

Choosing and Using the Right Valuation Methods for Physician Practices

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The Market in 2008-09

The volume of activity in healthcare industry transactions has certainly recovered from the late 1990s when the failure of the MedPartners/Phycor merger marked the end of that period of consolidation. One of the notable differences between today's market and that of the 1990s is that there is recognition in most quarters of the need to carefully tie physician compensation to the forecast used to value the practice. Another is that physician compensation is typically linked to productivity and not fixed, the latter practice having led to low patient volumes and large operating losses. These changes were re-emphasized in the 2008 Tax Court case *Derby*, cited in numerous places herein.

The consensus today, including that of many of the contributors to this Guide, is that future physician compensation is typically a more significant element of a transaction than is the value of the practice. In many circumstances, hospitals and Integrated Delivery Systems have superior contracts with insurers that in turn permit physicians to receive better compensation for the same amount of work. Over the course of 5 or more years, compensation is typically more valuable than sales proceeds to a physician, given the range of valuation multiples. Readers should note that it is not appropriate to value the practice using the buyer's better insurer contracts as that is inconsistent with fair market value.

As a final observation, practices with intensive investment in ancillaries are likely to be more valuable all things being equal. Given the Stark laws restrictions or prohibition on post-transaction compensation with respect to the technical component of ancillary services in different employment and independent contractor settings, there is not the usual tradeoff between future compensation and current value.

Introduction

Simply stated, valuation models require two major components: future cashflows and a discount or capitalization rate. All valuation results are a function of the interaction between these two factors. Once the valuation analyst has gained a sufficient knowledge of the marketplace, regulatory environment and the subject practice as described elsewhere in this Guide, the actual measuring of value can begin.

Other Chapters to review in this *Guide*:

1. Critical Condition: A Coding Analysis for a Physician Practice Valuation¹
2. The Anti-Kickback Statute and Stark Law: Avoiding Valuation of Referrals
3. Understanding Healthcare Markets
4. Tax-Exempt Healthcare Organization Valuation Issues Related to Excess Benefits, Private Inurement, and Intermediate Sanctions
5. The CPA's Role in Mergers and Acquisitions: Due Diligence Assistance to PPMC's and Private Equity Firms

Many experienced valuation analysts new to healthcare will be familiar and (perhaps) more comfortable with the Guideline Publicly Traded Company (Guideline) method or the Market Approach based upon databases such as those maintained by the IBA or *Pratt's Stats*TM. When considering the Merged and Acquired Company method, bear in mind that the historical data available regarding the "acquisition" of practices via management services agreements with Physician Practice Management Companies (PPMCs), is generally not relevant.² A PPMC transaction is fundamentally different from an outright purchase of the practice and therefore should not be used for such a valuation without various adjustments, including those to cash-equivalent consideration and compensation. Finally, my experience is that physicians focus on cash returns in the form of additional compensation when they buy practices and regulators expect hospitals to focus on cash returns from within the practice.

This chapter is organized with a discussion of rules of thumb presented first, in the expectation that someone new to medical practice valuation will benefit from a frame of reference when studying the actual methods. Bear in mind such rules are not methods and merely provide an oft-suspect means of a reality check.

A presentation of a discounted cashflow valuation is beyond the scope of the Chapter but considerable detail about the differences in DCFs for physician practices is provided. A discussion of the build-up method for determining discount and capitalization rates then follows.

The chapter explains in detail the use of the excess earnings method and the capitalization of cashflows (CCF). The focus of this Chapter is on asset purchases, not stock purchases, since the vast majority of physician practice transactions, aside from buy-ins, are assets only.

The excess earnings method is presented in its traditional physician-to-physician transaction approaches, using *pre-tax* excess earnings and a discount and capitalization rate applicable to *pre-tax* earnings for a hypothetical physician buyer.

