

Valuation of Healthcare Service Businesses

Performing valuations of healthcare service businesses and interests in those businesses requires fundamental business valuation expertise. It also requires special knowledge of the key economic drivers, trends, healthcare niche issues, and unique regulatory environment prevalent in the healthcare industry. This chapter provides insight into how these unique characteristics impact the valuation of healthcare businesses. We do not focus on the fundamental mechanics of performing a valuation but rather on the unique considerations that must be made in healthcare valuation. We also provide two detailed case studies to illustrate these nuances at the end of this chapter: an ambulatory surgery center (Addendum 1) and a hospital (Addendum 2). These case studies are only general examples since the procedures, methods and amount of detailed analysis can differ from engagement to engagement depending on the purpose and scope of the engagement.

The healthcare industry has its own language. Exhibit 25.1 contains a glossary of terms that may be reviewed to provide a foundation for understanding the healthcare industry.

Exhibit 25.1 Glossary of Terms

501(c)(3)—Refers to Section 501(c)(3) of the United States Internal Revenue Code of 1954. This section deals with nonprofit organizations that are exempt from federal income taxes (i.e., charitable, religious, scientific, and educational institutions).

Acute Care Hospital—A hospital caring for patients with serious debilitating illnesses and injuries; generally, the illnesses and diseases have an average length of stay of 30 days or less; commonly referred to as a short-term hospital.

Ambulatory Surgery Center (ASC)—A facility where physician surgeons perform outpatient surgeries. Generally, the patient is admitted and discharged within a 24 hour period. It is not uncommon for an ASC to perform the following services: Anesthesia, Dental, ENT, General Surgery, Orthopedics, Ophthalmology, Plastic, Podiatry, and Urology.

Ambulatory Payment Classification (APCs)—A prospective payment system for hospital outpatient services. APCs refer to a service classification system designed to explain the amount and type of services used in an outpatient encounter.

Average Length of Stay (ALOS)—The total average number of days between the time a patient is admitted and discharged from a healthcare facility.

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Exhibit 25.1 *continued*

Balanced Budget Act of 1997—This revolutionary act, enacted in August of 1997, contained significant changes in Medicare reimbursement for certain areas including skilled nursing services, home health services, and inpatient rehabilitation. Unlike the former reimbursement system whereby reimbursement rates were derived from cost reports subject to review by government agencies, the new Prospective Payment System (PPS) is based on established federal discharge diagnosis rates for a host of services. This new law required that the new PPS be phased in over a three year cost reporting period, beginning with those cost reports on or after January 1, 1999.

Capitation—A flat, periodic payment whereby a physician, hospital, healthcare facility, or healthcare system is compensated on a per-person per-month basis. Under the terms of these agreements, the provider assumes the risk that the fixed monthly payment will cover the costs associated with treating the patient.

Computed Tomograph (CT)—Refers to a technique for making detailed X-rays of a predetermined section of a solid object while blurring out the images of other planes.

Certificate of Need (CON)—A certificate, traditionally issued by a government (i.e., state agency) approving a healthcare facility's request for a specific service or function. In most cases, a CON is required to build, purchase, or occupy a service.

Cost-plus reimbursement—A type of reimbursement in which the recipient receives compensation for the costs associated with providing a service plus an additional amount as a fee or profit.

End-stage Renal Disease (ESRD)—The clinical term for kidney failure. This disease can be caused by a number of conditions, including: diabetes, sickle cell disease, hypertension, and congenital renal disease. Individuals with this condition must rely on kidney dialysis to survive.

Free-Standing Outpatient Surgery Center (FOSC)—A facility providing surgeries on an outpatient basis. Although a hospital may own one of these facilities, it is not a physical part of the hospital. In theory, FOSCs can be more profitable than inpatient surgery centers in hospitals since it is not subject to the same cost structures.

Health Maintenance Organization (HMO)—A type of managed care organization (MCO) that provides a form of health insurance coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract. Unlike traditional indemnity insurance, care provided through an HMO generally follows a set of guidelines set forth by the HMO's network of providers. Under this model, providers contract with an HMO to receive more patients and in return usually agree to provide services at a discount. This arrangement allows the HMO to charge a lower monthly premium, which is an advantage over indemnity insurance, provided that its members are willing to abide by the additional restrictions.

Managed Care Organization (MCO)—A term applied to those organizations that provide management services for the reduction or control of healthcare costs. Generally, MCOs offer their services to corporations and insurers. Health Maintenance Organizations (HMOs) also fall under this category.

Magnetic Resonance Imaging (MRI)—A special technique that images the internal soft tissue features of the human body. Generally, MRIs are superior in quality to traditional X-ray images.

Medicaid—Founded in 1965, this federal program provides healthcare to indigent persons and those individuals with certain illnesses or diseases. The Medicaid program is administered by the states.

Medicare—Also established in 1965, this federal program provides healthcare to those individuals 65 years and older and to others entitled to Social Security benefits. The Medicare program is administered at the federal level.

Exhibit 25.1 *continued*

Medicare, Part A: Medicare Part A refers to the hospital care portion of this program. Eligible enrollees are: (i) 65 years of age or older, (ii) under 65 years of age but have been eligible for disability for more than 2 years, or (iii) qualify for End Stage Renal Disease (ESRD).

Medicare, Part B: Medicare Part B refers to the part of Medicare whereby individuals who qualify for Part A obtain assistance with the payment for physician services.

Medicare Prescription Drug, Improvement, and Modernization Act (MMA)—A law passed in 2003 that produced the largest overhaul of Medicare in its history. After nearly six years of debate and negotiation in Congress, it was signed by President George W. Bush on December 8, 2003.

Ophthalmology—The subset of medicine that is concerned with the anatomy and treatment of the eye.

Physician Practice Management (PPM)—Refers to the industry that flourished in the early to mid 1990s. Companies using this model purchased independent physician practices and then provided these practices with the necessary business functions (i.e., accounting, human resources, etc.) based on a percentage of the businesses' revenue or cash flow stream.

Preferred Provider Organization (PPO)—A managed care organization (MCO) of medical doctors, hospitals, and other healthcare providers who have covenanted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.

Prospective Payment System (PPS)—The name given to the current pricing system for Medicare services. Under this system, patients are grouped under a diagnostic-related group (DRG) for which prices are negotiated and imposed on the healthcare facility.

Tertiary Care—Medical care that is highly specialized in nature. Typically, these types of services are provided in an educational setting, such as a university medical school or hospital.

TRICARE—A healthcare program for active duty and retired uniformed services members and their families (formerly known as the Civilian Health and Medical Program of the Uniformed Services, or CHAMPUS).

INDUSTRY BACKGROUND AND TRANSITION

From 1990 through 1998, transactions in the industry were driven primarily by the development of integrated delivery systems, the consolidation of health systems, and the consolidation of the physician practice management industry. The mergers and acquisition (M&A) market in the healthcare industry was very active during that period.

At the heart of the M&A activity in healthcare during the 1990s was an incredible number of transactions involving physician practices. A new company called Phycor emerged in 1989 with a new business model, which was the beginning of the Physician Practice Management (PPM) industry. By 1997 the PPM industry had become a public market segment with over 30 public companies and \$13 billion in public market capitalization. The PPM industry consisted of companies that were created and grown by acquisitions. This segment illustrated a classic rollup or consolidation strategy with public companies being priced based on their acquisition growth, then using the publicly traded stock as currency to continue acquiring physician groups.

In addition to PPMs, hospitals and healthcare systems sought to defensively secure patient volumes by owning primary care practices and other referring physicians. As the PPM segment was actively "rolling up" physician practices, hospitals also were competing for physician practices as part of their planned integrated delivery systems.

The rampant market consolidation of physician practices in the 1990s slowed dramatically with the failure of the PPM business model in late 1997 and the financial distress of hospitals and healthcare systems brought on by changes in reimbursement in early 1998 due to the Balanced Budget Act of 1997 (BBA97). The BBA97 fundamentally changed Medicare reimbursement to hospitals and health systems. The federal government had previously reimbursed hospitals based on their cost to provide services (cost plus reimbursement). The BBA97 converted payments to a prospective payment system or a specific fee for service. There was a significant reduction in payments to hospitals for the provision of services to Medicare patients. Although the hospital market expected those changes from the federal government, hospital management did not adapt quickly, resulting in financial difficulty during 1998 and 1999. In addition, all but several unique PPM companies failed and healthcare systems moved away from the integrated delivery system development strategy.

Another driving force in the M&A market during the 1990s was the consolidation of hospitals and healthcare systems. Columbia HCA Healthcare Corporation (Columbia HCA), a public company, was at the forefront of this consolidation. It was formed in 1994 when Columbia Healthcare Corporation was merged with HCA. Columbia HCA was intent on consolidating the hospital segment through acquisitions. By 1997 it had a portfolio of over 300 hospitals and 120 ambulatory surgery center partnerships. Columbia HCA and other public hospital corporations such as Tenet Healthcare stayed on the acquisition trail throughout much of the 1990s. This acquisition activity caused many health systems, including not-for-profit systems, to seek defensive mergers with other systems. However, the hospital M&A market slowed dramatically in 1998 with the introduction of the BBA97 and the fraud investigation of Columbia HCA brought by the federal government. Because of these financial difficulties, many public and private health systems greatly reduced their acquisition activity.

