

## **Identifying Appropriate Business Valuation Approaches under Stark and the AKS**

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### **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 healthcare 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.<sup>1</sup> 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<sup>2</sup>*

“The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.”<sup>3</sup> [This is the definition generally accepted in the valuation community.]

#### *Stark II, Phases 1 and 2*

“Fair market value means the value in arm’s-length transactions consistent with general

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<sup>1</sup> See, e.g., OIG Advisory Opinion No. 03-12

<sup>2</sup> International Glossary of Business Valuation Terms

<sup>3</sup> International Glossary of Business Valuation Terms

market value. ‘General market value’ means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party; or the compensation that would be included in a service agreement as a result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party on the date of acquisition or at the time of the service agreement. 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, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement.”<sup>4</sup> *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.*”<sup>5</sup> *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.<sup>6</sup> 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 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

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<sup>4</sup> 420 CFR 411.351

<sup>5</sup> 69 Fed. Reg. 16053

<sup>6</sup> See, e.g., *Valuing a Business, The Analysis and Appraisal of Closely Held Companies* Shannon Pratt, Robert Reilly & Robert Schweihs,

purposes.<sup>7</sup>).

### *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 noncompete<sup>8</sup> 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.*<sup>9</sup>

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.<sup>10</sup> Among a host of factors, the level of compensation paid to that covenantor as an employee<sup>11</sup> 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.<sup>12</sup>

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

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<sup>7</sup> 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 *Sum News*, Summer 2006, Mark O. Dietrich, CPA/ABV

<sup>8</sup> See, e.g., *Financial Valuation: Applications and Models*, James Hitchner, Editor.

<sup>9</sup> 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.

<sup>10</sup> See, e.g., *Financial Valuation* *ibid*, Identifying and Measuring Personal Goodwill in a Professional Practice, Mark O. Dietrich, CPA/ABV, *CPA Expert*, Spring and Summer, 2005

<sup>11</sup> Or, for example, the magnitude of the selling price in a sale transaction.

<sup>12</sup> 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.

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 noncompetition 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 valuers 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*<sup>13</sup> 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*.<sup>14</sup> Thus, valuation of a health care entity relies upon risk-based assumptions as to what patients, procedures or tests will occur in the future as of the valuation date. All of these patients, procedures or tests will rely upon referrals from a physician or other health care provider in some

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<sup>13</sup> The multiplier applied to some measure of cash flow used to determine value.

<sup>14</sup> See, e.g., *Valuing a Business, The Analysis and Appraisal of Closely Held Company* and the discussion of the Gordon Growth Model.

form.<sup>15</sup> 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 healthcare entities could never have a fair market value.<sup>16</sup>

### Risk of Future Cash Flow

Valuators quantify the risk of cashflow by studying **empirical** data about expected returns on investments in publicly traded stocks<sup>17</sup> 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 healthcare 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 healthcare 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 counter-intuitive facts about investment returns is that low risk investments have high valuation multiples while higher risk investments have low valuation multiples.<sup>18</sup> 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

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<sup>15</sup> Although certain self-referrals may not be proscribed, such as for radiologists or certain personally performed services.

<sup>16</sup> 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.

<sup>17</sup> See, e.g., the annual *Stocks, Bonds, Bills and Inflation Yearbook* published by Ibbotson Associates.

<sup>18</sup> 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 \$1000 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.

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.

### Growth Rates

Perhaps the greatest risk of overestimating value and implicating Stark or the AKS stems from improper or unrealistic assumptions as to future growth in cashflow or profits. Assume that the public company above with the expected return on equity of 10% had an expected long-term growth rate in cash flow to equity of 5%. The valuation multiple per dollar of cashflow would now be 20x, 20 being the inverse of 5%, which is the 10% return on equity less the 5% expected growth. 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.<sup>19</sup> What drives Part B revenue in general is utilization along with intensity of service as reflected in coding.<sup>20</sup>

### 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.<sup>21</sup> 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 cash 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<sup>22</sup> 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.

