



# PYA COMPENSATION STUDY: SPOTLIGHT ON HOSPITALISTS

*Ensuring Quality Inpatient Care and Patient Satisfaction*

*August 2017*

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## INTRODUCTION

With the Centers for Medicare & Medicaid Services' (CMS) introduction of the Hospital Value-Based Purchasing Program (HVBPP) in 2012, Medicare payments are increasingly tied to quality of care, not merely quantity of service. Clinical outcomes and patient/caregiver experience of care account for as much as 50% of all scores available to hospitals pursuant to the HVBPP.<sup>1</sup>

In this environment, the role of the hospital medicine practitioner (also referred to as a hospitalist) in coordinating care and ensuring positive clinical outcomes cannot be overstated. Hospitalists engage in clinical care, teaching, research, or leadership in the field of general hospital medicine, often supported by non-physician providers. Apart from providing care to hospitalized patients, these physicians may also support the emergency department by assisting with admissions and providing additional support in the event of patient emergencies.

## DEMAND FOR HOSPITALIST SERVICES

In the 1990s, with emergency admissions on the rise, primary care physicians found it increasingly disruptive caring for their patients in the hospital setting at the expense of their private practices; and, hence, many of them were willing to turn over patients to hospitalists. At about the same time, the combination of managed care for privately insured patients and Medicare's diagnosis-related-group-based payment system for inpatients pushed hospitals to manage care more efficiently without sacrificing quality or alienating patients, and hospitalists helped accomplish both goals. While continuity of care remains the single greatest concern under the hospitalist model, increasing evidence suggests that using hospitalists reduces costs, ensures appropriate lengths of stay, and preserves or even enhances quality of care and patient satisfaction.<sup>2</sup> Such results have increased the demand for hospitalist services.

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<sup>1</sup> Source: <https://www.medicare.gov/hospitalcompare/data/total-performance-scores.html>. According to CMS, for FY 2017, 25% of a hospital's total performance score is based on the "clinical care domain," which focuses on quality of care, including both outcomes and processes, and another 25% is based on the "patient- and caregiver-centered experience of care/care coordination domain," which is based on the results of a patient satisfaction survey.

<sup>2</sup> <http://www.nejm.org/doi/full/10.1056/NEJMp1607958#t=article>.

A report by the *New England Journal of Medicine* states that approximately 75% of all U.S. hospitals currently utilize hospitalists.<sup>3</sup> Between 2012 and 2016, hospitalist medicine remained the fourth most requested specialty in Merritt Hawkins search assignments, after family medicine, internal medicine, and psychiatry, only relenting to sixth place in 2017, displaced by searches for nurse practitioners and specialists in obstetrics and gynecology.<sup>4</sup>

Capstone Partners anticipates that the aging population and declining inclination among primary care physicians to take call coverage, as well as the compelling value proposition presented by hospitalists, will continue to generate demand for hospitalists.<sup>5</sup> Similarly, the Association of American Medical Colleges (AAMC) *Workforce Study* results indicate that between 2014 and 2025, changing demographics are projected to increase national demand for hospitalists by about 20%.<sup>6</sup>

The demand for hospitalists also is evidenced by the plethora of consolidation and transactional activity between private hospitalist groups. For example, Eagle Hospital Physicians, which acquired PrimeDocs Management Services in August 2011, was acquired by Sound Physicians in 2016, creating an organization that now serves more than 225 hospitals in 38 states with more than 2,500 providers. A transaction of even greater scale was the acquisition of IPC Healthcare by Team Health Holdings at the end of 2015 for approximately \$1.6 billion, resulting in an organization with as many as 16,000 clinicians.<sup>7</sup> The Society of Hospital Medicine (SHM) estimates that 25% to 30% of hospitalists work with multi-state hospitalist management groups (HMGs), as more and more hospitals turn to such groups for outsourcing their hospitalist needs.<sup>8</sup>

