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BUILDING VALUE

A Business Valuation Newsletter for Business Owners and the Professionals Who Advise Them

Trending Topics in Healthcare Valuation

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The healthcare industry is large, with many different subsectors that have unique risk profiles. Varying forms of consolidation transactions dominate many subsectors at present, with valuation multiples that differ considerably. I'll take a look at some of these trends in the material that follows.

AFFORDABLE CARE ACT (ACA OR OBAMACARE)

One thing is certain about the ACA: you cannot believe much of anything you read in the mainstream press about it, outside of the *Wall Street Journal*. Claims and counter-claims for coverage expansion, healthcare cost reduction, and low premiums abound. Truth is, there is no uniform national experience from the ACA's insurance changes. The peculiar way in which federal government subsidies to buy insurance are pegged to the second-lowest cost silver plan ("second silver," which covers 70 percent of the underlying policy's benefits, leaving the consumer to pay 30 percent) has focused insurer price competition there. Consumers may be obligated to change insurers annually to stay at the level of the second silver plan in order to maintain their subsidy. The pricing of many plans also includes very high deductibles, often $5,000 or more, meaning that most care is paid out of pocket unless a serious illness or injury occurs. As a result, the level of bad debt has increased for many healthcare providers.

Broad regulatory waivers granted hospitals and physicians under the ACA have spurred a consolidation trend. Hospitals continue to buy practices and in many cases move the ancillary services or even the practices themselves into the hospital or hospital campus to take advantage of so-called provider-based billing. Simply explained, this results in the hospital getting an additional facility fee, significantly in excess of the fee the free-standing physician practice received before the acquisition. Readers can think of it in the same fashion as a visit to the emergency room, where one almost always gets a bill from the hospital and another from the physician. A common valuation mistake is to value the physician practice and ancillaries on the basis of the increased fee the hospital will receive. This violates the Stark Law's anti-referral prohibition and for a tax-exempt hospital, the 501(c)(3) anti-inurement rules. Back-door attempts to build this difference into other transaction compensation is also problematic.

IMAGING

Imaging is capital intensive; full-service imaging centers require many millions of dollars of investment, including leaseholds. The nearly

decade-long attack on the fees paid physician office-based imaging by the Medicare program – often adopted by private payors as well – has led to a business increasingly focused on higher volumes to exceed breakeven levels. The ACA actually increased the volume or utilization assumption for high-tech imaging (MRI, CT, PET) to 90 percent; in contrast, in 2005, the utilization assumption was only 50 percent. This caused a dramatic cut in the payment rate under the Resource-Based Relative Value Scale because the number of Relative Value Units (RVUs) allowed to recover practice expenses declined as the volume assumption increased.

For imaging centers with low variable costs and high fixed costs, profits are made at the margin. Thus, imaging centers close or may be purchased by a stronger competitor, who then closes the weak center and moves the volume to his or her own center. This can create some challenging valuation scenarios in which the appraiser has to distinguish between strategic and fair market value. The fundamental question for the appraiser is whether the buyer would pay any of its discounted/capitalized marginal profit to a weak seller under a standard of fair market value. Valuations of low-volume centers often default to adjusted book value of equipment or even a liquidation scenario.

Mergers are also common, with imaging providers seeking to gain negotiating advantage with payors, or at least limit the number of centers in order to increase volume and profitability at a single center.

The standard practice for imaging valuation requires a distinct revenue forecast for each separate modality: MRI, CT, mammography, ultrasound, nuclear medicine, radiography, fluoroscopy, PET, and DEXA (bone densitometry). Each of these modalities has a distinct volume and RVU trend, so developing revenue assumptions at a higher level does not result in reliable projections.

PHYSICIAN PRACTICES

Primary care continues to rule the roost in terms of positive fee increases, patient volumes, and acquisition attractiveness. At the same time, finding value under the fair market value standard is problematic because the acquirer usually has no positive future cash flows after the payment of physician compensation. In many urban markets, primary care physicians who join a larger hospital/physician network may experience significant current income gains (as opposed to sale proceeds) because the payment rates for their services will be greater. This includes both fee-for-service payments as well as incentive payments for meeting clinical quality standards. Appraisers need to be familiar with local market conditions when evaluating practice value or compensation value.

COST APPROACH

In the valuation industry, a debate continues over sidestepping the return on investment requirement inherent in the income approach and income tax law by using the cost approach. This debate was front and center at NACVA's Advanced Healthcare Valuation and Consulting Symposium in San Diego this past December. As a debate participant and opponent of sole use of the cost approach, I found no takers among the attendees for any of the following scenarios:

- I make $2 million a year in my practice.[1] I will sell it to you for $3 million (one year's billings) and I will continue to work in it for 10 years and collect all the income generated by the practice. No synergies exist.

