Health care delivery is moving to a value-based environment where patients, payers and policymakers will hold providers increasingly accountable for costs and quality. To achieve the Triple Aim of improving the patient experience of care, improving population health and reducing per-capita health care costs, physicians and hospitals are developing different arrangements to improve care delivery. While direct employment of physicians has increased by 55 percent since 2000, physicians and hospitals are entering into a variety of arrangements to address the changes in health care delivery.

Executive Summary

To fully understand how physician practice and contracting arrangements and their relationships with hospitals are developed and affect care delivery, the American Hospital Association (AHA) surveyed the nation’s hospitals and health systems to gather data on the types of relationships physicians and hospitals are developing to improve care delivery and meet the needs of their communities.

From loose affiliations to employment models, hospitals reported a broad array of physician arrangements. Nearly half of responding hospitals and health systems indicated they engaged in an employment/salary model while 20 percent reported working with physicians through an open physician hospital organization.

Overall, responding hospitals and health systems indicated that 78 percent of physician arrangements were owned at least in part by the hospital or health system and 21 percent by physicians. Less than 1 percent of physician arrangements were reported as owned by insurers. However the majority of hospital-owned physician entities among responding hospitals and health systems had fewer than 25 physicians. Primary care practices are more likely to be owned by a hospital or health system than specialty care practices. Approximately one-quarter of hospitals report their employed physicians are self-governed.

As health care moves away from fee-for-service into new payment arrangements such as bundling and shared savings, physician-hospital relationships reflect this trend. Thirteen percent of responding hospitals reported participating in a bundled payment arrangement with physicians in 2013 while 16 percent participated in a shared savings arrangement with physicians.
Of those with shared risk arrangements, the vast majority are providing or plan to provide clinical quality, patient experience and cost indicators to participating physicians. Success in new payment arrangements requires hospitals and physicians to closely monitor performance on quality, satisfaction and efficiency and take steps to improve. To this end, most hospitals in bundled payment and shared savings arrangements are providing key metrics to their physicians and evaluating physicians on the basis of these goals.

The survey data show the impact of the current health care environment and the forces driving a rethinking of the relationships between physicians and hospitals. New payment methodologies, the increased employment of physicians by hospitals and the move to more accountable care organizations require closer integration to deliver value and meet the Triple Aim of better health, better health care and lower costs. The data indicate the potential for closer integration and organization, particularly among hospital-owned physician practices. Most hospital-owned practices are smaller, presenting an opportunity to consolidate into larger multispecialty groups to take advantage of quality improvements and standardized processes. In addition, to support the needs of clinical integration for improved quality, patient safety and streamlined care delivery, arrangements between and among physicians and hospitals need to promote mutual accountability and joint leadership. Only in this way will health care delivery fulfill its full potential.
Introduction

As new models of innovative care are being implemented, the field’s understanding of physician practice and contracting arrangements lags due to a lack of data. In order to better understand how these relationships are being created and affect care delivery, the American Hospital Association (AHA) surveyed the nation’s hospitals and health systems. Based upon results gathered from **985 responding hospitals** and health systems, this report examines the types of physician practice and contracting arrangements that exist in relation to hospitals.

Physician Relationships with Hospitals

While trends on the increase in the number of physicians employed by hospitals have been noted in several studies along with physician groups becoming larger to address the needs of new payment and care delivery models, this survey delves into some of the types of relationships hospitals and physicians are developing to improve care delivery and meet the needs of the communities they mutually serve. Bundled payments, formation of medical homes and accountable care organizations (ACOs) all contribute to developing physician integration strategies. At the same time, larger physician groups have greater access to capital, greater ability to standardize processes and the ability to accept more risk. The move towards greater care coordination and increased accountability for care delivery is driving group practice dynamics and physician-hospital relationships.

AHA’s Annual Survey data indicates the number of physicians employed by hospitals has increased by 55 percent between 2000 and 2013, with hospitals employing 244,830 physicians (Figure 1).

In 2009, the AHA surveyed all community hospital CEOs to better understand the impact of the recession on hospitals. Two-thirds of hospitals reported physicians approaching them for financial support, 74 percent noted an increase in physicians seeking employment.

