

¶450 Valuation of Medical Practices in the Current Health Care Environment

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The health care industry has undergone dramatic change over the last several years. Technological innovation and an aging population have fueled skyrocketing health care costs. The increased costs have triggered calls for dramatic reform. The inevitable reform efforts will have a profound impact on every sector of the health care industry. As a result of these changes, providers of medical care are resorting to various forms of integration.

The transactions necessary to form integrated health care delivery systems require a sophisticated valuation analysis. The scope of appraisals required for physician buy/sell agreements and marital dissolution litigation are no longer adequate in this environment. The financial appraiser must also serve in the capacity of an advisor.

In the current environment, the financial appraiser must understand the history of the industry, the various regulations, and the impact of the eminent health care reform. Finally, an appreciation for the direction of the industry is essential to effectively perform the valuation of a medical practice.

¶451 Changes in the Practice of Medicine

Political outcry over the escalating cost of health care has created pressure for change in the way health care is delivered in the United States. Simultaneously, changing demographics, specifically the aging of the population, has increased demands on the system. These and other factors are revolutionizing the practice of medicine and the delivery of health care.

The total number of doctors over the last 30 years has increased at a significantly faster pace than the population as a whole. The ratio of physicians to population has increased from 1:683 in 1963 to 1:410 in 1993. The aging U.S. population is having a dramatic effect on the utilization of health care services. The number of Americans over age 65 (who rely heavily on government-supported programs to cover medical expenses) is expected to more than double over the next 30 years to approximately 65 million people. The implications of an aging population are staggering. It has been estimated that individuals over the age of 65 spend, on average, four times as much on health care services as individuals under 65.

While doctors are working harder to serve greater patient demands, the funds available for this increased level of required care are becoming more restrictive. This is largely due to government cuts and the greater bargaining powers of health maintenance organizations (HMOs). In short, an increasing number of doctors are vying for fewer dollars available for practitioners.

¶451.1 Size and Complexity

The size and complexity of medical care practices are increasing. According to an American Medical Association (AMA) survey, almost one-third of all non-federal physicians operate in a group practice (defined as a formal

organization with three or more physicians). The median size of group practices in the United States is five while the mean is 11.5. While multi-specialty groups comprise only 22 percent of all medical groups, they account for over 50 percent of all group physician positions.

Despite the increase in the supply of physicians, there has been a sharp decline in the number of primary care physicians. Unchecked reimbursements for specialty medical procedures encouraged most of the medical students of the 1970s to pursue specialty fields of medical care. The five practices usually referred to as primary care: internal medicine, pediatrics, general practice, family practice, and obstetrics/gynecology, accounted for 46 percent of medical doctors in 1963; today, less than 30 percent of doctors are primary care physicians.

¶451.2 Geographic Distribution

Access to health care has become more limited in rural areas. As the population has shifted from rural to urban areas, many rural communities are unable to support hospitals. This has left rural America with 33 percent of the U.S. population, but only 12 percent of the nation's physicians. Physicians have been attracted to urban areas because of better pay and greater access to technological innovations. Additionally, the type and quality of health care delivery varies from state to state depending on each state's labyrinth of health care regulations. These regulations, coupled with the changing population dispersion patterns are impacting the formation of medical groups. According to an AMA survey, more than one-third of all physician groups in the United States are located in only six states.

¶451.3 Reimbursement

In recent years, the two primary sources of health care reimbursement, private and public funding, have undergone considerable change. In 1960, public funding (including federal, state and local government) accounted for less than 25 percent of reimbursement of health care costs.

Private funding (including reimbursement by traditional indemnity insurance plans) managed care, and individuals, accounted for over 75 percent. However, due to the introduction of the Medicare and Medicaid programs in 1965 and the expansion of these programs during the 1970s, public funding became a larger source of health care reimbursement. Today, public funding accounts for approximately 45 percent of health care reimbursements. In the absence of significant reform, it is projected that by the year 2000, public funding will reimburse a greater percentage of health care costs than private funding.

The Medicare program has been active in developing programs to control health care reimbursement to physicians. Last year marked the first year of the five-year transition phase for the implementation of the resource-based relative value scale (RBRVS), which is a legislated effort to control Medicare costs related to physician services. Changes in Medicaid programs have varied from state to state, but most have resulted in more cost controls on physicians. One side effect of the limitations on public health care funding has been cost shifting from public to private payers.

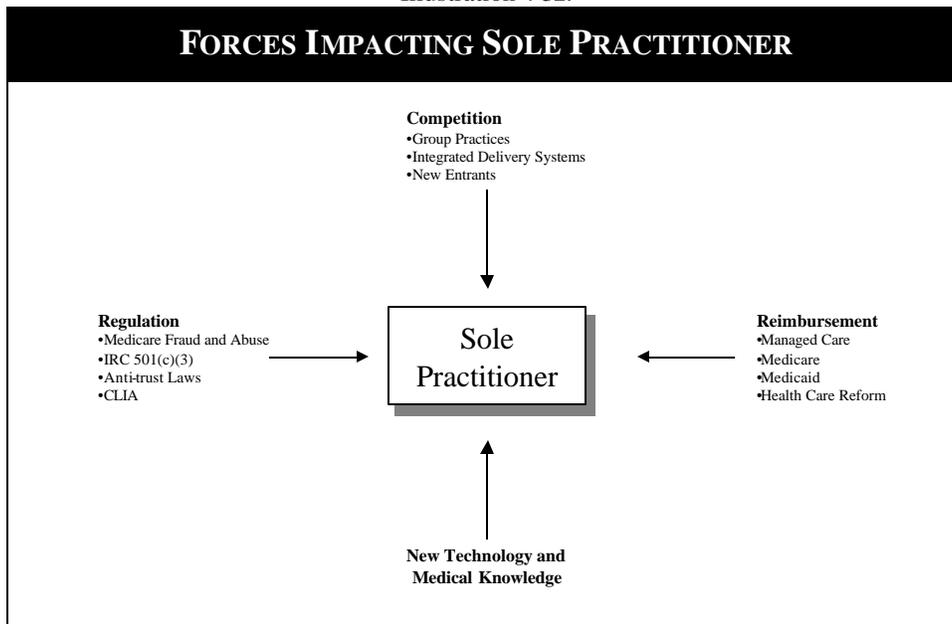
Employers, one of the largest contributors to the health care system, have realized a 300 percent increase in health care costs since 1980. As a result, employers have been very active in designing plans that attempt to control health care costs. These efforts have largely taken the form of managed care plans, most notably health maintenance organizations, which emphasize cost containment by providing a fixed monthly fee to health providers in exchange for an agreement to serve the health care needs of its employees.

Managed care continues to gain popularity and is the cornerstone of the Clinton Administration's proposed health care reform package. Under a preliminary version of the Clinton Administration's proposed plan, every American (including the approximately 37 million who are currently uninsured) will be guaranteed the right to health benefits. Consumers will choose among three prepaid managed care plans offered through regional health alliances. Although the details of reform remain uncertain, it is impossible to underestimate the impact of health care reform on the practice of medicine.

¶451.4 Transformation of Sole Practitioner to Integrated Groups

The decline in the number of sole practitioners in favor of more integrated practices is a result of a number of competitive pressures facing the sole practitioner. In a recent New York Times article, Dr. Steven M. Scott, chairman of Coastal Healthcare Group, Inc., stated, "With health care reform coming, private practitioners are scared... They are looking for any help they can get to economize and keep their income streams up." An illustration of the forces impacting by the sole practitioner is presented in Exhibit 1 and a description of each force follows in Illustration 4-32.

Illustration 4-32.



