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# FAIR MARKET VALUATION OF PHYSICIAN COMPENSATION--TEN PITFALLS TO AVOID

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Look hard at the changes within the nation's healthcare industry, and you'll see a growing number of business transactions between hospitals and their physicians. These can range from simple employment agreements to complex co-management agreements or compensation agreements related to multi-dimensional acquisition transactions. The common denominator between them is the need for a fair market valuation (FMV) by a qualified advisor.

Standards for FMV in a healthcare transaction have been well-defined by both valuation industry standards and governmental codification. However, many pitfalls and snares await those who are inexperienced with the FMV process. This article identifies ten common problems in determining physician compensation FMV, and how to avoid those traps.

## **PITFALL 1: TRYING TO PAY SUPERMAN OR WONDER WOMAN**

To support highly compensated physicians, compensation agreements sometimes define a work effort level (hours worked per week) that is in excess of what Superman or Wonder Woman could be expected to provide. While some physicians can sustain a 50-70 hour work week, requiring - 60 hours per week over a full work year invites skepticism of the arrangement. If a physician holds multiple roles in a given institution, i.e. administrative and clinical functions, requiring 60 hours a week in a single role is bound to draw regulatory attention.

Excess effort requirements are also an invitation to the physician to compromise the integrity of the time reporting process needed to insure accurate documentation of work effort under the compensation arrangement. Either of these outcomes is undesirable and will make it difficult to both obtain a FMV opinion and to maintain time- keeping records that will withstand possible audit.

## **PITFALL 2: THERE'S A GHOST IN THE HOUSE**

Hospital physician employment agreements and professional services arrangements normally contain a specific list of duties and responsibilities for the position. Clinical services are easy to define, but administrative, supervisory and teaching (AS&T) services are more problematic. Too often the tasks listed are overly broad, too vague or unnecessarily esoteric and raise questions of substance and authenticity of the physician's role under the arrangement.

To remove the "specter" of a padded scope of work, define the duties and responsibilities of the position to be consistent with organizational needs and expectations and also to be measurable for performance evaluation purposes.

## **PITFALL 3: FRUITLESS "CHERRY-PICKING"**

Valuation advisors are required to apply three methodologies when determining the FMV of a transaction. These approaches -income, market and cost--rarely yield the same result in a given valuation. While there may be reasons to select one result over another ("well, we don't want to pay too much for this practice" or "we really need to pay this physician top dollar to secure his services or loyalty") the FMV usually is determined by considering the applicability of all of the methodologies and then applying judgment as to which one(s) are best reflective of FMV.

When the "best" outcome is used to justify a compensation level, the result can be a biased or indefensible value. Like kids picking and eating unripe cherries, hospital leaders that pursue this strategy are setting themselves up for a belly ache.

## **PITFALL 4: TRYING TO BUY A CADILLAC AT A CHEVROLET PRICE**

Physicians interested in serving in an administrative, teaching or supervisory (AS&T) role are often offered compensation at a rate below what they could earn for equivalent time in their clinical practice. This can deprive a hospital of the services of a physician who is important to a core mission program. FMV standards may allow a compensation level that will be more appealing to the physician.

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In many instances, when the AS&T role is less than 50% of a physician's standard work week (defined as 40 hours), the FMV can be based on clinical benchmarks drawn from market-based data. Clinical compensation benchmarks for most specialties are higher than for administrative positions. Using clinical compensation benchmarks as the proxy for FMV in those situations is equitable for the physician while allowing the hospital to match his/her skills and experience to the position's requirements.

#### **PITFALL 5: ONE SIZE DOES NOT FIT ALL SITUATIONS**

Compensation for on-call services provided by physicians is both a political and a financial issue for hospitals and their medical staff. Valuation of on-call services should be objective and consistent, yet meet all parties' needs.

The bulk of on-call services in most hospitals is provided by physicians providing coverage from home while carrying a beeper. The FMV methodology most commonly used for these services involves the use of a discounted hourly rate derived from published benchmark data. The discounted rates range between 10% and 25% of the full hourly rate (annual compensation divided by 2080 hours) for the physician's clinical specialty.

The discounted rate selected should consider several factors: the importance of the call coverage to the hospitals operations, frequency of the required call coverage and the physician's ability to generate professional fee income when called into hospital to provide services.

#### **PITFALL 6: TREATING QUALITY DIFFERENTLY FROM QUANTITY**

Compensating physicians for productivity has become standard practice in the health care industry. Productivity measures using wRVU's (work Relative Value Units) are now commonly used to measure a physician's work effort and can be used to support FMV remuneration—especially the base component of a compensation package.

