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BVR Guide to

Ancillary Healthcare Services Valuation

BVR
What It's Worth

Chapter 19.
Home Healthcare Services

CONTENTS

Chapter 19.
Home Healthcare Services

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The valuation approaches and methods used to value home healthcare businesses are no different than any other business. However, to competently value these businesses, an appraiser must understand the industry and its associated risks. In addition, a number of home healthcare providers are also nonprofit organizations or they may be sold to a nonprofit organization. Valuing transactions involving nonprofit organizations has its own unique issues. As a result, we will focus on what differentiates these businesses from others and what appraisers need to understand to develop a credible business valuation.

1.0 The Industry

Home health and hospice care is a subset of all healthcare providers (such as hospitals, physicians, senior care, and so on) that further breaks down into the following five major service lines:

- Home health—skilled nursing, physical therapy, occupational therapy, speech therapy, aid service, and medical social work provided to patients in their home;
- Home hospice—care provided for terminally (life expectancy of six months or less) ill patients and their families in their homes (can also be provided at other care sites);
- Private duty and staffing services—personal care and supportive services that are primarily provided by a home care aid;
- Home medical and respiratory equipment—durable medical equipment such as walkers, beds, wheelchairs, and oxygen concentrators; and
- Home infusion—intravenous therapies such as parenteral nutrition, antibiotics, and chemotherapy.

The goal of home health care is to provide a continuum of services designed to allow disabled or older individuals to stay in their homes for support and treatment as an alternative to assisted living, nursing homes, and hospital facilities. Proponents of home health care believe it is less expensive and a better care alternative for most people.

These services, when combined, would represent a very comprehensive home healthcare business. But, more often than not, the appraiser will be valuing businesses with fewer service lines, and often the business may be comprised of only one service line.

The profitability and risks associated with each of these service lines is driven by a unique set of variables, making it difficult to make global assumptions about the home healthcare business. The appraiser needs to develop an understanding of each service line and how these service lines interact if the subject business operates in two or more.

Acronyms and Abbreviations Used

ACA—Affordable Care Act

ADC—average daily census

ASP—average sales price

AWP—average wholesale price

CAP—community alternative programs

CBSA—core-based statistical area

CIA—corporate integrity agreement

CMS—Centers for Medicare and Medicaid Services

CON—certificate of need

HHA—home health agencies

HHRG—home health resource groups

HIT—home infusion therapy

HME—home medical equipment funding

LUPA—low utilization payment adjustment

MedPAC—Medicare Payment Advisory Commission

OASIS—outcome and assessment information set

OIG—Office of the Inspector General

PPS—prospective payment system

In some organizations, each service line can stand on its own as an independent, financially viable business. When this is the case, each business has a broad source of patient referrals independent of the other service lines. Under this scenario, each service line and the business as a whole would have more value than when service lines are interdependent upon each other for referrals.

For example, a service line might have no value to a potential buyer if all or most of its business was dependent on a previously related entity. If the service line is sold without the related entity, there is no guarantee that referrals (and therefore, the business) will continue. This can happen when a home health business or service line is a "captive" of a hospital or nursing home. It can also happen when a service line gets most or all of its referrals because of its relationship or proximity to one or more other related service lines. Generally, a home health business is a core business or service line when it has a broad base of referral sources, and other service lines are added to enhance its profitability. In this case, most or all of the value may reside in the core business.

Appraisers need to understand the relationship among the service lines and referral sources to determine where the value resides. This is particularly important when the business is a captive or when not all of the service lines are being sold together.

In addition the Affordable Care Act (ACA) is challenging home health service lines to develop quality measures that will impact future payments. An appraiser needs an understanding of the evolving changes in value-based payment plans that will increase payments for positive performance and decrease payments for negative performance. Another ACA challenge for home health service lines will be the bundling of payments based on an acute episode of care. New bundled payment plans for hip and knee replacements are proposed to start in 2016. The bundled payment would be paid to the acute care hospital and the hospital will be responsible for providing the care needed by the patient for 90 days after discharge.

The appraiser will want to have a discussion with management about the changes that are occurring in the home health provider's community. Are there new entities such as accountable care organizations (ACOs) that are being established to manage the care of individuals in the community? Will these ACOs contract with any willing home healthcare provider or are they going to limit the number of providers? What will be the factors and measurements used to select a home healthcare provider?

2.0 Funding of Home Health Products and Services

Except for private duty services, most home care products and services are funded by government sources, such as Medicare and Medicaid, commercial healthcare insurance, and to a lesser extent, payments from individuals (self-pay or private pay).

Except for reimbursement by Medicare and individuals (because individuals, or "self-pay," would generally pay actual charges), the calculation and method of reimbursement for services can vary for each commercial insurance plan and for each state in the case of Medicaid. As a result, an explanation of each reimbursement system is beyond the scope of this book. However, since Medicare reimbursement is reasonably consistent and is frequently a significant percentage of a provider's total revenue, we will generally explain how Medicare reimbursement works and how it may change as of this writing.

