WHITE PAPER

The True Value of a Medical Group in an Integrated Health System

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The True Value of a Medical Group in an Integrated Health System

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White Paper, May 2026

Over the past three decades, the American healthcare landscape has undergone a significant transformation, marked by the rapid and accelerating consolidation of independent physician practices into hospital and health system ownership. In the early 1990s, the vast majority of physicians operated as independent practitioners or in small, physician-owned group practices—the model that had defined American medicine for generations.

Initially spurred by the advent of managed care, electronic health records, and escalating administrative burdens, health systems first acquired primary care practices. Over time, they added specialists and proceduralists to form the early, large multispecialty groups that were integrated into health systems.

Now, the proportion of physicians working in system-affiliated practices has increased to 57.8% according to the American Medical Association (AMA),[1] while other sources place the percentage even higher. This upward trend is expected to continue, driven by escalating technology costs, mounting administrative burdens, shrinking reimbursement margins, and the growing complexity of value-based care contracts that demand infrastructure well beyond the reach of most small practices.

Over the past 30 years, rapid acquisition pace has in some cases led to a significant disconnect between the health system and the physician enterprise. In many cases, integrated medical groups feel devalued, health system leadership views the group as a financial failure, and overall, a gap or disconnect occurs between providers and organizational leadership. Health systems need to ensure that the right financial metrics are utilized to accurately evaluate medical group performance. Only through such an enlightened approach will health system leaders and providers be able to understand the contributions and value of a medical group.

Medical Groups Are Central to Market Strategy

Providers drive healthcare; their orders are required for many of the services that patients and beneficiaries receive. Additionally, patients rely upon "their" physicians, especially their primary care physicians, to guide their access of any healthcare system. Health systems recognized early on in the acquisition trend that strengthening physician relationships was crucial to their market strategy—improving referral patterns, anchoring patient populations, securing call coverage, and positioning the organization for risk-based payment models. What began as a tactical response to managed care pressures in the 1990s evolved into a full-scale strategic objective by the decades of 2000 and 2010, as systems competed aggressively for multispecialty groups, primary care networks, and specialty practices. Acquiring practices improved market penetration, increased financial leverage, and prepared groups to succeed in value-based care arrangements.

[1] Smaller share of doctors in private practice than ever before, American Medical Association, 2025, https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever

Improving Market Penetration

- **Market Share and Competitive Defense.** Physician group acquisition is one of the primary ways that hospitals and health systems increase market share. Acquiring a multispecialty group preempts competitors from doing the same. Defensive acquisitions are often as strategically important as offensive ones.
- **Brand Extension and Geographic Footprint.** Acquiring a well-established independent group instantly extends the health system's brand into new communities and ZIP codes, capturing patients who might otherwise seek care at a competing system.
- **Referral Capture.** Hospital ownership of practices increases the odds that doctors will admit patients to their own facility instead of a competitor's. This is logical, as physicians build closer relationships within the integrated system, gaining familiarity and trust with other members of the medical staff. One survey found an average annual net revenue of $2.378 million generated per physician for their affiliated hospitals, with some specialties producing more than $3 million.[2]
- **Physician Recruitment and Workforce Stability.** The rising trend of health system ownership of physician practices is driven by factors on both the health system side and the physician practice side. Physicians are finding it more difficult to operate practices on their own and are seeking alternatives to manage the administrative burdens and escalating staff and technology costs they would otherwise face.[3] Acquiring established groups provides stability for physicians and gives health systems access to trained, credentialed physicians without the lengthy *de novo* recruitment process.

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Increasing Leverage

- **Payer Contracting.** When health systems employ physicians, they can use their combined market power to negotiate higher commercial reimbursement rates. Insurance plans need to have comprehensive specialties in their network, something that a health system with a strong physician enterprise can deliver; or not, if the insurance company's terms are not acceptable. A multispecialty group inside a health system can negotiate from a position of strength as a single entity, not dozens of individual practices.