Metrics for quality are more limited and must be carefully selected when being used in the FMV process. This is particularly true when quality is to serve as the basis for a performance-based incentive component of a physician's compensation package.

In determining the FMV of compensation for quality-based performance, several criteria need to be considered:

- > Are the quality measures clearly and separately identified?

- > Do they use an objective, verifiable methodology that is supported by credible medical evidence?
- > Are they reasonably related to the hospital's practice and do they consider the patient population?
- > Do they use historical baseline data with target levels based on national benchmarks?

These are the central questions upon which the FMV of performance-based compensation must rest.

#### **PITFALL 7: FAIR BUT UNREASONABLE!**

Compensation FMV determinations often overlook or ignore the two separate, but interrelated, concepts of which it is composed: fair market value and commercial reasonableness:

- > Fair market value is the compensation that would be included in an arrangement that results from bona fide bargaining between well-informed parties to the arrangement who are not otherwise in a position to generate business for each other
- > Commercial reasonableness requires that the arrangement would make commercial sense if entered into by other reasonable parties of similar size and scope of business interests.

As an example: A hospital may offer to compensate a cardiologist \$200 per hour to serve as the medical director of the heart station (FMV), but it is not commercially reasonable for them to hire three medical directors for the heart station.

Compensation paid by a hospital to a physician(s) under the arrangement must meet both of these tests. Being both fair and reasonable is necessary to avoid unexpected consequences in the future.

#### **PITFALL 8: FLYING TOO CLOSE TO THE SUN**

FMV analyses for physician compensation purposes use nationally published data for determining market-based rates. This data is stratified into percentiles—usually the 25th, 50th, 75th and the 90th. As a rule of thumb, compensation paid to a physician should fall between the 25th and 75th percentile of the market. Compensation above the 75th, but below the 90th percentile range, can be supported under FMV if one or more of the following criteria are evidenced:

- > The position and its requirements are unique to the market place

- > The physician under consideration has qualifications, credentials and experience that can support the use of this standard
- > There is a limited pool of qualified physician candidates available to fill the position

Setting a compensation level above the 90th percentile is ill-advised. Since it is likely to exceed the FMV threshold, it poses a significant risk of external review with the attendant justification issues. When extremely high compensation levels are required to obtain the services of a physician who meets the criteria above, the best approach is to structure the compensation package with a base component and an incentive component, both of which, if properly set, can be supported under FMV.

**PITFALL 9: TREATING A “ROCK STAR” LIKE AN OPENING ACT**

A step above the highly-compensated physician are the handful of doctors who can only be termed medical rock stars. These high profile physicians exhibit extraordinary performance levels with broad and diverse responsibilities. They are unique to a regional, or even national, marketplace and can command a compensation package that far exceeds usual and customary FMV considerations. They generally hold positions in academic medical centers and/or large metropolitan centers. It is impossible to establish the FMV of such a rock star by using standard market data.

Thus, FMV efforts for these physicians are usually based largely on anecdotal information that has been sourced and thoroughly vetted by an independent party knowledgeable about physician compensation within the industry.

Since these physicians typically wear multiple hats, the FMV evaluation can be strengthened by dividing their roles or functions and valuing each component separately. Then, by aggregating the individual valuation results, a composite result can be used as a proxy for the FMV.

**PITFALL 10: PUTTING THE CART BEFORE THE HORSE**

The most frequent and, often, egregious FMV mistake hospitals make is consummating a physician transaction before the financial remuneration being offered is subjected to a FMV analysis. If a compensation package fails to meet FMV tests, the resulting need to revise, renegotiate or even renege on a deal can cause substantial consternation among the parties or even destroy an important business relationship.

A proposed transaction term sheet should be conditioned upon obtaining a satisfactory FMV opinion. This simple step

provides a safeguard to the parties before the transaction is locked-in and the detailed documentation process begins. Another important step in this process is checking the final documentation for consistency with the term sheet to insure that they both agree for all items that could impact on FMV. In essence, there is no substitute for having an institutional protocol that provides a step-by-step process for completing a physician/ hospital business transaction. The protocol should clearly indicate when and how a FMV analysis is to be completed within the process.

Avoiding these pitfalls can take an organization a long way towards minimizing the risks associated with physician compensation and fair market value. To be sure these risks really are minimized, hospitals should also take time to appropriately structure all arrangements up front. A short delay in completing a transaction is far more tolerable than living under a long-term, intrusive government compliance agreement. Make sure that all details of the physician transaction are fully and complete documented. In an audit, “I don’t remember” is a poor substitute for proper documentation.



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