



2026 Provider Compensation and Productivity

Data Report



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Introduction

The market for physicians and advanced practice providers (APPs) is more complicated now than any point since the pandemic. In 2025, physician pay and productivity largely moved in opposite directions: compensation kept rising, though modestly, even as work RVU gains faded.

Across 23 common specialties, the latest [MGMA DataDive Provider Compensation and Productivity](#) data set shows median total compensation still climbing, but the story beneath that increase shows pay and productivity pulling apart. For the first time in several years, the productivity that has historically powered pay growth moved the other way: Work RVUs fell in 16 of the 23 specialties, and total encounters fell in all 23. Pay went up while measured output came down. Why the two parted ways, ending years of broad productivity gains, is the big question this report sets out to answer.

MEDIAN TOTAL COMPENSATION AND COST OF LIVING: ONE-YEAR AND FIVE-YEAR CHANGE

	One-Year Change (2024–2025)	Five-Year Change (2021–2025)
Primary Care Physicians	+2.23%	+15.04%
Surgical Specialists	+2.90%	+16.33%
Nonsurgical Specialists	+1.79%	+11.06%
Consumer Price Index (CPI)	+2.70%	+16.37%

CPI five-year change is the compounded change from December 2021 to December 2025. Sources: MGMA DataDive Provider Compensation; U.S. Bureau of Labor Statistics.

Buried in the data are several signs of transformation medical group leaders will want to watch closely:

- **A productivity reset:** After years of steady gains, wRVUs and encounters both declined in 2025. The wRVU-to-encounter ratio — the intensity captured per visit — is a key to why pay held up: fewer but heavier visits cushioned the drop in total wRVUs, most notably in primary care.
- **Inflation caught up over five years:** Pay rose in dollar terms but, measured against the 16.4% cumulative rise in consumer prices since 2021, nonsurgical specialists lost ground while primary care and surgical specialists roughly broke even.
- **Ownership lines kept shifting:** Physician-owned practices still post higher encounters and collections, but hospital-/system-owned groups kept the pressure on surgical pay, and the wRVU comparison by ownership stays mixed.
- **The recruiting market — off the boil but still running hot:** Median guaranteed compensation slipped from its highs in 2025 without truly cooling much for all newly hired physicians — only slightly for primary care (-2.49%) and surgical specialists (-0.12%), more for nonsurgical specialists (-6.77%) — yet all three still sit well above their 2021 levels, and signing bonuses and payback clauses remain common.
- **Hybrid pay models are here to stay:** Pure salary and pure productivity continued to give way to blended models with quality and other incentives.
- **A regulatory headwind arrives:** The 2026 Medicare Physician Fee Schedule introduced a wRVU “efficiency adjustment” that cuts the wRVU value of many procedures, reshaping benchmarks for many specialties and impacting physician pay. That change took effect Jan. 1, 2026, and this report’s benchmarks come from 2025 data, so the shifts described here reflect real clinician behavior. However, what we learn from last year’s data give us an understanding of the mechanical adjustment now underway and how practice leaders should respond.

MGMA DATADIVE PROVIDER COMPENSATION

Know the right numbers to build a strong practice. As a federally recognized source to assist in fair market value, the MGMA DataDive Provider Compensation data set delivers targeted insights to help practices recruit and retain top providers, drive revenue through improved productivity and contain costs — examining physician and APP compensation across specialties and subspecialties so leaders can benchmark pay against production and stay consistent with the market.

ABOUT THIS REPORT

This report highlights key benchmarks and emerging trends from the 2026 MGMA Provider Compensation and Productivity survey, with 2025 data from more than 245,900 physicians and advanced practice providers (APPs) nationwide, and contextualizes them with recent [MGMA Stat](#) polling of medical group leaders and other MGMA reporting. [Click here for our summary data reports.](#)

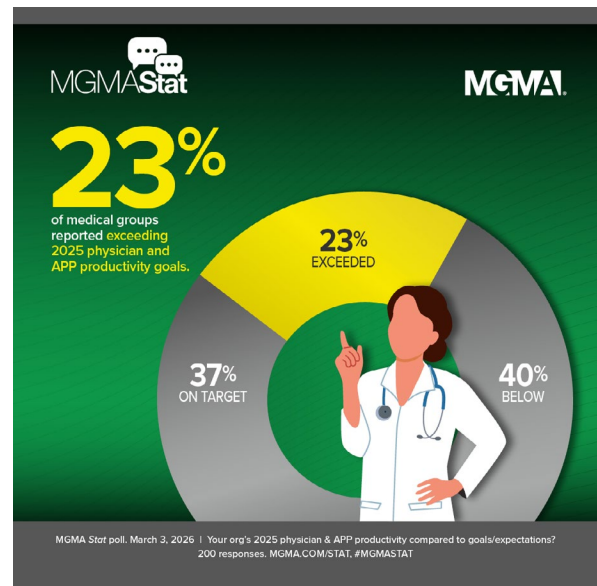
Productivity: What's Driving the Reset?

MEDIAN TOTAL ENCOUNTERS TREND BY PHYSICIAN GROUPING

	2024	2025	'24-'25 %
Primary Care Physicians	2,971	2,813	-5.32%
Surgical Specialists	2,380	2,207	-7.27%
Nonsurgical Specialists	3,306	2,788	-15.67%

The defining feature of the 2025 data is a clear step back in productivity. In a reversal from recent years, median wRVUs fell in 16 of 23 common specialties, and total encounters declined in every one of the 23. Group leaders saw it happen in real time: [in our March 2026 polling](#), the share of groups hitting or beating their physician and APP productivity goals slipped to 60% — 37% on target and 23% above — from about seven in 10 a year earlier, while 40% came in below goal.

Top-performing groups credited tighter operations: better scheduling and templates, expanded capacity and staffing, and targeted technology such as AI scribes. Those that fell short pointed to **limited provider availability from burnout and turnover, staffing shortages, softer demand and documentation friction.**



MEMBER-EXCLUSIVE RESOURCE

Many markets faced more demand than workforce in recent years, but the pendulum has swung the other way. Download [MGMA's analysis](#) of 10 major drivers behind softening volume in 2026, and specialty-specific playbooks that go beyond staff reductions and increased marketing spend.