In proposed rules from CMS for the 2016 Medicare home health rates, it was reported that Medicare paid home health agencies approximately $17.9 billion, covering 3.5 million beneficiaries, which means that the average Medicare reimbursement was $5,114 per beneficiary. Medicare home health cost report data for 2013 reflect a median Medicare payment of $2,804 per episode, a cost of $2,534 per episode, and a margin of $270 per episode or 9.6%. According to the 2015 MedPAC report, two factors have contributed to payments exceeding costs: Fewer visits are delivered in an episode than is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home healthcare. In 2013 the median volume of visits per episode was 16.42, which includes a mix of all disciplines of services. These are useful benchmarks in evaluating the relative performance of home health agencies.

It is incumbent upon appraisers to develop an understanding of reimbursement for the payors that drive each service line and those that drive the business being valued. While it is generally assumed that home healthcare services are provided to the elderly, it is not always the case. However, most services provided to the elderly and the disabled will be funded either directly by Medicare or through commercial insurance payors that operate Medicare Advantage plans. If and when Medicare coverage runs out, reimbursement may come directly from the individual or from Medicaid for low-income beneficiaries. Younger patients may be funded through commercial insurance, self-pay, or Medicaid if they meet the requirements. Similar to Medicare Advantage Plans, some states may contract with commercial insurance plans to operate a managed care organization (MCO) that assumes all risk for the coverage of the Medicaid population. Examples of commercial insurers that operate Medicaid managed care plans include Blue Cross/Blue Shield, United, CIGNA, and Humana. In some cases, the state retains administrative control of allowed services, fee schedules, and other costs, and a third-party administrator focuses on provider payment processing, claim denials, and other administrative functions. In addition, many insurance plans require some contribution (or payment) from the beneficiary. It should be noted that the health exchanges that have been established under the ACA are offering insurance products from some of these same insurance companies.

A general discussion of how Medicare reimburses home health services and products follows.

2.1 How Home Healthcare Services and Products Are Purchased

Home healthcare treatment plans are prescribed by a patient's physician and provided by a healthcare agency (the provider). Most home healthcare products and services are funded by Medicare, particularly for older or disabled patients. A portion of home health is funded by Medicaid, for lower-income patients; commercial insurance, primarily for patients below Medicare age; and self (or private) pay, for either uninsured patients or for products or services that are not covered by Medicare, Medicaid, or insurance.

During a valuation engagement, appraisers need to understand the mix of payors to evaluate risks and whether normalizing adjustments might be required.

For example, businesses funded primarily by Medicare are at risk for changes in reimbursement (rates and coverage criteria) and age demographics for the market. Businesses funded by commercial insurance may be at risk for the economy and employee layoffs, which would reduce the population covered by commercial insurance. Businesses reliant on payment from individuals (private or self-pay) would also be dependent on the economy. Medicaid rules can be different in every state and are subject to changes in state regulations. Population growth or decline by age and income also need to be considered because it would impact the number of potential patients and how they might pay for these services in the future.

When valuing a controlling interest, the appraiser should consider whether typical normalizing adjustments (for example, owners' compensation and other perquisites or nonrecurring revenues or expenses) need to be made. In addition, normalizing adjustments to revenue

might be required if the payor mix being evaluated is not normal for the market, if there are opportunities to add payors, or if the business is not billing properly or is not being reimbursed properly. Assuming these enhancements are available to most buyers in the marketplace, the adjustments would be consistent with the fair market value standard.

3.0 Home Health Funding

3.1 Medicare

Since October 2000, Medicare funds the base payment for home health care under a prospective payment system (PPS). Under PPS, providers are reimbursed a fixed payment for services. Future reimbursement is determined by Congress and is influenced by historical industry results. Medicare pays for home health services in 60-day episodes. Most patients complete their care within 60 days. Additional 60-day episodes may be reimbursed until the patient recovers or moves to an alternative provider, such as a hospital or nursing home, or dies. Often patients are discharged from a "skilled plan of care" and obtain in-home aid, chore, and homemaker services paid for privately (private duty[1]) or possibly using Medicaid funds.

Providers (home health agencies, or HHAs) are paid one fee for each 60-day episode. Medicare adjusts payments to reflect the level of care and services required based on home health resource groups (HHRGs) and local wage differences. It will also increase the payment for the costliest patients (outliers) and reduce the payment for patients needing significantly less than 60 days of services. If there were less than five visits in the 60-day episode, a low utilization payment adjustment (or LUPA) is made. Low utilization care is paid on a per-visit basis using a national standard rate that is wage-adjusted based on the core-based statistical area (CBSA) location of the patient.

Medicare implemented the HHRG-153 system on Jan. 1, 2008, which utilizes 153 resource groups and replaces the prior system that used only 80 resource groups. These resource groups establish different payment rates based on patient need (acuity values) that are derived from a standardized national assessment instrument (called outcome and assessment information set, or OASIS).