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**Figure 1: Number of Physicians Employed by Hospitals, 2000-2013**

Hospitals employ more than 244,000 physicians, up by 55% since 2000.

![Graph showing the number of physicians employed by hospitals from 2000 to 2013.](image)

Source: Analysis of AHA Annual Survey data for community hospitals, 2000-2013

**Figure 2: Percent of physicians who believe physicians and hospitals are likely or very likely to become more integrated in the next 3 years, by medical specialty, 2013.**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All physicians</td>
<td>66%</td>
</tr>
<tr>
<td>Primary care physicians</td>
<td>71%</td>
</tr>
<tr>
<td>Surgical specialist</td>
<td>73%</td>
</tr>
<tr>
<td>Non-surgical specialist</td>
<td>61%</td>
</tr>
<tr>
<td>Other</td>
<td>63%</td>
</tr>
</tbody>
</table>

The Deloitte 2013 Survey of U.S. Physicians (Figure 2) found that “Most physicians foresee increased consolidation of physicians into larger organizations. About two-thirds of all physicians believe that physicians and hospitals will become more integrated in the next one to three years.”

Survey Methodology and Responding Hospital and Health System Profile

Surveys were sent to all U.S. hospitals in February 2014 and responses were collected through June. The 985 responding hospitals and health systems provide a representative sample of the field. Given the nature of the topic, it is not surprising that the proportion of responses as compared to the universe were higher among large, urban, teaching hospitals; although for-profit hospital and health system response rate was lower as compared to the universe representing only 8 percent of responses (Figure 3).

Responding hospitals and health systems were geographically representative with the largest response from the Midwest at 33 percent.

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Section One:
Physician Practice and Contracting Arrangements
Types of Physician Practice and Contracting Arrangements

Hospitals have a range of organizational models for working with physicians including Independent Practice Associations (IPA), Open and Closed Physician Hospital Organizations (PHO) and Equity Models. The AHA asked hospitals and health systems to indicate the types of integrated health care delivery programs they were developing, the various contracting arrangements used and the hospital/health system ownership share for each type of arrangement. Models in which physicians are salaried by the hospital or another entity are on the rise according to data from AHA’s Annual Survey of Hospitals and Health Systems. These include the employed/salary and foundation models. Models are grouped under practice models (equity, foundation and employed/salary) and contracting models (PHOs, group practice, IPA and Management Services Organization) to reflect the different types of arrangements. Overall, 58 percent of hospitals report having at least one of these types of arrangements.4

The arrangements were defined as follows:

a. **Open physician-hospital organization (Open PHO).** A joint venture between the hospital and all members of the medical staff who wish to participate without restriction. The PHO can act as a unified agent in managed care contracting, own a managed care plan, own and operate ambulatory care centers or ancillary services projects, or provide administrative services to physician members.

b. **Closed physician-hospital organization (Closed PHO).** A PHO that restricts physician membership to those practitioners who meet criteria for cost effectiveness and/or high quality.

c. **Group practice without walls.** Hospital sponsors the formation of, or provides capital to physicians to establish, a “quasi” group to share administrative expenses while remaining independent practitioners.

d. **Independent practice association (IPA).** A legal entity that holds managed care contracts. The IPA then contracts with physicians, usually in solo practice, to provide care either on a fee-for-services or capitated basis. The purpose of an IPA is to assist solo physicians in obtaining managed care contracts.

e. **Management services organization (MSO).** A corporation, owned by the hospital or a physician/hospital joint venture, that provides management services to one or more medical group practices. The MSO purchases the tangible assets of the practices and leases them back as part of a full-service management agreement, under which the MSO employs all non-physician staff and provides all supplies/administrative systems for a fee.

f. **Equity model.** Allows established practitioners to become shareholders in a professional corporation in exchange for tangible and intangible assets of their existing practices.

g. **Foundation.** A corporation, organized either as a hospital affiliate or subsidiary, which purchases both the tangible and intangible assets of one or more medical

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4 From AHA Annual Survey data, 2012.
group practices. Physicians remain in a separate corporate entity but sign a professional services agreement with the foundation.

h. Employed/salary model. Physicians are salaried by the hospital or other provider entity to provide medical services for primary care and specialty care.

