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Valuation of Compensation for Healthcare Services: Physician Executive Services (Part Two of a Four-Part Series)

Nonclinical-related services are those services where the *tasks, duties, responsibilities, and accountabilities* (TDRAs) associated with the position are not directly related to the treatment of patients. Examples of *nonclinical-related* roles include: (1) *chief executive officer*; (2) *chief financial officer*; (3) *chief information officer*; (4) *chief legal counsel*; and, (5) other "*C-suite*" executives, as well as numerous *strategic and operational management positions*, such as, practice administrators, billing managers, payor contracting managers, and other *nonclinical-related* support staff. The progression of the *corporatization of medicine* has resulted in the transformation of the provision of healthcare services from a "*cottage industry*" where physicians have a more direct personal relationship with their patients, to a more commercial endeavor, where a patient may have multiple physicians, specializing in various fields, who may or may not collaborate together to provide for an *episode of care*. This trend toward *corporatization* has caused an expansion in the TDRAs of physicians, enhancing the traditional role of focusing solely on *clinical-related* activities, such as the production of *professional physician services*, by adding roles which include the provision of *nonclinical-related services*, e.g., administrative, *strategic management*, and/or *executive roles*.

This second installment in the four-part *Health Capital Topics* series on the classification and valuation of compensation for healthcare services will provide a brief overview of the valuation process for *physician executive services*.

The economic value analysis for determining the *fair market value* (FMV) of *administrative*, *management*, and *executive services* is governed by the *economic principles* of *Utility* and *Substitution.*[1] In the past, compensation for *administrative*, *management*, and *executive services* performed by physicians may have been based on the physician's *historical clinical practice earnings*,[2] which are similar to compensation arrangements that include *physician clinical services*.[3] However, there is increasing concern from regulators that compensating physician administrators based on the "*opportunity cost*" for the physician executive may raise regulatory concerns under the *Stark Law*. Physician executive compensation should instead be based on the value of the *actual services performed.*[4] (For a further discussion of compensation based on *actual services performed*, see the December 2014 *Health Capital Topics* article, "*Threshold of Commercial Reasonableness: The Qualitative Analysis.*")

While, in most circumstances, the *opportunity cost* of a physician provider of *clinical-related services* should not serve as the *sole* basis for determining physician executive compensation for the performance of *administrative, management, and/or executive services*, it is nevertheless important for the valuation analyst providing an opinion as to the FMV and *commercial reasonableness* of an *administrative, management, and/or executive* compensation arrangement to appropriately apply the *economic concepts* found in the *Principle of Substitution* and the *Principle of Utility* (which were also discussed in Part One of this four-part series) in performing their analysis.[5] It should be noted that compensation for *nonclinical-related* services provided by nonphysicians should also be based on the *actual services performed* (which are distinguished by the TDRAs related to each position).[6]

In developing a certified opinion of value regarding *nonclinical-related services*, a valuation analyst should request and obtain all of the requisite documents related to the proposed compensation arrangement(s). These documents may involve the following:[7]

(1) *The proposed employment agreement(s)* for the provision of *administrative, management, and executive services* (including a detailed description of all TDRAs related to the services to be performed);
(2) *Employment agreements for other similar positions* at the employer entity, including the *scope of services* to be performed under each of those agreements;
(3) *Documentation as to the board certification, qualifications, and tenure* of those individuals performing *administrative, management, and executive services under similar agreements*;
(4) *Documentation of offers* made to *previous* (*or other, current*) *professionals/executives* for similar positions;
(5) *Documentation as to the medical staff's need for administrative direction* (based on the scope of the employer's activities, research efforts, community outreach programs, etc.);

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(6) *The employer's medical staff bylaws and roster* of employees (both clinical and non-clinical);
(7) *The employer's administrative/management/executive employment agreement(s)*, with *annual hour requirements* and *annual compensation* paid to each professional/executive;
(8) *Time sheet records* documenting the *actual time spent* and *actual work performed* by the individual on each administrative function and service related to the position;
(9) Information related to the *size of the employer*, *revenue*, *number of patients*, *acuity levels of patients*, and the *specific needs* of the employer;
(10) Information related to the *number of committees/meetings* that require the professional/executive's involvement and/or attendance, as well as the average *frequency* and *duration* of each committee/meeting;
(11) *Documentation that the employer, at a minimum, annually assesses* the *effectiveness* of the professional/executive in performing the specified *tasks*, *duties*, *responsibilities*, *and accountabilities*; and,
(12) *A description of quality programs*, including *Centers of Excellence* and *"Never Event" Committees*, in which the individual may participate.[8]

Once the requisite documentation is collected, a detailed examination of the *attributes* of the subject *nonclinical position* should be undertaken, with each element of the attributes of the role first *identified* as to their *existence* and then *classified* as to the *specific factors* and *traits* (i.e., the TDRAs) related to each attribute. This classification would exhibit the means by which the subject services could reasonably be expected to provide *utility*, i.e., usefulness, to the employer contracting for the professional/executive services to be performed *going forward*.[9]

After the *administrative*, *management*, *and/or executive* TDRAs to be provided are established, the *proposed compensation arrangement* should be compared to applicable, external benchmarking sources reflecting similar TDRAs, in order to determine whether the compensation arrangement meets the regulatory thresholds of FMV and *commercial reasonableness*. This "*benchmarking analysis*" for *nonclinical-related services* should include the following steps to ensure that the most relevant external benchmarking data is used for the comparison:[10]

