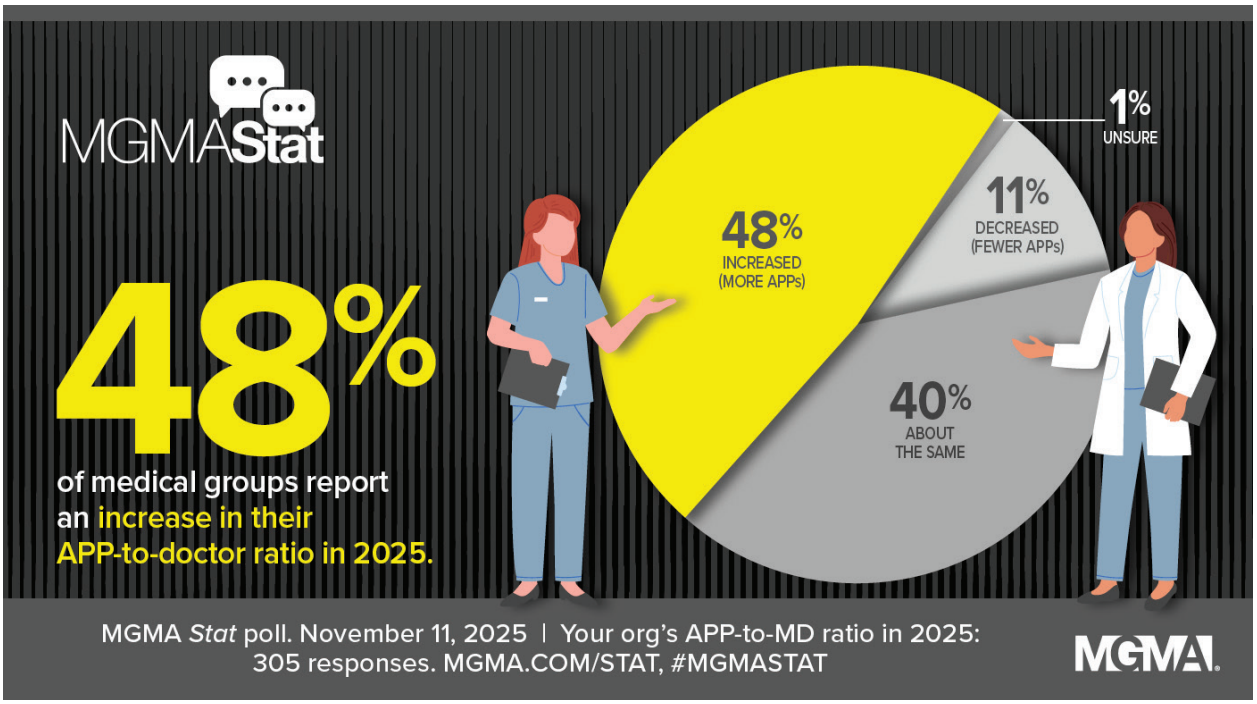
APPs per FTE physician, 2025	25th Percentile	Median	75th Percentile
Primary care	0.44	0.80	1.39
Single specialty	0.49	0.87	1.34
Surgical	0.53	0.99	1.49
Multispecialty	0.36	0.71	1.07

Among practices reporting APPs. Source: 2026 MGMA DataDive Financials and Operations (2025 data).

The current staffing pulse makes the distribution more than a snapshot. In August 2026, 51% of MGMA Stat respondents said their organization had added APP positions beyond backfills during the prior 12 months. A net-new position is different from replacing someone who left: leadership approved another salary and benefits line, found room on the schedule and in the clinic, arranged physician oversight where required and decided the added capacity justified the cost.[1]

Growth was the most common reason. Leaders cited service-line expansion, higher patient volume, new locations, extended hours, referrals and access. A second group was using APPs to replace hard-to-recruit or departed physician capacity. Practices that did not add positions most often cited adequate current capacity or financial and productivity constraints.[1]

A November 2025 MGMA Stat poll asked a different question and found 48% of groups had shifted their APP-to-physician ratio toward APPs. That earlier poll should not be trended directly against the 2026 net-new-role result, but both point to sustained demand for APP capacity rather than a one-time staffing adjustment.[3]