Appraisers need to be comfortable that historical and forecasted revenues are reasonable based upon the payment system in effect at the time or proposed changes being considered and the likelihood that they could become law (either Medicare or a state Medicaid program). In addition, historical and forecasted revenues could be too high or too low if the level of care provided to patients is not properly determined. However, few appraisers could make this determination without using a specialist and most appraisers will consider this outside the scope of their work. Nonetheless, appraisers should become familiar enough with the industry to understand changes in reimbursement and the associated risks so that they can evaluate management's

1 It is generally paid by the individual or the individual might get reimbursed through private insurance such as long-term care insurance.

forecast assumptions for reasonableness. Industry surveys and articles that include historical data or assumptions about the impact of future reimbursement changes may be available. Benchmarking the business against similar businesses may help appraisers determine whether historical and forecasted revenue assumptions are reasonable.

4.0 Hospice Funding

4.1 Medicare

Hospice services are available to terminally ill patients with less than six months to live. A physician must certify a patient's terminal illness to qualify for the benefit. Benefits are provided in two 90-day increments and an unlimited number of 60-day increments, but payments are subject to the caps discussed below.

Hospice agencies are paid a CBSA (core-based statistical area) wage-adjusted daily rate based on the level of patient care required, which include:

- Routine home care;
- Continuous home care;
- Inpatient respite care; and
- General inpatient care.

The daily rate includes a labor and nonlabor component and is intended to cover all services required during hospice care. The payment rates are adjusted annually by a congressionally approved market basket inflation rate to account for both inflation and differences in market wage rates. The labor component is adjusted based on the national wage index and the nonlabor component is adjusted based on the inflation factor approved by Congress.

Total payments to a provider are limited by two caps: (1) inpatient care (for example, in a facility such as a hospital or skilled nursing facility—not home hospice) may not exceed 20% of total patient care days; and (2) an aggregate annual payment amount (an amount available to pay all Medicare hospice claims in a given year intended to control increasing Medicare costs) based on the number of patients electing the hospice benefit for the first time within the cap period. The hospice aggregate cap is adjusted annually based on the consumer price index, but the base level of Medicare hospice funding stays constant.

Appraisers should research how these two caps might affect revenue forecasts. Longer average length of stays may cause the aggregate payment to be spread among fewer patients, thereby reducing the benefit available on a per-patient basis. The provider could be liable for a repayment to Medicare for having exceeded the cap limit. A national concern has arisen over inappropriate referrals to hospice, and payment rate reform was called for in the ACA. Starting Oct.

1, 2015, patients that exceed 60 days of coverage will be paid at a lower rate per day. Additional regulatory requirements for more frequent clinical assessments are required for patients that are in care over 180 days. The point is that this is a very tricky area, and revenue forecasts and risk rates need to be evaluated based on the facts known at the time of the valuation.

5.0 Private Duty Funding

Private duty home care services are not funded by Medicare but may be funded through self-pay or government-funded through Medicaid and Medicaid Waiver Community Alternative Programs (CAP) and long-term care insurance.

When valuing a private-duty business, appraisers need to consider patient demographics, particularly wealth factors, to determine the potential for services and profitability. Private-duty businesses are generally more profitable in wealthier communities where patients can fund services through self-pay and long-term care insurance. A provider that is heavily dependent on Medicaid funding for in-home aid services has an increased risk of losses or low margins on this service line.

6.0 Home Medical Equipment Funding[2] (HME)

6.1 Medicare

Medicare reimburses many parts of the country under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Under the DMEPOS Competitive Bidding Program, HME providers located in a competitive bidding area (CBA) are reimbursed the same single payment amount for each item. The reimbursement in each CBA is the result of a bidding process. Medicare regulations allow for the subdivision of CBAs in areas with populations of 8.0 million or more. Most metropolitan statistical areas (MSAs) have one CBA; however, the largest MSAs may have multiple CBAs. The single payment amount in CBAs replaces payments under a fee schedule based on historical supplier charges. The fee schedule was developed in the 1980s and periodically adjusted for inflation. HME providers not located in a CBA are reimbursed based on the adjusted 1980s fee schedule. Numerous studies have determined that payments under the 1980s fee schedule are excessive and that the DMEPOS has save hundreds of millions of dollars.

In addition, Medicare follows a policy referred to as "capped rental." Under a cap rental, many rented items will only be reimbursed for 13 months. The beneficiary must be given a "purchase option" at 10 months. Currently, the capped rental period for oxygen is 36 months; however, there are CMS proposals to lower it to 13 months as with other equipment, such as hospital beds and wheelchairs.

2 Payment basics, Durable Medical Equipment Payment System, Revised: October 2007, published by MedPAC.

There are the following exceptions to the general Medicare payment rule:

- Customized equipment and medications are paid at rates that are determined item by item, by the regional carrier.
- Motorized and special custom wheelchairs now require separate, unique physician certifications as to medical necessity *and* prior approval by Medicare.

Appraisers will need to evaluate the effect competitive bidding has had, on financial forecasts and how it affects risk-adjusted rates of return. Has management adequately incorporated these changes in their forecasts and, if not, how does that affect the appraiser's key assumptions? Also, when using valuation methods under the market approach, consider whether historical transactions reflect HME business that are reimbursed under the fee schedule or the DMEPOS Competitive Bidding Program.

