Advisory Board

ARCHETYPE
for suppliers and service providers

Physician series | Volume 5 of 5

Health System-Owned Medical Group

Published –September 14, 2020 • 15-min read

Key takeaways

- A health system-owned medical group is a group of physicians employed by a health system who practice in ambulatory clinics, ambulatory surgery centers, hospitals, or some combination of all of the above
- Individual physicians have little to no autonomy in making significant purchasing decisions
- As more early-tenure physicians choose employment over independent private practice, these health system-owned groups are expected to grow
- Health systems rely on medical groups to attract and retain patients but today, there are many competitors offering employment to physicians. To maintain grow and maintain strong relationships with their physicians, health systems must continuously improve engagement strategy and medial group support

PHYSICIAN ARCHETYPE SERIES

VOLUME 1 Read here

Physician-Owned Medical Group

Preview: A medical group that is wholly or majority physician owned, physician-governed, and not operated by a hospital, insurance company, or practice management company

VOLUME 2 To come

Enablement Partner

Preview: A private corporation that provides centralized, scalable business resources through a subscription service or investment in a medical group's managed service organization (MSO)

VOLUME 3 Read here

National Medical Group Franchise

Preview: A national, for-profit care delivery organization that is not owned by a hospital or health system

VOLUME 4 Read here

Virtual Care Organization

Preview: A care delivery organization that only offers telemedicine services

VOLUME 5

Health System-Owned Medical Group

Preview: A single or multi-specialty group of physicians employed by a hospital or health system

Physician Archetype Series Comparison Chart
Read here

TABLE OF CONTENTS

Who they are

A single or multi-specialty group of physicians employed by a health system who practice in ambulatory clinics, ambulatory surgery centers, hospitals, or all of the above. Health systems employ physicians to grow market share and increase referrals in a regional health care ecosystem. Physicians in the group may see patients, teach at a medical school and/or conduct clinical research.

State-level Corporate Practice of Medicine laws dictate how a health system can legally employ physicians. In most states, the medical group must have a separate management structure within the health system to avoid health system leaders from interfering with physicians' clinical judgement. In a few states, including California and Texas, physicians must be employed by a separate nonprofit entity that is affiliated with the hospital system and the physicians must legally control certain aspects of practice. Regardless of the specific means by which health systems employ their physicians, they are all similar in function.

How do these groups make money?

Health system owned medical groups generate revenue by billing payers for professional (physician) services, primarily using evaluation and management (E/M) codes. Although on average, each physician in a medical group bills over $400K[1] in net revenue annually, reimbursement from professional services isn't enough to offset physician salaries and group overhead costs. As a result, most medical groups operate at a loss of $200K or more per physician per year. The health system pays the medical group a subsidy that offsets this loss. The reason health systems employ physicians and pay this subsidy is because by employing physicians the system makes money from the technical revenues, ancillary revenues, and referrals generated by the medical group.

$200K

Most health system owned medical groups operate at a loss of at least $200K per physician per year

1. Advisory Board Integrated Medical Group Benchmark Generator 2019.

What's the group's relationship with physicians?

While all health system owned medical groups employ physicians, the specific compensation model varies. Most medical groups pay physicians based on a combination of production and non-production metrics.

Production for physicians is most commonly measured by wRVUs. Under this model, a physician must meet a minimum wRVU threshold to earn a base salary. Physicians also earn a bonus for work beyond the threshold, sometimes at a higher per-wRVU rate. wRVU payments are payer-agnostic, so physicians are not incentivized to see more commercially insured patients who bring in more net revenue. While these productivity measures are extremely common, in 2016, only 44% of employed physicians reported they were satisfied with their productivity targets.

For many groups, 10% to 20% of physician compensation is at risk for non-productivity incentives, this percentage has grown as more medical groups are involved in value-based contracts. There are numerous metrics groups can choose, but common categories are care quality, patient experience, access to care, and group citizenship.

Some medical groups have shifted to a salary-based compensation model to counter three challenges medical groups commonly face:

1. rising patient consumerism,
2. competition between specialists reducing patient access, and
3. physician and administrator burnout.

However, even those groups who have moved to salary-based compensation still typically tie some element of a physician's salary to productivity metrics.

What makes them different

Health system-owned medical groups are more closely-aligned with health system priorities and strategies than other physician entities. As group management typically rolls up to the health system C-Suite, these leaders may be able to influence broad strategies. However, individual physicians have less autonomy than in physician-owned groups to set strategy or make large-scale decisions.

As these groups are owned by a health system, their priorities are market-specific, matching the market that the health system serves. This makes them different than other physician entities who operate across the country and are concerned with broader priorities.

Key decision-makers

What is the group's governance structure?

While exact governance structures vary between groups, some common features include:

Medical group board

Serves as the highest-decision-making body. The board oversees medical group strategy and may have some decision-making delegated from the health system. Membership on the board is senior medical group leaders and at least one health system representative.

