Your practice has a staff pay structure, whether you built it intentionally or not

How grades, ranges and market data work in a practice, and what changes with size, ownership and state

By MGMA HR Insights

A 12-provider multispecialty group hires a medical assistant in March at $23.50 an hour, because that is what it took to fill the role after 11 weeks of trying. In June, an MA with six years at the practice — who trains new hires, floats between two specialties and holds a certification the newer employee does not — finds out she's making less than the new hire.

She does not resign immediately. She stops volunteering for the float rotation, declines the next training assignment, and starts answering recruiter messages. The practice loses her in November and spends four months replacing her.

Nobody made a bad decision in isolation. The March offer was a reasonable response to a real staffing problem. The failure was structural: there was nothing in place that would have shown, in March, what hiring at $23.50 would do to everyone already in that role.

Every practice has a pay structure; the question is whether it was designed or accumulated.

HOW STRUCTURES GET BUILT

If you do not set a pay structure, individual decisions will set one for you: a negotiated hire, a counteroffer, a retention adjustment or a raise for the employee who asked. Soon you have pay patterns nobody planned and managers cannot explain.

The symptoms are consistent across practice types. Recent hires catch or pass tenured staff in the same role. Two people doing comparable work start at rates that differ for no reason anyone can reconstruct. A retention adjustment becomes an unintended precedent. And once pay information moves — through a posted range, a candid conversation, or a state disclosure requirement — employees begin asking questions the practice has no framework for answering.

A compensation structure does not prevent hard decisions. It makes them consistent, explainable and defensible, which turns out to matter more.

THREE DECISIONS COME FIRST

Before any grade or range exists, leadership has to settle three things. They are strategic decisions with budget consequences, not administrative ones.

1 **Where do we intend to sit against the market?** Most practices start near the market median. Then decide which jobs you will pay above or below it. You may need to leader the market for hard-to-fill roles and pay less aggressively where candidates are plentiful. Make those choices deliberately and budget for them.

2 **How much pay variation will we accept?** If internal consistency matters most, compare roles carefully and check how each exception affects others. If recruiting pressure matters more, allow wider variation — but track it and be ready to explain it.

3 **How does pay move?** Merit tied to performance, general increases tied to budget, promotional increases tied to grade changes, and structural adjustments when the market itself moves. Each mechanism tells employees something about what the practice rewards.

TABLE 1. ELEMENTS OF MEDICAL PRACTICE STAFF PAY STRUCTURE

Element	What it does
Grade	Groups roles of comparable responsibility, skill and market value
Range	The floor-to-ceiling band for that grade, usually 15–25% either side of the midpoint
Midpoint	Where a fully competent, experienced employee sits; the point market data anchors to
Overlap	Adjacent grades share territory on purpose
Progression	New hires low in range, competent performers near midpoint, sustained top performers above

Practices that use them interchangeably teach employees that the distinctions are decorative.

Write it down. Two pages is enough. Revisit every three to five years, or sooner if the labor market makes the current approach unworkable — which it did for most ambulatory practices between 2021 and 2024.

GRADES, RANGES AND MIDPOINTS

The structure translates philosophy into something you as a manager can use.

A small single-specialty practice usually needs six to eight grades. A large multispecialty group may need 10 to 14. More grades than the work supports creates distinctions employees can see through, and each one has to be defended.

Overlap between grades is a feature. Without it, every promotion has to clear the next grade's floor, which forces oversized increases and makes lateral moves — often the ones the practice most needs — look like demotions. With overlap, a highly experienced person in a lower grade can legitimately out-earn a newer person one grade up.

Ranges should be narrower at entry level and wider for professional and management grades, where experience and specialized skill legitimately spread further.

Check every midpoint against market data annually. Do not update only the roles that are hardest to fill. That creates an uneven structure, and employees usually notice the inconsistencies before leadership does.

WHAT CHANGES BY PRACTICE SETTING

This is where generic compensation advice stops being useful. The same principles apply across ambulatory settings; the constraints and the machinery differ substantially.