7.0 Home Infusion Therapy (HIT) Funding

This is a very specialized service line and is fraught with regulatory complexities governing coverage and reimbursement. Many infused drugs and biologicals must be "incident to physician services," meaning that the drugs and procedures are administered under the direct supervision of a physician (e.g., drugs administered through implantable pumps). Historically, profit margins in this service line have been the highest of all home care service lines, but payment rates and margins are declining rather dramatically and driving industry consolidation even among large regional and national providers.

Increasingly, hospitals are discharging patients "sicker and quicker." When they return home, some patients will require infused drugs or biologicals. Many treatment regimens are of short duration (three to 10 days) and, as a result, patients are frequently discharged from an acute care hospital to a skilled nursing facility to complete therapy treatments before being sent home.

Home infusion therapy is covered by Medicare under Part B. Unlike home health, hospice, and home medical equipment service lines, however, private insurance (not Medicare) is the major payor of HIT services at this time. Private insurance companies have very competitive pricing and frequently select only a few suppliers in a geographic area for contracting (called "closed panels"). Increasingly, providers must be large in size to compete on rates and many smaller, independent providers have been exiting the market.

7.1 Medicare

A number of HIT therapy regimens and products have been incorporated into CMS's competitive bidding program. Some very specialized therapeutic regimens are paid at rates established by each local Medicare Part B carrier based on a percentage of the average wholesale price for infusion drugs, related administration supplies, and professional pharmacist fees. These services, like HME, are subject to Part B coinsurance and deductibles. The Part B benefit does not reimburse for any associated nursing visits for in-home infusion administration; however, there can

be additional funding available for the administration of the drug by a nurse if covered under a home health plan of care by a Medicare-certified home health provider or if covered under a state's Medicaid program or the patient's private insurance policy. If the nursing visits are not reimbursable through any of these sources, then the HIT provider can choose to absorb this cost or attempt to bill and collect it from the patient. However, smaller HIT providers may find that charging the patient for the nursing visits could put them at a competitive disadvantage if larger suppliers (especially national providers) do not charge for this as is their standard practice. Often, HIT providers contract for HIT nursing services from a local home health agency. Alternatively, a patient may elect to complete the required infusion therapy in a skilled nursing facility (SNF) where third-party coverage will pay for both the therapy and the nursing.

Appraisers must be keenly aware of the service area's demographics and median incomes because collection of coinsurances and deductibles is a significant factor in supporting gross margins in this service line. Also the development, or proposed development, of other competing "locations of care" (such as a new outpatient cancer center operated by local oncologists or the development of a hospital-owned (hospital-based) or physician-owned ambulatory infusion center) can dramatically reduce a HIT provider's revenue.

8.0 Home Health Industry Information

It is important for appraisers to compare the subject company being valued to industry benchmarks. The comparison can assist the appraiser in reaching a number of conclusions about the subject company. For example:

- Whether the subject company is being run effectively and efficiently relative to its peers;
- Whether the subject company has too much or too little debt;
- Whether the subject company has a favorable mix of payors or too little fee for service Medicare;
- Whether the subject company has too much or too little working capital; and
- Whether the subject company is growing faster or slower than other companies, and how growth is being financed.

In addition, it is important for appraisers to understand the outlook for the industry to evaluate growth, risks, and other factors that might affect the subject company.

8.1 It's All About Labor

As a service business, labor is the most important resource and cost component for most of the home healthcare service lines (home health, private duty, and hospice). If you understand labor cost and efficiency, you can generally tell how a home healthcare business is performing relative to its peers. First, it's important to know how a company's labor cost per full time equivalent

(FTE) employee compares to other home healthcare businesses. Second, you need to know how productive those employees are relative to their peers. For example, according to the *Homecare Salary & Benefits Report 2014-2015* (published by Hospital & Healthcare Compensation Service, October 2014), a registered nurse should be compensated $30.02 per hour or an average of $37.89 per visit. The report indicates that registered nurses average 5.19 visits in an eight-hour day.

It's also important to know the staffing mix (for example, registered nurses, licensed practical nurses, home care aids, physical therapists, occupational therapists, and social workers). The staffing mix can tell you whether the company is too heavy or too light at various staffing levels and whether it may be missing opportunities to provide additional services.

There can be severe medical personnel labor shortages in many markets. As a result, maintaining low turnover rates is critical and should be carefully assessed during a valuation engagement. Many studies have shown that turnover costs (for example, recruitment, new employee training, and lost productivity) can increase the annual cost of an employee by 33% or more, based on the nature of the position. High turnover rates may result from noncompetitive wages and benefits, poor moral, lack of leadership, and so on.

8.2 Unless They Sell Products

For those service lines that sell products (home medical and respiratory equipment, and home infusion), gross profit margins are the key benchmarks. Gross profit margins can be positively affected by payor mix on the revenue side or by cost of goods sold on the expense side. By understanding what revenue and margins should be, appraisers can evaluate whether or not there are opportunities available to a hypothetical buyer (under the fair market value standard).