Reimbursement. In addition to the changes already discussed, managed care networks are increasingly demanding "one-stop shopping" for their health care needs. Given the cost-containment objectives of managed care, payers are rejecting traditional fee-for-service plans in favor of plans paying a fixed capitation payment in exchange for providing health care services. National health care reform will likely encourage the development of integrated provider networks. According to the terms of President Clinton's proposed reform plan, regional health alliances will be formed for businesses and individuals. Insurers and providers will negotiate with the alliances to provide comprehensive health care packages to be offered to the members of the alliances. It will be difficult for sole practitioners to compete with integrated models for these managed care contracts. Therefore, there is little room in this proposed structure for the traditional fee-for-service sole practitioner.

Regulation. A myriad of regulations have impacted the way physicians conduct business. Fraud and Abuse statutes, which formalized the anti-kickback laws, and the Clinical Laboratory Improvement Act (CLIA) restricts referrals and physician ownership of ancillary services. Also, Medicare and Medicaid reform, including the RBRVS system, are increasing the administrative overhead requirements of sole practitioners, while at the same time cutting back on reimbursements. Utilization and peer reviews also require increased administrative resources. Physicians have even been attacked on the homefront with the denial, in many cases, of home office expenses by the Internal Revenue Service.

New Technology. Medical knowledge and new technology are advancing at a tremendous pace. It is difficult for a sole practitioner to remain proficient with all the latest research and innovation. Medical technology, including new procedures, computer equipment, and MRI equipment, is a large contributor to skyrocketing health care costs. Technological advancements require major capital expenditures for physicians in order to provide a competitive quality of care. Often times a sole practitioner is unable to borrow the necessary funds, and therefore must rent the equipment or share resources with other physicians.

Competition. The type and variety of competition in medicine today reads much like alphabet soup: IPAs, IPOs, MSOs, IDS, etc. New entrants into the market for the delivery of physician care include hospitals and HMO networks, many of which are affiliating themselves with physicians. Management service corporations are buying medical practices and merging administrative functions. Some employers are even establishing their own networks, contracting directly with large integrated or affiliated systems to provide health services to employees.

All these factors have given impetus to the transformation of sole practitioners to larger, more integrated practices. These larger groups have a greater ability to contract with large payers while containing costs through economies of scale. Larger, more integrated practices are also able to hire and train para-professionals to perform many of the more routine health care functions, making large practices even more cost competitive.

¶452 Integration

The changing nature of the health care industry has led to a frenzy of mergers and acquisitions of medical practices.' A great deal of this activity has taken place in Southern California and other areas with a high degree of HMO penetration, further supporting the premise that managed care plans are a major catalyst for integration. The reconfiguration of health care providers from sole practitioner to integrated systems has taken many forms. The degree of integration has ranged from loosely affiliated physicians to completely integrated health maintenance systems providing a complete continuum of care. The extent to which physicians affiliate with other physicians or with other health care entities depends on the trade-offs accompanying each model and the objectives of the parties involved.

Integration can be classified as either horizontal or vertical. Horizontal integration entails a collaboration or affiliation among independent physicians and/or medical groups. Vertical integration, on the other hand, entails the affiliation between physicians and other health care entities, such as hospitals or HMOs.

¶452.1 Horizontal Integration

The integration of independent physicians with other physicians is often pursued with the objectives of creating cost efficiency, expanding the services provided, and developing negotiating power in contractual relationships with health alliances or HMOs.

The benefits of horizontal affiliation for the physician include the ability to access managed care contracts to stem the decline in fee-for-service revenue. Physicians who merge their practices into a multi-specialty group also benefit from a reduction in time and resources devoted toward administrative overhead, leaving more time for patient care. The medical group can operate more profitably than sole practitioners given the economies of scale in administration and information management services. Other benefits of a medical group include lower financial risk for the physician and greater access to financing for expansion and capital expenditures. A disadvantage to the physician of any form of affiliation or integration includes the loss of autonomy and the tension created by questions of practice governance.

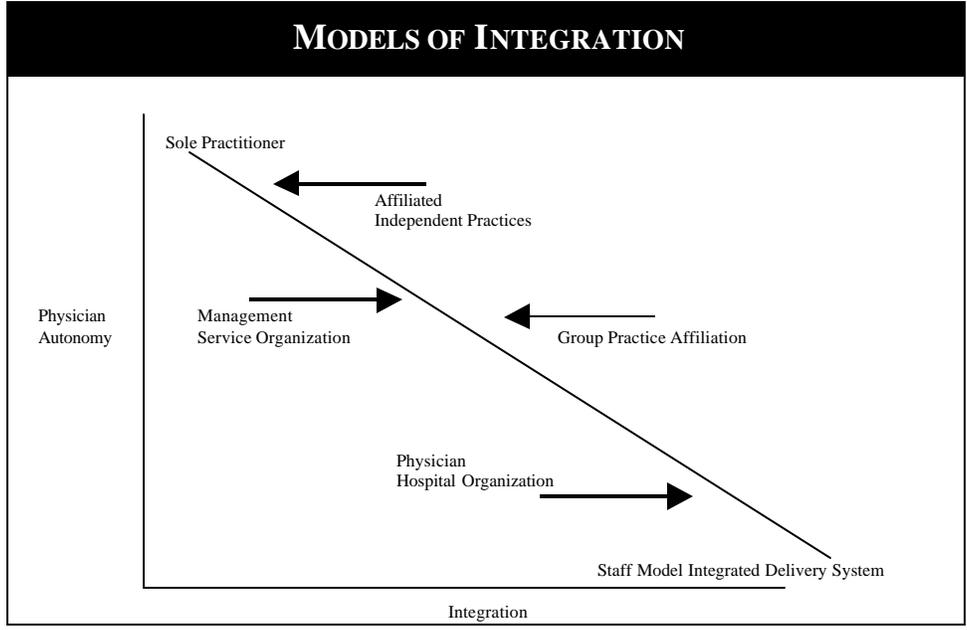
¶452.2 Vertical Integration

Vertical integration is generally accomplished through a merger or acquisition of a physician practice with or by a hospital. Integration allows providers to offer a broader range of services while enjoying the efficiency and cost savings attributable to centralized administrative functions. Physicians who affiliate themselves with hospitals or professional management corporations enjoy the benefits of strategic planning expertise, productivity systems, group buying discounts, and greater information systems providing patient outcome information. Additionally, a vertically integrated delivery system can also provide physicians the financial security of salary compensation and a less hectic lifestyle. As staff members, however, a disadvantage for the physician is the loss of upside potential that comes with owning a practice.

While a majority of personal health care expenditures are still devoted to hospital care (45 percent of 1992 health expenditures), technological innovation and out-patient facilities have affected hospital admissions and the procedures performed by hospitals. The decline in revenue has impacted hospitals' ability to meet their community health objectives. Integration allows the hospital to control more market share while expanding community outreach efforts. This is accomplished through the hospitals' affiliation with primary care physicians who control much of the revenue. Primary care physicians may be more attracted to an integrated hospital than a group practice because it allows physicians to focus on treating their patients rather than dealing with the pressures of the marketplace.

By forming a vertically integrated system, hospitals are also able to provide coordinated case management that can be expected to reduce utilization and, in turn, control health care costs. Hospitals in an integrated system are able to provide more diversified care alternatives and, therefore, a broader based revenue stream. The wider range of services offered by vertically integrated hospitals will also be attractive to regional health alliances. Illustration 4-33 exhibits the various levels of integration. The diagram depicts different types of models as the practices become more integrated.

Illustration 4-33.



¶452.3 Affiliated Independent Practices

Affiliated independent practices (AIPs) are horizontal integration models formed to facilitate contractual relationships with managed care plans. Often, horizontal integration can also generate cost savings for the participants by centralizing certain administrative functions. Examples of AIPs include Independent Practice Associations, Independent Physician Organizations, and network models.

