

## Valuation of Compensation for Healthcare Services: Medical Director Compensation (Part Four of a Four-Part Series)

In the face of uncertain reimbursement, the rising costs of healthcare services, and value-seeking reforms pushing for higher quality care at lower prices, providers are turning to alignment, integration, and cooperation as key strategies to create high-quality and high-efficiency healthcare delivery organizations.<sup>1</sup> This trend is resulting in the increased *corporatization of medicine*, including a greater number of physicians being employed by hospitals.<sup>2</sup> Concurrently, there has been a parallel growth in the number of hospitals compensating physicians for their performance of hospital administrative functions, including *medical directorships*.<sup>3</sup> Corresponding with the increase in the *corporatization of medicine*, governmental authorities have engaged in heightened regulatory scrutiny related to the legal permissibility of these arrangements, including whether physicians are actually performing the services outlined in the relevant *medical directorship agreement*.<sup>4</sup>

In light of the aforementioned trends that are creating a paradigm shift in the healthcare delivery system, it is important that valuation analysts ensure that the subject medical director services are appropriately classified and valued in order to provide a defensible opinion for their clients. This final 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 this process for *medical director services*.

There are numerous variations within the classification of *medical director services*, including:<sup>5</sup>

- (1) *Medical Director, General*: Generally responsible for all activities related to the delivery of medical care and clinical services, such as cost management, utilization review, quality assurance, and medical protocol development, as well as overseeing the activities of group physicians, including recruiting and credentialing;<sup>6</sup>
- (2) *Service Line Medical Director*: Similar to a “*Medical Director, General*” but specific to a particular clinical service line (e.g., cardiology, orthopedics);<sup>7</sup>
- (3) *Medical Director of Clinical Research* responsible for:

- (a) Research design, methodology, data collection, analysis, and summation of outcomes;
  - (b) Grant proposal preparation;
  - (c) Attending research conferences;
  - (d) Compliance with protocols, regulations, and research objectives; and,
  - (e) Serving as a liaison between funding agencies and the organization;<sup>8</sup>
- (4) *Medical Director of Clinical Operations*:
- (a) Monitors day-to-day operations;
  - (b) Develops, implements, and monitors policies/procedures;
  - (c) Oversees non-physician technical and records staff; and,
  - (d) Responsible for improving quality and reducing cost by streamlining workforce and technology;<sup>9</sup> and,
- (5) *Medical Director of Quality Management*: Responsible for developing and coordinating programs designed to ensure that medical practices meet the organization’s and third party’s quality goals and objectives. This position requires a licensed physician.<sup>10</sup>

The *alignment, integration, and engagement* of physicians are key strategies for health systems seeking to create *high-performing, high-quality, and high-efficiency* organizations.<sup>11</sup> Yet aligning physicians’ interests with those of hospitals and health systems has been an ongoing struggle, particularly due to the shift from *small, physician/provider-owned, independent private practices to captive practices* within larger integrated health systems, i.e., *the corporatization of the practice of medicine*.<sup>12</sup> Successful hospital enterprises have understood that “*to effectively respond to the economic incentives of reform, a hospital should achieve a deeper level of integration with the physicians that practice there.*”<sup>13</sup> This has also been a factor in using professionals with “*inside knowledge*” of the health system, as well as the collegial “*doctor-to-doctor*” relationship with fellow physicians on the medical staff, to perform administrative, management, or executive services within the organization in an enhanced, efficient manner.<sup>14</sup>

The economic value analysis for determining the *fair market value (FMV)* of *medical director services* is

governed by the *economic principles of Utility and Substitution*.<sup>15</sup> Similar to compensation arrangements that include *physician clinical services* (which were discussed in Part One of this four-part series), in the past, compensation for *medical director services* performed by physicians may have been based on the physician's *historical clinical practice earnings*.<sup>16</sup> However, there is increasing concern that compensating medical directors 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*.<sup>17</sup> (For a further discussion on this topic, see the December 2014 *Health Capital Topics* article, entitled, "*Threshold of Commercial Reasonableness: The Qualitative Analysis*".)