8.3 Additional Considerations for Home Hospice

For home hospice services where per diem (or daily) payments frequently represent the total amount available for patient care (that is, there are no separate payments for additional services), it is important to effectively manage the cost of drugs, HME, and continuous care nursing or home health aid expense. Hospice providers with abnormally high costs may be overpaying for these services or providing unnecessary services, and providers that have abnormally low costs may be missing out on necessary services that might attract a better mix of patients for financial success of the service line.

8.4 Data Sources

There are a number of standard industry data sources (such as the Risk Management Association and Integra Information Systems) appraisers use, and there may be industry-specific sources, such as surveys developed through trade associations or industry analyses complied by consultants and financial services companies. In addition, sometimes valuable information can be found in trade magazine articles.

For example, the National Association for Home Care & Hospice (www.nahc.org) and the

National Hospice and Palliative Care Organization (NHPCO) have valuable industry resources but membership is required to access some of the more substantive information.

For highly regulated industries, such as health care, there is a significant amount of information available from government agencies, think tanks, and advocacy groups.

8.5 MedPAC

The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

MedPAC, in numerous reports to Congress has criticized the home health industry for excessive margins above 10%. However, in the 2013 calendar year for Medicare home health cost reports, the median margin for all hospital-owned agencies was a negative (19%), which is significantly lower than margins reported for freestanding providers.[3] However, when CMS selects data for rate setting, all the hospital based providers (there were 1,102 hospital-owned providers in 2013) are excluded. Thus, over 10% of the providers are not included when MedPAC reports that providers should be able to absorb additional cost increases in addition to decreases in base (Medicare) payments. Also, it should be noted that in the 2013 MedPAC data 3,995 of the 8,875 freestanding businesses (not hospital owned) had a margin of less than 10% and 2,394 of these providers had negative margins. In addition, Medicare fee-for-service is the primary revenue source that has historically reimbursed above a provider's cost. As a result, it is important to determine whether the payor mix for the agency reflects a declining percentage of fee-for-service Medicare. If so, the agency could have a major financial challenge.

The negative margins typically found in hospital-owned agencies may relate to the allocation of hospitalwide overhead costs. Hospitals usually do a good job allocating direct costs. However, indirect costs are usually allocated based on a variety of methods such as the relative number of employees or hospital space used. As a result, when valuing a hospital-owned program, appraisers need to consider whether negative margins could be corrected if overhead costs were normalized to reflect a nonhospital agency. This is a critical consideration for the appraiser when valuing a hospital-owned agency. In most cases the appraiser will want to recast the agency as non-hospital-owned to reflect comparable overhead costs.

Under the ACA and recently passed legislation to correct years of inappropriate computations of physician payment rates, CMS plans to continue to reduce Medicare payments to HHAs through 2019.

3 From an analysis developed by CliftonLarsonAllen using a database of Medicare cost reports in the public domain.

A few highlights from 2015 proposed rules from CMS that will affect 2016 fiscal year payments:

Medicare Home Health

- Proposed rules were published July 10 for 2016 Medicare payment rates that call for a reduction in payments by 1.8% from 2015. The rate change would be effective Jan. 1, 2016.
- The rule includes testing of a new home health value-based purchasing (VBP) model to begin January 2016. The model would apply a payment reduction or payment increase to Medicare-certified home health payments, depending on 29 performance measures, for all agencies within nine states. Payment adjustments would be applied annually, beginning with 5% and increasing to 8% in later years. The VBP for these test states in 2018.

Medicare Hospice

- Proposed rules were published May 5 for 2016 Medicare payment rates that provide for 1.3% increase over 2015. The rate change would be effective back to Oct. 1, 2015.
- The rule includes a proposed change in the payment for routine home care services. CMS proposed to establish two different payment rates with a higher base payment for the first 60 days of care and a lower rate for days 61-plus. For hospice patients who are discharged and readmitted to hospice within 60 days of discharge, his or her prior hospice days will continue to follow the patient and count toward their patient days for the receiving hospice upon the original hospice election.
- Service Intensity Add-on (SIA)—CMS proposes to pay an additional amount above the routine home care rate for care provided in the last seven days of life when certain criteria are met. The SIA would not be paid for patients residing in nursing facilities or skilled nursing facilities. The SIA would be based on the continuous home care rate and limited to a certain number of hours and only for care provided in person by a registered nurse or social worker.

Knee and hip surgery with an all-inclusive bundled payment from Medicare … CMS proposed bundled payments for knee and hip surgeries marks the first time Medicare is making the payment model mandatory for 75 MSA locations across the country. The bundled service covers all related care for a 90-day episode of care for MS-DRG (medical severity-diagnosis-related group) 469 and 470.

- Begins Jan. 1, 2016, for a five-year test period.
- With very few exceptions, all post-acute care is included (intermediate rehab facility, long-term acute care hospital, home health, hospice, outpatient therapy, skilled nursing facility, physicians, etc.).

