MOB's Big Hurdle

THE AFFORDABLE CARE ACT & ITS EFFECTS ON HEALTHCARE REAL ESTATE

BY RODRIC J. BRADFORD & TIM J. RANDALL

The Affordable Care Act (ACA) has been controversial since its passage in 2010. However, the ACA has survived all legal challenges to date, and the healthcare industry has accepted the fact that the ACA is the law of the land going forward. While there are many regulations being written, with more to come, there are impacts and implications of the ACA on medical office developers, owners and tenants that are being assessed and implemented based on the best available information and projections today. With that in mind Commercial Executive Magazine gathered a roundtable to discuss the impacts the ACA will have on medial real estate going forward. This roundtable was designed to discuss the various trends the medical professionals and entities are experiencing today, as well as trends anticipated to unfold in the near future.

HEALTH CARE

"We know it's going to be messy…there are going to be things that come up that are unanticipated." This statement, from one of the architects of the Patient Protection and Affordable Care Act (ACA), underscores the realities of a complex and changing puzzle which politicians, businesses, and individuals are scrambling to piece together. With each passing month the regulatory and operational logistics of the ACA mean decisive action is necessary to provide some measure of certainty for stakeholders. Witness only in the last few days Governor Brewer and the legislature working on The Gordian Knot of health care exchanges and Medicaid expansion.

REAL ESTATE AND ACA

Amidst the backdrop of a $2.5 trillion health care economy in the U.S. undergoing tumultuous upheaval, there still remain fundamental questions which decision makers both connected directly and indirectly must confront: access, affordability, service, outcomes, and quality. In analyzing the impact of the ACA on these issues, one of the best perspectives interestingly comes from the vantage point of those connected to health care through the locale in which it is delivered. With this in mind, *Commercial Executive Magazine* gathered a roundtable of industry experts to discuss their expertise and experience with the Affordable Care Act and its impact on commercial real estate.

Doctors, pharmacists, nurses, and practitioners all provide their unique services to patients from some type and configuration of Medical Office Buildings (MOBs), as well as hospitals, rehab centers, and many other means. Dissecting the micro and macro issues of commercial real estate space offers illumination into the broader trends that will drive health care in the coming decades.

RENDERINGS OF BANNER HEALTH CENTER CONFIGURATIONS.

TOP: IRGENS, MERCY MEDICAL COMMONS, GILBERT, AZ.

ABOVE: CEM ROUNDTABLE PARTICIPANTS TAKE A BREAK FROM THE DISCUSSION.

TECHNOLOGY

Craig Jensen from Banner Health indicates that despite the entanglements and complexities of the ACA, the focus of the health industry will always be "increasing quality care and reducing cost." To achieve this objective MOBs are increasingly being transformed into technological innovation centers as opposed to the traditional spaces of waiting rooms with magazines and walls of medical charts. These new delivery areas are Wi-Fi connected and are "being equipped with technology throughout the patient experience, including pre-registration areas, kiosks, and identification verification."

The obvious purpose of this technological transformation is to better connect provider with patient and provide efficiency to operations be they large hospital spaces or small entrepreneurial offices. In these new environments, LCD monitors and iPads are staple tools right alongside the stethoscope and the blood pressure monitor. According to Mr. Jensen, for technology to perform its function it must turn data into knowledge more effectively thereby "getting the right information, at the right place, at the right time, to be able to manage someone's health and deliver a good outcome."

ELECTRONIC MEDICAL RECORDS

Part of the Affordable Care Act was a directive to replace the traditional paper medical records with electronic information. This change would over time provide operational synergies, reduce costs, and create advantages for patients and providers. The ACA, in its design, created deadlines for Electronic Medical Records (EMR) implementation as well as incentives and penalties for operations that complied or didn't. Larger scale operations with economies of scale are better able to comply with the deadlines, while the smaller practices will have difficulty with costs and setup. Much of the incentive and penalty program is aligned with Medicare providers who stand to lose by the deadline in 2015, Medicare reimbursements of 1%, and in subsequent years by 2% in 2016, 3% in 2017, 4% in 2018, and up to 95% depending on future adjustments.

