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Outpatient care invades our neighborhoods: How the Affordable Care Act impacts healthcare real estate transactions

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The future of healthcare delivery calls for doctors and hospitals to pool resources to reduce spending and improve the overall quality of care. Carrying through 2013, this paradigm shift changes the way healthcare real estate is configured, taking care from its traditional delivery center – the hospital – and distributing it locally to outpatient facilities. Pent-up demand, aging baby-boomers and soon to be newly insured patients contribute to this new surge in the marketplace.

For health providers to keep pace with their real estate needs, they must understand the Affordable Care Act's impact on compliance with Stark Law, the importance of due diligence when evaluating neighborhood properties and property design considerations that accommodate the future of healthcare delivery.

The Affordable Care Act's impact on healthcare real estate

By incentivizing value over volume, the Affordable Care Act evaluates Medicare and Medicaid reimbursements based on quality metrics. Among these new incentives, the act encourages providers to treat patients outside of the hospital, including financial bonuses for accountable care organizations to meet benchmarks established on both the cost and quality of care. It also includes penalties levied on hospitals that fail to prevent avoidable readmissions. Part of hospitals' response to these regulations is to bring outpatient services to neighborhoods.

In order to bring care to the patient by transferring services to neighborhoods, hospitals are interpreting the Affordable Care Act's regulations to reconfigure the purpose, structure and value of the traditional medical office building ("MOB") model. It is generally agreed that capital expenses involved in new hospital construction far outweigh the cost of transferring the care that would be provided in a hospital to an outpatient facility or other type of MOB. Neighborhood MOBs that offer higher-acuity care and/or non-acute care are attractive solutions because they cost less to build, operate and maintain than hospitals and inpatient facilities.

For example, Advocate Health Care, a not-for-profit healthcare system based in Oak Brook, Ill., saw outpatient care grow from 36.4 percent of revenue in 2007 to 42.9 percent in 2012. Part of this spike is attributed to Advocate's "outpatient zones of care," which transfer care to existing facilities in community locations. While hospitals will continue spending on existing facility infrastructure, new construction is largely being supplanted by outpatient expansion.

Other successful examples of expanded outpatient facilities are seen across the Midwest, including outpatient expansions by Northwest Community Healthcare in Chicago, Cleveland's MetroHealth System and UnitedHealth Group, and Columbus' Ohio Health Corporation and Ohio State University's hospital system.

Complying with Stark Law and reporting violations

Under the Affordable Care Act, healthcare real estate transactions require an added layer of regulatory compliance review. The act has painted a fresh face on Stark Law, compliance requirements that are accompanied by a self-disclosure system through the Centers for Medicare & Medicaid Services ("CMS"). Notwithstanding a few exceptions, Stark Law prohibits a health service provider from submitting Medicare/Medicaid claims for services rendered to a patient who was referred by a physician who has a financial relationship with the service provider.

When a physician leases office space

from or to a hospital to which he or she refers patients, the lease is considered a financial arrangement subject to Stark Law restrictions. For such a lease to fall within the Stark Law's lease exception it must be written and signed; specify the premises; carry a term of at least one year; contract for space that is reasonable and necessary for the legitimate business purpose; and be set in advance and be consistent with Stark Law's definition of fair market value. A lease arrangement that violates Stark Law can result in penalties ranging from denied or refunded reimbursement payments to civil monetary penalties and being excluded from federal healthcare programs.

Before the Affordable Care Act was enacted, the Office of Inspector General informed healthcare providers that it no longer accepted reporting of a Stark Law violation unless the Anti-Kickback Statute was also violated. As a potential remedy, the Affordable Care Act established a voluntary self-disclosure system, under which healthcare providers may self-disclose Stark Law violations. Stark Law's new self-referral disclosure protocol ("SRDP") requires healthcare providers to describe the actual or potential violation (including financial relationships with the involved parties), analyze the financials of the amounts due -- including supporting audits and documents -- and certify that the submitted information is true and made in good faith.

The SRDP provides hospitals an avenue to work with tenant-physicians to identify, negotiate, and settle Stark Law violations that might help the involved parties avoid Stark Law's stiffer monetary and participation penalties. In the leasing context, Benjamin Franklin's words ring true, "an ounce of prevention is worth a pound of cure." Hospitals should routinely conduct due diligence on current and future lease arrangements to avoid general pitfalls that could lead to violations, such as leasing space below market value, leasing space that is inadequately described and failing to enforce operating expense pass-throughs.

Due diligence when considering neighborhood outpatient locations

Trumpeting the retailization of healthcare is the disruptive innovation of retail clinics. Walgreens, CVS, Rite-Aid and others have nestled the routine exams and annual check-ups under the same roof as local check-out lanes. So that they can compete, hospitals are relocating care to neighborhood outpatient centers and considering branding, accessibility and visibility, all in an attempt to spare their patients the drudgery of having to travel to a far-off urban location for care. Real estate's guiding light of 'location, location, location' has enhanced the menu of MOB sites beyond medical offices to include a variety of retail centers and vacant commercial properties. Theoretically, repurposing property might enable a hospital to enter a new neighborhood cheaper than new construction would, bringing its services to market much quicker; however, commercial retail property is rarely outfitted to support medical staff, equipment and patients.

As the potential properties that can be repurposed for MOBs expands, so too does the due diligence required to evaluate them. For example, hospitals should review state and local ordinances governing zoning use and parking lot ratios, which might differ vastly between retail and medical spaces. If local ordinances require MOBs to have more parking spaces per gross square leasable area than, say, a supermarket, an acquirer may need to modify the size of current spaces or eliminate commercial vehicle parking to satisfy the ordinance. In addition to zoning studies and ALTA Surveys, hospitals should scrutinize Property Condition Reports to evaluate safety and accessibility (many patients are sick, injured or disabled), roofing conditions, capacity to support generators and patient sensitivities such as allergies and air quality.

Within the reach of MOB due diligence, hospitals should also evaluate a property's ability to embrace the growing technology of patient care. As medical technology advances and patient demographics shift, newly designed MOBs need to house healthcare of tomorrow, not simply of today. This means creating adaptable space for information technology, medical equipment and modular surgery and nursing stations, all in an effort to improve patient experience and satisfy the Affordable Care Act's 'quality over quantity' reimbursement models.

Virtually every aspect of healthcare is changing, from its delivery methods and costs to its technology and pharmaceutical advancements and the regulations to which it is subject. The economics of these forces require healthcare systems to reconsider their real estate needs. For some providers, this means assessing how to maximize their current property sites to deliver better care at a more effective cost. For others, due diligence is extended toward relocating services to neighborhood MOBs and other outpatient centers. Whichever direction is taken, hospitals and healthcare systems need to understand how changes in federal regulations impact their use of real estate, the importance of enhancing due diligence to account for these changes and how to structure real estate to deliver care in the future.

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