

Healthcare Valuation Series Part III: The Valuation of Physician Services

This four-part *HC Topics Series: Healthcare Valuation* examines the various aspects of valuation related to the healthcare industry. The first installment discussed the application of the *fair market value* and *commercial reasonableness* standards utilized by various regulatory bodies in valuing healthcare enterprises, assets, and services. Part II addressed the valuation of intangible assets, and Part III addresses the valuation of physician services. Part IV will conclude with a discussion of several of the more complex aspects of valuation related to the acquisition of physician practice enterprises and service lines; assets (both intangible and tangible); and, services, by exempt organizations. This *HC Topics Series* is excerpted from the book authored by HCC CEO Bob Cimasi, entitled, “*Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services*,” to be published by John Wiley & Sons early next year.

Last month’s installment of the *HC Topics Series: Healthcare Valuation* discussed the valuation of intangible assets in the healthcare industry. An equally significant healthcare valuation engagement is the valuation of physician services, and this month’s installment will examine the various types of services that physicians provide, the determination of the *fair market value* (FMV) of the compensation for these services utilizing benchmarking tools, as well as, the assessment of the *commercial reasonableness* of compensation arrangements to ensure compliance with relevant regulatory standards.

Healthcare services include the clinical and executive/administrative-related tasks, duties, responsibilities and accountabilities (TDRAs) of medical professionals employed in the healthcare industry. As the provision of healthcare services transforms from a “*cottage industry*,” in which physicians have a more personal relationship with their patients, to a more corporate structure in which a patient may have multiple physicians, specializing in various fields, who collaborate together to provide for an episode of care, there has been a shift in the TDRAs of physicians. Instead of focusing solely on clinical activities, physicians are increasingly being tasked to assist in the development and management of various clinical service lines and other strategic management roles. Large provider organizations require more administrative and managerial oversight, and are turning to medical professionals to fill this growing demand.

The challenge for the valuation professional is being able to allocate the various clinical TDRAs, as well as any executive/administrative services, into separate and distinct services in order to ensure that compensation for each service meets the legal restrictions imposed by the different regulatory bodies that implement and enforce the laws of the industry, e.g., the Stark Law, the Anti-Kickback Statute, etc. For an in-depth discussion of these regulatory restrictions in the healthcare valuation context, see [*Healthcare Valuation Series Part I: A Look at Fair Market Value and Commercial Reasonableness*](#).

Professional clinical healthcare services relate to the diagnosis and treatment of patients with various diseases and ailments may include the provision of medical services by physicians, non-physician practitioners, technicians, and other certified healthcare providers. Clinical services may also include coverage and call, research activities, clinical academic appointments, outreach, and clinical service line medical directorships. Executive/administrative healthcare services include *c-suite* executive positions, such as *Chief Executive Officer* and *Chief Medical Officer*, and other strategic management-related services performed by medical professionals. Because of the increased regulatory scrutiny related to federal fraud and abuse laws related to transactions between healthcare providers, the compensation paid to physicians for professional clinical, on-call, and executive/administrative-related services must be carefully structured to ensure compliance with applicable laws and regulations.

Compensation arrangements typically consist of: (1) *base salary*; (2) *incentive pay*; and, (3) *benefits*. The elements of a compensation arrangement will differ depending on an organization’s priorities and may be structured to incentivize productivity; quality of care measures and beneficial outcomes; permissible gainsharing arrangements; or, contributions from the physician-employee to achieve specified enhancement of enterprise, e.g. the development of a “*Center of Excellence*.” Financial payment for each of these elements may be driven by a number of factors, including: (1) industry trends; (2) the *Four Pillars* (i.e. the regulatory environment, the reimbursement environment, competition, and technology); (3) the practice dynamic and business structure; (4) a practitioner’s characteristic tendencies in both clinical and non-clinical professional areas; and, most recently,

(5) the impact of healthcare reform.

Compensation for professional clinical services will vary based on specialty; the method of valuing productivity (such as percentage of collections, percentage of gross charges, or per RVU); the hourly rate, if applicable; and, the provider's full-time equivalency (base salary). As an example, hospitals typically use several time frames (hourly, daily, etc.) as a metric in developing the basis of compensation for on-call services. Compensation levels can be influenced by whether the on-call services are *restricted* (i.e. the physician is required to stay on hospital premises during the call coverage period), or *unrestricted* (i.e. the physician is not required to stay on hospital premises during the call coverage period).¹

Physician executive/administrative services compensation should be based on the consideration to the physical and cognitive skill level input required to perform these services, including: medical knowledge and experience; as well as, business and management acumen. Also, an assessment of the physician's time that will be required in the provision of these executive/administrative functions should be undertaken, as well as a determination of any possible impacts on the physician's ability to perform their clinical duties.

