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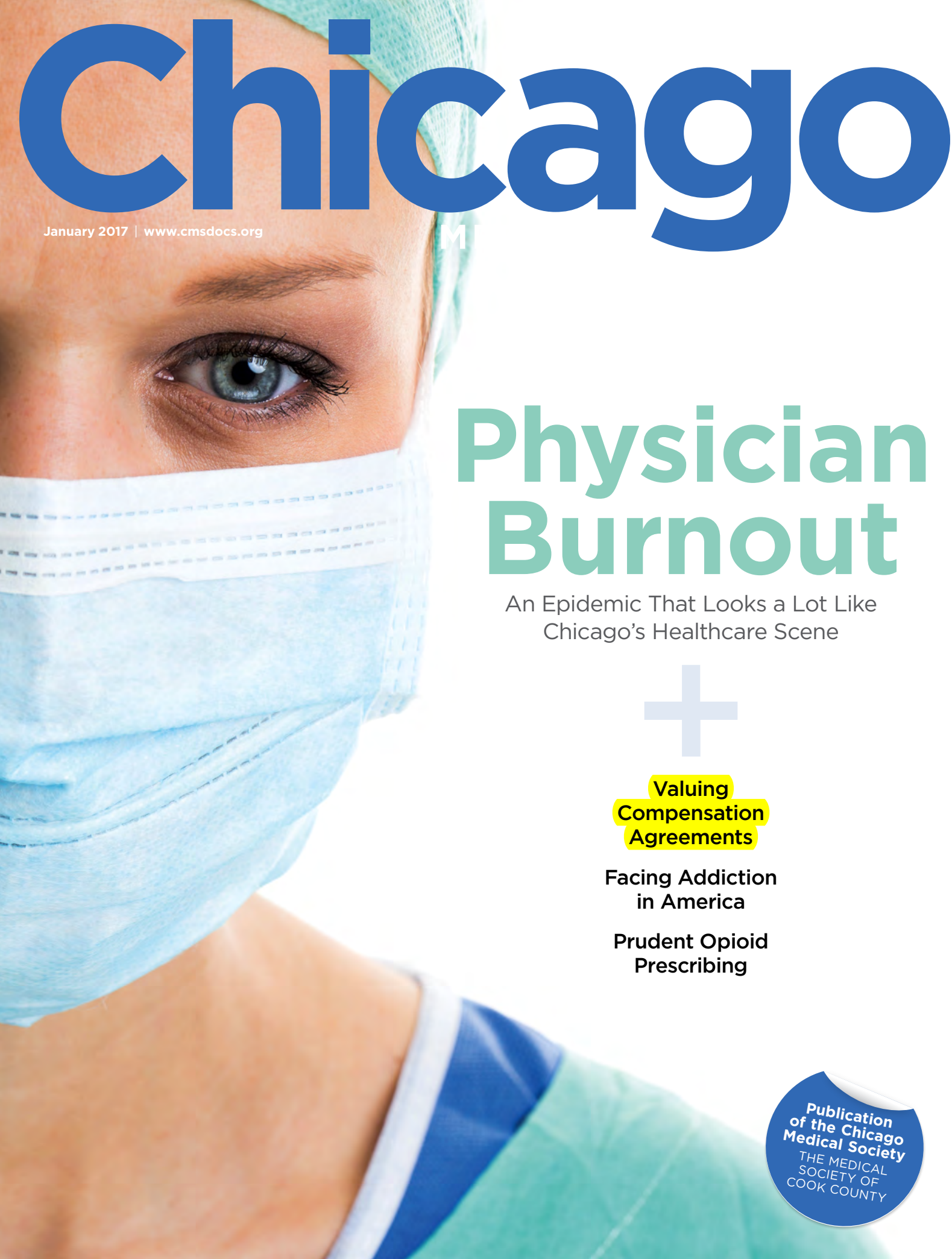

Physician Burnout

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Valuing Compensation Agreements

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Valuing Healthcare Services

An overview of the many components of physician compensation

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HEALTHCARE services may be divided into two general categories, clinical- and nonclinical-related, with nonclinical-related activities further divided into three generalized subcategories: administrative, management, and/or executive. These categories may be defined by the specific tasks, duties, responsibilities, and accountabilities (TDRAs) involved in each. The challenge for independent valuation professionals, working alongside hospital administration and legal counsel, is identifying and separating the various TDRAs for clinical services from non-clinical services in order to ensure that compensation for each service complies with the legal requirements of the Stark Law, the Anti-Kickback Statute, and, for non-profit entities, excess benefit/inurement of benefit regulations promulgated by the IRS.