The intensity question: wRVUs per encounter

The ratio of wRVUs to total encounters measures how much work value is captured in each patient visit, and it is the clearest explanation for why wRVUs held up better than encounter volume in 2025. When encounters fall but this ratio rises, each remaining visit is “heavier,” cushioning the decline in total wRVUs.

WORK RVUs TO TOTAL ENCOUNTERS RATIO (MEDIAN)

	2021	2022	2023	2024	2025	'24 – '25 % Diff	'21 – '25 % Diff
Primary Care Physicians	1.70	1.79	1.85	1.96	6.10%	1.54%	16.73%
Surgical Specialists	3.11	3.31	3.30	3.37	5.36%	-1.18%	7.01%
Nonsurgical Specialists	2.34	2.47	2.17	2.22	3.10%	3.46%	-1.69%

Primary care shows the most durable shift — its ratio has risen every year since 2021 (+16.73% cumulatively), which is why primary care wRVUs stayed essentially flat even as encounters declined. Surgical specialists are the exception: their ratio fell 1.18%, the only grouping to decline, meaning productivity softened on both volume and per-encounter intensity. Nonsurgical specialists remain volatile and net-flat over five years (-1.69%); their 2025 rebound (+3.46%) cushioned a steep encounter decline but reflects recovery rather than a lasting gain.

Editor's note: A meaningful share of primary care's rising wRVUs per encounter is mechanical rather than clinical: in 2021, CMS raised the wRVU values of the office/outpatient E/M codes (99202–99215) that dominate primary care billing, so the same visit now counts for more wRVUs regardless of clinical effort. With many organizations phasing in the higher values over several years — and a visit-complexity add-on (HCPCS code G2211) that took effect in 2024 — the ratio rose across the 2021–2025 window independent of true productivity.

The ownership divide

In primary care and among nonsurgical specialists, physicians in independent practices continue to report higher collections and total encounters than their counterparts in hospital-/IDS-owned practices. Surgical specialists are the exception: they now report somewhat lower collections and encounters than their colleagues in system-owned practices. The wRVU and compensation picture adds more nuance:

- Nonsurgical specialists in physician-owned practices report far higher encounters and wRVUs but only marginally higher total compensation.
- Surgical specialists in physician-owned practices post higher wRVUs yet lower total compensation — a sign that hospitals keep paying a premium for surgical talent.
- Primary care is close to even on both measures.

Total encounters reflect all direct provider-to-patient interactions, including tele-visits and e-visits; wRVUs also quantify productivity and account for visit complexity.

DIFFERENCE BETWEEN PHYSICIAN-OWNED AND HOSPITAL-/IDS-OWNED PRACTICES, 2025

	Collections	Total Encounters	Work RVUs	Total Compensation
Primary Care Physicians	11.67%	12.25%	1.38%	1.53%
Surgical Specialists	-5.91%	-5.86%	4.78%	-4.49%
Nonsurgical Specialists	23.93%	38.54%	17.78%	1.32%

Positive values indicate physician-owned practices exceed hospital-/IDS-owned practices.

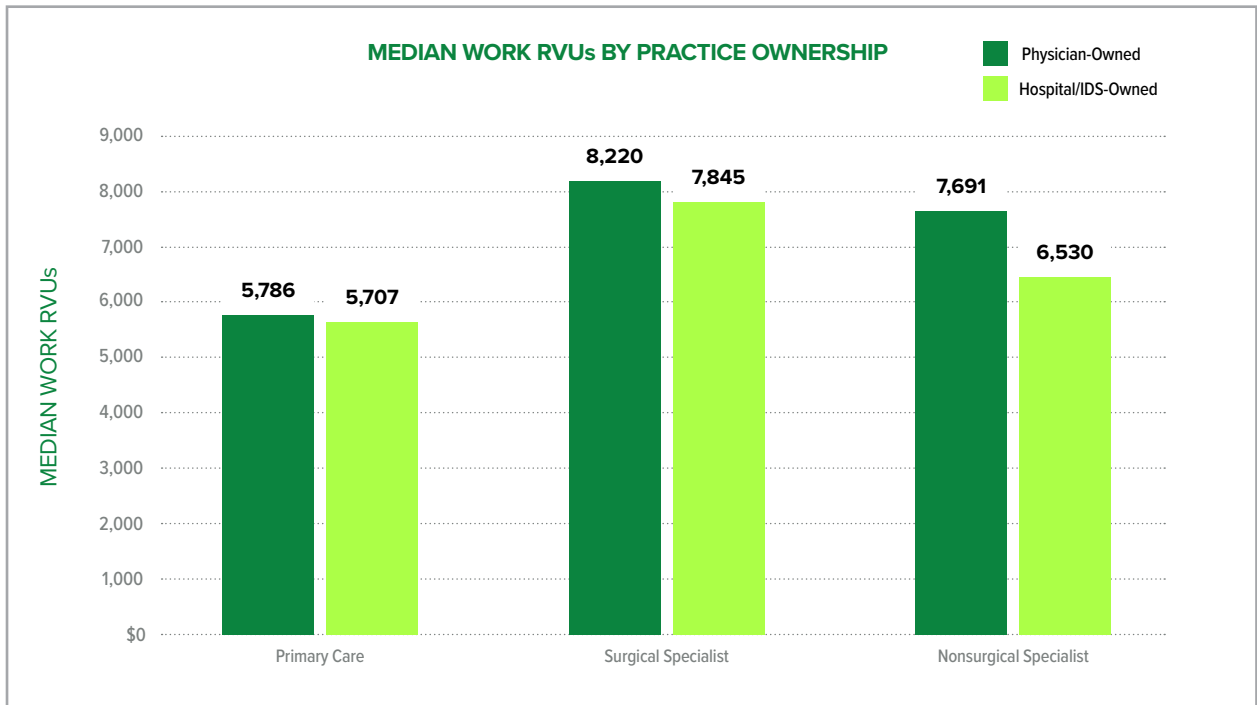
MEDIAN PRODUCTIVITY TRENDS, PHYSICIAN-OWNED

	Total Encounters 2024	Total Encounters 2025	Total Encounters '24-'25 %	Work RVUs 2024	Work RVUs 2025	Work RVUs '24-'25 %
Primary Care Physicians	3,273	3,144	-3.94%	5,191	5,786	11.46%
Surgical Specialists	3,545	2,087	-41.13%*	8,128	8,220	1.13%
Nonsurgical Specialists	4,240	3,724	-12.17%	7,421	7,691	3.64%

*The surgical physician-owned encounters change reflects an unusually high 2024 base (which rose roughly 106% from 2023) and should be read with caution.