In particular, courts are evaluating, under the *Stark Law* and *Anti-Kickback Statute*, whether physician medical directors are *actually performing* the services outlined in the agreement. For example, in *U.S. v. SCCI Hospital Houston*, the U.S. challenged the *commercial reasonableness* of the compensation paid by the hospital to three physician medical directors.<sup>18</sup> The government's financial expert stated that the *commercial reasonableness* of a medical director arrangement depended upon the agreement being "*essential to the functioning of the hospital*,"<sup>19</sup> and emphasized that there had to be "*sound business reasons for paying medical director fees to referring physicians*."<sup>20</sup> To examine these thresholds, the government's expert analyzed several factors in assessing the *commercial reasonableness* of the compensation agreement, including:

- (1) The size of the hospital, number of patients, patient acuity levels, and patient needs;
- (2) The quality of activities and involvement of medical staff in need of medical direction;
- (3) The number of regular committees and meetings requiring physician involvement; and,
- (4) The quality of hospital management and interdisciplinary coordination of patient services.<sup>21</sup>

While medical director compensation may be based on either: (1) an hourly payment, with the maximum number of hours specified in the contract; or, (2) an annual payment that is determined by a projected number of hours multiplied by a hourly rate consistent with FMV, it may be critical to surviving regulatory scrutiny for the employer to track *and* document the *actual* number of hours the medical director spends performing each of the services outlined in the agreement.<sup>22</sup>

In developing a certified opinion of value related to the provision of *medical directorship* services, certain requisite documents related to the proposed arrangement(s) should be obtained by the valuation analyst, including:<sup>23</sup>

- (1) The proposed agreement(s) for administrative, executive, and *medical director* services (including a detailed description of all *tasks, duties, responsibilities, and accountabilities*

[TDRAs] related to the services to be performed);

- (2) All agreements for similar positions at the employer entity, including the scope of services to be performed under each of those agreements, the annual hour requirements, and annual compensation paid to each *medical director*;
- (3) Documentation regarding the board certification, qualifications, and tenure of those physicians performing services under all similar *medical directorship* agreements;
- (4) Documentation of offers made to previous (or other existing) *medical directors*;
- (5) Documentation regarding the medical staff's need for administrative direction (based on clinical activities, hospital research efforts, community outreach programs, etc.);
- (6) The employer's medical staff bylaws and roster;
- (7) Timesheet records and the time spent and work performed by the physician on each service subject to the *medical directorship* agreement;
- (8) The size of the employer, number of patients, acuity levels of patients, and the specific needs related to the particular service line;
- (9) The number of committees and meetings that require the *medical director's* involvement and/or attendance, as well as the average frequency and duration of each committee and meeting;
- (10) Documentation that the employer (at least) annually assesses the effectiveness of the *medical director* in performing his or her TDRAs, as well as the *commercial reasonableness* of the contract; and,
- (11) Descriptions of quality programs, including *centers of excellence* and "*never event*"<sup>24</sup> committees.

The review of these documents by the valuation analyst, as well as results from interviews with employer management and physicians, will serve as the basis for supporting the development of the certified opinion related to the scope of services to be performed.<sup>25</sup>

The benchmarking of *medical director services* is similar to that of *clinical services* (discussed in the September 2016 *Health Capital Topics* article entitled, "*Valuation of Compensation for Healthcare Services: Physician Clinical Services*"), except that determination of the arrangement's specific characteristics should also include:<sup>26</sup>

- (1) Applicable job training and education level of the *medical director* that is relevant to the position;
- (2) The number of years of experience and reputation of the provider;
- (3) The size of the organization (e.g., revenue, number of employees);
- (4) The site of service (e.g., hospital, office-based physician practice, hospital service line, ambulatory surgery center); and,

- (5) The geographic location where the subject services are to be provided.