  At times, however, a health system may decide the best benefit comes from negotiating a better rate on the hospital side and a lesser rate for professional services. While this approach is not infrequent, given the sheer volume of fees related to inpatient volume vs. medical group revenue, it also becomes a self-fulfilling prophecy that the medical group's performance is going to be negative as a result. In our experience, utilized properly, investments in a robust medical group should benefit a health system's payer negotiations strategy.
- **Call Coverage and Inpatient Continuity.** Employed physicians provide more reliable call coverage for hospital services, including for the emergency department, inpatient units, operating room, etc. Independent physicians have less incentive to take call, and the physician shortage has made the cost of providing call coverage by outside physicians increasingly detrimental to a health system's financial results.

[2] New survey shows physicians are key revenue generators for hospitals, AMN Healthcare, 2019, https://www.amnhealthcare.com/blog/physician/perm/new-survey-shows-physicians-are-key-revenue-generators-for-hospitals/

[3] Report: Examining the real factors driving physician practice acquisition, AHA, 2023, https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf

- **340B Drug Program Eligibility and Expansion.** The 340B program is a federal outpatient drug pricing program, administered by the Health Resources and Services Administration, which provides access to certain discounted medications at less than market price. Eligibility to participate in the 340B program and its pricing are limited to a few types of federal grantees (e.g., FQHCs, Ryan White programs) and certain hospital settings (e.g., critical access hospitals, disproportionate share hospitals, children's hospitals, rural referral centers).[4] Eligible 340B hospitals have strong incentives to acquire community-based clinics and physician practices (such as outpatient oncology clinics) because doing so allows them to purchase more drugs at the deeply discounted 340B price. Acquisition of community clinics by health systems and their hospitals extends access to affordable drugs for low-income and underserved patients.

Succeeding in High-Value Care

- **Population Health at Scale.** Physician engagement and integration are critical to a health system's ability to achieve the Triple Aim of enhancing the patient experience, improving population health, and reducing the per capita cost of care (the goals of high-value care). ACOs, risk-based contracts, and Medicare Advantage arrangements all require the system to manage a defined patient population, which is challenging to accomplish without having the primary care access points. The metaphorical statement that "the physician's pen is the most expensive instrument" has been long used and is still relevant today due to the simple fact that physicians do, in fact, direct what services are provided and in what setting.
- **Care Coordination and Network Efficiency.** Keeping consultations and procedures within a network leads to lower costs for patients and providers while improving care coordination, reducing the chance of duplicate services or overlooked conditions. A fully integrated multispecialty group allows the health system to manage the entire episode of care—from primary care visit through specialist referral, imaging, and inpatient admission—as well as the entire care journey post-admission within one network.

Key Point: The above strategic benefits are essential to making a health system that is truly integrated.

Financial Performance: There Is More to It than Meets the Eye

In our work with AMGA members around the country, we often hear health system leaders lament the high cost of "subsidizing" an employed physician enterprise, which is often measured and reported as "investment per provider."

AMGA's national survey database provides the opportunity to compare bottom-line results per physician for system-affiliated and independent medical groups. The median bottom line (prior to allocations) for system-affiliated physicians is -$309,755 compared with a median bottom line of $314,942 for independent physicians. A more detailed side-by-side comparison (Figure 1) reveals these key points:

1. Total revenue is 50% lower for system-affiliated physicians.
2. Expenses are quite similar between system-affiliated and independent physician practices.
3. The difference in average profit/loss (P&L) can be traced back to the difference in revenue.
4. Once the system-affiliated physician P&L is normalized for the difference in revenue, and after deducting for allocations, both the system-affiliated and the independent physician P&Ls have a modestly positive bottom line.

[4] 340B Eligibility: who can participate in the 340B Drug Pricing Program? HRSA, June 2024, https://www.hrsa.gov/opa/eligibility-and-registration