Insight and Analysis

A notable aspect of valuing a physician practice is the need to get into the detail behind operating expenses for normalization purposes in order to identify discretionary expenses available to the owner of the practice in lieu of taking taxable compensation. A General Ledger is a basic element of a Data Request—like it or not! Prior to commencing the actual quantitative valuation analysis, I review in detail the normalized operating results and compare them to statistical norms from the Medical Group Management Association or other sources.³ You need to ask “How would the practice look if operated by the typical buyer or seller?” Bear in mind that the hypothetical buyer of a physician practice is interested primarily in what the cash return of the practice will be, not what anecdotal or “market” data says the practice might be bought or sold for.

For perhaps the best analysis of the general limitations of market data in valuation see Business Valuation Resources The Comprehensive Guide to the Use and Application of the Transaction Databases by Nancy Fannon, CPA/ABV and Heidi Walker, CPA/ABV.

Alleged Comparative Practice Sales Method

Medical practices, like most businesses, have rules of thumb for valuation. These are commonly expressed as a percentage of the practice’s receipts. The most common source of such information is *The Goodwill Registry*, published annually by The Health Care Group of Plymouth Meeting, Pennsylvania. This consulting firm’s figures are cited in such trade publications as *Medical Economics* and *Physicians Management* widely read by physicians. The *Registry* contains information on practice sales, valuations, and divorce settlements accumulated by The Health Care Group from its own activities, as well as others who submit data to it. The data is usually (and abusedly) cited as an average percentage of revenues ostensibly paid for “Goodwill.”

Insight and Analysis

It is a commonplace principle of research in the scientific community that “The plural of anecdote is not data.” Valuation analysts do well to remember this when using rules of thumb.

Rules of Thumb and Market Date: Understanding Comparatives

A comparative is only as useful as the underlying analysis of the subject practice. For example, if you decide to purchase a four-bedroom home, you cannot go to a Realtor’s office and get a standard price for a home. The price will vary with numerous factors, such as the age of the house, the size of the rooms, the number of bathrooms, the quality of the kitchen, the size of the lot, and so on. A medical practice is no different. It is not possible to value any practice by taking a percentage of its receipts. Further, just because Practice A is valued at 60% of receipts, it does not mean that Practice B is worth 60%. It may be worth 10%—or nothing.

Insight and Analysis

These “rules” originate from physician-to-physician transactions and have always been of limited use in a market area in which physician practice management companies operate or for purchases by hospitals or integrated delivery systems; in the latter circumstance, serious regulatory issues are raised from such use. In addition, during the buying frenzy of the mid-1990s, the market value (as reflected by actual transactions) often exceeded these levels. Like any rules of thumb, they need to be considered within the context of market conditions at the time a valuation is performed. I do not endorse use of such “Rules” as valuation methods and caution against their use even as reality checks, especially where regulatory factors govern.

Use of the Goodwill Registry to Determine Intangible Value

If one were to accept the premise that the *Goodwill Registry* constitutes a valid source of market data on the intangible value of medical practices, it is necessary to understand precisely what that “valuation method” includes.

The *Goodwill Registry* contains the following definition of “Goodwill:”

As we see it, professional practice “goodwill” is a combination of practice intangibles varying, on a case by case basis, as to existence and value. That combination might include location, use of a practice’s or an *individual’s name*, patient information (embodied in the clinical record), a favorable leasehold, a *covenant not to compete*, *compensation for past (or future) management and entrepreneurial services*, *payments made for referral to an associate or recommendation of a successor*, patient lists, credit records, patient care and or employee contracts, as well as assignments of future income. (*Emphasis added to identify those items denoting personal goodwill rather than practice goodwill and therefore not divisible property.*)⁴

Thus, the reported values in the *Goodwill Registry* clearly *include*, for example, nondivisible personal goodwill via a noncompete, which is relevant in many jurisdictions for marital dissolution purposes. The entries also include **control** and **noncontrol** transactions, valuations which did not result in a transaction and final divorce settlements, which are Court decisions, not transactions. In order for “market data” to be valid, it must represent actual transactions.

