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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang MBA, MHA, ASA, FACHE, Publisher

Valuation of Compensation for Healthcare Services: Physician Clinical Services (Part One of a Four-Part Series)

Healthcare 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]

This four-part series will provide a brief overview of the classification and valuation of compensation for four (4) common types of services rendered in the healthcare delivery industry: (1) compensation for *physician clinical services*; (2) compensation for *physician executive services*; (3) compensation for *call coverage services*; and, (4) compensation for *medical director services*. This first installment in the series will focus on the classification and valuation of compensation for *physician clinical services*.

Before commencing a valuation analysis of compensation for healthcare 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 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*."[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 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*."[8] 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*."[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 will need to 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; and,
(7) Documentation of *historical clinical productivity*, measured in *work Relative Value Units* (RVUs), *gross charges*, *net revenue*, or

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count by Current Procedural Terminology (CPT) code for an applicable time period 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*, for example, medical directorships, departmental management, and oversight (which services will be discussed in Parts Two and Four 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*); and,
(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-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, in the event that 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 in excess of 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 in excess of the industry indicated benchmark data for a particular service may include: (1) the unique and, accordingly, scarce skill set of the particular 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 particular provider *is higher* in relation to the wRVUs generated by the providers included in the benchmark survey data; (4) the production a similar quality wRVU but at a lower cost per unit; or, (5) other special circumstances regarding the wRVUs produced by a particular 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*, i.e., (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) (for a greater discussion on the evolution of VBR in healthcare, see the three-part *Health Capital Topics* series, entitled, "*Value-Based Reimbursement*", published February through April 2016).[26] This new

(Continued on next page)

paradigm of healthcare value metrics, that is, *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 healthcare services is the amount of *fringe benefits* included 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*; and, (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, in order 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);
   (e) Geographic location where the subject services are to be provided; and,
   (f) 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); and/or,
   (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., 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). 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* (for information regarding this statistical technique, please reference the September 2016 Health Capital Topics article entitled, "*Statistical Methods - Co-Efficient of Variation*");
   (c) *Geographic proximity* in relation to the area in which the subject services will be provided; and,
   (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 in order to meet the related threshold of *commercial reasonableness*.[35]

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

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3 *Ibid*, p. 894.
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8 "Principles of Economics" By Alfred Marshall, Eighth Edition, New York, NY: Cosimo, Inc., 2009 (originally published in 1890), p. 79.
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30 Cimasi, 2014, p. 912.
31 *Ibid.*
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33 *Ibid*, p. 913-914.
34 Wade and Levine, March 19, 2008, p. 35, 80; Cimasi, 2014, p. 914-915.
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Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Master in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institution of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Certified Valuation Analyst (CVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, and is the author of several books, the latest of which include: "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA]; "*Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services*" [2014 – John Wiley & Sons]; "*Accountable Care Organizations: Value Metrics and Capital Formation*" [2013 - Taylor & Francis, a division of CRC Press]; and, "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books].

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS). In 2016, Mr. Cimasi was named a "*Pioneer of the Profession*" as part of the recognition of the *National Association of Certified Valuators and Analysts* (NACVA) "*Industry Titans*" awards, which distinguishes those whom have had the greatest impact on the valuation profession.

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

John R. Chwarzinski, MSF, MAE, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC). Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, as well as, economic and financial analysis. Mr. Chwarzinski is the co-author of peer-reviewed and industry articles published in *Business Valuation Review* and *NACVA QuickRead*, and he has spoken before the Virginia Medical Group Management Association (VMGMA) and the Midwest Accountable Care Organization Expo.

Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. He is a member of the St. Louis Chapter of the American Society of Appraisers, as well as a candidate for the Accredited Senior Appraiser designation from the American Society of Appraisers.

Jessica L. Bailey-Wheaton, Esq., is Vice President and General Counsel of **HEALTH CAPITAL CONSULTANTS** (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the *Journal of Health Law & Policy*.

Kenneth J. Farris, Esq., is an Associate at **HEALTH CAPITAL CONSULTANTS** (HCC), where he provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services, and tracks impact of federal and state regulations on healthcare exempt organization transactions. Mr. Farris is a member of the Missouri Bar and holds a J.D. from Saint Louis University School of Law, where he served as the 2014-2015 Footnotes Managing Editor for the *Journal of Health Law & Policy*.