That expansion is happening while APP compensation and output are moving, too. The 2026 *Provider Compensation and Productivity* report found one-year APP compensation growth above the 2.7% rise in consumer prices in every grouping except primary care PAs. In primary care, NP and PA work RVUs each rose about 9% in 2025 even as physician encounters fell across all 23 core specialties. That does not definitively prove work shifted one-for-one to APPs, but it reinforces the need to track output by provider type instead of treating the ratio itself as the result.[4]

The companion Financials and Operations report includes the cost guardrail. Operating costs rose across every major grouping over the five-year window, and at the 25th percentile primary care, single-specialty and surgical groups were negative after operating and APP costs. Added APP capacity can still be the right investment; it simply needs a defined target in access, physician capacity or full-team economics.[5]

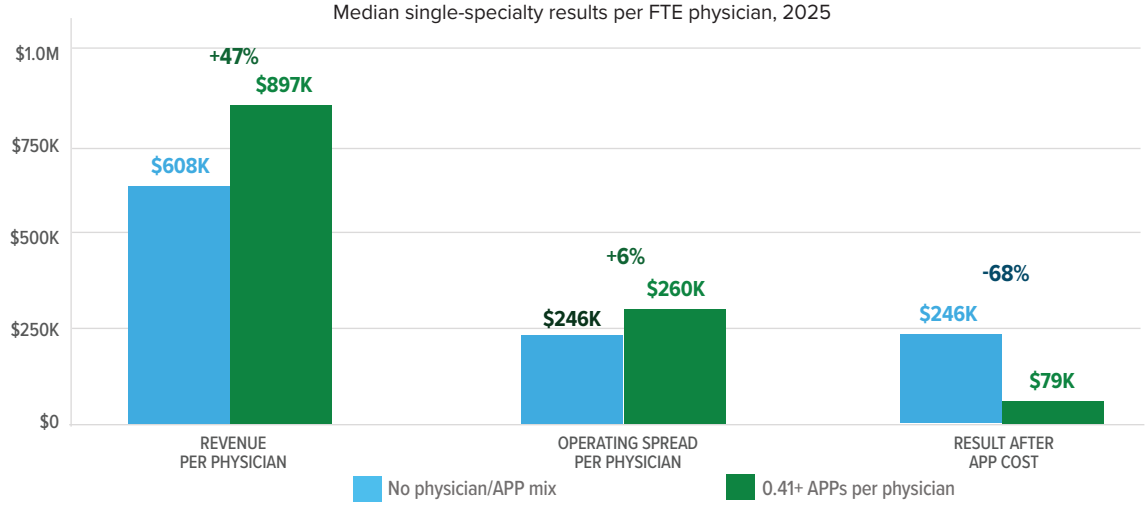
> **What this looks like in the practice**
>
> A net-new APP is not only a hire. It is compensation, onboarding, exam-room and schedule capacity, support staff, physician oversight and a result the practice expects to move. Define that result before the role is posted.

2. MORE APPS CAN MAKE PHYSICIAN-LEVEL ECONOMICS LOOK STRONGER THAN FULL-TEAM ECONOMICS

Operating spread is revenue remaining after operating expenses and before provider compensation. The figure after APP compensation goes one step further by subtracting APP pay; it is still before physician compensation and is not net income. These measures help show whether a larger care team is creating financial room, not just more revenue around each physician.

Higher APP ratios: More revenue per physician, less after APP compensation

Median single-specialty results per FTE physician, 2025



Source: 2026 MGMA DataDive Financials and Operations (2025 data). No-mix practices carry no APP cost; their spread is their full-team result.

In the single-specialty aggregate, practices with higher APP utilization (0.41-or-more per FTE physician) reported 47% more revenue per physician than practices with no physician/APP mix — $896,721 versus $608,117. The difference in operating spread was much smaller: $259,594 versus $245,881, or about 6%. After APP compensation, the higher-ratio cohort had $78,973 remaining per physician. These are associations across different practices, not before-and-after results from changing models.