The hospital and healthcare system M&A market increased during 2005. Private equity and venture capital firms began funding the development of new private proprietary hospital companies. Because of the amount of capital invested in new hospital companies and the competition to acquire hospitals to put that capital to work, the pricing of hospitals has increased from historical levels prior to 1995. Existing publicly traded hospital companies have begun taking advantage of current hospital pricing by selling noncore or nonstrategic hospital assets at favorable pricing.

**ValTip**

In the mergers and acquisition marketplace, the demand for business valuation services has shifted away from transactions involving physician practices toward various types of joint venture deals.

Another trend, which began in the late 1990s, involves strategic transactions with hospital/physician joint ventures. These joint ventures include ambulatory surgery centers, surgical hospitals, acute care hospitals, diagnostic imaging centers, cardiac cath labs, cancer centers, and other ancillary service lines.

However, there continues to be a need for valuation services for physician practices in the dispute area, particularly for purposes of marital dissolution. See Chapter 19 for more information on the valuation of professional practices and Chapter 17 on divorce valuations.

HEALTHCARE INDUSTRY'S UNIQUE ATTRIBUTES

The healthcare industry is unique because of the following major factors:

- Size
- Fragmentation
- Aging population and healthcare cost containment trends
- Physician factor
- Healthcare regulatory environment

Size

The healthcare services industry remains the largest component of the U.S. economy, accounting for approximately 15.3 percent, or \$1.7 trillion, of the nation's gross domestic product (GDP).¹ The healthcare dollar accounts for more than one out of every seven dollars spent in America.

The source of healthcare consumer dollars are "payers," which can be broken down into two major components:

1. Federal/state government
2. Employers (insurance companies)/private payers

The federal government is the largest single payer of healthcare services in the United States through the Medicare, Medicaid, and TRICARE programs. The Medicare program insures those citizens 65 years or older. Medicaid provides reimbursements to those who meet certain economic need criteria. TRICARE insures those individuals who are current or eligible retired members of the U.S. armed forces. The federal government spends approximately \$550 billion per year for healthcare services through the Medicare and Medicaid programs. On the private payer side, employers typically purchase health insurance and offer those plans to employees at a discounted rate as part of employee benefit packages.

The provision of healthcare begins with the physician who directs patient care, treats patients, orders diagnostic tests, and performs surgeries. According to the American Medical Association, there were approximately 870,000 physicians in the United States in 2003.² According to the Centers for Medicare and Medicaid Services

¹ "Health Care Spending in the United States Slows for the First Time in Seven Years" (January 11, 2005). Center for Medicare & Medicaid Services.

² *Physician Characteristics and Distribution in the US*, 2005 Edition. American Medical Association.

("CMS"), these physicians represent an estimated revenue stream of approximately \$370 billion.³ Those physicians represent the starting point or referral source of substantially all of the revenue generated in the healthcare services industry. The remaining expenditures are for hospital care, pharmaceuticals, postacute care, ancillary services, and the like. Physician participation in the healthcare service industry is a unique and very important characteristic of the healthcare industry and will be stressed throughout this chapter.

Fragmentation

The major segments of the industry include:

- Physician services
- Acute care hospital services
- Postacute care
- Ancillary outpatient care (surgery, diagnostic imaging, laboratories, cancer centers, dialysis facilities, etc.)

Within each of these segments there are large multiple niches. The following is a list of segments and niches with their annual estimated revenues:

<u>Healthcare Niche</u>	<u>Estimated Annual Expenditures</u>
Physician practices and clinics	\$397 billion ^a
Acute care hospitals	\$552 billion ^a
Nursing home care	\$115 billion ^a
Home health care	\$ 45 billion ^a
Assisted living facilities	\$ 18 billion ^b
Ambulatory surgery centers	\$ 6 billion ^c
Cancer treatment centers	\$ 56 billion ^d
Clinical laboratories	\$ 40 billion ^e
Dialysis centers	\$ 25 billion ^f
Durable medical equipment	\$ 21 billion ^g

NOTES:

^a "U.S. Health Spending Projections for 2004–2014," Health Tracking (February 23, 2005). Office of the Actuary, Centers for Medicare and Medicaid Services.

^b "Size, Scope and Performance of the Seniors Housing & Care Industry," National Investment Center for Seniors Housing & Care Industries.

^c "Acquirer or Acquired—A White Paper on the Ambulatory Surgery Center Industry" (July 13, 2005). Thomas Weisel Partners.

^d IMPATH, Inc. 10K as of December 31, 2004. www.sec.gov.

^e Laboratory Corporation of America Holdings 10K as of December 31, 2004. www.sec.gov.

^f Renal Care Group 10K as of December 31, 2004. www.sec.gov.

³ "Table 2: National Health Expenditures Aggregate Amounts and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1980–2003." Centers for Medicare & Medicaid Services. www.cms.hhs.gov/statistics/nhe/historical/.

The two largest segments, physician services and acute care hospitals, clearly illustrate the fragmented nature of the healthcare services industry. This is discussed below.

Physician Services

The majority of the estimated 870,000 physicians operate in small group practices or as sole practitioners. As previously mentioned, large-scale consolidation of physician practices has proven to be unsuccessful; physician practices have proven much more difficult to organize than other nonprofessional components of healthcare.

Acute Care Hospitals

According to the American Hospital Association, the acute care hospital segment in the United States consists of 5,764 hospitals. Only 790 hospitals operate as investor-owned for-profit facilities, some of which are part of publicly traded hospital corporations. In addition, approximately 2,984 are community not-for-profit, 1,121 are state and local government community hospitals, 239 are federal government hospitals, 130 are long-term care hospitals, and 23 facilities are units of institutions (prisons, college, etc.). Approximately 86 percent of the hospital market consists of not-for-profit or tax-exempt hospital facilities.⁴

Aging Population and Cost Containment Trends

The United States population is getting older. Seniors over the age of 65 are the fastest growing segment of our population. The baby boomers in the United States, those born between 1946 and 1964, will cause that trend to continue. According to the U.S. Census Bureau, there were approximately 35 million people over the age of 65 in 2000 comprising 12 percent of the total population. The Census Bureau also estimates that by 2010, this segment will exceed 40 million people. By the year 2030, when all of the baby boomers have reached the age of 65, the senior population is estimated to be 71 million, or 20 percent of the total population.⁵ As a result, the demand for healthcare services over the next 25 years will increase not only with population growth but also by way of greater per-capita utilization as the largest group of our population enters their senior years. The projected cost of that care to the federal government has been the topic of heated political debate.

Over the last 15 years, employers and the federal government have looked to health insurers to provide solutions to these escalating costs. During that time, managed care organizations (MCOs) were developed by insurers to reduce and/or control escalating healthcare costs. A significant shift in the economics and the operations of the healthcare industry came with the development of insurance products provided through health maintenance organizations (HMO) and preferred provider organizations (PPO).

HMO insurance products were introduced as an option to control the cost of care to employers and employees. The HMO product is a fixed-fee premium prod-

⁴ American Hospital Association, www.aha.org.

⁵ "Table 2a. Projected Population of the United States, by Age and Sex: 2000 to 2050" (March 18, 2004). U.S. Census Bureau, www.census.gov.

uct that has very minimal additional costs (copays) to patients as they utilize health-care services. However, by accepting the larger insurance risk, the insurers (MCOs) have stepped in to control this risk by dictating to physicians the conditions under which referrals are made and services rendered. As a result, many consumers, attorneys, and physicians have argued that insurance companies illegally dictate how care is to be given, i.e., illegally practice medicine.

PPOs are another form of product that is offered by commercial insurance companies. The difference between HMOs and PPOs are economic in nature, with PPO premiums higher than HMO premiums. In addition, there are additional costs associated with deductibles and copayments for services rendered. The offset to the higher cost in PPO products is greater choice of physicians and healthcare facilities. PPO products also allow patients to receive care out of the PPO network for an additional fee that is not as onerous as receiving care out of network in an HMO.

The federal government has embraced the HMO concept through the development of senior HMO risk products. By allowing MCOs to accept a fixed or capitated rate for services, the federal government shifts the risk to the insurance company. Many insurance companies have discontinued their Medicare risk programs because they are unprofitable. The difficulty stems from the high utilization of services by seniors who typically utilize healthcare services at a rate that is three to five times higher than the average nonsenior.

The federal government passed the Balanced Budget Act of 1997 in part to address escalating healthcare costs. The result of BBA97 was a significant reduction in reimbursement of healthcare services for Medicare-eligible patients. It shifted reimbursement of many hospital services from a cost plus reimbursement methodology to a prospective pay system (PPS). The change in reimbursement placed many hospitals and health systems in financial distress. Many hospitals eliminated or reduced the provision of certain hospital services, such as skilled nursing units, home healthcare, and physical therapy, because of an inability to generate reasonable profits. In addition, many companies participating in the long-term care segment were forced to file bankruptcy. The federal government, through legislative action, is requiring health service providers to operate more efficiently. There will no longer be any financial incentive or reward to have high cost of care services.

