

Healthcare Reform. (Clear as Mud.)

The New Healthcare Reform Act of 2010 has been the topic of discussion for quite some time. Those of us who focus our livelihood on healthcare real estate have been waiting for the “New Rules” to emerge and provide the long anticipated “Clarity” needed to develop an effective business strategy.

Well, the time has come for us to begin evaluating, reviewing and interpreting the actual provisions of the newly enacted Legislation. This commentary will attempt to get everyone back to a common starting point and provide a foundation for understanding the Legislation and its impact on Medical Real Estate.



Scott Kuklish | PMRG
Executive Vice President
Managing Director
Medical Property Services

Legislative Process

Before we can begin to understand the “New Rules” established by Congress, we need to grasp the process employed to enact the Legislation. Essentially, the plan to merge the previously passed House of Representatives’ (“House”) bill with the Senate’s previously passed bill (“Senate Bill”) was scrapped when Democrats lost a key election in Massachusetts. As a result the focus shifted to a less onerous process where a “Simple Majority” would be needed. On March 21, 2010 the House passed the Senate Bill and immediately passed a “fixer” bill with amendments to the Senate, on March 23, 2010, President Obama signed the Senate Bill into law.

Healthcare Reform Bill (H.R. 4872)

It is critical to understand that while the bill was signed into law on March 21, 2010, that until the full text is prepared, one must do a balancing act of reviewing the Senate Bill and then subsequently checking H.R. 4872 to see what changes, if any, were made. As if things weren’t confusing enough, the Senate Bill contains several amendments located in Title X. Phew!

Impact of Legislation-Increased Liability for Physician’s

One significant provision included in the legislation relates to limitations on physician ownership opportunities in hospitals, ambulatory surgery centers (ASC’s), and with regard to in-office ancillary services. The legislation amends STARK by requiring that disclosures be made under the in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services. Particularly noted is the fact that these disclosure requirements will be applied to services furnished after January 1, 2010, despite the fact that the law was not enacted until the end of March 2010. Physician Groups will be held accountable for non-compliance during this three (3) month “gap.”

Healthcare Reform. (Clear as Mud.)

Conclusion

While there will likely be years of dialogue and legislative commentary with regard to Health Care Reform we should begin to assess the impact of this legislation on our real estate environment. We can expect the following dynamics to emerge in 2011, if not sooner:

- Hospitals must prioritize in-patient and out-patient uses of owned or leased real estate to maximize revenues.
- Well monetized investor groups should position themselves for purchase and development opportunities of on-campus medical facilities, due to the increased demand to house more physician practices. Hospital administrators have determined that physician productivity is enhanced and revenues increase when physicians set up shop on or adjacent to the hospital.
- Real estate adjacent to hospitals will be sought after for ancillary health care uses primarily related to out-patient care.
- Physician/Investor owned facilities will continue to diminish, given the legislative restraints on ownership potential and regulatory operating requirements.
- Real estate managers will be required to reduce occupancy expenses as physician practices face reduced reimbursements.
- Major hospital providers will need to enhance their facilities to attract physicians and look to expand into suburban markets that were once considered rural markets

Increased Taxes

The Senate Bill contains a 5% tax on elective procedures as a means to help fund Health Care Reform then contradicts itself in the last three lines and determines instead, to charge the surcharge tax on indoor tanning services - another example of the confusion created by this legislation.

Reduced Medicare Coverage

The most discussed provision involves the restructuring of Medicare Advantage payments. These plans will be frozen in 2011, and beginning in 2012 will be reduced to traditional Medicare payment levels. This includes updates for inpatient acute care hospitals, home health agencies, long-term care hospitals (LTAC's) and inpatient rehabilitation facilities. It also includes applying productivity adjustments to these same providers and others including skilled nursing facilities and ASC's.

Regulation and Financial Stress on Physician Practices

Clearly the above-referenced legislative changes will ultimately affect a physician's bottom line as most managed care contract fee schedules are negotiated utilizing Medicare as the baseline. The combination of increased regulatory reporting and reduced recapture of fees will force physicians and healthcare practices to run for safety.

Safe Haven for Physicians

We can expect physicians to return to the safety of large, well-financed Healthcare Institutions. Managed Care "Meccas" such as Cleveland Clinic and Kaiser Permanente, models which were previously viewed by physicians as "restrictive" to a physician's financial growth potential, are now a welcome relief to the burdensome reporting requirements, reduced fee structures, and risk of ownership. Today these organizations represent a perceived higher quality of life and relief from the labors of assuming risk to run a single or group practice.

For More Information:

Scott Kuklish | PMRG
Executive Vice President, Managing Director
Medical Property Services
skuklish@pmrg.com
(972) 421-3311