- A bank CD with a stated value of $5,000 that pays no interest and reverts to the bank at maturity.

- A physician practice will generate no distributable income to the buyer and has no future market or resale value, but the value of $1 million is supported by a cogent application of the cost to replicate less economic obsolescence method.

Separately, Timothy Smith, CPA/ABV, also speaking in opposition to sole use of the cost approach, challenged the assumptions of assembled workforce value commonly used in cost-based valuations, including the recent AICPA White Paper. Tim worked for many years at Hospital Corporation of America before entering appraisal practice and demonstrated that the commonly employed benchmarks of 30 percent to 40 percent of one year's pay for "trained" physicians was unlikely to pass a smell test. His approach, based on experience, was simple: given a full-time physician's annual hours of 2,040, 600 (30 percent) to 800 (40 percent) hours of training to enable a licensed physician to practice medicine seems unrealistic.

For non-physician staff not subject to employment contracts and non-competes, I emphasized that paying the physicians who own the practice for those employees was likely to be considerably less effective than offering the same employees a signing bonus – if any payment were required at all in the current economy.

REASONABLE COMPENSATION

The Internal Revenue Code has taken a backseat to the Stark Law and Anti-Kickback statute in healthcare valuation, but appraisers may not ignore it. I believe the lack of familiarity of many with the tax laws explains the failure to account for them. Reasonable compensation is evaluated under the Independent Investor Test estab-

lished in *Exacto Springs*[2] that requires the separation of the return on labor from the return on equity or ownership. The recent tax court and appellate court case *Mulcahy*[3] involving a CPA firm debunked use of the well-known Rosenberg Survey to establish fair market compensation for CPAs because of its failure to separate return on labor from return on ownership. The commonly used MGMA Survey of Physician Compensation suffers from exactly the same shortcoming.

Padding practice valuation shortfalls with extra compensation payments is likely to fail the tests outlined in the Tax Court's earlier *Derby*[4] decision. Although many appraisers fail to see it, *terms* do, in fact, *make the deal*, as well as the valuation conclusion. Deal terms define exactly what the hypothetical buyer and seller are transacting. In the world of transaction valuation, there is no "hypothetical" transaction to value, unlike estate valuation, divorce valuation, or similar exercises.

COMMERCIAL REASONABLENESS

The Stark regulations' requirement that transactions be "commercially reasonable" has made healthcare valuation a practice area fraught with risk. Commercial reasonableness is a legal concept with a financial overlay. Few people seem to have an idea of the derivation of the term. While the term appears in the Uniform Commercial Code, where it is defined as follows, it has long been a feature of both common law and case law:

> **9-627. Determination of Whether Conduct was Commercially Reasonable**
>
> (a) [Greater amount obtainable under other circumstances; no preclusion of commercial reasonableness.]
> The fact that a greater amount could have been obtained by a collection, enforcement, disposition, or acceptance at a different time or in a different method from that selected by the secured party is not of itself sufficient to preclude the secured party from establishing that the collection, enforcement, disposition, or acceptance was made in a commercially reasonable manner.
>
> (b) [Dispositions that are commercially reasonable.]
> A disposition of collateral is made in a commercially reasonable manner if the disposition is made:
> (1) in the usual manner on any recognized market;
> (2) at the price current in any recognized market at the time of the disposition; or
> (3) otherwise in conformity with reasonable commercial practices among dealers in the type of property that was the subject of the disposition.

The Stark regulations state the following:

> We intend to accept any method that is commercially reasonable and provides us with evidence that the compensation is comparable to what is ordinarily paid for an item or service in the location at issue, by parties in arm's-length transactions who are not in a position to refer to one another. Depending on the circumstances, the 'volume or value' restriction will preclude reliance on comparables that involve entities and physicians in a position to refer or generate business. (Stark II, Phase II, FR Vol. 66, No. 3, p. 944)
>
> [Commercially reasonable is] An arrangement which appears to be 'a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.'[5]

The financial implications of the phrase "even in the absence of any potential referrals" are paramount. Not surprisingly, the issue commonly arises in situations where there is no expected return on investment and therefore no value under the income approach, so the cost approach is solely relied upon. Simply stated, the commercial reasonableness issue is why would the acquiring hospital pay for the practice if there is no cash flow? The obvious answer, it seems, is for the proscribed value of the referrals.

