

Health Care Industry Valuation Insights

THE VALUATION OF HOME HEALTH CARE AGENCIES

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Due to numerous demographic and economic factors, the demand for home health care agency services is expected to increase in the future. However, regulatory and reimbursement issues will force home health care companies to consolidate. This article discusses several of the factors that affect the pricing of home health care agency merger and acquisition transactions. And, this article presents a simplified illustrative example of one valuation method that is commonly used to value such agencies.

INTRODUCTION AND INDUSTRY BACKGROUND

The home health care services industry segment includes four broad categories:

1. home health nursing services,
2. infusion therapy,
3. respiratory therapy, and
4. home medical equipment.

The U.S. home health care industry includes about 12,000 companies and agencies with combined annual revenues of \$40 billion. Large companies in the home health care industry include Apria HealthCare, Gentiva Health Services, Lincare Holdings, Option Care, and Rotech HealthCare. Approximately one-quarter of the industry revenue is generated by nonprofit organizations, such as hospital-based agencies and visiting nurse associations.

The industry is highly fragmented: the 50 largest organizations control less than 25 percent of the market. A typical local home health care agency has 80 employees and generates annual revenue of \$3 million.

State and federal government programs provide almost 65 percent of industry revenue, including more than 30 percent from Medicare and 25 percent from Medicaid. Approximately 20 percent of revenue comes from private health insurers, the rest from individuals in the form of co-payments. The Medicare program pays for 2.5 million patients per year, with an average of 35 visits per patient and an average payment per visit of approximately \$85.

Many Medicare and private insurance plans closely follow the Medicare payment schedule. Under its Prospective Payment System (PPS), Medicare pays a set amount per

60-day period, regardless of the number of home visits completed.

The industry is highly regulated because of the large participation by Medicare and Medicaid. The Balanced Budget Act of 1997, the Medicare Balanced Budget Refinement Act of 1999, and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 affected reimbursement levels for various home health care services.

Historically, the detection of numerous instances of fraud in billing prompted new legislation. This legislation included:

1. the Medicare Anti-Kickback Law,
2. the "physician self-referral" provision of the Omnibus Budget Reconciliation Act of 1993 (known as Stark II),
3. the False Claims Act,
4. the Health Care Fraud Statute of 1996, and
5. the False Statements Statute of 1996.

Most large home health care companies have accreditation from the private Joint Commission on Accreditation of Healthcare Organizations. Home health care companies need state licenses. And, home health care agencies must meet eligibility standards for certification as Medicare and Medicaid providers.

This discussion summarizes changes in the reimbursement system with regard to the home health care industry sector. Further, this discussion presents a simplified valuation of a small home health care agency. This illustrative valuation is based on an analysis of guideline company merger and acquisition transactional data. This simplified illustrative example identifies both:

1. the common factors that affect the value of home health agencies and
2. the considerations that valuation analysts make when selecting valuation pricing multiples.

PROSPECTIVE PAYMENT SYSTEM

The Balanced Budget Act of 1997, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999, called for the development and implementation of the PPS for Medicare home health services.

The Balanced Budget Act of 1997 (BBA) put in place an interim payment system (IPS) until the PPS could be implemented. Effective October 1, 2000, the home health PPS replaced the IPS for all home health agencies.

The following discussion is based on the final provisions of the PPS:

- Medicare pays home health agencies for each covered 60-day episode of care. As long as beneficiaries continue to remain eligible for home health services, they may receive an unlimited number of medically necessary episodes of care. Payments cover skilled nursing and home-health aide visits, covered therapy, medical social services, and supplies.
- Medicare pays home health agencies at a higher rate to care for those beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians, as already required for all Medicare-participating home health agencies.
- For each 60-day episode, the payment system uses national payment rates, ranging from about \$1,100 to \$5,900. The rates depend on the intensity of care required by each beneficiary, with adjustments to reflect area wage differences.
- Agencies receive additional payments for an individual beneficiary, if the costs of care are significantly higher than the specified payment rate. Such "outlier" payments are intended to account for the unusual resource needs of specific beneficiaries.
- To ensure agencies are adequately paid up front, the Health Care Financing Administration (HCFA) pays 60 percent of the initial episode payment when the agency first accepts a new Medicare patient as part of a streamlined approval process. Agencies receive the remaining 40 percent at the end of the first 60-day episode. For subsequent episodes, payments are divided equally between the start and end of the episode.
- Payment rates are adjusted to reflect significant changes in a patient's condition during each Medicare-covered episode of care.

