

# BVR'S GUIDE TO HEALTHCARE VALUATION 2009 EDITION

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## **What It's Worth**

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CHAPTER 19  
VALUING MEDICAL  
DIRECTOR SERVICES

# Valuing Medical Director Services

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## Introduction

A wide variety of healthcare providers, including hospitals, long-term care facilities, and pharmaceutical and device manufacturers routinely engage physicians to provide administrative services. These arrangements are commonly termed “medical directorships,” but numerous other descriptions (e.g., “thought leadership agreements”) are also frequently used. While medical directorships have been in widespread use for quite some time, the healthcare regulatory and valuation climate has evolved in the last decade or so to the point where the parties to a medical directorship face some significant hurdles and issues that did not exist before.

This chapter discusses the various and sometimes complex issues that should be considered when valuing medical directorships in the current regulatory environment. It addresses issues related to the valuation of medical directorships in the following order:

1. Legal and regulatory issues to consider when determining compensation for medical directorships.
2. Identifying and analyzing the scope of services covered by a medical directorship arrangement.
3. Selecting and applying the appropriate valuation methodology to determine the fair market value of medical director services.
4. Arriving at an FMV range based on consideration of all relevant facts and circumstances.

## Legal and Regulatory Context for Valuing Medical Directorships

Understanding the application of healthcare laws and regulations to medical directorship arrangements is critical for establishing the scope of work for an appraisal assignment involving a medical directorship.<sup>1</sup> Healthcare laws and regulations will often dictate the intended use of the appraisal opinion (to the extent that, generally, when healthcare providers request the valuation of medical directorship agreements, their purpose in doing so is to ensure compliance with healthcare laws and regulations) as well as the definition of value to be used for the assignment. Healthcare laws and regulations require that certain types of agreements comply with specialized definitions of value that may differ from those used outside of the healthcare industry. For this reason and others, clients who engage appraisers to value health care arrangements will generally need the appraiser to understand the legal and regulatory context in which the arrangement is being entered, as well as any guidance from regulators concerning appropriate methods for valuing the subject services. Otherwise, the appraiser may provide a client with a value that is later found to be in violation of healthcare laws and regulations. The penalties for such violations can be significant and very costly to healthcare organizations.

Since healthcare laws and regulations may be complex and voluminous, it is advisable for appraisers to consult with the client and/or the client’s legal counsel to ensure that the applicable regulations are followed when determining the value of medical director services. These laws and regulations may be subject to varying and complex interpretations. As such, regulatory interpretation and guidance most often requires the expertise of legal counsel rather than that of the appraiser. Consequently, the appraiser should generally consider any regulatory guidance given by the client’s legal counsel as clarification with regard to the definition of value. In other words, legal counsel is articulating the regulatory definition of value for which the appraiser will provide an opinion of value. Such regulatory guidance is comparable to the legal direction given in litigation-related valuation assignments with respect to specialized, state law-based definitions of value, such as fair value in shareholder lawsuits or personal goodwill in divorce proceedings. The appraiser, however, should not subvert his or her judgment to that of the client or the client’s counsel for matters that are properly the domain of the appraisal professional. Unfortunately, the distinction between legal issues related to regulatory matters and valuation issues may not always be clear. To help the intended users of the report understand how such regulatory and valuation issues were handled, the appraiser should disclose any such client-provided regulatory guidance in the appraisal report as part of the discussion of the scope of work for the assignment.

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The three major categories of healthcare laws and regulations that should be considered by the appraiser are:

- the federal Anti-Kickback Statute and related regulations and advisory opinions (collectively, FAKS)
- the Stark Law and accompanying Stark Regulations (Stark)
- for not-for-profit entities, provisions of the Internal Revenue Code, and associated regulations and guidance promulgated by the IRS that prohibit private inurement in transactions with tax-exempt entities (Tax Regulations)<sup>2</sup>

By way of background information, prior to passage of the Stark Law<sup>3</sup> (*i.e.*, Stark), payments for medical directorships were subject to scrutiny under the federal Anti-Kickback Law<sup>4</sup> (*i.e.*, FAKS). Under the FAKS, an arrangement is illegal if even one purpose of the arrangement is to generate referrals between the parties.<sup>5</sup> Certainly, medical directorship arrangements involving no discrete services or questionable duties may be subject to scrutiny as potential violations of FAKS. Until recently, however, FAKS was not widely enforced (at least with regard to medical directorships) because prosecution under FAKS requires the government to prove that the parties possessed the intent to induce referrals at the time they entered into the arrangement.

The initial incarnation of the Stark, referred to as Stark I, was enacted in 1992 to regulate physician self-referrals for clinical laboratory services subject to Medicare reimbursement. In 1993, Stark II extended the physician self-referral restrictions to a wide variety of designated health services (aside from clinical laboratory services), and extended the reach of Stark enforcement activities to nearly all compensation arrangements between parties in a position to refer patients from federally-funded payment programs (*e.g.*, Medicare and Medicaid). Unlike FAKS, Stark is a *strict liability* statute. As such, enforcement of Stark does not require the government to prove any intent by the parties to induce referrals. In light of Stark, as well as increased vigor in enforcement of FAKS, payments to physicians for administrative services are now subject to considerable scrutiny.<sup>6</sup>

