WHITE PAPER

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The Myth of Breakeven Financial Performance: How Acquired Medical Groups Have Lost Their Margin

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Health systems have spent nearly three decades acquiring provider practices on the premise that scale, technology, coordination, and better management would eventually offset the negative bottom line financial results. That premise has not held true. Employed medical groups do not run at a loss because of a fixable inefficiency. They run at a loss because the model is built in a manner that can only lead to losing money, and the forces widening that gap are accelerating.

As noted in our recent white paper, "The True Value of a Medical Group," the median investment per physician is approximately $300,000 per year for physicians employed by a health system or in a professional services arrangement (PSA).[1] This paper contends that this high level of investment per physician is not a temporary challenge to be solved solely through better revenue cycle execution, cost cutting, or outsourcing. While these are important tactics that may be needed, structural barriers exist, and they will inhibit success. High investment per physician is the result of four compounding forces: provider compensation that exceeds collections in many specialties; health system provider compensation levels that trend at the high end of the market; a payer mix that is challenging and likely to worsen; and the transfer of revenue from medical groups to their parent health systems.

High reported losses in system-affiliated practices are a recurring feature of how hospitals account for their owned practices, and understanding why requires a deeper look, beyond the P&L's bottom line. For a board that is evaluating its provider enterprise strategy, the key questions should shift away from, "When and how do we get the provider enterprise to break even?" to more productive questions, which we propose at the conclusion. This paper lays out the evidence for why breakeven is not a helpful planning target, and what steps can be taken once that target is put to rest.

Four Structural Forces Behind High Investment per Physician in System-Affiliated Practices

1. Provider compensation-to-collections ratios leave no room for other expenses.

Through AMGA's annual surveys, we track what providers earn and what they collect. One metric that we calculate is the compensation-to-net professional collections ratio. In far too many specialties, professional collections fall short of covering providers' pay, leaving no room to cover the rest of the practice's operating costs, let alone generate a margin. Out of 150 specialties within system-affiliated groups, a staggering 62 specialties (41%) have median compensation that exceeds their median collections (see Figure 1). This is not a design flaw that better compensation plan administration efforts can fix, but rather the systematic result of a growing physician shortage and competition to recruit physicians.

[1] Professional Services Arrangement (PSA) is a type of contractual agreement entered into between a health system and a provider-owned organization, common in states that prohibit the corporate practice of medicine.

Figure 1

Compensation Exceeds Net Professional Collections in 41% of System-Affiliated Specialties

Comp-to-net-collections median ratio by specialty — the 62 specialties where compensation exceeds net professional collections, ranked high to low.

Bar length and shade show how far **above breakeven (1.00)** each specialty's ratio runs. 1.00 – 2.49

#	SPECIALTY	2026 RATIO
1	Hospitalist – Nocturnist	2.49
2	Pediatrics – Neurological Surgery	2.45
3	Cardiac/Thoracic Surgery – Pediatrics	2.30
4	Concierge Medicine – Primary Care	2.19
5	Anesthesiology – Cardiac	2.08
6	Critical Care/Intensivist	2.06
7	Hospitalist – Neurology	2.05
8	Palliative Care /Hospice Care	2.04
9	Neurology – Stroke	1.94
10	Certified Registered Nurse Anesthetist	1.92
11	Pediatrics – Infectious Disease	1.89
12	Trauma Surgery	1.88
13	NeuroIntensivist/Neuro Critical Care	1.87
14	Pediatric Surgery	1.84
15	Cardiovascular Surgery	1.80
16	Pediatrics – Genetics	1.80
17	Psychiatry – Inpatient	1.74
18	Hospitalist – Laborist	1.67
19	Hospitalist – Pediatrics	1.63
20	Hematology and Medical Oncology	1.60
21	Oncology – Medical	1.56
22	Transplant Surgery – Kidney	1.56
23	Pediatrics – Intensive Care	1.51
24	Psychiatry – Addiction Medicine	1.49
25	Psychiatry	1.48
26	Physician Assistant – Surgical	1.47
27	Cardiac/Thoracic Surgery	1.46
28	PA – Radiology/Anesthesiology/Pathology	1.46
29	Thoracic Surgery	1.44
30	Geriatrics	1.44
31	Cardio – Advanced Heart Failure and Transplant	1.41
32	Hepatology	1.39
33	Hospitalist – Internal Medicine	1.37
34	Hospitalist – Family Medicine	1.36
35	Psychiatry – Child	1.35
36	Neurosurgery	1.32
37	Pulmonary Disease (With Critical Care)	1.31
38	Pediatrics – Hematology and Oncology	1.30
39	Pulmonary Intensivist	1.20
40	Nuclear Medicine (MD Only)	1.19
41	Cardiology – Echo Lab and Nuclear	1.16
42	Pediatrics – Developmental-Behavioral	1.16
43	Anesthesiology	1.13
44	Orthopedic Surgery – Oncology	1.13
45	Psychiatry – Outpatient	1.12
46	Cardiology – Invasive Interventional	1.11
47	Pulmonary Disease (Without Critical Care)	1.09
48	Pediatrics – Radiology	1.09
49	Pediatrics – Anesthesiology	1.08
50	Infectious Disease	1.07
51	Nurse Practitioner – Geriatric	1.06
52	Pediatrics – Nephrology	1.05
53	Vascular Surgery	1.03
54	Neurology – EMG Lab	1.03
55	Pathology – Combined (MD Only)	1.03
56	Orthopedic Surgery – Trauma	1.03
57	Oncology – Surgical	1.01
58	Nurse Practitioner – Medical Specialty	1.01
59	Wound Care/Hyperbaric	1.01
60	General Surgery	1.01
61	PhD Only: Psychology	1.00
62	OB/GYN – Gynecological Oncology	1.00