As the aging population continues to grow and further tax the healthcare system, the federal government and commercial insurers will continue to implement cost-cutting measures. These cost-cutting measures will most likely take the form of reduced reimbursement. In addition, there will be pressure to move healthcare ser-

ValTip

Reimbursement is a critical assumption in the financial projections of healthcare organizations. Many analysts make the inaccurate assumption that reimbursement will continue to increase at the national inflation rates. Analysts must first understand the payer mix of the business being valued, including how specific payers reimburse for services and the prospect for future changes in that reimbursement.

vices from higher-cost-of-care settings to lower-cost-of-care settings, such as ambulatory surgery centers (ASCs).

Analysts can utilize the *Federal Register* to understand Medicare reimbursement for specific procedures. Changes in Medicare reimbursement typically are published in advance by the federal government. For example, on July 25, 2005, the CMS published a Proposed Rule detailing planned changes to the reimbursement rates for Medicare hospital outpatient services paid under the prospective payment system (PPS). The proposed changes would be applicable to services furnished on or after January 1, 2006. Because the government controls approximately one-third of healthcare spending, and the government has the ability to change reimbursement at any time, there is significant risk in the ability to project future reimbursements, especially given the state of the current Medicare program.

In many situations, the reimbursement for specific procedures can vary over time. For example, Medicare reimbursement rates for ASCs are expected to change over the next few years. Medicare reimburses ASCs for technical fees covering the cost of providing services, separate from any fees paid to the doctor. As part of the Medicare Modernization Act of 2003 (MMA), ASCs received a reimbursement increase on October 1, 2003, in line with the consumer price index (CPI). This increase was later eliminated on April 1, 2004. The current legislation dictates that ASCs will receive no CPI increase for the years 2006 to 2009.

MMA required the General Accounting Office (GAO) to study the relative cost of services in ASCs and hospital outpatient departments and determine whether the outpatient PPS procedure groups reflected ASC procedures. Based on its study, the GAO should recommend whether to use the outpatient PPS procedure groups and relative weights as the basis for the ASC payment system. Once the study is completed, regulators are charged with creating a new ASC payment system that links ASC payment rates to outpatient hospital rates. Therefore, it is expected that some procedures will be positively impacted and other procedures will experience a decrease in reimbursement rates.

**ValTip**

The volatility of reimbursement for individual procedures can be very high. It is important to consider prospective reimbursement changes when performing the valuation analysis.

Physician Factor

The single largest factor impacting the valuation of healthcare organizations is the recognition that a physician and only a physician can perform surgery, admit a patient to a hospital, order a diagnostic imaging test, perform a cardiac catheterization procedure, and so on. The starting point for understanding and ultimately valuing any healthcare service organization is to understand how physician practice patterns impact risks and ultimately the cash flow of the subject healthcare business.


 ValTip

Individual physicians exert a significant amount of control over the direction of patient referrals to healthcare service providers.

Example: A single-specialty ophthalmology outpatient surgery center is performing over 6,000 ophthalmic surgery cases per year, generating \$6.0 million in net service revenue (the net revenue of the surgery center net of contractual allowances-GAAP [generally accepted accounting principles] accrual net revenue) and \$2.7 million in earnings before interest, taxes, depreciation, and amortization (EBITDA). The center has exhibited a 10-year track record of profitability and growth. However, one ophthalmologist represents 80 percent of the volume.

This same ophthalmologist sold his surgery center to the current owners five years ago and simultaneously entered into a five-year covenant not to compete (relating to competition in the outpatient surgery business). That covenant not to compete will expire during the first year following the valuation date. In addition, the barriers to entry in the surgery center business are very low. There are no requirements for a certificate of need (CON) and the cost of the project can be financed primarily with debt. Therefore, the shareholders of the center are at risk of experiencing major loss of revenue if the key ophthalmologist:

- Decides to move out of the service area
- Is disabled and can no longer perform surgery
- Dies
- Retires
- Decides to compete

If any of these events occurs, the surgery center may lose 100 percent of its intangible asset value. Many valuation analysts do not properly identify this risk. A common mistake is to assume that the key ophthalmologist is replaced at similar volume levels. The replacement of a physician and the related revenues may be difficult in a community where the physician previously has built significant professional goodwill. As a result, this assumption may be erroneous and could lead to an overvaluation.

The actual results of operations of the ophthalmic practice in the example were that the key physician left and volume deteriorated to a run rate of 1,000 cases per year from a run rate of 6,000 cases per year in a period of one month. The EBITDA in the surgery center went from \$2.7 million annually to a net operating loss over the same period of time.

The opposite end of the physician factor spectrum would be a very large 450-bed tertiary care acute care hospital that exhibits the following characteristics:

- Very large barriers to entry—capital costs in excess of \$200 million
- Revenue stream in excess of \$250 million
- EBITDA of \$50 million
- 250 physicians on staff, multiple specialties and subspecialties

- No one single physician represents more than 5 percent of the net revenue of the hospital
- Very strong managed care contracts
- Long history in the community

The physician-factor risk profile of the hospital compared to that of a single-specialty ophthalmology center is very different. However, some valuation analysts might attempt to value both businesses using the same rules of thumb (e.g., x times EBITDA). Failure to understand the underlying risk/reward relationship in the valuation of healthcare firms can result in erroneous opinions of value.

Understanding how the “physician factor” impacts the volume of patients in a subject healthcare business is one of the very first steps that should be performed in valuation. Exhibit 25.2 presents several questions that should be answered as part of the valuation process for a healthcare business.

Exhibit 25.2 Physician Factor Evaluation

In order to properly evaluate the physician factor, the following questions must be answered and understood by the valuation analyst.

1. Does a physician dictate volume in a particular healthcare service entity? (in most cases the answer is yes)
2. Which physicians are primarily responsible for the current patient volume?
3. Are there any physicians that represent a significant percentage of the volume?
4. What is the age and expected remaining professional practice term of each physician?
5. What competition exists for the subject entity in the immediate service area?
6. Which key physicians might have compelling reasons to leave the subject entity and what might these reasons be?
7. Are there any barriers to exit or entry that would deter a departing physician from competing with the subject entity?
8. What capital costs are associated with the development of a new business?

Healthcare Regulatory Environment

The federal government has not overlooked the importance of the “physician factor” to the economics of healthcare. As a result, healthcare service providers are subject to an array of federal and state regulations that address the relationship between physicians and healthcare services businesses. In addition, the dominance of tax-exempt organizations in the healthcare industry has created heavy involvement by the Internal Revenue Service (IRS) in the operations, structure, and transactions of healthcare organizations.

The following laws are an important part of the healthcare regulatory environment:

- Federal anti-kickback laws (fraud and abuse law and regulations)
- Stark laws and regulations
- IRS private inurement regulations (impacting tax exempt organizations)
- State anti-kickback and self-referral laws

Federal Antikickback Laws

The most notable of the Medicare/Medicaid fraud and abuse provisions of the Social Security Law is 42 USC 1320a-7b(b), which is commonly referred to as the anti-kickback law. The anti-kickback law makes it a felony to offer, pay, accept or solicit payment for the referral of, or the arranging for the referral of, items, services or patients reimbursed by any federal or state healthcare program. Specifically, the law prohibits the willful and knowing offer, solicitation, or receipt of any remuneration (including any kickback, bribe, or rebate), directly or indirectly, overtly or covertly, in cash or in kind, for (1) referring an individual for an item or service reimbursed by a federal or state healthcare program; or (2) purchasing, leasing, ordering, arranging for, or recommending the purchase, lease or order of any good, facility, service, or item covered under any state or federal healthcare program.

Violations of the anti-kickback law are treated as felonies and are punished by up to five years' imprisonment per violation and/or a criminal fine of up to \$25,000 per violation. The Balanced Budget Act of 1997 also added a civil penalty of up to \$50,000 per violation plus up to three times the remuneration offered. In addition, civil sanctions include exclusion from participation in federal and state healthcare programs.

Safe Harbors to the Anti-Kickback Statute

Because the statutory language prohibiting kickbacks is so broad, many potentially harmless (and, in some cases, even beneficial) commercial arrangements could be prohibited by the anti-kickback law. Therefore, the Office of Inspector General (OIG) has issued several sets of regulations designating specific safe harbors for various payment and business practices that, while arguably prohibited by the law, would not be subject to criminal and civil prosecution enforcement under the statute. The safe harbors seek to protect various sorts of payment and business practices that Congress or the OIG have determined present little risk of fraud and abuse. In order to qualify for protection under a safe harbor, the arrangement must meet the precise terms and conditions of the safe harbor. It is important to note that failure to comply with a safe harbor provision does not mean that an arrangement is illegal. An investment that does not meet all the requirements within a safe harbor provision may still be perfectly lawful if there is no intent to generate remuneration for referral of Medicare or Medicaid patients.

