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Weaver Insights: Health Care Valuation

2021 Year in Review

February 2022

Introduction

This collection of articles offers a chance to read and reflect on Weaver's health care valuation insights from 2021. As professionals who work with health care stakeholders across the industry, we look forward to navigating the future with you.

By the end of December 2021, health care services transaction volume was brisk, as buyers and sellers adjusted to increasing clarity around the effects of the pandemic on the businesses of the target and the synergies with the buyer. While immediate concerns about capital gains tax increases abated, ongoing financial pressure on certain health care segments and independent physician groups led to a new wave of consolidation and new affiliations driven by health systems, payers, and private equity.

In 2022 and beyond, we expect health systems and private equity-backed platforms to continue consolidating to achieve more scale, and to re-invest in digital technology and alternate sites of care. Health care segments negatively affected by the pandemic will likely stabilize in the long run. These are likely to benefit from natural demand growth driven by aging demographics, increased demand for underserved segments such as mental health, and a favorable regulatory and reimbursement environment.

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Pandemic-Related Valuation Tailwinds

Amid enormous challenges facing every facet of the health care industry, there has been progress to mitigate the effects of the pandemic and create positive change. Some health care segments have stepped up and become part of the solution to the pandemic. Urgent care centers and laboratories continued to thrive throughout 2021 as COVID-19 testing volume appeared to become a permanent ongoing part of the patient diagnosis. In areas with lower COVID-19 volume and sufficient ICU capacity, many hospitals, including long-term acute care hospitals, have adapted operations by segregating and separately processing COVID-19 volume while benefiting from strong pricing gains. Telemedicine platforms have been adopted more rapidly and are poised to become a fixture of normal patient care as well as an effective outreach tool for mental health and other underserved segments. Increases in valuation and transaction volume are likely to persist in these segments.

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Pandemic-Related Valuation Headwinds

Many health care segments have experienced severe negative impacts as a result of the pandemic. Players in these spaces will be forced to reinvent key aspects of their business. Many health care businesses have been adjusting to new staffing scarcity by increasing salaries of patient care employees, implementing telemedicine technology, and expanding recruiting and education efforts. The tight labor market is now a well-established headwind for the sector as many hard-hit hospitals and other providers struggle to retain an overwhelmed or overworked staff. Post-acute providers saw admissions decline as depressed occupancy in referral sources decreased and excess deaths lowered patient census volumes. Staffing constraints due to quarantined employees and the industry-wide nursing shortage yielded additional lost admissions. Even with increased salaries, employment in most segments except outpatient ancillary services remains below pre-pandemic levels as turnover persists. For these segments, we expect lack of visibility and staffing challenges to remain a driver for continued consolidation in 2022 and beyond, perhaps lowering valuation of the subject enterprise.

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Enduring Topics In Health Care Valuation

Certain health care valuation topics are consistent and timeless, despite the long-term effects of macroeconomic events and social change. We emphasize the enduring importance of fair market value relationships between health care systems and their affiliated physicians. New forms of physician compensation arrangements and systems do not change this dynamic. As always, health care service providers with stable payer mixes and excellent patient care yield premium valuations, especially with the positive effects of local demographics and the aging of the population. The importance of long-term optimal management of physician partnerships will be amplified as the availability of independent physicians decrease, creating challenges in replacing retiring physicians.

Part I - Pandemic Related Valuation Tailwinds

How Will the Pandemic Affect Valuations for Long Term Acute Care Hospitals?

July 13, 2021

Long Term Acute Care Hospitals (LTACHs) have proved their crucial role in the health care system during the pandemic. Because LTACHs are uniquely qualified to care for patients with long-term debilitating medical conditions, acute care hospitals were able to rely on LTACHs to care for long-term critical COVID-19 patients. The ability to refer long-term patients to a LTACH allowed acute care hospitals to free up crucial ICU beds for other COVID-19 patients.

The Big Picture

- The pandemic created opportunities for LTACHs to educate acute care referral sources about their capabilities and allowed acute care hospitals to successfully decompress their ICU volumes by transferring high-acuity patients to LTACHs for high quality specialized care.
- Revenue per patient day for qualifying LTACH patients has continued to be favorable, especially with elevated patient acuity trends and positive Medicare rate updates. Favorable reimbursement trends reflect the shift in the industry towards higher acuity patients along with Medicare's desire to support providers that provide specialized care to critically debilitated patients.
- LTACH acuity case mixes will remain elevated as acute care ICUs continue to require a referral outlet for COVID-19 and serious non-COVID-19 patients.

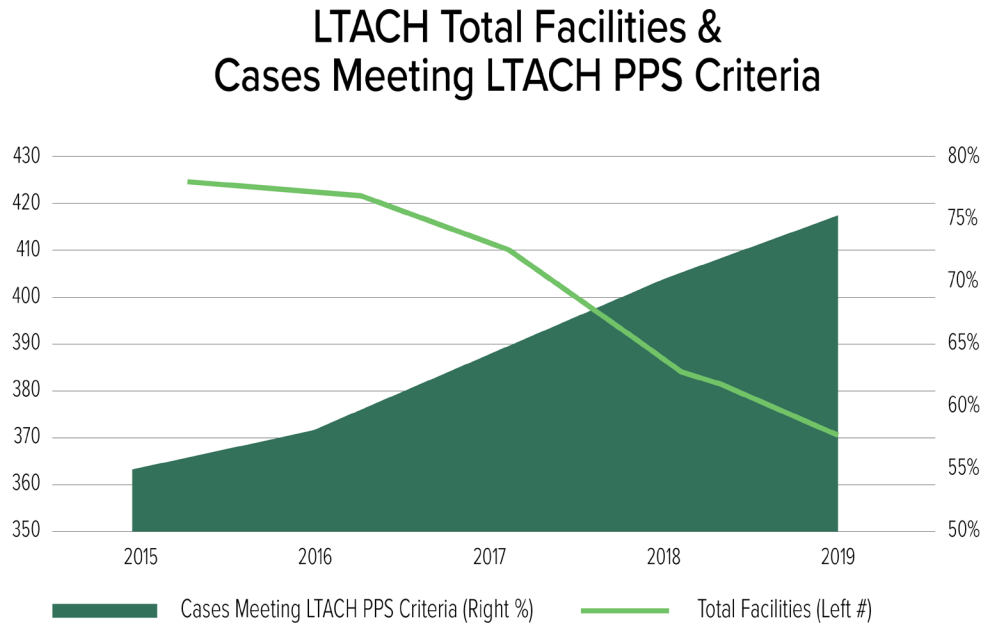
By the Numbers

- The supply of LTACHs has drastically decreased. In 2015, there were 425 LTACHs in the US. Due to the stricter patient eligibility criteria, by 2020, 78 LTACHs closed or merged, representing over 15% of the total facilities.
- While the total number of facilities has decreased, surviving operators have increased their share of patients that qualify for elevated reimbursement based on their high level of clinical complexity, reaching 75% in 2020. Surviving facilities have experienced an increasing acuity mix and higher reimbursement.
- Select Medical Corporation is the largest operator of LTACHs with 27% of the total facilities. The company reported increased Revenue (13%), EBITDA (34%), and increased EBITDA margin (16%) for the LTACH division in 2020.
- There is significant room for growth in the industry. According to Medicare data, 325,000 to 350,000 patients per year qualify for LTACH services, yet the industry only has 69,000 total annual discharges.