Valuation Community Professional Standards

Besides my own views of the limitations of Rules of Thumb, the broad valuation profession holds a similar view. A Rule of Thumb is a means of estimating what a transaction value might be, using a “deal” price rather than cash-equivalents. Valuation analysts use Rules of Thumb to gauge or reality check the results of valuation methods under the three approaches to valuation. Rules of Thumb are widely disparaged as valuation *methods* in the professional literature:

Formula values are not substitutes for careful consideration of other appropriate valuation methods that are applicable to the business being appraised.⁵

Sometimes called ‘rules of thumb,’ the industry method can prove to be a valuable tool but should *never* be relied upon by itself for the valuation of an appraisal subject. ... If enough transactions take place using a particular method, the end result is that *there is market data that will support the use of that method*. However, if these formulas are the only methods used, *an inappropriate valuation may result.*⁶ (*Emphasis added*)

Rule of Thumb—a mathematical relationship between or among variables based on experience, observation, *hearsay*, or a combination of these, usually applicable to a specific industry.⁷ (*Emphasis added*)

More importantly, Rules of Thumb do not represent *cash-equivalent values*, which is a key requirement of the definition of fair market value. Cash-equivalent value might well include proceeds attributable to a *stock* sale, not an *asset* sale. Rules of Thumb represent the value of assets, not stock. There is a substantial difference between valuing the *stock* of an entity, which is sometimes the relevant task such as in marital dissolution, and valuing the *assets*. The purchaser of *assets* obtains *tax benefits* consisting of 1) the basis step-up in fixed assets (e.g., equipment and furniture) and the resultant additional depreciation deduction and 2) the basis attributable to intangible assets and the resultant amortization deduction (IRC §197 allows the purchase price of intangibles to be written off over 15 years generating substantial tax savings). Rules of thumb are “deal” prices representing the “value” of assets.

There is no data provided in the Goodwill Registry to determine whether or not the values reflected are cash-equivalent values, a necessary prerequisite for its use in determining fair market value.

Levin Associates' Health Care Acquisition Report

One source used widely during the consolidation era of the 1990s for "market" data was Irving Levin Associate's *Health Care Acquisition Report*. This Report includes the location of the acquired practice, a brief description, the "price" paid (which may or may not represent cash-equivalent value, a prerequisite for fair market value), a brief summary of deal terms, the number of "units" (physicians) acquired, price paid divided by revenue and price paid divided by "income" are the data points available; few are actually reported since the information is not publicly available. This Report led to the questionable practice of valuing physicians based upon the number working for the acquired practice—something akin to the method during the Stock Market Bubble of valuing software companies with large accumulated deficits based on the number of engineers and programmers.

Pratt's Stats™⁸

Pratt's Stats™, perhaps the most comprehensive and justifiably highly-regarded of the databases, has data entry points for state, city, firm and individual submitting the report of the transaction, 14 Income Statement items, 13 balance sheet items, actual transaction data based upon equity, market value of invested capital, allocation to noncompete agreement and other assets and dozens of yes or no questions about the transaction as well as ratios computed from the core financial data. Often, however, not all of the data is submitted for each transaction and there are very few medical practices. Regionalization is also critical to assessing the usefulness of this market data. For example, in November 2004, nearly 90% of 96 items identified as general dentistry were from three states: Pennsylvania, Arizona and Oregon. 50 of the entries were submitted by one brokerage firm and 20 by another. As the investigations of Wall Street investment bankers indicates, a few individuals' views of the market value of a business can distort the picture. Even broadly held views of market value, such as those that preceded the bursting of the Stock Market Bubble in March 2000, can be based upon a *lack* of "reasonable knowledge of relevant facts."

A closer look at regional economics and the market data presents an even greater challenge. Managed care and limitations on services and pricing are most prevalent in urban areas, where population density and employers make attractive insurance markets. Rural areas have less managed care and fewer patients per square mile. The profitability of a practice per unit of service is likely to be better in areas with less managed care. For example, an analysis of mean physician salaries from the Medical Group Management Association (MGMA) *Physician Compensation and Production Survey* for 2004 indicates that incomes were greatest for 69 of the 108 specialties in the sample in the Southern Region, where population density is lowest. The greater incomes are a function of several factors, including lower managed care, higher unit fees and lower operating costs. This greatly limits the common use of "goodwill percentage" averages paid for all practices of a particular specialty from the *Goodwill Registry*. Valuation is, after all, a function of cashflow from profit not cashflow from revenue!

