



A Workforce Model **THAT NO LONGER WORKS**

What hospitals, health systems, and large practices are getting wrong about workforce capacity...and what they could get right.

Pick any hospital, health system, or large medical practice across the country, and you'll see the same story unfolding. There's more administrative work to do than ever before, and not enough people to do it.

And medical departments are ***scrambling*** to keep up.

This situation isn't temporary. The trained professionals needed to bridge the gap between work and workers aren't on their way. In fact, they're consistently on their way out of healthcare. That's a big reason why the current workforce problem is systemic rather than situational. Without an influx of new administrative workers, the pressure won't cease until the workforce model changes.

Hiring more full-time people and bringing in staffing agencies are the moves hospitals typically rely on to close workforce gaps. Neither one is working anymore. That's because both approaches assume the same thing: more employees, sitting where the work is, equals more capacity. That formula is missing a key ingredient: employees. The workloads are there, and then some. But the people needed to tackle them on-site are the exact ones the labor market can't supply.

ADMIN PRESSURE KEEPS RAMPING UP

The workload driving all of this shows no signs of easing up, and it isn't coming from any one direction. Some of the pressure comes on the front end of the patient journey, where patient volumes are up, and every new case requires administrative work. On the back end, insurance payers are using AI to generate denials at a pace that lean, in-house revenue cycle management teams can't match.

Both trends are working against healthcare organizations, creating healthcare administrative bottlenecks that widen the gap between the work that needs to be done and what's actually getting done.

More Work Requires More Capacity

Inpatient volumes rose 5.3% in 2025.¹ Each of these visits generates a chain of administrative work, including insurance verification, prior authorization, scheduling, documentation, coding, billing, and, if an insurance claim is denied, an appeal.

Prior authorization is also increasing. Medicare Advantage plans alone issued nearly 50 million prior authorization requests in 2023, up more than 40% from 2020.²

That kind of growth requires a proportional increase in capacity, and most hospitals don't have access to the people or processes to accommodate it. What they do have is the same-sized team facing more work, growing backlogs, and much longer odds of ever catching up on their own.

~50M

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Denials Are Surging, and Payer AI Is Why

Clinical denials, the ones covering prior authorization and medical necessity, are driving nearly all of the recent increases in denial rates.³ AI is the cause. Payers are using it to review and reject claims at unprecedented rates.

AI flags issues faster than human review teams can, and accelerates appeal timelines to the point where hospital RCM teams can't respond when they need to.⁴ Revenue gets lost. Only 14% of providers use AI to help reduce denials.⁵ Most still work denials by hand. Payers don't, and the financial impact is jarring.

\$48B

In 2025, across 2,300 U.S. hospitals, denials & bad debt drove \$48 billion in net revenue losses.³

Across 2,300 U.S. hospitals in 2025, denials and bad debt drove \$48 billion in net revenue losses, up 25% from the year before.³ That's revenue for care already delivered, going unpaid because the workforce and the technology to recover it can't keep up with AI.

THE OLD STANDBYS CAN'T BE TRUSTED

Throwing More FTEs at the Problem

Hiring more people is still every hospital's Plan A. When there are more applicants than openings, it makes complete sense. However, it stops working the moment the talent pool runs dry, which is where healthcare has been for years.

63% of providers now report staffing gaps in their RCM departments.⁶ An industry-wide hospital workforce shortage means the people needed to fill those gaps aren't out there in the numbers the workload demands, and the ones who are hired don't tend to stay very long.

Front-office roles turn over at a 40% annual rate.⁷ That means teams are effectively rebuilt every two and a half years. It also means

hospital administrators are in a permanent cycle of recruiting, interviewing, training, and starting over, if they can even find enough candidates to begin with.

The ripple effect from the employee shortage is significant. When positions stay open for an extended period, other in-house staff have to pick up the slack. Existing admin employees end up taking on more work than they should, increasing the risk of burnout. Oftentimes, clinical staff get pulled into administrative work, which means they're on the phone with payers and doing things like data entry instead of focusing on patient care. It's frustrating for the clinicians, a lesser experience for patients, and still doesn't solve the admin workforce gap.