The first regulatory safe harbors were published in 1991 in a final rule by the OIG (*56 Federal Register* 35952, July 29, 1991). The 1991 final rule established safe harbors in ten broad areas: investment interests, space rental, equipment rental, personal services and management contracts, sale of practices, referral services, warranties, discounts, employees, and group purchasing organizations. In 1999, the OIG published a final rule, establishing new safe harbor provisions and clarifying or modifying six of the original ten safe harbors published in 1991 (*64 Federal Register* 63518, November 19, 1999). The new safe harbor regulations included the following areas: investment interests in underserved areas, ambulatory surgical centers, investment interests in group practices, practitioner recruitment, obstetrical malpractice insurance subsidies, referral agreements for specialty services, and cooperative hospital service organizations. Additionally, the OIG established two new safe harbors to provide protection for certain managed care arrangements (*64 Federal*

Register 63504, November 19, 1999). Since then the OIG has issued another final rule in 2001 pertaining to ambulance restocking (66 *Federal Register* 62979, December 4, 2001). The OIG continually reviews suggestions for new and modified safe harbors, as Congress intended for the regulations to be evolving rules that would be updated periodically to reflect changing business practices and technologies in the healthcare industry.

ValTip

Valuation analysts should understand that the level of scrutiny may be very high when providing opinions of fair market value that could be subject to the anti-kickback laws. A very large number of transactions are subject to the anti-kickback regulations.

A significant number of healthcare business valuations are required as a result of the antikickback statutes. If the following fact pattern exists, the valuation will be subject to the criteria of the fraud and abuse regulations:

- Subject healthcare business receives reimbursement from a federal program (Medicare, Medicaid, TRICARE).
- There is a referral relationship involved between the parties involved in a transaction—for example, a physician/hospital joint venture of an ambulatory surgery center.

ValTip

It is important to identify applicable situations and possibly seek advice from healthcare attorneys as to the fraud and abuse implication of valuations performed in the healthcare services industry.

Stark Law

Section 1877 to the Social Security Act, commonly referred to as the “Stark Law,” addresses the general issue of physician self-referral. It prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which the physician or an immediate family member has a financial relationship, unless an exception applies. In addition, no entity may submit a claim to Medicare or bill any individual or entity for services furnished pursuant to a prohibited referral, and no payment may be made by the Medicare program for such services. Finally, the Stark Law requires entities that furnish Medicare-covered designated health services to submit reports on their financial relationships with physicians.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) added section 1877 to the Social Security Act and initially applied only to clinical laboratory ser-

vices. Numerous modifications and refinements were made over the next several years. For example, in 1993 the Stark Law was amended to cover 10 additional designated health services, including physical therapy services; occupational therapy services; radiology services; radiation therapy services; durable medical equipment; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. Additional legislative changes to Section 1877, for example, including Medicaid as well as Medicare, led to the further development of Stark regulations. These were issued in phases. Phase I was published in the *Federal Register* in 2001 (66 *Federal Register* 856, January 4, 2001) and Phase II regulations were published in 2004 (69 *Federal Register* 16054, March 26, 2004).

Services rendered pursuant to a prohibited referral are not payable by Medicare, and anyone submitting claims to Medicare or billing any entity for such services has an obligation to make a prompt refund. Submission of such claims or failure to promptly refund payments is punishable by civil monetary penalties of up to \$15,000 per service and, potentially, exclusion from the Medicare program. Failure to meet reporting requirements can result in a civil monetary penalty of up to \$10,000 per day.

ValTip

It is important to note that violations of the anti-kickback law are subject to criminal fines and possible imprisonment, whereas violations of the Stark law are punishable only by civil penalties at this time.

The intent of the Stark regulations is not only to prohibit referring physicians from owning an interest in businesses to which they refer but also to require that contractual relationships between referring physicians and parties to which they refer are consummated at fair market value. The Stark regulations actually define a valuation term called "fair market value," which requires emphasis on commercially reasonable standards and cannot be based on the value or volume of referrals from a particular physician as defined.

Exceptions to the Stark regulations allow physicians to own interests in certain entities included in the designated health services list. Two key exceptions are (1) the whole hospital exception and (2) the group practice exception. Physicians are permitted to own interests in whole hospital facilities that include designated health services. They also are permitted to own and provide designated health services as a component of their group practice. As with all healthcare regulations, detailed components

ValTip

Appropriately factoring the regulatory environment into the valuation is important when valuing healthcare businesses.

to each set of laws may require an analyst to consult with a qualified healthcare regulatory attorney to understand the complex nuances of each set of regulations.

RS Private Inurement and Private Benefit

A hospital or healthcare organization that is exempt from tax must be operated exclusively for charitable purposes. No part of an exempt hospital's net earnings may inure to the benefit of a private shareholder or individual. The primary purpose of the exempt hospital must remain to serve the public interest rather than a private interest. Revenue Ruling 69-545, 1969-2 C.B. 117, establishes the community benefit standard for the exemption of healthcare providers. It focuses on a number of factors, indicating that the operation of a tax-exempt entity such as a hospital benefits the community rather than serving private interests. An organization cannot be operated exclusively for charitable purposes unless it serves a public rather than a private interest. Thus, to meet the requirements of IRC 501(c)(3) as a tax-exempt entity, an organization must establish that it is not organized or operated for the benefit of private interests. Private inurement generally involves persons who, because of their relationship with an organization, can control or influence its activities. As such, the payment for businesses that exceed fair market value may cause an organization to lose its tax-exempt 501(c)(3) status.

ValTip

It may be necessary to consult a qualified tax lawyer to understand how to appropriately consider the tax laws when valuing a business that involves a tax-exempt enterprise.

Regulatory Environment and the Standard of Value

As a result of the fraud and abuse regulations, Stark laws, and private inurement requirements, many healthcare transactions are required to be consummated at fair market value. Fair market value is defined in the tax regulations as "the price at which property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of the relevant facts." The most notable transactions are between physicians and hospitals or any party to which they refer, where the physician might gain a prohibited economic benefit.

ValTip

If a valuation is being performed as a result of regulatory requirements, the valuation must apply the fair market value standard of value.

The following types of transactions are subject to the state and federal fraud and abuse regulations. To the extent that a transaction between a physician and a hospital exhibits one of the following characteristics, the federal government will take the position that referrals were being purchased or, in the case of a tax-exempt organization, that the tax exemption was being inured to the benefit of the non-tax-exempt organization.

- Physician sells surgery center to hospital for greater than fair market value.
- Physician buys interest in surgery center for less than fair market value.
- Physician buys interest in a hospital for less than fair market value.
- Physician sells interest to hospital for greater than fair market value.

Investment Value

There are several differences between fair market value and investment value. Investment value can be defined as the related value of a particular asset or service to a particular individual or entity. In other words, the investment value of a particular piece of property differs from buyer to buyer. Hence, investment value takes into consideration a specific buyer and seller. Fair market value does not assume a specified buyer or seller, but rather the hypothetical buyer(s)/seller(s) in the marketplace. See Chapter 1 for a more detailed discussion concerning standards of value.

The federal government takes the position that if a buyer (subject to the regulations) purchases a business or business interest from a potential referral source at greater than fair market value, there has been a monetary inducement for referrals. As a result, investment value transactions are less common. Publicly traded or proprietary healthcare companies sometimes enter into transactions that exhibit investment value. This should be noted and considered when analyzing publicly available transaction data.

OVERVIEW OF CONSIDERATIONS FOR VALUING HEALTHCARE ENTITIES

Understanding the Market and Economic Drivers for the Industry Niche

Performing a healthcare valuation requires that the valuation analyst have a thorough understanding of the market in which the subject healthcare entity operates as well as the economic drivers for each specific healthcare niche. These factors will affect the volume of service and the risk associated with that volume.

Understanding the Impact of Healthcare Laws and Regulations

Prior to accepting the engagement, the valuation analyst should have an understanding of the healthcare laws and regulations that might impact the valuation process. For example, the engagement might involve a fair market value opinion of a diagnostic imaging center partnership that has individual referring physician ownership. Since diagnostic imaging is a designated health service as defined by Stark regulations and cannot have referring physician ownership, the analyst may be unable to provide the fair market value of an entity that has been illegally structured. In fact, if there is any question about the legality of a business structure, a regulatory attorney should be consulted.

Understanding the Motivations and Economic Drivers of the "Typical Buyer" in the Marketplace

Two groups most commonly represent the typical buyer in the healthcare marketplace:

1. Local and regional not-for-profit healthcare systems
2. National or regional for-profit specialty healthcare service firms

The motivations and economic drivers for these two potential buyers are widely divergent. The not-for-profit healthcare system is driven by the requirement to serve the local community's healthcare service needs and generally reinvests significant levels of capital back into the community health system. The not-for-profit healthcare organization always must be cognizant of the regulations necessary to maintain its tax-exempt status. The board of directors of the tax-exempt hospital typically will require that third-party appraisers are engaged to determine the fair market value of a prospective entity for the purposes of supporting the price of a transaction.

The national or regional for-profit healthcare provider is driven by two factors:

1. Providing high quality services that successfully compete with the not-for-profit providers
2. Generating a return to the equity investors of the corporation

These factors will definitely change the dynamics of and motivations for transactions. The standard of value may shift from fair market value (the standard for not-for-profits) to investment value if the regulatory environment allows. This difference in standards of value can create an uneven playing field as not-for-profit entities compete with for-profit entities.