Generally, the process of valuing compensation agreements can be broken down into: 1) The economic principles underlying value; 2) The necessary documentation for compensation agreement(s); 3) The types of compensation plans; and 4) Industry benchmarking of the compensation agreement(s).

This article will provide a brief overview of this process for four common types of services in the healthcare delivery industry: physician clinical services; medical directorship services; physician executive services; and call coverage services.

Classification of Healthcare Services

Clinical-related services may be defined as the provision of professional medical services related to the diagnosis and treatment of patients who present with various injuries, diseases, and ailments by physicians, allied health professionals, midlevel providers, technicians, and paraprofessionals. Clinical-related services may also include coverage and call, research activities, clinical academic appointments, medical outreach and public health, and service line medical directorships.

Nonclinical services are those where the TDRAs associated with the position are not directly related to the treatment of patients. Typical nonclinical roles would include chief executive officer, chief information officer, and other "C-suite" executives, as well as strategic and operational management positions (practice administrators, billing managers), and nonclinical support staff.

While some types of services fit easily into a clinical or nonclinical category, due to the many combinations of TDRAs that can be present in various healthcare roles, careful analysis is warranted to ensure that the services under consideration in the valuation engagement are classified into an appropriate category for benchmarking and other valuation purposes. For example, the position of a medical director may be considered clinical and nonclinical. In such cases, each economic input provided by the physician must be identified and classified as either clinical or nonclinical.

The four healthcare services discussed in this article are clinical; call coverage, which is clinical; medical directorship, which is both clinical and nonclinical; and executive, which is nonclinical.

Economic Principles

In valuing physician compensation, it is important to understand what economic value is and how it is created. The dynamics of how economic value is created may be understood within the context of four basic principles. First, the Principle of Scarcity "influences market participants to assign relative value to goods and services in order to choose between the limited amounts available." Second, the Principle of Substitution asserts that "what normally sets the limit of what would be paid for property is the cost of an equally desirable substitute or one of equal utility." Third, the Principle of Diminishing Marginal Utility asserts that "... the additional benefit which a person derives from a given increase of his stock of a thing, diminishes with every increase in the stock that he already has." Fourth, and perhaps most important, the Principle of Anticipation asserts that: "The economic benefits of ownership of, or the contractual rights to control, the subject services to be performed under the contractual agreement are created from the expectation of those benefits or rights to be derived in the future; *therefore, all economic value is forward looking.*"

Specifically, the economic value analysis for determining the Fair Market Value (FMV) of compensation agreements for healthcare services should be focused on the economic benefits reasonably expected to be derived from the use or utility of the services in the future, bounded by the cost of an equally desirable substitute, or one of equal utility, for each of the elements of economic benefit (or utility) to be derived from the right to control the services to be performed.

Of note, there is increasing concern from government regulators that compensating physicians for nonclinical services, for example, a medical director, based on a "lost opportunity cost" may not meet regulatory scrutiny under the Stark Law, and should instead be based on the actual services performed. Additionally, as set forth in two Advisory Opinions by the Office of the Inspector

General of Health and Human Services (May 2009 and March 2013), compensation for healthcare services should be based on services actually rendered.

Documentation

To develop the valuation analysis for healthcare services, the valuation analyst should obtain the requisite documents related to the proposed compensation arrangement. These documents are listed in Table 1. In developing a valuation opinion related to a compensation arrangement, the valuation analyst uses this data to identify and classify the types and the amounts of tasks and duties, along with the level of responsibility and accountability, associated with the subject agreement for services.

Types of Compensation Plans

The types of compensation plans for physician services may include combinations of elements, which are listed in Table 2.

Note that, in developing a FMV analysis, the valuation analyst should consider the four provider-specific drivers of clinical productivity: time; efficiency; volume; and, quality performance, either in comparison to internal sources or outside industry normative benchmark data. First, the amount of time a provider dedicates to clinical activity will work to establish the bounds of that provider's volume of clinical productivity. In accordance with the Principle of Substitution, the provider has a finite limitation on both the number of hours and the volume of clinical-related services per hour the person can provide.

