



## ASHP Policy Analysis

# Hospitalist Payment: A Model for Health-System Pharmacists?

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Examining the model for hospitalist physician practice and compensation (the “hospitalist model”) could provide clues of what changes health-system pharmacists may experience upon achieving recognition as providers under Medicare Part B. Such recognition is a top advocacy goal of the American Society of Health-System Pharmacists (ASHP).<sup>1</sup> Pharmacists already have achieved this distinction under Medicare Part D and certain state health programs. Once pharmacists are recognized as providers under Medicare Part B, the structures under which health-system pharmacists are employed and compensated may change.

This paper examines the hospitalist model because of the similar goals hospitalists and health-system pharmacists share. Both provide direct and indirect patient care and support the hospital or health system in which they work by “developing the institutional policies, processes, and infrastructure that support patient care.”<sup>2</sup> By better understanding the hospitalist model, health-system pharmacists can begin to envision how their practices may change upon recognition as providers under Medicare Part B.

## What is a Hospitalist?

The Society of Hospital Medicine (SHM) defines a hospitalist as a physician who primarily focuses on “the general medical care of hospitalized patients.”<sup>3</sup> A hospitalist may also teach, conduct research, and lead other health care professionals.

A hospitalist’s duties are divided between directly caring for patients and performing administrative duties that affect the quality of care patients receive. As a patient care provider, a hospitalist typically takes patient histories, performs physical examinations, conducts follow-up visits, participates in family meetings, and provides patient discharge instructions.<sup>4</sup> As part of his or her administrative duties, a hospitalist may be expected to improve a hospital’s efficiency, serve as a leader by participating on hospital committees, coor-

dinate an interdisciplinary clinical team with instant access to a physician, and teach medical residents at academic health centers.<sup>5</sup> A hospitalist may also participate in quality improvement initiatives and develop institutional guidelines for caring for patients with specific diseases.<sup>6</sup>

Hospitalists are employed by hospitals (40%), academic centers (18%), local hospitalist-only groups (14.5%), multispecialty groups (14.5%), and management companies (13%) (WelliksonL, Society of Hospital Medicine, personal communication, 2009 Jul 16). Among the physician specialties, 82.3% of hospitalists are trained as general internists.<sup>7</sup> The remaining hospitalists are trained across the following specialties: general pediatricians (6.5%), internal subspecialists (4%), family physicians (3.7%), internal medicine/pediatrics (3.1%), and pediatrician subspecialists (0.4%).

A physician practicing as a hospitalist does not have a specialized certification program he or she can complete to recognize proficiency in the hospital medicine area of practice.<sup>5</sup> However, a hospitalist who is an internist is eligible to apply for certification from the American Board of Internal Medicine (ABIM) after successfully completing his or her residency.<sup>8</sup>

To recognize hospital-based internists’ contribution to improving patient care, ABIM is expected to recognize

hospital medicine as a focused practice through its maintenance of certification program in 2010.<sup>9</sup> ABIM will not recognize hospitalists as a subspecialty of internal medicine.

## Growing Profession

The number of hospitalists is steadily growing. There were approximately 28,000 hospitalists in the United States in 2009, up from about 15,000 in 2006<sup>7</sup> (WelliksonL, Society of Hospital Medicine, personal communication, 2009 Jul 16).

The number of practicing hospitalists increased over an 11-year period, a study analyzing Medicare claims data shows.<sup>10</sup> Among general internal medicine physicians in 1995, 5.9% were identified as hospitalists, which increased to 19.0% in 2006. As the number of hospitalists increased, so did the number of hospitalist inpatient Medicare claims. The percentage of hospitalist inpatient evaluation-and-management services claims rose from 9.1% in 1995 to 37.1% in 2006.

Hospitals are increasingly turning to hospitalists to provide inpatient care.<sup>10</sup> “The percentage of hospitals with at least three hospitalists increased from 11.6% in 1995 to 47.1% in 2006, with an increase from 41.9 to 83.7% among major teaching hospitals and an increase from 5.5 to 38.4% among nonteaching hospitals.”<sup>10</sup> As a result, “the odds that a hospitalized Medicare patient was cared for by a hospitalist increased 29.2% per year during the period from 1997 through 2006.”<sup>10</sup>

## Economic Trends Encourage Use of Hospitalists

Hospitals are increasingly using hospitalists because primary care physicians are choosing not to practice inpatient care and because hospitals are pressured to control costs and improve patient safety.<sup>11</sup>