BRING BOTH DENOMINATORS TO THE BUDGET MEETING

Revenue per physician shows how much revenue sits around each physician. Revenue per provider divides production across the full physician-and-APP team. A practice can improve the first number while weakening the second.

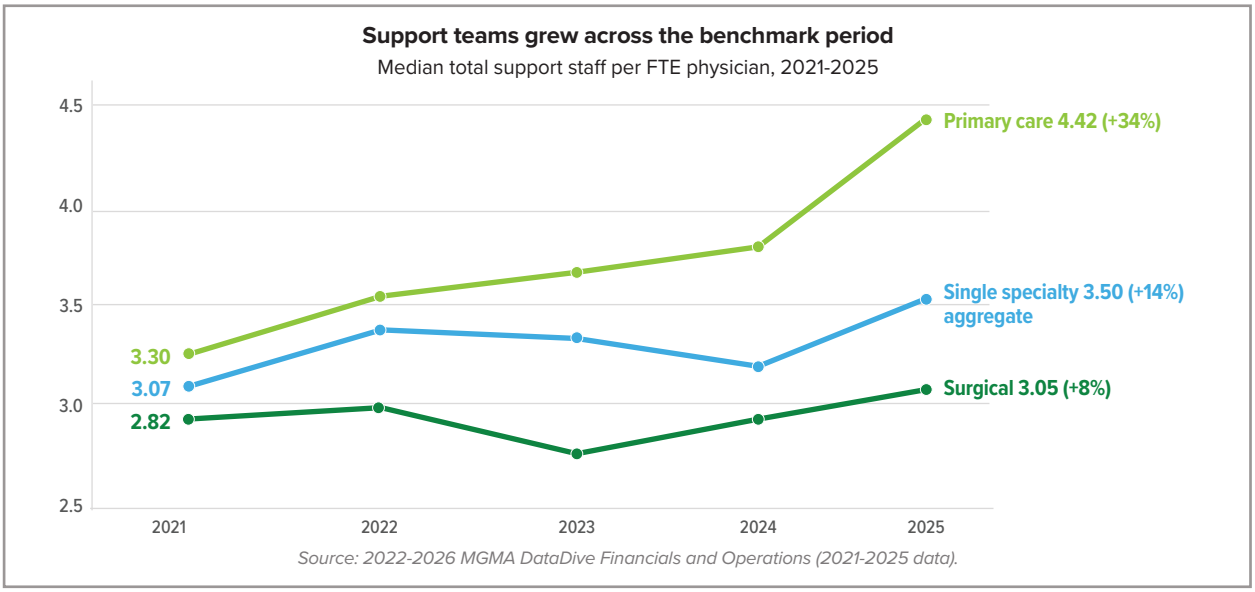
Revenue per provider	Lowest mixed-team APP-ratio band	Highest APP-ratio band
Primary care	$555,333	$489,016
Single specialty	$512,465	$432,788

The same management question is showing up in compensation. In May 2026, 43% of MGMA value or incentives in the prior two years. Most changes still leaned heavily on productivity, with some practices adding quality, access, call or team measures.[6]

For a new APP role, the pro forma should also price the work around the hire. Current MGMA Provider Compensation data show APP compensation continued to rise in 2025, while physicians with supervisory duties reported higher compensation than peers without them. The benchmark does not isolate APP oversight, but it is a reminder not to treat physician onboarding and supervision time as free.[4]

3. SUPPORT TEAMS GREW, BUT STAFFING RATIOS ARE NOT WORKLOAD

Support staff per FTE physician counts the nonprovider workforce surrounding each physician. It is useful for comparing staffing intensity, but it does not tell you how many calls, authorizations, portal messages, rooming tasks or rework items each employee is carrying.



Source: 2022-2026 MGMA DataDive Financials and Operations (2021-2025 data).