## SUPPLY OF HOSPITALISTS

The SHM reports that approximately 86% of physicians practicing as hospitalists were trained in internal medicine or family medicine.<sup>9</sup> With the board certification process in hospital medicine still in development,<sup>10</sup> and physicians more often self-identifying with the specialty for which they were trained, the current data on the number of hospitalists within the U.S. is, at best, an estimate. The American Hospital Association estimates that, between 2003 and 2016, the number of hospitalists in the U.S. increased from approximately 10,000 to more than 50,000.<sup>11</sup> The aforementioned AAMC *Workforce Study* used the Medicare fee-for-service billing records for physicians, where close to 100% of their evaluation and management billing was hospital-based, to identify 25,320 hospitalists in the U.S. in 2016.<sup>12</sup> This number only included internists, family physicians, and geriatricians.<sup>13</sup>

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<sup>3</sup> <http://www.nejm.org/doi/full/10.1056/NEJMp1607958#t=article>.

<sup>4</sup> Merritt Hawkins “2017 Review of Physician and Advanced Practitioner Recruiting Incentives.”

<sup>5</sup> Capstone Partners, *Q4 2016 Hospitalist Acquisition Report*.

<sup>6</sup> [https://www.aamc.org/download/458082/data/2016\\_complexities\\_of\\_supply\\_and\\_demand\\_projections.pdf](https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf).

<sup>7</sup> Capstone Partners, *Q4 2016 Hospitalist Acquisition Report*.

<sup>8</sup> Society of Hospital Medicine, *State of Hospital Medicine Report*, 2016.

<sup>9</sup> Ibid.

<sup>10</sup> <http://www.abpsus.org/hospital-medicine>. PYA understands that the American Board of Hospital Medicine, which was founded in 2009, has postponed the acceptance of new applications for the Initial Certification exam while awaiting a critical mass of applicants for the program.

<sup>11</sup> <http://www.nejm.org/doi/full/10.1056/NEJMp1607958#t=article>.

<sup>12</sup> [https://www.aamc.org/download/458082/data/2016\\_complexities\\_of\\_supply\\_and\\_demand\\_projections.pdf](https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf).

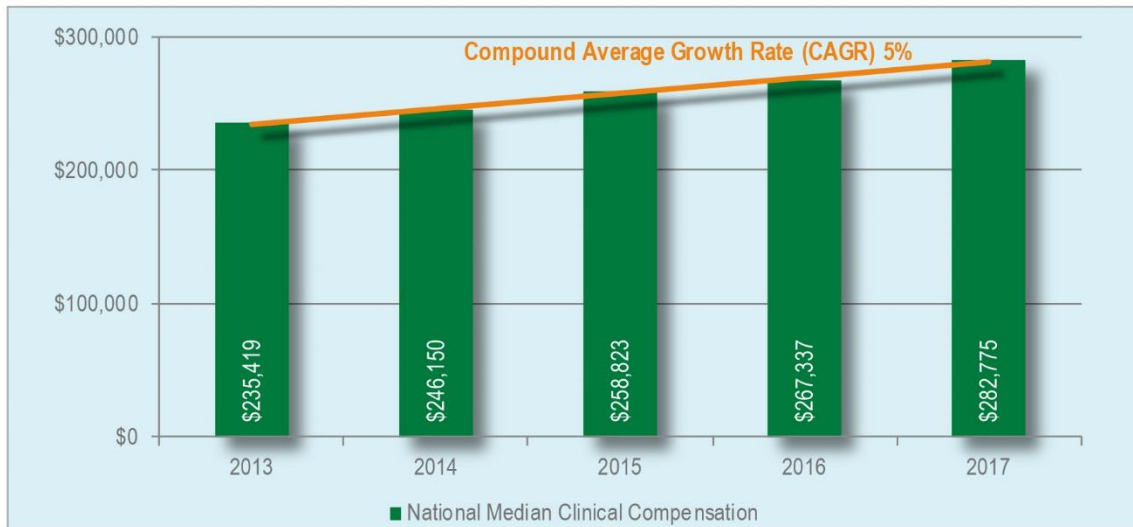
<sup>13</sup> Ibid.