The most prevalent arrangement was the employed/salary model where physicians are salaried by the hospital or other provider entity within the health system. Forty-six percent of responding hospitals and health systems indicated they engaged in an employed/salary model (Figure 4). The next most prevalent model was the open PHO at 20 percent. The rise of aligned arrangements reflects an increase in the degree of future collaboration required to be successful in an environment based on accountability for cost, quality and outcomes.

As indicated in Figure 5, when stratified by physician entity size, the plurality (46%) of groups under 50 physicians were in employed/salary models. For entities over 100 physicians, responses were nearly even between employed/salary models and the number of physicians in open PHO models while the largest numbers (over 500 physicians) were largely in open PHO models or employed groups.

Most responding hospitals and health systems indicated their physician arrangements were organized in groups of between 1 and 49 physicians with the largest proportion being PHOs and IPAs for groups between 100 and 499 physicians. Figures 6 through 13 show the distribution by group size for each arrangement. Figure 14 shows the average number of physicians by type of arrangement.
Figure 5: Physician Arrangements by Size

Figure 6: Closed PHO

Figure 7: Open PHO

Figure 8: Group Practice

Figure 9: IPA
Figure 10: MSO

Figure 11: Equity Model

Figure 12: Foundation

Figure 13: Employed/Salary

Figure 14: Average Number of Physicians by Type of Arrangement
Ownership of Physician Arrangements

In addition to asking about how hospitals and health systems engaged with physicians, the survey asked respondents the percent of hospital ownership by type of arrangement. Hospital and health system ownership is highest among employed/salary models with 70 percent reported as owned by hospitals and 26 percent by systems (96 percent total) and about 4 percent owned by physicians. Next were foundation models, which reported 89 percent hospital or health system ownership, followed by MSOs at 80 percent hospital ownership (Figure 15).

Physician ownership was highest among IPAs with 77 percent owned by physicians and 19 percent owned by hospitals and health systems. Notably, IPAs were the only arrangement with any significant insurer ownership at 4 percent.

For contracting models (PHOs, MSO, IPA, group practice without walls), hospitals and health systems represent 63 percent of ownership while physicians represent 36 percent. Insurers account for one percent of these arrangements. For practice models (salary, foundation, equity model), 92 percent reported ownership by the hospital or health system and only 8 percent owned by physicians and no insurer ownership.

Figure 15: Percent Ownership of Physician Arrangements by Type

Figure 16: Ownership of Contracting Models

Figure 17: Ownership of Practice Models
Section Two: Hospital-Owned Physician Practices
Section Two:  
**Hospital-Owned Physician Practices**

Hospital-owned physician groups vary in size, but to drive more efficient and effective care management, hospital-owned practices with larger numbers of physicians are forming multispecialty groups. Entities under 25 physicians are evenly split among multispecialty groups (32 percent), single specialty groups (36 percent) and solo practice (31 percent) (Figure 18). The majority of hospital-owned physician entities with more than 100 physicians report they are organized as multispecialty groups, with only 25 percent organized as single specialty groups. For entities over 500 physicians nearly all are multispecialty groups.

**Figure 18: Distribution of Physicians in Hospital-Owned Practices**
In Figure 19, hospitals report the majority (nearly 60 percent) of hospital-owned physician practices are under 25 physicians, indicating an opportunity to begin to consolidate practices into larger multispecialty groups to take advantage of quality improvements and standardized processes.
Section Three: Physician Contracting Models with Hospital and Health Systems

Hospitals are beginning to move away from fee-for-service into new payment arrangements such as bundling and shared savings. Bundled payment, where providers are reimbursed a set fee for an episode of care that can include pre-acute, acute and post-acute care, breaks down current payment silos and rewards providers for improving the coordination, efficiency and quality of care. Thirteen percent of responding hospitals reported participating in a bundled payment arrangement in 2013 with rates highest in the Middle Atlantic (29.2 percent) and New England (25 percent) regions (Figure 20). For those that do participate in bundled payment, the physician make-up breaks down to roughly equal numbers of employed (46.7 percent) and independent (44.3 percent) physicians.