Figure 1

AMGA 2025 Medical Group Operations and Finance Survey Report

Financial Summary per Physician

	Median per Physician			
NET REVENUES	Clinic Count	SYSTEM-AFFILIATED PHYSICIANS	Clinic Count	INDEPENDENT PHYSICIANS
Professional Revenue	3,440	687,716	364	1,124,743
Ancillary	1,385	82,504	273	104,277
Other Medical Revenue	2,298	40,791	288	341,610
Total Net Revenue	3,844	712,245	810	1,431,491
Nonmedical Revenue	1,164	674	266	47,970
EXPENSES				
Total Provider Salaries & Benefits	3,770	609,463	499	656,885
Total Clinic Staff Salaries & Benefits	3,671	218,985	871	265,464
Operating Expenses	3,789	192,806	810	219,639
Nonmedical Expense	501	1,233	-	-
TOTAL REVENUE	3,845	727,245	872	1,445,986
TOTAL EXPENSE	3,845	1,069,212	872	1,131,725
PROFIT (LOSS) BEFORE ALLOCATIONS	3,845	(309,755)	872	314,942
+ Adjustment for Net Revenue Differences		719,246		
Normalized Net Revenue		409,491		314,942
- Allocations, Overhead & Infrastructure		(350,000)		(300,000)
NORMALIZED PROFIT (LOSS)		59,491		14,942

Median values are independently calculated across different respondent sets during the standard AMGA survey tabulation process, which results in different total figures than if values were mathematically summed.

Net Revenue is half as much for system-affiliated physicians, a difference of $719,246. See discussion below for more about the reasons why.

$719k difference in Net Revenue adversely impacts profit/loss for a system-affiliated physician.

$719k difference is added back to normalize net revenue.

Allocations are deducted, with a higher allocation cost being the norm for system-affiliated practices.

Key Point: After normalizing net revenue and deducting allocations, bottom-line profit/loss for system-affiliated and independent physicians is nearly the same.

Why Are Revenues So Much Lower for System-Affiliated Providers?

Ancillary revenue is shifted to the hospital/health system. The single largest driver of the gap is how ancillary income changes under the system-affiliated practice. Ancillary revenues are a key component of independent physicians' income. In system-owned practices, radiology, infusion, lab, physical therapy, and other ancillaries typically flow to the health system entity—away from the physician practice—leaving the group's P&L with primarily professional fee revenue and a reduced volume of ancillary income.

Compensation and production differences. A review of several large specialties in AMGA's national database (based on provider count) reveals that compensation per work RVU tends to be higher for system-affiliated physicians than for independent physicians (Figure 2).

After normalizing net revenue and deducting allocations, bottom-line profit/loss for system-affiliated and independent physicians is nearly the same.

Figure 2[5]

Specialty	System-Affiliated		Independent		Difference	
	Provider Count	Median Comp Per wRVU	Provider Count	Median Comp Per wRVU	Comp Per wRVU Difference	Comp Per wRVU Diff%
Family Medicine	8,612	51.42	1,982	53.46	(2.04)	-4%
Hospitalist – Internal Medicine	6,838	72.94	497	69.84	3.09	4%
Internal Medicine	4,636	55.26	1,220	57.59	(2.34)	-4%
OB/GYN – General	2,856	56.81	448	51.30	5.52	10%
Pediatrics – General	2,723	50.79	808	46.16	4.63	9%
Cardiology – General (Non-Invasive)	1,962	67.45	276	60.58	6.87	10%
General Surgery	1,833	74.32	215	66.53	7.80	10%
Neurology	1,571	68.97	255	62.86	6.11	9%

Looking at the two components that drive compensation per work RVU (compensation and work RVUs), systems tend to pay slightly more than independent groups (Figure 3). However, the more significant driver is lower work RVUs for the system-affiliated physicians. The reasons for this are likely multifactorial but may include different incentives, as well as inefficiencies that decrease throughput.

Figure 3[6]

Specialty	System-Affiliated		Independent		Differences			
	Median Comp	Median wRVU	Median Comp	Median wRVU	Comp Difference	Comp Diff%	wRVU Difference	wRVU Diff%
Family Medicine	330,648	6,369	328,127	6,214	2,520	1%	156	2%
Hospitalist – Internal Medicine	342,370	4,856	353,683	5,166	-11,314	-3%	(310)	-6%
Internal Medicine	347,750	6,194	335,535	6,200	12,215	4%	(6)	0%
OB/GYN – General	407,173	7,523	402,131	8,383	5,043	1%	(860)	-11%
Pediatrics – General	296,080	5,878	292,748	6,478	3,332	1%	(600)	-10%
Cardiology – General (Non-Invasive)	621,398	9,198	573,587	9,886	47,811	8%	(688)	-7%
General Surgery	509,200	6,855	488,394	7,668	20,806	4%	(813)	-12%
Neurology	375,782	5,224	355,495	6,066	20,287	5%	(842)	-16%

Key Point: Apart from modest differences in physician productivity, the financial performance of a system-affiliated physician and independent physician is essentially the same.