In their current form, FAKS and Stark generally prohibit payments to physicians for referrals of healthcare services. To ensure that remuneration flowing between physicians and providers of healthcare services are not disguised payments for referrals, FAKS and Stark generally require all arrangements between such physicians and providers to be consistent with *fair market value* and *commercially reasonable*. Additionally, for purposes of complying with tax regulations, not-for profit, tax-exempt entities will have to give special attention to assuring that compensation paid for medical director services is consistent with *fair market value*. Appraisers need to be aware that fair market value for purposes of complying with healthcare laws and regulations differs in some respects from the standard formulation of fair market value as understood by the appraisal profession.<sup>7</sup> For example, as defined by the International Glossary of Business Valuation Terms, the term *fair market value* is defined as the price, expressed in terms of cash equivalents, at which property would exchange hands between a hypothetical willing and able seller, acting at arms' length in an open and unrestricted market, when neither is under a compulsion to buy or sell and when both have reasonable knowledge of the relevant facts. In the context of healthcare transactions, *fair market value* is generally defined as the value in arm's length transactions, consistent with the general market value, where "general market value" means the compensation that would be included in a service arrangement as the result of *bona fide* bargaining between well-informed parties to an arrangement when neither party is otherwise in a position to generate business for the other party.<sup>8</sup>

### Stark Exclusion of Market Comparables between Parties in a Position to Refer

Since it is a strict liability statute, Stark is generally the statute of greatest concern for parties entering into medical directorship arrangements. Over the years and through various phases of the Stark regulations, CMS and its predecessor agencies have provided guidance and commentary on the definition and determination of fair market value for purposes of complying with Stark. CMS has explicitly noted that fair market value as defined by Stark may differ from fair market value as determined through standard appraisal practices. One example of a critical difference in the valuation methodology prescribed by Stark and the valuation methodologies used in standard appraisal practice is that compliance with Stark requires certain limitations on the use of a market approach. [Editor's note: A critical point made in numerous other places in this Guide.] That is, the determination of fair market value for Stark purposes should not be based on market comparable transactions between referral-source physicians and providers of DHS.<sup>9</sup>

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This is because guidance from CMS suggests that transactions between parties who are in a position to refer or generate other business for each other are not “arm’s length” transactions. The prevalence of transactions between referral-source physicians and providers of health care services may distort pricing in the marketplace since, consciously or otherwise, the parties to such transactions may tend toward compensation that rewards referrals.<sup>10</sup> CMS has acknowledged that exclusion of such market comparables may prohibit the use of the market approach in valuing compensation arrangements in certain cases. In these cases, CMS advises the use of alternative approaches or valuation methods.<sup>11</sup> Applying this prohibition to the valuation of medical director services has critical consequences.<sup>12</sup> Market information on medical directorships between referral-source physicians and providers of DHS would appear to be excluded from the determination of fair market value for Stark compliance purposes. As a result, appraisers may be severely limited in the market information that can be used to establish fair market value for medical director services. Most medical director arrangements are between referral-source physicians and providers of DHS under Stark.

While many appraisers may take exception with this limitation on the use of the market approach, it is important to assess this prohibition within the larger context of business valuation body of knowledge. Most appraisers would exclude, discount, or treat cautiously any market comparables for transactions between family members, related parties, affiliated or sister companies, or parent-subsidiary companies. Such parties or entities would not be considered to be fully at arms-length, and therefore, any corresponding financial arrangements would also be viewed as not fully arms-length. In the case of the Stark Regulations, the potential for referrals is considered significant enough to warrant the required exclusion of arrangements between physicians and certain healthcare providers as sources of market data for purposes of determining fair market value under Stark.

### Stark Distinction between Clinical Services and Administrative Services

In Stark regulations issued in September 2007 (the “Stark Phase III Regulations”) CMS made an important distinction between the clinical and administrative work provided by physicians and the determination of fair market value for physician services. In its commentary to responses, CMS stated:

A fair market value hourly rate may be used to compensate physicians for both administrative and clinical work, provided that the rate paid for clinical work is fair market value for the clinical work performed and the rate paid for administrative work is fair market value for the administrative work performed. We note that the fair market value of administrative services may differ from the fair market value of clinical services.<sup>13</sup>

Given this guidance, an appraiser who is engaged to provide an opinion of value relating to medical director services should consider the distinction between clinical and administrative duties when appraising the services. Appraisals of medical director services obtained for Stark compliance purposes should address the distinction in clinical and administrative services and the corresponding levels of compensation for each type of service.

### Understanding the Types of Services Provided by a Physician Medical Director

In valuing the compensation provided under a service arrangement, it is essential for the appraiser to understand the nature and scope of the services provided under the subject arrangement. The types, level, and extent of services provided are key factors in arriving at the compensation paid under a service contract. Another critical element in determining the compensation is the required qualifications of the service provider. This relationship between the services provided and amount of compensation should be self-evident to appraisers, who establish appraisal fees on a routine basis with clients based on the scope of the particular appraisal assignment. The level and extent of valuation services coupled with the qualifications of the appraisers providing those services generally determine the fees. In a similar manner, the scope of medical director services and the required qualifications of the individual providing those services are fundamental factors in determining the compensation for a medical director arrangement. The beginning point for valuing medical director services, therefore, is cataloging and analyzing the scope of services and the qualifications necessary for providing these services.