**Figure 20: Percent of Hospitals Participating in Bundled Payment Arrangement**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>25.00%</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>29.20%</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>10.07%</td>
</tr>
<tr>
<td>East North Central</td>
<td>5.52%</td>
</tr>
<tr>
<td>East South Central</td>
<td>6.12%</td>
</tr>
<tr>
<td>West North Central</td>
<td>9.92%</td>
</tr>
<tr>
<td>West South Central</td>
<td>10.00%</td>
</tr>
<tr>
<td>Mountain</td>
<td>10.45%</td>
</tr>
<tr>
<td>Pacific</td>
<td>12.26%</td>
</tr>
<tr>
<td>Nationwide</td>
<td>12.63%</td>
</tr>
</tbody>
</table>

Shared savings arrangements look at the total spending for an attributed population and reward physicians and hospitals that are able to achieve savings relative to a targeted amount over the course of a year. The share of the savings distributed to the provider group is usually also dependent on achieving certain quality goals.

Sixteen percent of responding hospitals reported participating in a shared savings arrangement in 2013, including 43 percent of hospitals in the New England region (Figure 21). Those that did report risk arrangements indicated that 60 percent of their affiliated physicians participate in the arrangement.
Participating or preparing for new payment arrangements requires hospitals to have a legal structure in place to receive and distribute payment to affiliated physicians. These include corporations and limited liability corporations, among other arrangements. More than 40 percent of those indicating they have a legal structure in place use a corporation, while more than a quarter use a limited liability company (LLC).

Overall, just under half of hospitals report having such a structure, with rates highest in the West South Central region. About 5 percent indicated they plan to establish a structure in the next year with nearly half of those responding hospitals and health systems indicating they plan to set up an LLC while a quarter plan to set up a corporation (Figure 22).
Figure 23: Percent of hospitals providing performance metrics to physicians participating in a shared risk payment arrangement.

- Clinical Quality: 89.8% currently provide, 1.5% not planning to provide, 9.8% planning to provide.
- Patient Experience/Satisfaction: 76.6% currently provide, 21.2% not planning to provide, 2.2% planning to provide.
- Cost/Efficiency: 69.9% currently provide, 27.2% not planning to provide, 2.9% planning to provide.

Figure 24: Percent of hospitals evaluating physician performance against performance metrics for physicians participating in a shared risk payment arrangement.

- Clinical Quality: 92.7% yes, 7.3% no.
- Patient Experience/Satisfaction: 79.9% yes, 20.2% no.
- Cost/Efficiency: 77.6% yes, 23.4% no.
The majority of hospitals that have shared risk arrangements are providing clinical quality, patient experience and cost indicators to participating physicians or plan to provide the data. Quality indicators are the most commonly provided at nearly 90 percent while cost indicators are the least often provided data at 70 percent (Figure 23).

For those that provide the indicators of clinical quality, patient experience and cost, most evaluate physician performance against goals for each area. As with the provision the indicators, over 90 percent of reporting hospitals assess physician performance against clinical quality goals, while only 77 percent do so against cost and efficiency goals (Figure 24). Of the physicians participating in shared risk payment arrangements, hospitals report more than 80 percent are part of the performance evaluation programs.
Section Four:
Hospitals’ Relationships with Employed Physicians
Success in new payment arrangements requires hospitals and physicians to closely monitor performance on quality, satisfaction and efficiency and take steps to improve. To this end, many hospitals are providing key metrics to their employed physicians. Sharing this data provides a basis for dialogue and collaboration. Most hospitals are or are planning to evaluate physicians on the basis of meeting clinical quality (82 percent), patient experience (83 percent) and efficiency (65 percent) goals (Figure 25).

More than 70 percent of responding hospitals report providing clinical quality and patient experience indicators to employed physicians with almost 54 percent providing cost/efficiency indicators. About three quarters of hospitals report that employed physicians are evaluated against the clinical quality and patient experience measures while just over half report evaluation against cost and efficiency measures (Figure 26). Hospitals report that 90 percent of their employed physicians are included in the performance evaluation programs.

**Figure 25: Percent of hospitals providing performance metrics to employed physicians.**

**Figure 26: Percent of hospitals evaluating physician performance against performance metrics for employed physicians.**
Section Five:
Physician Practice Governance
Physician groups and other physician practice arrangements have differing governance structures. Responding hospitals and health systems were asked to indicate which physician arrangements have separate governing boards and the composition. Nearly 60 percent reported separate governing boards responsible for the physician arrangements with the largest percentages among open (80 percent) and closed PHOs (72 percent), foundation (74 percent) and equity models (63 percent) and IPAs (66 percent). While two of the practice models with employed physicians (foundation and equity) report higher levels of self-governance, employed/salary models lag behind with only 41 percent reporting a separate board (Figure 27).