Health Care Valuation Implications

- During the 2016-2020 restructuring period, distressed LTACHs were trading for very low multiples of revenue. Some facilities closed or went bankrupt, while others closed or consolidated. The market did not differentiate between strong and weak LTACHs.

- LTACHs proved their value to the health care system during the pandemic and are currently experiencing sustainable revenue growth trends and double-digit EBITDA margins. There is reason to believe those successful trends will continue as LTACHs receive more referrals from existing and new sources.
- A reasonable argument can be made for the stability of the industry due to the value shown during the pandemic; therefore, all other factors equal, the long term valuation implications for a typical LTACH are positive.



Source: Medicare Payment Policy, Report to Congress. Medicare Payment Advisory Commission, March 2021

Urgent Care Centers Embrace a Once in a Generation Business Opportunity

May 11, 2021

Urgent care centers have been a key player in testing the U.S. population for COVID-19. With the efficiency and customer service acumen embedded in their business model, urgent care centers have stepped up to the challenge of processing high COVID-19 testing volume in an accessible and efficient setting.

Why It Matters

Most urgent care centers score high on patient satisfaction surveys. However, a large percentage of the population had not visited a local urgent care center prior to the pandemic.

- First time patients have flocked to urgent care centers for quick and efficient COVID-19 testing. A large percentage of these new patients will convert to regular recurring patients of the urgent care center for future health conditions and diagnoses.

- Urgent care centers have proven not only resilient in the crisis, but have also gained market share and awareness in the general population for high quality on demand health care.

By the Numbers

- Based on patient volume statistics from Experity Inc., the industry leading software and services company focused on urgent care software solutions, urgent care volume in 2020 was up significantly from the average of the last 3 years (2017-2019).

- After an initial decline in volume at the beginning of the pandemic, most urgent care centers (85% according to data from Experity, Inc.) introduced COVID-19 testing in or around May or June 2020.

- From June to September 2020, total visit volume was approximately 30% above the average volume of the last 3 years.

- From October to December 2020, volume spiked and averaged around 40% higher than the average of the last 3 years.

- Also according to Experity Inc., nearly half (48%) of all visits to urgent care centers in 2020 were new patients to the center.

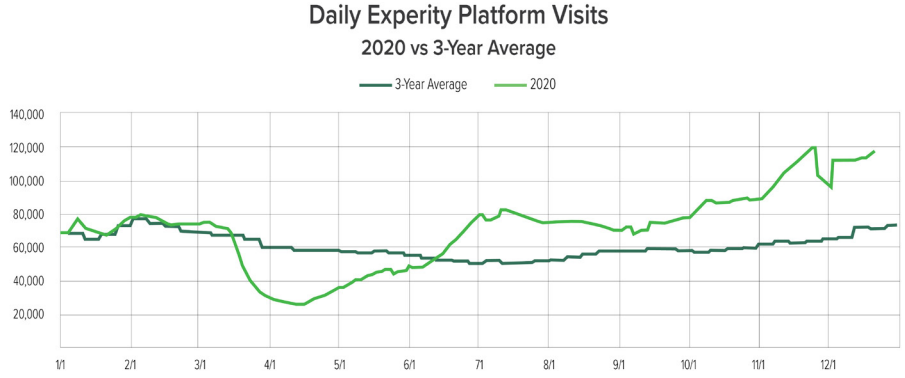
Health Care Valuation Implications

- The urgent care industry has introduced itself to a large cohort of new patients, with the expectation that a large percentage of those patients will turn into repeat patients.

- High COVID-19 testing volume is likely not permanent and is likely to diminish to a lower baseline over time. However, COVID-19 tests may be required for many years, even at a diminished level.

- While formulating financial projections will be challenging due to the uncertainty of predicting at what level future patient volumes will settle, there is reason to believe that, on average, urgent care patient volume will remain at levels that are higher than pre-pandemic levels.

- Given these assumptions, there is evidence, all other factors equal, to support a sustainably higher valuation for the average urgent care center, assuming historical market valuation metrics (i.e. EBITDA multiples) also hold.



Source: Experity, Inc.

Closing the Gap Between Perceived and Actual Demand in Behavioral Health

June 1, 2021

Type of innovation	Description	Private equity/venture capital funding through June 2020,[1] $M	Number of companies
Digital platforms to provide care	Platforms that connect patients with behavioral health providers	1,352	37
Digital therapeutics	Clinically validated digitalized therapy options that can be prescribed to treat behavioral health conditions	924	28
Patient self-help/ management	Support tools that enable people to manage their behavioral health conditions (eg. guided/recorded exercises, suggested activities, daily reminders)	846	27
Data and analytics	Solutions that generate and deliver analytic insights, such as personalized behavioral health treatment plans or predictive analytics to inform early interventions	620	19
Innovations in care delivery	Care delivery models that offer wraparound supportive services or integrated primary and behavioral health care	441	13
Electronic health record/workflow tools	Platforms that enable comprehensive patient management (eg, case documentation, clinical information system, behavioral health electronic health records)	119	5

Source: Fall 2021 Urgent Care Quarterly, Experity, Inc.

A large gap persists between people who perceive they need behavioral health services and those who actually seek out and receive appropriate care. There have been significant investments recently in innovation designed to close this gap and reach a greater percentage of the "perceived need" population.

Between the Lines

- According to KFF's 2020 Mental Health and Substance Use and State Fact Sheets, 37.7% of adults in the U.S. reported symptoms of anxiety and/or depressive disorder, a drastic increase from the reported 11.0% in 2019.
- Many of those who perceive a need for mental health services do not use them. This suggests that perceived need is a necessary, but not sufficient, factor in accounting for behavioral health services utilization.
- Untreated behavioral health conditions may have serious effects on peoples' lives and on health care spending. Co-occurring regulative conditions and chronic medical conditions are associated with significantly more acute and expensive episodes.
- The investment community is responding to this problem by investing in innovation that can facilitate an increase in the percentage of the "perceived need" group that translates into actual demand by receiving appropriate care.

