Ambulatory surgery centers ("ASCs" or "outpatient facilities") have become an important source of competition to hospitals for outpatient surgical services. More recently, specialty hospitals have provided similar alternatives to general acute care hospitals in the provision of inpatient care. By offering convenient, effective, and potentially lower-cost options for patients and physicians, ASCs and specialty hospitals can provide important substitutes to traditional hospital care.2

On the other hand, because these facilities are often owned by physicians who share in their profits, critics sometimes view them as cream-skimming operations that take away a hospital's most profitable customers while free riding on the emergency care or other high-cost services that hospitals are required or have a mission to provide. Add into this mix that the physicians who staff ASC's and specialty hospitals are often dependent on general acute care hospitals for staff privileges. These power dynamics can readily create situations of either actual or imagined antitrust abuse by hospitals in the face of ASC or specialty hospital competition, and have led to a flurry of antitrust cases against general acute care hospitals.1

One such situation involving an ASC recently arose before the United States Court of Appeals for the Third Circuit ("Third Circuit") in Gordon v. Lewistown Hospital. Dr. Alan Gordon, an ophthalmologist who filed with the state to open an ASC near the hospital where he practiced, brought antitrust claims against a hospital that revoked his staff privileges following a peer review allegedly based on Dr. Gordon's contact with the patients of a competing hospital ophthalmologist to win their business and alleged disparagement of that doctor's skills to those patients.5

The Third Circuit panel applied the Health Care Quality Improvement Act ("HCQIA" or "the Act")6 to immunize the hospital's peer review action from antitrust damages liability, even though the Act specifically withholds antitrust immunity from actions based on certain competitive acts, such as soliciting customers.6 Additionally, the Third Circuit applied a
IDENTIFYING APPROPRIATE BUSINESS VALUATION APPROACHES UNDER STARK AND THE AKS

Mark O. Dietrich, CPA/ABV
Dietrich & Wilson, PC
Framingham, MA
Reed Tinsley, CPA, CVA
Houston, TX

Introduction

One of the most problematic areas for valuation consultants and attorneys is establishing a clear understanding of the relationship between quantitative assumptions in a valuation model of a health care entity and the prohibitions of the Stark laws and Anti-kickback statute (“AKS”). Failure of one advisor or the other to understand both topics can lead to incorrect valuation and the possibility of an inadvertent, catastrophic result for the client and the advisors in legal and financial terms due to civil and criminal penalties that could be incurred. This article explores the problems commonly encountered by the authors in their health care valuation practices and in educating attorneys, providers and valuation analysts, particularly why for health care entities the income approach to valuation is generally preferred over the market approach.

Defining Fair Market Value

Defining the standard of value to be employed in a valuation engagement is critical. There are different standards of value that influence the result of a valuation. Fair market value assumes a hypothetical buyer and seller while investment value, for example, is the value to a specific buyer. Health care transactions are typically subject to a fair market value standard, and that term is used throughout the Stark laws and regulations as well as in the AKS and advisory opinions. Thus, it is necessary to understand what that term means and how it affects the determination of value. Here are some common definitions of fair market value and their sources. Note that the Stark regulations contain their own specific requirements for defining “fair market value.”

Internal Revenue Service
Revenue Ruling 59-60

“The price at which the 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 relevant facts.”

International Glossary of Business Valuation Terms

“The price, expressed in terms of cash equivalents, at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement.” Phase 1

“Moreover, the definition of “fair market value” in the [Stark] statute and regulation is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies. For example, the methodology must exclude valuations where the parties to the transactions are at arm’s length but in a position to refer to one another. While good faith reliance on a proper valuation may be relevant to a party’s intent, it does not establish the ultimate issue of the accuracy of the valuation figure itself.” Phase 2 (Emphasis added)

What is included in Fair Market Value?

In the case of any entity, such as a restaurant, bank, hospital, imaging center or physician practice, fair market value includes all of the cash flows associated with the operating assets of the entity that are included in the valuation model. This includes cash flows associated with those operating assets, including fixed assets (e.g., equipment), working capital assets (e.g., accounts receivable) and all intangible assets, such as goodwill, location, trade name and trained workforce. In order to have value, an asset must have an associated cashflow.

