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FEATURE STORY

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10 myths of healthcare business valuation

Common misconceptions about business valuations can sabotage hospital-physician deals.

People who negotiate business deals have something in common with high-performance athletes: Both are propelled by the desire to "Just do it!" Just as an athlete in the heat of competition and with the end in sight is undeterred by any obstacle, a negotiator seeking to close a deal can feel strongly motivated to cut to the chase and establish a value.

This comparison is apt because making a business deal, such as purchasing a physician practice, requires intense determination, and it can bring a good measure of excitement and satisfaction. But there is an important difference. For the athlete, the end and the obstacles are both clear. Not so for the negotiator. In deal negotiations, particularly in health care, common myths about business valuations can pose hidden obstacles to success.

In any business deal, the core question is, "What is it worth?" The temptation to speculate and even to perform a rudimentary "back of the envelope" analysis can be strong. But it is important to understand the risks associated with rough estimates before committing to the results. Those risks are magnified in the healthcare industry due to tight regulation, the symbiotic and often contentious relationship between physicians and hospitals, and constantly evolving technology.

Given the profound complexities of health care, an indiscriminate acceptance of the common misperceptions about business valuation can increase the likelihood of errors in deal structures, lost time, and weakened relationships between physicians and the healthcare organization. Indeed, when those relationships involve *key* physicians, the consequences of an inadequate valuation analysis can be extremely costly.

Healthcare organizations can avoid such pitfalls if they understand the most common of the myths associated with business valuation and why operating under these misconceptions can ultimately undermine a deal's success.

AT A GLANCE

> Acceptance of common myths regarding business valuations can undermine a hospital's efforts to successfully negotiate deals with physicians.
> Hospitals need to clearly understand the nature of fair market value (FMV), the use of multiples, the "guideline company technique," whether the FMV can be based on acute care revenue stream, the physician compensation model used in the valuation, and the applicability of the physician's historical production level.
> Other matters that warrant careful consideration include whether to tax effect, whether to pay for goodwill, and whether obsolescence can be accounted for in the valuation.

Myth #1

Fair market value (FMV) is a nebulous concept that hospitals always use to gain the upper hand in negotiations with physicians.

Mention the term *fair market value* during negotiations with a physician and you might well observe a certain look appear on the physician's face. That look says: "Here it comes. This is where I get taken by the hospital." But that look tells you only that the physician doesn't really understand the exact meaning of the term and the regulations that govern a hospital's use of FMV.

Physicians need to understand that, when properly executed, an FMV analysis provides *everyone* with the valuation conclusion needed to pursue a given transaction.

What is needed is education. Physicians need to understand that, when properly executed, an FMV analysis provides *everyone* with the valuation conclusion needed to pursue a given transaction, and that the process itself provides a more thorough understanding of the business involved and of the proposed transaction. Physicians are likely to be more accepting of the use of FMV if they understand the basic federal regulatory requirements—the federal Stark, anti-kickback, and private inurement issues—and similar legislation at the state level.

Myth #2

Multiples always represent a reasonable approach to valuation.

The use of multiples—whether earnings multiples, revenue multiples, or some other multiple applied to the subject's financial production—is part of what is referred to as the *comparable transaction technique*. A comparable transaction multiple involves simply applying a multiple (3x, 4x, etc.) to some element of the subject's financial production. A common example is the multiple of earnings before interest, taxes, depreciation, and amortization (EBITDA). When properly executed, the application of an EBITDA multiple produces an estimate of total assets value.

This technique typically forms the basis of the *market approach* to business valuation in closely held entities. The rationale for this approach is expressed in the question "What better measure of the price is there than the price that would be paid by a hypothetical, willing, uncompelled, knowledgeable, prudent buyer to a seller fitting the same description?" After all, shouldn't "market value" bear some resemblance to how the "market" actually values something?

In theory, this reasoning makes perfect sense. But the approach is almost impossible to execute properly because of significant practical limitations. Accurate, timely, and complete data are rarely available from "comparable transactions." Typically a physician practice, surgery center, imaging center, or radiation oncology center is owned by a privately held entity. There is no effective and reliable means of retrieving the full details of a "comparable transaction." Often we get only aggregate dollar figures, sometimes at second or third hand—even through the rumor mill. Without knowing the specific details about the terms and structure of the "comparable transaction," the EBITDA multiple derived from that transaction can be misleading or incorrect.

Myth #3

The guideline company technique is a meaningful approach to valuing a closely held surgery center, imaging center, or similar healthcare business.

