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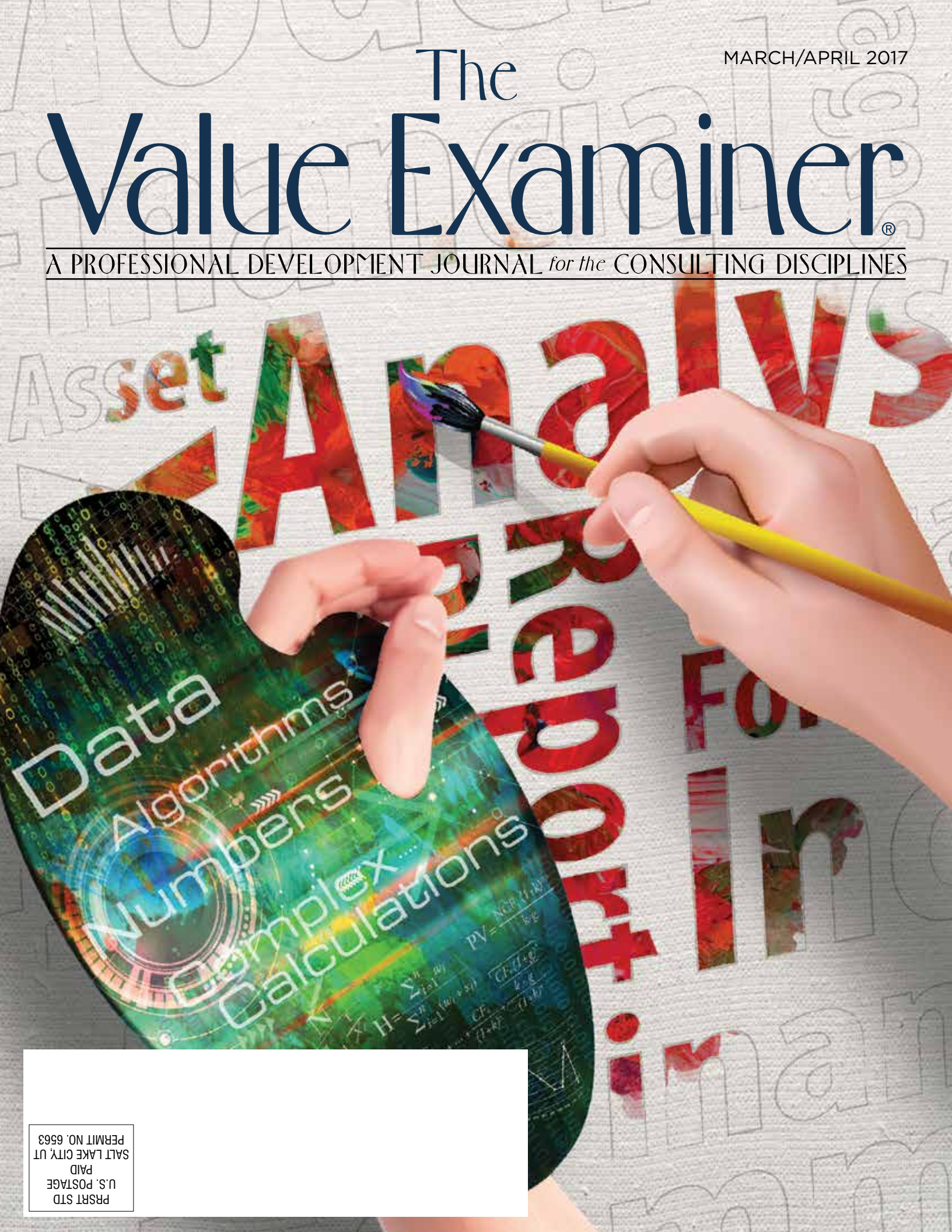

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HEALTHCARE VALUATION INSIGHTS

VALUATION OF COMPENSATION FOR PHYSICIAN SERVICES: CLINICAL SERVICES

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This column will provide a brief overview of the classification and valuation of compensation for the common types of services rendered in the healthcare delivery industry: I) compensation for physician clinical services; II) compensation for physician executive services; III) compensation for call coverage services; and IV) compensation for medical director services. This first installment in the series of columns will focus on the classification and valuation of compensation for physician clinical services.

Physician services may be divided into two general categories, i.e., clinical related 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.[1] The challenge for valuation professionals is identifying and separating the various TDRAs for clinical services from those to be provided for administrative, management, and/or executive functions, 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 Internal Revenue Service (IRS).[2]

Before beginning a valuation analysis of compensation for physician services, it is important to understand the economic principles that support the entire valuation endeavor. The dynamics of how economic value is created may be understood within the context of four basic principles related to the economic benefits to be derived from the right to control the subject services to be performed under the contractual arrangement.[3] 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."[4] Scarcity of goods and services leads to the concept that economic value derives from economic usefulness, also termed utility, which arises from the benefits and/or satisfaction to be derived from the use or ownership of goods and services.[5] Second, the Principle of Substitution asserts, "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."[6] This principle is the basis for the decision as to whether to "buy or build" a product or service.[7] Third, the Principle of Diminishing Marginal Utility asserts, "…the additional benefit which a person derives from a given