Executive committee

Focuses on strategy and implementation, but typically does not make decisions. The executive committee usually consists of medical group executives, committee leaders, and physician executives.

Other governance structures

Standing committees, subcommittees, and task forces that advance specific priorities tied to the larger strategy.

- **Standing committees:** Typically oversee quality, physician engagement, patient experience and technology.
- **Subcommittees:** Support a specific subset of a standing committee. Though they are not time-limited, medical groups often reassess and renew subcommittees annually.
- **Task forces:** Chartered for a specific function or topic for a limited duration. These task forces typically exist for six to twelve months and are dissolved when the goal or task is completed. Example task forces are women in leadership, millennial issues, or physician compensation.

What is the group's management structure?

Health system-owned medical groups are led by a CEO or Medical Group President. This leader reports to a member of the health system's C-Suite, typically the COO, CMO, or occasionally the CEO. The medical group CEO or president has direct reporting authority over medical group C-suite roles including the CHRO, CFO, CMO, and COO. As groups have grown both in terms of the geographic footprint they serve and the variety of outpatient sites they practice at, they have also expanded their management structures. Many now also have operational physician leaders regionally and practice administrators and frontline physicians at individual clinics/practice locations.

How much autonomy do physicians have in purchasing decisions?

LOW

Employed frontline physicians have little to no autonomy in making significant frontline purchasing decisions but they may participate in purchasing conversations and lend some influence. Physicians may be able to make small purchases for their practice (often those under $100K).

How much autonomy do physicians have in clinical standardization efforts?

MEDIUM

Care standardization decisions begin at the system-level. Health systems often engage physicians in Clinical Consensus Committees, which:

- define the system's standard of care for a specific DRG,
- consult with the design teams that create workflow maps and clinical decision support,
- and serve as champions during implementation.

Currently, these efforts are more common in the hospital setting than in the ambulatory/practice setting, so physicians may have more autonomy for clinical practices in the ambulatory setting.

Three market trends to watch

01

TREND

Physician employment continues to rise

02

TREND

Medical groups becoming even more critical to strategy

03

TREND

Dissatisfaction and competition causing relationship friction

01 Physician employment continues to rise

Physician employment continues to rise and recent surveys suggest that most final-year medical residents prefer employment to independent practice. According to an AMA survey, the percent of physicians employed increased from 41.8% in 2012 to 47.4% in 2018. 2018 was also the first year that the percentage of employed physicians was higher than those that were owners of their practice, as only 45.9% of physicians were owners.

This trend is likely to continue. A 2019 survey of medical residents in their final year reported that 91% would prefer to be an employee of a hospital, medical group, or other facility than to be in independent private practice.

02 Medical groups becoming even more critical to strategy

As care shifts from the inpatient to the outpatient setting, medical groups are even more critical to health systems' strategy to retain current and attract new patients. Health systems rely on medical groups to refer patients who need medical or procedural services to sites of care that are part of the health system. One of the drivers of health system employment of physicians is that employment will encourage physicians to refer patients care at the health system. As care moves more to the ambulatory space and health systems include more diverse care sites, these referral patterns are even more important. Medical groups, and the clinics and offices they practice in, are a key part of the health system's ambulatory network strategy. Health system leaders see these practices as an important way to retain current and attract new patients.

03 Dissatisfaction and competition causing relationship friction

Health systems are experiencing friction with employed physicians and risk losing physicians to competitors. Despite both the growth in physician employment and physicians' desire for employment over private practice, there are some early signs that the trend toward hospital-affiliated employment could be changing. Many employed physicians report they feel undervalued by health systems, describing the relationship as feeling like a "cog in the wheel." These physicians feel that, despite supports offered by health systems, that health system leaders are not investing in the physician enterprise, but rather just using physicians to feed referrals.

Alongside this dissatisfaction is the rapid growth of several non-hospital medical groups offering a secure alternative to health system employment. Private equity investors and network aggregators are infusing new money into physician-owned medical groups. Physicians can also be employed by new care delivery organizations such as virtual care organizations or national medical group franchises, or vertically integrated models with health plans. These new options, along with an environment where both private and public payers are favoring non-hospital employed physicians, could change physician-health system relationships. In 2019 we saw two early examples of this, as two large hospital medical groups in North Carolina broke from their hospital employment arrangement to move to independent practice.

Related content

Advisory Board resources

RESEARCH REPORT

Report from the Frontier of Physician Compensation
Read now

RESEARCH REPORT

How to Design an Effective Medical Group Organizational Structure
Read now

BLOG POST

The 5 biggest trends (and the data) affecting medical groups today
Read now

RESOURCE PAGE

Resources to Expand Ambulatory Access
Read now

Project director
Miriam Sznycer-Taub
sznycerm@advisory.com

Program leadership
Madhavi Kasinadhuni

Design consultant
Kevin Matovich

655 New York Avenue NW, Washington DC 20001
202-266-5600 | **advisory.com**