By the Numbers

According to McKinsey & Company there has been a wave of investment in innovation in the behavioral health industry, with private equity and venture capital companies having invested more than $4.3 billion in behavioral health through June 2020.

- Those technologies seeking to "close the gap" between perceived and actual demand include Digital Platforms to Provide Care, Digital Therapeutics, and Innovations in Care Delivery.
- Together, these three categories make up 63.2% of the financial investment and 65.1% of the number of companies focused on reaching those with a perceived behavioral health need.
- These technologies, if effective, will lower the barriers to behavioral health and help close the gap between perceived and actual demand.

Behavioral Health Care Valuation Implications

- For those Behavioral Health providers that effectively integrate one or more of these innovations into their service lines, providers of inpatient and outpatient behavioral health services will likely experience an increase in business as access to their behavioral health improves.
- Supply, or competition, will increase as new entrants enter the market to meet increased actual demand.
- Supply constraints, such as available staff, psychiatrists, and techs will be exaggerated. Funding will continue to be a challenge.
- Although there will be mitigating headwinds of increased competition, staffing constraints, and funding challenges, there is evidence to suggest that innovation and investment into technologies improving behavioral health access, assuming rapid adoption, will increase the value of existing behavioral health providers.

Navigating Urgent Care Valuations in Unusual Times

October 26, 2021

Recent Urgent Care Volume Surge Supports Elevated Patient Volume Forecasts

The urgent care industry has been experiencing accelerated patient visit volume into 2021, continuing trends started in 2020. Factors contributing to this surge include return visits from 2020 first-time users who are more familiar with urgent care offerings, the emergence of the delta variant combined with a reduction in the number of public testing sites for COVID-19, as well as the re-emergence of normal medical conditions (e.g. flu, sprains, etc.) from the reopening of schools and general activity. Whether these volumes are sustainable is the key question buyers and sellers are asking.

By the Numbers

After a moderate spring 2021, visit volume began to surge during the summer, according to patient volume statistics from a report in the fall 2021 issue of Urgent Care Quarterly by Experity Inc., the industry's leading electronic medical record (EMR) and practice management software company. Example statistics from the report include:

- Industry-wide visit volumes were up 6.5% in 2020 compared to 2019, and are up 14.5% so far in 2021 compared to prior 2020 year-to-date numbers.

- In 2021, same-store urgent care clinics have seen an average of 45 patients per day, a 32% increase since the average of 34 in 2016.

- First-year revenue for a new center averaged $874,000 for those opened between 2016 and 2019; first-year revenue increased to $1.65 million for new centers that opened in 2020. Experity projects revenue of $2.4 million for new centers that open in 2021.

- The percentage of urgent care clinics seeing more than 60 patients per day increased from 6% in 2019 to 43% between January and August 2021. This suggests that a larger percentage of the population is relying on urgent care centers for their urgent health care needs. (See chart below)

Yes, But...

With the surge in volume, a number of new business and operational challenges have emerged, including:

- With the increase in current and projected volume, centers will need to make a concerted effort to recruit and retain talented staff. Operating with sufficient qualified staff will be crucial to serving patients with high standards in a timely manner.

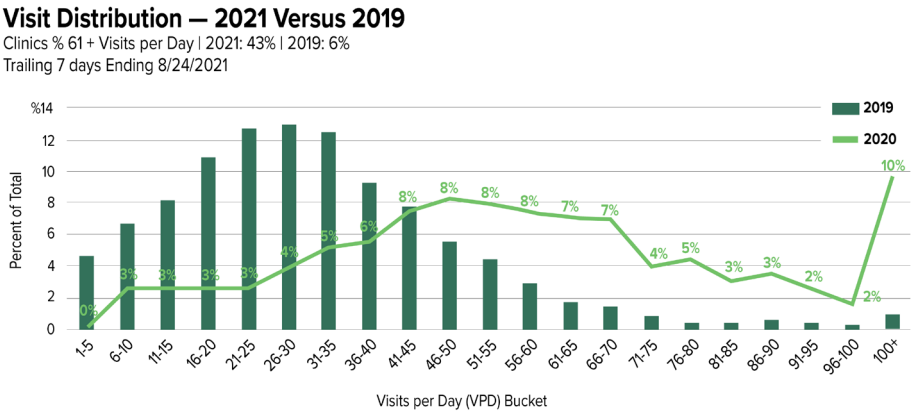
- The careful measurement, management and maintenance of patient satisfaction metrics in a higher volume environment is crucial to sustain elevated volume in the long term.

Health Care Valuation Implications

- Visit volume will likely moderate in the long-term from today's levels; however, evidence suggests volumes will likely stay well above be above pre-pandemic levels.

- Higher volume creates operational challenges along with increased expenses. These realities should not be ignored, and must be properly managed to ensure sustainable high-levels of profitability.

- With all else being equal, industry characteristics are in place to support higher valuations for urgent care centers due to increased levels of sustainable profits driven by volume growth. Of course, microeconomic factors affecting any single urgent care center may differ from global industry trends.



For the seven-day period ending August 24, 2021, 43% of clinics saw more than 60 patients per day, up from 6% in 2019

Source: Fall 2021 Urgent Care Quarterly, Experity, Inc.

Part II - Pandemic Related Valuation Headwinds

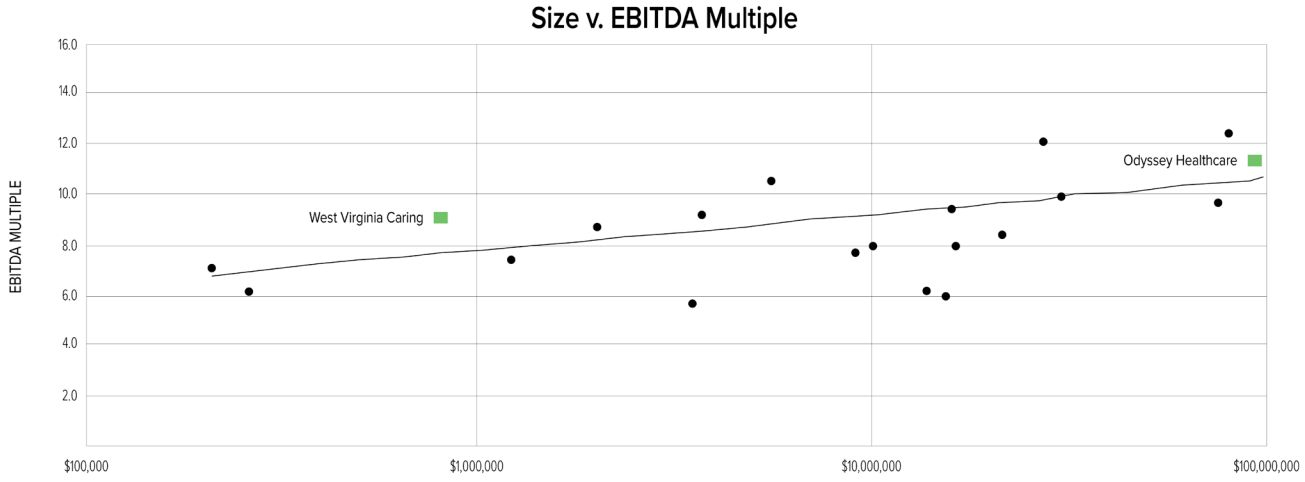
Hospice Valuations in a High Multiple Comparable Sales Environment