Although this concept may seem simple at first, it has significant implications in that advisors and clients must be careful not to count entity cash flows more than once in the valuation. Double counting would result in a

continued on page 20
payment that exceeds fair market value. For example, when valuing a physician practice for acquisition by a hospital, the value of the physician not competing with the practice after it is sold is already part of the practice’s cash flows: The cash flow methodology anticipates that the revenue generated by the selling doctor will remain with the practice and is valued accordingly in determining the fair market value of the entity. The noncompete agreement is merely the “fact” that enables the assumption that the revenue will remain at the entity level. Thus, an additional payment over and above the fair market value of the entity should not be made for the noncompete agreement executed in a transaction because the value of the practice already includes any cash flows attributable to the noncompete. (It is possible to separately identify the separate values of each of the practice’s assets, such as equipment or a noncompete, which may be independently desirable for tax allocation or other purposes.7).

Noncompetes and Referrals

When valuation of a noncompete agreement is appropriate, what is important is the general prohibition under Stark and AKS that the value or volume of referrals not be considered in the determination of fair market value. Presumably, there is some risk that paying a physician not to compete will enhance the volume or value of referrals to the purchasing entity making the payment, just as a payment for actually referring would enhance referrals. Moreover, the valuation technique commonly accepted for valuing a noncompete8 would consider the business lost by the holder of the noncompete if it were violated. Thus, the accepted valuation method considers the impact on future referrals.9

Notably, to value a noncompete the valuator must also consider the probability that the individual signing the covenant (the covenantor) would, in fact, compete. If the probability is zero, the covenant has no value. This is because when you multiply the cash flow otherwise attributable to competing by a factor of zero, the result will be zero.10 Among a host of factors, the level of compensation paid to that covenantor as an employee11 is one of the principal determinants of that probability adjustment. Therefore, reasonable compensation analysis is critical to the determination of the value of a noncompete.

Given the definition of ‘general market value’ in the Stark regulations, valuing a noncompete without taking into account the volume or value of referrals would seem to require distinguishing what referrals a physician without such a noncompete would make to the employing or purchasing unit absent the relationship. For example, an employed cardiologist might exclusively use the employing hospital’s cath lab and nuclear medicine units. If the employee leaves and establishes a competing freestanding practice with the same equipment, the hospital would expect to lose a considerable amount of future cashflow, determined with reference to historical utilization. Clearly, while historical results are one important element of forecasting future cashflows, it seems inappropriate for the hospital to pay the physician for not competing based upon those historical referrals.12

Another approach to paying for a noncompete would be to base the payment on the difference in compensation the physician might earn in a competing situation: in effect, a fair market value of compensation analysis. The higher the compensation received by the physician in the employed setting, the less likely the physician will compete and the lower the value of the noncompete. Market forces can be expected to drive employed physician compensation to levels commensurate with private practice earnings, with appropriate adjustments for work effort and return on the capital investment of the employing unit.

Understanding what terms and dollars are customarily included in employment agreements and whether continued employment is considered compensation for a noncompete in a given area is critical to determining whether an additional payment for a noncompete is appropriate, as is the enforceability of any noncompete provision. Valuing a noncompete agreement in a transactional setting such as a physician-hospital joint venture, is similarly problematic. Since such noncompete provisions are typical in joint venture agreements – at least as far as ownership of competing facilities, but not use of competing facilities – paying the physicians for signing one raises the specter of paying for referrals.

Examples of Problem Areas: Income Methods

Stark’s Phase 2 regulations’ most important contribution to the matter of “fair market value” was to specifically state that the definition for Stark purposes did not necessarily comport to the common usage of that term. Of course, a business valuation expert would have to be familiar with those regulations to have a chance of incorporating the concept into a valuation model.

Valuators use quantitative models to establish the value of business entities of all types. Fundamentally, a valuation model consists of mathematical assumptions about the future cash flows of the entity, consistent with the standard of value, which is generally fair market value. One valuation model problem area that is not well understood in the general community of business valuators and even less well understood in the legal community is the modifications to valuation assumptions required under the definition of fair market value, as
modified, under the Stark regulations and by inference, under the AKS. There are but a small number of business valuation experts with the requisite understanding of these modifications and fewer still with the experience in implementing them in valuation models.