For primary care physicians, reimbursement rates for patient services are not keeping pace with increasing practice costs.<sup>11</sup> Since primary care physicians find that they can bill more for outpatient visits than for inpatient visits in the same amount of time, there is a financial incentive for primary care providers to stop treating inpatients. Malpractice insurance costs also discourage primary care physicians from seeing inpatients and from being on call for the emergency department. Instead, malpractice insurance costs encourage primary care physicians to refer patients who have complicated

health problems or who are acutely ill to emergency departments.<sup>11</sup>

## Financial Impact of Hospitalist Programs

When examined at the institutional level, hospitalist programs should generate a return on investment, reduce hospitalization costs, shorten lengths of stay, and increase admissions<sup>12-21</sup> (Table 1). However, most hospitalist programs operate at a loss when analyzed solely on the traditional physician practice billing models that are based on patient care encounters.<sup>7</sup> One study has examined the Current Procedural Terminology (CPT) code categories hospitalists use for inpatient and outpatient evaluation and management—hospital care, inpatient consultation, office or other outpatient visit, and patient office consultation.<sup>10</sup> (A listing of the hospitalist evaluation-and-management CPT codes identified in the study, a description of the codes, and the national Medicare payment rate for the codes are listed in the Appendix.)

The reimbursement rates for hospital inpatient and outpatient evaluation and management billing codes (Appendix) and the number of patient care encounters expected of hospitalists (Table 2) do not generate the revenue necessary to provide competitive salaries and cover the general administrative and liability expenses for a hospitalist program.

A 2007-2008 SHM survey shows that hospitalist programs operate at an average annual deficit of \$954,000.<sup>7</sup> As a result, 91% of hospitalist groups receive financial support, such as “payment subsidies, services in kind, or case rate reimbursement.”<sup>7</sup> The 2007-2008 survey showed that hospitalist groups received an average of \$949,410 in financial support, well above the \$549,000 reported in the society’s 2005-2006 survey.

Hospitalist groups’ financial support comes from a variety of sources.<sup>7</sup> The 2007-2008 SHM survey showed that of the \$949,410 average financial support hospitalist groups received, \$897,750 came from hospitals, \$38,550 came from physician organizations, \$1,850 came from academic organizations, and \$11,260 came from other organizations. The average amount of financial support per hospitalist full-time equivalent (FTE) was \$97,375 in the 2007-2008 survey, compared to \$58,400 per hospitalist FTE in the 2005-2006 survey.

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## Hospitalist Programs Generate Profits Institution-wide

Although most hospitalist programs operate at a deficit when examined by themselves, hospitalists benefit the institutions employing them. One method of examining hospitalist program expenditures and revenues found that these programs are projected to generate a profit when their effects are examined hospital-wide because the programs lower inpatient costs, lower inpatient lengths of stay, and increase admissions (Table 1).<sup>22</sup> The method shows that the larger the hospital, the greater the profit hospitalist programs generate.

Under this method, an estimate of revenues and expenses was provided for two types of hospitalist programs: those that provide 24-hour coverage and those that provide services during the day but are on-call in the evening (traditional call).<sup>22</sup> Under both staffing types, hospitalist programs considered in isolation show a net income loss. The income loss is greater for programs with 24-hour hospitalist staffing than for on-call staffing, regardless of the number of hospital beds. The net income loss for both types of hospitalist programs lessens under both hospitalist staffing types as the number of hospital beds increases.

However, once the method takes into account the impact of the hospitalist program on the hospital as a whole and factors in lowered hospitalization costs and increased hospital admissions, a net profit is projected for hospitals under both

hospitalist staffing types and for every hospital bed size category.<sup>22</sup> Profits are greater for hospitals that have hospitalists on call during the evening than for those with 24-hour hospitalist staffing and are greater as the number of hospital beds increase.

Hospitalists are asked by their employers to decrease health care costs and improve patient safety.<sup>11</sup> “Although they still most commonly care for patients who do not have a physician with admitting privileges, or whose physician prefers not to provide inpatient care, hospitalists also can care for patients in intensive care units as an alternative to intensivists; team with subspecialists to care for complicated patients; function as primary attendings in skilled nursing facilities; and care for nursing home patients admitted at night.”<sup>11</sup>

## Hospitalist Payment Methods

Hospitalists are paid for their services through one of four different methods: all salary, a base salary plus incentive payments, a base salary plus a case rate, or compensation based completely on productivity.<sup>23</sup> All of these payment methods have advantages and disadvantages as employers weigh the ease of budgeting for personnel costs and recruiting employees with providing performance incentives to improve care.