An independent practice association (IPA) is a legal organization established by physicians. It is designed to facilitate participation in managed care contracts. These organizations represent independent physician interests in negotiations with purchasers of physician services. Physicians are not employees of the IPA, only members, and each physician maintains his or her own office. Certain administrative tasks, such as claims processing, contracting, and coordinating the utilization review function can be performed by an outside management company under contract with an IPA. An IPA may be established as a for-profit or not-for-profit corporation depending on state laws. However, not-for-profit status does not necessarily mean the organization will be tax-exempt.

An independent physician organization (IPO) is similar in structure to an IPA; however, it is organized to accommodate the physicians' participation in numerous managed care plans rather than a single plan. As such, an IPO is similar to an IPA with the additional benefit of lowering practice risk due to the diversity of revenue sources.

A network model is another form of loose affiliation, where IPAs, medical groups, hospital physicians, and individual physicians contract with an HMO. This structure is also similar to an IPA, although it provides a more comprehensive health care package to purchasers.

The advantages of the AIP model include its ability to access managed care contracts for member physicians. Additionally, horizontal integration does not require the sale of practice assets. Other advantages include a minimum loss of autonomy for the physician and the fact that these models are relatively quick and inexpensive to form. The primary disadvantage of an AIP model is that the structure fails to eliminate the excess administrative overhead necessary to maintain individual offices. Therefore, it is still unable to generate the savings necessary to effectively compete with larger, more integrated practices. The flow of information, resources, and patient referrals between physicians will likely be less efficient than in a more integrated model. Also, the interests of the participating physicians are not necessarily aligned.

AIPs can be considered organizational vehicles for facilitating the physicians' transition from private practice to managed care. The models allow the physicians to develop trust by working with other physicians, hospitals and payers. The physicians also develop the cost management skills necessary for successful participation in managed care contracts. An AIP model can also eliminate a hospital's ability to pursue a "divide and conquer" approach to physician practice acquisition.

Group Practice Affiliation. A Group Practice Affiliation involves a higher degree of integration than an AIP and provides the economies of scale related to shared facilities. Two models described below are the Group Practice Without Walls (GPWW) and the Integrated Group Practice.

A GPWW is a legal organization formed by a number of sole practitioners and/or physician groups. A central office is established to provide administrative services and house shared facilities and ancillary services. The participating physicians or physician groups maintain separate offices. The model is similar to an AIP except that more economies of scale can be achieved through shared facilities and centralized administration.

The GPWW is attractive to managed care payers because the network of physicians covers a larger geographic area than a single-site practice. An advantage to physicians is that the GPWW does not require large capital expenditures for new clinic sites.

The most important disadvantages of a GPWW are legal in nature. A GPWW that lacks sufficient integration may be subject to antitrust challenges. Since the organization is loosely affiliated, a GPWW could be accused of being simply a price-fixing arrangement with little real economic integration. Secondly, the OIG may interpret a GPWW as a vehicle for avoiding prohibitions against referral practices related to ancillary services. Because of these legal concerns, GPWW models are assuming more economic integration and are establishing structures that resemble Integrated Group Practices.

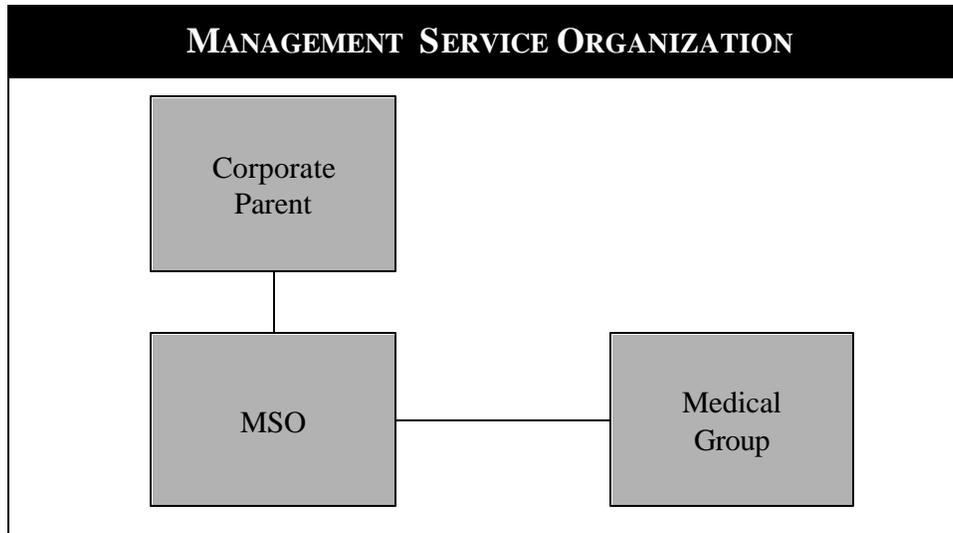
Integrated Group Practices are economically integrated medical groups where both physicians and non-physician personnel are employees of the group. Group practices are typically either professional corporations or partnerships and are largely owned by some or all of the physician employees. The group may be a single-specialty or a multi-specialty practice and can maintain multiple sites to accommodate a large geographic area.

Compared to a GPWW, the advantages of an Integrated Group Practice include greater economies of scale, since separate physician offices do not need to be maintained. Secondly, greater economic integration provides greater access to capital and avoids many of the antitrust and anti-kickback concerns.

¶452.4 Management Service Organizations

A management service organizations (MSO) is a for-profit corporation that provides a management infrastructure to physician practices. The infrastructure is designed to centralize the administrative functions of running a medical group practice. Administrative functions performed by the MSO include facility management, contract negotiations, accreditation, utilization review, claims adjudication, and billing. Typically, an MSO will own the tangible assets of the practice. Following the transaction, the MSO and the medical group enter into a long-term management service agreement, where the MSO provides all clinic facilities and administrative support for a fee. The physicians usually earn a salary plus a share of the profits. An MSO model is shown in Illustration 4-34.

Illustration 4-34



MSOs offer enhanced practice management, facilitate the flow of information on patient outcomes, and provide access to capital. The physicians are able to devote more resources to patient visits and quality of care issues thereby generating increased revenues for the medical group. A disadvantage of an MSO is that the physicians are generally required to sign long-term employment contracts with the medical group restricting them from leaving to establish competing practices. Some physicians may consider this restriction an infringement on their right to work.

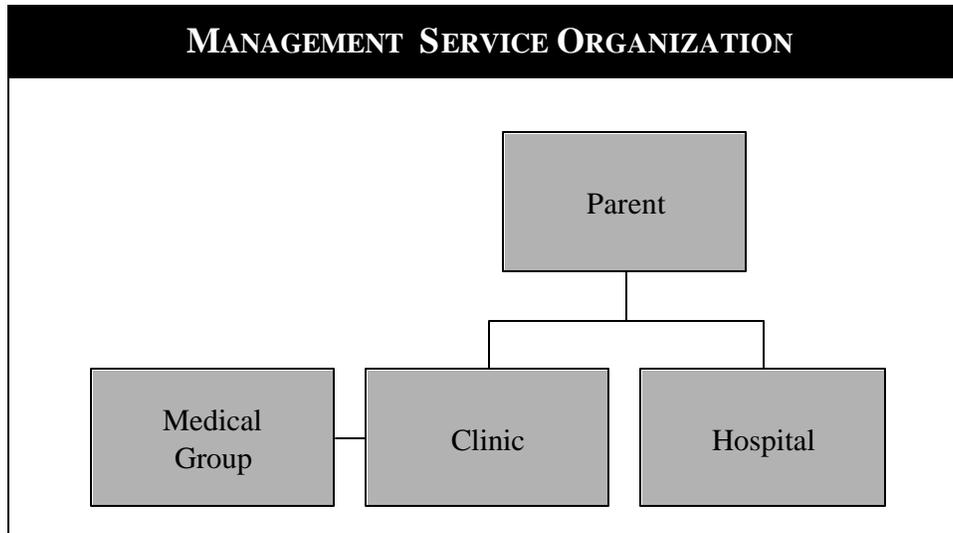
Three better-known companies engaged in providing management services to physician practices are PhyCor, Pacific Physician Services, Inc. and Caremark International, Inc. These companies have been acquiring physician practices throughout the United States. A recent Wall Street Journal article described these physician practices as the medical equivalent of franchised restaurants or stores.