Key Assumptions in a Valuation Model and What may Implicate the Prohibitions

All (that’s all) valuation is about future cashflow, not historical cashflow, and a valuation multiple\(^\text{13}\) that is based upon the risk of that future cashflow. Thus, a simple valuation formula would be Cashflow times Valuation Multiple equals Value. Importantly, valuation models typically assume that cashflow is perpetual.\(^\text{14}\) Thus, valuation of a health care entity relies upon risk-based assumptions as to what patients, procedures or tests will rely upon referrals from a physician or other patients, procedures or tests will rely upon referrals from a physician or other health care provider in some form.\(^\text{15}\)

The AKS precludes not only future referrals but also past referrals as a basis for determining fair market value. Presumably, these facts in and of themselves do not preclude a determination of a “fair market value” as modified by the Stark regulations and AKS. This is due to the fact that all fair market value assumes future cashflow from the entity; in health care, the entities typically rely upon referrals for the business that generate the cashflow. A too-literal reading of the AKS might cause one to conclude that health care entities could never have a fair market value.\(^\text{16}\)

Risk of Future Cash Flow

Valuators quantify the risk of cashflow by studying empirical data about expected returns on investments in publicly traded stocks\(^\text{17}\) and subjectively modifying those returns for the risk associated with investments in private entities. In general, public companies in the health care industry have lower risk and correspondingly lower rates of return than public companies in other industries. This is in large part because the health care industry does not experience the cyclical swings of other sectors of the economy: people are always getting ill and seeking treatment, and government programs cover many who could not otherwise afford care in a bad economy. For example, a public health care company with an expected return on equity of 10% would have a multiple (excluding growth, which is discussed below) per dollar of cashflow of 10x, 10 being the inverse of 10%.

One of the arguably counterintuitive facts about investment returns is that low risk investments have high valuation multiples while higher risk investments have low valuation multiples.\(^\text{18}\) As such, the valuator may mistakenly overstate the value of a private health care entity by underestimating the risk associated with that entity, or underestimate its value by overestimating the risk. The low risk associated with large public health care companies operating nationally often causes valuation consultants to underestimate the risk associated with small private entities operating in a single market, resulting in a valuation overstatement.

The Stark laws and AKS may therefore be implicated whether value is overstated or understated. For example, in a hospital purchase of a physician practice, underestimating the risk of future cashflow will overstate the value. To the extent that the resultant value exceeds fair market value, the excess could be considered a payment for future inpatient referrals or referrals to hospital-owned ancillary services. In a physician-hospital joint venture of an existing hospital outpatient surgery center, underestimating the value would result in the hospital receiving less than fair market value and may be deemed a prohibited payment by the hospital to physicians for future referrals. On the other hand, overestimating value may be deemed a payment from the physicians to the hospital for the right to participate in the profits resulting from the physicians’ future referrals. This illustrates how dramatic the impact of growth assumption can be on the value of a business.

In the valuation community, much of the potential inaccuracy in growth rates stems from a poor understanding of the impact of growth on value and of the limitations in the growth of per unit revenue under the current reimbursement system. For example, the Medicare Conversion Factor which represents the value per Relative Value Unit or RVU of services provided under Part B has increased less than .5% in the last 9 years; the compound rate of growth – which would be used to compare it to inflation, for example – is virtually zero, while annual inflation has been in the 3% range.\(^\text{19}\) What drives Part B revenue in general is utilization along with intensity of service as reflected in coding.\(^\text{20}\)

Components of Growth

In developing growth assumptions, the valuator would typically consider 1) the price per unit, 2) the expected number of units of service and 3) the cost of providing each of those units.\(^\text{15}\) In the Part B world, there is little or no growth in Medicare price per unit. In the broader economy, Bureau of Labor Statistics data on the Producer Price Index for physician services indicates less than 2% growth in the price per unit. For physician services, the Medicare Payment Advisory Commission (“MedPAC”) estimates an increase of 3.7% in the cost of providing services in 2007. Thus, there is little basis for the per unit growth component to result in an increase in cashflow.

continued on page 22
profit; in fact, given unit cost increases, a decline may be indicated.