## NATIONAL CLINICAL COMPENSATION BENCHMARKS

The aging population and the move toward HVBPP is likely to continue to create demand for hospitalists, potentially impacting compensation and productivity of physicians. To understand recent trends, PYA reviewed industry benchmark data<sup>14</sup> on compensation, productivity, collections, and subsidies, and noted the following:

- As seen in **Figure I**, hospitalist clinical compensation was observed to grow at a compound annual growth rate (CAGR) of 5% over the last five years, an increase in actual compensation by nearly \$50,000 per physician over the five-year period.

Figure I: Trends in Clinical Compensation – Hospitalist<sup>1</sup>

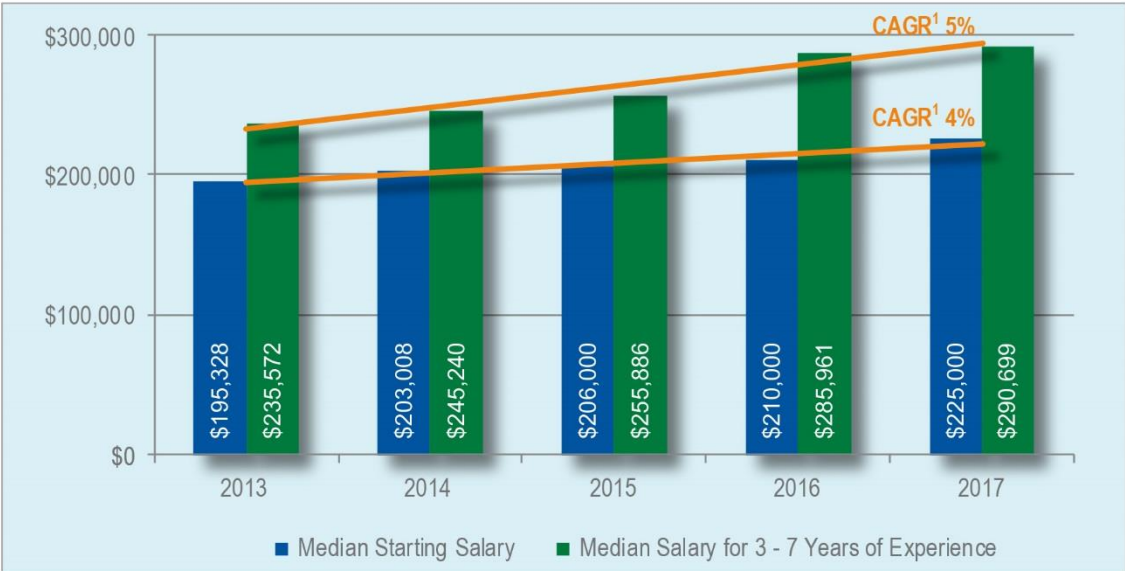


<sup>1</sup> The total compensation received by the physician reported as direct compensation which may include salary, bonus and/or incentive payments, research stipends, honoraria, profit-sharing, clinical medical directorships, call coverage, and voluntary salary reductions. The compensation reported excludes fringe benefits paid by the medical practice (e.g., retirement plan contributions and health insurance).

<sup>14</sup> Resources utilized include: American Medical Group Association (AMGA) *Medical Group Compensation and Productivity Survey*; Medical Group Management Association (MGMA) *Cost Survey*; MGMA *Medical Directorship and On-Call Compensation Survey*; MGMA *Provider Compensation Survey*; Sullivan, Cotter and Associates, Inc. (SullivanCotter) *Physician Compensation and Productivity Survey*; and Hospital & Healthcare Compensation Service (HHCS) *Physician Salary & Benefits Report*. Benchmark data presented for each year is based on prior year data. PYA notes SullivanCotter data for 2017 was not available at the time of this publication.

- In **Figure II**, a general upward trend (4% CAGR) was observed for all starting salaries, but the growth was slightly higher (5% CAGR) for those with more years of experience.