Small single-specialty practice (roughly under 15 staff). Formal grades are usually more apparatus than the practice needs, but the underlying logic still applies. Six broad bands, priced against survey data, reviewed once a year, is sufficient. The real risk here is that the administrator or physician owner carries the entire structure in their head — which works until they are out for a month, or leave. Write down the bands and the reasoning even when the structure is informal. Survey samples will often be thin at this size; widening the peer set by adjacent specialty or geography is usually better than pricing off a sample of four.

Midsize single-specialty (15–50). This is where informal structures typically break. Enough employees exist for comparisons to be made, tenure has spread out, and one-off adjustments have accumulated for several years. Practices at this size usually need a real structure, a documented starting-pay approach with approval thresholds, and a first pay-equity review. It is also the size at which compression becomes acute rather than theoretical.

Large multispecialty (50+). Multiple labor markets operate inside one organization. Clinical support, revenue cycle, IT, imaging and administration recruit against different competitors and move at different speeds. A single structure with differentiated market positioning by job family works better than either one blended approach or separate structures per department. Job evaluation becomes necessary rather than optional, because the number of adjacency arguments grows faster than headcount.

Multi-site and multi-state. If you operate in several markets, choose one approach: a national structure with location adjustments, or separate structures for each market. Do not switch between the two case by case. Apply wage, overtime, transparency and equal-pay rules where each employee

TABLE 2. HOW PAY STRUCTURE CHANGES BY PRACTICE SETTING

Practice setting	Best-fit approach	Main pressure point	Administrator priority
Small single-specialty (roughly under 15 staff)	About six broad pay bands; annual market review	Thin survey samples and too much knowledge held by one leader	Document the bands and reasoning; widen the market peer group when local samples are weak
Midsize single-specialty (15–50 staff)	Formal grades and ranges; starting-pay rules and approval thresholds	Compression and years of one-off adjustments	Conduct the first pay-equity review and place limits on hiring exceptions
Large multispecialty (50+ staff)	One structure with different market positions by job family	Clinical, revenue cycle, IT, imaging and administrative roles move in different labor markets	Use formal job evaluation and healthcare-specific market data
Multi-site or multi-state	One national structure with location differentials, or separate structures by market	Geographic pay differences and varying state and local laws	Choose one geographic model and apply the rules where each employee works
Health-system-owned or hospital-affiliated	Systemwide structure, with ambulatory roles mapped into existing grades	Hospital-oriented classifications may not fit clinic work	Build an evidence-based case for job matches, grade changes and market exceptions
MSO-backed or private-equity-owned	Centrally managed structure across the portfolio	Limited local discretion and inconsistent market conditions	Document exceptions and ensure local implementation complies with applicable law
FQHC or community health setting	Formal, audit-ready structure tied closely to budgeting	Grant-funded budgets slow responses to labor-market changes	Anticipate adjustments during the budget cycle and monitor compression
Academic-affiliated practice	University classification and pay-band system	Academic classifications may poorly describe ambulatory roles	Translate clinic responsibilities into the institution's classification language

works. For remote staff, that means the employee's location, not the practice's.

Health-system-owned or hospital-affiliated practices. The structure usually arrives from the system, built primarily around inpatient roles. Ambulatory positions frequently map poorly onto it — a clinic MA and a hospital MA do similar-sounding work under different conditions, volumes and supervision. The administrator's leverage here is usually job matching and market data rather than structure design: making the case that a particular ambulatory role should be graded differently requires evidence the system's compensation team will accept. MGMA data does work in that conversation that hospital survey data will not.

MSO-backed and private-equity-owned groups. Staff are often employed by the management company, with structure set centrally across a portfolio of practices in different markets. Practical consequence: local administrators have less discretion on structure and more responsibility for documenting exceptions. Where a portfolio structure is applied across states, the multi-state legal issues above become the MSO's problem to solve and the local practice's problem to comply with.

Federally qualified health centers and community health settings. Two differences matter. These organizations typically have more formal HR infrastructure than a comparably sized private practice, because federal funding brings reporting and audit expectations. And compensation decisions sit inside grant-funded budgets with less flexibility to respond to market movement mid-year. Structure work here tends to be more rigorous and slower-moving. The compression risk is higher, because market adjustments require budget processes that private practices can shortcut.