Many forms of arrangements include duties typical of a medical director, and such arrangements do not always come with a label that clearly identifies the services to the appraiser as a medical directorship. An arrangement for medical director services may be found on a generic form agreement labeled a “Professional Services Agreement,”

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or may be a component of a complex management services arrangement, employment arrangement, or other service arrangement between healthcare providers.

Since medical directorships are diverse, comparison for purposes of either identification or valuation is not an easy task. Nonetheless, most medical directorships share at least a few common characteristics. To identify and appropriately appraise medical directorships, appraisers of healthcare relationships should have some understanding of the common as well as distinguishing characteristics of the subject medical director arrangements.

### Medical Directorships Frequently Involve Specialized Physician Services

In basic terms, a medical directorship is an arrangement by which a physician is engaged to provide leadership, oversight, and planning services for a clinical program or department of a healthcare provider, healthcare entity, or healthcare facility. Generally, medical directorship services consist of duties that are most appropriately performed by a physician and often, by a physician of a particular specialty. Many medical director duties require the professional training, experience and peer-to-peer communication skills that only a physician (or in some cases, a physician of a particular specialty) is likely to possess. Examples of a medical director's responsibilities may include the following:

- Developing, leading and/or managing quality and efficiency initiatives for a particular clinical unit, department or program. Specifically, a medical director's duties may include developing clinical quality assessment and improvement programs, providing direct oversight of the care that is provided to patients by the clinical practitioners in the department or program, and selecting, procuring and/or directly providing clinical education for practitioners in the department or program.
- Identifying clinical equipment needs, and selecting appropriate equipment for purchase to meet those needs and assure that the department or program is able to maximize the quality, efficiency and safety of care.
- Communicating and securing "buy-in" for operational initiatives from clinical staff that are reluctant to take directives from non-physician managers.

The training, knowledge and communication skills of a physician are certainly an asset—if not a requirement—in effectively performing these types of tasks. Accordingly, general training as a physician is a requisite qualification for almost all medical directorships.

Training and experience in a particular specialty or subspecialty is a hallmark qualification for some types of medical directorships. For example, consider an internal medicine physician who has never personally performed or participated in a cardiac surgery. This individual would not reasonably be expected to develop clinical quality assessment and improvement programs, anticipate the equipment and staffing needs, or secure clinical practitioner "buy-in" for operational initiatives in a cardiovascular surgery program. There are a number of reasons why a training and practice in a specific specialty or subspecialty may be required to perform the required duties of a medical director position..

### Understanding the Duties to be Performed by the Medical Director

An appraiser needs to analyze the nature of the duties to be provided in a medical director arrangement in order to assess the value of the services to be provided. Accordingly, an appraiser should seek to answer questions of "who, what, when, where and how." Although the nature of the arrangement will dictate the specific questions that should be asked, questions may generally be similar to those posed here:

1. *Who* will perform the duties required by the arrangement?
  - Do the duties require the expertise of a physician?
  - Do the duties require the expertise of a physician of a particular specialty (e.g., pediatrics, cardiology, neurology or surgery)?
  - Do the duties require the expertise of a physician of a particular subspecialty (e.g., pediatric cardiology, stroke, or sports medicine)?

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- Do the duties require the expertise of a physician with highly specialized training, experience or expertise (e.g., joint replacement, fetal surgery, or neuroradiology)?
2. *What* are the specific duties to be performed under the arrangement?
    - Is the physician providing oversight of a department or program?
    - Is the physician developing or administering quality assessment or quality improvement programs for a particular department or program?
    - Is the physician assessing need for, selecting, developing and/or personally delivering education programs for staff in a department or program?
    - Is the physician selecting, purchasing, testing or developing protocols for the use of new equipment or supplies in a department or program?
    - Is the physician performing other duties related to leadership, oversight or planning of specific services, departments, facilities or clinical units?
  3. *When* are the duties to be performed?
    - What is the term of the agreement under which the duties are to be performed?
    - What is the specific schedule or time interval over which the duties are to be performed (e.g., a fixed or maximum number of hours per month, per year or per week)?
    - Can the duties be performed during regular work hours (i.e., Monday through Friday during regular business hours)?
    - Does the physician have a greater or lesser burden as a result of the schedule (or lack thereof) for performing the duties?
  4. *Where* will the duties be performed?
    - What is the geographic region where the services and related duties will be performed?
    - In which facility or service location will the physician perform the duties?
    - What is the specific service center or unit within a facility where the physician will perform the duties?
  5. *How* will the physician be compensated for performing the duties?
    - Will payment be hourly, based on hours worked and documented?
    - Will payment be a fixed fee or salary?
      - If compensation is with a fixed fee or salary payment, the valuator should discern whether the payment is based on:
        - The estimated time (hours) required to perform the duties;
        - The completion of discrete tasks or work products that have a measureable and discernible value; or
        - Other measurable and discernible measures of value.

Detailed answers to the questions of “*who, what, when, where and how*” assist the appraiser in specifically identifying the scope and level of contemplated medical director services. The appraiser then uses this information to determine the value of these services with greater accuracy and precision.