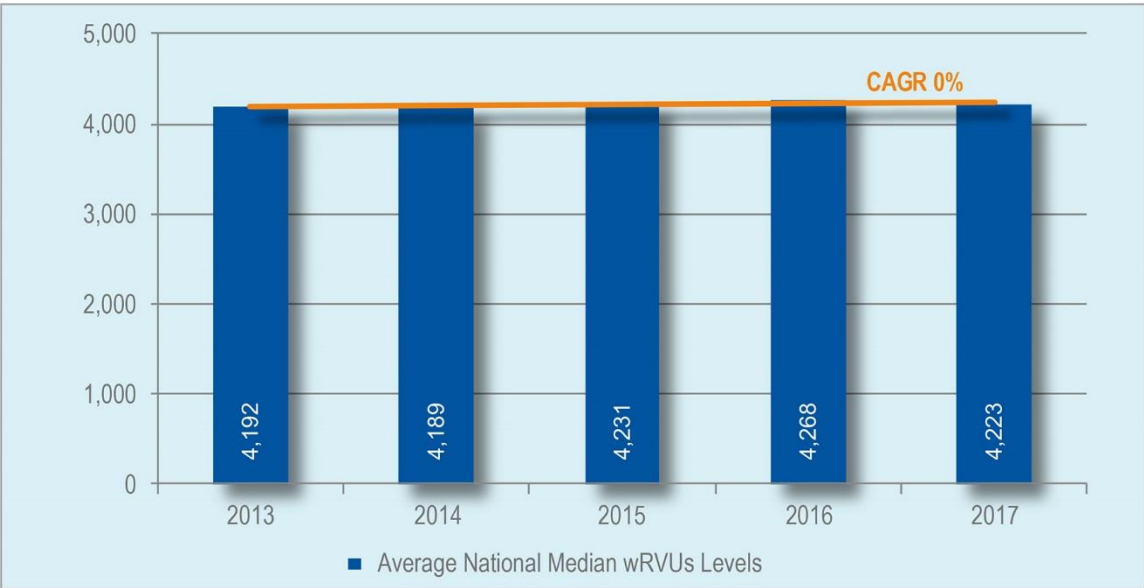
Figure II: Trends in Starting Salary and Salary at 3-7 Years of Experience – Hospitalist



<sup>1</sup> The number of data points available with respect to the above figure was limited.

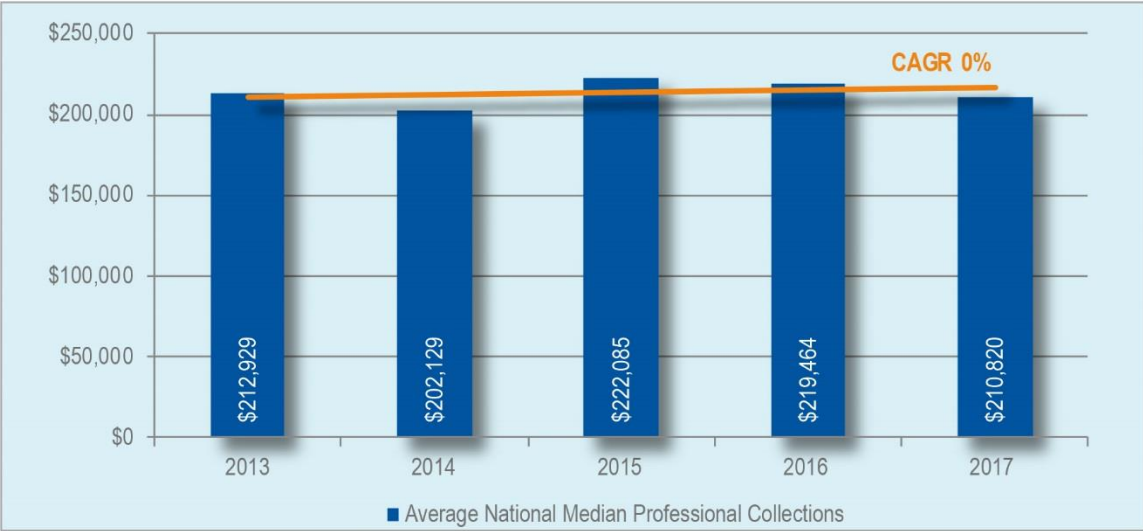
- Physician work relative value units (wRVUs) did not match growth in physician compensation, and were, in fact, flat over the last five years as seen in **Figure III**. With Medicare reimbursement dependent on quality, clinical outcomes, and patient satisfaction, greater attention is required of physicians. One possible reason for the flat wRVU growth may be that efforts have been made to maintain physician workload at reasonable levels to allow for quality care. Additionally, hospitalists are often required to work shifts regardless of the number of patients they see, which can also affect productivity levels.