Increase in the hospital outpatient department (HOPD) setting vs. the doctor's office. Health systems recognize that their owned practices provide the opportunity to increase total organizational revenue through collecting both facility and professional fees for physician services. When a doctor's office becomes an HOPD, the health system can bill a facility fee in addition to the physician's professional fee, often substantially increasing total revenue per encounter.

Figure 4 provides an example of CMS professional fees for 99203, one of the most common Current Procedural Terminology (CPT®)[7] codes, when services are performed in a doctor's office (non-facility setting) vs. an on-campus HOPD (facility setting).

[5] AMGA 2025 Medical Group Compensation and Productivity Survey Report; 2025 Report Based On 2024 Data. Percent differences were calculated relative to the System-Affiliated Median values.

[6] AMGA 2025 Medical Group Compensation and Productivity Survey Report; 2025 Report Based On 2024 Data. Percent differences were calculated relative to the System-Affiliated Median values.

[7] Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association.

Figure 4[8]

		CMS Median Fee All MACs			
CPT® Code	Description	Doctor's Office (Non-Facility)	HOPD (Facility)	Difference	Diff %
99203	Office o/p new low 30 min	$119.46	$71.24	$48.22	40%

In the example in Figure 4, the difference between the doctor's office and HOPD reimbursement is 40%. This would equate to 40% less reimbursement for a physician in a HOPD setting. An HOPD would then bill Medicare using code G0463, with resulting reimbursement of approximately $90 per visit,[9] placing the total visit reimbursement for 99203 at $161.24 ($71.24 + $90) in the HOPD vs. $119.46 in a doctor's office. (Other CPT® codes would have varying degrees of this differential.) One can see from this example that overall revenue is substantially higher in a HOPD setting.

However, when a place of service is changed from doctor's office to an HOPD, professional fees decrease for the provider, and it can appear that an acquired physician practice is realizing lower revenues. In reality, the physicians are performing the same services but receiving lower reimbursement due to the change in setting. A portion of Medicare revenue that used to go to the billing physician for practice expenses shifts to the hospital/health system for facility fees. This may be appropriate in order to cover rent and staff costs; however, it distorts the picture of the medical group's performance.

Key Point: Instead of focusing on solely the bottom-line performance, savvy health system leaders will comprehend how changes to ancillary revenue and place of service billing have impacted their medical group's performance.

A Shifting Model: Bed Days Declining While Ambulatory Visits Increase

American healthcare has experienced a dramatic shift in where care is actually delivered. For decades, the hospital inpatient admission was the central unit of healthcare, around which systems, payers, and physicians organized themselves. However, inpatient utilization has declined steadily since the early 1980s, when the introduction of Medicare's Diagnosis-Related Group (DRG) prospective payment system first created financial incentives to reduce length of stay and move care out of the hospital bed.

In the years since, advances in anesthesia, minimally invasive surgical techniques, and post-operative pain management have made it possible to safely perform procedures on an outpatient basis that once required multiday hospitalizations. Payers accelerated this transition with utilization management and tougher inpatient authorization processes. There has also been vertical integration with ownership of Ambulatory Surgery Centers (ASCs) and/or contracting with an increased number of ASC facilities for care. For a growing list of procedures, patients are steered more toward ASCs, physician office settings, and same-day facilities. The result has been a consistent decline in inpatient bed days per capita (Figure 5).