Utilization or Number of Services

Increased utilization is a fact of health care delivery. This utilization is driven by more services per patient and technological advancements resulting in new services being provided to each patient. In valuing an imaging center, for example, it is clear that MR and CT utilization has been growing at 15% to 20% a year. This does not suggest, however, that an individual imaging center can sustain annual growth of that level. Further, even if such growth is reasonable for a few years, it is not reasonable for many years. Eventually, there are only so many hours per day and patient throughput will be maxed out. Finally, such rapid growth eventually brings action from the government and private insurers, as evidenced by the payment cuts in same day imaging of contiguous body parts implemented in 2006, or the recently announced reallocation of the work component of Relative Value Units under the Resource-Based Relative Value Scale.

Keep in mind that the more growth included in future revenues, the more growth is required in future expenses, as well as in capital outlays for new equipment. A significant component of high tech imaging growth has been the faster speeds and better image quality of new equipment. A facility which does not have such equipment cannot grow at the same rate as one that does. Purchasing such equipment is a cash outflow that will reduce the value derived from a valuation model, all other things being equal.

Intensity of Service

Increases in intensity of service as reflected in coding is similarly undeniable and should be reviewed by the valuator. For example, CMS data provided to MedPAC indicates a significant shift in the coding of established patient office visits with fewer level 2 visits and more level 4 visits. Level 4 visits pay more than twice as much as level 2 visits. Building coding creep into a valuation model raises, or should raise, serious regulatory questions because government payors and private insurers have identified overcoding as a problem and have implemented software-based audits to reign it in. However, there are few, if any, valuation experts with health care industry experience who also have the skills to perform chart review to determine if coding is properly documented and clinically appropriate. It is possible, however, to use the Medicare database of CPT codes billed and their allowed charges, readily available from the CMS website, to do a statistical analysis and assess the reasonableness of coding. It behooves valuators and attorneys to consider the impact of coding on the income stream of a physician practice, laboratory or imaging center. Situations of suspected overcoding may warrant chart review by an individual with the requisite training. Coding issues should be incorporated by the valuator into the measure of future cashflow.

The joint venture example described above points to one of the most difficult aspects of proscribed assumptions in valuation models: not considering the growth impact on future revenues and cashflows of having physicians participate in joint ventures. Joint ventures are desirable, of course, because of the alignment of the joint venture parties’ incentives and resultant clinical quality and improved economic performance. In the absence of this expectation, the joint venture would likely not take place; for a tax-exempt hospital, in the absence of such an expectation it might be prohibited under the inurement prohibitions to which such a hospital is subject. A successful joint venture, therefore, is likely to be more valuable and perhaps significantly more so than the operation that it replaces. Since the Stark regulations specifically require that fair market value not consider the impact of the parties being “in a position to generate business for the other party” valuation model assumptions must be based upon what would be expected to happen absent the joint venture.

Expense Growth Assumptions

In the real world, expenses associated with generating revenue consist of those that are 1) variable, i.e., they increase at the same rate of revenue; 2) fixed, e.g., rent, for a range of revenue volume and 3) semi-variable and grow at some fraction of the growth rate in revenue. Over time, however, total expenses tend to grow at the same rate as revenues because industries mature and have stable margins, and an entity cannot increase its charges by more than what its customers can increase their charges for products or services. This means that the profit margin available to an owner of a given business will be stable in perpetuity. A common valuation error is to forecast increasing profit margins for a period of, say, five years and fail to normalize or adjust that profit margin for the likelihood that the perpetual profit margin included in the valuation model will be stable.

Examples of Valuation Problem Areas: Market Methods

There are two principal methods under the Market Approach to valuation. One is to look at the price of public companies in the same line of business, see what multiples their stock prices sell at, and use the result to derive a multiple for the private company. This is known as the “Guideline Publicly Traded Company Method.” The other approach is to look at acquisitions of private companies in the same or
similar line of business, derive valuation multiples based on revenues, net income, cashflow, EBITDA\textsuperscript{28} and the like and apply those multiples to the same elements of the private company. This is known as the “Merged and Acquired Company Method” or “Direct Market Method.”

**Guideline Publicly Traded Company Method**

Perhaps the single greatest leap of faith in the application of this method is the “as if public” premise that underlies it. This valuation method has as a threshold assumption that the hypothetical investors of the fair market value standard would invest in the private company if it were, in fact, public. The origins of this method flow from Revenue Ruling 59-60, published by the IRS in 1959 at a time when the income methods in valuation were poorly developed and not well understood, particularly in the courts.