Academic-affiliated practices. University pay bands and classification systems often govern, with their own grade nomenclature and approval routes. The administrator's work is usually translation — mapping clinical roles into an academic classification scheme designed for a different workforce.

PRICING THE MARKET: CLINICAL AND ADMINISTRATIVE ROLES BEHAVE DIFFERENTLY

Use credible survey data, match the actual work — not the title — and adjust older figures to the current market using one documented method. A patient access coordinator may appear in a survey as a registration specialist or patient services representative. Compare duties, scope and required skills before using the number.

Age the data, and write down the assumption. Survey data always lag. Aging forward too aggressively inflates what the market actually pays; aging too conservatively leaves the practice behind without anyone noticing until recruiting stalls.

Use the labor market that actually applies to the job. MA, LPN and RN pay is usually local because practices compete with nearby clinics and hospitals. Coding, billing, and prior-authorization jobs can often be done remotely, so they may compete regionally or nationally. Local-only data can underprice those roles and lead to declined offers.

Anchor healthcare-specific roles in healthcare-specific data. MGMA's Management and Staff Compensation resources break out by practice type and size, by geography, and by specialty — cuts general surveys cannot produce.[1] For roles that are not healthcare-specific — accounting, IT, marketing — general surveys are usually the better match. Blending sources improves reliability when the job genuinely spans both.

Keep a record of where the numbers came from, how each role was matched, what aging factor you applied and what you concluded. Two years from now somebody will need to reproduce that reasoning, and it will not be you.

THE THINGS THAT SIT OUTSIDE THE RANGE

Base ranges do not carry the whole load in a medical practice. Several common differentials belong in the structure explicitly rather than as informal arrangements:

- **Certification premiums** — CMA, CPC, CCS and similar credentials, paid as a defined differential rather than as an individually negotiated bump
- **Bilingual differentials**, where language capability is genuinely used in patient care
- **Shift and weekend differentials** for extended-hours or urgent-care operations
- **Float and cross-coverage premiums** for staff who work across specialties or sites
- **On-call pay**, where the practice covers call
- **PRN and per diem rates**, typically higher hourly with no benefits eligibility

Each should have a written rule. Handled informally, they become the mechanism through which unexplainable pay differences enter an otherwise sound structure — and they are the first thing a pay equity analysis surfaces.

SETTING STARTING PAY

Anchor the offer to the range and the candidate's qualifications. Minimum qualifications and limited experience land near the floor. Substantial relevant experience lands nearer the midpoint. Above midpoint should be reserved for genuinely exceptional credentials and should require approval from someone other than the hiring manager.

Two anchors that should not drive the offer: what the candidate previously earned, and what the candidate asked for. Both import someone else's pay decisions into your structure, and both correlate with the disparities pay equity analysis is designed to find. Paying less because a candidate undersold themselves is precisely the pattern that shows up later as an unexplained gap.

Document each offer: applicable range, candidate qualifications, offer made, rationale for any deviation. That record is the raw material of every future equity review.

MOVING PAY: FIVE MECHANISMS, KEPT DISTINCT

1. **Merit** rewards performance during a defined cycle. Size should account for where the employee already sits — someone still well under the midpoint has room ahead of them that a colleague near the ceiling, rated identically, does not.
2. **General increases** apply broadly, usually in response to cost pressure or a budget decision. Fine to use; explain that it is what you are doing.
3. **Structural adjustment** moves the ranges themselves when market data show a grade has shifted. Employees below the new floor

TABLE 3. WHY IS PAY CHANGING? 5 MECHANISMS THAT SHOULD REMAIN DISTINCT

Mechanism	The question it answers	What changes	Typical timing
Merit increase	How did this employee perform?	Individual pay	During a defined performance cycle
General increase	What broad increase can the organization support?	Pay for most or all eligible employees	During annual budgeting or periods of cost pressure
Structural adjustment	Has the market value of this job changed?	The range or midpoint; sometimes employee pay	After the annual market review
Promotional increase	Has the employee moved into a higher-level job?	Grade and individual pay	When the promotion takes effect
Equity adjustment	Is there an unjustified pay difference to correct?	Individual pay, usually off-cycle	After a documented equity or compression review

need correction. This moves the structure, not individual pay.