Support staff per FTE physician, by role, 2025	Clinical	Front Office	Business Ops	Ancillary	Total
Primary care	2.22	2.06	0.54	0.51	4.42
Single specialty	2.00	1.88	0.53	0.60	3.50
Surgical	1.43	2.11	0.54	0.70	3.05

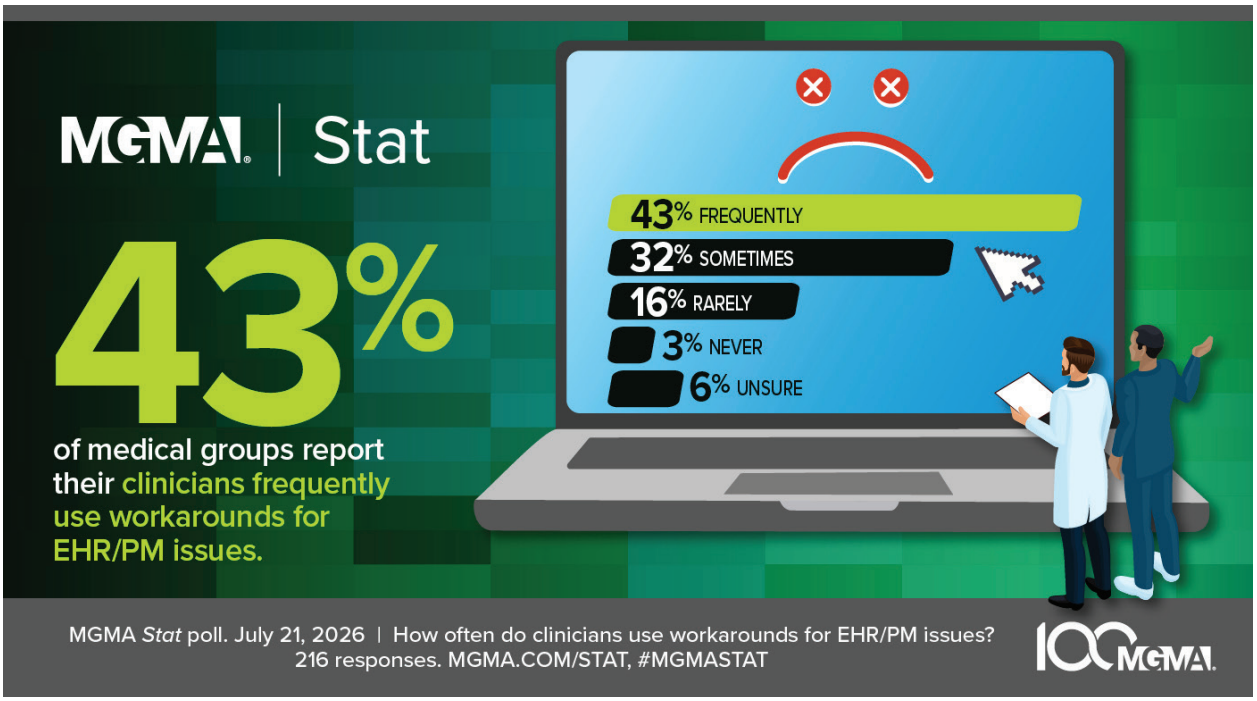
Source: 2026 MGMA DataDive Financials and Operations (2025 data).

Primary care reported the most clinical support per physician. Surgical practices reported the most front-office staff, across work that commonly includes scheduling, authorizations and payer follow-up. Nonsurgical practices were the exception to the broader growth pattern: total support staffing remained below its 2021 level.

The **companion Financials and Operations data report** puts a price on that growth: support-staff cost reached $300,700 per physician in primary care, $227,700 in single-specialty practices and $200,800 in surgical practices, consuming roughly 30% to 34% of revenue at the median. The question is whether those dollars bought capacity or simply absorbed more work.[5]

The 2026 pulse shows why a flat ratio can still feel tight. In July, 63% of groups said their support staff-to-physician ratio was unchanged, while 18% increased and 19% decreased it. Among leaders whose ratio rose or held steady, roughly one in four still said staffing was inadequate or only marginally adequate.[3]

Newer MGMA Stat polling shows how that workload can hide inside a stable ratio. In July, 75% of medical groups said clinicians frequently or sometimes used workarounds for EHR or practice management system problems, often creating duplicate entry, manual tracking and extra work for medical assistants. In September, only 7% said prior-authorization turnaround was faster than in 2025, while 44% said it was slower; status checks, peer-to-peer reviews and documentation demands were common bottlenecks.[7, 8]