Another problem with this method is that there are very few “pure play” public companies—that is, with only a single line of business, such as a hospital—those are truly comparable to a private company in the same line of business. The determination of “comparable” is typically made by reference to Standard Industry Classification (“SIC”) codes. For example, there are eight public companies in SIC code 801, which is the code for physicians. The eight public companies include surgery center operators, a Medicare HMO/clinic, a fertility clinic operator, a laser company and a billing company. It is very difficult to think that any of these are “comparable” to a physician practice. Comparability is an issue with hospitals as well. For instance, HCA, a publicly traded hospital chain, also operates surgery centers, imaging centers and other businesses. HealthSouth, another publicly traded company, operates outpatient surgery centers and physical therapy, but not an identical range of services to HCA.

Of course, since private companies by definition are not public and do not have their stock readily bought and sold on a stock market, the valuator has to consider lack of marketability in determining the relevant valuation multiple or conclusion of value, as well as discounting the multiple for the smaller size of the private company, if applicable.\textsuperscript{29} Market multiples of private companies are less than those for public companies for the very same reason that was described above under the discussion of the income methods: risk.

**Direct Market Method**

There are a variety of criticisms of this method,\textsuperscript{30} but the need to enumerate those can be dispensed of by looking directly to the Phase 1 regulations under the Stark Laws cited above:

Usually the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition…

The common uses of the method can also be dispensed with by looking to the Internal Revenue Service (“IRS”) in its 1995 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, which states the following in a section entitled “Establishing Comparability under the Market Approach”:

Factors affecting comparability include markets served; practice and specialty type; competitive position; profitability; growth prospects; risk perceptions; financial composition (capital structure); physician compensation; physician age, health and reputation; physician productivity; average revenues per physician; cost structure; and average revenue per visit or covered life to revenue to revenue mix (capitated versus fee for service): with a reference or citation to Financial Valuation: Businesses and Business Interests.\textsuperscript{31}

The prospects for finding actual, current transactions in the same market area that correspond to the Stark definition or IRS requirements are indeed slim, as many transactions are not disclosed or contain insufficient detail. Even if one were to find a single transaction conforming to the requirements, one should be reminded that “the plural of anecdote is not data.”

With respect to larger transactions involving public companies which report to the Securities and Exchange Commission (“SEC”), there are several common approaches to obtaining ‘comparable’ transactions. One is to search the SEC filings of public companies, typically Form 8-K, for transactions that meet the reporting threshold. Another is to search the 10-Qs and 10-Ks for such data as a company may choose to disclose about its acquisitions. Public announcements and the limited data provided are also summarized in such publications as Irving Levin\textsuperscript{32} and Mergerstat,\textsuperscript{33} but they are often “deal” prices and do not represent cash-equivalent values as required by the fair market value standard. “Deal” prices frequently include unregistered stock that cannot be sold, debt instruments with below market interest that are not negotiable and earnouts, where the amount payable is uncertain. Earlier, fair market value was defined as “The price, expressed in terms of cash equivalents.” An element of consideration in a transaction that cannot be converted to cash at the transaction date is by definition not a cash-equivalent. The amount of data disclosed, unless pursuant to the 8-K requirements, is typically insufficient to conform to the IRS standard or to permit more than a rough benchmarking of the transaction.

All that being said, the method is implemented by taking the purported multiples derived from limited information. In the best of circumstances, one may find half to a dozen recent transactions in various areas of the country. Typically, only a few of the transactions have all of the data reported, such as the price paid as a percentage of revenue, the value of invested capital (equity and debt) to revenue, invested capital to earnings before interest, taxes, depreciation and continued on page 24
Identifying Appropriate Business Valuation Approaches under Stark and the AKS

continued from page 23

amortization ("EBITDA") and so on. The reason that the data is not available is that private companies do not typically make such data available to the public.

For example, if the acquisition target is a tax-exempt hospital that is a separate legal entity, the valuator may obtain data not reported in transaction summaries from such resources as Guidestar\(^34\) where Forms 990, which are public record, can be obtained. This requires significantly more work and often only the summary data is used in the valuation.