Valuation consultants sometimes apply the *guideline company technique* to the valuation of a closely held business such as a surgery or imaging center. The guideline company technique is similar to the comparable transaction technique in that it involves the application of a multiple to the subject's earnings. In the case of the guideline company technique, however, that multiple is based on adjusted publicly traded equity data. Because guideline companies, by definition, are publicly traded, the information can be reasonably

regarded as accurate, complete, and timely. Unfortunately, the comparability of such companies with the typical closely held surgery center or imaging center is highly questionable.

Publicly traded guideline companies in the surgery center or imaging center or most other ancillary provider business make their money in a variety of ways, with the most significant revenue stream usually derived from management fees. Management fees are a revenue stream with little risk and little resemblance to the general business associated with the typical surgery, imaging, or other ancillary provider center. A guideline company in the surgery center business also may be a poor choice as the basis of a closely held surgery center valuation because the guideline company may enjoy many benefits in corporate and administrative efficiency, managed care contracting, capital access, and vendor pricing that are not available to a typical surgery center operation.

Although arguably one could adjust for the differences between the guideline company and the closely held subject of a valuation, it would require rare expertise to make such adjustments accurately and appropriately.

Myth #4

An acute care revenue stream can serve as the basis for FMV.

To understand the fallacy of this myth, one must first recognize that an FMV conclusion must be based on the consideration of a transaction between knowledgeable, willing, uncompelled buyers and sellers. The common approach is to view the transaction from the perspective of the "hypothetical buyer" who possesses all of these characteristics.

The definition and characteristics of this hypothetical buyer vary according to the type of organization being valued. For example, when a hospital outpatient department (HOPD) is being valued, the hypothetical buyer should have the ability to bill as an HOPD, and therefore perpetuate the hospital's revenue stream. In this instance, to use an acute care revenue stream as the basis for FMV, the hypothetical buyer would also have to possess an acute care license. How many likely buyers in the universe of potential buyers would both be able to bill as an HOPD and have an acute care license that could be applied to the operation of the HOPD in question? The likely answer is none.

If the hypothetical buyer does not have an acute care license, how does one value the HOPD revenue stream? The possibilities are numerous, as are the ultimate billing structures. In any case, the subject revenue stream will probably need to be repriced to reflect the revenue that could be generated by the most likely hypothetical buyer.

Myth #5

Whatever physician compensation model was employed in the fair market valuation is irrelevant subsequent to the purchase transaction.

Consider the following scenario: You have completed the purchase of a physician practice and intend to employ the physician who sold the practice. Now you want the physician's compensation package to reflect the physician's role as a key contributor to your overall integration strategy. The practice valuation was completed under an FMV standard, and compensation levels were developed after considering specialty productivity levels and regional compensation trends and norms.

Is it a problem that the practice's negotiated physician compensation will bear little resemblance to that employed in the valuation?

In short, yes. When compensation is increased after a valuation, the buyer's ability to realize the full value of the price paid for those assets decreases. That erosion of value occurs not because some external risk factor has materialized, but because management has consciously deviated from the business plan employed in the valuation. Such an approach puts the entire transaction at regulatory risk.

One sure way to falsely estimate the value of things is to neglect the issue of taxes.

The same principle also applies to other types of transactions. With imaging centers, radiation oncology centers, or any potential acquisitions in which the professional services are to be paid in accordance with the terms of some form of professional services agreement (PSA), the post-transaction professional services compensation must bear a relationship to that employed in the fair market valuation that supported the purchase transaction.

The implications are clearly significant. It is critical that the hospital as purchaser work closely with the valuation consultant regarding the physician or professional compensation model employed in the valuation.

Myth #6

The historical productivity level of a physician selling his or her practice should serve as the unadjusted basis for the FMV.

This myth is particularly likely to trip up a hospital that is negotiating with a physician who generates an impressive top line relative to his or her patient volume. In this situation, the valuation consultants may make a downward adjustment in the revenue basis associated with the physician's patient volume. The consultants would do this if, when comparing the physician's billing profile with a database of others in the same specialty, they were to find that he or she routinely employs higher-paying codes than are considered typical of the specialty.

Although implying that there may be a problem with upcoding will probably infuriate the physician and jeopardize the deal, the consultants' adjustment would be correct. The FMV standard requires them to look at business operations from the perspective of the hypothetical buyer. In practice acquisitions, the hypothetical buyer is typically another physician of the same specialty. Because that physician should have more typical billing patterns, a review of the coding patterns that generate the revenue stream is proper, as is any subsequent adjustment needed to account for material deviations.