WHEN THE RATIO FEELS WRONG, CHECK THE WORK

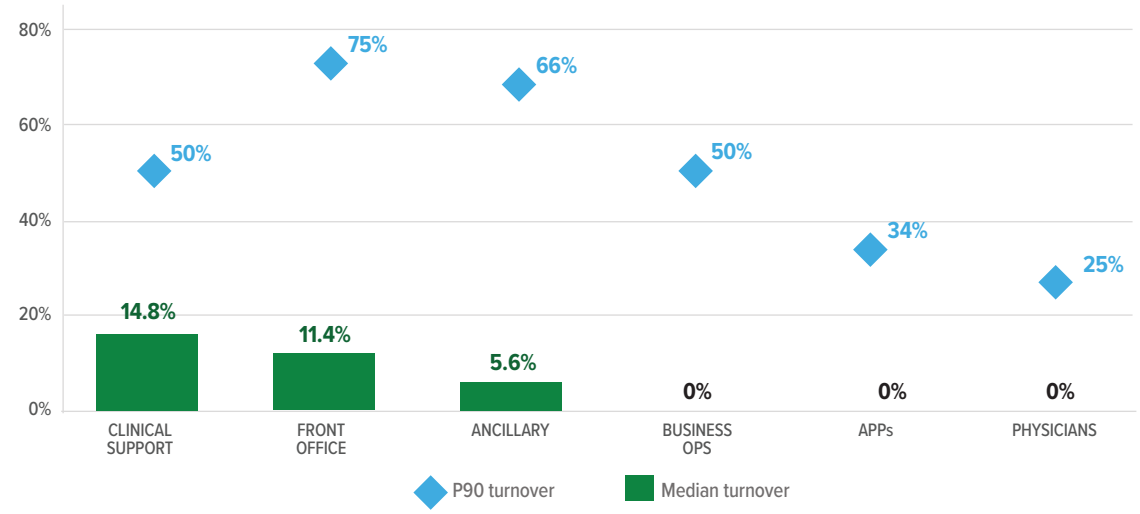
Look at the queue behind the headcount: prior authorizations waiting, phone and portal volume, rooming delays, referral backlogs, claim work and overtime. A stable ratio can still mean more work per person.

4. TURNOVER IS CALMER OVERALL — YET STILL DISRUPTIVE IN ROLES THAT KEEP CLINICS RUNNING

Turnover measures who left during the year. A zero median means at least half of reporting practices had no departures in that role; it does not mean turnover is absent across the market. The upper percentiles show the smaller group of practices experiencing much heavier churn.

Turnover concentrates in the roles that keep clinics running

Single-specialty turnover by role, 2025, median (bar) and 90th percentile (marker)