August 3, 2021

Transactions for large hospice providers are yielding historically high multiples of EBITDA and revenue. In this environment, however, the valuator should use caution in uniformly applying comparable sales metrics to the subject hospice provider. Certain factors and milestones should be analyzed to determine how to apply and weight the comparable transactions method under the market approach in the valuation analysis.

Yes, But...

- Length of stay across the hospice industry has decreased over the past year. This is due to surging deaths related to COVID-19 and late-in-life admissions to hospice due to pandemic-related delays. Medicare reimburses hospice providers on a per day basis. Because decreased length of stay will have a negative effect on revenue over time, the valuator should analyze current data and determine whether length of stay returns to pre-pandemic levels. If not, there may be fundamental flaws in referral source dynamics or unfavorable local demographics.
- Clinical staffing has historically been, and will continue to be, a challenge. Hospice nurses and techs have a very specialized skill set and temperament. The pandemic has exacerbated recruitment and retention issues which will likely outlast the pandemic. Hospice providers with chronic and enduring labor issues may not be able to accommodate new patients, even at historical profit margins.
- It is clear based on historical transaction data that size matters. Empirical evidence exists that multiples paid for hospice transactions are correlated with size. Annual revenue is the most common metric, but revenue will correlate closely with patient census and geographical reach.



Source: Scope Research

By the Numbers

According to Irving Levin Associates, LLC, deal volume in the home health and hospice sector accelerated in the second quarter of 2021, up 48% from the 1st quarter and up over 300% from the 2nd quarter 2020. This deal volume clearly reflects favorable industry trends and patient demographics for hospice providers.

Based on a study by Scope Research of nine years' worth of hospice transactions, there appears to be a real correlation between size and deal multiple. Scope Research's results are based on publicly available data between 2010 and 2019.

- While there is significant variation in the multiples due to company and deal specific factors, the resulting regression equation (represented visually by the line running through the dataset) indicates a strong relationship between size and multiple paid for hospice providers.

Health Care Valuation Implications

- Health care valuators should understand the subject company's exposure to decreased length of stay issues and ensure key revenue metrics, like census data and length of stay will normalize.
- Valuators should understand and consider the provider's ability to attract and retain hospice staff and how staff recruitment and retention efforts will impact profit margins.
- Health care valuators should understand the relationship between size and valuation multiple and adjust accordingly. With all other factors being equal, significantly smaller hospice providers will command a lower multiple and larger hospice providers will yield higher multiples (compared to industry averages).

ASC Partnerships Face Succession Challenges

November 16, 2021

Increased Hospital Employment and Accelerated Retirements Result in Shortage of Replacement Physician Investors along with Valuation Impacts

In the years leading up to the pandemic, many ambulatory surgery centers (ASCs) were already facing a chronic long-term issue: how to replace an aging physician investor cohort with younger counterparts. Generally, younger physicians today have preferred employment with guaranteed income over taking risk to build an independent practice. Many senior physicians have even moved away from their independent practice due to a plethora of new management challenges and stressors. Hence, we have seen the trend of physician employment rising for years. At the same time, the post-pandemic "great resignation" is having a disproportionate impact on physicians by accelerating thoughts of early retirement. On a macro scale, neither physician employment nor early retirements are beneficial to existing ASC partnerships.

By the Numbers

Based on new data released by the Physicians Advocacy Institute and Avalere Health in June 2021, it is clear that recruiting new physician investors into ASC partnerships will be difficult due to accelerated employment trends associated with COVID-19. Some of the observations from the study are as follows:

- Between 2019 and 2020, 48,400 additional physicians left independent practice and became employees of hospitals or other corporate entities. This represents a 12% increase in the percentage of employed physicians over the two-year study.
- By January 2021, ~50% of physicians were hospital-employed and another ~20% were employed by corporate entities.

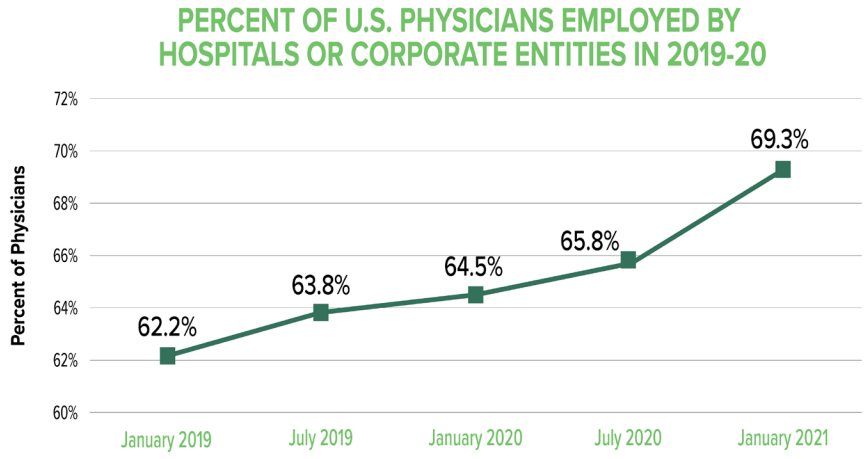
At the same time, a recent publication by MGMA and Jackson Physician Search in October 2021 observed the following:

- Over that past year, 46% of physicians considered leaving to work for a new health care employer, and 43% considered early retirement.
- An astonishing 27% of physicians considered leaving the practice of medicine, but still working in a different environment.