Understanding the Types of Revenues Generated by Healthcare Entities

There are two types of revenue in healthcare services, "technical" and "professional." The technical revenues in healthcare represent the reimbursement levels related to the facility, equipment, supplies, other operating expenses, and capital costs associated with the provision of care. For example, a hospital is reimbursed a technical fee for the services associated with a surgical procedure. Surgery requires a licensed hospital or outpatient facility, operating room, supplies, staff, and other operating and capital expenses to perform the procedure. The technical fee represents the cost of services excluding the physician's professional fee. The physician's professional fee is called the professional component of reimbursement. A combination of technical fees and professional fees is known as a global fee.

ValTip

It is important to understand what is included in the revenue stream of the subject entity since professional versus technical revenue generation can involve different valuation dynamics.

VALUATION PROCESS

Fundamental Understanding

The valuation process should begin with a discussion with the client pertaining to:

- Standard of value
- Date of valuation
- Purpose and use of the valuation
- Specific business or interest to be valued

These fundamental factors set the foundation for the remaining steps of the engagement:

- Information gathering
- Valuation approaches and methods
- Income approach

Information Gathering

The information-gathering process can be challenging and time consuming for healthcare valuations. Many entities operate on a cash basis and do not have audited financial statements. In addition, many are small and do not have the administrative resources needed to facilitate information gathering. As a result, the quality of information obtained may vary widely and careful attention must be paid to anomalies. If the analyst does not have healthcare expertise, an industry expert may need to be consulted.

Valuation Approaches and Methods

Similar to any other business valuation, the three primary approaches to value— income, market, and asset—should be considered. Selecting the appropriate valuation methodology, as always, depends on the facts and circumstances of the subject business being valued. However, most healthcare services businesses that are going concerns are valued with heavy reliance on the income approach due to the nature of service businesses. The market approach has less applicability due to limitations on the quantity and supportability of the underlying data. Under the asset approach, the value of the underlying net tangible assets of healthcare organizations is typically less than the overall value of the organization such that the intangible component of value can be the largest percentage of the overall value. The primary exception to this rule is in the valuation of some acute-care hospitals that have significant investment in land, buildings, improvements, equipment, and working capital.

Income Approach

For transaction-based valuations, the discounted cash flow (DCF) method of the income approach is typically one of the primary methods that is used to value healthcare service businesses. The DCF allows the analyst to work with detailed assumptions regarding volumes, reimbursement, payer mix, growth, staffing levels, staffing costs, medical supply costs, occupancy costs, other operating expenses, cap-

ital expenditures, and working capital. When analyzing projections, it is important to consider these components:

- Net patient revenue
- Operating expenses
- Working capital requirements
- Capital expenditures

Net Patient Revenue. Net patient revenue is the product of volume and charges (gross patient revenue) less contractual allowances. The contractual allowance is the difference between the charges and the amount that payers are contractually obligated to reimburse the provider for services.

Obtaining a concrete picture of the volume of patient flows and the charges associated with the types of procedures being performed by the subject entity will help quantify gross patient revenue. Since volumes are dependent on physician activity, the following information will be useful when analyzing current volumes and developing volume projections for the subject entity:

- The source of volume at the physician and physician specialty level
- Changing practice patterns of utilizing physicians
- Competition in the service area that could impact existing volume
- Population growth and demographic changes in the service area

The final component of the projection of net revenue is the reimbursement to be received on patient charges. However, this is not a straightforward issue since the payer mix will determine the anticipated amount of reimbursement to be received. The analyst must understand the subject company's payer mix for various services/procedures, and, if necessary, tie this to the Medicare reimbursement schedules in the *Federal Register*, and use these data to evaluate reimbursements used in the net revenue projections.

ValTip

A negative reimbursement trend for certain healthcare services is not uncommon. It may be erroneous to assume, without performing a reimbursement analysis, that reimbursement will increase at inflationary rates.

Operating Expenses.

- **Salaries, Wages, and Benefits.** This is typically the largest expense for healthcare service businesses. It is appropriate to analyze the staffing patterns and projected staffing as a function of patient or procedure volume in the business.
- **Medical Supply Costs.** Supply costs are a significant cost for most healthcare service businesses. Supply costs should also be analyzed and projected based upon volume.

- **Occupancy Costs.** These costs are relevant if the company rents its property. Typically, occupancy costs include utility costs.
- **Insurance.** Liability insurance can be a significant cost.
- **Bad Debt.** This expense can change significantly from year to year and can be benchmarked against other facilities to consider the reasonableness of the expense.
- **General and Administrative.** This category includes telephone, postage, office expenses, travel, entertainment, marketing, management fees, and other administrative costs.

ValTip

One of the erroneous assumptions sometimes made in healthcare valuations is that variable expenses are always solely a function of revenue.

As in other industries, the operating expenses of a healthcare firm are both fixed and variable. Most of the variable expenses, although related to revenue, are really a function of volume.

Salaries and medical supplies vary with the number of procedures performed rather than the net revenue of the business. Even when reimbursement revenues are flat or declining, staffing and medical supplies continue to be affected by volume. If volumes continue to grow, staffing and supplies must keep up. Over the last five years, profit margins of some healthcare services businesses have declined because reimbursement has been flat or, in some cases, declined, while volumes continued to grow, increasing the costs associated with employees and supplies.

ValTip

The net result of volatile reimbursement levels for some healthcare entities is declining margins. Valuation professionals must carefully track variable costs.

Working Capital Requirements. Working capital for a typical healthcare service business includes cash, accounts receivable, inventory, and prepaid expenses, less vendor payables and other current liabilities. Accounts receivable is usually the most significant component of working capital. Working capital costs often are based on a reasonable level of working capital in the business as compared to similar businesses. It is common for normal working capital requirements to be between 10 and 25 percent of net revenue for healthcare services firms.

Capital Expenditures. Depending on the type of healthcare entity, capital expenditure assumptions can have a dramatic impact on the valuation. Issues that must be considered include age and condition of equipment, technological obsolescence, historical capital expenditures, and plans for any nonroutine capital expenditures.

Income Approach Discounted Cash Flow Method: Developing A Discount Rate

The next step in a DCF analysis is the development of a discount rate. Although direct equity methods can be used, the invested capital method of the income approach, using the weighted average cost of capital (WACC), is more common in the acquisitions area. Both direct equity and invested capital models are used in other areas such as tax and litigation.

To derive the equity return within the WACC, analysts can use the build-up method or the Modified Capital Asset Pricing Model (MCAPM). One of the most challenging issues in using the MCAPM to develop a discount rate for a healthcare entity is the selection of beta. The healthcare industry has been less volatile than the rest of the stock market for several years. The extreme volatility in the stock market has forced the current beta for the healthcare services industry to be significantly less than one. Using MCAPM with low betas (0.2 to 0.4) can cause the equity return to be much lower than other industries. Analysts must consider the reasonableness of a low beta and whether it applies to the subject business.

Income Approach Discounted Cash Flow Method: Estimate of Value

If performed properly, the DCF typically yields a valuation that most effectively considers the facts, circumstances, and risk of the cash flow of a particular business. See Chapter 4 (Income Approach) and Chapter 5 (Rates of Return) for more detailed information.

Market Approach

Two accepted methodologies may be considered in the valuation of healthcare businesses utilizing the market approach:

1. Guideline public company method
2. Guideline company transactions method

Guideline Public Company Method

The guideline public company method uses similar publicly traded companies (if available) as sources for market multiples that are used to determine the value of the subject entity. Market multiples may include:

- Invested capital/sales
- Invested capital/EBITDA
- Invested capital/EBIT
- Price/net income

Based on the comparability of the public companies, adjustments are made to the market multiples that are then applied to the subject company. See Chapter 6 for a more detailed discussion of the guideline public company method.

Information on public healthcare companies can provide an analyst with an overview regarding financial characteristics of companies engaged in the same niche as the subject company. However, utilizing publicly traded company valuation data is very difficult. In the healthcare industry, publicly traded companies are valued based on such characteristics as size, diversification, growth (acquisitions), access to capital, and so forth, factors that simply are not present in most single-location or single-market healthcare businesses. For example, publicly traded hospitals sometimes trade above nine times EBITDA. However, individual hospitals often are priced in the range of five to eight times EBITDA, which is higher than historical multiples for individual hospitals due to the demand the current private equity market is placing on the hospital market. As a result, publicly traded comparable company multiples are often not applicable.

ValTip

Historically, public healthcare companies have been acquisitive and have had high valuation multiples. As a result, the multiples generated by public companies are usually not comparable to those of small private businesses.

Guideline Company Transactions Method

The guideline company transactions method involves developing the pricing multiples from transactions of similar companies in the marketplace and applying these multiples to the subject company. The information is synthesized through a number of different sources including Securities and Exchange Commission 8-K reports, Irving Levin and Associates Healthcare M&A report, *Mergerstat Review*, *Done Deals*, and *Pratt's Stats*. The benefit in utilizing individual transaction data is that the companies often are more similar in size and may be affected by similar economic factors.