¶452.5 Physician-Hospital Organization

A physician-hospital organization (PHO) is a hospital's version of an MSO, since the hospital performs many of the same functions as the management service organization. The relationship between the hospital and the physician, however, is more complementary in a PHO than in an MSO. The hospital, as investor and administrator, can be expected to have a greater understanding of physician needs, as well as greater knowledge of the entire health care delivery system. As an integrated delivery system, a PHO provides more information on patient outcomes throughout the entire organization from primary to acute care.

A possible disadvantage of a PHO is the potential conflict arising from the organization sending admissions to an unaffiliated hospital. Additionally, the negotiation between physician and the hospital over fair distribution of the capitalization payments can create tension between the two parties. A PHO model is shown in Illustration 4-35.

Illustration 4-35



Additional benefits to this model can be gained by forming a foundation. A foundation is a not-for-profit medical group created by a hospital. A foundation can be created by acquiring a medical group with 27 or more physicians for its appraised market value. Physicians in the medical group are limited to 20 percent representation on the foundation's board. In this structure, the foundation is responsible for all non-physician functions while the medical group is responsible for all patient care decisions. If certain guidelines are adhered to, the foundation can be granted an exemption from federal income tax under §501(c)(3) of the Internal Revenue Code. An example of a tax-exempt integrated delivery system is the recently formed Friendly Hills HealthCare Foundation. The formation of this foundation, as well as the valuation issues surrounding the approval of its tax-exempt status by the IRS, are more fully described later in this chapter.

¶452.6 Staff Model Integrated Delivery System

The strongest form of affiliation is the fully integrated model in which physicians are employees of either the hospital or a wholly owned subsidiary. A well-known example of this model is the Mayo Clinic's Mayo Foundation in Rochester, Minnesota. A fully integrated system provides a seamless continuum of care and can include primary care, acute care, home care, long-term care, rehabilitation services, and outpatient medical care. This system could improve patient outcomes while lowering the cost of health maintenance.

In a fragmented health care system, the patient serves as the case manager, tying together the health and billing information from various health care providers. A fully integrated model will take the burden of information management away from the patient. This information flow will be much more reliable when specialty physicians are constantly exchanging patient information and working collectively to determine the most appropriate health care solution.

The advantages of this model to a hospital include a greater degree of control over primary care physicians, who serve as gatekeepers of the system. The fully integrated system captures referrals that might otherwise go to specialty practices or outpatient clinics. For physicians, the benefits include proceeds for the sale of their practice and the financial security of an employment relationship with the hospital or professional corporation. As mentioned earlier, many primary care physicians will find the integrated environment more satisfying. As primary care physicians join integrated systems, the availability of third-party referrals is reduced. This places pressure on specialty physicians to also join integrated systems.

¶453 Regulation

While the trend in health care delivery moves toward integration, state and federal regulations are obstructing its path. A description of the regulatory obstacles and their impact on integrated health care delivery systems follows. The increased scrutiny by regulators in practice acquisitions demands an understanding of these regulations and their impact on the determination of value, as well as greater care in the documentation of the rationale and support underlying the value conclusions. The major regulations affecting the valuation of a medical practice are:

- ◆ Medicare Fraud and Abuse
- ◆ Internal Revenue Code §501(c)(3)
- ◆ Antitrust Laws
- ◆ Corporate Practice of Medicine Laws

¶453.1 Medicare Fraud and Abuse

Medicare Fraud and Abuse legislation was enacted to prevent physicians from receiving government reimbursement for false, unnecessary, or overpriced medical tests and procedures. The anti-kickback provision of the Medicare and Medicaid Patient and Program Protection Act of 1987 provides criminal penalties for individuals or entities that knowingly and willfully solicit, receive, offer, or pay remuneration to induce business that is reimbursable under Medicare or state health care programs.

These regulations can affect a hospital's ability to pay for the intangible assets of a physician practice if regulators consider the payment as an inducement for referrals. Given one legal definition of goodwill as “the probability that customers will return to the old stand,” the Office of the Inspector General (OIG), in the Thornton letter, has hinted that it may interpret any payment that exceeds the value of the tangible assets of a group practice as constituting an inducement for future referrals, and therefore a violation of the anti-kickback statute.

The OIG issued legislation specifically identifying those medical relationships that it considered exempt from existing anti-kickback statutes. These safe harbors exist for the sale of physician practices that occur as a result of retirement or some other event that removes the physician from the practice of medicine or from the service area.

¶453.2 Internal Revenue Code §501(c)(3)

This section of the Internal Revenue Code provides an exemption from federal income tax for qualifying not-for-profit entities. A merged integrated delivery system may qualify for tax-exempt status if it meets the fundamental requirements for tax exemption, which were traditionally applied to stand-alone hospitals. In reviewing applications for tax-exempt status the IRS considers, among other things, three issues:

1. the community benefit standard;
2. prohibitions under §501(c)(3) against private inurement and private benefit; and
3. the provisions of the Medicare anti-fraud and abuse statutes previously discussed.

Revenue Ruling 69-545 sets forth the following community benefit standard for tax exemption:

“By operating an emergency room open to all persons and providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third-party reimbursement, [a hospital] is promoting the health of a class of persons that is broad enough to benefit the community.”

Private inurement and private benefit restrictions prohibit payment in excess of fair market value by an exempt organization for goods, services, facilities, or financing. Likewise, providing goods, services, facilities, or financing by an exempt organization for an amount less than fair market value is also prohibited. Inurement restrictions were put in place to prevent the channeling of profits from the tax-exempt organization to the benefit of an individual.

Tax-exempt status could be jeopardized by a violation of the anti-kickback statute. In early 1992, the Internal Revenue Service's Chief Counsel, in General Counsel Memorandum 39862, linked revocation of exempt status with violation of Medicare anti-fraud and abuse laws, and, by implication, with violation of any other federal statute.

¶453.3 Antitrust Laws

Federal and state antitrust laws are aimed at controlling anti-competitive practices through the promotion of competition and the prevention of unfair trade practices. Antitrust enforcement against integrated delivery systems will most likely be analyzed under the rule of reason, in which the societal benefits of the integration are weighed against its actual or potential anticompetitive effects. In the case of horizontal integration, an affiliation of health care providers cannot operate so as to exclude other physician groups from entering a geographic market for medical services. For example, if an IPA became the exclusive provider of physician services to all the health alliances in a given region, it may be subject to antitrust enforcement. In the context of vertical integration, a PHO that deliberately drives out competing physician practices and/or hospitals in a regional market could also be subject to antitrust enforcement.

¶453.4 State Corporate Practice of Medicine Laws

Certain states prohibit the practice of medicine by individuals or entities (including corporations) that are unlicensed to practice medicine. The rationale for such laws was recently expressed by Dr. Robert Mayo Tenery, president of the Texas Medical Association, who stated, “All of us in medicine have a concern that stock exchange companies may put the dollar before the quality of care they deliver.” According to a study by the U.S. General Accounting Office, five states—California, Colorado, Iowa, Ohio, and Texas—clearly prohibit certain hospitals from employing physicians. Given these restrictions, integrated models in states that prohibit the corporate practice of medicine must be structured carefully to avoid the perception that corporation is determining the course of treatment.

¶454 Valuation Principles

The fundamental premise on which all investment decisions are based is that value to a potential investor is equal to the present worth of future benefits. This basic concept can be applied to the valuation of a medical practice, as well as particular securities that comprise the capital structure of that practice. In each instance, it is a matter of identifying the future returns that the practice can be reasonably expected to generate, and determining their present value in the context of the uncertainty associated with realizing these returns.