1 "Healthcare Valuation: Financial Appraisal of Enterprise, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Volume 2, Hoboken, NJ: John Wiley and Sons, 2014, p. 863.
2 *Ibid,* p. 866.
3 *Ibid,* p. 894.
4 *Ibid,* p. 893; "Economics" 8th ed. By Michael Parkin, Boston: Pearson Addison Wesley, 2008, p. 2.
5 "Appraisal and Valuation: An Interdisciplinary Approach" By Richard Rickert, American Society of Appraisers Washington, DC: International Valuation Sciences Institute, 1987, p. 6.
6 Cimasi, 2014, p. 894.
7 *Ibid.*

increase of his stock of a thing, diminishes with every increase in the stock that he already has."[8] Fourth, and perhaps most important, the Principle of Anticipation asserts,:

> "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*."[9] [Emphasis Added]

Consequently, the economic value analysis for determining fair market value (FMV) 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.[10]

To develop the valuation analysis of physician clinical services, the valuation analyst must obtain the requisite documents related to the proposed compensation arrangement(s), including:

1) The proposed agreement(s) for physician clinical services (including a full description of all TDRAs related to the services to be performed)
2) The time requirements, e.g., the number of hours per week anticipated under the agreement
3) The curriculum vitae for the provider performing the clinical services
4) Documentation as to the board certification, qualifications, and tenure of the providers
5) The medical staff bylaws and roster
6) Agreements for other similar positions at the employer entity, including the scope of services to be performed under each of those agreements
7) Documentation of historical clinical productivity, measured in work relative value units (RVUs), gross charges, net revenue, or count by Current Procedural Terminology (CPT) code for an applicable time-frame to establish a relevant trend for forecasting purposes.[11]

The development of a valuation opinion related to a compensation arrangement makes use of 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.[12]

The various types of compensation plans for clinical-related services may include, but are not limited to, combinations of the following elements:[13]

1) Base salary (i.e., equal compensation paid to each physician)
2) Productivity-based compensation (e.g., cap compensation and a given productivity percentile by specialty)
3) Compensation based on a per wRVU method
4) Incentive bonus based on productivity[14]
5) An annual stipend for the performance of administrative services, e.g., medical directorships, departmental management, and oversight (which services will be discussed in parts II and IV of this series)
6) Incentive payments based on achieving quality of patient and beneficial outcomes gauged by agreed-upon measures and benchmarks
7) Incentive payments based on specified legally permissible gainsharing arrangements (e.g., achieving certain cost savings and efficiencies)
8) Incentive payments based on the contributions and economic input of the employed physician(s) to achieve specified enhancement of the performance of the enterprise (e.g., the development of a "Center of Excellence."[15]

It should be noted that when considering elements of a compensation arrangement that are productivity-

8 "Principles of Economics" By Alfred Marshall, Eighth Edition, New York, NY: Cosimo, Inc., 2009 (originally published in 1890), p. 79.
9 Cimasi, 2014, p. 894; Rickert, 1987, p. 47.
10 Cimasi, 2014, p. 895.
11 *Ibid,* p. 895–896.
12 *Ibid,* p. 896.
13 *Ibid.*
14 It should be noted, compensation based on productivity (wRVUs), even if not directly tied to an "incentive bonus," may be viewed by the IRS as an "incentive compensation arrangement" as it can vary based on performance.
15 "Fair Market Value: Analysis and Tools to Comply with Stark and Anti-Kickback Rule" By Robert A. Wade, Esq., and Marcie Rose Levine, Esq., Audio Conference, HC Pro, Inc. (March 19, 2008), p. 33; Cimasi, 2014, p. 896–897.

based, careful attention should be paid as to whether the compensation is based on a: 1) percentage of collections; 2) percentage of gross charges; or 3) per wRVU basis. In those compensation structures where compensation is based on a per wRVU basis, such arrangements have the benefit of being based on the physician's actual productivity, i.e., their work effort, regardless of the employer's payor mix or collection rate, which is beyond the control of the physician. Also, if compensation is on a per wRVU basis, special attention should be given to the analysis to ensure that the amount of compensation per wRVU reflects only those amounts that are solely related to the production of wRVUs, and not any amounts related to activities separate and distinct from their clinical productivity, such as a physician owner's profit arising from the provision of ancillary service and technical component (ASTC) by the practice.[16]

Similarly, when a compensation plan proposes paying more than the indicated, industry benchmark survey data (even after the homogenous badges of economic contribution composing the subject services have been identified and separated from one another), an appropriate justification for the excess payment should be documented, supported, and explained.[17] "Special circumstances" that could warrant paying more than the industry indicated benchmark data for a service may include:

1) the unique and, accordingly, scarce skill set of the provider

2) additional TDRAs required of the subject provider, above those of the typical providers in comparable positions, reported in the benchmark survey data

3) the quality of the wRVU generated by a provider is higher in relation to the wRVUs generated by the providers included in the benchmark survey data