The Electronic Medical Record push is fundamentally changing the convention of the medical office building space. Julie Johnson, executive vice president with GPE's healthcare investment group, emphasizes this point, saying "there used to be a demand for large rooms to hold paper records and that has been replaced with a need for internet connections." The practical application of this change is that the new MOB's have almost zero defined space for traditional medical records. Margaret Blue of Desert Practice Management concurs. "In terms of trends that we are seeing there is less room being dedicated for chart space- definitely."

BUILDING DESIGNS

If the EMR is changing the look and feel of the medical space, it is only one aspect of the technological adaptation of the 21st century medicine. Internet technology and connectivity are the new surgical tools according to Jason Anzalone, vice president of development for Irgens. "The IT piece has dramatically affected building design, with older buildings becoming obsolete…and the overall efficiency being examined. What is occurring is a move away from the complexes of the 80's and 90's that are now facing technology obsolescence, and a movement toward the connectivity of providers, patients, and information."

Healthcare Trust of America's Director of Acquisitions Ann Atkinson states, "on a national level, information technology is the number one capital expenditure for most hospitals, followed closely by the acquisition of physician practices. Much of these capital requirements are being funded through the monetization of the hospital system's real estate."

The medical clinical space itself still is a mixed bag of larger multi-tenant MOB's (both on campus and off campus), smaller condominium office buildings, and the new movement toward home health initiatives. Steve Stack, Devenney Associates, indicates that "the trend is to move medicine out of acute care facilities and to more MOB settings and we are seeing that demand." Yet, larger physician groups do offer the size and scope from a real estate perspective, which can directly impact financial operational efficacy that smaller participants may not be able to achieve. There was a transition occurring even before the Affordable Care Act which placed the smaller physician practice at a financial disadvantage to the larger players, and now with the increased regulatory pressure on providers, greater size does come with advantages.

OPTIONS FOR SPACE

Nick Reed, Vice President of Professional Banking Services at Wells Fargo Bank sees a definite trend toward the merger of physician practices. "Some independent practices are moving out of condominium office buildings and grouping together to buy office buildings slightly larger than what the practice needs right away. Often they are leasing out a portion with the expectation they will continue to grow and lease the rest. Again, the costs of maintaining small independent space are becoming burdensome, particularly as the technological pressures on integration and connectivity are imposed." Mr. Reed sees information technology financing as an ever increasing part of medical office loan commitments. "We see a lot of IT expenditures in the $30,000-$50,000 range, while multi-specialty groups have larger expenditures to fund."

If the trend is to be consolidation, and Ms. Atkinson points out "25% of specialty physicians and 40% of primary care physicians, who see patients at hospitals, are currently employed by hospitals". These figures are up from 5% and 20%, respectively, in 2000. Larger specialty practices are combatting this trend by merging to avoid being purchased by larger healthcare or hospital entities." Atkinson adds "what's more, health systems are more cost conscious than ever. The ACA has resulted in a change in reimbursements and incentives that shift more healthcare procedures out of hospitals and into more cost-efficient settings. Specifically, into MOBs." The question becomes what does that portent for the real estate market and its players?

DECISIONS ON MEDICAL SPACE

Succinctly, the answer for the smaller groups or independent physicians is to control their timeline on leases as well as the terms if possible. The move is toward shorter leases, two or three years as opposed to a traditional seven year. The exit strategy is critical too as independents must confront the possibilities of sales to larger hospital groups. In this context, flexibility is crucial, and the Affordable Care Act has added a layer of uncertainty in its regulatory and cost structure that warrants maintaining an added degree of dexterity.

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To this end, Mr. Reed adds, "Those with the ability, typically large, multi-location groups have begun renegotiating leases with similar rates across all of their locations. Just as reimbursements are compressed for healthcare providers, landlords of healthcare tenants are seeing rental rates compressed and borrowing costs increase. Purchasing is the trend among practices looking to stay the course or expand in the near future. Some are buying their own space as a strategy to fix real estate costs now and ensure they can manage monthly outflows going forward." It becomes then a game of chess for the occupants, owners, financiers, brokers, and larger health providers to develop their strategies for profitability.