The drawbacks to utilizing these data include:

- Lack of disclosure of all transaction terms
- Facts and circumstances that may differ dramatically between the target company being analyzed and the subject company

The information needed to appropriately analyze market transactions include:

- Terms of purchase agreement
- Historical financial and operational information of target company
- Facts, circumstances, history, and outlook of the target company

Detailed private transaction data such as that listed above is rarely made available to the public. The details of a purchase agreement include price, consideration

paid, assets and liabilities included, assets and liabilities excluded, postclosing adjustments, conditions, and warranties of the transaction. Publicly available information such as transaction announcements typically exclude the data necessary to perform a reasonable guideline transaction analysis. Without thoroughly analyzing the data, it is very difficult to develop reasonable pricing multiples.

ValTip

Many analysts try to force the use of guideline company transaction multiples. This can increase the risk of a flawed valuation. Unfortunately, rarely is the information at the level of detail necessary to perform a supportive guideline company transaction analysis. However, they can sometimes be used as a general reasonableness test depending on the situation.

If the valuation analyst follows the industry closely and develops relationships with those responsible for buying and selling healthcare businesses in each niche, he or she can develop general ranges of market multiples for transaction pricing and use them as a test for reasonableness.

Asset Approach

The asset approach is applicable in those situations in which the value of the underlying assets of the business are greater than the values derived from the income and market approaches. Underperforming healthcare entities sometimes experience this situation.

The asset approach begins with proper identification of the tangible and intangible assets of the entity. A typical asset base can include:

Tangible Assets

- Working capital
- Furniture
- Leasehold improvements
- Medical and other equipment
- Real estate

Intangible Assets

- Trained workforce
- Customer contracts
- Trade name
- Covenants not to compete
- Managed care relationships
- Customer/patient relationships
- Leasehold interests
- Proprietary software

If the analysis requires significant fixed assets or real estate valuation, a qualified appraiser in each area may be engaged. If the underlying profitability of a healthcare entity decreases significantly because of systematic changes in the industry, such as reimbursement, the underlying assets of the business may experience economic obsolescence. The assets may no longer be able to generate an adequate rate of return over their remaining economic useful lives. Many assets in healthcare, such as buildings, improvements, and equipment, are single purpose by nature. As the economics of the industry change, so can the underlying value of the tangible assets. Obsolescence of assets should be considered when performing an asset approach to value. See Chapter 7, Addendum 2 (Understanding Real Estate Appraisals) and Addendum 3 (Understanding Machinery and Equipment Appraisals) for more details on tangible asset valuations.

CONTROL PREMIUMS AND MINORITY DISCOUNTS

When performing a healthcare valuation, it is important to consider the appropriate level of value. Generally, there are four basic levels (sometimes five) of value applicable to a business or business interest (see Chapter 8):

1. *Control strategic*—The value of the enterprise including synergies
2. *Controlling interest*—The value of the enterprise as a whole
3. *Marketable minority interest*—The value of a minority interest lacking control but enjoying the benefit of market liquidity
4. *Nonmarketable minority interest*—The value of a minority interest lacking both control and market liquidity

Control interests are usually more valuable than minority interests on a pro rata basis. Although the issue of control is very broad and may encompass several factors, some common prerogatives of control are:

- Appointment of management and the determination of their compensation
- Setting business policy and control of the day-to-day operations
- Acquisition or liquidation of assets
- Acquisition of other companies or the sale of the company itself
- Selection of customers
- Acquisition or sale of treasury shares
- Control of dividends, distributions, and contributions
- Change or amendment of the articles of incorporation
- Dilution or constriction of ownership
- Inclusion of buy/sell provisions in a partnership or corporation agreement

To determine whether a discount or premium is warranted, the analyst must consider the valuation method used and whether the cash flows are on a minority or control basis. Some valuation methods result in a control level of value. If one of those methods is used to value a minority interest, a discount may be warranted. But if a valuation method yields a minority interest level of value, then the base value already reflects the minority owner's lack of control, and a further discount would not be appropriate.

One of the differences in minority discounts for healthcare businesses is that many healthcare joint ventures and partnerships are structured to minimize the disadvantages of minority ownership. Healthcare partnerships are typically structured to be favorable to the minority shareholder in terms of distributions, buy-sell provisions, and participation in management. Partnerships that involve physician ownership include surgical hospitals, ambulatory surgery centers, diagnostic imaging centers, cardiac cath labs, and other ancillary businesses. A common feature of a healthcare partnership is a provision for regular (quarterly and semiannual) distributions based on a formula or protocol.

Minority partners (physicians) in most healthcare partnerships are also customers of the business. Management in hospitals and ancillary healthcare businesses, such as surgery centers, typically provide utilizing physicians very high levels of input in the day-to-day operations of the business. In addition, physician owner/customers usually are asked to provide input related to clinical policies and practices. If the physician owner/customer is not satisfied with management of the operations, they typically do not practice at that location. The underlying operating agreements and specific facts and circumstances should be considered carefully before applying a minority discount.

ValTip

Some minority interests in healthcare businesses do not exhibit the general characteristics that affect the magnitude of discounts in other closely held businesses.

DISCOUNTS FOR LACK OF MARKETABILITY

Marketability relates to the ability of an investor to convert the ownership interest to cash quickly, incur minimal transaction and administrative costs, and enjoy a relatively high degree of certainty of realizing the expected amount of net proceeds (see Chapter 8). Although the issue of marketability discounts is very broad and may encompass several factors, the key areas considered are:

- Restrictions on transfer of shares
- Availability of a ready market
- Approach and method of value

As with minority discounts, many healthcare partnerships are structured with provisions that minimize the issues associated with lack of marketability:

- Regular distributions typically are paid, making the interest more desirable.
- The qualified buyers of a partnership are peers (i.e., surgeons/customers), which creates a built-in market.
- Many operating or partnership agreements provide buy/sell provisions that often define the calculation of value or require a value analysis in advance of the sale of an ownership interest.

ValTip

The analyst should read the operating and/or partnership agreement to determine the level of minority or marketability discount.

VALUATION ISSUES FOR SPECIFIC HEALTHCARE INDUSTRY NICHEs

The next section provides insight into the unique issues associated with the valuation of healthcare services organizations that operate in specific niches of the industry. Healthcare organizations in specific market niches are subject to the pressures and trends of the healthcare industry as a whole. However, each niche presents unique economic and operations issues of its own that impact the valuation of those organizations. This section identifies the key issues to consider when valuing entities in the following industry niches:

- Hospitals and health systems
- Physician and physician group practices
- Ambulatory surgery centers
- Diagnostic imaging centers
- Dialysis centers

ValTip

The regulatory and legal issues discussed earlier in this chapter may pertain to the valuation of entities in many industry niches.

Hospitals and Health Systems**Background**

Hospitals and health systems make up a large segment of the healthcare industry. Not-for-profit hospitals make up 86 percent of the 5,764 hospitals in the United States. Only 790 investor-owned hospitals are operated in the United States. Hospitals and health systems are one of the largest employers in most cities and urban areas. Although the hospital market has gone through a rapid consolidation process over the last 10 years, it still remains considerably fragmented.

After reaching its lowest level of merger and acquisition activity in 15 years in 2003, the hospital M&A market rebounded in 2004. Currently, the market is being driven substantially by private hospital companies funded by private equity firms or venture capital funds. In addition, existing public hospital companies are typically looking for growth in acquisitions. The result has been more demand than supply for hospital acquisitions, causing pricing to increase.

Regulatory Issues

Federal antikickback statutes, Stark regulations, and IRS private inurement are all potentially relevant in a hospital valuation. The antikickback statutes will be important in transactions that involve physician ownership. The Stark regulations define the exceptions that allow physicians to own interests in hospitals and health systems, called the whole-hospital exception of the Stark regulations. The IRS regulations are important to the extent that the buyer or seller of a hospital is a tax-exempt organization.

Typical Purpose of Valuation

Valuations typically are performed prior to hospital sale or purchase, hospital partnership interest sale or purchase, and financing associated with a hospital transaction. In addition, in some situations the value of a hospital is contested and litigated among shareholders.

Investment value is usually not the required standard of value except certain situations where two proprietary hospital companies negotiate the sale/purchase of a facility.

Valuation Methodologies

In most situations, the *income approach*, more specifically the discounted cash flow method, is used. This method captures the facts, circumstances, risks, and ultimately the cash flow of the hospital in an ever-changing environment.

The *market approach* has several deficiencies that make it difficult to apply to hospitals:

- Individual hospitals are typically not purchased/sold at the same values as publicly traded health systems.
- Transactions are difficult to use because of the lack of detailed information regarding the hospital purchased as well as the terms of the transaction.
- Popular price-per-bed multiples often do not reflect the economics of a hospital, resulting in unreasonable values.

The guideline company transactions method can be used as long as the appropriate data regarding the transaction and the sellers' financial statements and operations have been provided. Care should be taken to analyze each transaction.

ValTip

A common oversimplification is utilizing limited market transaction data without understanding the transactions, a situation that can lead to faulty conclusions. They can be used as a reasonableness test.

The *asset approach* to value may be considered in situations where the income approach to value produces a valuation that is similar to or less than the underlying value of the net tangible assets of a hospital. However, because hospitals are single-

use facilities, impairment of the asset base should be considered if the asset value exceeds the income approach value.