While 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*. Significantly, 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 *duplicate* or *redundant*. *Duplicate* TDRAs are those that are *exactly* the same as TDRAs already being provided to the organization, the presence of which may *not* meet the threshold of being *commercially reasonable*. *Redundant* TDRAs are those that may be *similar* to TDRAs already being provided to the organization, *but may be justified* in those circumstances in which the *size* and *scope* of the organization require that *higher level* of service.<sup>27</sup>

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 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 with all regulatory requirements.<sup>28</sup> 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 for entering into transactions and arrangements that subsequently may be found to be legally impermissible.<sup>29</sup>

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- 2 "Monopolizing medicine: Why hospital consolidation may increase healthcare costs" by Scott Baltic, February 24, 2012, Medical Economics, <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/monopolizing-medicine-why-hospital-consolidation-?page=full> (Accessed 12/15/2016).
- 3 "The Managed Health Care Handbook" By Peter R. Kongstvedt, 3rd ed., Gaithersburg, MD: Aspen Publishers, Inc., 1996, p. 147-48, 158.
- 4 "U.S. ex rel. Kaczmarczyk, et al. v. SCCI Hospital Ventures, Inc.," Civ. No. H-99-1031, (July 12, 2005), Fair Market Valuation Report – Kathy McNamara.
- 5 "Healthcare Valuation: Financial Appraisal of Enterprise, Assets, and Services, Volume 2" By Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Hoboken, NJ: John Wiley and Sons, 2014, p. 868-869.
- 6 *Ibid*, p. 869; MGMA 2015: Management Compensation Report Based on 2014 Survey Data" By Medical Group Management Association, 2015, p. 227.
- 7 Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, 2014, p. 868.
- 8 *Ibid*, p. 868; MGMA, 2015, p. 230.
- 9 Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, 2014, p. 868.
- 10 "The 2015 Physician Compensation and Productivity Survey: Including PhDs, Medical Group Executives and Mid-Level Providers" By Sullivan, Cotter, and Associates, Inc., 2015, p. A-53.
- 11 Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, 2014, p. 875.
- 12 Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, 2014, p. 874.
- 13 "Achieving Physician Integration with the Co-Management Model," Healthcare Financial Management Association, <http://www.hfma.org/anihandouts/xtbce9adrpp1/E09.pdf> (accessed 12/21/16).
- 14 Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, 2014, p. 875.
- 15 *Ibid*, p. 920.
- 16 *Ibid*.
- 17 *Ibid*.
- 18 "U.S. ex rel. Kaczmarczyk, et al. v. SCCI Hospital Ventures, Inc.," Civ. No. H-99-1031, (July 12, 2005), Fair Market Valuation Report – Kathy McNamara.
- 19 *Ibid*.
- 20 *Ibid*: "Fair Market Value in Health Care Transactions" By Lewis Lefko, Haynes and Boone, LLP, July 20, 2007, <http://www.worldservicesgroup.com/publications.asp?action=article&artid=2086> (Accessed 10/9/2009).
- 21 "U.S. ex rel. Kaczmarczyk, et al. v. SCCI Hospital Ventures, Inc.," Civ. No. H-99-1031, (July 12, 2005), Fair Market Valuation Report – Kathy McNamara, p. 4.
- 22 "The Adviser's Guide to Health Care: An Era of Reform – The Four Pillars, Volume 1" By Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, and Todd A. Zigrang, MBA, MHA, FACHE, ASA, New York, NY: AICPA, 2015, p. 244.
- 23 *Ibid*, p. 213-214.
- 24 '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 health care provider. Additionally, 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." "Eliminating Serious, Preventable, and Costly Medical Errors—Never Events," Centers for Medicare & Medicaid Services, May, 18, 2006.
- 25 Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, and Todd A. Zigrang, MBA, MHA, FACHE, ASA, 2015, p. 214.
- 26 *Ibid*, p. 222.
- 27 Robert James Cimesi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, 2014, p. 924.
- 28 *Ibid*, p. 927.
- 29 *Ibid*.





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