The implications of this shift for health system strategy are enormous, creating both a threat and an opportunity. A hospital that fails to develop a robust ambulatory network risks watching its most profitable procedural volume migrate to freestanding surgery centers, independent imaging facilities, and

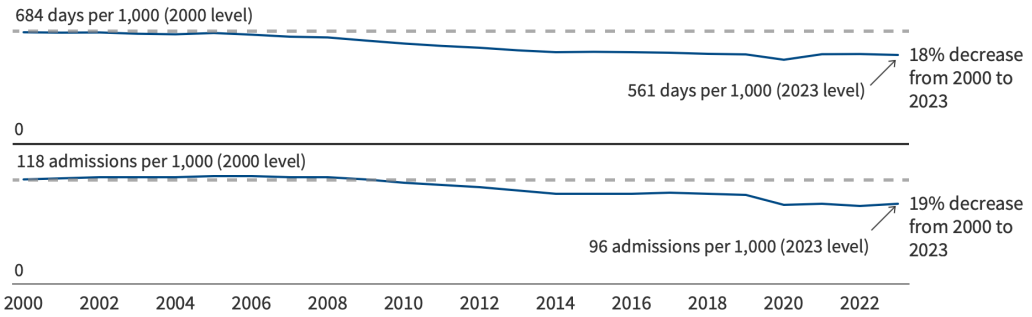
[8] CY2026 Physician Fee Schedule, CMS.gov, https://www.cms.gov/medicare/physician-fee-schedule/search. MAC is an acronym for Medicare Administrative Contractor.

[9] Hospital Outpatient PPS, CMS.gov, https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient. HOPD facility fee reimbursement may vary due to factors including, but not limited to, relative weight and geographic location.

Figure 5[10]

Hospital Inpatient Utilization Has Decreased Over Time

Hospital inpatient admissions and days per 1,000 people, 2000-2023



Note: Analysis of community hospitals. Excludes hospitals in U.S. territories.

Source: AHA, Trendwatch Chartbook Supplementary Data Tables, 2019 (for 2000-2009 numbers); KFF analysis of AHA Annual Survey Database and Census Bureau population estimates (for 2010-2023 numbers). Get the data • Download PNG

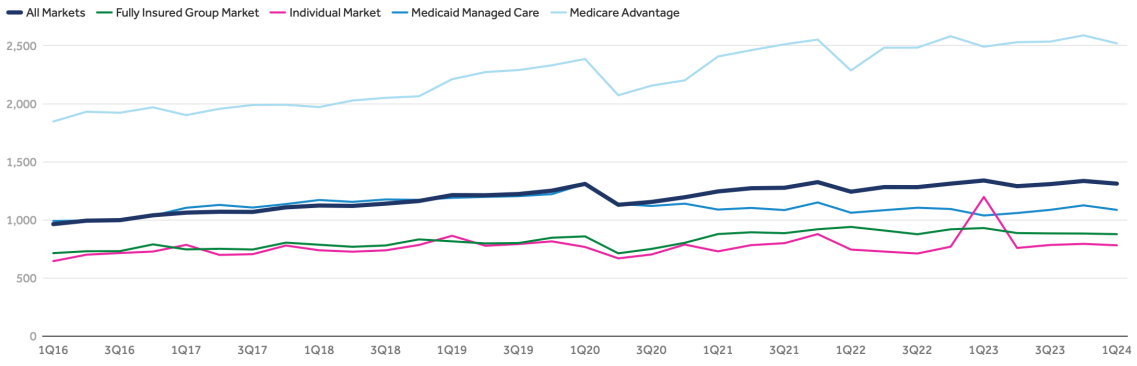
KFF

competitor-owned physician offices. Multispecialty physician groups are, in this context, not merely a source of referrals; they are the ambulatory network itself, serving as the front door through which patients enter the system, the platform on which outpatient procedures are performed, and the mechanism by which health systems position themselves to capture value in a world where the hospital bed is no longer "the center of gravity."

In keeping with this evolution, ambulatory encounters are increasing (Figure 6).

Figure 6[11]

Total Ambulatory Encounters per 1,000 Member Months, by Market, 2016 Q1 – 2024 Q1



Note: Data does not include NAIC plans licensed as Life, Accident, and Health or plans managed by the California Department of Managed Health Care.