Hospital-owned physician practices are beginning to organize into self-governing entities as hospitals develop strategies to allow employed physician groups greater clinical autonomy in care coordination and delivery. Approximately one-quarter of hospitals report their employed physicians are self-governed.

Figure 27: Report a Separate Governing Board
In terms of the board composition, across all physician arrangements, separate governing boards averaged nearly seven physicians, three executives and four lay members. IPAs had the largest number of physicians on the board with more than 11 on average, while equity models are the only ones with more executive than any other representation by a small margin (Figure 28).

Responding hospitals and health systems were also asked to indicate whether the board authority was fiduciary only, advisory only or both. Employed/salary models have a large number of boards with only an advisory role (Figure 29).
Section Six:  
Electronic Health Record Usage
Section Six:
Electronic Health Record Usage

The ability to share clinical data across the care continuum greatly facilitates efforts to improve care coordination, another key to success under value-based payment models. Eighty-nine percent of hospitals report that the majority of their owned practices use an electronic health record (EHR), but only 46 percent report that employed physicians groups are fully integrated into the hospital EHR (Figures 30-31).

**Figure 30:**
Physician Practices Use EHRs

**Figure 31:**
Practice EHRs Integrated into Hospital
Section Seven:
Physician-Hospital Arrangements by Specialty
Responding hospitals and health systems were asked to share how they arrange for different services by type of arrangement. Primary care (internal medicine, pediatrics, geriatrics and family medicine) is provided through employed arrangements in 32 percent of respondents while specialty care is provided through employed arrangements in 25 percent. Contracting arrangements provide primary and specialty care in roughly equal proportion (Figures 32-33).

Figures 34-62 show the distribution of employed models, contracting models and voluntary staff provision of care by specialty. As expected, those hospital-based specialties have higher percentages of employed models compared with voluntary staff ranging from a low of 13-14 percent for ophthalmology and nephrology to a high of 40 percent for hospitalists.
Finally, primary care practices (internal medicine, pediatrics, geriatrics and family medicine) are more likely to be owned by the hospital or health system than specialty care arrangements (Figure 63).
Conclusion

In order to strengthen patient outcomes and ensure financial stability, hospitals are working more closely with physicians to achieve greater efficiency and improved outcomes. The nature of physician-hospital relationships is changing from those that enhance patient referrals to formal structures that can accept clinical and financial risk. These arrangements also allow for the joint establishment of clinical protocols, financial mechanisms that align incentives, tracking of performance across the care continuum and integration of information systems. These efforts should optimize the potential for achieving the Triple Aim of better health, better health care and lower costs.

From loose affiliations to employment models, hospitals report a broad array of physician arrangements. Nearly half of responding hospitals and health systems indicated they engaged in an employment/salary model while 20 percent report working with physicians through an open physician hospital organization.

While hospital-ownership of physician practices is increasing, the majority of the practices are under 25 physicians, and only one quarter are self-governed indicating an opportunity for hospitals and health systems to work with physicians to develop physician-governed care organizations. As health care moves away from fee-for-service into new payment arrangements such as bundling and shared savings, physician-hospital relationships are starting to reflect this trend. Thirteen percent of responding hospitals reported participating in a bundled payment arrangement with physicians in 2013 while 16 percent participate in a shared savings arrangement with physicians.

New payment methodologies, increased employment of physicians by hospitals and the move to accountable care organizations require closer integration to deliver value and meet the Triple Aim. The data indicate the potential for closer integration and organization, particularly among hospital-owned physician practices. Most hospital-owned practices are smaller, presenting an opportunity to consolidate into larger multispecialty groups to take advantage of quality improvements, standardized processes and the ability to accept risk. In addition, to support the needs of clinical integration to improve quality, patient safety and streamline care delivery, arrangements between and among physicians and hospitals need to promote mutual accountability and joint leadership to bring health care delivery to the next level.

For more information on physician/hospital collaboration, please visit: www.ahaphysicianforum.org