A New Physician Enterprise: Rethinking Physician–Hospital Alignment

By Susan Corneliuson and Ryan Harris, Guidehouse

In recent years, physicians have largely abandoned the model of independently owned private practice in favor of being employed. Nearly three-quarters of all U.S. physicians are now employees, and about half are employed by health systems or hospitals.[1]

The trend has continued to accelerate over the past few years as new disruptors and innovators have entered the space, resulting in an 88 percent increase in corporate ownership of physician practices.[2] Yet it's become clear that current physician alignment structures within hospitals and health systems are struggling to remain economically viable.

As payers shift more volume to ambulatory care and physicians become further isolated from market forces, health systems need to start thinking differently. Progressive health systems are beginning to position ambulatory services on par with acute services, opening up opportunities for new physician enterprise structures that can succeed under changing market forces. This has created an imperative for board leaders to recognize the existing market opportunity to unlock physician potential by realigning economic incentives and the value of the physician enterprise.

KEY BOARD TAKEAWAYS

- **Transform your perspective.** Understand the true value the physician enterprise brings to your health system and take a transformative view.
  - » Has the system maximized its physician enterprise value?
  - » Is the physician enterprise driving market growth?
  - » What community impact are you creating related to prevention, wellness, and outcomes?
- **Consider a more deliberate approach for aligning economic incentives with physicians.**
  - » Which structure is best for your system?
  - » How can the physician alignment model evolve to drive long-term value for the system and for physician stakeholders while delivering quality care to the patients served?
- **Be willing to give up some control.** Creating economic alignment will require a loss of control and increased investment from physicians in not only the corporate structure but also management of operations.
  - » Which tradeoffs of control and hospital outpatient department revenue are you willing to make in exchange for decreased physician enterprise financial losses and greater physician alignment?
- **Do your due diligence.** Changes of this scale require thoughtful consideration related to governance, leadership, and legal matters. Work with trusted partners to develop a well-laid strategy and achieve the ideal structure, partnerships, and operating model.

How We Got Here

In the 1990s, as health maintenance organizations were gaining a stronghold, health systems raced to employ physicians with the intention of securing those primary care gatekeepers. Then, as professional fees were squeezed in the early part of the new millennium, health systems felt pressured to secure specialty business by employing specialty-care physicians.

The initial impetus for these strategies was driven by the expectation that employing physicians would:

- Expand patient access to necessary services.
- Provide a pathway to value-based care and population health.
- Secure financial viability for acute care services.
- Create opportunities for enhanced continuity of care.

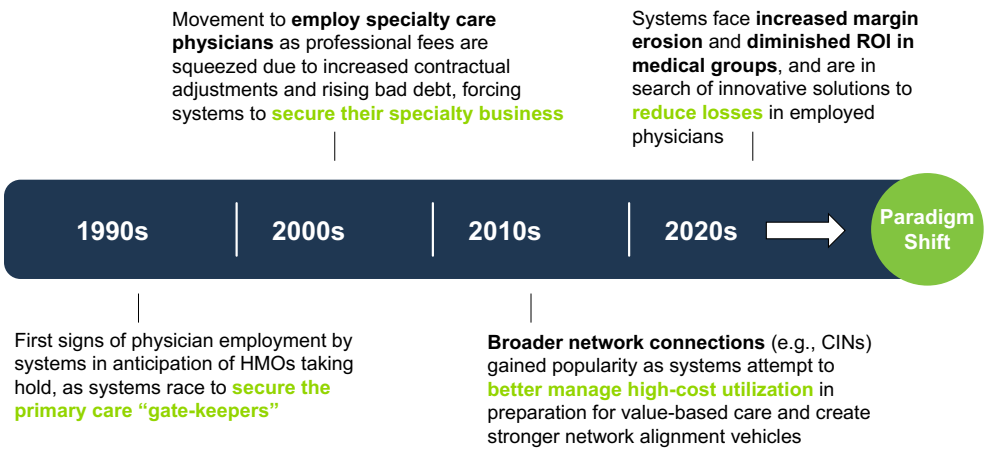
Over the next decade, CMS's push toward value-based care and desire to control total costs of care, combined with health systems' desire to better align with independent physicians, led to increasing development of clinically integrated networks (CINs) and other broad network connections. However, these networks often lacked appropriate incentives and the right balance of physician risks and rewards, resulting in lackluster performance. And with the pandemic accelerating margin erosion and diminishing medical groups' return on investment, health systems have been searching for innovative solutions to mitigate these growing losses.