As an example, assume that the valuation analyst attempting to value a hospital for a transaction subject to regulatory scrutiny identifies five publicly reported transactions involving “comparable” acquisitions of hospitals. The EBITDA for each alleged comparable is obtained and the valuation multiples derived. The mean, median and percentiles for the EBITDA multiples are calculated.

<table>
<thead>
<tr>
<th>Transaction</th>
<th>EBITDA Multiple</th>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18.2</td>
<td>FL</td>
<td>6-04</td>
</tr>
<tr>
<td>2</td>
<td>3.5</td>
<td>TX</td>
<td>12-04</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>AR</td>
<td>3-05</td>
</tr>
<tr>
<td>4</td>
<td>5.0</td>
<td>TN</td>
<td>11-05</td>
</tr>
<tr>
<td>5</td>
<td>10.0</td>
<td>TX</td>
<td>3-06</td>
</tr>
<tr>
<td>Median</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>7.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What does the above transaction data reveal say or reveal about the value of a hospital with EBITDA of $1.0 million located in North Carolina? Does it tell a valuator that it could be worth the median value of $5 million or the average value of $7.5 million – the average being 50% greater than the median? Could it be worth $18.2 million? Given the Stark regulations requirement that comparable transactions be in a particular market at the time of acquisition, can any of these multiples be used?

Even without the dictates of the Stark regulations, at best, out of market transactions may provide the valuator with some insight into the reasonableness of a valuation result under the Income Approach described earlier. Different market areas of the country have very different payor dynamics. Most urban markets are dominated by a few health insurers who hold significant influence over the fees paid to providers.\(^35\) Medicaid reimbursement rates vary widely from state to state. A valuation multiple derived from a transaction involving a guideline company with a good payor mix in a state with high levels of reimbursement will be of only limited use in valuing a provider entity with poor reimbursement in a state with low levels of reimbursement, and then only after extensive analysis by the valuator. If only summary information is reported on the transaction, as is often the case, only very limited insight is possible.

If the acquirer is a public company, an important dynamic is in effect. Public companies’ stock prices or valuation multiples are heavily based upon their earnings growth. The higher the earnings growth, the higher the valuation multiple and the higher the value of the company. Thus, that growth needs to continue or the stock’s price will decline. There is an arbitrage effect when the earnings of private companies are placed in the public equity markets through acquisition that can enable a public company to afford a higher price than a private company, all other things being equal. Although fair market value in a given market area may be driven by the economics of public companies,\(^36\) the Stark requirement that comparable transactions be in a particular market at the time of acquisition addresses this if public companies are not active acquirers in a given market area.

Using the Stark regulations or IRS text as standards, there are sources of purported market data used to value healthcare entities that are deficient. The Goodwill Registry\(^37\) for medical practices is one example when the buyer is a hospital. The publication’s authors wisely state that it is to be used only as a benchmark but many times valuers will misuse it to actually determine value, rather than as a benchmark or reality check. The publication has entries representing purchases and sales of minority and control interests which are transactions,\(^38\) as well as marital court decisions and valuations which are not actual transactions. Users commonly cite the average “goodwill percentage” paid for a physician practice, with the average including transactions that took place as many as 20 or more years ago. For many specialties, there are but a few transactions, making the “data” anecdotal at best. Properly using this source for benchmarking requires a careful analysis of the entries in order to extract those that are relevant to the particular valuation.

The Goodwill Registry benchmark is most appropriate for physician-to-physician transactions. Using the Goodwill Registry to value a practice for purchase by a hospital would be a critical mistake as there would be no way of determining if the hospital was receiving an appropriate return on its investment without a disciplined application of the Income Approach\(^39\) described earlier. This is because an asset that has or will generate no cash flow has no value to the hypothetical buyer of the fair market value standard. An attorney advising a hospital client on the purchase of a physician practice should not rely upon a valuation not supported by the Income Approach.