- Home health agencies receive less than the full 60-day episode rate if they provide only a minimal number of visits to beneficiaries.
- Medicare pays home health agencies and other suppliers separately for medically necessary durable medical equipment provided under the home-health plan of care. In the Balanced Budget Refinement Act of 1999, Congress eliminated an earlier law that would have required agencies to bill for this equipment even if outside suppliers provided it.
- To ensure agencies provide adequate services to beneficiaries, HCFA conducts extensive medical review to obtain early feedback on common errors, vulnerabilities, and trends. The HCFA also monitors the quality of patient care, using information from the comprehensive patient assessments already used by agencies.

The industry highly depends on the reimbursement rates that insurers allow for specific home health care services, especially Medicare. Because home health care providers are reimbursed only a set amount for care provided to Medicare patients under the newly implemented PPS, this will likely force providers to consolidate in order to achieve economies of scale. As a result of this consideration, the industry may be transformed from the current multitude of "mom and pop" agencies to larger regional or national health care companies that can provide low cost services.

The rapid increase in national health care costs in recent years continues to keep health care at the forefront of political discussions. Because the home health industry generally is forced to operate at an overall low-cost structure, any cuts in reimbursement regarding Medicare rates detrimentally affect profitability. This, in turn, typically exerts a detrimental impact on an agency's value.

Many home health care companies went bankrupt after Medicare reimbursements were cut in the late 1990s. The first of several five percent annual reductions in Medicare reimbursement rates is scheduled to start in 2006, potentially reducing home health care reimbursements.

INDUSTRIAL TRANSACTIONAL ACTIVITY

As previously discussed, the home health care industry has traditionally been highly fragmented. The industry is comprised primarily of smaller local home health agencies offering limited services. With the implementation of the Medicare PPS on October 1, 2000, and other legislation, the home health care industry experienced major consolidation.

Industry participants and investors appeared to react in part to the fact that PPS allowed profit growth opportunities for efficiently operated agencies. These profit growth opportunities are based on the fixed payment nature of PPS.

The home health care industry experienced a record-setting year for 2004, as merger and acquisition (M&A) transaction volume topped 200 for the first time, closing out at 222 transactions. This level of M&A activity represented a 14.4 percent increase over the level of transactions recorded in 2003, according to the Braff Group *M&A Annual Report*.

Exhibit 1 summarizes the merger and acquisition activity trends in the home health care industry (and related industry segments) in 2003 and 2004.

Historically, home health agencies have represented attractive acquisition targets for hospitals. A hospital that acquires a home health agency has the ability to present itself as a full service organization, based on the expanded continuum of care available.

Further, the implementation of the PPS has made certified agencies more attractive than in past years. This is due to the profit-generating potential created by the fixed payment structure implemented.

COMMON FACTORS CONSIDERED IN THE VALUATION OF HOME HEALTH CARE AGENCIES

When performing a valuation of a home health care entities, the analyst should focus on several key factors:

1. Referral Source Diversity.

Generally, the more diverse the agency's referral sources, the more predictable the revenue stream. In essence, the fact that referrals are not concentrated in a relatively limited number of sources reduces the risk that the loss of a referral source will exert a significant detrimental impact on the future revenue-generating capacity—that is, cash flow potential—of the subject agency.

2. Middle Management Strength.

Generally, the less the subject agency's success is contingent upon the current owner, the greater the likelihood of continued success if the owner departs. Ideally, the subject agency will be structured in a manner that separates the key "business" functions from the "provider" functions. In addition, different individuals within the subject agency should fulfill such management responsibilities.

3. Current Business Trends.

Generally, stable or growing businesses are less risky than those in decline. A long-standing agency is likely to be established in the communities it serves. Such an agency may operate with strong name recognition and diversified referral sources. Such a circumstance typically translates into potential for future growth.

4. Competition.

Generally, the fewer the competitors, the more predictable the revenue stream. However, it is important to note that most markets can only support a limited number of home health care providers.