An Outdated Model

Current market dynamics and increasing financial losses are driving health systems to rethink their physician enterprise and alignment strategies. In order to create a viable future-forward structure, organizations must understand how some or all of the following features of existing models are impacting their ability to succeed.

Insulation from market forces: Employment of physicians has led to conflict

Exhibit 1: Health System Employment of Physicians: A Quick Timeline



1 *Physician Employment and Acquisitions of Physician Practices 2019–2021 Specialties Edition*, Physician Advocacy Institute, June 2022.
2 *Ibid.*

between the provision of healthcare and the realities of business economics, with insufficient risk to induce behavioral change and insufficient reward to fire the entrepreneurial spirit. Incentives implemented as a measure to balance quality and cost have been minimal. A study published in *JAMA Health Forum* notes that quality and cost performance-based financial incentives average just 9 percent of total compensation, while volume-based productivity incentives comprise the majority of physician compensation.[3]

There has also been minimal disincentive when physician productivity has underperformed. Sheltering physicians from market forces and economic realities has resulted in higher health system expenses, aggravating losses. In a recent American Medical Group Association (AMGA) survey, reported average physician enterprise losses were in excess of $250,000 per physician, with expenses outpacing revenue gains due to high labor costs, stagnant fee schedules, and regulatory changes.[4]

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Loss of ancillary revenue: Changes in hospital financial reporting have made it appear that the physician enterprise is losing money when compared with how successful independent medical groups operate. For example, hospitals have typically realigned billing for ancillary services such as imaging and lab tests to capture higher hospital outpatient department (HOPD) rates, which were previously billed for and collected by physicians. What remains for the physician enterprise to bill and collect on is evaluation and management services—resulting in higher incurred losses and lower income for the practice.

Payers are now shifting site of service to the ambulatory space and to lower cost-of-care settings, resulting in a loss of HOPD business. This space has also become ripe for disruptors, who are aggregating ambulatory surgery centers and other ancillary revenue streams to capitalize on this economic dynamic. Hampered by outdated models and regulatory constraints, the physician enterprise faces increasing pressures to turn around losses despite the reality that there's no good way to do that under the current employment model.

Increased administrative burdens: With increasingly stringent documentation and regulatory requirements falling on physicians' shoulders, the time they must devote to administrative tasks has increased. Studies estimate that physician time spent on administrative work can range from about 50 minutes per visit to six hours a day interacting with electronic health records.[5]

To address these administrative duties, physicians increasingly find themselves working outside of normal business hours to stay afloat. And the persistent volume of messages they have to review and respond to has been linked to physician burnout as detailed in a research article published by *Health Affairs*.[6] The impact of these burdens—which often stems from poor operational efficiencies, insufficient technology-enabled solutions, and high workforce turnover—limits the number and types of patients physicians can see each day. This further restricts access to care and opportunities for revenue generation.

Lethargic employment structures: Today's physicians have become burdened with the traditional hospital structure's inherent slower pace at a time when they need to be significantly nimbler and more responsive, especially given the speed of technology advancements and patient care models. Overburdened with high overhead cost allocations, sluggish information technology platforms, and limited capital investments, the physician enterprise is unable to keep pace with the market. And rigid hospital employment models often fail to address the growing desire for increased flexibility, enhanced work-life balance, and greater autonomy expressed by many physicians.[7]

The Consequences

As a result of these factors, many physicians are choosing to either leave the workforce entirely or take advantage of new opportunities such as virtual care delivery work or roles with private equity-backed organizations—believing that this will allow them to focus more on patient care delivery and quality of care while achieving a better work-life balance.

Employed physicians are also earning less money in real dollars as a result of inflation outpacing flat to modest salary gains.[8] Combined with the number of doctors aging out of the workforce, this is expected to lead to physician shortages—particularly in key specialties such as primary care, cardiology, and oncology. The American Association of Medical Colleges predicts a shortage of at least 37,000 physicians to potentially more than 100,000 physicians nationwide over the next decade.[9]