Conclusion

The income approach offers the most realistic possibility of arriving at a conclusion that is appropriate for the regulatory environment in the health care industry.\(^40\) The knowledgeable
valuator or appraiser can incorporate the special circumstances often present for a particular transaction into the valuation model assumptions and select a valuation multiple that is appropriate for the degree of risk in the investment, absent any potential referrals between the parties. He or she can do so by excluding volume assumptions that reflect the parties' relationship, and by adjusting the valuation multiple to reflect the risk of future cashflow, assuming that the parties are NOT in a position to refer. Market methods pose significant risk as the details of a particular transaction in a database or public record are rarely known; without such details, the appraiser cannot assess the appropriateness of the assumptions utilized by the transacting parties. The special restrictions on the use of market data contained in the Stark regulations further complicate the market approach's use.

Valuation is an increasingly critical component of the various transactions among health care entities and referring providers. The Stark regulations make it clear that even a "proper" valuation “does not establish the ultimate issue of the accuracy of the valuation figure itself.”

Certainly, a valuation prepared by someone without the requisite knowledge of the regulatory framework offers even less protection for the parties to a particular transaction. The result of a bad method can be liability under the AKS, False Claims Act, or Stark, and Administrative Sanctions such as exclusion from the Medicare Program. Attorneys would do well to assist their clients in selecting appraisers and valuation consultants who understand the regulatory parameters of “fair market value” in the health care industry.

Mark O. Dietrich of Dietrich & Wilson, PC, holds a Masters of Science Degree in Taxation, an MBA with high honors, and a BSBA (Accounting), summa cum laude, Beta Gamma Sigma. He is a member of the AICPA and the Massachusetts Society of CPAs. He holds the ABV (Accredited in Business Valuation) designation from the AICPA. His web address, www.cpa.net, is the leader in medical practice valuation information.


Mr. Dietrich co-authors PPC’s Guide to Healthcare Consulting and is contributing author to Shannon Pratt’s The Lawyers’ Business Valuation Handbook (published by the American Bar Association) and to Valuing Professional Practices and Licenses, A Guide for the Matrimonial Practitioner (published by Aspen). He is also on the Editorial Board of the AICPA’s CPA Expert and a frequent presenter at the AICPA National Valuation and Health Care Industry Conferences. In addition to his health care industry expertise, Mr. Dietrich is considered an expert in the area of personal and enterprise goodwill and noncompete agreements.

Mr. Dietrich is an experienced negotiator, with numerous contract and merger and acquisition transactions to his credit, including such diverse transactions as managed care contracts and a sale of an Internet technology company to a Fortune 50, with values from under $1.0 million to in excess of $100 million. He has performed more than 150 valuations and testified as an expert witness in divorce, civil litigation and qui tam proceedings. He can be reached at 508-877-1999 or dietrich@cpa.net.

Reed Tinsley is a Houston-based CPA, Certified Valuation Analyst, and health care consultant. He works closely with physicians, medical groups, and other health care entities with managed care contracting issues, operational management, strategic planning, and growth strategies. His entire practice is concentrated in the health care industry. He can be reached at 281-379-5988 or reedt@rtacpa.com.

Endnotes
1 See, e.g., OIG Advisory Opinion No. 03-12.
2 International Glossary of Business Valuation Terms.
3 International Glossary of Business Valuation Terms.
4 420 CFR 411.351.
7 See, e.g, Internal Revenue Codes section 1060 and 197; Personal Goodwill: Who "Owns" it and How Much is it Worth? Massachusetts Society of CPAs Sam News, Summer 2006, Mark O. Dietrich, CPA/ABV.
8 See, e.g., Financial Valuation: Applications and Models, James Hatchner, Editor.
9 This appears to be an example where attorneys drafting regulations were unfamiliar with how a valuation model would measure the value of a particular employment contract or practice sales agreement provision.
11 Or, for example, the magnitude of the selling price in a sale transaction.
12 Computing damages to the hospital as a result of the physician violating an enforceable noncompete would, however, likely consider the lost referrals. A damages analysis is different than a fair market value determination.
13 The multiplier applied to some measure of cash flow used to determine value.
15 Although certain self-referrals may not be proscribed, such as for radiologists or certain personally performed services.
16 There have been such suggestions, e.g., in the Thornton Letter to the AHA Deputy Counsel back in the early 1990s, with respect to physician practice goodwill.

continued on page 26
Identifying Appropriate Business Valuation Approaches under Stark and the AKS

continued from page 25

17 See, e.g., the annual Stocks, Bonds, Bills and Inflation Yearbook published by Ibbotson Associates.

18 This is basic finance and economics: Investors expect to be compensated for risk, thus, the higher the risk, the greater the expected return per dollar invested. If a $100 investment has a 5% or $50 annual return forever, the valuation multiple is 20: 20 times $50 = 1000. If that investment were more risky and had a 10% or $100 return which is twice as high, the multiple would decline to 10. Thus, the lower the risk of the investment, the higher the value associated with a given cash flow from that investment and the higher the risk, the lower the value.