4. **Promotional increases** accompany grade changes. Too small and the promotion rings hollow; too large and it distorts everything around it.
5. **Equity adjustments** correct identified problems off-cycle. They rest on documented analysis, and they should be structured so the correction does not seed the next inequity.

Practices that blur these — calling a market adjustment a merit increase, or handling a promotion as a discretionary raise — lose the ability to explain their own decisions.

COMPRESSION COSTS MORE THAN FIXING IT

Compression is what happened to the MA in the opening paragraph: newer or less experienced employees approaching or passing more experienced ones in comparable roles.

It arises from three sources, usually in combination. New-hire rates climb faster than what existing staff receive each year. Promotional increases are too small to create separation. And individual negotiations produce outliers that comparable employees eventually learn about.

Employees read compression as unfairness, and they respond by leaving, demanding correction, or staying and disengaging — the third being the most expensive and the hardest to see. Targeted equity adjustments almost always cost less than the turnover they prevent.

Review compression every year. Look for experienced employees paid nearly the same as newer peers, recent hires who have caught up, and corrections needed to restore reasonable separation. Fund major corrections separately instead of forcing them into the merit pool.

THE LEGAL LAYER

Overtime, and the trap inside incentive pay. Nonexempt employees earn overtime on their *regular rate*, not their base rate — and nondiscretionary bonuses must be folded into that calculation. A bonus announced in advance and tied to defined criteria is nondiscretionary whatever the practice calls it. The genuinely discretionary bonus, excludable from the regular rate, is narrowly defined.[2] A quarterly attendance or productivity bonus paid to nonexempt clinical staff, without a regular-rate recalculation, is one of the most common wage-and-hour errors in ambulatory practice. Exempt classification itself rests on three independent tests — salary basis, salary level, and duties — and failing any one makes the employee nonexempt.[3]

Equal pay. The federal Equal Pay Act prohibits sex-based pay differences for equal work in the same establishment, with defined affirmative defenses; Title VII reaches compensation discrimination more broadly.[4] Several states go further, extending the comparison to work that is *substantially similar* or *comparable* rather than strictly equal, which reaches further than the federal formulation. Some also narrow the set of justifications an employer may rely on. Multi-state practices should build to the most demanding standard that applies to them.

Pay transparency. There is no federal requirement, but the state landscape has expanded quickly. As of mid-2026, roughly a dozen jurisdictions require a good-faith pay range in the job posting itself — Colorado, California, Washington, New York, New Jersey, Illinois, Minnesota, Maryland, Massachusetts, Hawaii, Vermont and

the District of Columbia — joined by Virginia and Maine in July 2026.[5] Connecticut, Nevada and Rhode Island require disclosure on request or before an offer rather than in the posting. Delaware has enacted a posting requirement effective Sept. 26, 2027 for employers with 25 or more employees. Several cities impose their own rules, including New York City, Jersey City, Cleveland, and Columbus.

The details vary in ways that matter operationally. Employee-count thresholds differ, and some jurisdictions require benefits and other compensation to be described alongside the range. Colorado additionally requires notice of promotional opportunities to existing employees. California amended its statute effective Jan. 1, 2026 to tighten what "pay scale" means and to extend the recovery period. California, Illinois and Massachusetts also impose pay data reporting on larger employers.[6]

For a practice hiring remotely, the operative question is where the work will be performed. A posting open to candidates in a covered state generally needs to comply with that state's rule regardless of where the practice sits.

Compliance

Compliance requires three things practices routinely miss: ranges defensible enough to post, control over what external recruiters and job boards publish on your behalf, and managers trained on what they may say when a candidate asks how the number was set.

Salary history. A growing set of states and localities restrict or prohibit asking candidates what they currently earn.[7] Even where permitted, the question imports another employer's decisions into your structure.

Employees may discuss their pay. Section 7 of the National Labor Relations Act protects non-supervisory employees who discuss wages and working conditions with each other, whether or not a union is anywhere in the picture.[8] Handbook language discouraging pay discussion is a recurring finding in medical practice handbooks and should be reviewed and removed.