Source: AMGA 2026 Medical Group Compensation and Productivity Survey Report; 2026 Report Based on 2025 Data

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2. System-affiliated practices pay physicians more.

System-affiliated groups often pay physicians more than independent groups, according to AMGA's survey data. Why does this occur? The full answer could fill a white paper of its own, but a few drivers stand out: fierce competition among systems (also insurance plans and private equity firms) to acquire established medical groups, building high-quality service lines, achieving network adequacy requirements, and covering specific hospital needs.

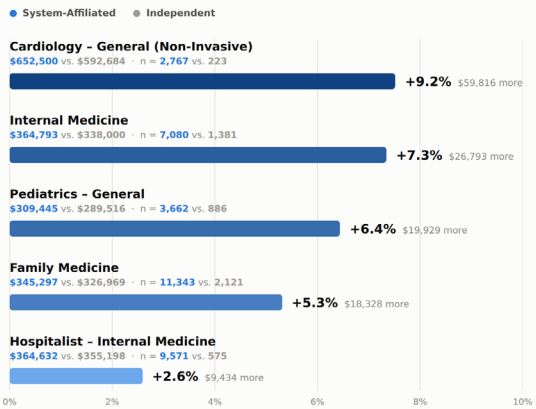
Consider the examples in Figure 2, which contrast compensation for five common specialties.

Figure 2

Differences in Physician Compensation for Five Common Specialties

System-Affiliated vs. Independent

Percentage by which system-affiliated median compensation exceeds independent median compensation, by specialty — ranked highest to lowest premium. Darker, longer bars mark the widest gaps.



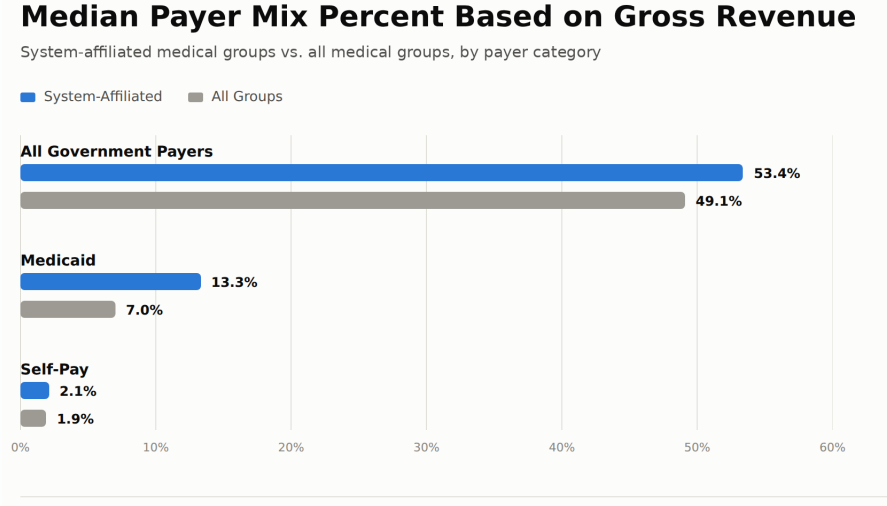
Source: AMGA 2026 Medical Group Compensation and Productivity Survey Report; 2026 Report Based On 2025 Data.

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3. Payer mix inside system-affiliated practices is challenging and potentially growing worse.