Source: KFF analysis of data Exhibit of Premiums, Enrollment and Utilization data from Mark Farrah Associates Health Coverage Portal TM • Get the data • PNG

[10] Hospital Inpatient Utilization Has Decreased Over Time, Kaiser Family Foundation, www.kff.org/health-costs/key-facts-about-hospitals, chart source attributed to AHA, Trendwatch Chartbook Supplementary Data Tables, 2019 (for 2000-2009 numbers); KFF analysis of AHA Annual Survey Database and Census Bureau population estimates (for 2010-2023 numbers)

[11] Total ambulatory encounters per 1,000 member months, by market, 2016 Q1 – 2024 Q1, Peterson-KFF Health System Tracker, https://www.healthsystemtracker.org/chart-collection/, chart source attributed to KFF analysis of data Exhibit of Premiums. Enrollment and utilization data from Mark Farrah Associates Health Coverage Portal™

At AMGA, we have seen this trend born out. Ashok Rai, MD, CEO of Prevea Health in Wisconsin, recently conducted an analysis of patient encounter patterns that showed patients have ten ambulatory encounters to every one hospital encounter.[12] These findings are not an anomaly.

Key Point: Increasingly, the ambulatory care setting will be where the majority of care is delivered, and the medical group will be key to a health system's success.

Conclusion and Recommendations

The value of a medical group is not defined solely by a metric like investment per provider. To truly determine the value of a medical group, health system leaders need to understand how their medical groups are helping to achieve market strategy and also prepare for declining bed days in the coming years. The medical group is ideally positioned in the current and future environment to execute on the health system's ambulatory strategy as acute care and bed day revenue declines. Further, given post-integration structures, revenue that was previously part of the medical group accrues to the hospital under the newly merged health system's financial accounting structure. To be truly integrated, it is essential that a health system support and develop a medical group so that it can drive patient care and overall performance within an integrated setting.

Instead of focusing on solely the bottom-line performance, savvy health system leaders will comprehend how changes to ancillary revenue and place of service billing have impacted their medical group's performance.

High-performing health systems seeking metrics for medical group performance have alternatives available to them. Trinity Health monitors multiple "levers" that they continuously strive to move in a positive direction in order to optimize revenues and efficiently manage costs.[13] AMGA Consulting has also published key performance indicators to accurately measure performance and then develop a plan for improvement where needed.[14] These approaches provide more appropriate options for medical group metrics than investment per provider.

When health systems look exclusively at the inadequate metric of Investment per provider, they risk placing lower value on the medical group based upon this artificial and, at times, arbitrary metric. This view can negatively impact organizational culture, which is an important aspect of a high-performing medical group. Ironically, while many a system's top investment has been the development of its medical group, the process by which organizations tend to evaluate performance would suggest this investment has been unsuccessful. While inappropriate application of metrics oftentimes leads to such a conclusion, nothing is further from the truth. When there is a devaluing of the perception of performance, it results in a degradation of organizational culture, a significant decrease in provider engagement, and an inability to realize the

[12] Performance by design: Nine attributes of a successful service line strategy, AMGA Consulting, 2026, https://www.amga.org/amgaconsulting/featured-insights/2026/performance-by-design-nine-attributes-of-a-successful-service-line-strategy

[13] Using 5 levers to optimize medical group financial and operational performance, Trinity Health, 2025. https://www.amga.org/resources/solutions-library/using-5-levers-to-optimize-medical-group-financial-and-operational-performance

[14] The keys to maximizing an aligned physician enterprise, AMGA Consulting, 2025. https://www.amga.org/amgaconsulting/featured-insights/2025/the-keys-to-maximizing-an-aligned-physician-enterprise

promise of a healthy integration of the medical group within the health system. Health systems must look beyond investment per provider as they assess and understand the true value of their physician enterprise.

The path forward requires action. Health system leaders should convene medical group and system finance leadership to review current performance metrics, identify if and where investment-per-provider thinking has distorted strategic decisions, and adopt frameworks that reflect the medical group's full contribution to system performance.

The health systems that thrive in the coming decade will be those that recognize their physician enterprise as a valuable strategic asset, not a negative margin cost center. With looming cuts to hospital revenue sources, the time to make that shift is now.

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