Second, variances in the level of provider efficiency typically account for differences in total volume once adjustments for the incongruity introduced by nonclinical time worked, as well as for the variability introduced by fewer hours worked by part-time providers. Third, volume may be limited by the time spent on

Table 1: Requisite Documents to be Obtained in Valuing Healthcare Services

Requisite Document to be Obtained	Clinical	Call Coverage	Medical Directorship	Executive
The proposed agreement(s) for the healthcare services (including a full description of all related TDRAs) to be performed.	X	X	X	X
Documentation as to board-certification, qualifications, and tenure of the providers (both of the subject professionals and of providers performing services under similar arrangements).	X	X	X	X
The medical staff bylaws and roster of physician medical directorships.	X	X	X	X
Agreements for other similar positions at the employer entity, including the scope of services to be performed under each of those agreements.	X	X	X	X
The time requirements anticipated under the agreement.	X	X	X	X
The curriculum vitae for the provider performing the services.	X	X	X	X
Documentation of historical clinical productivity, measured in work RVUs, gross charges, net revenue or count by CPT code for an applicable time period to establish a relevant trend for forecasting purposes.	X	X		
Documentation as to the size of the employer, number of patients, acuity levels of patients, and specific needs related to the organization.		X	X	X
The number of times the current (specialty specific) on-call physician was: paged and required to be present at the hospital for the last two years.		X		
Time sheet records and the time spent and work performed by the physician on each subject service.		X	X	X
Documentation of offers made to previous (or other existing) professionals.	X	X	X	X
Documentation of the medical staff's need for administrative direction (based on clinical activities, hospital research efforts, etc.).			X	X
The number of committees/meetings that require the professional's involvement and/or attendance, as well as the average frequency and duration of each committee and meeting.			X	X
Documentation that the employer (at least) annually assesses the effectiveness of the professional in performing his or her TDRAs, as well as the commercial reasonableness of the contract.			X	X
Descriptions of quality programs, including Centers of Excellence and "never event" committees that the professional may participate in.			X	X
Employer's administrative/management/executive agreement(s), with annual hour requirements and annual compensation paid to each professional/executive.			X	X

nonclinical activities, in a manner similar to that of time and efficiency. Thus, the extent to which the potential volume of clinical production is limited should be considered when calculating productivity.

Fourth, quality metrics are playing an increasingly important role in measuring a provider's performance for purposes of determining FMV compensation. The rise in the importance of the quality metric is manifested, in part, in the movement toward value-based reimbursement as set forth in the ACA and MACRA. This new paradigm of healthcare value metrics is a foundation of current healthcare reform efforts.

Another component of a compensation plan that should be considered is the amount of fringe benefits included. As set forth in the definitions of the Stark Law, any remuneration, whether in cash or in kind, is considered to be compensation for the purpose of determining FMV and commercial reasonableness. The types of benefits that are often part of a compensation arrangement include:

- Health insurance.
- Contributions to retirement plans.
- Payment of automobile expenses.
- Compensation for continuing medical education.
- Reimbursement for business-related travel and entertainment.
- Payment of malpractice insurance coverage.

The valuation analyst should compare the level of benefits in the compensation package to those of applicable, industry normative benchmark industry survey data, and if the amount of benefits to be provided is significantly above those reported by the benchmark surveys, an adjustment should be made to add the excess benefit amount to the cash compensation being paid to the provider.

Benchmarking

After an assessment of the four value drivers of clinical productivity, the proposed compensation arrangement should be compared to applicable, normative benchmark industry sources reflecting similar TDRAs, to determine whether the compensation arrangement meets the regulatory thresholds of FMV and commercial reasonableness. This benchmarking analysis should include the steps listed in Table 3.

Some compensation arrangements for physician on-call services allow the physician to be compensated for the services provided, as well as to bill and collect for the clinical services provided while on-call. Other arrangements compensate the physician only for the on-call services, while the entity location bills and collects for the professional services. This may be particularly true of hospital-employed physicians who do not receive compensation based on a productivity formula, and instead receive a stipend for the coverage and care provided to hospital patients regardless of the patient's ability to pay.