AMGA's survey data show that as system-affiliated practices fulfill their mission, they carry a significant burden of government payers and "low-to-no-payers," such as Medicaid and self-pay (see Figure 3). We see two main reasons for this. First, health system emergency departments are an entry point for uninsured and under-insured patients due to EMTALA regulations.[2] Second, health systems sometimes route lower-margin, higher-acuity, and safety-net patient populations into employed practices, as the employed practices serve the same population and share the same payer relationships as the health system. The more a system leans on its employed group to absorb access points that the community needs, the worse the employed group's payer mix and financial performance becomes.

Figure 3



Adding to the payer mix problem, the Medicaid funding changes in the *One Big Beautiful Bill Act* (H.R. 1) are projected to reduce Medicaid enrollment by 7.6 million people.[3,4]

Some sources place this figure as high as 11 million people, with a corresponding $36 billion increase in uncompensated care. If several million Medicaid recipients convert to self-pay, it will significantly and disproportionately impact system-affiliated practices due to the two factors noted above.

4. Revenue from profitable services moves upstream from acquired medical groups to their health systems, while increased overhead flows downstream.

A medical group's economics typically rely on internal cross-subsidization: a small number of high-margin service lines fund a much larger base of lower-margin, harder-to-monetize care that is nonetheless clinically and operationally essential.

When a health system acquires a medical group, it typically redirects the group's high-margin ancillary service lines and ambulatory surgery center (ASC) facility revenue to the system level, where that revenue

[2] Emergency Medical Treatment & Labor Act (EMTALA), https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act

[3] Rao, P., Baker, L., Girosi, F., Li, E., Kerber, R., & Eibner, C. (2026). State-level impacts of key Medicaid provisions in the One Big Beautiful Bill Act (RR-A4098-1). RAND Corporation. https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html

[4] AMGA (2026). Protect Medicaid Funding (Issue Brief). Alexandria, VA. https://amga.org/getcontentasset/5eea2347-4dec-4236-93df-f67aa26a1d68/dfc3d011-8f63-43f6-9ed8-4b444333a1d0/2026-protect-medicaid-amga-issue-brief_1?language=en-US

is centralized and managed according to systemwide priorities. The medical group is left managing the remaining service mix, comprised of the lower-margin components that were not designed to stand on their own financially and tend to be exclusively professional fee-based.

Furthermore, overhead in systems runs higher than in independent practices. Employed practices inherit hospital-scale overhead: enterprise electronic health record (EHR) costs, system HR and benefits packages, compliance infrastructure, and administrative layers that a physician-owned group of comparable size does not carry.

Real-World Case Study

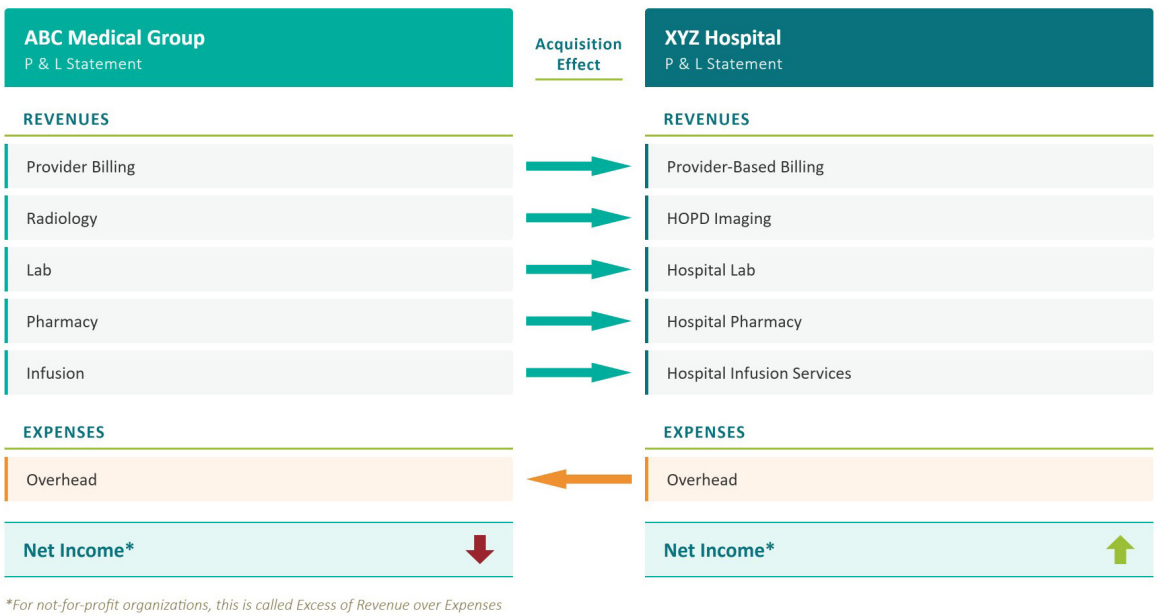
One medical group executive from an AMGA member organization shared their experience in this situation. This executive was leading a freestanding medical group that was eventually acquired by a health system in the same market. The executive's pre- and post-acquisition experiences were consistent with the typical situation described above.