The value of a medical practice consists of the aggregate market value of the current, fixed, and intangible assets of the medical practice less noninterest-bearing current liabilities. This is referred to as the business value of the operations, which includes the market value of both the debt and the equity. Typically, a buyer or a seller of a medical practice is more interested in the shareholders' equity, or the net worth of the medical practice. This value is obtained by subtracting interest-bearing debt from the business value of the operations.

¶454.1 Definition of Value

Deciding on the proper definition of value to be used is an important first step in the valuation of medical practices. Lack of clarity concerning the definition of value can create needless confusion and debate. Fair market value is the most commonly used definition of value. It is generally defined as:

“the price at which property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, and both have reasonable knowledge of the relevant facts.”

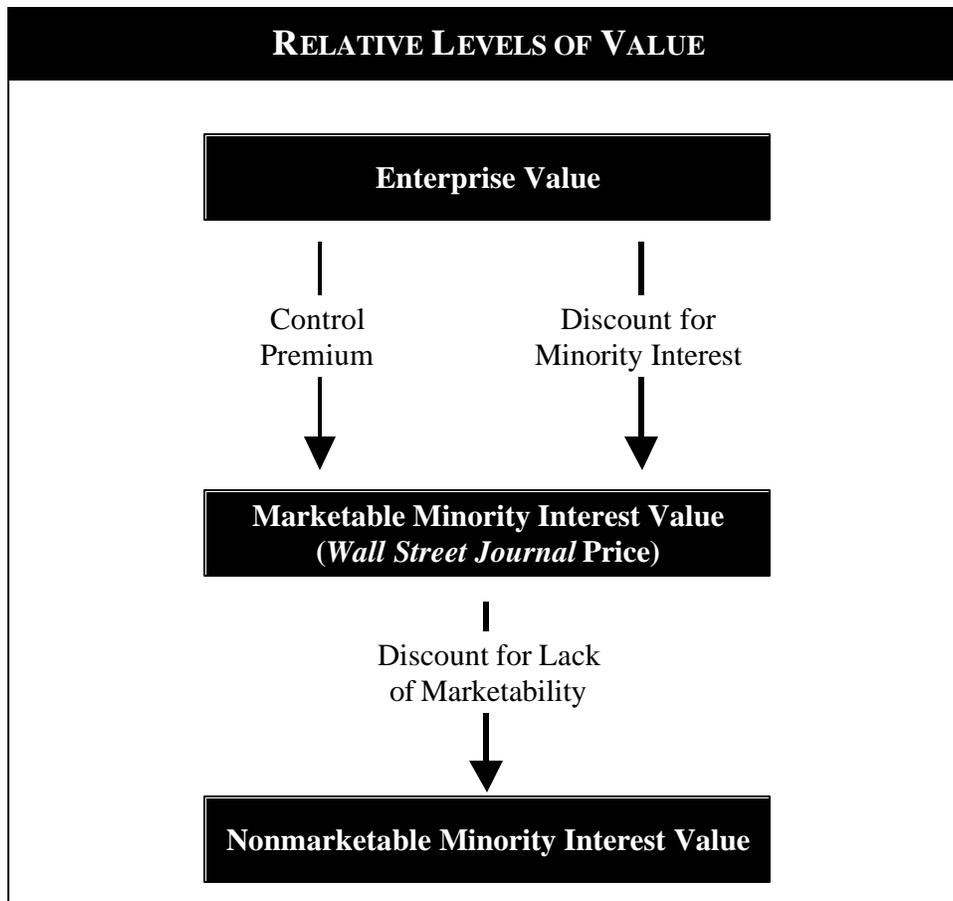
For the majority of medical practice valuations, fair market value represents the value of the practice on a stand-alone basis without regard to increased earnings that may arise as a consequence of an acquisition due to synergies and/or economies of scale with the acquirer. Furthermore, fair market value reflects the assumption that the key medical and administrative personnel will remain with the practice post-transaction to provide continuity and insure retention of the practice's earning capacity.

Fair market value can be determined on either of two bases: going concern or liquidation. These concepts are not standards of value, but rather assumptions about the status of the business. Going concern assumes that the business is being valued as a viable entity that continues in operation. Liquidation assumes the business is terminated and the assets are sold. In determining the value of an ongoing medical practice, liquidation value is generally not relevant.

¶452.2 Relative Levels of Value

The size of the block of stock being appraised is an important factor to be considered in any valuation. If a specific block allows the owner or a purchaser to control a practice, a higher value (relative to a minority position) is justified. Just as a controlling interest is worth more on a per share basis than a minority interest, a marketable minority interest is worth more than a nonmarketable minority interest. Thus, there are three relative levels of value that exist in the context of valuing a stock interest, as shown in Illustration 4-36.

Illustration 4-36



Prices quoted in the Wall Street Journal for public companies whose shares trade on the various exchanges represent the per share value of a marketable minority interest. However, if the subject stock being valued represents greater than a 50 percent interest of a practice, then controlling interest is the appropriate level on which to value the stock. A controlling interest is worth more, per share, than a minority interest because of the owner's ability to control the

business. The owner of a controlling interest has the power to change the corporation's bylaws, redeploy assets, alter capital structure, or otherwise dictate corporate policy.

A control premium represents that premium (expressed on a percentage basis) over the minority interest value that an investor would be willing to pay to control a practice. Empirical evidence on control premiums can be obtained by analyzing successful tender offers for companies in the public marketplace. The difference between the price per share paid to acquire control of the company and the pre-announcement (or marketable minority) price per share represents the premium paid for control.

¶454.3 Analysis of Medical Practices

In performing an appraisal, factors described in IRS Revenue Ruling 59-60, 1959-1, and C.B. 237, must be considered. These factors include:

- ◆ nature and history of the practice;
- ◆ economic outlook and condition of the industry;
- ◆ book value of the stock and financial condition of the practice;
- ◆ earning capacity of the practice; dividend paying capacity;
- ◆ goodwill and other intangibles;
- ◆ prior sales and size of the block to be valued; and
- ◆ market price of similar stocks actively traded in open markets.

Any analysis of a medical practice should specifically consider:

1. practice type (sole practitioner, single group, multi-specialty group);
2. specialty type (including consideration of average term of the patient/physician relationship and average volume encounters per patient);
3. facilities (including the location, length of time, and surrounding demographics);
4. historical profitability;
5. current physician utilization;
6. payment mix;
7. physicians' age/health;
8. physicians' reputation;
9. quality of management and staff; and
10. competition.

These factors try to encapsulate the basic values that the market may place on the quality of earnings of a particular medical practice.

For capitated practices, the analysis should also focus on the contracts and provider agreements with managed care payers. Information on the volume of patient visits and the utilization of the practice's resources must also be addressed. Specifically, the valuation requires an estimate of the projected growth in capital fee, enrollment, and the incremental expenditures required to handle growth of utilization.

For the valuation of a going concern, the practice's earning potential is the primary focus and individual assets are only a secondary concern. However, the financial appraiser must appreciate the assets that drive a practice's earnings potential. The assets of a medical practice can be divided into tangible and intangible assets. Tangible assets include financial assets, such as cash accounts receivable; supplies; prepaid expenses; and fixed assets, such as land; buildings; leasehold improvements; medical equipment; and office furniture. The intangible assets of a medical practice usually include patient records, physician/employee employment contracts, covenants not to compete, favorable lease agreements, and unidentifiable intangible assets. Unidentifiable intangible assets account for the ability of medical practice to earn income in excess of a fair return on the aforementioned tangible and intangible assets and is referred to as goodwill.