### Medical Director Compensation: Hourly Rate or Fixed Fee Arrangements

Medical director services are often provided through independent contractor agreements that provide for hourly compensation to the physician based on time actually worked and documented. As noted previously, however, physician administrative services are sometimes included as a component of employment relationships, manage-

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ment arrangements, or independent contractor agreements wherein the physician receives fixed compensation at regular intervals (e.g., weekly, monthly, or yearly). When a physician is compensated for medical director duties with a fixed fee, the appraiser must carefully consider: 1) the nature of the administrative duties that the physician performs, 2) the range of reasonable hourly compensation for performing such duties; and 3) the hours that are reasonably required and likely to be spent actually performing such duties. A more detailed discussion of valuation considerations for fixed fee arrangements is provided later in this chapter.

### Application of the Three Approaches to Value

While the conceptual framework for generally accepted appraisal practice was developed to value assets and business interests, the valuation principles and concepts supporting the three approaches to value can also be applied to the appraisal of compensation in services agreements, including the valuation of medical directorships. At the foundation of the three approaches to value are the fundamental appraisal principles of substitution, alternatives, and future benefits. The following section of this chapter seeks to demonstrate how these principles can be applied in valuing medical director services.

### The Market Approach

The International Glossary Business Valuation Terms (the “International Glossary”), defines the market approach as “a general way of determining a value indication of a business, business ownership interest, security, or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities, or intangible assets that have been sold.” In basic terms, the market approach uses comparable sales transactions that have occurred in the marketplace to determine the value a subject asset or business interest. The valuation principle of substitution is employed in the market approach as the concept that a buyer will not pay more for a subject asset than for substitute asset that provides the equivalent economic utility. As applied to service agreements, the market approach seeks to value the subject arrangement by referencing comparable arrangements in the marketplace.

The key to utilizing the market approach for valuing the compensation paid in service agreements is identifying and obtaining information on comparable agreements that can be used to establish the value of the subject contract. Yet, finding such information on comparable agreements with sufficient detail is often the greatest difficulty an appraiser experiences in applying the market approach to the valuation of service agreements. It should be noted, however, that an appraiser can often use market information from arrangements that are not fully similar to the subject arrangement, as long as the appraiser has sufficient information to make the appropriate adjustments to the market data and/or the subject arrangement in order to make them comparable for valuation purposes.

Use of the market approach in valuing medical director services underscores the need for the appraiser to identify and understand the scope of services provided in both the subject arrangement and the market comparables. Without such information, the appraiser may treat as comparable service arrangements that are essentially different as to the services provided and/or the qualifications required of the service provider. As a result, the appraiser may arrive at a range of value for the subject arrangement based on a fundamentally dissimilar mix of services or qualifications. In addition, the specific facts and circumstances of the service arrangement, such as the geographic locality and other characteristics of the local market in which the services are being provided, should be carefully analyzed and factored into the valuation. The understanding of the specific facts and circumstances of an arrangement is crucial to identifying appropriate market comparables, which is a key step in valuing the services using a market approach.

### Applying the Market Approach

In utilizing the market approach to value medical director services, the appraiser performs market research to accumulate information on medical director arrangements, including the scope of services provided, the required qualifications of the physician director, and the level of compensation paid. Multiple sources of published data exist relating to physician compensation for clinical services or for compensation from all sources, such as the MGMA, AMGA, or SCA physician compensation surveys described in detail below. There are few sources of published survey data, however, that are specific to physician compensation for specialized services such as medical directorships.<sup>14</sup> One potential source of market data for medical director compensation is the *Medical Director Survey* that is published annually by Integrated Healthcare Strategies (formerly Clark Consulting—Healthcare Group). The *Medical Direc-*

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*tor Survey* reports data on a comprehensive list of specialty medical directorships. It sorts the universe of medical directorships into a large number of specialty categories and reports compensation levels by hospital size. Other medical director surveys or information such as proprietary databases may be available to an appraiser as well.

Appraisers should be aware of the issues and limitations that may be encountered in using medical director compensation surveys or other market databases. Such surveys and other sources of market information on medical directorships often do not present survey compensation results in terms of the specific duties or services that are provided under the directorship arrangements included in the survey or database. As a result, comparisons between the subject medical directorship and those reported in the information source are difficult for purposes of valuation. In addition, labels and descriptors assigned to the categories of medical directorships in such information sources may lack precision or uniform definition. The valuation analyst should use caution in making comparisons based solely on such labels and descriptors.

Since the essence of the market approach is using comparable transactions in the marketplace to establish the value of the subject arrangement, sole or unqualified use of medical director surveys or information databases for establishing the fair market value of medical director services is problematic. Differences in the detailed scope of services distinguish medical directorships, even though agreements may appear to be similar on the surface. Significant differences in the “*who, what, when, where and how*” of the medical director’s duties may have a material impact on the comparability of services and the valuation analysis. The valuation of medical directorships is not a “one size fits all” analysis. Unless information is available for the appraiser to determine comparability, survey results reported in a general or summary manner may not be adequate for establishing the value of medical director services. As stated previously, fair market value is ultimately a function of the specific facts and circumstances of the arrangement being analyzed.

A second layer of difficulty may be encountered in using medical director surveys to establish the value of medical director services. Most market information on medical directorships will come from physicians and healthcare providers who have referral relationships that implicate Stark or the FAKS. When, as is often the case, the valuation is requested for purposes of complying with healthcare laws and regulations, market comparables derived from physicians and providers with referral or potential referrals relationships may need to be excluded from consideration. Compensation to physicians under these types of arrangements may be skewed by the potential for referrals between the parties, and as such, may not be an appropriate benchmark for fair market value in these types of transactions. Even when the Stark limitation on the use of market comparables is not part of the valuation assignment scope of work, it may be advisable not to rely solely on market data concerning medical director compensation to establish the fair market value of medical director services. Simply put, some market data points may not represent arms-length transactions.

