Looking Forward

Top 5 Trends Affecting Provider Compensation in 2026

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Overview

Structural shifts across the healthcare landscape are accelerating, reshaping market dynamics and intensifying pressures on provider compensation models.

Workforce shortages, shifting regulatory frameworks, evolving compensation structures, and increasing pressure to deliver value over volume are reshaping how hospitals, health systems, and medical groups operate. These challenges are not emerging in isolation. They are intersecting, accelerating, and compounding one another in ways that threaten clinical access, financial stability, and long-term organizational sustainability.

As the market continues to evolve at a progression that outpaces traditional governance and compensation models, healthcare leaders must anticipate change rather than react to it. The trends outlined in this article highlight the most critical forces influencing provider compensation and workforce strategy in 2026.

Trend #1: Provider Shortage and Sustainability
Trend #2: Policy Shifts Affecting Compensation
Trend #3: Breakdown of Call Pay Models
Trend #4: Rapid Integration of Advanced Practice Providers
Trend #5: Value-Based Compensation vs Compensation Models

#1

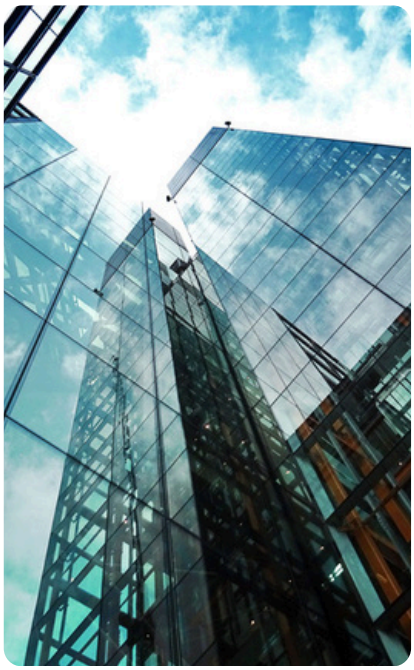
The Ever-Growing Provider Shortage and Its Ripple Effects on Healthcare Sustainability

The United States healthcare system continues to face critical provider shortages. According to the Association of American Medical Colleges (AAMC), the nation is projected to face a shortage of up to 86,000 physicians by 2036, with 47 states expected to experience primary care deficits by 2037.

This looming gap threatens patient access and the quality of patient care received, particularly in rural and underserved communities. While potential solutions such as partnering with local and regional medical schools, enhancing recruitment offerings like student loan repayment, and leveraging advanced practice providers (APPs) can be impactful, they only begin to address the structural challenges ahead.

Provider recruitment and retention pressures only add to the complexity. Despite modest improvements in late 2023 and early 2024, physician burnout remains alarmingly high, driven by administrative burdens, lack of flexibility, and intense competition for talent. To remain viable, hospitals and health systems must design creative, tailored compensation plans that align with institutional goals while fostering provider engagement and well-being. These types of compensation plans attract and preserve productive, high-quality providers as a tangible outcome tied to their contributions.

Compounding the problem, compensation amounts are escalating at a pace that exceeds revenue growth, particularly in shortage specialties. The inflation experienced is not episodic, it's structural. Retirement cliffs, training bottlenecks, and geographic disparities are pushing pay upward faster than market surveys can capture, creating internal compression and volatility in benchmark data.



“These developments underscore a fundamental reality: the market is reshaping itself faster than traditional compensation frameworks can adapt.”

Many organizations are raising base salaries, total cash compensation guarantees, sign-on bonuses, loan repayment packages, and subspecialty premiums to recruit and retain providers. For example, according to American Association of Provider Compensation Professionals (AAPCP) data, rural family medicine offers can reach up to $400,000 per year, well in excess of traditional benchmarks. Further, gastroenterology recruitment packages often exceed $700,000 with top offers approaching $925,000 per year. Oncology median annual total cash compensation is now $575,000 with the 90th percentile exceeding $775,000, and urology new hire offers often average $575,000 per year. Without comparable revenue growth, these increases are making operations unsustainable for many rural and community hospitals.

These developments underscore a fundamental reality: the market is reshaping itself faster than traditional compensation frameworks can adapt. Organizations must implement fair market value guardrails, internal equity frameworks, and dynamic market-adjustment policies to prevent pay disparities from becoming destabilizing forces. Without bold, strategic action, the convergence of provider shortages, burnout, and unsustainable compensation models will continue to erode access, equity, and financial stability across the healthcare landscape.

Next: Policy Shifts Create Disruption

#2

Policy Shifts and Structural Disruptions in Physician Compensation

The 2026 Medicare Physician Fee Schedule (MPFS) introduces sweeping changes that could reshape care delivery and physician compensation models. Beginning in 2026, the Centers for Medicare and Medicaid Services (CMS) reduced the indirect practice expense relative value units allocated to facility-based services by 50% when compared to the non-facility methodology.