- Hospitals and post-acute providers would be paid under the usual Medicare fee-for-service model throughout the year. At the end of each year, actual spending for the episodes (total expenditures for related services under Medicare Parts A and B) would be compared to the hospital-specific benchmark for the responsible hospital.
- Hospitals would be paid a bonus or be required to repay Medicare based on the quality and efficiency of the care provided during the episode, as determined by a standard set of quality measures (complications, readmissions, and patient experience). In the first year, there is no risk of payback; only the opportunity for a bonus.
- Patients will continue to have the freedom to choose their post-acute providers.
- Allows for telehealth services, but they cannot be a substitute for in-person home health services provided under the Medicare home health benefit.

9.0 Valuing Home Healthcare Businesses

9.1 The Income Approach

The income approach, and more specifically the discounted cash flow method, is the valuation approach and method preferred by most appraisers to value profitable operating businesses. This method can be difficult to use for marginally profitable or unprofitable businesses if there is inadequate cash flow to provide a reasonable return on the business' assets. In that case, methods under the market or asset approach may be more appropriate.

Under an income approach, it is important to determine whether the forecasted cash flows are reasonable and achievable. If the appraiser thoroughly understands the business and the industry (as previously discussed), he or she should be able to reasonably make this determination and factor it into the development of a discount rate applicable to the cash flows forecasted for the subject company.

When evaluating forecasted cash flow growth rates, the appraiser needs to consider imminent changes and proposed changes to reimbursement, opportunities for the subject company to expand, population growth, age demographics, and age-cohort specific use rates where data might be available.

Looking at the specific operational issues affecting the company, its historical operations, and by making comparisons to industry data, the appraiser should be able to evaluate the reasonableness of future working capital needs and capital expenditure requirements.

Care must be used in developing an equity discount rate that results in a risk-adjusted rate of return necessary to attract buyers to invest in the subject company. Appraisers need to ensure that they understand the operating characteristics (for example, size, growth rates, margins,

product, and service mix) of the business or businesses from which discount rates and equity risk premiums are derived and make appropriate company-specific risk adjustments to reflect differences between the subject company and the source of these rates or premiums. In addition, there could be other changes such as new legislation, proposed or enacted, that was unknown when the market-derived discount rates or premiums were published.

Most home healthcare businesses are not capital intensive. (One exception would be a hospice with an inpatient and residential facility.) As a result, they generally do not incur (nor do they have a need to incur) significant long-term debt. The appraiser must consider this and other factors when determining a debt-to-equity ratio for a weighted average cost of capital (WACC) assumption. Caution should be used in automatically using debt-to-equity ratios derived from publicly traded companies because they may not be "pure plays"[4] and the subject company may have significantly different operating characteristics and growth opportunities. Under the fair market value standard, the debt-to-equity ratio, used in the WACC, should be one that is reasonably achievable by the subject company and likely to provide the returns anticipated to debt and equity investors from the anticipated cash flows used in the forecast.

Appraisers need to ensure that risk-adjusted rates of returns used match the earnings stream being valued. It is generally acknowledged that most discount rates are derived from public company transactions on an after-tax basis. When valuing healthcare businesses for regulatory purposes (for example, under the anti-kickback statute and transactions involving nonprofit IRC 501(c)(3) entities), it is generally accepted that controlling interests must be valued on an after-tax basis (including pass-through entities) under the assumption that the most likely buyer is a commercial C corporation. One rationale for this is that, without having to pay taxes, nonprofit organizations could theoretically afford to pay more than a comparable for-profit organization for the same business. Valuing after-tax cash flows also keeps after-tax discount rates derived from public companies consistent with the subject company's earnings stream. Appraisers need to consider adjustments to the discount rate or methodology that might be required for nonregulatory valuation engagements and for engagements involving minority interests in pass-through entities to maintain consistency between the discount rate and the earnings stream.

9.2 The Market Approach

Methods under the market approach can be useful but difficult to use correctly when valuing home healthcare businesses because it is always hard to find publicly traded companies and sales transactions for companies that are truly comparable to the subject company. Unless the comparable company is publicly traded, it is almost impossible to adequately evaluate a comparable company's operating characteristics. Some comparable sales transactions may predate current reimbursement levels, economic changes, or not have anticipated proposed legislation, which might result in an erroneous conclusion about a current transaction. Furthermore, a significant number of comparable sales transactions represent acquisitions by existing healthcare

4 A pure play is a company that is only in one line of business. Many public companies are in multiple lines of business.

companies that may recognize economic synergies resulting in an investment or synergistic standard of value (not fair market value if that is the standard desired).

Despite these limitations, a thorough analysis of publicly traded companies and comparable sales transactions is extremely useful in developing an understanding of the marketplace, value drivers, who the most likely buyers are, and in determining a reasonable range (low to high) to test values indicated under other approaches.

The market approach can also be useful when operating income and cash flows are indeterminable because of poor records or commingled operations, or in the case of the mismanagement of an otherwise sound company. In those cases, market-derived valuation multiples that are not tied to earnings can be useful. Assuming you have reliable revenues and daily census data for the subject company, price-to-revenue multiples, or price-to-average-daily-census multiples from guideline publicly traded companies or comparable sales transactions are useful in estimating an indicated range of potential values.