Specific Issues to Address

- Analyze the top 20 admitters and top 20 surgeons on staff of the hospital, including any risks associated with key physicians.
- Understand where medical patient admissions and surgical patient admissions originate.
- Understand the services provided by the facility on an inpatient and outpatient basis.
- Understand the facility's case and payer mix.
- Understand the commercial insurance reimbursement environment.
- Analyze the staff and supplies expenses and benchmark the subject hospital to peer groups to understand the efficiency of the hospital. Common benchmarks are full-time equivalent (FTE) per adjusted occupied bed and supply cost per adjusted patient day.
- Review annual capital expenditures for replacement of the depreciating capital base, and review any potential one-time capital expenditures for new programs or new facilities.

Physician and Physician Group Practices

Background

The M&A market associated with physician practices has declined dramatically from the activity levels associated with the early to mid-1990s. Hospitals are no longer purchasing large numbers of physician practices as part of their strategic growth, and the PPM market segment proved to be a strategic failure.

Regulatory Issues

Antikickback statutes, Stark regulations, and IRS private inurement are involved.

Typical Purpose of the Valuation

Valuations typically are performed prior to a new partner's buy-in, sale of practice by retiring physician, shareholder disputes, divorce, merger, sale to a strategic buyer, or sale to a hospital.

Valuation Methodologies

In the application of the *income approach*, the most important consideration is physician compensation. It is common for physicians to retain 100 percent of the earnings as compensation. Since this leaves no earnings in the practice to value, the income approach can result in zero value. Many valuation analysts use published data to overlay comparable median or average physician compensation. This assumption may be arbitrary since an individual physician generating a certain compensation stream may not take a pay cut and continue to produce the same amount of revenue. The PPM industry overwhelmingly demonstrated that physician pay cuts create an unsustainable relationship (even when the physician was paid consideration for taking the pay cut).

Without making an assumption concerning a lower level of physician compensation, the income approach may not produce value. An exception to this occurs

when the practice uses physician extenders such as physician assistants or nurse practitioners. There also can be value in a growing practice that employs younger physicians at lower compensation levels.

In the *market approach*, the availability of accurate market transaction data is very limited. Several sources of information are published, such as the *Goodwill Registry* and transactions reported by publicly traded companies. The difficulty with all these sources is twofold: accuracy and completeness of terms. As discussed previously, to understand the economics of the transaction one must understand the terms of the transaction. For example, the same physician practice could have significantly different valuations if two different physician compensation models were assumed on a posttransaction basis. The Physician Practice Management Companies created an economic model that proved to be unsustainable. As a result, the transaction market for physician practices has changed dramatically. Physicians no longer have the opportunity to sell their practices to third-party management companies. The market that remains is composed primarily of junior employed physicians buying into an existing physician practice. Valuation analysts must fully understand historical transaction data before using it to develop a transaction method to value.

The *asset approach* is used to determine the aggregate value of all tangible and intangible assets, including practice and professional goodwill. This determination is often unnecessary, as this value is captured in the income approach. The tangible assets sometimes are valued when there are nominal earnings in the practice and the practice is worth only its net fixed asset value.

Specific Issues to Address

The valuation of a physician practice is significantly different from that performed for any other healthcare entity. Since a single or group physician practice is a professional practice, most of the entity value is based on underlying intangible assets commonly referred to as professional goodwill and practice goodwill. The separation of professional goodwill from practice goodwill is arguably the most difficult analysis that analysts are required to do in healthcare valuation. How much of the intangible value of the practice walks out of the office everyday in the form of a single physician?

Separating "professional compensation" from "practice earnings" may be one way to quantify an answer to this question. However, this may be challenging to accomplish, depending on the facts of the valuation.

Under yet another scenario, certain physician practices do not generate profits based on the professional goodwill of the physicians but, rather, based on contractual relationships with hospitals. Hospital-based physicians in specialties such as emergency room care, anesthesiology, radiology, and pathology may have exclusive contracts to provide their services to a hospital. As a result, the intangible value—professional goodwill—of these physicians is partially converted into a corporate-owned intangible asset (i.e., a contract). See Chapter 19 for more details on the valuation of professional practices.

Ambulatory Surgery Centers

Background

The development of outpatient or ambulatory surgery centers has been one of the most active areas in the healthcare services industry over the last five to seven years. The trend has been driven by two factors:

1. The desire of surgical or procedural specialists to own an interest in the outpatient surgery centers where they work and to be more involved in management of those centers.
2. The movement of outpatient surgical cases into lower cost-of-care settings out of higher cost acute care hospitals.

Currently there are four pure-play public surgery center companies: AmSurg, Symbion, Novarred, and United Surgical Partners International, Inc. However, because of attractive public multiples and the natural movement to outpatient surgery, many venture capital-backed ambulatory surgery center companies have started recently. There are at least 20 private surgery center management companies, some of which probably will be taken public or acquired by public companies over the next several years.

Regulatory Issues

These issues include antikickback statutes, IRS private inurement, and Stark regulations.

The regulatory environment is crucial to determining who is allowed to own an interest in a surgery center and under what terms. On November 19, 1999, the Office of the Inspector General published the "Clarification of the Initial OIG Safe Harbor Provisions Under the Anti Kickback Statute." These regulations created new safe harbor provisions which protect arrangements from prosecution under the antikickback statute, which prohibits anyone from knowingly and willfully offering, paying, soliciting, or receiving payment or remuneration to induce volumes reimbursable under the federal or state health care programs. Within the new safe harbors, the federal government created an ambulatory surgery center safe harbor. The basic theme of this safe harbor is the extension of the practice theory. The safe harbor allows those physicians for whom outpatient surgery or outpatient procedures represent a significant percentage of their practice and practice income to own interests in outpatient surgery centers. The federal government views the surgery center as an extension of those physicians' practices. As a result, they do not receive remuneration for making a referral but rather make additional returns on procedures that are a normal part of their everyday practice.

Typical Purpose of Valuation

- Sale of controlling interest in surgery center
- Minority interest of a partnership
- Disputes

Valuation Methodologies

The discounted cash flow method of the *income approach* often is used and should consider, by specialty, patient volume, reimbursement changes, and physician practice pattern changes. In addition, the underlying cost structure of the surgery center should be considered, as should routine capital expenditures since ambulatory surgery centers must constantly replace and/or purchase new surgical equipment.

The guideline public company method of the *market approach* usually is not appropriate since usually there are no public companies whose multiples can be applied to the typical ambulatory surgery center. If the guideline company transac-

tion method of the market approach is used, detailed data concerning private transactions should be considered carefully. These data include:

- Purchase price
- Considerations paid (cash or stock)
- Percentage interest of ambulatory surgery center
- Assets and liabilities purchased
- Assets and liabilities excluded
- Specialty case mix
- Payer mix
- Volume growth or contraction
- Utilizing surgeon analysis
- Unique capital expenditure requirements in facility
- Terms of any underlying covenants not to compete
- Terms of shareholder agreements or partnership documents
- Certificate of need in place
- Competition in the subject service area
- Post-closing purchase price adjustments

Each transaction is unique. If the detailed components of a reported transaction are not fully understood, the results are less reliable.

An *asset approach* should be considered to the extent that the subject surgery center does not generate sufficient profitability.

Specific Issues to Address

In most cases the structure of the ambulatory surgery center is a partnership (limited liability partnership, S corporation, limited liability corporation, limited partnership). Ownership includes physicians, physicians and hospitals, and physicians and ambulatory surgery center management companies.

Ambulatory surgery center regulatory safe harbors dictate who the shareholders of the surgery center can be. The only physicians who are allowed to own an interest in a surgery center are surgeons and proceduralists (gastrointestinal doctors and anesthesiologists). The physician owner of a surgery center is by definition a shareholder and a customer. The surgery center will operate in the manner that the customer or physician shareholder desires, or the customer will find another location to perform cases. This is an important issue when analyzing minority and lack of marketability discounts. In general, operating agreements in surgery center partnerships are designed to minimize the issues associated with discounts.

Addendum 1 to this chapter presents a case study for the valuation of an ambulatory surgery center.

Diagnostic Imaging Centers

Background

The outpatient diagnostic imaging center is a business that is named in the Stark regulations as a designated health service. As a result, ownership is limited to physicians. The in-office ancillary services exception to the Stark regulations exempts services personally provided by a physician member of the same group practice as

the referring physician or personally by individuals who are directly supervised by the referring physician or another physician in the same office. As a result of this exception, the only way a referring physician may own an interest in an imaging center would be to operate the business within the group practice exception of Stark. By definition, this would not be a freestanding outpatient imaging center but rather a component of a group practice.

Radiologists are not considered referring physicians (much like surgeons in a surgery center), since the federal government views a diagnostic imaging center as an extension of the practice of radiology. Therefore, radiologists are not prohibited from owning an interest in a freestanding outpatient imaging center. The typical imaging center valuation consists of a partnership between radiologists and a hospital or health system. Radiologists perform procedures in hospitals, so the same regulatory requirements exist for radiology joint ventures.

Regulatory Issues

The issues involved are antikickback statutes, Stark, and IRS private inurement.

Typical Purpose of the Valuation

- Sales of Center
- Minority interest in joint venture
- Disputes

Valuation Methodologies

The discounted cash flow method of the *income approach* typically is used as it captures estimates of future volume, reimbursement, revenue, expenses, and capital cost assumptions.