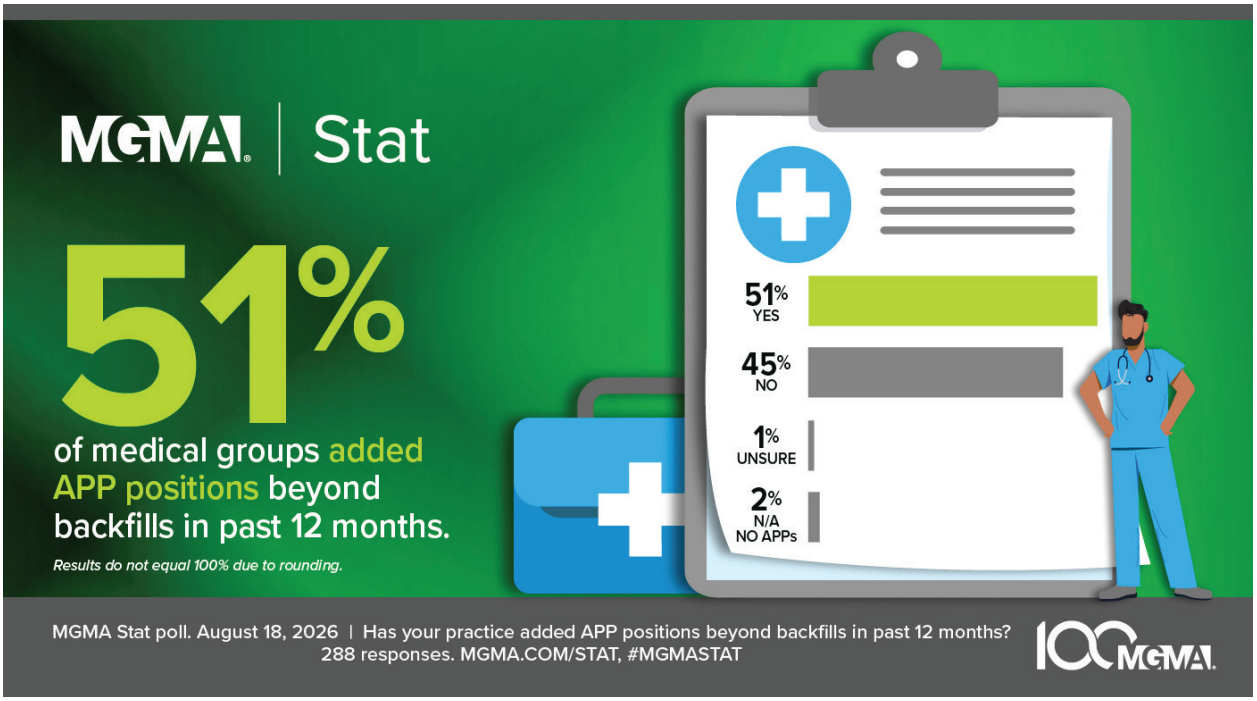


Source: 2026 MGMA DataDive Financials and Operations (2025 data). Zero medians reflect most practices reporting no provider departures.

Clinical support and front-office roles show the most consistent turnover at the median, while the 90th percentile reached 50% for clinical support, 75% for front office and 66% for ancillary staff. Provider turnover was zero at the median but reached 25% for physicians and 34% for APPs at the 90th percentile. In a small practice, one departure can change the next morning's rooming flow, phone coverage or schedule even when the percentage looks modest.

The May 2026 MGMA Stat poll points to a calmer but not solved labor market: 69% of leaders said staff turnover was the same or lower than a year earlier, while 28% said it was higher. Practices still experiencing churn most often named medical assistants, nursing and other clinical support, and front-desk or administrative roles — the same parts of the workforce that move most in the benchmark distribution.[9]

Turnover and recruiting should be read separately. In a May 19 MGMA Stat poll, 56% of practices said medical assistant hiring had become more difficult over the prior year, 37% said it was about the same and only 7% said it was easier. A calmer turnover rate can therefore coexist with persistent vacancy risk: fewer departures do not make a hard-to-fill role easier to replace.[10]



Do not treat these as the same measure	What it answers	Management check
Turnover	Who left?	Which roles are churning?
Vacancy	What is still unfilled?	How long do roles stay open?
Workload pressure	What are the remaining staff carrying?	Are overtime, queues or delays rising?

READ THE ZERO CORRECTLY

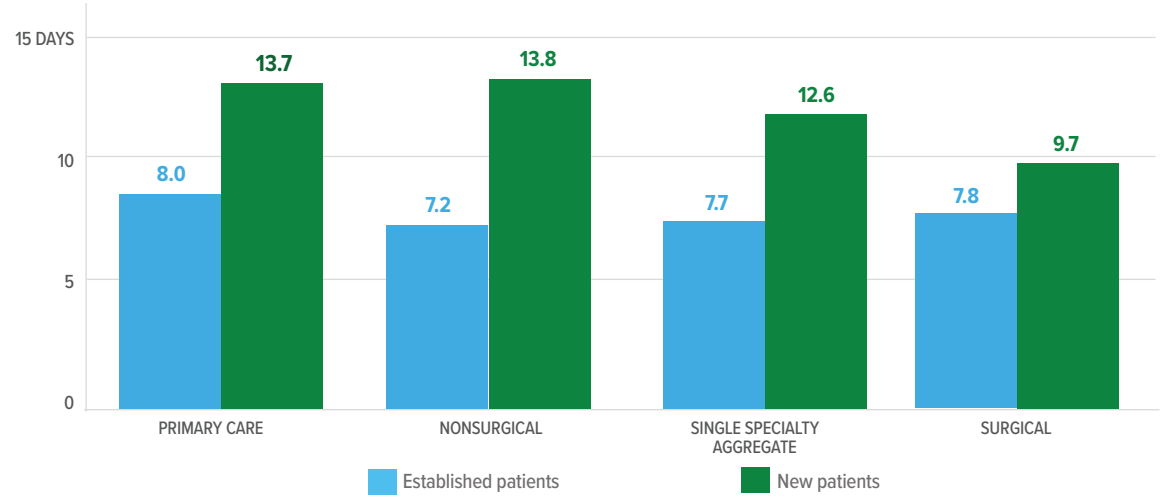
A zero median for physician or APP turnover means at least half of practices reported no departures in that role. It does not mean provider retention requires no attention; the upper tail can still be operationally significant.

