

How physician compensation models work: Salary, wRVU, hybrid and value-based plans compared

Physician compensation models are designed to balance recruitment, performance alignment, and practice sustainability. Understanding the strengths and limitations of salary, productivity, and hybrid plans is crucial for adapting to market and reimbursement changes.

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A physician compensation plan is one of the clearest statements a medical group makes about what work it values, what risk it will share, and how it expects physicians to practice. The main models are salary, productivity (work RVUs or collections), revenue-less-expense, equal share, panel-based, and hybrid designs that blend them.

To start, a **work RVU (wRVU)** is Medicare's standardized measure of the physician effort a service requires — the time, skill and intensity behind it, independent of what the practice actually collects. A routine office visit might be worth roughly 1.5 wRVUs and a complex procedure several times that. Adding up a physician's wRVUs over a year gives a payer-neutral measure of how much work they did, which is why so many production-based plans pay a set dollar amount per wRVU rather than per dollar billed.

The formula used should help the group recruit and retain physicians, align pay with performance, and protect the economics needed to run the practice. Those aims become harder when physician supply is tight, reimbursement changes, team-based care expands, and payer contracts reward outcomes that traditional production formulas may not capture.^{1,2}

No model stays correct indefinitely. Recent *MGMA DataDive Provider Compensation and Productivity* data offer a useful example: In the early 2020s, most years saw productivity — as measured by work RVUs — move in lockstep with

total compensation. In 2025, median physician compensation continued to rise across broad groupings even as wRVUs fell in 16 of 23 common specialties and total encounters declined in all 23.³

There is no permanent forecast; compensation and productivity can move apart when the market, coding, access, visit mix and recruitment pressure change. Plans built only for yesterday's production environment can keep calculating correctly while rewarding the wrong things. This is why practice leaders should understand impact modeling.⁴

COMPENSATION AS A WORKFORCE STRATEGY

Compensation design should also be viewed through a workforce sustainability lens. Recent workforce data reinforces a growing shortage of physicians across all specialties. Two studies released in 2026 are of specific concern and indicate that physicians are leaving clinical practice earlier in their careers. A study in the *Journal of the American College of Surgeons* found that 9.7% of surgeons left active clinical practice over an eight-year period, with mid-career surgeons most at risk.⁵ Additionally, the American Medical Association conducted a national survey of clinically inactive physicians to identify factors driving early retirement from the clinical physician workforce and to evaluate physicians' motivations for leaving early. The mean age at which physicians left clinical practice was 48.1 years — about nine years younger than the 57.1-year mean in a comparable



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➤ 2008 survey.⁶ According to the AMA, “This study suggests that physicians who have left practice early have had shorter clinical careers than in the past. Interventions to reduce “hassle factor” and workplace stress may address the motivations for leaving practice.”

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COMPENSATION DESIGN PRINCIPLES

Start with understanding your compensation design principles before tinkering with formula mechanics. Before comparing formulas, leaders should settle four questions: which work the group wants to encourage, which work it must protect, how much pay variability physicians will accept, and how much complexity the practice can administer accurately. A plan that physicians cannot understand will not build trust. A plan the business office cannot calculate consistently will not survive. A plan the practice cannot afford will eventually force exceptions that undermine its credibility.

A fifth consideration is how the plan will be communicated to the providers it aims to incentivize and engage. Transparency should involve clear explanations of the methodology, data sources, and compensation components to eliminate any uncertainties. Physicians need to understand which benchmarks were used; how thresholds and conversion factors were determined; how incentives related to productivity, quality, access, or citizenship are measured; call-pay details; how exceptions will be managed; and how frequently leadership will review, benchmark, and update the model. As provider compensation evolves quickly, it is best practice to review, update, and communicate the details to providers annually.

Most plans draw from a familiar set of structures. A **salary model** pays a fixed amount and works well for recruiting guarantees, ramp-up periods, hospital-employed arrangements and roles

where predictable coverage matters more than short-term production swings. In practice, the physician earns the same paycheck whether they see 18 patients a day or 25. That predictability is the point — and the catch. Its weakness is that salary alone does not tell physicians what additional work, access, quality, efficiency or citizenship the practice expects.

A **productivity model** ties compensation to a measured output such as wRVUs, collections, charges or encounters. The most common version multiplies a physician's annual wRVUs by a set dollar rate — the conversion factor — so a physician who records 5,500 wRVUs at \$60 each earns \$330,000 before any other component. It is direct and can reward physicians who produce more. It also can overvalue billable volume, undervalue cognitive and care-management work, and expose physicians to payer mix, collection lag or coding changes they do not fully control. Because CMS updates Physician Fee Schedule RVUs and related payment policies, practices that use wRVUs should review their conversion factors, code cross-walks and specialty impact at least annually.⁷

Revenue-less-expense models are common in physician-owned practices because they make practice economics visible. The physician receives credit for revenue and is charged with a share of expenses; the residual becomes compensation or distribution. Put simply, the physician is treated something like a small business owner inside the group: they keep what they bring in after their share of the bills. This can strengthen cost discipline, but it also makes allocation rules central to physician relations. Rent, clinical staffing, supplies, malpractice, shared administration and physician-specific expenses should be assigned by methods that match the cost driver and can be explained in plain language.