Figure III: Trends in Physician Productivity as Measured by wRVUs



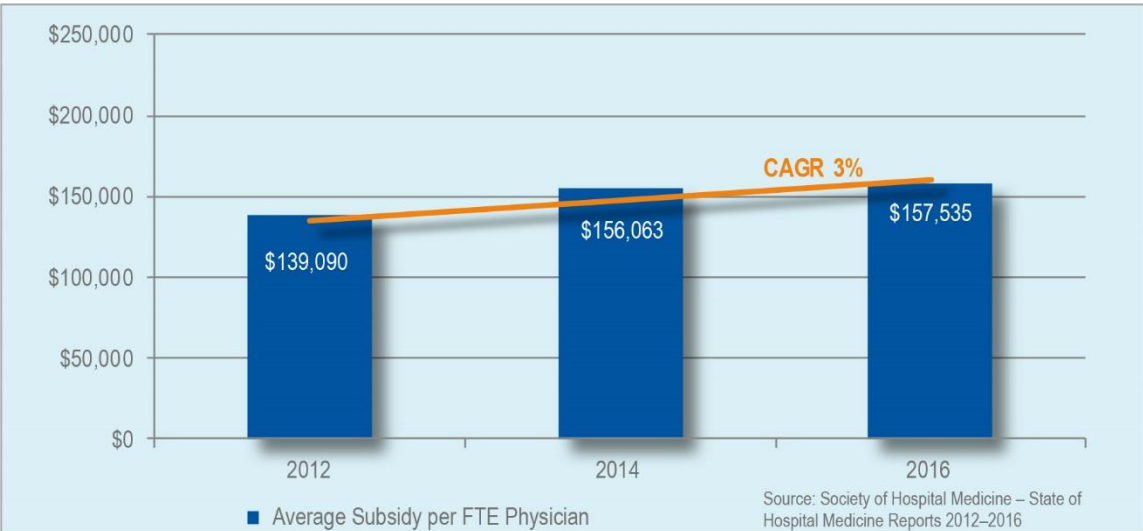
- To further assess hospitalist productivity, PYA evaluated trends in professional collections as shown in **Figure IV**. As the wRVU productivity results may suggest, the CAGR for professional collections was 0% over the last five years.

Figure IV: Trends in Physician Productivity as Measured by Professional Collections



- With physician compensation increasing, and wRVUs and collections relatively constant, hospitals have had to provide greater levels of financial assistance or subsidies to HMGs. According to the SHM 2016 *State of Hospital Medicine (SoHM) Report*, more than 93.8% of hospitalist medical groups receive financial support in addition to professional collections from their host hospital. Based on the SoHM Report, representing data from 216 groups, the median support is \$157,535 per full-time physician (FTE) in 2016, which is an increase of 13.2% from the 2012 SoHM Report as seen in **Figure V** below.

Figure V: Trends in Average Subsidy per FTE Physician



## **CONCLUSION**

While hospitalist productivity and professional collections have remained relatively constant over the previous five years, clinical compensation for both experienced and new graduate hospitalist physicians has increased. The growing success of this model continues to drive the demand and corresponding compensation for hospitalists. In essence, hospitalist physicians have become essential providers as they help to alleviate the burden for their fellow office-based physicians, while promoting quality and continuity of care for patients in hospital-based settings.

## **About PYA**

PYA provides independent and objective valuation and consulting services to a broad range of healthcare organizations. We support our clients' many needs, including physician employment arrangements, medical directorships, call coverage, and many other types of arrangements associated with various acquisitions and/or affiliations.

We serve many hospital clients seeking to establish professional services arrangements with private hospitalist groups to assist with fair market value compensation analysis, including the calculation of implied financial support/subsidy payments.