Compensation amounts for physician administrative (*i.e.*, non-clinical) or medical director services that are paid by entities that are not in a position to receive referrals from physicians are less likely to be distorted by an over-compensation bias. Accordingly, to the extent available, data concerning compensation paid by (as an example) an automotive manufacturing company to a physician who oversees the company’s cardiovascular health program for employees may be a reliable supporting benchmark for valuation of hospital-based cardiovascular health medical directorship, assuming that the duties of the company and hospital-based programs are comparable.

For use of the market approach, additional comparability issues are encountered when service contracts for medical director duties are included with other service arrangements between the parties. On occasion, a candidate for a medical directorship may be a party to other (existing or contemplated) compensated service agreements with the contracting healthcare entity, such as professional services, management, or employment agreements. When this situation occurs, the appraiser must be attuned to possible overlapping duties in the various arrangements to which the physician and healthcare entity are parties. If appropriate, the appraiser should demonstrate that the physician is not compensated for the same duties through different arrangements, since multiple payment for a single set of duties would result in compensation to the physician that is *in excess of fair market value for the overall bundle of services*.<sup>15</sup>

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### The Cost Approach

The International Glossary defines the Cost Approach as “a general way of determining a value indication of an individual asset by quantifying the amount of money required to replace the future service capability of that asset.” The cost approach looks to the replacement cost of an asset or business interest as the basis for valuing the subject asset or interest. In business valuation, the cost approach is categorized as the asset-based or build-up approach because the appraiser attempts to recreate the value of the subject business by accumulating the values of the individual assets that comprise the subject. The appraisal attempts to recreate the business one asset at a time, building up a business enterprise value based on the value of each asset. The cost/asset-based/build-up approach illustrates the valuation principle of alternatives: the idea that there are alternatives to acquiring the future service capacity of the subject asset or business interest.<sup>16</sup>

The cost approach as applied to service contracts seeks to value the compensation for the subject arrangement by looking to the value of alternatives for those services in the marketplace. As applied to valuing medical director services, the cost approach seeks to value an arrangement between a healthcare entity and a medical director by considering the healthcare entity’s costs in the alternative to contracting with a medical director. For example, such alternate cost might be based upon the employment of one or more physicians to provide the required medical director services. As a practical matter, however, the appraiser should keep in mind that most medical directorships are structured as independent contractor arrangements. The duties of a medical director require variable and often limited hours. As such, securing medical director services through an employment arrangement is generally less practical than through an independent contractor arrangement.

### Applying the Cost Approach

In following the valuation principle of alternatives, an appraiser may look to physician compensation levels in the marketplace, whether from employment or private practice, as a basis for the alternative cost to procuring the physician services provided in medical directorship arrangements. There are several reliable and readily available sources of survey data for physician compensation in the marketplace. These sources include:

1. **Medical Group Management Association (MGMA), *Physician Compensation and Production Survey*.** This is an annually-published survey that typically reports compensation data from over 2,300 physician practices (predominantly, independent physician-owned organizations).
2. **Sullivan, Cotter and Associates, Inc. (SCA), *Physician Compensation and Productivity Survey Report* (SCA).** This is a compendium of data reported by 263 healthcare organizations (including medical centers, group practices, integrated delivery systems, and HMOs). The 2007 edition represents responses from 39,407 MDs, PhDs, midlevel providers, residents and medical group executives.
3. **Client & Healthcare Compensation Service (HCS), *Physician Salary Survey Report and Client Salary & Benefits Report*** The *Physician Salary* report incorporates data from 302 healthcare organizations (including group practice facilities and HMOs). The 2008 edition represents responses from 21,412 physicians. The “Client Salary” report incorporates data from 374 HCS clients, including responses from various Client executives, administrators, and non-physician and midlevel providers.
4. **American Medical Group Association (AMGA), *Medical Group Compensation and Financial Survey*.** The AMGA report discloses salary survey data obtained from medical groups, (predominantly large multi-specialty group practices). Second in size to only the MGMA survey, the AMGA survey is one of the most reliable sources of physician clinical compensation data.
5. **Watson Wyatt Data Services (WW), *Client and Healthcare Management Compensation Report, 2007/2008 Survey Report*.** The WW report incorporates data from 415 healthcare organizations representing 63,886 physicians, midlevel providers, and healthcare executives.

It is essential that appraisers understand how these various physician compensation surveys gather and report financial information on physician compensation. Such knowledge is needed for the valid use the survey data to determine physician compensation rates. An appraiser will need to address four critical issues in using the survey data to establish the fair market value of physician compensation for purposes of medical director services. These issues include:

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1. The distinction between clinical services and administrative services and any corresponding differentiation in compensation levels for clinical versus administrative work.
2. The distinction between compensation for physician services and business owner compensation.
3. Determining the appropriate level of annual hours worked for purposes of computing an hourly rate for physician services.
4. Adjustment of employment compensation hourly rate to an independent contractor basis.

The appraiser's analysis and resolution of these critical issues may have a material impact on the valuation opinion for a subject medical directorship arrangement.