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<sup>19</sup> See, e.g., the Federal Reserve Bank of Philadelphia website at <http://www.phil.frb.org/econ/spf/index.html>

<sup>20</sup> See, e.g., CMS annual letter to MedPAC, April 7, 2006; MEDPAC Report to Congress, 2004, 2005, 2006

<sup>21</sup> See, e.g., Medical Practices: A BV RX (peer-reviewed), *Journal of Accountancy* November 2005, Mark O. Dietrich, CPA/ABV

<sup>22</sup> See, e.g., MEDPAC Report to Congress, 2003, 2004, 2005, 2006

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<sup>23</sup> 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<sup>24</sup> 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 valuers and attorneys to consider the impact of coding on the income stream of a physician practice, laboratory or imaging center.<sup>25</sup> Situations of suspected overcoding may warrant chart review by an individual with the requisite training. Coding issues and 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

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<sup>23</sup> June 29, 2006 Federal Register, CMS-1512-PN

<sup>24</sup> See, e.g., CMS annual letter to MedPAC, April 7, 2006

<sup>25</sup> Critical Condition: A Coding Analysis for a Physician Practice Valuation; Frank Cohen, CMPA & Mark O. Dietrich, CPA/ABV, *CPA Expert*, Fall 2006

consider the impact of the parties being “in a position to generate business for the other party”<sup>26</sup> 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) those that are fixed, e.g., rent, for a range of revenue volume and 3) those that are semi-variable and grow at some fraction of the growth rate in revenue.<sup>27</sup> 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<sup>28</sup> 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 physical therapy --that 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

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<sup>26</sup> 420 CFR 411.351

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

<sup>28</sup> **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.

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.<sup>29</sup> 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,<sup>30</sup> 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 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*.<sup>31</sup>

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 the detail of a transaction is insufficient. 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.”

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<sup>29</sup> *Stocks, Bonds, Bills and Inflation Yearbook* ibid

<sup>30</sup> See, e.g., [The Direct Market Data Method: Common Errors in Application and a Closer Look at the Transaction Databases](#), Nancy Fannon, ASA, MCBA, CPA/ABV, Heidi Walker, CPA/ABV, *Business Valuation Alert*, September, 2003

<sup>31</sup> *1995 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook*

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<sup>32</sup> and Mergerstat,<sup>33</sup> 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 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<sup>34</sup> 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.

Transaction	EBITDA Multiple	Location	Date
1	18.2	Florida	6-04
2	3.5	Texas	12-04
3	.8	Arkansas	3-05
4	5.0	Tennessee	11-05

<sup>32</sup> <http://www.levinassociates.com/publications/markethealthcare.htm>

<sup>33</sup> <http://www.mergerstat.com/new/store.asp#2002review>

<sup>34</sup> An Internet database of nonprofit organizations <http://www.guidestar.org/>

5	10.0	Texas	3-06
<b>Median</b>	<b>5.0</b>		
<b>Mean</b>	<b>7.5</b>		

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.<sup>35</sup> 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,<sup>36</sup> 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*<sup>37</sup> 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.

<sup>35</sup> See, e.g., Government Accounting Office *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*

<sup>36</sup> See, e.g., Understanding the Difference between Strategic and Fair Market Value in Consolidating Industries, *Business Valuation Review*, May 2002, Mark O. Dietrich, CPA/ABV

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

The publication has entries representing purchases and sales of minority and control interests which are transactions,<sup>38</sup> 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<sup>39</sup> 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 healthcare industry.<sup>40</sup> 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 and 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.”<sup>41</sup> 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

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<sup>38</sup> There are specific issues in valuing control versus minority interests that are beyond the scope of this article

<sup>39</sup> Particularly with respect to the physician compensation used in the valuation model.

<sup>40</sup> See, e.g., *Medical Practices: A BV RX* (peer-reviewed), *Journal of Accountancy* November 2005, Mark O. Dietrich, CPA/ABV; *Zeroing In On The Value Drivers In Healthcare*; Shannon Pratt’s *Business Valuation Update*, January & February, 2006 Don Barbo, CPA/ABV, Carol Carden, CPA/ABV, Mark O. Dietrich, CPA/ABV

<sup>41</sup> 69 Fed. Reg. 16053

Claims Act, Stark, or Administrative Sanctions such as exclusion from the Medicare Program Attorneys do well to assist their clients in selecting appraisers and valuation consultants who understand the regulatory parameters of “fair market value” in the healthcare industry.