¶454.4 Goodwill

One of the biggest issues in the valuation of medical practices is the treatment of goodwill. The goodwill of a business is typically a fragile asset which, but for constant nurturing, would quickly disappear. It is also an asset that has no market value, liquidation value, or salvage value separate from the enterprise of which it is a part. A thorough definition of goodwill has been set forth as follows:

“The advantage, or benefit, which is acquired by an establishment beyond the mere value of the capital, stock, funds, or property employed therein, in consequence of the general public patronage and encouragement which it receives from constant or habitual customers, on account of its local position, or common celebrity, or reputation for skill or affluence, or punctuality, or from other accidental circumstances or necessity, or even from ancient partialities or prejudices” [Metropolitan Bank v. St. Louis Dispatch Co., 149 U.S. 436, 446 (1893)].

Goodwill exists where there is an “expectancy of both continuing excess earning capacity and also of competitive advantage or continued patronage” [Wilmont Fleming Engineering Co. v. Commissioner {Dec. 33,634}, 65 T.C. 847, 861 (1976)].

Goodwill in a medical practice can be classified as either practice goodwill or professional goodwill. Practice goodwill is attributed to a medical group while professional goodwill is attributed to the individual physicians. The more integrated the practice, the greater the ability to "carve out" identifiable intangible assets and practice goodwill. This is an important distinction with regard to Fraud and Abuse laws. An acquiring hospital payment for *professional* goodwill could easily be construed as an inducement for referrals. Payment for *practice* goodwill, however, may be seen as a more legitimate acquisition.

¶454.5 Methods of Valuation

There are three generally accepted approaches used to estimate the value a medical practice or its underlying assets. These approaches can be generally aggregated into three distinct categories:

- ◆ Income Approach
- ◆ Market Approach
- ◆ Cost Approach

The Income Approach assumes value based on the projected income expected to be generated by the medical practice. The most common method of determining value using the Income Approach is the discounted cash flow approach. The Market Approach measures value based on what investors paid for similar medical practices. This approach relies on either similar publicly traded medical practices or actual sales transactions of similar medical practices as an indication of value. The Cost Approach focuses on the balance sheet and relies on the estimated value of the assets, both tangible and intangible, which comprise the medical practice. The most common method of valuing a medical practice using a Cost Approach is the Asset Accumulation or Excess Earnings Approach.

¶455 Discounted Cash Flow Approach

The discounted cash flow (DCF) approach is based on the present worth of the projected cash flow of the practice and theoretically available, although not necessarily paid, to the owners as dividends during a particular period. The cash flow of the practice is projected for a finite period of time, termed the forecast period, and is discounted to the present based on a selected discount rate. Provisions are made for the value of the practice after the forecast period through the calculation of the residual, or terminal value. The present value of the projected cash flow during the forecast period plus the terminal value yields an indication of the value for a 100 percent ownership interest in the practice. Therefore, the DCF approach to value incorporates three major components:

1. estimated future cash flows;
2. discount rate; and
3. terminal value.

Each will be described in turn.

¶455.1 Estimating Future Cash Flows

Estimates of available cash flows are developed for several years of future operations. Available cash flow represents the amount that could be paid out to the practice's owners/investors without impairing future business prospects. It is generally computed after marginal corporate income taxes, but before personal income taxes. Available cash flow for each period is defined as follows:

Operating Income less Taxes
plus
 Depreciation
minus
 Increases in Net Working Capital
minus
 Capital Expenditures
equals
 Available Cash Flow

It is important to analyze the projections in the context of historical operating performance and management's expectations regarding the future prospects of the practice. Furthermore, management's expectations and the practice's ability to achieve the projected levels of performance must be judged in the context of relevant economic and industry factors. The available cash flow for each period is then discounted to a present value based on a selected discount rate.

¶455.2 Determination of the Discount Rate

The discount rate is intended to reflect all risks of ownership and the associated risks of realizing the stream of projected future cash flows. It can also be interpreted as the rate of return that would be required by providers of capital to the practice to compensate them for the time value of their money, as well as the risk inherent in the particular investment. Unless the capital providers could expect to earn this required rate of return, it would not be in their interest to invest in the practice. Thus, capital providers use the "opportunity cost of capital" or the return that could be earned on other investments with similar risk/return profiles as the basis from which to analyze each new investment opportunity.

The DCF approach uses a weighted-average cost of capital (WACC) to calculate the enterprise value of the practice. The WACC is an average of the costs of all sources of capital (debt and equity) for the practice, with each source weighted by its respective percentage share in the capital structure of the practice. The formula for deriving the WACC follows:

WACC	=	$K_d (1 - t)(D/D + E) + K_e (E/D + E):$
Where:		
WACC	=	Weighted-average cost of capital
Kd	=	Cost of debt (pre-tax)
Ke	=	Cost of equity
D	=	Debt capital (market value)
E	=	Equity capital (market value)
t	=	Marginal tax rate

The cost of debt capital is the yield to maturity on long-term debt securities bearing comparable risk as the debt of the subject practice. This is easy to compute given that the amount and timing of future payments from a fixed income security. (interest or dividends) are contractually fixed.

The most widely used method of estimating the cost of equity is the Capital Asset Pricing Model (CAPM). The CAPM is an expectational model that attempts to relate the risk inherent in an investment with the returns expected by investors. In short, the price paid for an asset must yield an expected return sufficient to compensate the investor for the risk that the expected future value of the asset is not realized. Expected return estimates generated by the CAPM will not, however, compensate the investor for elements of risk that can be easily reduced through diversification in a portfolio of investments.

In the CAPM the cost of equity capital is a function of the risk-free rate of return (typically U.S. Treasury Bills) plus an equity risk premium times the beta for the equity investment. The equity risk premium is the premium that equity investors require above the expected return on a risk-free investment. The beta of an investment is a measure of the investment's risk (relative to a market portfolio of investments). The formula for the CAPM is:

$$K_e = R_f + (B \times R_m)$$

Where:

K_e	=	Cost of equity capital
R_f	=	Risk-free rate of return
B	=	Beta
R_m	=	Equity risk premium

¶455.3 Terminal Value

The terminal value used in the DCF approach is essentially an estimate of the value of the practice as of the end of the final period for which cash flow projections have been made. It is necessary to compute this value because it is generally assumed that the practice will remain a going-concern beyond the forecast period. There are two basic methods of computing the terminal value for a going-concern. One method is the "multiple method," which applies a projected market multiple (as in the market comparison approach) to the normalized earnings level for the final projection period to yield an indication of the terminal value for the practice.

The other common method of computing the terminal value is referred to as the "perpetuity method." For this method, the projected free cash flow in the final period is adjusted to arrive at a level of cash flow at the end of the projection period that is representative of the future cash-generating capability of the practice. This "normalized" cash flow figure incorporates expectations of the level of investment required to maintain the business into the future, as well as the return on investment that the business can be expected to sustain. The normalized cash flow figure is then capitalized as a perpetuity by the previously determined discount rate, adjusted for some level of growth which can be expected into perpetuity. The following is a representation of the perpetuity method formula:

T	=	$CF_n / (WACC - G)$
Where		
T	=	Terminal Value
CF _n	=	Normalized cash flow
WACC	=	Weighted average cost of capital
G	=	Growth rate in perpetuity

Using either method, the terminal value must then be discounted back to the present using the previously selected discount rate. The total enterprise value is the sum of the present value of the available cash flows during the projection period and the present value of the terminal value. Subtracting the interest-bearing debt yields the fair market value of the shareholders' equity of a medical practice.

¶456 Market Approach

Two methods are commonly considered under the Market Approach. The *Market Comparison Method* is based on the stock prices of publicly traded companies and the *Comparative Transaction Method* is based on the actual sale of medical practices. Many of the procedures involved in the valuation are common to both methods. Both methods are based on the capitalization rates derived from an analysis of medical practices that are either publicly traded or have recently been sold that are considered comparable to the medical practice being valued (subject practice).

There are four steps involved in applying either market approach to a medical practice. These steps are as follows:

1. Determination of representative earnings and cash flow levels for the subject practice.
2. Selection of comparable publicly traded practices or practices recently sold (comparable practices).
3. Selection of appropriate capitalization rates based on a relative risk analysis between the subject practice and the comparable practices.
4. Determination of fair market value of the subject practice's debt and equity.