Equal-share models distribute available compensation evenly across a defined pool. In the simplest form, the group adds up what is left to pay physicians and divides it equally, so each partner takes home the same amount regardless of individual volume. They can support



Major Physician Compensation Designs

Most medical groups use a familiar set of structures — each with different strengths, risks and strategic uses.

1 Salary

 How it works	Fixed pay regardless of short-term production swings.
 Best fit	Recruiting guarantees, ramp-up periods, hospital-employed roles, predictable coverage.
 Watchouts	Clear expectations are essential — salary alone does not define access, quality, efficiency or citizenship.

 A physician may earn the same paycheck whether they see 18 patients a day or 25.

2 Productivity

 How it works	Compensation is tied to output such as wRVUs, collections, charges or encounters.
 Best fit	Directly rewards higher production.
 Watchouts	Can overemphasize billable volume and expose physicians to payer mix, collection lag, coding changes and policy shifts.

 **Example:**
5,500 wRVUs × \$60 = \$330,000

 Review conversion factors, code crosswalks and specialty impact at least annually.

3 Revenue Less Expense

 How it works	Physician gets credit for revenue and a share of expenses; the residual becomes compensation or distribution.
 Best fit	Common in physician-owned groups where practice economics are visible.
 Watchouts	Allocation rules matter. Shared costs and physician-specific costs must be assigned clearly and explained in plain language.

4 Equal Share

 How it works	Available compensation is divided evenly across a defined pool.
 Best fit	Supports teamwork when physicians have similar schedules, productivity and specialty economics.
 Watchouts	Creates friction when workload, call burden, procedural mix or revenue contribution differ.

 Works best when minimum expectations are clearly defined.

5 Panel Size / Team-Based

 How it works	Rewards management of attributed patients, team performance and population health — not just visit volume.
 Best fit	Attributed lives, care management, shared savings and total cost of care models.
 Watchouts	Needs clean attribution rules, risk adjustment, reliable panel data and clear individual vs. team accountability.

 Can better recognize continuity, chronic care, APP supervision and care-team performance.

6 Hybrid

 How it works	Combines a stable base with incentives for productivity, quality, access, call, leadership, APP supervision or other responsibilities.
 Best fit	The most practical approach for many groups as work grows more complex.
 Watchouts	Success depends on clearly defined responsibilities, incentives and expectations.

 **Typical hybrid: base salary + per-wRVU pay above threshold + quality bonus**

 Leaders often use hybrids to recognize work that wRVUs or collections alone miss.

Physician compensation plan distribution

Share of reported compensation methods, 2024–2025

	2024	2025
100% salary	18.7%	18.5%
100% productivity or equal share	6.1%	6.3%
50%+ salary plus quality metrics	32.0%	32.5%
50%+ production plus quality metrics	6.3%	6.8%
Other compensation plan	36.9%	35.9%

➤ teamwork and discourage internal competition when physicians have similar schedules, productivity and specialty economics. They create predictable friction when one physician’s workload, call burden, procedural mix or revenue contribution differs substantially from peers. Equal share works best when the group also defines minimum expectations for access, productivity, quality, documentation and professional participation.

Panel-size and team-based models are increasingly relevant where practices are paid for attributed lives, care management, shared savings or total cost of care. Instead of paying for each visit, these arrangements pay the practice to keep a defined group of patients healthy, so the compensation plan rewards managing a panel well rather than simply seeing more people. These models can recognize continuity, chronic-disease management, advanced practice provider (APP) supervision and care-team performance better than visit-only formulas. They require clean attribution rules, patient-risk adjustment, reliable panel data and a clear line between individual and team accountability.

For many groups, a **hybrid model** is the most practical answer. It can combine a stable base with incentives for productivity, quality, access, call, leadership/directorship duties, APP supervision, or other responsibilities. A typical hybrid pays a market base salary that funds an expected level of production, then layers on a per-wRVU rate for work above that level and a quality bonus on top — so the physician has both a floor and a reason to do more. MGMA’s recent report found that pure salary and pure productivity or equal-share approaches together accounted for less than a quarter of reported physician compensation methods, while blended methods with quality and other incentives represented a larger share.³ That pattern will change over time, but the strategic point should endure: as the work

becomes more complex, compensation plans usually need multiple levers to reflect that complexity and influence physician behavior.