MEDIAN PRODUCTIVITY TRENDS, HOSPITAL-/IDS-OWNED

	Total Encounters 2024	Total Encounters 2025	Total Encounters '24-'25 %	Work RVUs 2024	Work RVUs 2025	Work RVUs '24-'25 %
Primary Care Physicians	2,918	2,801	-4.01%	5,536	5,707	3.09%
Surgical Specialists	2,288	2,217	-3.10%	8,140	7,845	-3.62%
Nonsurgical Specialists	3,273	2,688	-17.87%	6,754	6,530	-3.32%



The two dominant ownership models pursue productivity in different ways. Independent practices keep driving volume and collections, working to get the most out of every provider and every visit, while system-owned groups tend to see fewer patients but capture more work value per visit through case mix, facility resources and coding practices — a reminder that what counts as “productivity” depends heavily on how, and where, care is delivered.

Data Trends: Provider Compensation

Compensation continued to rise across all three physician groupings in 2025, but the pace slowed. On a one-year basis, increases generally trailed the cost of living — only surgical specialists kept pace with the 2.7% rise in CPI. Over five years, surgical specialists essentially matched the 16.4% cumulative increase in consumer prices, primary care physicians trailed slightly, and nonsurgical specialists lagged more meaningfully. Nominal pay is still climbing; real pay is closer to flat.

Most physician specialties again posted comp increases in 2025, with larger gains over the five-year window — but productivity moved the opposite way. Invasive cardiology (+13.09%) led all specialties on the year; urology paired the second-strongest one-year gain (+6.92%) with a robust five-year run (+17.32%); and hematology/oncology was the lone specialty to see median comp decline (-1.46%). Family medicine was effectively flat (+0.16%).

