

## In-House Counselor

### Unique Factors Impact Fair Market Value Determinations for Children's Hospitals and Pediatric Providers

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**T**he Children's Hospital Affinity Group (CHAG) is designed for those members of the In-House Counsel and Teaching Hospitals and Academic Medical Centers Practice Groups who work with or for a health care institution dedicated to children's health care needs. CHAG explores medico-legal issues that are unique to providing health care to children such as consent, Children's Health Insurance Programs, Medicaid, and other government program funding, guardianship, and state protective services agencies. Additionally, CHAG covers issues impacting children's academic medical centers including research and graduate medical education matters.

Several factors distinguish the evaluation of fair market value (FMV) for compensation arrangements involving children's hospitals and pediatric providers from the typical FMV value analysis. Smaller numbers of pediatric subspecialists result in fewer compensation survey responses and influence the quality and interpretation of the survey data. Additionally, smaller numbers mean a lack of pediatric subspecialists in certain markets impacting FMV in some communities.

Lack of supply also requires pediatric subspecialists to assume multiple roles within a provider or even among several providers. It is not unusual for children's hospitals to contract with a provider for a fixed number of hours per week or for a specific element of care or patient population. Many times these arrangements also include other duties such as administrative responsibilities and call. These "parts and pieces" types of arrangements tend to be more complex and evolving as the parties negotiate the services to be provided to address the changing needs of the pediatric population.

#### Limited Supply of Pediatric Subspecialists

There are about 24,000 pediatric subspecialists and more than 105,000 general pediatricians<sup>1</sup> in the United States. The U.S. Census Bureau reports about 74 million children under the age of 18.<sup>2</sup> There is a marked connection between access to pediatric subspecialty care for children who have complex, severe, acute, or chronic conditions and better outcomes.<sup>3</sup> When compared to care given by general (adult)



specialists, studies demonstrate care provided by pediatric subspecialists reduces the length of hospital stays, number of readmissions and complications, and decreases medical costs.<sup>4</sup> According to the American Academy of Pediatrics,<sup>5</sup> when a community lacks pediatric subspecialties:

- Care may be provided by adult medicine subspecialists who lack training in pediatric care;
- Care for children who have complex illnesses may be provided by general pediatricians;
- Families must travel to a distant center for care; and
- Families may need to locate to another community.

As cost and quality become even more important, demand for pediatric subspecialist services is likely to increase, and the valuation hurdles associated with establishing these relationships in a compliant manner may become more prevalent.

#### Evaluating Survey Data

In evaluating compensation survey data, it is important to consider the survey response rate and the number of entities reporting. The most-recent Medical Group Management Association (MGMA) Physician and Compensation and Production Survey (MGMA Survey), one of the most frequently cited compensation surveys, reported about 1,500 responses in the pediatric subspecialties out of 60,000 overall responses.<sup>6</sup> Pediatric response rates by specialty





ranged from a low of 13 respondents (pediatrics: radiology and pediatric: genetics) to a high of 156 respondents (pediatrics: neonatology).<sup>7</sup> For comparison purposes, pediatric anesthesiology had 91 respondents while anesthesiology had 2,660 respondents.<sup>8</sup> In evaluating the use of survey data to determine FMV, low response rate is one of the first items to consider. Similar to any sampling, higher sample size (responses) indicates higher confidence in the result.

Valuation consultants utilize several ways to increase the number of available responses. One way is to utilize multiple surveys in the evaluation of FMV. The Stark Phase II Interim Final Rule<sup>9</sup> provided a list of sources for survey data, including: Sullivan Cotter and Associates Inc.—Physician Compensation and Productivity Survey; Hay Group—Physicians Compensation Survey; Hospital and Healthcare Compensation Services—Physician Salary Survey Report; MGMA—Physician Compensation and Productivity Survey; ECS Watson Wyatt—Hospital and Health Care Management Compensation Report; and William M. Mercer—Integrated Health Networks Compensation Survey. Unfortunately, while the list was current in 2004, some surveys listed are no longer available.