*100% Salary:* Compensating hospitalists entirely by salary makes it easier for employers to budget personnel costs and recruit employees.<sup>23</sup> This can become a production-based

**Table 1. Projected Hospitalist Program Expenditures and Revenues<sup>22</sup>**

Census	30-bed		50-bed		70-bed		100-bed	
	24-hour coverage	Traditional call	24-hour coverage	Traditional call	24-hour coverage	Traditional call	24-hour coverage	Traditional call
<b>Net Income (Loss)</b>	(\$393,591)	(\$44,821)	(\$319,784)	(\$46,334)	(\$264,206)	(\$45,446)	(\$153,295)	(\$25,685)
<b>Hospitalization Cost Reductions</b>	\$1,314,000	\$1,314,000	\$2,190,000	\$2,190,000	\$3,066,000	\$3,066,000	\$4,380,000	\$4,380,000
<b>Profit from 5% increase in admissions</b>	\$109,500	\$109,500	\$182,500	\$182,500	\$255,500	\$255,500	\$365,000	\$365,000
<b>Profit from 17% increase in admissions due to lower lengths of stay</b>	\$372,300	\$372,300	\$620,500	\$620,500	\$868,700	\$868,700	\$1,242,000	\$1,241,000
<b>Overall System Financial Impact</b>	\$1,402,209	\$1,750,979	\$2,673,217	\$2,946,667	\$3,925,994	\$4,144,754	\$5,832,705	\$5,960,315

payment method if the employee is paid by the hour. However, this payment method does not allow an employer to motivate or reward desired behavior. It also is inflexible and is seen as an income floor by physicians who are not incentivized to work harder.

*Salary plus incentives:* Compensating hospitalists with a base salary eases recruitment while the incentive payments reward good performance.<sup>23</sup> Hospitals can reward physicians for performing desired tasks, such as coding services properly, meeting quality targets, achieving patient or referring physician satisfaction, performing administrative or committee work, and teaching. However, setting the right balance between a base salary and incentive payments can be problematic. In many cases, it is either far too easy for a hospitalist to hit the incentive targets that trigger payments or the incentive payments are too small to change hospitalists' behavior. In other cases, the incentive targets are too complex to easily measure a hospitalists' performance.

*Salary plus case rate:* Compensating hospitalists with a base salary and a payment for each new patient seen, regardless of the number of patient visits (case rate), helps align the hospital's and the physician's incentives.<sup>23</sup> Under this method, keeping a patient in the hospital longer does not yield additional income and denying a patient care does not result in payment. This method also rewards physicians for accepting referrals. However, implementing the case rate requires accurate tracking of new admissions and physician consultations. The case rate also may encourage a hospitalist to admit patients who do not need to be admitted.

*100% Productivity:* Hospitalist compensation under this method is based on fees collected or on the number of patients seen by the hospitalist, the number of patient visits, or other measures with overhead costs deducted from the funds collected.<sup>23</sup> This payment method is easy for hospitals to administer and makes physicians responsible for "practice economics and income."<sup>23</sup> Further, it allows physicians within a group to have different incomes. However, there are also disadvantages to this method. A new hospitalist practice using this method cannot easily estimate what fees it can expect to collect. This method also rewards a physician who takes more cases than is advisable for one practitioner. It also can encourage physicians to "cherry pick" patients based on payers and to keep patients in the hospital longer.

## Productivity and Compensation

The number of patient encounters a hospitalist has within a 12-hour period, the number of hours a hospitalist works in a year, and the total compensation a hospitalist receives in a year varies by the type of hospitalist employer (Table 2).<sup>7</sup> Hospitalists employed by management companies earned the most annually, with an average salary of \$212,500, had the most patient encounters (3250), and averaged 16.5 patient encounters per 12-hour period. Hospitalists employed by academic groups earned the least annually, with an average salary of \$167,000, had the fewest patient encounters (1900), and averaged 11 patient encounters per 12-hour period.

**Table 2. Hospitalist Productivity and Compensation by Employer<sup>7</sup>**

Hospitalist Employer	Encounters	Number of Encounters/ 12 Hours	Hours Worked	Total Compensation
Hospital	2400	13.5	2120	\$187,000
Academic	1900	11	2050	\$167,000
Management Company	3250	16.5	2400	\$212,500
Local Hospitalist-only Group	2800	14	2410	\$210,000
Multispecialty Group	2250	13	2040	\$190,000

## Observations

Health-system pharmacists' pursuit of federal recognition as providers under Medicare Part B may stimulate development of different pharmacy practice, compensation, and reimbursement models. The similarities between health-system pharmacists and hospitalists could encourage employers and payers to consider incorporating some or all of the elements of the hospitalist model into those emerging pharmacist models.

Health-system pharmacists, like hospitalists, have long justified their programs on the overall benefit they provide to patients and the health system, rather than on the revenue they generate.<sup>24-27</sup> The hospitalist experience shows that, unless pharmacy departments can achieve net revenue generation with Medicare Part B reimbursement, pharmacists will need to continue to demonstrate the benefit they provide to patients and the cost-savings they provide to the institution. Pharmacy departments may want to explore the methods used to support hospitalist programs, such as payment subsidies, services in kind, or case rate reimbursement, as well as the sources of payment subsidies, which include hospitals, physician organizations, academic organizations, and other organizations.<sup>7</sup>

Staffing structure is another aspect of the hospitalist model that may be applied to pharmacy. Hospitalist programs with 24-hour staffing require more financial support than those with only on-call services overnight; health systems may consider a similar model for pharmacy.

