Building a Physician Enterprise That Actually Works

Stop buying referrals. Start building care.

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If you lead a health system, you almost certainly own a physician enterprise. And if you are like most, it loses money every year, and you are not entirely sure what you are getting for it.

You are not alone. As of January 2026, 82 percent of U.S. physicians were employed by hospitals or corporate entities, according to the Physicians Advocacy Institute and Avalere Health. In 2018 it was 52 percent. Only 18 percent still practice in physician-owned settings.

The cost is real. Kaufman Hall's Physician Flash Report puts the median investment, or subsidy, per employed physician at $315,358 in the fourth quarter of 2025. When that figure first passed $300,000, the firm's physician enterprise leader said plainly that current models of physician employment are not sustainable.

I have spent much of my career inside these organizations, including leading a 350-provider employed physician enterprise. I have seen them work, and I have seen them struggle. The difference is rarely the physicians.

As a health system, you have to ask yourself: what do I want from my physician enterprise? Is success defined as stable referrals and downstream revenue? Or is the enterprise a fulcrum to lower readmission rates and inappropriate admissions? If you are going to put up with those losses, you need to get something for it.

The loss is not the whole story

Let me be fair. A subsidy is not automatically a failure. Employed physicians bring patients into the system, fill specialty gaps, staff the emergency call schedule and keep services in communities that could not otherwise support them. For years, health systems justified the loss as an investment in downstream volume.

But that is volume logic, and volume-based payment is running out of road. If the only reason your enterprise exists is to feed referrals to the hospital, you have built an expensive referral network, not a medical group. In a value-based world, that model only gets more expensive.

The enterprises that work are built for something else: caring for a population, well, over time.

Five things that separate the ones that work

1. Know why you exist. Write the purpose in one sentence, and make it about patients, not referrals: access for a community, care for a defined population, or a service line no one else will provide. Then measure the enterprise against that purpose, not just against the subsidy.

2. Put physicians at the table, not just on the payroll. Employed physicians who have no voice in decisions about their own patients behave like employees, and who can blame them? Give them real governance: physician leaders paired with administrative leaders, with shared authority over the decisions that shape care. Treat them as partners and you can ask them to act like owners.

3. Pay for what you actually want. If compensation rewards only work RVUs, you will get volume, whether or not the system needs it. Tie a meaningful share of pay to what matters: quality, access, patient experience and total cost of care. People do what they are paid to do.

4. Standardize the back office, not the bedside. Shared scheduling, revenue cycle, technology and data should run like a utility. Physicians should not spend their evenings fighting the billing system. Clinical judgment should stay with the clinicians.

5. Own the results, without blinders. Put the enterprise's real numbers in front of physician and administrative leaders every month: access, quality, patient experience, cost and the subsidy itself. Name one leader accountable for each. If improving the enterprise is everybody's job, it becomes nobody's job.

Where the subsidy can become a strategy

Here is the good news. A physician enterprise organized around a population is exactly what value-based contracts reward. In 2024, according to CMS, accountable care organizations in the Medicare Shared Savings Program saved Medicare $2.5 billion and earned $4.1 billion in performance payments. An enterprise that coordinates care, manages its sickest patients and keeps people out of the hospital can earn some of its subsidy back, and earn it for the right reasons.

That does not happen by accident. It happens when the enterprise was built for it.

Maybe there is another way

And maybe employment is not the only answer. There are ways to build real clinical affiliation that do not require the losses to stay on the hospital's books.

A clinically integrated network can bring independent and employed physicians together around shared protocols, shared data and shared payer contracts. A management services organization can run the back office, from revenue cycle to technology to contracting, while physicians keep ownership and clinical governance. A joint venture or jointly owned MSO lets the health system and its physicians share ownership, with physicians running the clinical side. In rural and high-Medicaid markets, partnering with a federally qualified health center can bring cost-based reimbursement and federal support a hospital-owned clinic cannot. Kaufman Hall's physician enterprise leaders laid out several of these same options in 2025 as alternatives to direct employment.

In my experience, a strong affiliation with an MSO can deliver real value. Independent practices get what they rarely can build alone: a professional revenue cycle, modern technology, purchasing power, care management and the data and contracting muscle to take on value-based agreements.

Physicians keep their independence and their clinical judgment. And the health system gets aligned, engaged physicians working toward the same quality and cost goals, without carrying a subsidy for every one of them. Done well, everyone at the table is pointed at the same thing: the patient.

None of them is simple. Governance gets more complex, the legal structures take care, and partners have to be chosen well. But each one answers the question differently. Affiliation is built on shared purpose and shared risk, not on a paycheck and a subsidy. And physicians who keep a stake in their practice tend to act like owners, because they are.

What to do Monday morning

Ask five questions. Can your leaders state in one sentence why your physician enterprise exists? What share of physician pay is tied to anything other than work RVUs? Do physicians have a real vote on decisions that affect their patients? What is your subsidy per physician actually buying? And have you asked whether employment is the right model at all, or whether affiliation could give you the same clinical alignment without the same losses?

Then test the answers with my two questions. Does it serve the patient? Can it keep doing so?

If the answers are uncomfortable, I would welcome the conversation. My goal is to help you become your own best consultant, with your physicians at the table.

When it seems crazy out there, and it sometimes is, remember that the patient is still a reliable true north. A physician enterprise that works is one that keeps pointing toward it.

Sources

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