Moreover, there are other prominent surveys not listed in the Stark Phase II Interim Final Rule. The American Medical Group Association produces an annual compensation survey, which is available for purchase, with a large response rate. There also are other restricted sources of survey data available, including association surveys and proprietary

subscription databases. For example, the Association of Administrators in Academic Pediatrics (AAP) conducts an annual survey (Faculty Salary and Productivity Survey) that is utilized by many pediatric providers. However, the survey results are only available to AAP's provider members and are not generally available to third parties or consultants.

While pediatric-specific restricted surveys can provide a good snapshot of market compensation, the use of restricted surveys presents challenges. Survey data that can be accessed by a variety of users is typically considered more impartial because responses for restricted sources tend to be low and the responses may be limited to a select demographic. Additionally, the data can be tainted by a large provider reporting results. If a large provider both reports and uses a low response survey, they may actually be benchmarking against themselves. These factors should be considered before relying solely on data presented in a restricted survey.

To ensure an adequate number of survey responses and impartial results, some accounting and consulting firms utilize multiple surveys in each valuation, ensuring that each survey's respondents target a different demographic; thus, providing a broader representation of reporting providers. In determining which surveys to use, it is important to align the survey with the type of services to be provided. If evaluating compensation for clinical services, FMV should be based on surveys where the respondents provide clinical services, like the MGMA Survey. If evaluating compensation for administrative duties, a survey like Sullivan Cotter, which reports compensation for administrative positions, should be considered.

Another method to increase the number of available responses is to utilize historical surveys. In business valuations, it is common to look back several years to evaluate past results. This same standard can be applied to compensation arrangements by using several years' survey results in the evaluation. This method not only provides additional responses, but also normalizes fluctuations between years that are more prominent when response rates are low in the pediatric subspecialties.

Once the surveys have been selected, care must be taken to ensure that the survey responses are a valid basis for supporting a FMV conclusion. Low response rates in pediatric subspecialties are typical. However, the number of respondents is not the only determinant for validity. It is important to consider the number of entities reporting as well. As the number of entities reporting increases, the validity of the survey increases because the results come from many different sources. For example, a survey with 52 responses from 23 entities will yield better data than 52 responses from six entities.

Survey responses across the various percentiles also should be tested to better understand and evaluate the survey results. One way to test the percentiles is to review the standard deviation as a percentage of the mean. A higher percentage indicates the data is spread out over a large range



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of values meaning more variation or less reliable. A lower percentage indicates the survey results are more closely clustered around the mean and less variation or more reliable. Another test is to compare mean to median. Similar amounts indicate a more-symmetric distribution that increases reliability, while dissimilar amounts indicate an asymmetric distribution with more outlier responses. If the mean significantly exceeds the median, there is more disparity and less reliability on the responses in the upper end of the range. This evaluation of survey results is more important among pediatric subspecialties as the adult or general subspecialties have many more physicians reporting in greater numbers, raising confidence in those results.

If a review of the available survey information results in a low number of aggregate responses for the relevant pediatric subspecialty, an alternative source of survey data is the adult or general subspecialty category. Adult subspecialists provide services to pediatric patients. Consistency in the determination of survey category among surveys is important to reduce the likelihood of mixing pediatric provider data and adult provider data. However, all surveys do not necessarily examine all of the same specialties. Subjective judgment is required to determine the proper specialties for each survey. This problem is more prevalent in pediatric valuations due to the lower number of pediatric specialists. Fewer providers in each pediatric specialty or subspecialty mean fewer responses that are then aggregated and mapped to more-general specialties. For example, the survey data for a pediatric hand surgeon may be embedded in the pediatric orthopedic surgery data that does not appropriately represent the complexity and acuity associated with hand surgery. Accordingly, care must be taken to properly match the duties performed by pediatric subspecialists to the most appropriate survey specialty and to acknowledge and account for differences between the survey specialty and a physician's actual specialty.