Guideline Publicly Traded Companies

With very rare exception, a physician practice should not be valued based upon public company multiples. It is very difficult indeed to find a public company, even in SIC 801, which is comparable to a physician practice. Pediatric Medical Group, Inc. (NYSE: PDX) and IntegraMed America, Inc. (NASDAQ: INMD) could be relevant in limited circumstances depending upon the nature of the transaction.

Insight and Analysis

Always look at the underlying components of any SIC data to be certain you understand what the companies actually do. The result is often amazing.

Current Recruiting Data

Data on annual recruiting engagements from such firms as Merritt Hawkins⁹ and Delta Medical indicates that the specialties in highest demand include internists, family medicine, orthopedic surgery, gastroenterology, dermatology, interventional and general radiology, and interventional cardiology. Hospitals or existing practices looking to recruit physicians typically find the starting salary very high and the structure of a future buy-in on the table from the

outset. It is not uncommon for a well-informed physician exiting residency to base his or her employment decision on competing buy-in opportunities—and the lower the better. For example, orthopedic surgeons are often looking for practices with Ambulatory Surgery Centers, which offer significantly enhanced incomes and better working conditions, and the buy-in opportunity has to be affordable.

Recruiting data is another application of the Market Approach in that it represents Market Data on physician income. Income is what the investor in a physician practice is buying. There is a substantive question of whether a hypothetical buyer will pay for an asset that generates less income to that buyer than a position as a noninvestor employee. Thus, it is important to compare the earnings available from the practice being valued to that offered in the recruiting market.

A serious shortage of physicians and particularly primary care (generalist) physicians is expected in the next several decades. This has negative implications for practice value as new suppliers ease of entry to the market is enhanced when there is unmet, excess demand for services.¹⁰

The ratio of physician to population varies quite significantly from state to state and from urban to suburban and rural areas. Medicare-participating physicians by specialty and region can be found in the publication *2007 CMS Statistics*.¹¹ This in turn affects the value of practices as well as the incomes available in recruitment settings.

Value of Transactions in another Market Area

There are regional differences in what sellers will pay for physician practices, much of which are or were driven by the presence or lack of presence of for-profit buyers, as well as such items as the enforceability of noncompetes and enhanced income opportunities. These factors along with the Stark regulations' requirement that data in a "particular market" be used for determining fair market value make the data for one region of questionable relevance to another in the absence of appropriate correlation. What should drive price differentials from market to market are differences in the availability of cash profits and ease of entry of competitors.

Insight and Analysis

For those circumstances in which government regulations such as the Stark laws or the Anti-Kickback Statute (AKS) are implicated, regionalized market data is further suspect. In recognition of the seeming abuses—intentional or unintentional—of market data, the Stark II regulations specifically define "fair market value" as "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"¹² (emphasis added).

During the period of the 1990's consolidation, the vast majority of purchases were in the South and Southwest, although the available market data was widely used in all regions. The Stark II regulations create a critical limitation on market data when the valuation is being undertaken for regulatory purposes, unless the valuation analyst can demonstrate that data from one region or state is somehow relevant to another.

The *IRS Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook for 1995*¹³ 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)" citing *Financial Valuation: Businesses and Business Interests*. I know of no database with such information!

Empirical Study of Healthcare Markets

My article "Healthcare Market Structure and Its Implication for Valuation of Privately Held Provider Entities: An Empirical Analysis" was published in the Summer 2008 *Business Valuation Review*. The idea for that article came from a Government Accounting Office study of market share of health insurers in various states and my experience that pricing and profit differed significantly across the country. I reasoned that this Insurer Market Share and related Market Power would be one key element defining a Market and set out to find out how it and other factors contributed. This, in turn, would define Comparability for purposes of the Market Approach to valuation.