This reduction will lower reimbursement for the same services when performed in a hospital setting, shifting indirect cost payments to office-based settings. This shift aims to discourage hospital consolidation and promote care in lower-cost environments, but it poses a significant revenue risk for hospitals and health systems that rely heavily on facility-based reimbursement.

“the rule includes a -2.5% efficiency adjustment which cuts work relative value units”

Compounding this risk, the rule includes a -2.5% efficiency adjustment which cuts work relative value units (wRVUs) for physician services, driven by productivity adjustments in the Medicare Economic Index over the past five years. For hospitals employing physicians or billing under facility-based models, these changes could translate into lower reimbursement and additional financial strain.

Beyond payment reductions, disparities in MPFS adoption has emerged as one of the most significant variances in physician compensation governance. Adoption of different MPFS years across specialties creates inconsistencies in wRVU attribution. For example, AAPCP reports 34% and 69% of oncology and family medicine providers are compensated on the current 2025 MPFS while 23% and 16% are still compensated on the 2020 MPFS, respectively.

With wRVU increases between 2020 and 2025 ranging from 8.7% to 21% for certain specialties, physicians are effectively being paid at different rates, driving artificial inflation or deflation of compensation per wRVU. This misalignment risks internal inequity and introduces fair market value volatility, sometimes creating misleading productivity comparisons across multispecialty groups.

“Organizations must treat MPFS-year alignment as a material governance issue, requiring a standardized approach, not just an operational adjustment.”

Policy changes show no sign of slowing. In addition to the 2026 MPFS, the One Big Beautiful Bill Act (OBBBA), signed into law on July 4, 2025, includes over $900 billion in healthcare cuts, impacting Medicaid, Affordable Care Act subsidies, and various tax provisions. The legislation is projected to increase the uninsured population by 14 million by 2034, while introducing new eligibility and documentation requirements that demand robust compliance strategies. Hospitals must also monitor the potential impact of H-1B visa fees, though advocacy efforts are underway to secure exemptions for healthcare personnel.

These policy shifts underscore a fundamental truth: healthcare organizations face a convergence of regulatory, financial, and operational pressures that demand proactive governance. Organizations that act decisively by standardizing strategy, while remaining agile, will be best positioned.

Next: Call Pay Breakdown

#3

The Breakdown of Call Pay Models

According to AAPCP research and reports, call compensation is now one of the most fragmented aspects of provider pay and a major source of physician dissatisfaction. Data across specialties show not only variation in compensation but also structural differences, increasing the organizational risk of inequity and turnover and leading to challenges with determining fair market value. In 2025, the AAPCP published multiple reports, performing deep dives into oncology, urology, gastroenterology, and family medicine call practices. The results supported this assertion.

- In oncology, only 20% of organizations pay separately for call, even though call.
- Urology presents an opposite problem. A majority of organizations pay for call, with little consistency in how rates were derived.
- More than half of organizations pay only after a physician exceeds five to ten call days per month, effectively treating call as a baseline requirement for employment.
- Finally, according to AAPCP's latest research, family medicine largely bundles call into base compensation. This likely makes sense given the lack of any need to physically present at a location.

"The reality, however, is that the resulting approaches vary widely across markets and groups, leaving ambiguity to the logic behind the structure."

Another concern is that most call pay models do not reflect actual burden, nor the underlying job requirements. Frequency alone does not capture the work involved. Factors such as call intensity, facility coverage, after-hours workload, and activation likelihood significantly affect the intensity of the work but are inconsistently considered in compensation.

As a result, physicians with different call experiences may receive the same pay, while others with similar burdens are paid very differently based on precedent rather than analysis. As an example, an organization might pay a 90th percentile rate for base compensation and pay for call in addition, without it being excessively burdensome (in comparison to peers in the same specialty), resulting in risk.

However, another organization might pay a 25th percentile rate for base compensation, but not pay for any call with only three individuals in the rotation. This situation creates several risks for compensation strategy. Inequity becomes apparent, especially in multispecialty groups with varying call demands. Turnover risk rises as physicians seek employers who recognize call burden more transparently. Fair market value defensibility is at a high risk when rates are not linked to objective workload factors.

The solution is greater standardization, not more individualized negotiation. Health systems should adopt burden-based call structures that account for frequency, intensity, facility count, after-hours workload, and activation patterns. These frameworks are required to be applied consistently, with specialty-specific adjustments rather than exceptions.

Implementation can follow three phases: (1) Conduct an in-depth audit to assess current practices and identify gaps; (2) Pilot the new framework in select departments and modify based on outcomes; and (3) Roll out the standardized model system-wide.

Delivering a straightforward strategy and timeline will help turn advocacy into action. Until call compensation is treated as a measurable workload (sometimes that is simply a part of the job and not paid incrementally) rather than a negotiated assumption, it will remain a persistent source of dissatisfaction and risk in provider compensation programs.