The referral problem, specific to healthcare. Get legal review before using staff incentives tied to referrals, imaging orders, ancillary volume or service-line throughput. Those metrics can raise issues under the physician self-referral law and federal anti-kickback statute.[9] Employment arrangements may have protections, but the conditions are technical. Review the plan before it is announced, not after the first payout.

Tax treatment of small awards. Gift cards and gift certificates are cash equivalents. They are wages regardless of amount, and they belong in payroll with normal withholding — not in a manager's desk drawer as informal thank-yous.[10]

PAY EQUITY ANALYSIS

The analysis asks whether pay differences track legitimate factors — experience, credentials, performance, tenure, scope — or something else.

Group roles carefully. Comparing jobs that are not really alike generates noise; slicing so finely that each group holds three people produces numbers nobody can read. Most practices need both a grade-level and a role-level view.

Involve counsel *before* the analysis begins rather than after results exist. Depending on how the work is structured, findings may or may not be protected, and that determination cannot be made retroactively.

When gaps appear that legitimate factors do not explain, correct them promptly and document the correction. An unexplained gap becomes harder to defend with every year it persists — and in a practice moving toward posted ranges, it will surface eventually whether or not the practice went looking.

WHERE TO START

If your practice does not have a pay structure yet, do not try to build the perfect system all at once. Start with the work that will have the biggest effect.

First, identify your 10 roles with the most employees and compare their pay with current market data. Use that information to set reasonable pay ranges. Then place every employee in the appropriate range and look for problems.

Start with anyone paid below the minimum. Those cases are the clearest to fix, and correcting them shows employees that the new structure means something. Next, set a rule for starting pay, including who must approve

offers above a certain point. That keeps new hiring decisions from creating more problems while you work through the rest of the structure.

Be careful how quickly you share pay ranges. Follow any disclosure laws that apply, but do not volunteer more information until you have reviewed compression and other obvious inconsistencies. Publishing ranges before fixing those problems does not create transparency. It simply gives employees a clearer view of what was wrong.

The structure will not make compensation decisions easy. It will make them consistent — and consistency, explained plainly, is most of what employees mean when they ask whether pay here is fair. ■

NOTES

1. MGMA. "Compensation and Production Data." https://www.mgma.com/data
2. U.S. Department of Labor, Wage and Hour Division. "Fact Sheet #56C: Bonuses under the Fair Labor Standards Act (FLSA)." https://www.dol.gov/agencies/whd/fact-sheets/56c-bonuses
3. U.S. Department of Labor, Wage and Hour Division. "Fact Sheet #17A: Exemption for Executive, Administrative, Professional, Computer & Outside Sales Employees Under the Fair Labor Standards Act." https://www.dol.gov/agencies/whd/fact-sheets/17a-overtime
4. U.S. Equal Employment Opportunity Commission. "Equal Pay/Compensation Discrimination." https://www.eeoc.gov/equal-paycompensation-discrimination
5. Jackson Lewis. "Navigating 2026: Pay Transparency Laws and Employer Obligations." https://www.jacksonlewis.com/insights/navigating-2026-pay-transparency-laws-and-employer-obligations
6. Colorado Department of Labor and Employment. "Equal Pay for Equal Work Act." https://cdle.colorado.gov/equalpaytransparency
7. State salary-history restrictions include California Labor Code § 432.3, New York Labor Law § 194-a, Massachusetts General Laws ch. 149 § 105A, Colorado Revised Statutes § 8-5-102, and Washington Revised Code § 49.58.100. Requirements vary and should be verified for each jurisdiction in which the practice recruits.
8. National Labor Relations Board. "Employee Rights." https://www.nlrb.gov/about-nlrb/rights-we-protect/your-rights/employee-rights
9. Centers for Medicare & Medicaid Services. "Physician Self-Referral." https://www.cms.gov/medicare/regulations-guidance/physician-self-referral; and U.S. Department of Health and Human Services, Office of Inspector General. "Fraud and Abuse Laws." https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/
10. Internal Revenue Service. Publication 15-B, Employer's Tax Guide to Fringe Benefits. https://www.irs.gov/publications/p15b
11. WorldatWork. "Compensation Resources." https://worldatwork.org