Why It Matters

- ASC partnerships rely heavily on alignment via physician investment. Due to these accelerated employment and retirement trends, many partnerships may struggle to find unaffiliated (or otherwise unrestricted) replacement physician investors. Adding new physician investors to an ASC partnership is crucial to extend its business lifecycle.
- On top of recruitment issues, many senior physicians are highly productive having spent their entire career building a practice. For decades, the ASC partnership may have relied on the activity of these key physicians. Now near retirement, the ASC partnership may need to recruit more than one young physician investor to replace the case volume and productivity of a single productive senior member.

National Trends: Nearly Seven in Ten Physicians Employed by Hospitals or Corporate Entities at the End of 2020



Source: "COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020," Physicians Advocacy Institute and Avalere Health, Avalere analysis of IQVIA OneKey database, June 2021

- From a financial standpoint, expenses for ASCs are largely fixed. The loss of just one or two high producing physicians will have a disproportionate impact on bottom line profitability all else equal (e.g. a 10% decline in revenue may equate to a 50% decline in EBITDA).

Yes, But...

- ASCs remain an optimal and efficient site of service for many outpatient surgeries. They specialize in catering to physician schedules and clinical team preferences, while also allowing physicians to benefit financially from facility profits in a compliant manner.

- Payers continue to drive patients toward ASCs as a lower cost of care setting; patients continue to prefer surgery in an ASC over a hospital when medically appropriate. The list of surgeries that can safely be performed in the ASC continues to grow. For these reasons, total cases will continue to increase in the ASC setting over time.

- The industry has been very excited about the addition of total joint surgeries, which are extremely profitable. Unfortunately, only a small percentage of ASCs are positioned to take advantage this opportunity from a capital and surgical specialty perspective. Those with the right orthopedic alignment have significant growth potential.

- Some ASCs have large hospital partners that allow their employed physicians to co-invest. Compared to the independent ASCs, these partnerships may be less vulnerable to succession planning issues.

Health Care Valuation Implications

- Valuations for ASC partnerships are bifurcating between the “haves” and “have nots”.

- The “haves” are well-aligned ASC partnerships that successfully recruit new physician investors (or have a young cohort), have a profitable specialty mix and are benefiting from the expansion of the ASC surgical procedure list. Valuations for this group will likely remain above historical averages due to their scarcity.

- The “have nots” are having difficulty performing succession planning due to lack of available physicians in the market and face looming retirements of highly productive surgeons. Valuations for this group are lower than historical averages due to fewer options. These ASCs may consider closing, consolidating with better situated centers or joint venturing.

- Specific physician dynamics and fact-patterns underlying a particular ASC will always matter most in the context of determining fair market value. The level of value (i.e. controlling, minority block, minority) will also have an impact to any valuation and must be considered.

Managed Care Companies Predicting the "Worst of Two Worlds"

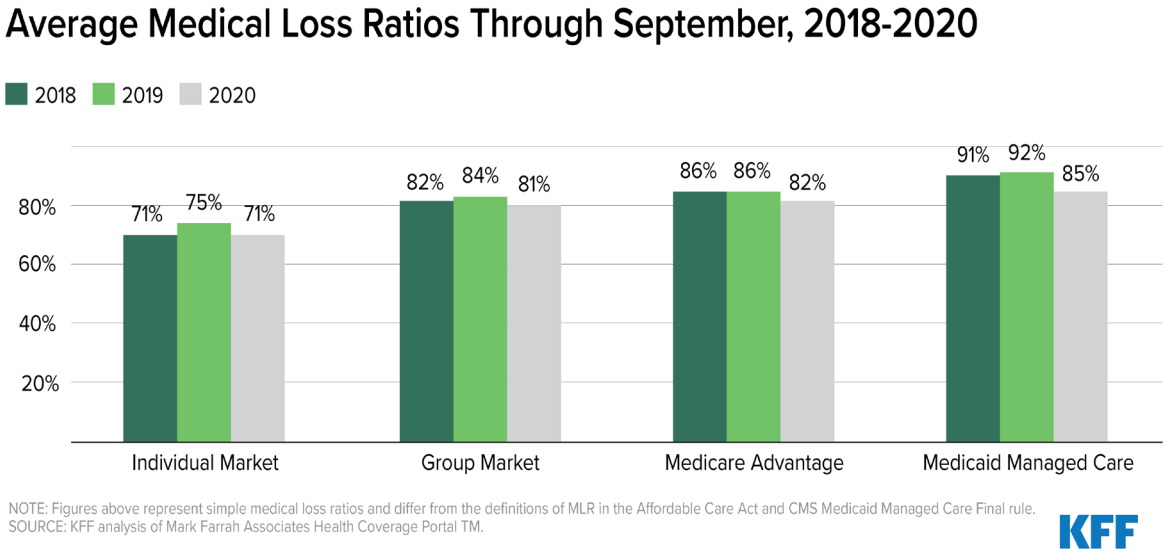
September 14, 2021

Incorporating MCO Utilization Estimates into Provider Valuations

Commentary from publicly traded Managed Care Organizations (MCOs) regarding their insurance spend expectations can be an excellent source of macroeconomic data for health care valuation professionals when projecting performance for provider entities. Now halfway through 2021, MCOs are generally factoring continued COVID-19 costs coupled with higher non-COVID-19 utilization into their full year 2021 earnings estimates: the worst of two worlds from the MCO's perspective.

Why It Matters

- Since providers earn the dollars that MCOs spend, these predictions, (if accurate) are a good macroeconomic source to assist when developing a forecast of provider revenue in the near term by payer and population segment.
- The medical loss ratio (MLR) reflects the percentage of MCO premiums paid to providers due to insured patient utilization of health care services. This ratio was lower in 2020 compared to prior years due to less overall non-COVID-19 patient utilization from deferred, delayed, or canceled services and patient hesitancy.
- For the second half of 2021, MCO commentary indicates that they anticipate continued payout for patients with COVID-19. However, unlike the low levels experienced in 2020, MCOs also expect commercial non-COVID-19 utilization to be at or above the 2019 baseline. Comparatively, the Medicare Advantage patient non-COVID-19 utilization is expected to be below the 2019 baseline, and Medicaid patient non-COVID-19 utilization is expected to be below Medicare Advantage.



NOTE: Figures above represent simple medical loss ratios and differ from the definitions of MLR in the Affordable Care Act and CMS Medicaid Managed Care Final rule.
SOURCE: KFF analysis of Mark Farrah Associates Health Coverage Portal TM.