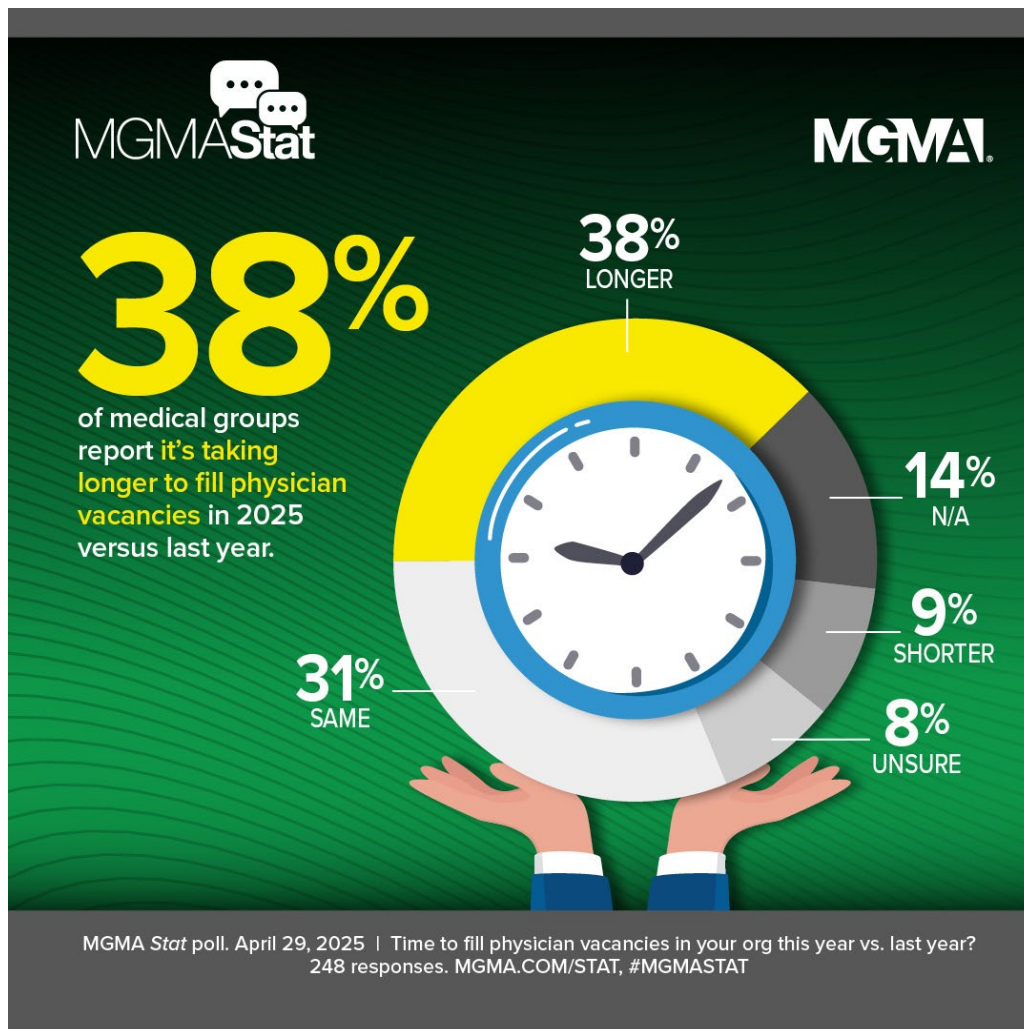
COMPENSATION AND WORK RVU CHANGES ACROSS 23 CORE SPECIALTIES

	'23-'24 % Compensation	'24-'25 wRVUS	'22-'25 % Compensation	'21-'25 % wRVUs
Cardiology: Invasive	13.09%	10.28%	24.62%	20.22%
Cardiology: Invasive-Interventional	5.49%	4.46%	25.86%	17.27%
Cardiology: Noninvasive	0.86%	-2.65%	16.79%	13.18%
Dermatology	2.03%	-0.65%	7.83%	7.18%
Emergency Medicine	0.99%	-8.50%	8.93%	9.94%
Family Medicine (without OB)	0.16%	-1.62%	16.04%	14.32%
Gastroenterology	5.83%	-1.12%	14.39%	3.06%
Hematology/Oncology	-1.46%	-9.47%	17.41%	5.34%
Internal Medicine: General	3.21%	1.84%	15.48%	18.66%
Neurology	2.69%	0.21%	12.32%	3.29%
Obstetrics/Gynecology: General	3.25%	0.0%	12.46%	5.44%
Ophthalmology	2.38%	-6.01%	9.69%	6.10%
Orthopedic Surgery: General	3.47%	-5.39%	12.11%	-0.74%
Otorhinolaryngology	1.43%	-5.73%	13.22%	9.94%
Pathology: Anatomic and Clinical	3.31%	2.18%	16.97%	20.07%
Pediatrics: General	2.98%	-0.55%	15.10%	17.43%
Psychiatry: General	5.44%	5.62%	12.46%	11.21%
Pulmonary Medicine: General	1.70%	-7.60%	7.40%	-13.74%
Radiology: Diagnostic	2.86%	-3.11%	15.23%	12.96%
Surgery: General	2.21%	-0.74%	13.07%	1.52%
Surgery: Neurological	2.21%	-9.22%	13.98%	-2.06%
Urgent Care	4.79%	-5.80%	7.30%	17.32%
Urology	6.92%	-5.00%	17.32%	2.06%

Total encounters declined for all 23 specialties in 2025.

WHY PAY KEEPS RISING

Pay keeps climbing mainly because physicians are scarce, not because they're producing more. The [AAMC projects](#) a U.S. physician shortage of up to 86,000 by 2036, retirements are picking up as the workforce ages, and the hardest specialties [take longer](#) and cost more to fill than ever. In that market, groups pay up to land and keep clinicians even when their measured production slips — exactly as this year's numbers show.



Newly Hired Providers

GUARANTEED COMPENSATION TREND, 2024-2025 – ALL NEWLY HIRED PHYSICIANS

-2.49%	-0.12%	-6.77%
Primary Care Physicians	Surgical Specialists	Nonsurgical Specialists

After several years of escalation, the market for newly hired physicians eased off its highs in 2025 without truly cooling. Guaranteed compensation declined or held flat across all three groupings — most sharply for nonsurgical specialists (-6.77%), while primary care dipped 2.49% and surgical pay held essentially flat (-0.12%). Even with this dip, all three still sit above their 2021 levels, so it is more likely a leveling off from the post-pandemic run-up on pay rather than a retreat.

CHANGE IN MEDIAN GUARANTEED COMPENSATION, POST-RESIDENCY/FELLOWSHIP HIRES

	One-Year (2024–2025)	Five-Year (2021–2025)
Primary Care Physicians	-1.64%	6.66%
Surgical Specialists	-17.59%	-1.44%
Nonsurgical Specialists	-6.97%	-6.67%

Editor’s note: Median guaranteed compensation differs from total compensation reported elsewhere; it excludes incentive components that can be significant for lower-base starting roles. Source: MGMA DataDive Provider Placement Starting Salary.

Early-career physicians hired straight out of residency or fellowship moved more sharply. The steepest one-year drop was among surgical specialists (-17.59%), with primary care down only slightly (-1.64%) and nonsurgical specialists down 6.97%. The five-year trend splits by grouping, too: only primary care remains above its 2021 level (+6.66%), while surgical (-1.44%) and nonsurgical (-6.67%) new-graduate guarantees have fallen below where they were in 2021, a sign the early-career specialist market has cooled more than the broad ‘newly hired’ numbers let on.

Beyond the guarantee, signing and starting bonuses remain common — and increasingly come with strings attached. Signing bonuses were offered to a majority of newly hired physicians (57.5%) and about a third of APPs (34.6%); starting bonuses were less common for both, about 17%. Most organizations that offer a signing bonus now attach a full or prorated payback clause, protecting against early departures and “bonus shopping.”

NEWLY HIRED PROVIDER INCENTIVES

	Physicians	APPs		Physicians	APPs
Signing bonus offered	57.48%	34.59%	Starting bonus offered	16.66%	16.69%
Signing bonus not offered	38.23%	62.33%	Starting bonus not offered	66.67%	76.27%
Unknown	4.29%	3.08%	Unknown	16.67%	7.04%

SIGNING-BONUS PAYBACK

	Physicians	APPs
Full payback required	38.13%	33.23%
Prorated payback required	43.55%	33.23%
No payback required	18.32%	33.54%

Compensation Methodologies

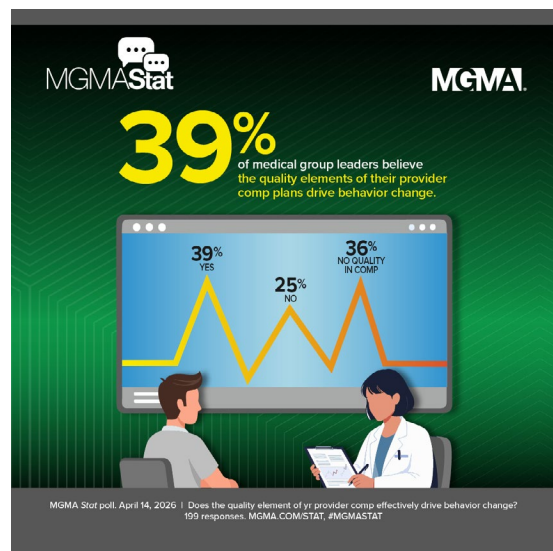
PHYSICIAN COMPENSATION PLAN DISTRIBUTION, 2024 → 2025

	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%

Pure salary and pure productivity have solidly given way to blended models — their combined share has fallen from roughly 44% of reported methods in 2020 to less than 25% in 2025, as quality and “other” incentives take their place. This distribution shows very little changed year over year in 2025.