It is important that the subject practice's respective earnings and cash flow levels are based on the normal operation of the practice. Therefore, the effects of one-time or nonrecurring charges should not be reflected in the subject practice's representative levels. An income or expense item is considered to be nonrecurring if it is not expected to occur on an ongoing basis. Examples of nonrecurring items include unusual legal and professional fees; start-up costs associated with new ventures; temporary declines in operating margins; and gains or losses on the sales of assets. Adjustments are also made for income and expenses relating to nonoperating assets or liabilities since these assets or liabilities are valued separately.

In order to compare the subject practice with the comparable practices, a relative risk analysis is performed. The risk analysis compares the subject practice to the comparables on the basis of several quantitative as well as qualitative factors. Quantitative factors include size, revenue composition, payer concentration, leverage, profitability, and growth. This comparison is done to determine the overall investment risk of the subject practice relative to that of

the selected comparable practices. Through these comparisons, a representative capitalization rate for the subject practice's earnings and cash flow is determined.

Both market approaches rely on the determination of a market multiple or capitalization rate that is applied to the subject practices representative earnings or cash flow levels. Typically in determining capitalization rates, the aggregate market value of the comparable practice's debt and equity is divided by the subject practice's debt-free earnings and cash flow. The use of a practice's earnings and cash flow on a debt-free basis is useful when comparing medical practices that have substantially different levels of debt in their capital structures. Although traditional medical practices do not have a great deal of debt, this approach reduces the distortions in price/earnings (P/E) or price/cash flow (P/CF) ratios that might be present, due to the use of various degrees of debt in each practice's capital structure. There are four commonly used debt-free earnings and cash flow levels: earnings before interest and taxes (EBIT), earnings before depreciation, interest and taxes (EBDIT), debt-free earnings (DFE) and debt-free cash flow (DFCF).

¶456.1 Market Comparison Method

In the market comparison method, the value of a practice is based on the market prices of publicly traded practices found to be similar to the subject practice. This implicitly takes into account the consensus opinion of what investors are willing to pay for the stock of comparative public companies, adjusted for the specific circumstances of the subject practice. The prices paid in relation to the practice's earnings and cash flows result in capitalization rates that are an expression of what investors believe to be fair and reasonable rates of return for these securities given the risk inherent in those businesses.

The market comparison method requires a search in the market for publicly traded practices that are similar to the subject practice in terms of medical services, markets, size, operations, growth, and stability. Unfortunately, no physician practices are publicly traded. Three public companies are involved in MSCs, but the market capitalization rates of these companies reflect growth expectations that cannot be duplicated by a single medical practice. Therefore, comparisons of these publicly traded companies to most medical practices is not meaningful.

¶456.2 Comparative Transaction Method

The comparative transaction method estimates the value of a subject firm by analyzing similar practices that have recently been acquired. For the comparative transaction method, access to reliable information pertaining to medical practice acquisitions is required. The terms of the transaction must be carefully analyzed to determine appropriate capitalization rates. The subject practice's business growth and risk attributes are compared to the acquired practice. The ratio of the purchase price to the acquired practice's earnings and/or cash flow suggest how much investors will pay for the earnings and/or cash flow of the subject practice. In addition to the capitalization ratios previously described, medical practices are sometimes sold based on revenues, full-time equivalent physicians, and number of enrollees. Since these multiples are derived from transactions involving entire practices (i.e., a controlling interest), a control premium is implicit in the multiples.

¶457 Excess Earnings Approach

The "excess earnings" assumes that a practice is worth the value of its tangible assets plus a premium representing the value of the intangible assets. Based on the practice's earnings and the estimated value of the tangible assets, the excess earnings approach estimates the value of the intangible assets, including goodwill. The basic steps using the method are as follows:

- Normalize historical earnings and project next year's earnings before depreciation, interest and taxes (EBDIT);
- Estimate the value of the tangible assets, both working capital and fixed assets;
- Calculate the annual cost to replace fixed assets;
- Estimate normal returns for investments in both working capital and fixed assets (normal return on the investments);
- Estimate "excess earnings" (normalized EBDIT less both the annual cost to replace fixed assets and the normal return on the investments in tangible assets);
- Subtract applicable federal and state income taxes;
- Estimate a capitalization rate to apply to the excess earnings;
- Calculate the value of the intangible assets (excess earnings less taxes, multiplied by the capitalization multiple); and
- Estimate the total enterprise value by adding the tangible asset values to the value of the intangible assets.

¶457.1 Excess Earnings

Excess earnings is defined as the earnings above and beyond a normal return for the use of the tangible assets of the practice. Normalized earnings represent the expected earning power of the medical practice before depreciation, interest, and taxes. Expected earning power is defined as the typical earnings that may be generated over a 12-month period beginning on the valuation date. If value-in-use is the premise of value, the normalized earnings should reflect the current position of the practice without regard to changes or investments that management may intend to make in the future.

The annual cost to replace fixed assets is a substitute for depreciation. However, it is based on the fair market value rather than the historical cost of the fixed assets. The annual cost to replace fixed assets is calculated by dividing the estimated fair market value by the estimated remaining economic life of the various fixed assets.

The normal return for investments in tangible assets should be calculated on the fair market value of both the working capital (current assets less noninterest-bearing current liabilities) and the fixed assets. When determining the value of the tangible assets, only those assets that are to be transferred as necessary components of

the practice are included. The normal return on tangible assets is calculated by multiplying the value of the tangible assets by rates of return appropriate for each type of asset.

The rate of return is defined as the annual opportunity cost of owning the tangible assets of the practice. The rates differ for each type of asset, depending on the risk of the asset. For example, land has relatively little risk when compared with the risk associated with high technology equipment. Therefore, the rate for land should be lower than the rate for equipment.

¶457.2 Capitalization Rate

The next step in the excess earnings approach is to estimate a capitalization multiple that is to be applied to the excess earnings. Capitalization rates are determined by market factors and are expressed as a percentage return on an expected stream of income. The stream of income to be capitalized is the excess earnings previously determined. Capitalization rates vary depending on the perceived risks, stability, and other factors inherent in the practice. As in the calculation of the discount rate in the DCF approach, the investment that is generally considered most risk-free is U.S. Treasury Bills. Venture capitalists, on the other hand, require 30 percent to 40 percent compounded annual rates of return on equity investments in new and riskier ventures. The selection of the appropriate capitalization rate is based on a detailed analysis of the medical practice. Revenue Ruling 68-609 suggests capitalization rates of 15 percent to 20 percent may be appropriate for intangible assets. These guidelines, however, should only be used as an indication and not as a substitute for independent analysis.

To determine the value of the intangible assets, the excess earnings is multiplied by the capitalization multiple (the inverse of the capitalization rate estimated previously). The fair market value of the tangible assets is added to the fair market value of the intangible assets, including goodwill to yield the fair market value of the practice.

¶457.3 Other Valuation Approaches

Two commonly used methods for valuing medical practices are Rules-of-Thumb and the Goodwill Registry. A brief description of these methods follows:

Rules-of-Thumb. Examples of rules-of-thumb for a medical practice include price-per physician, price per patient record, etc. Rules-of-thumb should be used with extreme caution. Rules-of-thumb are usually developed based on rumor regarding the details of transactions that are usually inaccurate. In addition, rules-of-thumb do not accurately consider specific practice factors such as leverage, operational and financial risks, growth prospects, or the revenue composition of the medical practice.

Goodwill Registry. The goodwill registry, published by the Health Care Group of Plymouth Meeting, Penn., provides the average goodwill value of physician practices as a percentage of annual gross income. Average goodwill values are broken down by specialty. The analysis entails simply adding the calculated goodwill value to the estimated value of the practice's tangible assets. The concern with using the goodwill registry is the lack of

information available on the transactions that comprised the sample. Additionally, the figures provided are mean values, rather than median values, and can be heavily influenced by outliers. Finally, the reliability of the data is an issue. There is no way to verify the completeness or the accuracy of the data provided by the respondents.