KFF

For Example:

- Overall, MCOs do not expect the strong performance (i.e. low MLR) of 2020 to continue into 2021. Examples of MCO commentary regarding 2nd quarter actual utilization, COVID-19 estimates for the second half of 2021, and non-COVID-19 utilization estimates for the second half of 2021 are summarized below:

Managed Care Organization	Historical Q2 2021	Rest of Year	
	Observations	COVID Estimates	Non-COVID Estimates
Cigna	▸ Ongoing COVID costs above expectations ▸ Non-COVID returned faster than expected ▸ Medicare Advantage below expectation	▸ Lower than first half '21	▸ Commercial at baseline ▸ Mental health and surgery above baseline ▸ Radiology and ER below baseline
Anthem	▸ Non-COVID utilization up from depressed levels ▸ Medicaid below baseline ▸ Overall utilization above baseline	▸ Higher than first half '21	▸ Above baseline in 2nd half '21 ▸ Inpatient and ER below baseline ▸ Physicians and outpatient above ▸ Unclear if patients will defer because of Delta
CVS Health / Aetna	▸ Higher than expected COVID costs ▸ Vaccine revenue slightly down	▸ Slightly higher than first half '21	▸ Return to baseline by 4th quarter ▸ Inpatient, lab, behavioral elevated ▸ ER depressed
UnitedHealth	▸ COVID testing and treatment highest in April ▸ Commercial utilization marginally above baseline ▸ Government utilization marginally below	▸ No change	▸ Utilization trending higher ▸ Inpatient volume near baseline ▸ Physician visits trending up

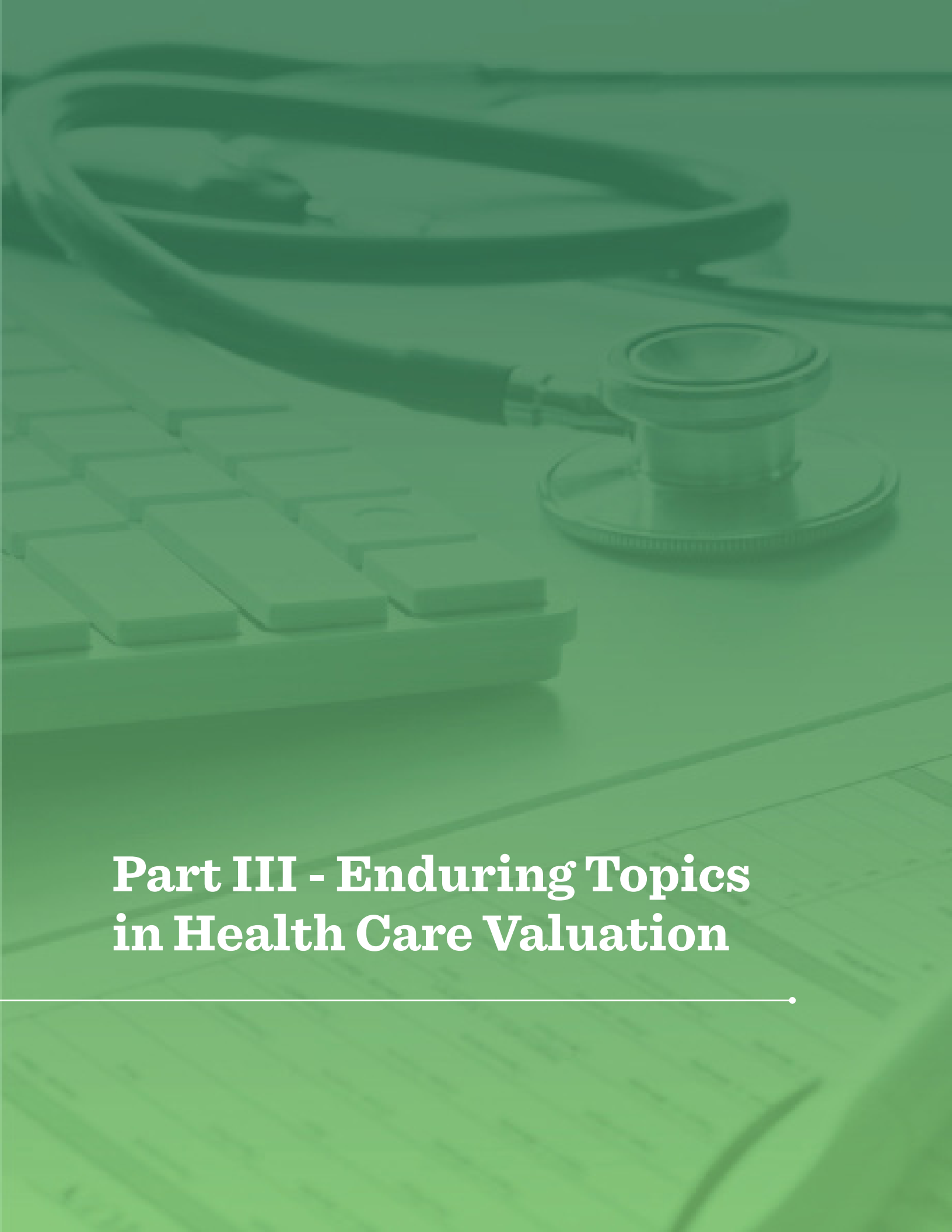
Note: Baseline = adjusted 2019 utilization

Health Care Valuation Implications

- A health care valuation professional should analyze and incorporate economic data from a wide variety of sources. Analyzing MCO expectations for utilization is an excellent source of macroeconomic data. If MCOs are pessimistic about their spend (i.e. higher MLRs), this conversely could be a positive macroeconomic indicator of higher revenue expectations for provider entities.

- MCO commentary seems to indicate that many providers have mitigated patient fears about returning to the health care system, and have succeeded in insulating non-COVID-19 volume. Providers have successfully implemented COVID-19 protocols that have allowed the non-COVID-19 business (especially the commercial segment) to return to pre-pandemic baseline levels in many cases.

- According to MCO commentary, the success of providers bringing back non-COVID-19 core volume is payer class dependent. MCOs report commercial non-COVID-19 volume back to or close to baseline 2019 volumes. Medicare and Medicaid volume remain below baseline, possibly reflecting hesitancy of returning to the health care system by a portion of this population.



Part III - Enduring Topics in Health Care Valuation

Navigating Health Care Valuation EBITDA Multiple Ranges for Fair Market Value

October 5, 2021

Dispersion of Multiples within the Range Varies Widely by Segment

Many business valuations begin with calculating a multiple of EBITDA (earnings before interest, taxes, depreciation, and amortization). In health care, however, valuators should deliberate just when and how to apply general valuation EBITDA transaction multiples for fair market value opinions. Rather than just applying median or mean multiples derived from a historical data set for the industry segment, valuators must recognize that data set dispersion within an applicable range varies widely by segment.