But the more interesting question for 2026 is how quality in the plan influences care delivery. In an [April 14, 2026, MGMA Stat poll](#), 39% of leaders said the quality piece of their compensation drives behavior change, 25% said it does not, and 36% don't use quality in their comp models at all. In other words, even among the groups that tie pay to quality, nearly four in 10 say it isn't effectively changing behavior yet.

What separated the plans that worked from the ones that didn't was rarely the percentage at stake; it was whether physicians saw the measures as fair, specialty-relevant and within their control. Concrete, operationally visible measures — closing care gaps, documentation and chart-closure timeliness, blood-pressure and A1c control, screening rates — moved behavior; vaguely defined or frequently re-benchmarked metrics got dismissed as box-checking. The takeaway for plan designers: whatever the measure, make it credible to clinicians.



COMPENSATION ALLOCATION (MEAN REPORTED)

	Base Salary	Productivity	Quality & Patient Experience	On-call	Other
Primary Care Physicians	68.28%	20.21%	4.45%	0.96%	6.10%
Surgical Specialists	75.59%	15.23%	2.11%	1.71%	5.36%
Nonsurgical Specialists	78.96%	14.69%	2.38%	0.87%	3.10%

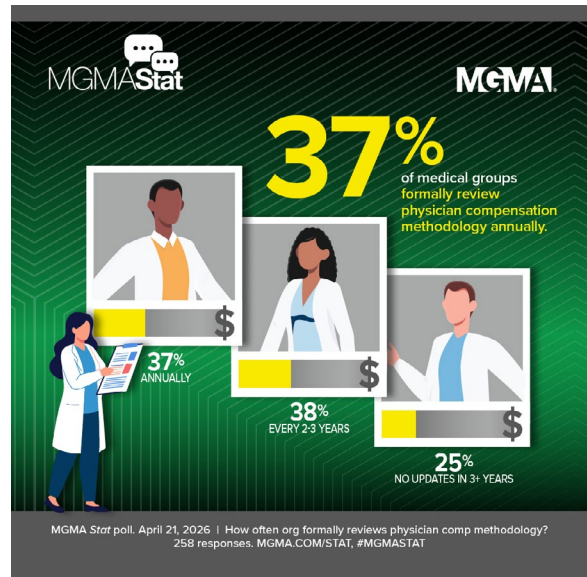
Even as quality elements spread, base salary still anchors the package — and physicians on production-based plans continue to out-earn peers on non-production plans, with the widest gap among nonsurgical specialists. Plan design is squarely on leaders’ minds, but governance varies.

MEDIAN TOTAL COMPENSATION BY PLAN TYPE

	Production-Based	Non-Production Based	% Diff
Primary Care Physicians	\$345,852	\$314,404	10.0%
Surgical Specialists	\$642,589	\$588,094	9.3%
Nonsurgical Specialists	\$450,000	\$392,400	14.7%

MGMA STAT | COMPENSATION METHODOLOGY REVIEW

Just 37% of groups [review their physician compensation methodology annually](#); 38% do so every two to three years, but about one in four (25%) have not updated their methodology in three or more years. With quality and value pay spreading and 2026 wRVU changes resetting how production is counted, a comp plan that hasn’t been touched in years can be a real risk, especially slow-to-adjust wRVU-based plans.



Additional responsibilities

Physicians who take on supervisory duties report 15% to 21% more in total compensation than peers without them — a substantial premium, reflecting how much more supervision — especially of APPs in team-based care models — is now part of the physician role.

MEDIAN TOTAL COMPENSATION BY SUPERVISORY DUTIES

	Without Supervisory Duties	With Supervisory Duties	% Diff
Primary Care Physicians	\$322,865	\$383,275	18.7%
Surgical Specialists	\$614,674	\$708,275	15.2%
Nonsurgical Specialists	\$418,729	\$505,552	20.7%

Advanced Practice Provider Compensation

Nurse practitioners and physician assistants posted steady compensation gains in 2025. One-year raises beat the 2.7% CPI in nearly every grouping — the lone exception was primary care PAs at 2.10% — and five-year gains were strong, with only surgical NPs (14.72%) trailing the cumulative cost-of-living increase. Over five years, APP pay has climbed faster than compensation for many physician specialties — most strikingly in primary care, where NP and PA gains (about 22% and 27%) ran well ahead of the 15% for PCPs.

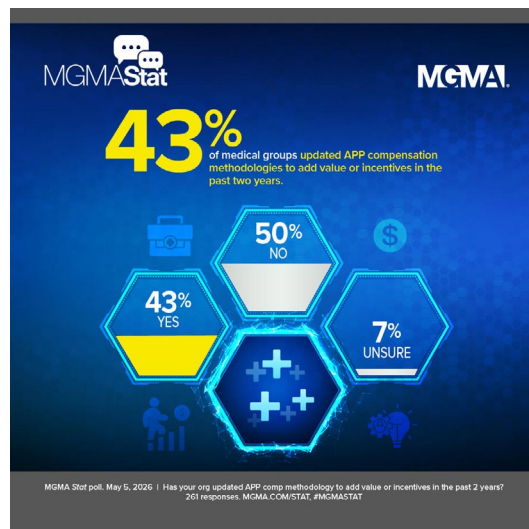
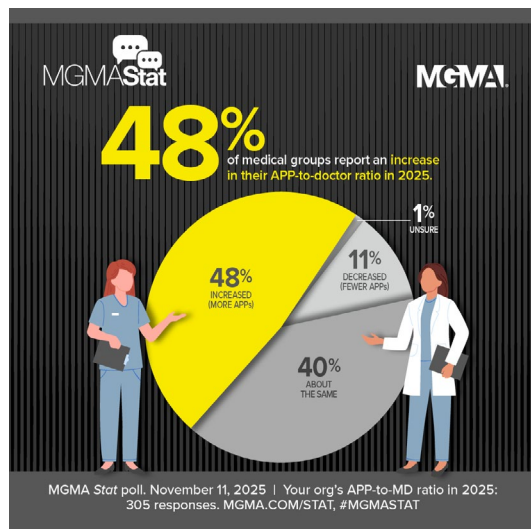
CHANGE IN MEDIAN TOTAL COMPENSATION, NPS AND PAS