The absence of competitors may indicate limited market potential. This limited market potential could effect the revenue-generating capacity of an agency.

5. Payor Mix.

Generally, the greater the diversity of payors, the less a change in reimbursement from one payor will impact the agency. As previously discussed, however, approximately two-thirds of home health industry revenue is represented by Medicare reimbursement.

Therefore, a demonstrated ability on the part of the subject agency to contain costs is key to a higher value for the agency.

6. Product and Service Mix.

Generally (1) the greater the oxygen and other non-capped rental items (for home medical equipment com-

**Exhibit 1
Health Care Industry Segments
Merger and Acquisition Activity
For the Period of 2003 and 2004**

Industry Segments	Number of M&A Transactions in 2003	% of Total	Number of M&A Transactions in 2004	% of Total	% Change
Home Health Agencies	45	23.2	57	25.7	26.7
Hospice	17	8.8	15	6.8	(11.8)
Health Care Staffing	20	10.3	37	16.7	85.0
Home Medical Equipment	86	44.3	90	40.5	4.7
Infusion Therapy	7	3.6	11	4.9	57.1
Specialty Pharmacy	19	9.8	12	5.4	(36.8)
Total Number of M&A Transactions	194	100.0	222	100.0	14.4

panies) and (2) the greater the diversity of products and services (for IV therapy and home nursing providers), the more predictable the revenue stream.

Diversity in product and service mix (similar to diversity in referral sources) reduces risk with regard to continuity and growth in revenue-generating capacity.

7. Accounts Receivable.

Generally, the lower the bad debt expense and the lower the number of days sales are outstanding, the more reliable and predictable the cash flow. While operational statistics (e.g., number of visits, procedures, equipment/product sales, etc.) and revenue generation are indicators of performance success, earnings (and ultimately cash flow potential) drive value.

8. Regulatory Environment.

Generally, the more hostile the regulatory environment, the greater the volatility in reimbursement. A “hostile” regulatory environment generally can be interpreted as an environment of significant regulatory supervision.

Such regulatory supervision imposes a high level of required administrative cost in conjunction with significant downward pressure on reimbursement rates.

In addition to consideration of these key valuation factors, a thorough understanding of the regulatory environment is important to the valuation of home health care agencies and other health care organizations. The valuation analyst should be aware of the state and federal regulations that affect the valuation process and related calculations.

A valuation analyst who is unfamiliar with the civil and criminal statutes that are unique to the health care industry (such as discussed in many of the articles in this issue of *Insights*), may be unprepared to address the issues that affect value.

In addition, a valuation report prepared by an analyst who is unfamiliar with the relevant statutes may not withstand regulatory scrutiny. This would be due to the analyst's failure to demonstrate an understanding of the relevant regulatory guidelines and the related impact on value.

A SIMPLIFIED ILLUSTRATIVE EXAMPLE OF A HOME HEALTH CARE AGENCY VALUATION

All generally accepted health care entity valuation methods can be categorized into three valuation approaches: (1) the income approach, (2) the asset-based approach, and (3) the market approach.

The income approach is based on the premise that the value of any health care organization equals the present value of all estimated future economic income to be derived by the individuals who own the organization.

The discounted cash flow method of the income approach is particularly useful in valuing home health care agencies as these entities have developed a better understanding of their actual and expected future performance under the Medicare PPS. When agencies are able to provide reliable income projections that incorporate PPS assumptions, the valuation analyst can reasonably rely on the discounted cash flow method to produce a relevant value indication.

The asset-based approach is based upon the economic principle of substitution. This principle reflects the premise that an investor will pay no more for an asset (i.e., business or interest in a business) than the cost to obtain—either through purchase or construction—an asset of equal utility (typically, as measured by economic earning capacity).

The market approach is based on the premise that the value of a health care entity is equal to the price investors are willing to pay for similar assets, as represented by investments in guideline publicly traded companies or the acquisition of guideline public or private companies.

The two most common market approach methods are: (1) the guideline publicly traded company method and (2) the guideline merged and acquired company method.

The guideline publicly traded company method relies on data from publicly traded health care companies as the source of guidance in the valuation of a closely held health care organization. The guideline merged and acquired company method relies on data from completed transactions involving public or private health care companies as the source of valuation guidance for the subject health care entity.