Pre-acquisition: The group only broke even. The medical group was running lean on expenses and had a physician compensation model that was well aligned with productivity. All provider billing was retained by the group, and several ancillary services, such as lab, pharmacy, infusion, and radiology, comprised a substantial source of revenue for the group.

Post-acquisition: Provider-based billing, as well as the medical group's former lab, pharmacy, infusion, and radiology services, accrued to the hospital P&L. Overhead expenses increased due to functions like legal and compliance that were more robust in the health system than in the initial medical group. Due to these changes and others, it became more difficult to determine how the medical group was truly performing. Post-acquisition, the medical group looked unprofitable and the hospital looked stronger. But nothing about real performance had changed.

Figure 4 directionally illustrates the "Acquisition Effect" on the case study organization's P&L.

Figure 4



These Forces Are Accelerating

Each of the structural forces above is compounded by further national healthcare trends that are outside of a health system's control:

- Medicare provider fee schedule payment adjustments have lagged behind the rate of expense increases for years, with further payment cuts possible.
- Site-neutral payment reform has bipartisan momentum in Congress and is a stated priority of Centers for Medicare and Medicaid Services (CMS) rulemaking, directly targeting the facility-fee offset.
- Private equity- and payer-owned entities employ more providers than ever before and continue to change the medical group marketplace.
- Value-based care still constitutes a modest proportion of revenue and in many cases has not delivered sufficient return on investment to cover its costs.

Breakeven Was Never the Right Target

It's simple math, and the math does not add up.

Taken together, these impacts are widening the differential between expenses and revenues. As noted above, this is not a temporary gap that better tactics can close. It's simple math, and the math does not add up.

From Diagnosis to Action

In this paper, we have described the structural forces that are putting breakeven financial performance out of reach for a provider enterprise that is part of a health system. While breakeven is not a realistic target, there are steps that can be taken and changes that should be made.

First, identify key metrics impacting the financial performance of the provider enterprise and take action to move them in a positive direction. In AMGA Consulting's work with healthcare organizations, we see many opportunities for improvement. Figure 5 contains a few common examples.

Figure 5

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Common Opportunities for Improvement

A few examples of the metrics and key steps AMGA Consulting most often sees drive improvement in medical group financial performance.

Revenue Optimization

- Target 60%ile productivity for all providers
- Align provider compensation and productivity with each other (within 10%ile points)

Access

- Schedule 36 hours/week of patient-facing time for primary care and non-surgical specialties (not proceduralists)
- Deploy Advance Practice Clinicians where there are physician shortages and/or high physician productivity

Expense Management

- Review clinic staffing for efficiency, informed by national benchmarks (either per provider or per 10,000 work RVUs)

Second, separate access obligations from margin expectations. For example, practices carrying a disproportionate Medicaid or safety-net mix should be budgeted and evaluated differently due to organizational mission and their important role in access for these populations.

Finally, reduce reliance on the facility-fee offset before federal policy forces the issue. Site-neutral payment reform is happening for an increasing share of services.

When will the medical group break even? It will not, when the structural and accounting elements are as described in this paper. We must stop asking this question, as it can lead to inadvertent assumptions about performance and ultimately erode culture. Better questions to be asked—and answered—are:

- What are true indicators of performance, and how can they be applied to uncover opportunities while promoting provider engagement?
- How can we leverage our provider enterprise to best serve our market?
- Where can we optimize our provider enterprise as care settings increasingly transition from acute care to ambulatory care?
- Which reachable metrics (not investment per physician) should we target to continuously improve and achieve high performance?

These questions will tee up more fruitful financial performance discussions in the C-suites and boardrooms of high-performing health systems.



Fred Horton, MHA (fhorton@amgaconsulting.com), is president of AMGA Consulting Services. Fred is a dynamic healthcare advisor who possesses industry experience, market insight, exemplary capabilities managing diverse and challenging projects, and the ability to create tangible results on behalf of his clients. Fred has more than 20 years of experience working inside the healthcare industry. He brings his operational, strategic, and financial acumen to his clients in order to create effective and market-sensitive solutions to their challenges.



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