For example, buyers within the industry will frequently use a multiple of patient average daily census (ADC) data to benchmark the value of these businesses. If the benchmark is $50,000 per ADC and the ADC is 200 patients, the business might be worth $10 million.

However, remember that when choosing a revenue multiple or census multiple, you are implicitly assuming that the subject company has all of the operating characteristics from which the revenue or census multiple was derived. So appraisers must be extremely careful when relying primarily on market multiples.

Developing a significant understanding of the subject company and the industry can go a long way toward overcoming the shortcomings inherent in the market approach. For example, if you can benchmark a company's revenue and direct labor costs relative to its peers, you may become more comfortable in choosing a revenue or daily census multiple.

Methods under the market approach appear simple and intuitive and therefore, have great appeal. But these methods need to be used judiciously and generally in conjunction with other approaches.

Aside from traditional public company research and general sales transaction databases, Irving Levin Associates Inc. (www.levinassociates.com) publishes *The Senior Care Acquisition Report*, which includes information about publicly announced home healthcare transactions.

9.3 The Asset Approach

Methods under the asset approach are rarely used as the primary method to value operating companies such as home health care unless the business is unprofitable or marginally profitable whereby cash flows do not produce an adequate return on assets. However, methods under the asset approach should still be considered to ensure that values under other approaches (primarily

the income approach) exceed values that would be developed under an asset approach, which is usually viewed as the lowest or floor value.

Under an income or market approach, the premise of value is almost always a going concern. When using an asset approach, the premise of value is sometimes more difficult to determine but the valuation methods used must be applied consistent with the premise chosen.

10.0 Special Situations Affecting Home Healthcare Value

10.1 Management's Integrity

Health care is arguably the most highly regulated industry in the country. Many of the regulations facing providers today were enacted to address years of providers abusing the system and profiting illegally and unethically under government programs, such as Medicare and Medicaid, and private insurance programs.

Today, there are significant fines, penalties and the possibility of prison for violating federal and state regulations governing the healthcare industry and nonprofit organizations. While enforcement has helped to curb abuses, they still exist.

While appraisers generally are not performing due diligence, it is important for them to do a high level assessment of management's integrity. Appraisers who understand the home healthcare industry and the associated regulations also understand many of the illegal schemes and can evaluate management's integrity fairly effectively through benchmarking the company against its peers (looking for anomalies) and interviewing management (looking for inconsistencies).

The risk associated with management's integrity can impact whether revenue levels and profitability can be maintained by a hypothetical buyer who may not be willing or able to operate the business illegally or unethically. The appraiser should always require that the organization being valued disclose any and all correspondence and external audit findings that have been conducted by state licensure agencies, Medicare-certifying organizations, Medicare and Medicaid fiscal intermediaries, focused medical review audits and findings, and any past or ongoing notifications from the Office of the Inspector General (OIG) including past or current corporate integrity agreements (CIAs). Other useful tools to test the operational integrity of the organization is whether there is a compliance plan in place that is modeled after the OIG's suggested format as well as internal audit committee reports and findings that would be a component of the compliance plan.

The appraiser's assessment of management's integrity may create the need for normalizing adjustments and should have a direct effect on risk-adjusted rates of return used under an income approach as well as judgments made by the appraiser using methods under other approaches.

10.2 Certificate of Need (CON) States

States may restrict or limit new home health businesses though CON legislation. Typically, these states limit CON application to service lines that are "skilled in nature" and heavily dependent on Medicare and Medicaid certification and reimbursement such as home health and hospice. However, some states also have regulations that govern establishment of new "licensed-only" providers that will not be Medicare-certified but will obtain reimbursements from Medicaid.

To start a new home healthcare business in a CON state, you generally need to demonstrate adequate demand and need. Depending on the state, the CON process can be time-consuming and expensive. Generally, home healthcare businesses in CON states will be worth more compared to a similar business in a state without a CON. However, each state's CON rules may be more or less restrictive, and the appraiser should research the state's current plan for home healthcare services to determine whether there is opportunity for new businesses to enter the market. Even if the business is no more profitable in the CON state, the lack of new competition will generally reduce risk compared to businesses in non-CON states.

In states where CONs are very restrictive, the CON alone can be worth a significant amount of money, even without an operating business and, as a result, sometimes CONs are valued independent of the operating business.

Appraisers need to consider the effect on the discount rate when valuing home healthcare businesses in CON states versus non-CON states. When valuing a CON alone (without an operating business), appraisers should generally rely on the income approach (relief from royalty method) or possibly the cost approach, unless comparable transaction data for the CONs in the state are available. If using a relief from royalty method, consider what percentage of the expected operating margin should be allocated to the CON when doing a pretax royalty rate calculation. For example, if agencies are expected to earn 12% in that market, the pretax royalty rate for the CON valuation calculation might be 3% (or 25% of the 12% operating margin, for example) of the forecasted revenues expected if the CON were used in an operating business.