A simplified example of a guideline merged and acquired company valuation analysis of a home health care agency is presented below. Based on this method, the value of a home health agency is estimated by analyzing completed transactions involving similar home health care agencies.

To identify relevant transactions, analysts typically search for acquisitions of agencies operating within the same industry classification, as represented by the appropriate Standard Industrial Classification (SIC No. 8082) or North American Industry Classification System (NAICS No. 621610) code.

Some of the sources that valuation analysts commonly use to identify M&A transaction data include: *Mergerstat Review*, the *Merger & Acquisition Sourcebook*, and *The Health Care M&A Report*.

Exhibit 2 presents market-derived pricing multiples from 10 selected M&A transactions for use in the valuation of XYZ Home Health, Inc. (“XYZ”). This illustrative analysis focuses on the consideration of price-to-revenue pricing multiples developed from the analysis of the selected transactions.

Based on the analysis of XYZ in relation to the guideline transactional data, the analyst selected a pricing multiple of 0.75—lower than the median price-to-revenue multiple of

Exhibit 2
XYZ Home Health Care, Inc.
Illustrative Guideline Merged and Acquired Company Analysis
Market-Derived Price-to-Revenue Pricing Multiples

Guideline Merged & Acquired Company	Latest 12 Months Revenue (\$)	M&A Transaction Price (\$)	Indicated Price to Revenue Multiple
John Davis Company	16,000,000	12,000,000	0.75
Ocean Breeze Infusion Care of Farmington	4,000,000	1,940,000	0.49
Metro Preferred Home Health	17,251,000	8,194,779	0.48
Home Health Services Program	3,000,000	1,500,000	0.50
Helpful Home Health Agency, Inc.	29,000,000	19,000,000	0.66
Arcadia Services, Inc.	78,400,000	17,200,000	0.22
Abundant Nursing, Inc.	3,300,000	445,000	0.13
On Duty Metropolitan Connecticut, LLC	3,000,000	1,078,000	0.36
Best Service Health Agency, Inc.	1,750,000	3,500,000	2.00
Median	4,000,000	3,500,000	0.88
XYZ Home Health, Inc.	8,500,000		

0.88 noted for the guideline merged and acquired companies—to apply to XYZ revenues of \$8.5 million.

The analyst selected a pricing multiple lower than the indicated median pricing multiple based on consideration of relative differences (i.e., risk and expected return investments characteristics) between (1) XYZ and (2) the selected guideline merged and acquired companies.

These relative differences in risk and expected return factors include consideration of the following:

- XYZ revenue was approximately 213 percent of the median revenue level of the guideline merged and acquired companies.
- XYZ generated historical returns approximately 15 percent below the median level of identifiable returns realized by the guideline merged and acquired companies.
- XYZ generally operated in a less populated area, with lower expected population growth relative to the typical guideline merged and acquired company.
- XYZ generally reflected a less diverse service and product mix than the typical guideline merged and acquired company.

The factors listed above do not represent an exhaustive listing of factors typically considered when selecting valuation pricing multiples. It is also noteworthy that factors other than revenue size are typically considered in the analyst's selection of the appropriate revenue pricing multiple.

Applying the selected price-to-revenue multiple of 0.75X to the XYZ revenues of \$8.5 million produces an indicated

subject agency business enterprise value of \$6.4 million. This value indication represents a marketable, controlling ownership interest level of value.

SUMMARY AND CONCLUSION

Currently, 40 million seniors live in the United States, a number that is expected to double to 80 million in the next 30 years (as the baby boomers age). Since home health care generally is a preferred, lower-cost alternative to hospital or nursing home care, the demand for these services is expected to increase. The personal consumption of medical services, which includes home health care, is projected to increase at a compound annual rate of 7 percent between 2004 and 2007.

These demographic and economic factors, combined with the continued use of, and experience with, PPS, suggest that home health agencies may experience favorable growth in the future. However, the planned reductions in Medicare reimbursement rates—which account for approximately two-thirds of home health care industry revenues—will require agencies to focus on cost containment in order to enhance value.

The valuation of a home health agency requires (1) the consideration of numerous industry-specific factors and (2) an appropriate knowledge of the regulatory guidelines that affect the revenue and cash flow generating ability of the subject agency.

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