### Compensation for Clinical versus Administrative Services

As noted in the section on the regulatory context for valuing medical director services, CMS recently indicated that it recognizes a distinction between clinical and administrative services with regard to physician compensation. According to the regulators, the fair market value for physician clinical services may differ from the fair market value of administrative services provided by a physician for Stark compliance purposes. Appraisers valuing medical director services for Stark compliance purposes should address this distinction between clinical and administrative duties when determining the fair market of those services. The salient point to this distinction appears to be that the value of clinical work may be greater than the value of administrative work. The presumption is that clinical services warrant higher levels of compensation than administrative services such as medical directorship services. Under this line of reasoning, clinical work is deemed to involve a higher degree of complexity and risk than administrative work. Clinical procedures involve the immediate health and well-being of patients, and in some specialties and cases the literal difference between life and death. While administrative functions and duties, such as those of a physician medical director, may require a skill set only found in physicians of a given specialty, these functions and duties do not generally entail the same level of complexity or risk as the provision of healthcare services to patients. As a result, the level of compensation paid for administrative services should be less than the compensation paid for the same amount of time spent performing clinical procedures. [Editor's Note: Readers should take note of this key point.]

An alternative line of reasoning derived from an opportunity cost analysis argues against the opinion that administrative services should be compensated at a level different from clinical work. It contends that physicians would not agree to provide services at a lower rate because of the opportunity cost for providing administrative services in comparison to clinical services. Compensation levels for clinical procedures are the indicator of the value of a physician's time. Physicians should be paid at clinical levels in order for them to agree to provide non-clinical types of services. Otherwise, physicians have no incentive to provide administrative services. [Editor's Note: And similarly, this point, as it is the key to understanding the hypothetical physician seller of services' opportunity cost.]

Whatever position an appraiser takes on this issue, appraisal opinions prepared for Stark compliance purposes should address the distinction and provide support and defense for the position taken on the issue. Failure to consider this question may constitute an inadequate scope of work for such appraisal assignments. In addition, appraisers may be given regulatory guidance by the client and/or the client's legal counsel that determines the approach to be taken by the appraiser in valuing administrative services. In such cases, the appraiser should document this regulatory guidance as part of definition of value applicable to the assignment.

The approach taken in comparing compensation for clinical and administrative work is critical in determining how physician compensation survey information is used in valuing medical director services. Physician compensation surveys generally report compensation from all sources. The primary source of income for a physician outside of an academic practice setting or a purely administrative role is clinical services. As a result, the compensation in most of the published surveys primarily represents clinical compensation. If an appraiser takes the position that administrative services should be compensated at a lower rate than clinical services, the appraiser may need to adjust the survey compensation levels or choose the lower percentiles from the survey to derive hourly physician compensation rates applicable to medical director services. On the other hand, appraisers who argue in favor of the opportunity cost basis for valuing medical director services will tend to use compensation levels from the published surveys without such adjustment or consideration of the lower percentiles.

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### Compensation for Physician Services versus Business Owner Compensation

The various published physician compensation surveys gather and publish data from a variety of physicians who practice in diverse settings. The surveys report compensation information in varying levels of detail corresponding to these diverse practice settings. The key compensation measures, however, tend to report total compensation received by the physician from all sources. This reporting of compensation from all sources may obscure the fact that certain forms of compensation received by physician may not relate to services provided directly or personally by the physician. Income received from ancillaries, employment of mid-level providers or physician extenders, leasing of space or equipment, or sharing in group practice earnings may relate more to ownership of a medical practice rather to physician services. In other words, business owner compensation is often reported along with compensation from physician services in the physician compensation tables in published surveys. Other forms of non-clinical income such as on-call pay stipends, medical directorship payments, expert testimony fees, and other forms may also be included in the physician compensation tables.

Appraisers seeking to find the market information on the value of physician services may need to adjust reported compensation levels to eliminate forms of compensation not related to physician services, such as business owner compensation. Quantifying these amounts, however, may be extremely difficult. Analysis of various financial, production, and operational metrics, ratios, and benchmarks reported in the surveys may be required for the appraiser to attempt to adjust for business owner compensation that is included in the survey-reported physician compensation tables. While there are clear practical difficulties to addressing this issue, appraisers valuing medical director services should be aware of disparate forms of income or compensation that are included in the published surveys and make adjustments to the valuation analysis where they deem appropriate and practicable. In other words, appraisers should not use compensation amounts from the published surveys in an uncritical or unqualified manner. Such use may lead to an overstatement of the cost of physician services for valuing medical director services.

### The Annual Hours for Used in Computing Hourly Physician Compensation Rates

In using published survey data on physician compensation to arrive at hourly rates for valuing medical director services, appraisers must select the number of annual hours to be used as the divisor for the published annual compensation amounts. Many appraisers use 2,000 or 2,080 hours as the best approximation of typical hours worked by physicians. While this convention may be appropriate and valid, appraisers should be aware of the reported levels of annual physician work hours as provided by certain of the surveys. For those surveys that do report physician work hour levels, reported levels may indicate a continuum of annual hours worked that deviates from the standard 40 hour work week less 10 holidays (*i.e.*, 2,000 hours). Indicated hours may be below or above the typical annual hours. The assumption of standard annual hours may have the greatest valuation impact when an appraiser uses the upper percentiles of the reported compensation levels to determine an hourly rate. In reality, physicians at these higher compensation levels may be working higher annual hours than assumed in the standard rates for annual hours worked. As a result, appraisers may need to perform additional research and analysis using survey information to arrive at the appropriate annual hours amount used for determine hourly physician compensation rates when relying on the upper percentiles of the compensation surveys.