Why It Matters

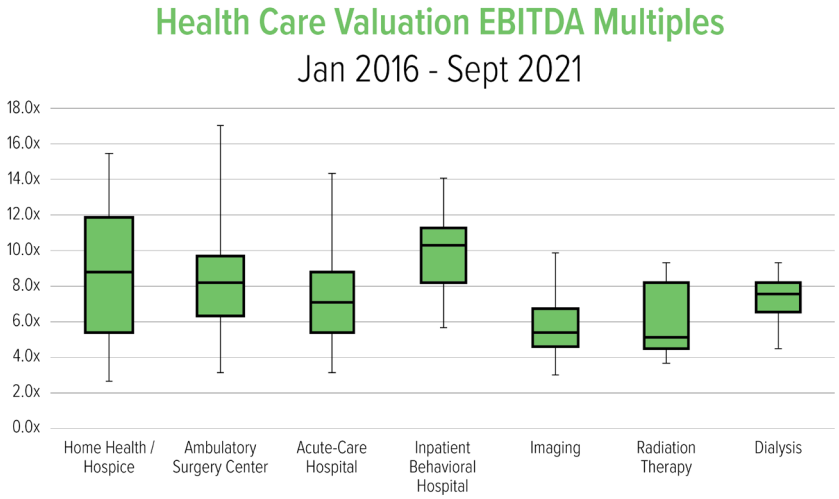
- Understanding the range and data dispersion of EBITDA transaction multiples is crucial to developing a supportable fair market value opinion. The wider the range (difference between minimum and maximum values) and higher the dispersion (variation of data point distribution), the less likely that a pure application of industry mean or median EBITDA transaction multiples is appropriate or supportable (all else being equal).
- EBITDA multiple ranges and dispersion are higher in some health care segments (e.g., Home Health and Hospice) and lower in others (e.g., Dialysis).
- Differences in valuation multiple ranges and dispersion are caused by many factors, such as the number of active buyers, the efficiency of the transaction market and the homogeneity of enterprise characteristics (size, profitability, growth, market positioning, etc.).

For Example:

A graph makes it easy to see data ranges and dispersion by health care segment. The chart below is based on publicly available EBITDA transaction multiples between January 2016 and September 2021. The data is presented visually via a box and whisker plot, which displays the median (horizontal line inside the box), lower and upper quartiles (top and bottom lines of the box), and lower and upper extremes of the data (the “whisker” lines).

As illustrated, material differences exist in historical dispersion and range by segment:

- Some segments, such as Dialysis and Imaging, have displayed multiples with a low dispersion around the median (i.e., lower and upper quartile ranges are closer) and a narrower range (i.e. less extreme lower and upper bounds).
- Other segments, like Ambulatory Surgery Centers, have displayed a moderate multiple dispersion around the median but a much wider range.
- A few segments, notably Home Health and Hospice, have displayed both extremely high dispersion around the median and a wide multiple range.



Source: Weaver analysis of Scope Research database.

Health Care Valuation Implications

- Health care owners and investors should consult with their valuation professionals to determine whether they are observing caution when using the market approach and applying multiples to company data.
- Blindly utilizing the median of a data set in the context of the market approach to value is not always appropriate. There is a risk of a large valuation error when using data subsets with varying dispersion and ranges.
- Within any health care segment, the valuator should investigate EBITDA transaction multiple data dispersions and ranges to understand the primary factors driving differences (e.g. size, growth, profitability). Factor adjustments to the median can be utilized to ensure a more supportable fair market value opinion.

The Importance of a Stable Payer Mix to a Premium Valuation

June 22, 2021

The Implied Valuation Risk of Long Term Payer Mix Shifts

Health care providers face future revenue challenges as patient payer categories gradually shift from Commercial Payers to Government Payers. The valuation implications of lower future average pricing can be significant, but largely depends on the starting point. If the subject company enjoys a high relative Commercial Payer mix, future pricing diminution will be more drastic as the payer mix shifts toward Government Payers.

The Big Picture

- The reasons for the payer shift are complex, but have their roots in demographics and the aging of the population. In 2014, Government Payers represented 44.7% of the hospital payer mix. Since then, Government Payers increased their share of the pie by approximately 0.5% annually to 46.8% by the end of 2018 (Source: Moody's). At this rate, Government Payers will (conservatively) represent ~52.0% of the hospital payer mix by 2028.
- Some providers have "more to lose" as payer relationships and local market power yield much higher than average commercial payments.
- Higher relative commercial payment rates equate to a higher risk of significant profit diminution as the payer mix shifts.
- Typically, commercial payment rates are determined through negotiations with insurance companies, and can vary depending on market conditions, such as the bargaining power of individual providers relative to insurers in a community.

By the Numbers

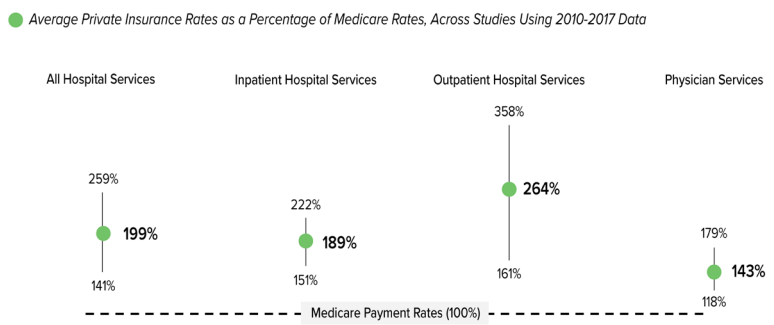
In a report issued April 15, 2020, The Kaiser Family Foundation **reviewed the findings of 19 recent studies** comparing Medicare and private health insurance payment rates for hospital care and physician services.

Among the findings:

- On average, commercial premium payments (i.e. commercial payment rates to facility operators as a percentage of the Medicare payment rate for the same service) exceed Medicare by 189% for inpatient services and 264% for outpatient services, and 143% for physician services.
- The variability of commercial premiums was greater for outpatient services (200% spread) than for inpatient services (70% spread). The wide variability suggests that, even within a given health care market, some individual providers are outliers in that they can command extremely high private reimbursements.
- Measuring the commercial premium is complex and inexact. The studies KFF analyzed may omit unique payment characteristics and features such as Medicare supplementary payments, risk-based contracts, and may include or exclude commercial out of network payments.

ES Figure 1

Private Payment Rates Are Higher Than Medicare Rates for Hospital and Physician Services



SOURCE: KFF analysis of 19 published studies comparing private insurance and Medicare payments to providers. Because some studies analyze payments to providers in multiple service categories, the number of studies across all categories is greater than 19.