When a compensation plan proposes paying in excess of industry normative benchmark survey data, an appropriate justification for the excess payment should be documented, supported, and explained. Special circumstances that could warrant paying in excess of the industry indicated benchmark data for a particular service may include:

- The unique and scarce skill set of the provider.
- Additional TDRAs required of the provider, above those of typical providers in comparable positions, reported in the benchmark.
- The quality of the work RVU generated by a provider is higher in relation to the work RVUs generated by the providers in the benchmark survey data.

Table 2: Types of Compensation Plans for Physician Services

Compensation Plan Element	Clinical	Call Coverage	Medical Directorship	Executive
Fixed base salary.	X	X	X	X
Variable compensation (compensation per hour spent).	X	X	X	X
Clinical productivity (compensation based on a per wRVU method, percentage of collections, or percentage of gross charges).	X	X		
Incentive bonus based on clinical productivity.	X	X		
Incentive payment based on the performance of the area for which the individual is responsible, e.g., an entity, department, service line.			X	X
Incentive payment based on achieving quality of patient and beneficial outcomes gauged by agreed-upon measures and benchmarks.	X	X	X	X
Incentive payments based on specified legally permissible gainsharing arrangements (achieving certain cost-savings and efficiencies).	X	X	X	X
Incentive payments based on the contributions and economic input of the employed physician(s) to achieve specified enhancement of the performance of the enterprise.	X	X	X	X

- The production is a similar quality work RVU but at a lower cost per unit.
- Other special circumstances regarding the work RVUs produced by a particular provider.

While benchmark data can be used to establish FMV compensation rates, further analysis should be performed in order to meet the related threshold of commercial reasonableness. Even though a proposed compensation amount for medical director services may be deemed to be within the range of FMV, the TDRAs of the medical director should be analyzed to determine whether they are redundant.

A certified opinion as to whether the proposed compensation is both within the range of FMV and commercially reasonable, prepared by an independent, certified valuation professional, working with healthcare legal counsel, and supported by due diligence and documentation, will significantly enhance the efforts of healthcare providers to establish a defensible position that the proposed compensation arrangement is in compliance. This is particularly important in the ever-changing healthcare regulatory environment, with potential severe penalties, as well as business consequences for entering into arrangements that may later be found to be legally impermissible.

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Table 3: Steps in the Benchmarking Analysis

Benchmarking Analysis Step	Clinical	Call Coverage	Medical Directorship	Executive
Determine the specific characteristics of the arrangement, including:				
Applicable job training and education level of the provider, relevant to the position.	X	X	X	X
Number of years of experience and reputation of the provider.	X	X	X	X
Site of service (hospital emergency departments, hospital service lines, trauma centers, birthing centers, ambulatory surgery centers, office-based physician practices).	X	X	X	X
Geographic location where the subject services are to be provided.	X	X	X	X
Specialty/subspecialty of the provider.	X	X	X	
Nature of the revenue stream that produces the income available for clinical-related services compensation.	X		X	
The size of the organization (revenue, number of employees).			X	X
Establish the homogenous units of economic contribution to be used as the metric(s) of comparability:				
Productivity components (charges, collections, RVUs).	X		X	
Time components (annual, monthly, hourly, full-time equivalent).	X	X	X	X
Develop the range of applicable, normative benchmark industry data, which should include measures within the range (10th percentile, 25th percentile, 75th percentile, 90th percentile), as well as measures of central tendency (mean, median) and measures of dispersion (standard deviation). The range of normative benchmark industry data is typically compiled by taking a weighted average of the selected benchmark data from external sources that report the specified metric(s) of comparability. The percentage of consideration assigned to each data source, used to compile the range of normative benchmark industry data, should include contemplation of the following statistical and descriptive survey characteristics:				
Size of the data population sample included in the external benchmark.	X	X	X	X
Dispersion of the data. A useful metric for comparing the relative dispersion between data sets for the purposes of determining an applicable weight of consideration in calculating a range of applicable, normative benchmark industry data is the coefficient of variation.	X	X	X	X
Geographic proximity in relation to the area in which the subject services will be provided.	X	X	X	X
Other elements of comparability between the external benchmark survey source and the subject services (such as whether the external benchmark survey source includes elements of compensation not present in the subject physician on-call services).	X	X	X	X