Hybrid models are valuable engagement tools for leaders, offering a structured, holistic approach to recognizing and rewarding mission-driven and patient care work that isn’t always reflected in wRVUs or collections. This may include call coverage, leadership contributions, supervision of advanced practice providers (APPs), mentoring, program development, care coordination, and efforts to enhance patient experience and satisfaction. The key is to clearly define these responsibilities and associated compensation so that physicians have clear expectations about pay, feel their work is recognized and valued, and remain aligned with the organization’s mission for patient care.

WHERE MANY SPECIALTIES SIT TODAY

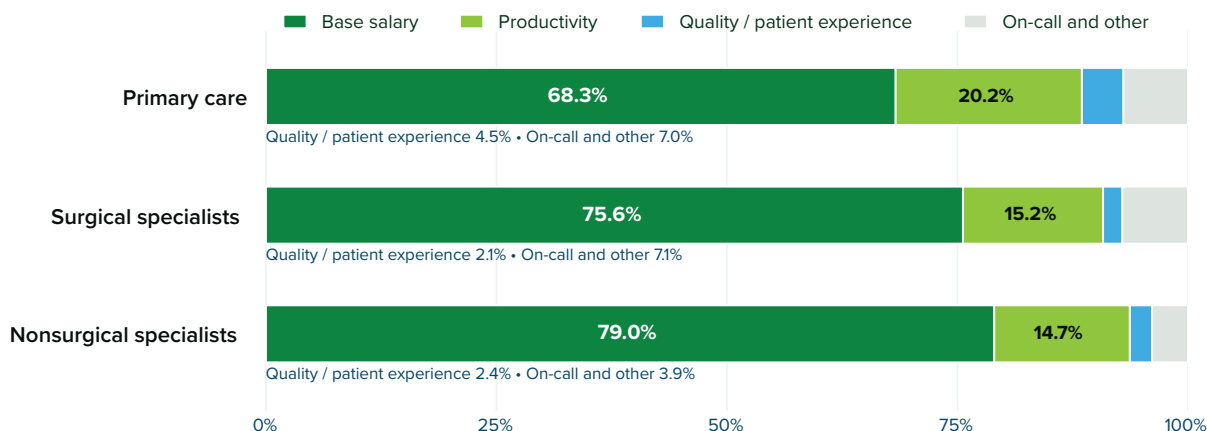
That shift toward hybrid models is not specialty neutral. In 2025, blended designs dominated across the board — roughly half of reported methods paired a majority-salary or majority-production base with quality metrics, and another third fell into “other” hybrid designs — but how the package is built, and what it pays, differs sharply by physician grouping.³

- **Primary care physicians** carry the most productivity-based pay mix: productivity averages 20.2% of the package and quality and patient experience 4.5% — both the highest of the three groupings. Panel-based and value-based hybrids are most viable here, where attribution, care management and team-based revenue concentrate, and an E/M-driven coding profile leaves primary care largely insulated from the 2026 wRVU efficiency adjustment.^{3,7}
- **Surgical specialists** attach the most dollars to coverage and leadership: on-call duties carried a 16.6% compensation premium and



Mean pay-mix allocation by physician grouping

Share of mean compensation



medical directorships a 16.4% premium in 2025. Hospital- and system-owned groups continue to pay a premium for surgical talent relative to measured production, and procedural specialties absorb the largest share of the 2026 efficiency adjustment — which makes conversion-factor governance most urgent in this grouping.³

- **Nonsurgical specialists** are the most salary-anchored grouping, at 79.0% of the mean pay mix, yet show the widest plan-type gap: physicians on production-based plans out-earned non-production peers by 14.7%, and supervisory duties carried a 20.7% premium — the largest of any grouping, reflecting how much APP oversight has migrated into the specialist role.³

The dollar levels in this table will age, but the relationships have proved to be lasting. Across recent survey cycles:

- Production-based plans out-earn non-production plans in every grouping;
- Base salary anchors the package even in production-oriented cultures; and
- Documented additional responsibilities command double-digit premiums for the physicians who have them.

Build the plan on those relationships and refresh the numbers annually.

The main objective is to build a coherent compensation plan that is consistent, concise, and unambiguous. Focus on identifying the work that is strategically important, measurable, and clearly expected. It is important to assess whether current compensation methods

are up to date, rooted in data-driven methodology, recognize this work, and consistently communicate the rationale. When compensation plans are designed with structural integrity so that compensation components recognize and reward providers' contributions, they make sense, are easy to communicate, represent fair pay, and reinforce engagement with the organization.