### Adjustment of Hourly Physician Compensation to an Independent Contractor Basis

Because most medical directors serve as independent contractors to healthcare facilities, many appraisers argue that the hourly rates derived from physician compensation surveys should be grossed-up to include a provision for benefits. The theory supporting such gross-up is that independent contractors across all industries are generally paid at higher rates than employees. Such premium rates are intended to cover benefits and other costs incurred by contractors providing services. In the area of physician services, it is argued that one can observe such premiums in the rates paid to locum tenens physicians. Appraisers who value medical director services should be aware of this issue and provide the support and defense in the appraisal report for the position taken.

### The Income Approach

The income approach may be the most difficult of the three approaches to value to apply to the valuation of service arrangements. This difficulty derives from the traditional definition in the business valuation body of knowledge. As defined by the International Glossary, the income approach is a "a general way of determining a value indication of

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a business, business ownership interest, security, or intangible asset using one or more methods that convert anticipated economic benefits into a present single amount.” Converting the compensation under a service agreement to a “present single amount” often represents a conundrum for appraisers. How can such a statement of value be meaningful for a service contract? For valuing service agreements, the definition of the income approach may need to be adapted in terms of the valuation principle of future benefits as the basis for value, but without the conversion to a present value amount. With this adaptation, the income approach can be employed to calculate the future economic benefits to be received by each party to the service agreement.<sup>17</sup> These benefits are then evaluated in terms of investment levels, resources utilized, and services provided in comparison to market rates of return and profitability. Under this reformulation of the income approach, the appraiser seeks to value the services by ensuring that each party receives market returns or margins given the levels of investment, risk, and resource utilization attributable to either party to the service contract.

For valuing medical director services, use of the income approach may be limited or impracticable. An appraiser might attempt to isolate such benefits by borrowing the with-and-without competition technique commonly used in business valuation to arrive the value of a covenant not-to-compete. Under such a method, the appraiser would attempt to place a value on medical director services by showing the decrement in net cash flow to the healthcare entity by not contracting with a medical director. Isolating the specific amount of future benefits attributable to contracting with a medical director, however, is a difficult task. In addition, the appraiser would need to prepare projections of revenues and expenses related to the entity or service line in question. The cost of preparing such a pro forma statement appears to outweigh its benefit. Applying the income approach to the other party to the arrangement, *i.e.*, the physician, would require the appraiser to assess the future benefits to the physician in terms of market rates of compensation for physician services. This evaluation returns the appraiser to the analyses of the market and cost approaches. In general, the income approach appears to be the least relevant and applicable of the three approaches available for valuing medical director services.

### Formulation of the Opinion of Value

After completing the applicable approaches to value, the appraiser engages in an evaluation and reconciliation process to determine the fair market value of the subject arrangement for medical director services. This process is ultimately based on the independent and professional judgment of the appraiser. Weight may given to a greater or lesser degree to the results of any particular valuation method or technique based on a variety of considerations, such as the reliability of data, extent of comparability, scope of information, regulatory guidance, and facts and circumstances unique to the subject arrangement. The opinion of value may be stated a specific dollar amount or a range. Whatever the conclusion of value determined, the appraiser should be prepared to support and defend the conclusion based on the relevant information and sound valuation methodology.

### Evaluating the Method of Compensation: Hourly versus Fixed Fee Arrangements

Medical directorships may be independent contractor or employment relationships. In either case, the method of compensation for medical director services is most often hourly and paid in accordance with the number of hours actually worked and recorded by the physician on a time log. The alternative compensation structure is a fixed fee paid in weekly, monthly, or other time intervals, or upon the achievement of certain milestones or the completion of certain tasks.

Regardless of whether an arrangement provides for hourly or fixed fee payments, all payments should be based on a fair market value hourly rate. Accordingly, to evaluate fixed fee payments, the valuator must determine the hours reasonably required to perform the services provided and calculate an underlying hourly rate. Unfortunately, benchmark data to assist with the estimation of time requirements for medical director tasks is rarely available, forcing the valuator to rely upon his or her own best judgment, client representations, or the requirements specified in the arrangement.

In order to appraise and/or validate the fair market value of an arrangement involving a fixed fee payment for medical director services, a valuator must be able to compare the compensation derived from the arrangement to benchmark data from the marketplace. To permit such comparisons, values must be in comparable units (*i.e.*, they must have the same denominator). If all compensation values are reduced to and expressed in terms of dollars *per*

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hour, the valuator can freely make comparisons to benchmark data, as is required to validate an appraisal using a market data.

When asked to value a medical director arrangement that provides for fixed fee payments, the valuator may tie the fixed fee payment to an hourly rate using the following four step process:

1. As specifically as possible, identify the duties that the medical director is required to perform.
2. Determine (from benchmark data) reasonable hourly compensation for performing such duties.
3. Determine the hours that are reasonably necessary (based on any available benchmark data, client representations, or the valuator's independent judgment) or that will actually be required under the arrangement to perform the duties.
4. Multiply the reasonable hourly compensation for performing the duties by the hours that are reasonably necessary or that will actually be required to perform the duties.