Here is a summary of my findings as to the key elements defining a Market:

1. Total Medicare spending and Medicare spending per capita,
2. The presence and market strength of Blue Cross plans,
3. The degree of market strength of local nonprofit hospitals versus for-profit hospitals,
4. The degree of market strength of local nonprofit health insurers versus for-profit health insurers,
5. Certificate of Need laws, and
6. Other local demographic and economic factors.

These factors contribute to the fact that most (certainly not all) larger for-profit healthcare providers are primarily located in Florida, Texas, California and Tennessee. They also confirm the underlying rationale for the Stark Laws restrictions on the use of out of market data as "comparable." The "Checklist of Factors to Consider when Evaluating the Significance of Out-of-Market Transactions" included in this *Guide* provides a means for undertaking this analysis as well as links to websites where the underlying data is located.

As I observed with my friend Reed Tinsley in a 2006 article for the American Bar Association's Health Law Section

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.¹⁴ Although fair market value in a given market area may be driven by the economics of public companies, 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.¹⁵

Other common Pitfalls in the Market Approach

Valuation analysts frequently prefer the market approach to valuing a business. As a colleague observed "Appraisers are market observers not market makers."¹⁶ Courts tend to understand easily that if businesses of a certain type sell for 3 times earnings, then a given business is likely worth three times earnings. Valuation analysts tend to be comfortable for the same reason; there is less judgment¹⁷ in the market approach than in the income approach, if a good database of transactions for a type of business exists.

Medical practices present a unique challenge for proper use of the market approach. As we will see in the analysis that follows, the market data often does not contain sufficient data to determine precisely what the multiples in a given transaction were.

Example

Assume that a representative transaction in a database contains the following information:

Date of Transaction: July 1, 1997

Type of Practice: Ophthalmology

Subject Revenues: 1,000,000

Owner compensation: 450,000

Earnings after taxes: 2,000

Purchase Price: 540,000

Debts assumed: -0-

Working Capital Included: Yes

Multiples:

Owner's Discretionary Comp: 1.20

Revenues: .54

What does this tell us about the value of this practice, or about the practice we are trying to value today? Painfully little, unfortunately.

Analysis

1997 represented the last "big year" of buying by the PPMC industry, which collapsed and died following the failed merger between MedPartners and Phycor at the end of that year. We do not know if the above transaction was a purchase by a PPMC, but it is likely that it was, since very few other transactions in medical practices were disclosed.¹⁸

PPMC's purchased practices based upon a multiple of earnings contracted to the PPMC. The contracted earnings typically were 15% to 20% of the earnings of the physician. In the above sample transaction, the purchase price of 540,000 could have been based upon a multiple applied to an earnings stream between 67,500 (15% of 450,000) and 90,000 (20% of 450,000). As such, the correct valuation multiple to be garnered from this transaction could be as little as 6.0 (540,000 divided by 90,000) or as much as 8.0 (540,000 divided by 67,500). Generally, such multiples ranged between 4.0 and 7.0, but we cannot tell what the multiple was from the transaction. The purchase price included working capital, intangibles and fixed assets. The illustrated multiples of 1.20 times Owner's Discretionary cashflow and .54 of revenues are not meaningful if this is a PPMC transaction. The PPMC was not buying 100% of the physician's earnings, nor was it buying the revenues—it was buying a portion of the practice's earnings before physician compensation.

If this was a physician to physician transaction, of course, the valuation multiples would be more meaningful. One clue that this is *NOT* a physician to physician transaction, however, is that accounts receivable were included—that is rarely the case in physician to physician deal, while it was normally the case in a PPMC transaction. This, of course, is critical to the valuation analyst attempting to use the data to develop a market conclusion of value.

Particular problems for hospital buyers

It is critical from a regulatory standpoint that the hospital receives an accurately determined fair market value for the practice. Using "market" data from the 1990s which includes a class of buyers (PPMCs) no longer present for most physicians, even if normally reasonable to general business valuation analysts, is a serious mistake from a regulatory standpoint. Besides the problems with using such data outlined above, equally important is the fact that the market conditions today are no longer what they were in 1990s.

Use of the *Goodwill Registry* "rule of thumb" based on a percentage of collected revenues is risky from a regulatory standpoint.