(1) Determine the specific characteristics of the arrangement, including:
  (a) Applicable job training and education level of the professional/executive that is relevant to the position;
  (b) Number of years of experience and reputation of the provider;
  (c) Size of the organization (e.g., revenue, number of employees);
  (d) Site of service (e.g., hospital, office-based physician practice, hospital service line, *ambulatory surgery center*); and,
  (e) Geographic location where the subject services are to be provided;
(2) Establish the *homogenous units of economic contribution* to be used as the *metric(s) of comparability* (e.g., annual, monthly, hourly, per employee, per dollar of revenue); and,
(3) Develop the range of applicable, industry normative benchmark data, which should include *measures within the range*, (e.g., 10th percentile, 25th percentile, 75th percentile, 90th percentile), as well as *measures of central tendency* (e.g., mean, median) and *measures of dispersion* (e.g., standard deviation).[11] The *range of industry normative benchmark data* is typically compiled by taking a weighted average of the selected external benchmark data sources that report the specified *metric(s) of comparability*. The percentage of consideration assigned to each data source, used to compile the *range of industry normative benchmark data*, should include consideration of the following statistical and descriptive survey characteristics:
  (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 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*;[12]
  (c) *Geographic proximity* in relation to the area in which the subject services will be provided; and,
  (d) Other areas of comparability between the external benchmark data source and the subject services (e.g., whether the external benchmark data source includes information specific to the subject nonclinical-related services position, the date the external benchmark data was compiled).[13]

While normative benchmark industry survey data may be sufficient to establish FMV compensation rates, further analysis should be performed to determine whether the arrangement meets the related threshold of *commercial reasonableness.*[14] Significantly, even though a proposed compensation amount for *administrative*, *management*, *and/or executive services* may be deemed to be within the range of FMV, the related *administrative*, *management*, *and/or executive* TDRAs should be analyzed to determine whether they are *reduplicate* or *redundant*. TDRAs for an executive position that *exactly* mirror the TDRAs already being provided to the organization by an alternative position, i.e., *reduplicative*, may *not* meet the threshold of *commercial reasonableness*. Further, TDRAs that are *similar* to TDRAs already being provided to the organization by an alternative position, also may not meet the threshold of *commercial reasonableness.* However, these reduplicative and

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redundant services *may be justified* in those circumstances where the *size* and *scope* of the organization necessitate a greater level of service than could be provided by a single individual.[15]

A certified opinion as to whether the proposed executive compensation agreement is both within the range of FMV and *commercially reasonable*, prepared by an *independent*, certified valuation professional, working with competent healthcare legal counsel as to the pertinent regulatory thresholds, and supported by adequate 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.[16] This is particularly important in the heightened and ever-changing regulatory environment in which healthcare providers operate, with the potential severity of penalties, as well as related business consequences of entering into transactions and arrangements that may subsequently be found to be legally impermissible.[17]

The third article in this four-part series on the valuation of compensation for healthcare services will discuss the valuation of compensation for call coverage services in the healthcare industry.

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1 "Healthcare Valuation: The Financial Appraisal of Enterprise, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Hoboken, NJ: John Wiley and Sons, 2014, p. 920.

2 "The Managed Health Care Handbook" By Peter R. Kongstvedt, MD, FACP, 3rd ed., Gaithersburg, MD: Aspen Publishers, 1996, p. 159.

3 For more information, please reference the September 2016 *Health Capital Topics* article entitled, "*Valuation of Compensation for Healthcare Services: Physician Clinical Services.*"

4 "Beyond Anti-Mark-Up: 'Stand in the Shoes' and Other Practical Implications" By Michael W. Paddock, Crowell & Moring LLP, February 2008, http://www.crowell.com/documents/Stark-Phase-III_Anti-Markup-Rules_Mike-Paddock.pdf (Accessed 12/18/12); "Health Law: 2007 Highlights and Reminders for 2008" HaynesBoone, January 10, 2008, p. 3.

5 Cimasi, 2014, p. 921.

6 *Ibid*.

7 *Ibid*, p. 922.

8 "Eliminating Serious, Preventable and Costly Medical Errors—Never Events," Centers for Medicare & Medicaid Services, May 18, 2006, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863 (Accessed 8/20/07). "'Never events' are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, thereby indicating a serious problem in the safety and credibility of the healthcare provider." In addition, CMS indicated that such "never events like surgery on the wrong body part or mismatched blood transfusion, cause serious injury or death to beneficiaries, and result in increased costs to the Medicare program to treat the consequences of the error."

9 Cimasi, 2014, p. 923.

10 *Ibid*, p. 923-924.

11 For more information, please reference the August 2016 *Health Capital Topics* article entitled, "*Statistical Methods in Valuation Analysis: Descriptive Statistics.*"

12 For information regarding this statistical technique, please reference the September 2016 *Health Capital Topics* article entitled, "*Statistical Methods in Valuation Analysis – Co-Efficient of Variation.*"

13 "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. 55, 80; Cimasi, 2014, p. 914-15.

14 Cimasi, 2014, p. 924.

15 *Ibid*.

16 *Ibid*, p. 927.

17 *Ibid*.

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