5. AN ACCESS BASELINE TO TEST THE STAFFING PLAN

Third-next-available appointment (TNAA) is the number of days until the third open appointment on a provider schedule. Using the third opening makes the measure less sensitive to one lucky cancellation. It gives practices a repeatable way to test whether staffing and schedule changes are improving access.

The access baseline: about a week for established patients, roughly two for new

Median third next available appointment (days), 2025



Source: 2026 MGMA DataDive Financials and Operations (2025 data).

2025 access benchmarks (median)	No-show rate	Same-day share	TNAA established	TNAA new
Primary care	6.0%	11.0%	8.0 days	13.7 days
Nonsurgical	7.0%	3.0%	7.2 days	13.8 days
Single specialty	6.0%	6.0%	7.7 days	12.6 days
Surgical	5.0%	3.0%	7.8 days	9.7 days

Source: 2026 MGMA DataDive Financials and Operations (2025 data).

The first baseline is straightforward: established patients waited about a week at the median, while new patients waited roughly two weeks. No-show rates ranged from 5% to 7%, and same-day appointments were much more common in primary care than in nonsurgical or surgical practices. These benchmarks do not prove that practices with more APPs had shorter waits; they give leaders a reference point for testing that question locally.

The July 2026 MGMA Stat poll shows why the baseline matters: 46% of groups said new-patient waits were unchanged, 28% said they were longer and 22% said they were shorter. Practices in all three groups described adding providers, APPs, hours or schedule changes. For some, a flat wait time may represent running hard enough to keep up with demand rather than doing nothing.[11]

No-shows are a different constraint. In August, 32% of groups reported higher no-show rates, 58% were about the same and 10% were lower. Practices with worsening attendance often used the same reminder tools as those that improved; leaders also cited patient costs, transportation and work conflicts. Creating an appointment slot does not guarantee the visit will be completed.[12]

SUPPLY AND CONVERSION ARE DIFFERENT ACCESS PROBLEMS

Supply asks whether the patient can get an appointment. Conversion asks whether the scheduled patient completes it. Track TNAA, no-shows and same-day availability together before deciding whether the next fix is another provider, a template change or a patient-facing workflow change.

FIVE QUESTIONS FOR YOUR NEXT WORKFORCE REVIEW

Measure	What it tells you	Question for the next review
APPs per physician + revenue per provider	Which staffing model you use and whether full-team economics are holding	Is revenue per provider keeping pace as the team grows?
Remaining after APP compensation	What remains before physician compensation	Does the compensation plan fit the revenue and workload the team is reporting?
Support staff per physician + workload	Whether staffing matches the work, not just physician count	Where is the gap: rooming, calls, authorizations, referrals or billing?
Turnover + vacancy + workload pressure	Whether the team is stable enough to carry the work	Which two roles would disrupt operations most if someone left tomorrow?
TNAA + no-show + same-day share	Whether added capacity becomes usable appointments	Is the main constraint provider supply, schedule design or patients' ability to complete visits?

Bigger teams are not automatically better or worse. They change how the practice uses people and money, add cost and need to produce a visible result. A useful workforce review connects APP ratio, revenue per provider, the amount remaining after APP compensation, role-level staffing and turnover, and access measures. The management question is not simply how many people the practice employs. It is what changed in capacity, finances, and patient access.

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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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