Any such adjustments should be brought to the attention of the physician involved as soon as the issue is identified, and an agreeable resolution negotiated. Otherwise, at the end of the process, the seller will be confronted with both the upcoding issue and a lower-than-expected valuation conclusion—results hardly conducive to a positive outcome.

Myth #7

There is no need to tax effect.

To tax effect or not to tax effect? That question haunts those who perform fair market valuation analyses for pass-through entities (e.g., LLCs, LPs, S-Corporations) and not-for-profit/tax-exempt entities. Tax effecting involves the recognition of income taxes as a reduction to the ultimate cash flow that a hypothetical buyer would derive from the purchased assets or equity.

The arguments are always the same: "The hospital doesn't pay taxes on its earnings. Why should my earnings stream be tax effected when the hospital (as buyer) won't pay taxes?" and "The entity is an LLC. Taxes are paid at the shareholder (member) level. Why tax effect the LLC earnings when it won't pay taxes?"

The short answer was supplied long ago by none other than Ben Franklin when he said, "In this world, nothing is certain but death and taxes." It is noteworthy, and humbling, that Ben Franklin also said that "the great part of the miseries of mankind is brought upon them by false estimates they have made of the value of things." One sure way to falsely estimate the value of things is to neglect the issue of taxes.

So when does one tax effect, and why? And more specifically, why should an income stream be

tax-effected when the buyer is a not-for-profit entity?

The answer lies once again in the definition of the hypothetical buyer. If one can successfully argue that the entire universe of hypothetical buyers is dominated by not-for-profit, tax-exempt entities, then it would make sense to forgo the tax-effecting exercise. However, one can rarely sustain such an argument—indeed, there is usually a high likelihood that the hypothetical buyer would be a taxable entity. And given this likelihood, under an FMV standard, the income stream is tax-effected in the income approach analysis even if the buyer in question is tax-exempt.

If one does tax effect, how should it be done?

The answer here boils down to whether the tax advantages of an entity create additional value. If so, questions need to be asked regarding what is being valued: assets or equity. If equity, the central question is whether what is being valued is a majority or minority interest.

Ultimately, before one can determine how the earnings stream should be tax effected, one needs first to consider the familiar old question: What does the hypothetical buyer look like?

It is beyond the scope of this article to answer these questions. Suffice it to say that under an FMV standard, the most accepted approach (and the one that is most consistent with IRS guidelines) is to tax effect in accordance with the tax position of the most likely hypothetical buyer, whether that be an individual or a C-corporation, and to treat pass-through entities as individuals for tax-effecting purposes. In essence, the tax advantages afforded to a pass-through entity are given little, if any, recognition in a fair market valuation.

Myth #8

Always get the valuation done as early as possible in the deal structuring process.

Sometimes it feels like discussion with the physician group has gone on for years. Everyone wants to move forward with the fair market valuation and get the deal rolling, even though there might be holes in the structure and the agreements.

Unfortunately, unresolved issues can pose serious pitfalls. What will happen, for example, when a radiation oncology business is redirected to a newly formed joint venture. Will it really be possible to secure the needed managed care contracts? And what about radiation oncologist support? Will the medical oncologists, urologists, and neurosurgeons really change their referral patterns?

And, as another example, consider the questions that need to be addressed with a surgery center joint venture. Have the physicians adequately addressed the impact of the revised Medicare ASC payment system? Are they prepared for the follow-through actions of other payers? Does the venture contain sufficient fall-back measures? Will the orthopedists continue to go along with the other specialties, or will they separate and build their own?

There also are many general questions that must be addressed in any case: What, exactly, is to be valued? Will there be a noncompete agreement? If the hospital's or health system's name is to be applied to the venture, is there or should there be any value associated with that arrangement, and if so, how much should that be?

If these questions are not addressed before the valuation, they will be brought up for the first time during the valuation process. That can kill the deal—as well as the physician relationship. If the valuation consultant understands this concern and has played a role in resolving similar issues in real-life situations, awkward and deal-killing situations can be avoided.

Myth #9

Not paying for goodwill means it doesn't really exist.

Many health systems have a policy of not paying for goodwill. That's understandable. Measuring intangible asset value is fraught with difficulty.

Although many physicians claim ignorance regarding the concept of FMV, the concept and value of goodwill is one thing they do understand. And more often than not, they want to be paid for it.

Convincing the board to pay for intangibles is even more difficult. Explaining to the physicians why payment for goodwill differs from one practice to the next is nearly impossible. The relationship between goodwill and potential anti-kickback predicaments is simply too close for comfort. And purchasing goodwill, the valuation of which implicitly ties the hospital to a compensation level going forward, is too confining.

