

The Value Examiner®

A PROFESSIONAL DEVELOPMENT JOURNAL *for the* CONSULTING DISCIPLINES

Monte Carlo Simulations in Damages Analysis

$$P(t) = \exp \left\{ \frac{\ln[P(t-1)] \exp \left[\frac{\ln(P) (1 - \exp[-\eta \Delta t])}{1 - \exp[-2\eta \Delta t]} \right] - \sqrt{(-1 \exp[-2\eta t]) \frac{0}{4}}}{\ln(P) (1 - \exp[-2\eta \Delta t])} \right\}$$

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The Four Pillars of Healthcare Valuation— Advanced Distance Education

“Valuation is a branch of financial economics, and it can be short-sighted and dangerous to develop an appraisal that does not reflect the economic foundations of the transactional elements to which statutes, regulations, and case law apply.”

David W. Grauer, Esq., Jones Day, nationally-known healthcare attorney

About the Program

The Institute for Healthcare Valuation (IHV) and Consultants' Training Institute (CTI) are pleased to announce premier healthcare valuation training through a distance education program: the Certificate of Educational Achievement (CEA) for Advanced Education in Healthcare Valuation.

The program will launch in the summer of 2017 and will bridge the interdisciplinary nature of healthcare valuation to include: the Four Pillars of Healthcare (regulatory, reimbursement, competition, and technology); the market forces shaping the U.S. healthcare industry; and the valuation of healthcare enterprises, assets, and services.

The program is developed and is being presented by industry thought leaders Robert James Cimasi, MHA, ASA, MCBA, FRICS, CVA, CM&AA, Chief Executive Officer of Health Capital Consultants (HCC), and

Todd A. Zigrang, MBA, MHA, FACHE, ASA, President of HCC, alongside a blockbuster faculty comprised of healthcare subject matter experts from the legal, regulatory, and valuation professions.

Why This Training is Critical

“In the current volatile regulatory environment, with the consolidation of hospitals, physicians, and other providers, the determination that the arrangements do not exceed Fair Market Value and are commercially reasonable are essential safeguards for the parties entering into these vertical integration transactions. It is critical that experienced, well-trained valuation professionals consult and collaborate with regulators and legal professionals before establishing and promoting so-called accepted methodologies and approaches,” states nationally-known healthcare attorney, David W. Grauer, Esq., of Jones Day.

The training consists of ten four-hour course modules (including eight core courses and two

electives) covering basic valuation tenets, competitive forces in healthcare, an overview of the regulatory environment, technological advancements in the industry, changes in reimbursement, development of a commercial reasonableness opinion, inpatient and outpatient enterprises, valuing intangible assets and tangible personal property, and the classification and valuation of healthcare services.

Who Should Attend

Legal professionals and healthcare providers, as well as those valuation professionals wishing to expand their scope of activities in healthcare valuation engagements and those seeking to enhance their current healthcare valuation service lines, will gain comprehensive knowledge through the expansive program. Attendees who successfully complete the course requirements, assessment quizzes, and interactive case study will earn a CEA.



**More details forthcoming
at www.theCTI.com.**



HEALTHCARE VALUATION INSIGHTS

VALUATION OF COMPENSATION FOR PHYSICIAN SERVICES: EXECUTIVE SERVICES



*By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA;
and Todd A. Zigrang, MBA, MHA, FACHE, ASA*

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
- 5) other “C-suite” executives (including 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 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 this four-part series on the classification and valuation of compensation for physician 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

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 article entitled, “Valuation of Compensation for Physician Services: Clinical Services,” which was published in the March/April 2017 issue of *The Value Examiner*.

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_

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 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.)
- 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
- 12) A description of quality programs, including Centers of Excellence and "Never Event" Committees, in which the individual may participate⁸

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 how the subject services could reasonably be expected to provide utility, i.e., usefulness to the employer

Mike-Paddock.pdf (Accessed 12/18/12); "Health Law: 2007 Highlights and Reminders for 2008" Haynes Boone, January 10, 2008, p. 3.

5 "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. 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."

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, 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)
 - 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)
- 3) Develop the range of applicable, industry normative benchmark 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 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
- c) Geographic proximity in relation to the area in which the subject services will be provided
- 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)¹¹

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.¹² 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 like TDRAs

9 “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. 923.

10 *Ibid*, p. 923–924.

11 “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.

12 “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. 924.

already being provided to the organization by an alternative position, also may not meet the threshold of commercial reasonableness. However, these reduplicative and 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.¹³

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.¹⁴ 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.¹⁵

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



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13 *Ibid.*

14 *Ibid.*, p. 927.

15 *Ibid.*