FUTURE

A number of healthcare appraisal experts, including myself, Gregory Anderson, CPA/ABV, the aforementioned Tim Smith, and Laura Pfeiffenberger of Meyers, Harrison and Pia, have been drilling into the physician compensation survey data as well as dramatic payment rate differences in local markets for physician services. The bottom line is that if your local market insurers are paying, say, $32 per physician-work RVU for compensation and benefits, it is unlikely that fair market value for that physician's work can be equal to the MGMA national median of ~$50 per work RVU for direct compensation. Stay tuned!

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[1] I wish! I spend too much time writing and speaking.
[2] http://caselaw.findlaw.com/us-7th-circuit/1082767.html
[3] http://www.ustaxcourt.gov/inophistoric/mulcahy.tcm.wpd.pdf
[4] http://www.ustaxcourt.gov/InOpHistoric/derby2.TCM.WPD.pdf
[5] 63 Fed. Reg. 1700 (Jan. 9, 1998).

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FEATURED CASE

ESTATE OF NATALE GIUSTINA

CITATION:
Estate of Natale B. Giustina, Deceased, c/o Laraway Michael Giustina, Executor, Petitioner - Appellant, v.
Commissioner of Internal Revenue, Respondent – Appellee

Docket No. 12-71747 Tax Ct. Docket No. 10983-09. Appeal from a Decision of the United States Tax Court
Argued and Submitted March 5, 2014. Portland, Oregon. Submission Withdrawn March 6, 2014. Resubmitted December 1, 2014.

OVERVIEW

As requested by the taxpayer, the Ninth Circuit evaluated the following decisions in the Tax Court's *Estate of Giustina v. Commissioner*, T.C. Memo 2011-141, ruling:

- weight assigned to the cost approach in the final reconciliation of valuation methods,
- appropriateness of tax-affecting income in a pass-through-tax entity ("PTE"),
- choice of a 25% discount for lack of marketability ("DLOM"), and
- adjustment to the discount rate for the company-specific risk premium.

DISCUSSION

Disagreeing with the Tax Court's ruling, the taxpayer's estate ("Estate") appealed the decision to the Ninth Circuit Court of Appeals.

While the Tax Court recognized that the owner of the subject limited partner interest could not unilaterally force liquidation, it used the following hypothetical assumptions to assume that interest could form a two-thirds voting block with other limited partners to do so: (1) a hypothetical buyer would somehow obtain admission as a limited partner from the general partners, who repeatedly emphasized the importance that they place upon continued operations of the partnership; (2) the buyer would then turn around and seek dissolution of the partnership or removal of the general partners who just approved his admission to the partnership; and (3) the buyer would manage to convince at least two other limited partners to go along, despite the fact that no limited partner ever asked or ever discussed the sale of an interest. Alternatively, existing limited partners, or their heirs or assigns, owning two-thirds of the partnership, would have to consent to dissolution.

Citing the following court cases, the Circuit Court determined the Tax Court was in clear error to assign a 25% weight to the cost approach conclusion, based on hypothetical assumptions.

- In *Estate of Simplot v. Commissioner,* 249 F.3d 1191 (9th Cir. 2001), the Tax Court engaged in "imaginary scenarios as to who a purchaser might be, how long the purchaser would be willing to wait without any return on his investment, and what combinations the purchaser might be able to effect."
- In *Olson v. United States*, 292 U.S. 246, 257 (1934) the Appeals court said, "elements affecting value that depend on events or combinations of occurrences which, while within the realm of possibility, are not fairly shown to be reasonably probably, should be excluded from consideration."

Considering other factors in the determination of value, the Circuit Court determined there was no clear error in adopting a pretax rather than post tax methodology.

Also, the Circuit Court decided there was no clear error in the 25% DLOM, especially since the Estate's expert acknowledged that such discounts range between 25% and 35%.

Conversely, the Tax Court clearly erred by failing to adequately explain its basis for cutting the Estate's company-specific risk premium in half. Furthermore, the Tax Court did not consider the taxpayer wealth needed to adequately mitigate risk through diversification of owned assets.

CONCLUSION

The Ninth Circuit concluded the Tax Court erred by:

- Assigning weight to an asset-based valuation method using hypothetical assumptions contrary to the evidence in the record.
- Reducing the company-specific risk premium without an adequate explanation.

However, the Appeals Court upheld the Tax Court's ruling on the following issues:

- Not tax affecting income.
- Accepting a discount for lack of marketability of 25%.

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