23 June 29, 2006 Federal Register, CMS-1512-PN.


26 420 CFR 411.351.

27 See, e.g., Preparing Financial Models AICPA BVFLS Practice Aid 06-2.

28 Earnings Before Interest, Taxes, Depreciation & Amortization, a commonly used proxy for cashflow and profitability to which valuation multiples are applied to estimate the value of an entity.

29 Stocks, Bonds, Bills and Inflation Yearbook ibid.


33 An Internet database of nonprofit organizations http://www.guidestar.org/.


35 See, e.g., The Bogatin Law Firm, PLC


37 A publication of the consulting firm The Health Care Group which contains various entries involving the values of physician practices http://www.healthcaregroup.com.

38 There are specific issues in valuing control versus minority interests that are beyond the scope of this article.

39 Particularly with respect to the physician compensation used in the valuation model.


The Editorial Board provides expertise in specialized areas covered by the Section. Individual Board members were appointed by the Interest Group Chairs and Editor Marla Durben Hirsch. If you are interested in submitting an article to the magazine, you may contact one of the Editorial Board members or Ms. Hirsch. With the establishment of the Editorial Board, the Section strengthens its commitment to provide the highest quality analysis of topics in a timely manner.

Marla Durben Hirsch
Potomac, Maryland
301/299-6155
mdhirsch@comcast.net

Michael E. Clark
Hamel Bowers & Clark, LLP
Houston, TX
Publications Chair
713/869-0577
mclark@hbctrial.com

Charles M. Key
The Bogatin Law Firm, PLC
Memphis, TN
Managed Care & Insurance
Editorial Board Chair
901/474-6129
ckey@bogatin.com

John Blum
Loyola University Law School
Chicago, IL
Health Care Facility Operations
312/915-7175
jblum@wpo.it.luc.edu

Howard D. Bye
Cox Smith Matthews, Inc.
San Antonio, TX
Employee Benefits & Executive Compensation
210/554-5435
hbye@coxsmith.com

Jason W. Hancock
Hospital Corporation of America
Nashville, TN
Young Lawyer Division
615/344-5412
jason.hancock@hcakhealthcare.com

Michael A. Clark
Sidley Austin Brown & Wood
Chicago, IL
Tax & Accounting
312/853-2173
mclark@sidley.com

Marcelo N. Corpuz III
Michael Best & Friedrich LLP
Milwaukee, WI
Transactional & Business Health Care
414/225-2744
mncorpuz@michaelbest.com

Lisa Dahm
Houston, TX
Health Care Litigation & Risk Management
713/859-6114
ldahm@earthlink.net

Sharon M. Erwin
Law Offices of Sharon M. Erwin, L.L.C.
Philadelphia, PA
eHealth, Privacy & Security
215/438-8813
erwin@erwinlegal.com

C. Elizabeth O’Keeffe
Presenius Medical Care
Lexington, MA
Public Health & Policy
781/402-9000
elizabeth.o.keeffe@fmc-ma.com

Kathleen Scully-Hayes
Office of Hearings
Dept. of Health & Human Services
Baltimore, MD
Payment & Reimbursement
410/786-2055
kscullyhayes@cms.gov

Lois Snyder
Center for Ethics & Professionalism
American College of Physicians
Philadelphia, PA
Medical Research, Biotechnology & Clinical Ethical Issues
215/351-2835
lsnyder@mail.acponline.org

Bethany Spielman
Dept. of Medical Humanities
Southern Illinois University
School of Medicine
Springfield, IL
Medical Research, Biotechnology & Clinical Ethical Issues
217/782-4261
bspielman@sumed.edu

Andrew B. Wachler
Wachler & Associates
Royal Oak, MI
Health Care Fraud & Compliance
248/544-0888
awachler@wachler.com

The Health Lawyer Volume 19, Number 2, December 2006