	One-Year (2024-2025)	Five-Year (2021-2025)
Nurse Practitioners		
NP (Surgical)	3.62%	14.72%
NP (Primary Care)	4.79%	21.93%
NP (Nonsurgical/Nonprimary Care)	8.46%	27.13%
Physician Assistants		
PA (Surgical)	5.78%	21.07%
PA (Primary Care)	2.10%	27.46%
PA (Nonsurgical/Nonprimary Care)	7.43%	24.04%

Two things are pushing that pay up, and neither will surprise a practice leader:

First, groups are leaning on APPs harder than ever — in a [November 2025 MGMA Stat poll](#), 48% said they had added APPs relative to physicians over the past year, mostly because patient demand kept rising while physicians got harder to recruit and keep.

Second, leaders are rethinking how they pay these roles as APPs carry bigger, steadier panels: a [May 2026 poll](#) found 43% of practices had reworked their APP pay methodology in the past two years to fold in incentives or quality. Base salary still does most of the work, and earlier polling showed APP models split roughly evenly between straight salary or hourly and salary-plus-incentive, with only small shares paying on RVUs or volume alone.



Regional Compensation

Where a physician practices can be worth tens of thousands of dollars a year; in 2025, the regional map held a few surprises.

The clearest is the East: it posts the lowest median pay in all three groupings and the softest growth in 2025, with nonsurgical specialists there actually losing ground (-4.4%). The region's pay for surgical specialists was built up then stalled — they led every region in five-year growth (19.9%), then flattened to 0.1% last year.

The momentum in 2025 ran through the Midwest and South instead, where nonsurgical pay jumped 7.8% in the South alone. Those two regions also tend to pay specialists the most, a reminder that the biggest paychecks often sit in lower-cost markets where competition for clinicians is fiercest — not in the coastal metros.

And the region you practice in matters far more in some fields than others: nonsurgical specialists earn about \$91,000 more (roughly 22%) at the top of the range (in the South) than at the bottom (the East) while primary care pay barely moves from one region to the next.

CHANGE IN MEDIAN TOTAL COMPENSATION BY REGION — ONE-YEAR (2024–2025)

	Eastern	Midwest	Southern	Western
Primary Care Physicians	0.0%	4.5%	1.4%	2.4%
Surgical Specialists	0.1%	4.1%	3.9%	1.9%
Nonsurgical Specialists	-4.4%	3.8%	7.8%	2.1%

CHANGE IN MEDIAN TOTAL COMPENSATION BY REGION — FIVE-YEAR (2021–2025)

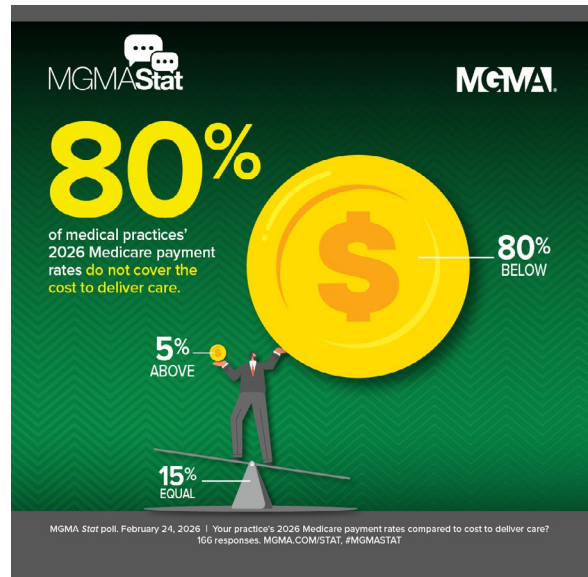
	Eastern	Midwest	Southern	Western
Primary Care Physicians	15.9%	19.0%	11.1%	13.1%
Surgical Specialists	19.9%	14.8%	16.9%	12.2%
Nonsurgical Specialists	10.8%	11.9%	11.0%	11.3%

At a Glance: Physician and Practice Issues

Throughout the year, MGMA Stat polls healthcare leaders nationwide to capture real-time signals that augment the annual DataDive surveys and hint at what is ahead. The 2025–2026 polling reinforces a consistent message: the pressures behind this year’s benchmarks — softer productivity, a tightening cost squeeze and persistent workforce strain — are carrying into 2026.

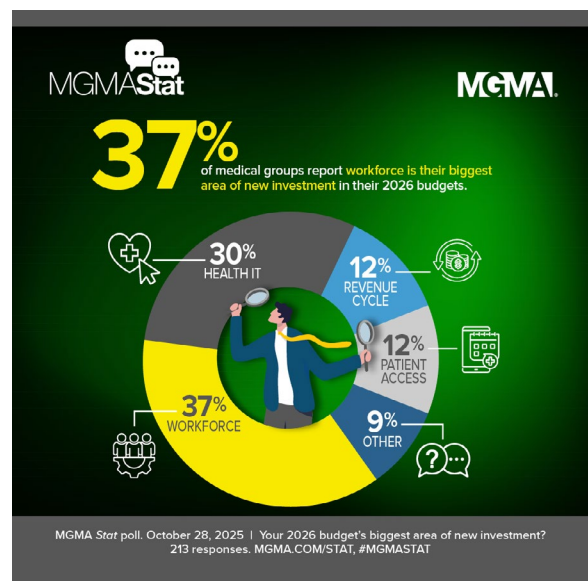
THE REIMBURSEMENT SQUEEZE

The economics underneath compensation grew tighter. CMS set the 2026 conversion factor at \$33.57 for qualifying APM participants and \$33.40 for non-qualified clinicians — increases of 3.77% and 3.26% — a welcome change after years of flat or negative updates, but not a reset given that operating costs per physician have far outpaced payment over the past decade. Still, [80% of medical groups report their Medicare reimbursement is below the cost to deliver care](#), while 15% say it is roughly equal and 5% say it is above. The pressure compounds with rising Medicare Advantage denials and downcoding — the same forces medical groups must absorb while still investing in pay to recruit and retain.