KFF

Health Care Valuation Implications

- Health care valuators should understand the subject company's exposure to possible payer mix shifts and the related implications on future profits.
- Health care valuators should analyze the size of the subject company's commercial premium along with the speed and magnitude of the shifts. Importantly, they should assess management's long-term strategic plans to alter the structure of the business to mitigate these trends in order to operate successfully under a new payment environment.
- With the high variability of the average commercial premium, the subject company could be significantly higher than the average and therefore may be at risk for accelerated payment rate diminution. To maintain and support a valuation premium, the valuator should ensure the payer mix is steady and displays durability for future time periods.
- Due to the shift to Government Payers, applying general market multiples to current profit metrics may not sufficiently capture the risk of payment rate declines specific to the subject entity. This is especially true if the current commercial premium is above the averages identified in the KFF study.

Guarding the Shelf Life of Fair Market Value Opinions for Management Services Organizations

August 24, 2021

Questions about the shelf life of a fair market value (FMV) opinion can arise when the parties seek certainty about compliance with government regulations or wish to maintain arrangements that are financially viable to all parties. When it comes to the FMV of compensation to a health care management services organization (MSO), the question of the FMV shelf life is especially common. Unfortunately, authoritative literature or rule books do not provide a definitive answer.

There are three smart ways to help determine the FMV shelf life of your MSO compensation arrangement.

Look to comparable guidance.

While not specifically intended to govern FMV opinions for MSOs, public accounting rules for fair value (**Accounting Standards Codification 350**) require testing for impairment the sooner of 1) annually or 2) upon occurrence of a triggering event.

In the context of testing annually for impairment, financial reporting puts forward the notion of "qualitative testing." An annual assessment can take the form of a general review of an appropriate set of factors that, taken together, provide a reasonable indication of whether there has been a material enough change in the overall arrangement to require a fully updated FMV. These financial accounting standards provide a reasonable paradigm for FMV in MSOs.

The physician self-referral **"Stark"** and **Anti-Kickback statutes** (AKS), allow for exceptions and safe harbors related to compensation in personal services arrangements if:

- The duration of each arrangement is at least one year;
- The compensation to be paid over the term of each arrangement is set in advance;
- The compensation does not exceed fair market value; and,
- A holdover arrangement after 1 year is on the same terms and conditions as the preceding arrangement.

Put time on your side.

A compensation FMV opinion should cover ongoing payments over a certain time frame, which is most often defined in the management services agreement (MSA). Therefore, the effective dates of legal documents (i.e. MSA and lease agreements) and FMV reports become an important element of determining shelf life. Aligning effective dates helps keep the start of the FMV shelf life at the same starting point as the legal documents.

The risk of changes in future market conditions often prompts valuators to limit their FMV opinions to be valid for two years, sometimes three. Parties need to be aware of such limitations when designing an MSO arrangement with the expectation of a going-concern enterprise.

Tie shelf life to enterprise risk.

Arrangements that have higher risk profiles generally have shorter FMV shelf lives. Higher risk can come in many forms, including heavy reliance on a low number of providers or certain types of payers, short term agreements that can be terminated without cause on short notice, and de novo operations. As risks change, so might compensation expectations and what is supportable as fair market value.

Valuation and Compliance Implications

- Unexpected triggering events can occur at any time throughout the life of an MSO arrangement. The parties share responsibility for determining the need for a review of FMV at the time of a triggering event. Often a valuator will assist in the review process, and in determining whether or not compensation arrangements remain consistent with FMV.
- Many MSAs contain a clause to review compensation for FMV on an annual basis, mirroring the annual testing requirement under ASC 350.
- To maximize FMV shelf life, start by syncing the effective dates of the FMV and legal documents.
- A one to three year shelf life is possible, but manage expectations to review FMV at least annually. Update FMV after at least two-three years, depending on the nature of your arrangement.
- When users of the FMV opinion limit shelf lives for riskier arrangements, they can create more flexibility to adjust compensation and remain compliant with FMV.

New Payment Models May Impact the Valuation of Freestanding Radiation Therapy Centers

December 2, 2021

Medicare reimbursement changes may affect the valuations for freestanding radiation therapy centers, with likely changes in long-term cash flow projections and industry risk premiums. Valuation professionals should observe the inter-play between Medicare reimbursement reductions and operating company cost mitigations to properly appraise freestanding radiation therapy centers for acquisitions or joint ventures.

Beginning in July 2021, the Centers for Medicare & Medicaid Services (CMS) will implement a new **radiation oncology mandatory payment model** (RO Model) that provides prospective episodic bundled payments for 16 identified common cancer types. The payment model will apply to freestanding radiation therapy centers located within selected zip codes, which collectively represent about 30 percent of total cancer treatment episodes.

Freestanding centers not subject to the RO Model will continue to bill under the Medicare Physician Fee Schedule (PFS), which reflects price cuts of **6.0% - 12.0% for 2021** according to the American Society for Therapeutic Radiology and Oncology.

In response to the dramatic structural change of payment methodology, freestanding radiation therapy operators are likely to re-align costs and business processes in various ways. These cost initiatives, coupled with an operator's potential ability to increase market share from weaker competitors, could neutralize the impact of any anticipated reimbursement pressure.

By the Numbers

- About two-thirds of patients undergoing cancer treatment receive radiation therapy
- Freestanding centers treat about 40 percent of cancer patients who receive radiation therapy
- Medicare payments represent about one-third of freestanding radiation therapy center revenue

Background

A **November 2017 Health and Human Services report** to Congress laid the groundwork for the new payment methodology. CMS observed that freestanding (i.e. non-hospital based) radiation therapy providers steer patients towards higher-cost treatment plans (e.g. IMRT, SRS) and perform more fractions per patient than comparable sites of care. In providing fixed reimbursement for these 16 cancer types under the RO Model, CMS is experimenting with changing provider incentives as a way of reducing Medicare spending growth for radiation therapy.

The RO Model includes significant discount factor cuts (3.75% and 4.75% for professional and technical components, respectively), in addition to withholds (3.0% in aggregate) for incorrect payments and quality measure performance. For practitioners, the RO Model encourages value-based decisions surrounding radiation therapy treatments including selected modality type (e.g. IMRT, SRS), dosage amount and fraction count.

What to Watch

Freestanding radiation therapy centers that were not historically making value-based decisions when billing under the PFS (e.g. higher fraction counts, higher cost modalities, etc.) could face larger revenue impacts than the RO model discount factors suggest. While the current RO model only pertains to a sample of centers during a five-year demonstration period, it is very likely CMS intends to ultimately implement the RO Model nationwide, especially if savings are realized without impacts to patient outcomes.