KaufmanHall
a Vizient® company

April 2025

Hospitals Keep Losing Money on Physicians. Is There Another Way?

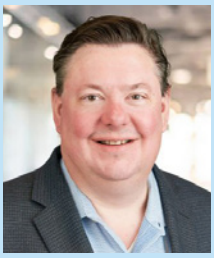
Hospitals are losing money on physician practices. Hospitals know this, and yet they keep hiring them. Maybe they should consider alternatives.

Today, about 55.1% of physicians are employed by hospitals or health systems. The shift away from independent practices was intended to enhance care coordination and streamline operations. But losses, stemming from generous salary and benefit packages, escalating malpractice insurance premiums and lower-than-expected returns on investment, are mounting. Hospitals currently lose an estimated $306,792 per physician per year, an increase of 5% over a year ago, according to the most recent Kaufman Hall Physician Flash report.

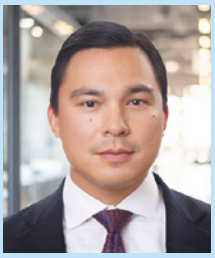
Health systems cannot sustain this kind of financial strain indefinitely. The thinking behind the broad-based employment of physicians and, in some instances, the acquisition of their practices may have made sense at the time, but the numbers are no longer working.

There are several reasons why. Start with **challenges with reimbursement**. The shift to hospital employment often leads to physician services being billed under hospital outpatient (HOPD) rates, which are higher than those of independent practices. However, regulatory changes and competition from independent ambulatory sites have reduced these reimbursement advantages, making it more difficult for hospitals to offset the costs of employing physicians.

Secondly, there is **overutilization of low- or negative-margin services**. Many hospitals incentivize physicians to increase service volume. But more isn't necessarily better. Too many hospitals have fallen into the trap of focusing on volume and/or revenue growth over margin. But more volume can actually compound the loss if the service underperforms. The continued decline of revenue per wRVU demonstrates this all too clearly.



Matthew Bates
Managing Director,
Service Line Leader,
Physician Enterprise



Kristofer Blohm
Managing Director and
Mergers & Acquisitions
Practice Co-Leader

Third is **administrative burden**. Integrating physicians and, in particular, whole practices into hospital systems requires significant investment in administrative infrastructure, including electronic health record systems and compliance programs. These integration efforts are costly and can lead to operational inefficiencies, particularly if the hospital struggles to standardize procedures across newly acquired practices.

In other words, hospitals have been acquiring physicians with little attention paid to their profitability. They've been hoping to achieve economies of scale that in many instances just haven't been there. As Ken Kaufman has pointed out: "If a factory is losing $5 on every widget it produces, the answer is not to produce more widgets. Rather, expenses need to come down."

Alternatives to physician employment

So, what to do about it? Hospitals have tried affiliation models like professional services agreements in the past, with limited success in some instances. But it might be time to consider new potential arrangements. Systems are only starting down this path, so the field does not yet have many tried-and-true models. Still, hospitals

do have options—models that align their goals with physician interests without assuming full employment costs. These alternatives provide flexibility, shared risk and opportunities for sustainable financial growth or at least ways to reduce losses. Consider:

1. **Joint ventures in ambulatory surgery centers**

   Ambulatory surgery centers (ASCs) represent a strategic avenue in an increasingly decentralized care environment. By working with physicians through joint ventures that offer autonomy and align financial incentives, hospitals can retain some market share and preserve a stake in downstream profitability. These partnerships should create a shared incentive structure that supports operational efficiency and positive margin.

2. **Converting primary care clinics into federally qualified health center look-alikes**

   Hospitals can transition primary care clinics into federally qualified health center (FQHC) look-alikes, reducing financial burden while ensuring continued patient access. FQHC look-alikes receive enhanced Medicaid and Medicare reimbursement, as well as federal grants, reducing the need for direct subsidies from the hospital. Physicians working in FQHCs often receive medical school loan forgiveness, making this an attractive alternative to hospital employment. Options to collaborate with existing FQHCs to provide primary care may also be viable options in some markets.

3. **Value-based care arrangements**

   Hospitals can align with physicians through value-based care models such as accountable care organizations, bundled payment arrangements or other revenue-sharing plans. These models reward both hospitals and physicians for cost-effective, high-quality care without requiring employment. By sharing savings and risks, providers can incentivize quality while reducing unnecessary utilization. Value-based care plans aren't new, but health systems by and large have been slow to embrace them.

> **Hospitals have been acquiring physicians with little attention paid to their profitability. In many instances, economies of scale just haven't been there.**

By considering these alternatives, hospitals can foster stronger clinical relationships and improve financial sustainability without directly employing physicians. If they're successful, these could lead to an added benefit: improved access to care for patients.

Mapping out a strategy

If some of these ideas seem familiar, that's because we've been down this road before. Hospitals have had a "can't-live-with-them, can't-live-without-them" relationship with doctors for decades. But this time around it's worth asking whether the cycle of acquiring, then divesting, then reacquiring practices is good for the long-term health of the organization. This current period—in which the cycle of physician ownership may be approaching the divestiture phase—might be an ideal time to engage in that once-and-for-all conversation.

First, **physician employment shouldn't be treated as a binary proposition**. Health systems should assess where they're consistently losing money and where they're at risk of losing high-performing physicians. Underperforming service lines may no longer justify continued investment, especially if shifting care models or reimbursement pressures make future profitability unlikely. Conversely, profitable service lines may face physician attrition as private equity-backed groups and independent ASCs offer more attractive arrangements. The strategic challenge is to identify where hospitals are already losing margin—and where they could soon lose clinical talent.

Secondly, hospitals may **contemplate partnerships with nontraditional entities**. Start with existing FQHCs and ASCs as mentioned above. Then there's the potential to work with physician groups backed by private equity, although this carries its own set of risks, so caution is required. The same is true with retail- and pharmacy-based providers; some are aggressively growing, some are pulling back, and it's best to make sure that expectations are clear and incentives are aligned. Collaborations with payers (e.g., a large managed care organization) and/or direct contracts with large employers may make sense in certain markets.

This brings us to our final point. Hospitals know their markets best and should not necessarily follow the latest trends if they don't fit the particulars of an individual situation. Neither, however, should hospitals hope the problem will go away on its own. It won't. Organizations will have to guard against nearsightedness and the temptation to please traditional stakeholders at the expense of doing the right thing for their communities. Be bold when examining opportunities and identifying threats, or you may keep losing money on physicians for years to come.

Be bold when examining opportunities and identifying threats.

For more information, please contact Matthew Bates (Matthew.Bates@kaufmanhall.com), or Kristofer Blohm (Kris.Blohm@kaufmanhall.com).