These weaknesses in the current physician employment model have

3 Rachel Reid, et al., "Physician Compensation Arrangements and Financial Performance Incentives in U.S. Health Systems," *JAMA Health Forum*, January 28, 2022.
4 "New Survey Finds Medical Group Operating Costs Continue to Outpace Revenue" (press release), AMGA, December 18, 2023.
5 Lisa Rotenstein, et al., "System-Level Factors and Time Spent on Electronic Health Records by Primary Care Physicians," *JAMA Network Open*, November 22, 2023; Brian Arndt, et al., "Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations," *Annals of Family Medicine*, September 2017.
6 Ming Tai-Seale, "Physicians' Well-Being Linked to In-Basket Messages Generated By Algorithms in Electronic Health Records," *Health Affairs*, July 2019.
7 Leslie Kane, "Medscape National Physician Burnout & Suicide Report 2020," *Health Affairs*, 2020.
8 Kim Abraham and Daniel Novinson, "Physician Salaries Not Keeping Pace With Inflation, Delaying Retirement for Many," Voices from the Doximity Network, August 30, 2022.
9 "AMA President Sounds Alarm on National Physician Shortage" (press release), AMA, October 25, 2023.

led to the rise of physician enablement organizations and new-entrant disruptors such as private equity firms, retailers, and tech companies. While provider enablement companies are generally incentivized to work together with physician groups, partnering with a private equity firm can be problematic depending on how expectations are structured.

According to a recent study by the American Antitrust Institute, acquisitions by such firms can be associated with price and expenditure increases—and these conditions can be exacerbated when the firm controls more than 30 percent of the market.[10] Physicians in that situation may also feel a greater loss of autonomy, increased pressure to maximize profits, and higher levels of burnout and dissatisfaction with the practice of medicine.

Despite these concerns, more physicians are turning to new market entrants. Without making changes to compete with these disruptors, health systems now face increased risk of deteriorating financial conditions and market position—with the real possibility of takeovers or insolvency looming on the horizon for many.

For Consideration: A New Approach

The health system physician enterprise model of the future must look radically different from historic models, evolving to drive long-term value for system and physician stakeholders while delivering quality care to patients.

To achieve this vision, health systems should consider models that create a higher level of economic ownership with their physicians as well as partnerships that appropriately capitalize the physician enterprise—allowing them to compete with new market entrants and disruptors. Models to be explored could include physician enterprise joint ventures or other mutually beneficial partnerships that drive value and win-win solutions for stakeholders.

These partnerships could be augmented to include third-party investors such as private equity companies, venture capital firms, or other market disruptors, including tech and retail players. Doing so could allow for fresh injections of capital, innovative business management principles, and technical capabilities for the newly formed partnerships.

From a health system perspective, this next-generation model would:

- Accelerate the shift to a value-based care model—a paradigm shift that's critical to addressing healthcare's rising costs while improving patient outcomes.
- Create a platform for long-term value creation by helping to reduce high-cost utilization, hospitalizations, and length of stay—allowing a stronger focus on prevention, wellness, access, capacity, and the patient experience.
- Right-size system investments in employed groups through reduced physician subsidies—a prudent, significant cost-control measure.
- Improve patient capture rates, reduce leakage, and support patient continuity of care.

From the physician group perspective, an effective model would:

- Increase physicians' earning potential through a share of technical fees and other profits made possible by a joint venture ownership stake (subject to regulations).
- Realign incentives to drive revenue and cost containment, thereby improving access, keepage, and high-cost utilization.
- Create a nimbler, more responsive management structure to enable rapid change, mobilization, and enhanced technology/automation.
- Give physicians more autonomy when it comes to clinical decision making,

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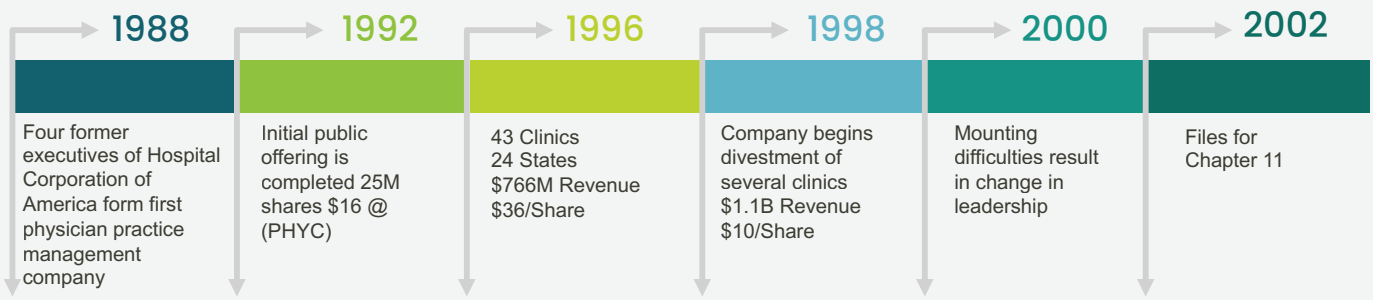
A History of Physician and Private Equity Ventures

PhyCor, Inc. and its subsidiaries provided administrative management services to physician networks and medical groups. The company managed 40 medical groups with more than 2,500 doctors in 21 states and nearly 26,000 physicians through networks in 29 healthcare markets. Through PhyCor's subsidiary, CareWise, Inc., the company provided support and assistance to more than 3.3 million consumers in making decisions about medical care. To create, with physicians, the best value in medical care for its community.

