Multiples in Healthcare Valuation

On May 4th, 2022, there was an event that had a significant impact on healthcare valuation. The Fed raised the interest rates with much fanfare and in a predictable fashion. Last week another change occurred, but it was with no fanfare and little notice except by consultants working actively within the spreadsheet world. This less obvious event was the increase in the published Kroll standard for the application of business risk.[1]

Interest rates are rising, and risk factors are increasing. So too are the costs of materials and labor. This means that cost projections in healthcare projections must follow. While we know that Starbucks is raising its prices,[2] there are no projected increases on payments for Medicare, Medicaid, or commercial payors.

Each of these increases impacted the multiples that would be used to describe the value of a health care enterprise. Clients throw around ideas that they read in a two-year-old magazine article to describe value with biblical certitude. If they are correct, it is by pure coincidence. How many times has anyone said, "Our ASC is worth 6.145 times EBITDA?"

Multiples are a derivative of valuation, not an indicator. They can be pushed up, or down, by fundamentals. What are some of the factors that might impact value and, in turn, the multiplier?

1) The longevity and stability of earnings history impact the valuation process. Short-lived businesses or those with earnings volatility have lower multiples.

2) The payor mix is a key indicator of the value. A more favorable payor mix produces higher multiples.

3) Single specialty operations can be highly efficient; however, they also limit recruitment of specialists, and there is some value to diversity. This is a factor that could go either way. A single specialty operation that is well run and which has a critical mass of providers involved is not going to be considered any riskier than a multiple-specialty business.

4) The licensure and certification process affects market access and cost of entry. States like New York with licensure barriers have higher multiples due to costs of licensure and delays to market entry. Think of certificates of need (CONs) and the current New York State moratorium[3] on Certified Home Health Agencies (CHHAs).

[1] Kroll used to be Duff & Phelps which used to be Ibbotson SBBI. This is a business reporting service that passes judgment on factors that make up an applied discount rate which is a major input for future projections of EBITDA. (https://www.kroll.com/en).
[2] Retail wire (4/25/22), "The coffee chain is planning to raise prices by up to 30 cents on some drinks beginning on July 12." (https://retailwire.com/starbucks-plans-price-increase/).
[3] New York State does have a moratorium on CHHAs. In the case of Licensed Home Care Services Agencies (LHCSAs), it has a need methodology that has yet to be implemented. This unpublished need criteria are as good as a moratorium without using the exact word. (https://www.leadingageny.org/providers/home-and-community-based-services/lhcsa/doh-guidance-available-on-lhcsa-moratorium/).

5) The source and nature of referrals is also a factor since an aging medical staff or a staff that is serving a unique or specific population is less likely to be able to regenerate referrals if some major source of patients is abruptly interrupted. Multiple doctors from various practices serving a variety of patients results in less risk (higher value and increased multiple). A concentration from any one practice or doctor suggests higher risk, lower value, and lower multiples.

6) Complex and/or unconventional operating structures have an impact on multiples. The Diagnostic & Treatment Center with a convoluted operating agreement that advantages one class of owner over another, or which has lengthy contracts with vendors or suppliers, has less value than a similar operation with a traditional governance structure which is free to contract through open-market (competitive) transactions.

7) Relationships matter. Contractual relationships matter a lot. If there are MSO agreements, long-term medical director commitments, block time guarantees, employee compensation guarantees, hospital linkages, supplier arrangements, etc., there may be costs that cannot be controlled. The practice or the business entity is not scalable. This lack of flexibility would suggest higher risk and lower resulting multiples.

8) Related parties can be either an advantage or a hindrance. To the valuator, related party transactions are a limiting factor. Value is impacted negatively, and multiples are as well.

9) Real estate is a significant factor in the compilation of costs, but it is also a factor in longevity and the stability of a business. Lease rates and occupancy costs are sensitive to inflation. The nature of the lease can impact risk. The related party lease is especially troublesome in a valuation. Occupancy costs and the risk of relocation might each have a significant impact on a health care entity. The result of each would push value down.

10) The environment in which a business operates must be considered. Connecticut is a state with low penetration of managed care. New York and New Jersey are both impacted by higher levels of managed care. Each state has different business tax structures. Similar businesses in each of these areas will have differing multiples.

11) Balance sheet recalculations often have an impact on valuation. This is where payments to past partners, non-traditional debt contrivances, and undefined allocations often require adjustments to value. Seldom is value added through the correction of balance sheets. Lower values result.

12) The structure of the transaction can impact a value and, thus, force a higher or lower multiple. This is most evident when the transaction is related to controlling or noncontrolling interest, or when there is a payout schedule or contingent portions of the transaction.

13) The parties to the transaction impact the price. The regulatory and compliance constraints impact the price as well. A non-profit must prove that any transaction is fair market value.[4] A for-profit does not. A private equity group with capital to deploy on its way to some future open market offering can pay whatever it wants. This is especially true if it is paying with a combination of stock and cash. This is an area where the price is not only unpredictable, but it is also not easily described.

Multiples describe the value of a transaction. They are used by parties who need a short form to discuss, or brag about, a deal that is the result of a complex set of variables. The value of a business entity depends upon the business assets (adjusted for liabilities) and the business performance – past and projected.

Today, the interest rate went up. Last week, published risk factors increased. Cost projections in spreadsheets that were pretty accurate a month ago are being updated. Discount rates are increased as a result of uncertainty and the climbing cost of capital. The practice that was worth a million dollars last week is now worth $950 thousand. More problematic is that the fair market value has decreased in the middle of the transaction that has been negotiated for months.

Many conversations begin with “My practice is worth one-times-gross” or “The literature says our ASC should sell for six-times-EBITDA.” The real answer is “maybe.” When the literature suggests that an “average multiple” is in the range of five or six times something, one should remember that the average is a result of pooling transactions that are higher and lower, and that each transaction has its own set of inputs and assumptions.

[4] Fair market value has a specific definition within the disciplines of economics and finance. It has a different definition and application under regulatory guidelines promulgated by the various states and the Office of the Inspector General (OIG). Health care counsel familiar with the regulations related to the parties in the transaction under consideration should always be at the table when terms are considered.