¶458 Impact on Trends on the Valuation of Medical Practices

Traditionally, medical practice valuations were performed for the purpose of physician practice buy/sell agreements, marital dissolution litigation, and estate planning. The medical practice being valued usually consisted of a few physicians. Today, medical practices are larger and more complex entities. In addition, the evolution of managed care and the related shift to capitated revenue has had a profound impact on the operational and financial characteristics of practices. The purpose of medical practice valuations in the current environment includes joint ventures, group practice mergers, and group practice acquisitions by non-physician entities. This has required the appraiser to conduct more sophisticated valuations resulting in a more rigorous analysis of the subject practice, giving due consideration to the regulatory environment and the current health care industry.

Any valuation must consider the regulatory context in which the valuation is being performed. Certain regulations dictate the most appropriate premise and standard of value. The greater level of sophistication is necessitated by the increased scrutiny applied by the IRS and various regulatory bodies. Inconsistencies on valuation issues between certain government agencies makes valuation particularly challenging.

The Friendly Hills transaction provides an example of the formation of an integrated delivery system. Certainly in all practice valuations will be the size and complexity of the Friendly Hills transaction, however, it does serve to highlight some of the current issues involved in medical practice valuation and certain inconsistencies between the various agencies.

¶148.1 Friendly Hills

The Friendly Hills HealthCare Network (the Network) is comprised of five separate legal entities: the Friendly Hills Medical Group (the Medical Group), an integrated group practice consisting of approximately 160 physicians representing over 30 medical specialties; the Friendly Hills Regional Medical Center (the Medical Center), an affiliated 274-bed general acute care hospital; and one corporation and two general partnerships holding the land and certain tangible assets utilized by the Medical Group and Medical Center. The network provided care to over 120,000 prepaid patients, including 15,000 Medicare senior risk enrollees.

The Network's business is approximately 96 percent capitated on both the inpatient and outpatient operations. The administrative and clinical departments of the Medical Center and the Medical Group are fully merged. Given the extent of capitation contracting and its experience with Medicare, the network has developed a cadre of both administrative and clinical staff sophisticated in the delivery of high quality and cost efficient managed care services.

The Network joined with Loma Linda University Medical Center (Loma Linda), a nonprofit, tax-exempt medical center affiliated with Loma Linda Medical School, to create the Friendly Hills Foundation (Foundation). The foundation was designed as a tax-exempt IDS offering a full spectrum of health care services, ranging from community-based primary care to inpatient tertiary care.

The foundation was formed through a bargain sale of the tangible and intangible assets of the network, partially funded through a tax-exempt bond financing. Pursuant to §1206 (1) of the California Health and Safety Code, the foundation is the provider of care, contracting with the Medical Group to render services to the foundation's patients. While this "independent contractor" model of the tax-exempt medical foundation is required under California law, other states may allow a foundation to employ physicians directly.

Tax-Exempt Status. The key question addressed by the IRS National Office in determining if the foundation qualified for tax-exempt status was whether the foundation would benefit the community. To make this determination, the IRS considered the community benefit standard.

The challenge for the IRS was to apply this standard, developed for application to hospitals, to far more complex integrated delivery systems.

On February 8, 1993, the IRS issued an exemption from federal income taxation to the Friendly Hills Health Care Foundation. On March 31, 1993, the IRS also issued an exemption to the Facey Medical Foundation. In reviewing both applications, the IRS considered the following community benefit standard criteria:

- ◆ the IDS must maintain an open emergency room;
- ◆ the IDS must maintain an open medical staff;
- ◆ governance and control by physicians is limited to a minority ownership position in the aggregate;
- ◆ terms of the Medical Group covenants not to compete must not preclude departing physicians from providing important services to the community;
- ◆ the IDS must participate in Medicare and Medicaid in a "nondiscriminatory manner";
- ◆ the IDS must support a program of medical education and clinical research; and
- ◆ the tax-exempt IDS must acquire assets only on an arm's-length, fair market value basis. The tax-exempt status is disregarded as a factor in determining fair market value since the "most likely buyer" is defined as a tax-paying corporation. The IRS placed the greatest reliance on the Discounted Cash Flow methodology in reaching the final determination of fair market value.

The IRS also considered the prohibition under Internal Revenue Code §501(c)(3) against private inurement and private benefit, as well as provisions of the Medicare anti-fraud and abuse statute. The IRS's interpretation of the transaction with respect to private inurement and private benefit is unclear.

It should be noted that there is no minimum threshold for inurement nor must there be proof of intent. Any evidence of private inurement could result in the revocation of the organization's exempt status, but an incidental level of private benefit will be tolerated. It follows, then, that any payment to insiders (including physicians) in excess of fair market value by an applicant for exempt status would be cause for denial of exempt status.

Anti-Kickback Provisions. Both exemptions were conditioned on the applicants not being found in violation of the anti-kickback provisions of the Medicare anti-fraud and abuse statute. The application of these regulations in medical practice transactions has been the subject of much debate. Several hospitals requested that their practice of buying medical practices for fair market value and then retaining the physicians be afforded the protection of a safe harbor. The OIG flatly declined to include these relationships in the safe harbor exemption.

Several months before issuing the Friendly Hills tax-exempt determination letter, T.3. Sullivan, special assistant for health care in the Associate Chief Counsel's office of the IRS, requested the OIG's views on the applicability of the anti-kickback statute to an acquisition of a medical practice similar to Friendly Hills, D. McCarthy Thomson, Associate General Counsel, replied to Mr. Sullivan's request on December 22, 1992. The letter stated that "when attempting to assess the fair market value attributable to a physician's practice, it may be necessary to exclude from consideration any amounts which reflect, facilitate, or otherwise relate to the continuing treatment of the former practice's patients." He went on to state that "any amount paid in excess of the fair market value of the hard assets of a physician practice would be open to question." Specific items that may implicate the payment for a referral stream were listed as:

1. goodwill;
2. the value of an ongoing business unit;
3. covenants not to compete;
4. exclusive dealing agreements;
5. patient lists; and
6. patient records,

Both letter rulings issued by the IRS recognized that among the assets to be acquired for cash or to be donated were medical records, covenants not to compete, HMO contracts, and other intangible assets generally categorized as goodwill. The rulings also clearly recognized that the prices to be paid by the foundations for each entity included remuneration to the physician-owners for these intangible assets. These qualifications are evidence that a great deal of confusion exists between the OIG and the IRS.

¶459 Conclusion

The health care industry has undergone significant change over the last decade. Changes have impacted the delivery of health care, the payment mechanisms, and the organizational structure of health care providers. Managed care has

become a permanent element of the health care industry. Passage of a comprehensive national health plan care reform package will simply accelerate the changes that were already underway.

Integrated delivery systems are essential to an organized and efficient managed health care system. An IDS offers the coordinated case management and information systems necessary to provide a seamless continuum of care to the entire population. Government regulation will continue to impact both the operations of medical practices and the formation of integrated delivery systems. In fact, various state and federal government agencies will often contradict each other, making the health care environment even more confusing. On one hand, national health care reform encourages integration as a means of efficiently delivering affordable health care. At the same time, antitrust enforcement and Fraud and Abuse legislation hinders the ability of health care providers to coordinate their efforts. Hospitals and physician must look beyond these intimidating obstacle to the many potential benefits provided by integration.

The formation of an IDS requires a series of complicated transactions. The financial appraiser must understand the industry and appreciate the complexities of structuring an IDS. In fact, the financial appraiser must assume the roles of both appraiser and advisor. Financial and legal advisors experienced in structuring complex integrated delivery systems are essential to the successful structuring of an integrated delivery system.