Typically, independent valuation consultants are hired to provide certified valuations as to the *FMV* and *commercial reasonableness* of a particular compensation arrangement. In addition to their knowledge of historical and current trends for a particular compensation arrangement, the consultant will typically require some basic documents and information, including: (1) the proposed agreement(s); (2) all agreements for other similar positions at the employer entity; (3) the curriculum vitae for the contracted physician; (4) documentation as to the board certification, qualifications, and tenure of those physicians performing the services under all similar agreements; and, (5) the medical staff bylaws and roster. Additional documents may be necessary depending on the type of physician service being appraised.

Benchmarking techniques have been adopted by various industry sectors, including healthcare, and are generally used to compare business processes and/or products against reported industry standards, typically an *average*, *median*, or other *measure of central tendency*. Benchmarking can be used to establish an understanding of the operational, clinical, and financial performance of healthcare professional practices. As part of compensation plan development, benchmarking can serve such purposes as: (1) comparing physician-specific rates of compensation for fairness; (2) comparing physician-specific rates of production; (3) comparing physician-specific rates of compensation to rates of production to determine if there is an appropriate correlation; and, (4) ensuring that practices comply with the Stark Law and the Anti-Kickback law and regulations, as well as, when applicable, laws placed on tax-exempt organizations.²

Healthcare industry survey benchmarking data may be obtained from several publicly available sources, and this data enables an analyst to compare the financial, operational, and clinical performance data for a particular healthcare entity to peer group (industry-specific) data. A critical step in utilizing compensation surveys to

benchmark a given compensation arrangement is to accurately establish the homogenous units of economic contribution to be used as the metrics of comparability. Additionally, the valuation professional must be careful to determine whether the particular compensation survey utilized includes data for ancillary services and technical component (ASTC) revenue, in addition to professional fee revenue, in its indication of "*salary*." The most current survey data possible should always be utilized, but it should be noted that survey data publication delays of a year or more are not uncommon. The rapidly changing healthcare reimbursement and regulatory environment often lead to significant annual changes in the compensation survey data. Utilizing data from different years due to publication delays may reflect only partially the impact from regulatory or reimbursement changes and can affect the efficacy and applicability of the analysis.

There are a wide variety of compensation arrangements (plans) for providing remuneration to physicians for the utility derived from their services, and any valuation analysis must include a detailed review of the type of plan being proposed and all the elements of compensation being provided. It is critical to obtain and maintain appropriate documentation that the given compensation arrangement (whether it be for clinical services, on-call services, executive-administrative services, or a combination thereof) meets both the *FMV* and *commercial reasonableness* thresholds in order to withstand scrutiny from the various regulatory agencies. This is particularly important in the heightened and ever-changing regulatory environment in which healthcare entities and providers operate, with the potential severity of penalties, as well as business-related consequences for entering into transactions and arrangements which may subsequently be found to be legally impermissible. Healthcare entities and providers should seek a certified opinion as to whether the proposed transaction is both at *FMV* and *commercially reasonable*, prepared by an independent certified valuation professional, working with legal counsel, and supported by adequate documentation, to significantly enhance the efforts of healthcare providers in establishing a defensible position that their proposed compensation arrangement meets the required compliance standards. Next month's installment of the *HC Topics Series: Healthcare Valuation* will examine several of the more complex aspects of valuation related to acquisitions by exempt organizations.

- **Healthcare Valuation Series Part II: The Valuation of Intangible Assets**
- **Healthcare Valuation Series Part I: A Look at Fair Market Value and Commercial Reasonableness**

1 It should be noted that most facilities that employ physicians for unrestricted on-call services require physicians to remain within 15-30 minutes of hospital premises during call.

2 "Measuring Physician Work and Effort," in "Physician Compensation Plans: State-of-the-Art Strategies," by Bruce A. Johnson, JD, MPA and Deborah Walker Keegan, PhD, FACMPE, Medical Group Management Association, 2006, p. 110-112.



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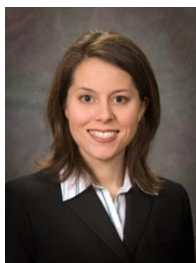
Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – 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, the author of several books, the latest of which include: *“Accountable Care Organizations: Value Metrics and Capital Formation”* [2013 - Taylor & Francis, a division of CRC Press], *“The Adviser’s Guide to Healthcare”* – Vols. I, II & III [2010 – AICPA], and *“The U.S. Healthcare Certificate of Need Sourcebook”* [2005 - Beard Books]. His most recent book, entitled *“Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services”* will be published by John Wiley & Sons in the Fall of 2013.

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).



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