4) the production of a similar quality wRVU but at a lower cost per unit

5) other special circumstances regarding the wRVUs produced by a provider[18]

In developing a FMV analysis regarding physician clinical services, the value of services rendered should consider the four provider-specific drivers of clinical productivity: 1) time; 2) efficiency; 3) volume; and 4) quality performance, either in comparison to internal sources or outside industry normative data. [19] 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.[20] 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 that they can provide.[21] 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, have been accounted for.[22] Third, volume, i.e., the amount of clinical productivity possible, may be limited by the time spent on nonclinical activities, in a manner similar to that of time and efficiency.[23] Therefore, the extent to which the potential volume of clinical production is limited should be taken into consideration when calculating productivity.[24] Fourth, quality metrics are playing an increasingly important role in measuring a provider's performance for purposes of determining FMV compensation.[25] The rise in the importance of the quality metric as a value driver of clinical productivity is manifested in the movement toward value-based reimbursement (VBR) set forth in the provisions of the Patient Protection and Affordable Care Act (ACA).[26] This new paradigm of healthcare value metrics, i.e., value equals cost plus quality, is a foundation of current healthcare reform efforts.[27]

Another component of a compensation plan that should be considered by a valuation analyst when assessing the FMV of the total compensation to be paid for a particular set of physician services is the amount of fringe benefits included

16 *Ibid*, p. 897.
17 *Ibid.*
18 *Ibid,* p. 897–898.
19 "Measuring Physician Work and Effort" By Bruce A. Johnson and Deborah Keegan, in *Physician Compensation Plans: State-of-the-Art Strategies*, Medical Group Management Association, 2006, p. 114.
20 Cimasi, 2014, p. 908–909.
21 *Ibid.*
22 *Ibid,* p. 910.
23 *Ibid,* p. 910–911.
24 *Ibid,* p. 911.
25 "Pay for Performance: Quality- and Value-Based Reimbursement" By Norman (Chip) Harbaugh Jr., *Pediatric Clinics of North America* 56, No. 4 (2009): p. 997–998; Johnson Keegan, 2006, p. 114.
26 Cimasi, 2014, p. 911.
27 *Ibid.*

within the total compensation arrangement.[28] 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.[29] The types of benefits that are often part of a compensation arrangement include:

1) contributions to retirement plans
2) payment of automobile expenses
3) compensation for continuing medical education
4) reimbursement for business-related travel and entertainment
5) payment of malpractice insurance coverage[30]

The valuation analyst should compare the level of benefits in the compensation package to those of applicable, 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.[31]

One often overlooked type of benefit that should be considered in the determination of FMV and commercial reasonableness is not only the payment of malpractice insurance coverage by the purchaser of the subject services, but also an agreement that would require the employer to be liable for prior claims from services rendered during the malpractice insurance premium period from previous employment, referred to as "prior acts coverage."[32]

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.[33] This "benchmarking analysis" should include the following steps to ensure that the most relevant external benchmarking data is used for comparison purposes:

1) Determination of the specific characteristics of the arrangement, including:
    a. Specialty/subspecialty of the provider
    b. Applicable job training and education level of the provider, relevant to the position
    c. Amount of experience of the provider
    d. Site of service (e.g., hospital-based practice, office-based practice); geographic location where the subject services are to be provided
    e. Nature of the revenue stream that produces the income available for clinical-related services compensation
2) Establish the homogenous units of economic contribution to be used as the metric(s) of comparability, which may include:
    a. Productivity components, (e.g., charges, collections, RVU)
    b. Time components (e.g., annual, monthly, hourly, full-time equivalent)
3) Development of the range of applicable, normative benchmark industry data, which should include measures within the range, (e.g., tenth percentile, twenty-fifth percentile, seventy-fifth percentile, ninetieth percentile), as well as measures of central tendency (e.g., mean, median) and measures of dispersion (e.g., standard deviation). The range of normative benchmark industry data is typically compiled by taking a weighted average of the selected external benchmark data sources. The weights 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:[34]
    a. Size of the data population sample included in the external benchmark survey
    b. Dispersion of the data; it should be noted that a useful metric for comparing the relative dispersion between data sets is the coefficient of variation

28 *Ibid.*
29 "Definitions" 42 C.F.R. § 411.351 (October 1, 2014).
30 Cimasi, 2014, p. 912.
31 *Ibid.*
32 *Ibid.*
33 *Ibid,* p. 913–914.
34 Wade and Levine, March 19, 2008, p. 35, 80; Cimasi, 2014, p. 914–915.

c. Geographic proximity in relation to the area in which the subject services will be provided

d. Other elements of comparability between the external benchmark data sources and the subject services (e.g., whether the external benchmark data source includes information specific to the specialty/subspecialty of the provider, the date the external benchmark data was compiled in relation to the valuation as of date).

While industry normative benchmark industry survey data can be used to establish FMV compensation rates, further analysis should be performed to meet the related threshold of commercial reasonableness.[35]

The second article in this four-part series on the valuation of compensation for physician services will discuss the valuation of executive compensation agreements in the healthcare industry. VE

35 *Ibid,* p. 915.

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