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A strategic guide to primary care physician employment alternatives

Hospitals continue to lose money employing their physicians—an estimated $312,528 per physician in the first quarter of 2025, up 6% from the same period last year, according to the most recent Kaufman Hall Physician Flash Report. The physician employment model is entrenched, but no health system can sustain losses of this caliber over an extended period. Previously, we shone a light on this disconnect and asked if there is another way. Now, let's focus on primary care physicians in particular and examine what the actual alternatives are, and when and whether they're worth considering.

Matthew Bates
Managing Director,
Service Line Leader,
Physician Enterprise

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

Strategic alignment with primary care physicians remains vital. No one questions that. Primary care, with physicians leading the care team, is still the front door for getting patients into the system and coordinating their care. It's the foundation of most value-based care initiatives and the organizing principle behind population health.

But alignment does not have to mean employment. In many markets, models other than straight employment appear to make more sense.

Is it time to rethink your model?

A few threshold signs indicate that it's time to consider new approaches. Questions to consider include:

- Are we facing persistent financial losses in employed primary care practices?
- Is our payer mix getting worse? Are we seeing a prolonged shift over time toward Medicaid or self-pay?
- Are our physicians expressing unusually high dissatisfaction, burnout or high turnover?
- Does our market have new, non-traditional players, such as value-based care (VBC) platforms or physician groups backed by private equity?

If you can answer "yes" to any one of these questions, it's time to look at whether the current employment model still serves your organization's long-term interests. If you answer "yes" to 2 or more of these, these strategic discussions should be of the highest priority.

Three strategic alternatives to direct employment

No single model will work for every market. But several doable alternatives to direct employment are worth exploring. Each has its own benefits, risks and operational considerations. Here are 3 options that health systems are exploring.

1. Partner with a VBC MSO platform

VBC platforms—national or regional organizations that offer physician groups access to value-based contracts, care management infrastructure and operational support—have risen to prominence in some markets. These platforms often operate through joint ownership models and align physician incentives with clinical and financial performance. The underlying legal structure typically involves a Management Services Organization

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(MSO), which supports administrative functions while leaving clinical governance with the physicians.

Potential pros

- Accelerates access to VBC capabilities, including analytics, care coordination and payer contracts
- Offloads practice management responsibilities from hospitals back to the medical group and/or a third party
- Can deepen physician engagement through shared ownership and performance-based incentives

Potential cons

- May introduce brand dilution if physicians are co-branded with a national platform
- Often requires complex legal and financial arrangements
- May lock in a long-term arrangement that could turn disadvantageous to physicians and to the local community

Scaled examples of this model exist and have proven successful in some instances. Similar structures can be explored in smaller, regional contexts as well.

2. Transition to or collaborate with an FQHC or FQHC look-alike

In high-Medicaid and safety-net markets, Federally Qualified Health Centers (FQHCs) or their look-alike counterparts offer another viable alternative. FQHCs typically are not-for-profit community health centers that provide care regardless of a patient's ability to pay. They are reimbursed through a cost-based methodology that can significantly improve financial sustainability.

Hospitals can collaborate with existing FQHCs to handle management of primary care clinics or, in some cases, convert their own clinics into FQHC look-alikes. The latter maintain many of the same benefits without requiring full federal designation.

In many markets, models other than straight employment appear to make more sense.

Potential pros

- Cost-based reimbursement helps cover operational losses
- Access to Health Resources and Services Administration (HRSA) funds
- Eligibility for federal malpractice coverage and loan repayment programs for physicians

Potential cons

- Often face capital constraints that limit growth or facility upgrades
- Regulatory navigation, including HRSA requirements, can be complex

This model works particularly well in rural areas and in urban safety-net settings with a substantial proportion of Medicaid and uninsured patients.

3. Restore independence through joint venture or MSO structures

Another approach is to help physicians re-establish independence while maintaining a strategic relationship. This often takes the form of a joint venture or an MSO structure jointly owned by the health system and the physician group.

In this model, physicians regain autonomy over clinical decisions and day-to-day operations, while the system may continue to support back-office functions or offer shared services through the MSO.

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Potential pros

- Physicians may be more engaged when they feel ownership and autonomy
- Reduces direct employment costs while preserving alignment
- Can be structured flexibly to suit local market needs

Potential cons

- More complex governance structures
- Must overcome initial skepticism from some physicians
- Requires careful partner selection and long-term succession planning

Though it may sound like a throwback to earlier decades, this "what's old is new again" model can provide a sustainable middle ground in the right context.

Tailor to your market, not the headlines

These models offer promising alternatives. But the decision to pursue them should be rooted in local market realities, not trends or trade press.

Payer dynamics, patient demographics, competitive threats and regulatory and legislative changes will all determine which options make the most sense. What works in rural Kansas won't necessarily work in Philadelphia. Rather than choosing a model and forcing it to fit, systems should evaluate their needs and build or adapt a structure that fits the community and clinical context.

In some cases, phased transitions—like pilot programs, clinic carve-outs or narrow-scope affiliations (e.g., urgent care or telehealth partnerships)—can serve as testing grounds for larger change. Strategic optionality thrives in environments where leaders resist the pressure to copy others and instead focus on what their market demands. In other words: if you don't know what to do right away, think carefully and consider starting small.

Conclusion

Primary care alignment remains essential, but employment is only one tool in the toolbox. Health systems facing mounting losses, shifting patient populations or rising competition from disruptive entrants should consider whether a different model might better serve their mission, physicians and patients.

There is no universal solution. But in today's environment, staying locked into one model—especially one that's underperforming—may be the costliest decision of all.

For more information, please contact Matthew Bates (matthew.bates@kaufmanhall.com), or Kristofer Blohm (kris.blohm@kaufmanhall.com).

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