Next: It's Not Just a Physician World After All

#4

Advanced Practice Provider Integration

Advanced practice providers (APPs) are now central to care delivery in nearly every specialty, but compensation models have not kept pace with their integration. This lack of alignment between responsibility, accountability, and pay creates legal, operational, and morale risks.

Many organizations might hear an APP state something like the following: ‘We often have substantial clinical responsibilities, but it’s disheartening that our compensation does not reflect that.’ A physician working alongside an APP might also state: ‘Collaboration and training demands time and effort that aren’t adequately recognized, especially at the beginning of an APP’s career, which affects our job satisfaction and team functioning.’

One critical issue in any compensation strategy is the need to align compensation with actual roles and responsibilities. The evolution of productivity and effort-based compensation for APPs is lagging, as is the understanding of how to compensate physician and APP integration.

“compensation should be driven by actual and incremental work, not historic anecdotes”

According to AAPCP data, in primary care, nearly two-thirds of organizations compensate physicians for APP collaboration. In urology, fewer than half do so, with wide variation in structure. Gastroenterology lags further, with only about 30% providing supervision pay. Even in oncology, where APPs manage complex services, only about one-third of organizations offer supervision compensation. Payment for supervision and training should either be an expectation or paid incrementally based on actual incremental work beyond normal activities.

Aggravating the situation is that APPs are increasingly being asked to provide the initial training for new APPs through fellowships and formal transition to practice programs, removing the training burden from collaborating physicians. Further, APPs are increasingly functioning as independent clinicians.

Panel ownership, clinical complexity, and care coordination responsibilities often sit with the APP, even when collaborative relationships exist. An AAPCP member survey revealed a wide disparity in production or effort-based compensation models for APPs. For example, close to 30% of participating organizations stated they did not have APPs on production models in primary care.

“This is significant and creates a scenario where APPs are independently managing care but are not financially supported to do so.”

From a workforce strategy standpoint, physicians perceive oversight as uncompensated work, layered on top of already demanding clinical responsibilities. APPs experience variability in support and governance, which can affect quality, integration, and job satisfaction. Organizations face compliance risk when requirements are not matched with appropriate time allocation and compensation.

To resolve these problems, engaging both APPs and physicians in co-design sessions for new compensation models can play a key role. By encouraging a cooperative environment, both groups can contribute insights, which can help minimize resistance and support smoother adoption of new strategies.

Sustainable models need clear frameworks. Supervision and production compensation should be driven by actual and incremental work, not historic anecdotes. Without addressing these alignment issues, APP integration will advance operationally while compensation and governance will continue to lag, creating friction that undermines long-term staffing stability.

Next: Value-Based Battle

#5

Value-Based Compensation Versus Compensation Models

Value-based incentives are now common in provider compensation discussions, but their role remains limited compared to the financial and business demands of most organizations. Although adoption is increasing, the structure and weighting of value-based pay have not kept pace with payer demands or care delivery models.

According to AAPCP research, nearly three-quarters of primary care organizations have adopted value-based incentives, positioning the specialty as early majority adopters. Oncology follows at just over half, while gastroenterology and urology lag at 20% to 35%, indicating late adoption. This lag may be an indicator of trends amongst most procedural and surgical specialties. Even where value-based compensation exists, it usually accounts for only 5% to 15% of the total. Most payouts are annual, retrospective, and not linked to instantaneous decisions. Metrics frequently lack clarity at the clinician level, and compensation is still centered on wRVU production.

The failure to keep pace with value-based models creates a growing disconnect. All specialties are increasingly influenced by payer incentives, downside risk arrangements, and federal programs. Compensation systems, however, still reward volume over value, sending mixed signals to clinicians expected to manage cost, quality, and access.

The challenge is not whether to include value-based compensation, but how to integrate it. Bonus style models treat value as optional and secondary, rather than a core component of clinical performance. This limits impact and supports volume centric decision making. More effective approaches embed value directly. This approach can include adjusting wRVU rates based on quality, adding panel-based outcome components, or using blended models that weight value and production together. These structures recognize it as integral to clinical work.

Organizations should form a value-based compensation committee, co-led by a clinician and a leader in provider compensation, with the sole responsibility of managing value-based compensation integration. The committee should be responsible for integration, not negotiation or how much to pay, but rather creating practical measures that help align compensation models with the evolving healthcare environment.

Conclusion

The trends shaping today's healthcare landscape point to a clear reality: legacy approaches to provider compensation, workforce planning, and governance are no longer sufficient. Provider shortages, policy volatility, call pay fragmentation, APP integration challenges, and the uneven adoption of value-based incentives each represent significant risks on their own. Together, they form a structural inflection point that demands strategic, data-driven action. Organizations that succeed will be those that modernize compensation frameworks, lean into cross-disciplinary collaboration, and proactively align their models with operational, regulatory, and financial foresight.

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