WORKFORCE INVESTMENT LEADS THE BUDGET

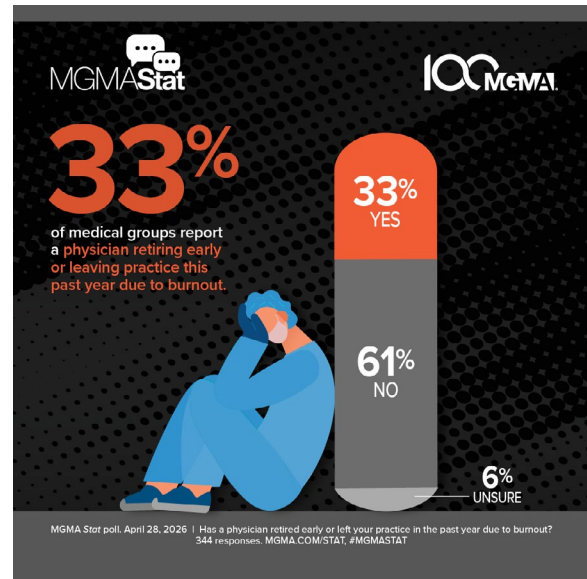
Workforce — adding staff, improving retention and adjusting compensation — was named the [single largest area of new 2026 investment](#) by 37% of leaders, ahead of health IT (30%) and revenue cycle and patient access (12% each). A [September 2025 poll](#) found nearly two-thirds (64%) of groups targeted a 1%–3% base-pay increase for staff in 2026 and 23% planned 4%–6%, even as margins tightened — confirming that pay pressure persist into 2026 even as productivity softens.



BURNOUT: A BASELINE CONDITION

Physician burnout has settled from a pandemic-era spike into a persistent baseline that keeps pushing experienced clinicians out earlier than planned — and the administrative load is a primary culprit.

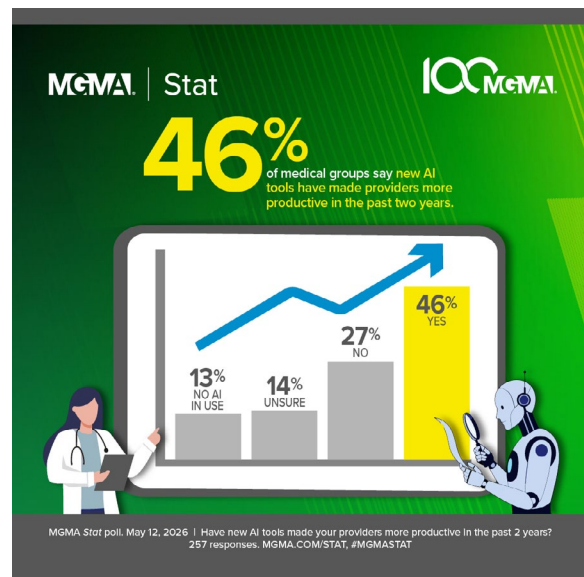
One in three (33%) medical groups reported [a physician retiring or leaving in the past year due to burnout](#), up from 27% in late 2024. [MGMA's 2026 Regulatory Burden Report](#) found 77% of practices cite regulatory and administrative burden — prior authorization, denials, automatic downcoding and quality-reporting mandates — as a major contributor to burnout. Even so, [national survey data](#) point in a modestly hopeful direction, with overall physician burnout symptoms easing to roughly 42% in 2025, though emergency medicine, urologic surgery and hematology/oncology remain near 50%.



WASN'T AI SUPPOSED TO FIX ALL THIS?

A few years into AI's rollout in medical group practices, the productivity question has moved past the pilot stage. Practice leaders who signed contracts and shepherded adoption of AI tools are now asking sharper questions: Are they delivering returns in the operational metrics that sustain a practice — patients seen, documentation completed, revenue captured, and rework avoided — beyond improvements in clinician enthusiasm or satisfaction scores?

Our [May 12, 2026, MGMA Stat poll](#) put that question directly to medical practice leaders: **Have new AI tools made your providers more productive in the past two years?** Less than half (46%) say they have. Another 27% report no productivity gains from AI, 14% are unsure, and 13% say they do not use AI at all. The poll had 257 applicable responses.



The topline numbers already suggest a complicated story; open-ended responses show how textured it really is.

- **In practices reporting gains**, ambient AI scribes dominate as the primary driver of productivity. Respondents repeatedly named ambient tools for speeding note completion and easing administrative burden. Coding assistance, clinical decision support, and generative AI tools (for denials, summaries, and patient messaging) came up too, but far less often and usually mentioned as complementary tools.
- **Where AI hasn't moved productivity**, leaders pointed to adoption and integration friction: resistance to change, inconsistent use, training needs, and poor EHR interoperability that breaks the workflow. Cost and implementation burden came up frequently, along with doubts about the tools' maturity — particularly around accuracy, specialty fit, and day-to-day practicality. Several leaders in this group told MGMA that even where AI cuts documentation time and burnout, it hasn't translated into more visits or measurable productivity, which feeds their skepticism.
- **The “unsure” group is largely a measurement problem.** Many practices are still implementing AI, waiting for access, or lack visibility into who is using the tools and how often. That inconsistency, paired with limited tracking and feedback, makes it hard to establish a productivity baseline, let alone measure change. Some leaders cited anecdotal drops in administrative burden, but the impact on visit volume, RVUs, or other measurable productivity metrics isn't clear yet.

Most non-users plan to adopt AI within the next 12 months, drawn by expected gains in efficiency, productivity, cost reduction, and patient satisfaction — and many are already researching or piloting AI scribes and scheduling tools. A smaller group is hesitant or opposed, citing leadership disinterest, clinical or data sensitivity concerns, and dissatisfaction with their existing EHR-native AI features. Others are limited by practice structure (e.g., hospital-based settings) or general uncertainty. Intent to adopt is broadly high; readiness and feasibility vary.