After applying this four step process, the fixed fee should reflect reasonable hourly compensation for the duties, based on a reasonable estimate of the time to be spent performing the duties as required under the arrangement.

### Conclusion

Applying the three approaches in valuing medical directorship agreements requires the skill and analytical ability of an experienced and well trained healthcare appraisal professional. The appraiser must analyze and synthesize three areas of specialized knowledge in order to arrive at an opinion of value. First, the appraiser studies and evaluates the scope of services and the physician qualifications required to provide the medical director services in the subject agreement. Second, the appraiser completes research and analysis of market data and information to derive comparables for use of the market and cost approaches. Third, the appraiser must adjust and adapt the valuation analysis and the scope of work to comply with any regulatory guidance and specialized regulatory definitions of value. To arrive at an opinion of value, the appraiser evaluates the findings of the valuation process and arrives at a conclusion of fair market value for the subject agreement.

1. While the Uniform Standards of Professional Appraisal Practice (USPAP) do not formally apply to the valuation of compensation amounts under service arrangements, appraisers would do well to follow the broad outlines of USPAP's Scope of Work Rule in appraising such arrangements. Identifying key assignment elements, such as intended use and users of the appraisal opinion, definition of value, etc. are useful tools in providing clients with appraisal reports that meet their needs, especially in the healthcare regulatory context.
2. Detailed discussion of the IRS regulations and guidance is not provided herein, as many of the issues are similar or identical to the issues under Stark and FAKS.
3. The physician Self Referral Law (the "Stark Law") is codified at 42 U.S.C.S. §1395nn
4. 42 U.S.C. §1320a-7b
5. *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985).
6. Note that a wide variety of State legislation exists which is similar to Stark and FAKS, and some require additional considerations, depending on the particular State.
7. See the definition of fair market value in the *International Glossary of Business Valuation Terms* or in Revenue Ruling 59-60 for examples of the commonly accepted definition of FMV in the appraisal profession.
8. This is the Stark definition, set forth in 42 CFR §411.351. This definition is also consistent with similar fair market value guidance related to FAKS (codified at 42 U.S.C. §1320a-7b) and with the definition relied upon by the Internal Revenue Service (See, for example, Treas. Reg. 53.4958 et seq.)
9. CMS has stated, "...the definition of "fair market value" in the [Stark] statute... is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies. For example, the methodology must exclude valuations where the parties to the transactions are at arm's length but in a position to refer to one another." 69 FR 16107 (March 24, 2004).
10. 66 FR 876-77, 919, 941, 944 (January 4, 2001)

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11. 66 FR 876-77, 919, 944 (January 4, 2001)
12. We should also note that some attorneys argue that the above limitation on the market approach is applicable only to the office space and equipment lease exception under Stark. They argue for this qualification because the limitation on the use of market comparables between referring physicians and DHS providers is discussed under the rubric of the space and equipment lease exception. On this exclusion, therefore, an appraiser may be given conflicting guidance from different clients. Appraisers should therefore obtain clarification from the client and/or the client's legal counsel as to the interpretation of Stark that is required for the particular appraisal assignment.
13. 72 F.R. 51016
14. We have elected to treat medical director compensation surveys under the rubric of the market approach and the more general physician compensation surveys (e.g. MGMA, AMGA, SCA, etc.) under the cost approach for purposes of valuing medical director services. Some appraisers, on the other hand, place use of the general compensation surveys under the market approach and directorship surveys under the cost approach. Either categorization has merit and validity. Yet, such variations in categorization can be confusing to appraisal users and appraisers alike. It would be helpful for the healthcare valuation community to adopt a universal convention as to how the use of the surveys should be categorized relative to the approaches to value.
15. As explained elsewhere in this chapter, to comply with healthcare regulations, agreements and transactions between physicians and healthcare entities must generally be consistent with *fair market value*. Healthcare regulations also generally require such arrangements to be *commercially reasonable*. An arrangement or series of arrangements wherein a physician is compensated multiple times for performing a single function: (a) may result in the physician being paid an aggregate amount that exceeds fair market value for the overall bundle of services to be provided under the arrangement; (b) may fail the test of *commercial reasonableness* based on the definition of *commercially reasonable* provided in the applicable regulations.
16. One can also argue that the cost approach is derived from the principle of substitution in that the individual assets separately valued are substituted for the subject business. Conversely, it can be argued that the market approach illustrates the principle of alternatives: market comparables indicate the existence of alternatives to the subject in the marketplace. Such lines of reasoning illustrate the integral relationship among the fundamental principles of valuation and the three approaches to value. They also indicate the difficulty in assigning a given principle to only one approach to value. The principles may be found in more than one approach.
17. Under this adaptation of the income approach, future economic benefits are not intended to include the value or volume of referrals. Rather, the appraiser looks exclusively to the revenues, expenses, and resources investments related to the specific services and/or service lines provided for in the agreement. For example, in applying the income approach to physician employment arrangements, the appraiser would project future economic benefits deriving from the physician practice only. The value or volume or referrals to other business lines of the employer or the employer's parent or affiliated companies is not included in the projection. In some cases, future benefits may not be separately attributable to the subject agreement. In other cases, the future benefits may indirectly or unintentionally include certain ancillaries or other revenues that arise out of referral relationships. In these cases, the appraiser may be prevented from using the income approach to value the future benefits to one or both parties to a service arrangement.