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 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.¹⁹

When confronted with this type of valuation engagement, a valuation analyst can also consider a *replication cost* approach, looking at such intangible assets as workforce-in-place and going concern value, in addition to fixed assets such as equipment and furniture. At a minimum, one might think, the practice should be worth the cost to a physician buying it of establishing a similar practice, including the quantification of the reduced revenue during the start-up period. Nonetheless, there is a substantive question for a Hospital as to whether replication cost is appropriate because a hypothetical investor will likely not invest in something which lacks cash return.

The key question, of course, is whether or not the hypothetical buyer of the fair market value standard would incur a value based upon replication cost if there was no return on the investment. Most experienced healthcare appraisers would likely answer no in the absence of some additional mitigating factors. It is worth noting that, at least in this author's view, a hospital employing a physician post-transaction should evaluate the practice value differently than a physician buying a practice from another physician, where the seller retires or otherwise ceases to practice in the service area.

Tax-exempt hospitals generally are subject to a standard of providing community benefit for the costs they expend. Thus, one potential mitigating factor in utilizing replication cost would be where the acquiring hospital met the community benefit standard. This might occur where the service area of the target physician was underserved and/or the physician serving that area planned to leave for a better opportunity.²⁰

Note should be taken as well of any contractual relationships between the hospital and the physician in the proposed transaction documents, including a covenant not to compete held by the hospital, and any guaranteed rights under an employment contract held by the physician. Valuing such contractual rights can be an important part of a proper fair market value determination when a transaction is being consummated or unwound. This was a critical issue in *Derby v. Commissioner*²¹ which involved valuation issues associated with the donation of the intangible value of a medical practice to a tax-exempt Hospital.²²

Conclusion

Old market data in particular is only relevant if the market conditions today are the same as when the comparable transaction took place. We cannot sell 100 shares of a NASDAQ market index future today for the same price that we would have gotten in March of 2000. Similarly, we cannot sell a physician practice today for a market multiple, or even to the same class of buyers, as we could have during the period 1990 through 1997. Care needs to be taken to understand the market conditions and terms when using databases of market transactions.

Understanding Physician Practice Discount and Capitalization Rates

Insight and Analysis

What is a Discount Rate? One of the most difficult concepts to grasp in valuation is the relationship between stock market returns and discount rates for businesses. A discount rate is the percentage of cash return an investor expects to receive for an investment of given risk. In the stock market—from where we derive discount rates used in all valuation engagements—the cash return consists of dividends plus capital appreciation on the stock. In a medical practice, the return consists of enhanced compensation and perhaps dividends, if the practice is an S Corporation or LLC, or if the entity is an Ambulatory Surgery Center or Imaging Center. There *may* also be capital appreciation at the time the practice is sold, although most physicians realize the bulk of the net present value of their investment through annual earnings, not from a business sale. When a business distributes all or most of its cash profits, it tends to have a lower rate of appreciation than a business which reinvests its cash.

The terms discount rate, expected rate of return and cost of equity²³ all mean the same thing. It is important to note that the *actual* return in a given year is not likely to be equal to the *expected* return—that is what risk is all about! Over a long period of time, for investments in physician practices with the same risk profile, the actual return should equal the expected return—much the same way that stocks go up and down and have good years and bad years, but are known to outperform bonds and money market funds over the long haul.

A capitalization rate is obtained, of course, by subtracting the expected long-term (perpetual) growth rate in net cashflows from the discount rate. Growth rates are discussed in detail below.

Practice Risk Premium: Being Objective with the Subjective?

The actual unsystematic risk premium— RP_u —or the medical practice premium will depend upon whether your build-up method approach uses 1) the microcap premium or 2) the 10th decile premium. For example, a significant amount of the unsystematic risk of a physician practice is accounted for in the 10th decile premium, considering that the healthcare industry is *less* risky than the broad market (S&P 500) from which the equity risk premium for large companies is derived. This can be seen by examining the industry risk premium data for healthcare companies contained in the Valuation Edition of the Morningstar Yearbook, bearing in mind that excessive reliance on the Industry