## Fair Market Value

Due to the low number of pediatric subspecialists, there can be variation in FMV based on an individual community and its needs. While some surveys report compensation by region, it is difficult to draw any conclusions. Also, the low number of pediatric subspecialists reporting means there are few pediatric subspecialty survey results by region.

Generally, physician salaries are driven by a national market. However, supply and demand is determined at the community level. There are communities that cannot meet their physician needs using FMV derived from survey data. Ultimately FMV is determined based on "facts and circumstances." The appropriate method of determining FMV will depend on the nature of the transaction, its location, and other factors.

A good place to start is to consider the following: is this a new subspecialty not previously recruited? If adding to an existing pediatric subspecialty, how does the expected compensation compare to existing compensation? What is causing the need for higher compensation? Is its specialty

specific or a general recruiting issue for all pediatric specialties that is perhaps related to the provider or community?

Due to the shortage of pediatric subspecialties, there is often an imbalance between demand and supply. Studies have shown that patients have to travel much greater distances for access to pediatric subspecialties than for adult or general subspecialties. According to a study by Mayer,<sup>10</sup> about 98% of adults have access to a general surgeon within 20 miles. Only 63% of children have access to a pediatric surgeon within 20 miles. More than 42% of pediatric patients would have to travel greater than 40 miles to access a pediatric neurosurgeon while only 6% of adults travel this distance for a neurosurgeon. Studies have concluded that while practice locations of pediatric subspecialists parallel the geographic distribution of children in the United States, many hospital referral regions lack pediatric subspecialists suggesting an inequitable distribution.<sup>11</sup>

General principles used in business valuations also are relevant to determining FMV in compensation arrangements. One such principle is called the "Principle of Alternatives."<sup>12</sup> It states that each party always has an alternative to completing the arrangement. It serves as a reminder that the arrangement does not need to be completed. The second is called the "Principle of Substitution."<sup>13</sup> It means that the value of something tends to be the price paid for an equally desirable substitution.





These principles may be used to support alternative or unique applications of survey data in certain geographic markets. For example, when applying the Principle of Substitution, one would evaluate whether there are other viable alternatives to the proposed pediatric subspecialist. Alternatives may include contracting for the services from another provider, using locum tenens physicians, securing telemedicine services, engaging an alternative background physician like an adult subspecialist, or even referring patients to another provider outside the community. One must consider which of the alternatives would provide the necessary quality of care. The cost of each alternative also is important to consider. If under the Principle of Substitution these alternatives would be delivered at a higher cost, then FMV also may support a higher compensation range.

### Multiple Role Arrangements

Due to a more-limited demand for pediatric subspecialty services, it is common for children's hospitals and pediatric providers to contract for services that require less than a full-time clinical physician. Children's hospitals or other providers may need a pediatric subspecialty but not have enough demand for a full-time clinical position.

The limited supply and demand means these arrangements require the physicians to assume multiple responsibilities requiring an evaluation of multiple compensation components. Each contract is individualized with common duties

that may include clinical services, medical directorship, administration, teaching, and on-call services. Multiple component arrangements should be carefully evaluated. A key aspect of the valuation is to develop an understanding of how each component relates to the others and how each component will be delivered.

It also is important to avoid "double dipping" when FMV compensation is determined for individual components that are delivered at the same time. For example, if an arrangement includes a half-day clinic and medical director duties, will the medical director duties be delivered outside the half-day clinic? If the arrangement provides for fixed clinic hours, what happens if the clinic is not fully scheduled for the fixed clinic hours? Will the physician be allowed to leave or provide other duties? These questions tend to be more relevant to pediatric valuations given the frequency of part-time or multiple-component service arrangements in the pediatric context.

### Conclusion

Lack of survey information and increased demand for pediatric subspecialty services require a different approach to assessing FMV. It is important to review the underlying survey data and make sure it supports any FMV conclusions. Consider alternative sources of delivering comparable quality services and what impact these sources have on FMV. Additionally, the nature of the part-time and multiple-component agreements typical with children's hospitals and pediatric providers require a thorough understanding to document the arrangement and verify that the FMV assessment matches the arrangement and appropriately values the services provided.



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