The guideline transaction method of the *market approach* often is not reliable because the following information is usually not available:

- Assets and liabilities purchased (excluded assets such as working capital not reported)
- Consideration (cash versus stock in the buyers company)
- Modality and volume mix of the imaging center (MRI, CT, ultrasound, fluoroscopy, mammography, X-ray, bone density, nuclear, etc.) as some modalities are far more profitable than others
- Volume growth
- Competition in service area
- Payer mix
- Global fee revenue versus technical fee only
- Radiology relationship and/or contract
- Maintenance agreement
- Equipment manufacturer, age, and condition
- Available capacity in the center
- Need for large capital reinvestment

The *asset approach* can be applied if the valuation of the business on an income approach is similar to or less than the estimated net asset value. Engagement of spe-

cialized equipment appraisers is probably necessary given the unique type and use of the assets.

Specific Issues to Address

Capital expenditures as a percent of operating earnings for diagnostic imaging centers is higher than in other healthcare businesses. Equipment in a diagnostic imaging facility is very expensive: MRI machines can cost \$1.0 million to \$2.0 million, and CT machines can cost \$0.7 million to \$1.2 million. In addition, the technological obsolescence in imaging technology is very rapid, resulting in more frequent equipment purchases. There has also been a continual downward pressure on reimbursement of diagnostic imaging procedures over the last 10 years, with that trend expecting to continue. These major economic influences result in valuation multiples that are often lower than those in other healthcare businesses.

Dialysis Centers

Background

Patients who suffer from end-stage renal disease (ESRD) are required to have dialysis treatments approximately 12 to 13 times per month. Regardless of age, patient ESRD is the only program that is reimbursed by the Medicare program. Patients who are diagnosed with ESRD qualify for the Medicare program 24 months after having been diagnosed. As a result, Medicare is always a very large payer for dialysis services.

Medicare's heavy participation in the dialysis business creates the risk that CMS will change reimbursement levels for a significant percentage of the business. With the government as a major payer, the regulatory requirements in the business are significant.

Purpose of the Valuation

- Sales and buy-ins
- Disputes
- Regulatory issues
- Antikickback statutes, Stark, IRS private inurement

Valuation Methodologies

The DCF method of the *income approach* typically is used, as it captures estimates of future volume, reimbursement, revenue, expenses, and capital cost assumptions.

The guideline transactions method of the *market approach* can be utilized in the valuation of dialysis facilities, unlike most other healthcare entities. The uniformity of utilization (volume by patient) and payer mix (Medicare) allows careful use of transaction data. Price per patient can be used very carefully as a check on the results established in the income approach. The quality and depth of information is also important. Availability of total purchase price, consideration paid, assets and liabilities included, number of patients, and payer mix are desirable to rely on this approach. In some cases that data can be found in the Irvin Levin Healthcare M&A database and public company SEC reports.

Typically the *asset approach* to value is not relied on in the valuation of a dialysis facility unless the facility is financially underperforming. Each dialysis machine costs between \$20,000 and \$30,000, so for a 30-station facility, the machines could cost almost \$1 million. In addition, special water purification systems used in the dialysis process must be installed in each facility. The underlying cost of the facility, including equipment, tenant improvements, working capital, and other intangible assets, should be considered during the valuation process. To the extent that the valuation under an income and market approach falls below that of the asset approach, the underlying net assets should be considered as an appropriate indication of value.

Specific Issues to Address

The volume of patient treatments is very predictable based on the number of patients treated at the dialysis center. However, the risk associated with competition from the patient's primary physician (the nephrologist) is very high. Nephrologists who are responsible for the patients in a dialysis center can direct patients from center to center. As a result, nephrologists typically are subject to medical directorship agreements that include strong covenants not to compete. The lack of covenants not to compete with the nephrologists treating patients in a dialysis center would increase the risk of the cash flow stream dramatically. The medical directorship payment should also be evaluated.

ValTip

Understanding the dialysis center's relationship with the nephrologist is critical in assessing risk.

PUBLIC AND PRIVATE HEALTHCARE SERVICES COMPANIES BY NICHE

The following healthcare entities are some of the best known within their niche. Public information about these companies and information disclosed in their public filings can assist the analyst in understanding the dynamics influencing the economic performance of the particular niche. (Note: This list is not meant to be all-inclusive, nor does it address medical device or pharmaceutical companies).

<u>Niche</u>	<u>Public Companies</u>	<u>Private Companies</u>
<i>Behavioral Health Companies</i>	Horizon Health Corporation Magellan Health Services, Inc. Psychiatric Solutions, Inc. Res-Care, Inc.	NextHealth, Inc.
<i>Dental Services</i>	American Dental Partners, Inc. National Dentex Corporation	Bright Now! Dental, Inc. InterDent, Inc.

<u>Niche</u>	<u>Public Companies</u>	<u>Private Companies</u>
<i>Diagnostic Imaging</i>	Alliance Imaging, Inc. Primedex Health Systems, Inc. Radiologix, Inc.	American Radiology Services, Inc. InSight Health Corp. Raytel Medical Corporation (subsidiary of SHL Telemedicine Ltd.)
<i>Dialysis Providers</i>	DaVita Inc.* Dialysis Corporation of America Fresenius Medical Care Corporation Gambro AB* Renal Care Group, Inc.	Dialysis Clinic, Inc. U.S. Renal Care, Inc.
<i>Disease Management</i>	Curative Health Services, Inc. American Healthways, Inc.	
<i>Home Health Care</i>	Allied Healthcare International Inc. (formerly Transworld HealthCare, Inc.) Almost Family, Inc. (formerly Caretenders Health Corp.) Amedisys, Inc. American HomePatient, Inc. Apria Healthcare Group Inc. Continucare Corporation LHC Group, Inc. Lincare Holdings Inc. National Home Health Care Corp. New York Health Care, Inc. Option Care, Inc.	Coram Healthcare Corporation
<i>Hospice</i>	VistaCare, Inc. VITAS Healthcare Corp (subsidiary of Chemed)	
<i>Hospitals</i>	Community Health Systems, Inc. HCA Inc. Health Management Associates, Inc. Lifepoint Hospitals, Inc. Tenet Healthcare Corporation Triad Hospitals, Inc. Universal Health Services, Inc.	Ardent Health Services LLC Attentus Healthcare, Inc. Capella Healthcare Essent Healthcare, Inc. Hospital Partners of America Inc. Jasis Healthcare Corporation Vanguard Health Systems, Inc.
<i>Lab Companies</i>	Genzyme Corporation Laboratory Corporation of America Holdings Quest Diagnostics Incorporated Specialty Laboratories, Inc.	AmeriPath, Inc. Pathology Partners, Inc.
<i>Lithotripsy</i>	HealthTronics, Inc.	American Kidney Stone Management, Ltd.
<i>LTACHs</i>	Kindred Healthcare, Inc.	LifeCare Hospitals Promise Healthcare, Inc. Select Medical Corporation Triumph Healthcare

<u>Niche</u>	<u>Public Companies</u>	<u>Private Companies</u>
<i>Pharmacy Benefit Management</i>	Caremark RX, Inc.	
<i>Physician Organizations</i>	Pediatric Medical Group, Inc.	US Oncology, Inc.
<i>Postacute Care</i>	Advocat Inc. Beverly Enterprises, Inc. CabelTel International Corporation (formerly Greenbriar Corp.) Capital Senior Living Corporation Emeritus Corporation Extendicare Inc. Five Star Quality Care, Inc. Genesis Healthcare Corporation InterWest Medical Corporation Manor Care, Inc. National HealthCare Corporation Salem Senior Housing, Inc. (formerly Diversified Senior Services) Sun Healthcare Group, Inc. Sunrise Senior Living, Inc. (formerly Sunrise Assisted Living, Inc.)	Alterra Healthcare Corporation Atria Senior Living Group Balanced Care Corporation Hearthstone Management, Inc. Leisure Care, LLC Merrill Gardens, LLC Regent Assisted Living, Inc. Sava Senior Care LLC Southern Assisted Living, Inc. Trans Healthcare, Inc.
<i>Radiation Therapy</i>	Radiation Therapy Services, Inc.	Vantage Oncology Inc.
<i>Rehabilitation Hospitals</i>	HealthSouth Corporation RehabCare Group, Inc.	
<i>Specialty Hospital Companies</i>	MedCath Corporation	
<i>Surgery Center Companies</i>	Amsurg Corp. HealthSouth Corporation NovaMed, Inc. PainCare Holdings, Inc. Symbion, Inc. United Surgical Partners International, Inc.	Ambulatory Surgical Centers of America Endoscopy Management Services Organization Foundation Surgery Affiliates Health Inventures, LLC National Surgical Care, Inc. Nueterra Healthcare LLC Pacific Cataract and Laser Institute Physicians Endoscopy Center Ltd, LLP Podiatry Associates, P.A. Regent Surgical Health, LLC Surgis, Inc. Woodrum Ambulatory Systems Development

*Note: On December 6, 2004, DaVita Inc. entered into an agreement to acquire Gambro Healthcare Inc from Gambro AB. The transaction is subject to certain closing conditions including the receipt of required regulatory approvals.