A Closer Look: The 2026 Efficiency Adjustment

The 2025 trends in this report reflect operational, access, volume, mix, coding and plan-design movement. They are not the results of the new Medicare Physician Fee Schedule; however, it is important for practices to understand how provider compensation is already being reshaped and the impacts for next year's benchmarks.

CMS finalized a 2.5% “efficiency adjustment” that reduced the wRVU value of roughly 7,700 non-time-based codes — procedures, surgery, imaging interpretation and diagnostics — effective Jan. 1, 2026. Time-based services are exempt, including office and emergency-department E/M, critical care, observation, care management, behavioral health, telehealth-list services and maternity global codes. The conversion factor rose, which lifts what practices collect per service. But that increase doesn't reach physicians paid on wRVUs — the procedures they perform now book fewer wRVUs — so for procedure-heavy specialties, the practice's reimbursement and the physician's measured production move in opposite directions.

MEMBER-EXCLUSIVE RESOURCES

- Access MGMA Government Affairs' [Work RVU Efficiency Adjustment resource](#).
- Read our [specialty strategies for comp impacts from the adjustment](#).
- Revisit the basics of how to [impact model an RVU shift and compensation impacts](#).

The key thing that changed is measurement. A physician doing the exact same work in 2026 will simply record fewer wRVUs on the affected codes. Two things follow for next year's benchmarks:

1. Procedural, surgical and imaging specialties start the year with a built-in wRVU drag of roughly 0.5% to 2.5%, depending on their mix of services.
2. Comp-per-wRVU ratios will climb on their own — the same pay divided by fewer wRVUs — so fair-market-value (FMV) thresholds and plan conversion factors can look like they're rising even though no one's actual pay changed.

The pain lands where it hurts most. The fields facing the deepest 2026 wRVU cuts — urology, interventional cardiology, diagnostic radiology, ophthalmology — are also some of the hardest specialties to recruit, and several of them already showed softer productivity in 2025, before this change took effect. Groups will have to keep pay competitive for these doctors at the very moment their measured production gets squeezed, while E/M-driven primary care and the cognitive specialties are largely protected.

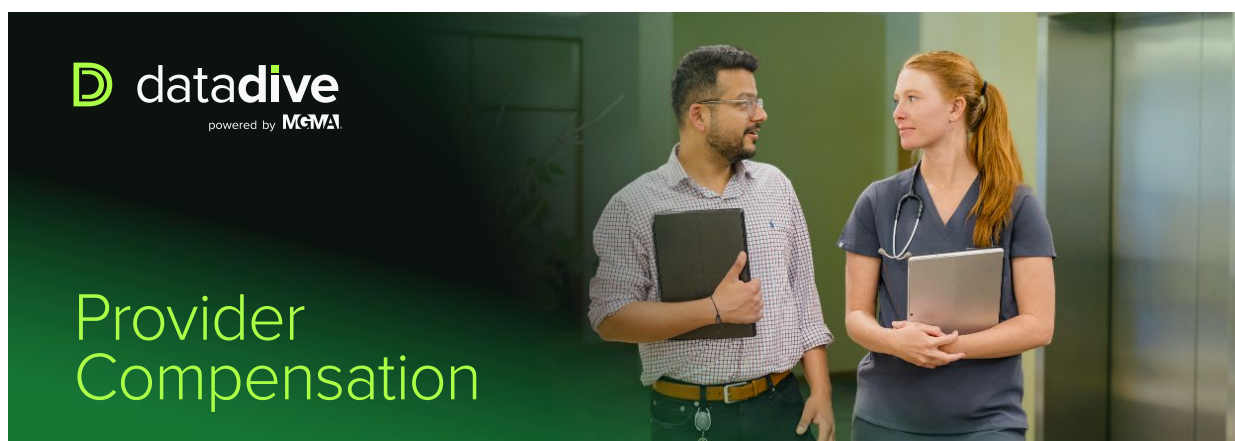
Bottom line: expect 2026 benchmarks to show a second straight year of falling wRVUs for procedural specialties — but this time part of the drop is on paper, not in the exam room. Comp-per-wRVU ratios will drift upward simply because the same pay is divided by fewer wRVUs, not because anyone got a raise. Read 2026 comp-per-wRVU and FMV numbers with that in mind.

Conclusion

We've witnessed an unfamiliar split: pay kept rising while productivity slipped. Work RVUs fell in most specialties and encounters fell in all of them, yet compensation climbed across the board — a sign that groups are still paying more to attract and keep scarce providers than they are paying for output. How that shakes out differs by setting. The simple cut between ownership models shows real gaps: most physicians in independent practices still lead in volume and collections, while physicians in system-owned groups often get paid comparably or more for less measured production. The real world is messier than those two buckets — independent, system-employed, academic, government, and a growing set of MSO- and investor-backed arrangements all behave differently — but the basic tension holds no matter who signs the checks.

What's testing every group is the same short list of issues. Productivity softened, Medicare still pays most practices below the cost of care, and a 2026 Medicare wRVU revaluation changes how production itself gets counted. Underneath those numbers sit the issues keeping leaders up at night: burnout has hardened into a baseline cost of doing business — one in three groups lost a physician to it last year, with most pointing to administrative and regulatory load — and every departure is harder and costlier to backfill. In response, leaders are rebuilding care teams around APPs, with nearly half of groups adding them relative to physicians to protect access, and betting on AI to win back clinician time, even if the payoff so far looks uneven.

It all comes down to one question: can the practice keep its doors open and its schedule within reach for patients? Getting there takes more than watching wRVUs. The leaders who track the full picture — volumes and CPT® code mix, payer mix, the cost to deliver care, and the true “value per encounter” — will make the soundest staffing and strategic calls in a year when the benchmarks themselves are shifting underfoot.



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Medical Group Management Association (MGMA) is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 58,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures and specialties that deliver almost half of the healthcare in the United States.