As interest rates have gone up, disruptors are facing demands for margin overgrowth. This quickly impacted "insur-techs" like Envision Healthcare and Cano Health, Inc.



10 Richard Scheffler, et al., "Monetizing Medicine: Private Equity and Competition in Physician Practice Markets," American Antitrust Institute, July 10, 2023.

their approach to patient care, and practice management.

The combination of this type of structure with an emphasis on economic alignment can attract physicians by providing entrepreneurial rewards, quality-of-life enhancements, and greater control over day-to-day practice decisions.

When executed with thorough planning and precision, a new physician enterprise model can lead to:

- Better patient care through improved operational and clinical efficiencies
- Improved margins and a better market position for health systems
- Enhanced physician autonomy, investment, and satisfaction with the practice of medicine

The result? A true "win-win-win" for health systems, physicians, and patients.

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Caveats

This type of model might be easier to accomplish in markets in which physician groups are accepting higher levels of risk reimbursement and have a greater level of control over total cost of care. Essentially, physician organizations that can tap into new revenue sources by controlling costs and aligning incentives will have a greater potential to drive profits. Organizations that have been moving more slowly into value-based care will need to evaluate the probability of higher levels of productivity, as well as the potential opportunity to bill for ancillary services and the total impact on margin before the physician enterprise strategy can be reset.

The reality is that in employing physicians, hospitals have destabilized physician practice economics and asserted "divine rights" over what was once considered physician revenue streams. Board leaders and executives need to acknowledge that this type of restructuring means giving up a portion of that revenue—recognizing that physicians aren't a drain on resources but are rather the engine that can drive revenue if properly positioned.

Of course, contemplating a new physician alignment model represents a significant shift for leaders who have already been struggling with so much change and market pressures in recent years. It can't be accomplished overnight, and health systems need to consult with their advisors and partners to thoroughly consider various options. This requires a more intensive investment of time and strategic thinking—meaning leaders may need to first determine the depth of internal commitment before pursuing these options further.[11]

Case Study: Evolving Physician Enterprise Strategy Supports Larger Transformation Initiative

Guidehouse is working with a nationally recognized health system that is in the thick of pursuing this new physician enterprise model today. After developing with full board support an enterprise transformation initiative, the organization redesigned its clinical operations and invested in a future-focused, high-tech ambulatory strategy. Within just a short period, system leaders were able to mitigate risk, enhance safety, and meet community needs against the challenging backdrop of a volatile industry environment. Having successfully strengthened its market position through that initiative, the health system has recently decided to sell off a portion of its clinical assets to a physician enablement firm, which will allow for an infusion of capital for needed technology and infrastructure that will further its transformation.

Making the Business Case

From a board perspective, if significant investments in physician groups have already been made and continue to lose money, how can you create a different model to lessen or eliminate those losses?

It can be difficult to globally identify whether this next-gen physician enterprise model would be ideal for a health system to pursue because that largely depends on unique state laws and regulations. Being able to make the business case for doing so requires a thorough independent analysis that considers your organization's broader strategy, current business health, and pending capital investments.

A True Market Opportunity

The ultimate aim of this type of structure is to marry a nimble, responsive organization with a patient-centric mindset. When done right, organizations can create a real market opportunity to not only attract new physicians but also regain the trust of employed doctors who are facing burnout as well as independent physicians struggling with the burdens of private practice.

The Governance Institute thanks Susan Corneliuson, Director, Physician Enterprise Services, and Ryan Harris, Managing Consultant, Physician Enterprise Services, Guidehouse, for contributing this article. They can be reached at scorneliuson@guidehouse.com and rharris@guidehouse.com.

11 Thomas Zenty and Danielle Dyer, "Moving from 'Yes Boards' to 'Best Boards': 5 Things to Consider," Guidehouse, January 10, 2023.