10.3 Valuing Provider-Owned Home Healthcare Businesses

Home healthcare businesses owned by hospitals or nursing homes are unique because they generally will not have their own financial statements or tax returns and will almost never have a balance sheet. They generally only track costs directly applicable to departments or service lines such as home health services (for example, direct supplies, direct compensation, and benefits) but allocate indirect overhead (such as telephone, security, maintenance, rent, utilities, human resource, and information systems) from the parent entity's total overhead. As a result, operations for provider-owned home healthcare businesses are generally not comparable to stand-alone businesses.

Without objective financial statements (and particularly balance sheets), it is usually impossible to develop meaningful financial ratios and analysis. However, a number of operational

benchmarks, such as revenue per visit, average daily census, or visits per employee, can still be developed and compared to industry benchmarks to evaluate the quality of operations.

Another potential problem in valuing a provider-owned home healthcare business is that sometimes they are not motivated by profit. In some cases, the lack of profit motivation may be because home health is not a core part of the overall business and may contribute little to overall operations. In other cases, the business may be viewed solely for its contribution to the parent entity's mission or as part of a continuum of care. While lack of profitability is not inconsistent with being a nonprofit organization, management sometimes uses its nonprofit mission to rationalize underperformance. Appraisers need to understand that marginal profitability, or even losses in the hands of management, doesn't necessarily mean these businesses cannot be run profitably in the hands of profit-motivated management.

To value provider-owned businesses, historical and forecasted operations need to be normalized and made comparable to non-provider-owned or stand-alone businesses. Great care must be exercised in doing this to ensure that only controllable costs are adjusted and uncontrollable costs, which may be unique to that marketplace, are not changed. Care must also be exercised to ensure that, under the fair market value standard, adjustments are not unique to a particular buyer.

Appraisers need to develop a reasonable understanding of industry benchmarks for home healthcare businesses to support or evaluate the assumptions that will be necessary to convert the hospital-owned business into a non-hospital-owned business.

Some questions typically asked during these assignments are:

- How much space (square footage) does the business really need?
- Is the rent too high and location too expensive for the needs of the business?
- Is the business sharing management with other departments and how are those costs allocated?
- Are the parent entity's labor costs and benefits comparable to a non-provider-based business?
- Are there costs and other administrative functions that are only required because they are part of the larger entity (for example, Joint Commission accreditation)?
- How are patients referred for home healthcare services?

How referrals are made to a provider-owned business can have a significant impact on its value—and, of course, referrals are a key regulatory risk area. For example, there is less risk of losing referrals if they come from a variety of physicians as opposed to only physicians employed by or on the staff of the parent entity. While this is a typical risk associated with a concentration of customers, it may be more prevalent for provider-owned businesses. In valuing the business

under a fair market value standard, the appraiser should evaluate what would change if the business were not part of, or reliant upon, the parent entity.

10.4 Real Estate and Nonoperating Assets

Most home healthcare businesses are not capital-intensive (an exception might be a hospice that has an inpatient or residential facility). As a result, real estate and other nonoperating assets can create special problems in determining value. In particular, cash flows from the operating business often will not provide an adequate return on the real estate and nonoperating assets.

Generally, these assets should be excluded from the value of the operating business and valued separately if they are, in fact, going to be acquired as part of the transaction. These assets should be removed from the balance sheet, and their historical costs should be removed from the income statements. For those assets, such as real estate, that are used in the business, fair market value rent expense (assuming a fair market value standard) should be substituted for the cost of owning and operating the real estate. Fair market value rent for the operating business should be consistent with rents that would be paid by other home care businesses for only the square footage needed to operate a similar business within the subject company's market. Fair market value rent could be more or less than rents paid historically or agreed to prospectively.

If the valuation is being done for regulatory purposes, rent that is below or above fair market value is a potential issue that should be evaluated by a healthcare attorney familiar with applicable regulations.

11.0 Conclusion

Valuing home healthcare businesses is not unlike valuing other businesses except that appraisers should have a significant understanding of their operating characteristics and the industry. Changes in future reimbursement can significantly affect earnings and value. Accountable care organizations and bundled payments may completely change providers' business models and cost structures and the way they are reimbursed. As a result, it is incumbent on appraisers to be familiar with the affect these changes may have on the business. In addition, for any healthcare engagement, appraisers should have a reasonable understanding of regulations affecting healthcare providers and nonprofit organizations and a grasp of the current changes that may be enacted by Congress and state legislatures.

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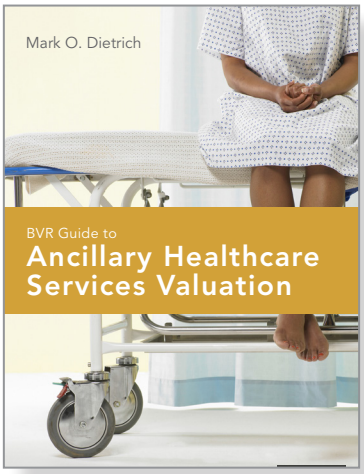

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