As understandable and appropriate as these reasons for not paying for goodwill might be, the fact remains that in many businesses, goodwill is an asset that has measurable value. Although many physicians claim ignorance regarding the concept of FMV, the concept and value of goodwill is one thing they do understand. And more often than not, they want to be paid for it.

So what do you do when there is a corporate policy prohibiting the purchase of goodwill, but the key physician in the community insists that you pay for it? The answer may lie in exploring the inclusion of other assets in the purchase. Is there room to consider the value of a noncompete arrangement? Although not necessarily the same as goodwill, such an arrangement would arguably be a necessary precursor to paying for goodwill.

Can the practice in question be carved up into professional and technical businesses? This type of division sets the stage for greater flexibility in terms of structuring a transaction. Perhaps the hospital can simply purchase the technical side and leave the professional side to the physician, thereby achieving the ultimate goal of integration without the hassle of practice acquisition.

There are numerous tools and possibilities that can enhance the policy of not paying for goodwill and improve the organization's ability to effectuate meaningful integration and the transactions that facilitate it. The key is in understanding the assets that comprise the business in question and in having the ability to structure transactions around those assets.

Myth #10

We cannot account for obsolescence in a business valuation.

The pace of technological evolution magnifies the valuation challenge. How do you develop a capital budget for a capital-intensive healthcare business in the face of technological evolution?

Thirty-five years ago, who could have anticipated the emergence of computed tomography (CT) and magnetic resonance imaging (MRI)? These dramatic advances in diagnostic capability represent a modality shift that virtually eliminated the practice of exploratory surgery, shifting considerable business from general surgeons to radiologists.

Other emerging technologies represent modality expansions, having spawned completely new sources of business. Examples include gamma and cyber knife technologies that provide the oncologist and neurologist with a means to treat formerly untreatable tumors.

Then there are the emerging technologies that remain speculative in terms of their eventual impact. Virtual colonoscopy and CT angiography are two advances based upon CT technology that may represent either considerable business opportunities or hazardous blunders. Everyone agrees that the technology is a marvel, but it

remains to be seen whether it is simply technology for technology's sake or true advancement.

Often, the technological advancements are more subtle. Each new MRI magnet and CT machine represents the next generation of existing technology. And each time an imaging center installs the next generation equipment, it gains an advantage over the local competitor that has yet to upgrade. This kind of technological "one-upmanship" may be the most commonly seen consequence of technological evolution.

The point is not so much that technology evolves, but that the constantly changing technological landscape presents a variety of risk factors. The first challenge to valuation is in identifying the nature of the risk factor at hand. Are we facing a modality shift or a true expansion of business? Will it be something different altogether that can be either an opportunity or bust? Or will it be simple technological "keeping up with the Joneses" to maintain market share?

There is no simple answer to these questions. In circumstances where the predominant issue is maintenance of technological parity, the approach is relatively simple. The focus is on determining the reasonably required annual future capital expenditures (whether they be capital reserves or other expenditures such as capital or operating lease payments). An analysis of historical expenditure levels coupled with research regarding anticipated growth in equipment prices can serve as the basis to address this type of capital issue.

Addressing more speculative capital planning issues is far more difficult. It starts with a determination of the type of risk most threatening to the valuation subject. For example, in a valuation of a gastrointestinal endoscopy lab, the question would be, "How much should the valuation be affected by the potential modality shift from endoscopy to virtual colonoscopy?" Addressing this question requires an exercise in risk measurement, considering, for example, the degree to which the subject revenue stream relies on colonoscopy, whether providers of virtual colonoscopy are emerging in the market area, and to what degree local payers accept virtual colonoscopy.

The results of this risk measurement exercise should be factored into an analysis of various scenarios measuring potential valuation conclusion impacts. These impacts then become the subject of probability analysis with the ultimate goal being a reasonable risk factor to include in a discount and/or capitalization rate.

Clearly, addressing the potential risk associated with modality shift and expansion and speculative technologies becomes somewhat speculative in itself. But just as clearly, it is a mistake not to address these risks. A well-conceived and implemented analysis will provide a reasonable measurement of the risk and impact to the valuation conclusion.

Reaching to the Heights

Just like the high-performance athlete, you can recognize an effective deal negotiator by his or her degree of determination to succeed, and desire to achieve that success with dispatch. If you have done your homework, and understand the nuances of one of the most critical, and subtle, elements of the deal—the business valuation—you may well find that each deal you negotiate with physicians will feel less like an endurance test, and more like an exhilarating accomplishment. ●

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