WHAT THE FORMULAS LOOK LIKE TODAY

The accompanying MGMA sample compensation model tables work through each structure at 2025 median production levels, with every input exposed so leaders can substitute their own benchmarks, conversion factors and incentive pools. To illustrate:

- A traditional wRVU plan paying a primary care physician \$60 per wRVU at 5,500 wRVUs produces \$330,000 in production-based pay; a quality layer consistent with the prevailing 4% to 5% allocation brings the package to roughly the \$345,852 median for primary care physicians on production-based plans.
- The same architecture lands at surgical and nonsurgical medians with conversion factors near \$82 and \$68, respectively. The tables extend that logic to tiered rates, base-plus-threshold hybrids, salary-plus-quality and production-plus-quality designs, collections-based and revenue-less-expense models, partnership distributions, panel-based plans, new-hire guarantee ramps and additional-responsibility stipends.³



➤ In a market where most plans are now blended, the quality layer is most often the first one added to existing models. **Quality incentives** deserve special discipline. A quality measure should be important to the practice, relevant to the specialty, based on reliable data, and meaningfully within the physician's influence. Measures such as care-gap closure, chart-closure timeliness, screening completion, patient-experience follow-up or chronic-disease control often work better than broad goals that physicians see as vague or disconnected from their day-to-day work. In our 2026 report, leaders who said quality incentives changed behavior pointed less to the size of the incentive than to whether the measure was credible to clinicians.³

Communication is a key priority and matters as much as calculation. Compensation redesign often raises questions about fairness, predictability, autonomy, and peer comparison. To provide certainty and encourage open communication, stakeholder interviews and a high-level analysis to gather critical feedback and themes on compensation can be pivotal tools. Leaders should share a clear timeline for review and implementation, the priorities and purpose for a compensation update, the data and methodology to be used, the expected impact, and the

process for review, correction, or appeal. The more complex the model, the more intentional the communication plan and stakeholder input and involvement should be. Clear communication is kind.

The plan also needs governance. Compensation should be benchmarked against appropriate specialty, region, ownership and practice-type data, but external medians should not replace internal economics. A practice should also know its own net revenue per wRVU, overhead structure, staffing model and payer mix before declaring a compensation rate “at market.” Federal fraud-and-abuse laws and Stark Law also make documentation and fair-market-value (FMV) support critical for arrangements involving referrals, directorships, call coverage, ancillaries, or other financial relationships tied to physicians. *[One note of caution: When CMS revalues wRVUs — as the 2026 efficiency adjustment did for roughly 7,700 non-time-based codes — comp-per-wRVU ratios and FMV thresholds move upward mechanically, because the same pay is divided by fewer wRVUs. Benchmarks from a revaluation year should be read — and conversion factors reset — with that in mind.]*^{8,9}

Governance also supports retention. An annual review of base compensation, total compensation, benchmarks relevant to your organization,



Physician compensation benchmarks by grouping

2025 medians, mean pay-mix measures and compensation premiums

Benchmark	Primary care	Surgical specialists	Nonsurgical specialists
Median total compensation	~\$330,000	~\$600,000	~\$460,000
Median work RVUs	5,538	7,726	6,531
Mean pay mix: base salary	68.3%	75.6%	79.0%
Mean pay mix: productivity	20.2%	15.2%	14.7%
Mean pay mix: quality and patient experience	4.5%	2.1%	2.4%
Comp premium: production-based versus non-production plans	+10.0%	+9.3%	+14.7%
Comp premium with supervisory duties	+18.7%	+15.2%	+20.7%

Provider compensation is a paradox. It is highly regulated and subject to legal compliance, data-driven and formulaic, and, at the same time, someone's paycheck. Pay is personal. Compensation and culture are inextricably linked. Your provider compensation plans directly reflect your organization's culture, commitment to recruitment and retention, and the value you place on providers.

➤ productivity patterns, payer changes, fee schedule updates, recruitment trends, and physician feedback helps prevent outdated formulas from becoming retention risks. It also reduces the need for one-off exceptions, which can erode trust and transparency. Engaged providers feel valued and respected, have certainty around compensation and expectations, experience autonomy in decision-making, feel connected to the organization, and believe they are paid and treated relative to their peers. Solid physician compensation plans rarely hinge on a simple formula. What gives a plan its durability is a formula the group can explain, fund, measure and update. The best plans connect pay to strategy, use measures physicians can influence, document revenue and expense allocation, protect confidentiality, and give leaders a regular review cycle before market or reimbursement changes force a crisis. The sample model tables that accompany this article are built for that review: start from the structure that fits the work, test it against current medians, and replace the illustrative inputs with your own.

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To take the review one step further — quantifying how fee schedule changes such as the 2026 wRVU revaluation impact your own code mix — MGMA members can use the **MGMA Physician Fee Schedule Tool**, free with membership. The tool customizes CMS fee schedules by locality and non-Medicare payment rates, surfaces the top procedure codes by specialty, compares fee schedule versions across years and lets you model adjustable conversion factors — the same inputs that drive the wRVU-based plans above.

NOTES

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