Hospitals and health systems that currently compensate pharmacists under a 100% salary or hourly rate method may incorporate incentives or case rates along with a smaller salary to reward performance, or they may base payment entirely on a the pharmacist's productivity. Should such models be considered, health-system pharmacists will need to determine which of these four compensation models best suits their circumstances and advocate for that one.

Finally, health-system pharmacists should explore opportunities to collaborate with hospitalists. Health-system pharmacists and hospitalists share an interest in and responsibility for indirect patient care and service activities—developing the institutional policies, processes, and infrastructure that support patient care.<sup>2</sup> Pharmacists can collaborate with hospitalists by:

- consulting with hospitalists and other health care providers,
- managing collaborative practice agreement medication management protocols,
- supporting the development of treatment protocols and monitor therapeutic responses,
- assessing and managing adverse drug reactions,
- obtaining patient medication histories,
- reconciling patient medications, and
- educating patients and caretakers.

Health-system pharmacists should consider which aspects of the hospitalist model they may or may not want to see adopted for them and should be prepared to work with employers and payers to create a model that recognizes and reimburses pharmacists for their expertise and contributions to patient care.

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*Readers are encouraged to send any comments they have about this paper and ASHP policy to [policy@ashp.org](mailto:policy@ashp.org).*

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## Appendix: Hospitalist 2009 Evaluation-and-Management CPT Billing Codes

### Inpatient evaluation-and-management billing codes

CPT Code Number	Description	National Medicare Payment Rate Non-facility*/Facility**
99221	Initial hospital care, per day—30 minutes	\$89.81
99222	Initial hospital care, per day—50 minutes	\$122.63
99223	Initial hospital care, per day—70 minutes	\$180.33
99231	Subsequent hospital care, per day—15 minutes	\$37.15
99232	Subsequent hospital care, per day—25 minutes	\$66.72
99233	Subsequent hospital care, per day—35 minutes	\$95.58
99251	Inpatient consultation for a new or established patient—20 minutes	\$48.69
99252	Inpatient consultation for a new or established patient—40 minutes	\$75.74
99253	Inpatient consultation for a new or established patient—55 minutes	\$114.69
99254	Inpatient consultation for a new or established patient—80 minutes	\$165.55
99255	Inpatient consultation for a new or established patient—110 minutes	\$201.97

### Outpatient evaluation-and-management billing codes

CPT Code Number	Description	National Medicare Payment Rate	
		Non-facility	Facility
99201	New patient office or other outpatient visit—10 minutes	\$36.79	\$23.44
99202	New patient office or other outpatient visit—20 minutes	\$63.48	\$45.08
99203	New patient office or other outpatient visit—30 minutes	\$91.97	\$68.17
99204	New patient office or other outpatient visit—45 minutes	\$141.74	\$113.97
99205	New patient office or other outpatient visit—60 minutes	\$178.89	\$148.23
99211	Established patient office or other outpatient visit—5 minutes	\$18.75	\$8.66
99212	Established patient office or other outpatient visit—10 minutes	\$37.15	\$23.08
99213	Established patient office or other outpatient visit—15 minutes	\$61.31	\$44.72
99214	Established patient office or other outpatient visit—25 minutes	\$92.33	\$69.25
99215	Established patient office or other outpatient visit—40 minutes	\$124.79	\$98.46
99241	New or established patient office consultation—15 minutes	\$48.69	\$33.18
99242	New or established patient office consultation—30 minutes	\$90.89	\$69.97
99243	New or established patient office consultation—40 minutes	\$124.79	\$97.38
99244	New or established patient office consultation—60 minutes	\$184.30	\$154.00
99245	New or established patient office consultation—80 minutes	\$226.50	\$192.23

The information provided in this table is based on 2009 CPT codes and Medicare payment information, [https://catalog.ama-assn.org/Catalog/cpt/cpt\\_search.jsp](https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp). (accessed 2009 May 12).

\*Non-facility: All settings other than hospitals, ambulatory surgical centers (ASCs), and skilled nursing facilities (SNFs).

\*\*Facility: Includes hospitals, ASCs, and SNFs.

Hospitalist codes used in this table were identified in the following study: Kuo Y, Sharma G, Freeman JL, et al. Growth in the care of older patients by hospitalists in the United States. *N Engl J Med*. 2009; 360:1102-12.