63%

of providers now report staffing gaps in their RCM departments.⁶

40%

Front-office roles turn over at a 40% annual rate.⁷

Temporary Fixes Are Just That: Temporary

Staffing agencies are built for a specific job: filling short-term gaps like maternity leave, illness, and unexpected departures. They perform that function well. What they weren't built for is providing long-term administrative capacity in specialized areas like prior authorization and revenue cycle management. But without enough qualified candidates to hire full-time, hospitals are leaning on short-term contract workers to operate above their capabilities, which usually doesn't turn out well for anyone.

The costs only exacerbate the situation. Staffing agency markups can run 25% to 100% over base admin pay. Between 2019 and 2022, contract labor expenses at U.S. hospitals grew 258%.⁸ That growth came from hospitals with no other choice as they attempted to work around a labor market that wasn't producing enough experienced people. What was designed as a temporary fix has become much more of a fixed cost, without the increase in administrative capacity to justify it.

258%

Between 2019 and 2022, contract labor expenses at U.S. hospitals grew 258%.⁸

TIME FOR A NEW MINDSET AND MODEL

In most hospital business offices, desks are stacked with work. The chairs in front of those desks? Several are probably empty. That's not just a particularly bad Tuesday morning. It's the way things are at many hospitals and health systems across the country. Hiring out of the situation isn't an option. And the operational and financial squeeze only gets tighter. So what's a hospital to do?

Replace the model that isn't working with one that does: a new approach that focuses on increasing capacity instead of adding more on-site FTEs, and on delivering sustainable **workforce infrastructure** instead of short-term Band-Aids.

What Is Workforce Infrastructure?

Workforce Infrastructure is a category of administrative capacity that falls outside traditional full-time hiring or outsourcing. It's not a group of temporary employees filling seats until permanent employees can be hired. And it's not an outsourced function that happens on a vendor's platform, disconnected from a hospital's day-to-day workflows.

Instead, it's trained administrative professionals working inside a hospital's native systems, following established processes, and meeting expected productivity and quality standards. The administrative professionals are not on the hospital's payroll, and they're not on site. But operationally, they function as part of the hospital's administrative team.

The work the admin professionals do spans the patient journey, from financial clearance and authorization management to patient access staffing support and revenue cycle recovery. This admin work gets done by people trained specifically to do it, and emulates the work of the hospital's own team. With workforce infrastructure in place, clinical staff can focus on patient care instead of waiting on hold with a payer.

Workforce infrastructure also solves the capacity problem in a way traditional staffing can't. "Static" staffing runs out of capacity when volumes spike and pays for capacity that isn't needed when volumes are low. Workforce infrastructure, on the other hand, moves with the work. When patient volumes climb, capacity increases easily to meet the need.

Plus, a permanent layer of workforce infrastructure gets hospitals off the hamster wheel of recruiting, hiring, training, and re-training in response to a 40% admin employee turnover rate. The workforce infrastructure and team stay in place and become part of the hospital's day-to-day admin function.

That's the mindset change. Administrative capacity goes from being measured by how many employees you have to do the work to how much work you can actually get done. In-house headcount is no longer a key indicator. What matters instead is having access to the workforce infrastructure that supports the ebbs and flows of the operation, and getting it without giving up the control or standards that are typically lost with traditional outsourcing.

HOSPITALS DON'T HAVE TIME TO WAIT

The paradox hospitals and health systems find themselves in is easy to explain but much harder to solve: too much admin work and not enough people to do it.

There's no answer in the current workforce model. So, a new model is required. One that favors built-in workforce infrastructure over hiring cycles and headcounts. That's the change that puts hospitals, health systems, and large practices back in control of their administrative function and capacity.

Since 2019, GMVA has been building workforce infrastructure and healthcare administrative support for hospitals, health systems, and large practices. Epic-approved, integrated into existing EHR and workflow environments, and trusted by more than 1,000 providers, the company has **maintained a core client retention rate above 90%**. GMVA deploys the model described in this paper, and it's already operating at scale for healthcare organizations across the U.S.



To find out where your hospital, health system, or large practice's admin function stands and where workforce infrastructure could take it, visit gmva.com/contact-us.

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