A LOSS OF ENTREPRENEURSHIP

The independent physician provides value to his patients with an emphasis on quality and service while balancing their drive to be self- reliant, build an operation, be profitable, and control their future. However, the surge toward acquisitions has "led to some loss of the entrepreneurial spirit in the healthcare industry," says Nick Reed. What's more, the increasing complexities of being an entrepreneur - increasing regulatory pressure and compliance costs that provide financial challenges to the smaller health care providers - will drive an even greater trend for the larger organizations with their scope and scale attributes. Yet, this movement is not necessarily a dead

end for the industry. The size of the organizations allows operational efficiencies that will "allow physicians to still exercise clinical creativity and innovation," according to Craig Jensen of Banner Health.

THE MACRO STEP BACK

Often in the midst of a complex change such as the Affordable Care Act it can be easy to miss the forest through the trees. So too in an industry as large as health care and real estate, the overall trends must be discerned from the micro "noise."

Ann Atkinson points out the number of individuals over 65 year old – a demographic that seek medical care with greater frequency than younger generations – is expected to increase by 30 million by 2030. Add to this figure the addition of up to an estimated currently uninsured 30 million patients to the health care system because of the ACA, according to Cassidy Turley's Arizona Health Care Practice Group's Tom Weinhold, and these two industries will have sizeable demographic trends pushing them to change and innovate.

The initial, knee-jerk response to this overload of patients either through traditional coverage or Medicare/ Medicaid will be the need for more medical space, perhaps 60-100 million square feet. However, Mr. Weinhold makes the case that "demand for space per capita or per physician may actually not grow but may stay steady or decline as health care is delivered in different ways. In particular, telemedicine, mini-clinics inside of pharmacies and grocery stores, and other technologies may drive the trend to less total square footage for traditional MOB space." This notion is seconded by Craig Jensen who cites Kaiser Permanente figures that indeed "square foot per doctor has gone down." And this is a macro operative that can reconnect costs, deliverability, and quality back to changes to the Affordable Care Act.

TOP: BANNER HEALTH CENTER IN THE CITY OF MARICOPA. **ABOVE:** IRGENS' JASON ANZALONE TAKES NOTES ACROSS FROM (L TO R) NICK REED, TOM WEINHOLD AND JULIE JOHNSON.

PATIENT VS. DOCTOR MODELS OF DELIVERY

The traditional model of medicine was the physician centered approach, however, that model is losing its value. The roundtable emphasizes that the new pattern of care is moving from doctor centered health care to patient centered health care, and the patient is the consumer, with the healthcare provider team (including the physician) coordinating the care. This approach is about the delivery of care from: telemedicine, home based care options, integrated care, and patient centered medical homes. The underpinnings of all of these are the linking of technology to the doctor, patient, and the delivery mechanism.

As a specific example, the introduction of telemedicine into the lexicon of care comes with its own twists of technology and MOB functional design. As Craig Jensen explains, "leveraging specialist physicians with telemedicine involves videoconferencing with rooms set up with high resolution monitors and cameras." Mr. Jensen even talks about specific paint colors on the walls as necessary for dermatologists to discern facial

pigments correctly. "These are the new realities of modern medicine from: special exam tables, internet connectivity, broadband, iPads, shared physician workspaces, and touchscreen monitors. This 21st century medicine is not just 'open up your mouth and say ahh.'"

ABOVE: IRGENS, SHEA MEDICAL PLAZA, SCOTTSDALE, AZ. BELOW: FROM L TO R: TOM WEINHOLD, JULIE JOHNSON, NICK REED, STEPHEN STACK, ANN ATKINSON, JASON ANZALONE AND CRAIG JENSEN. NOT PICTURED, MARGARET BLUE.

TECHNOLOGY 2.0

Whether the discussion is Electronic Medical Records or patient interactive software, the ubiquity of technology is present in changing the dynamic of how care is delivered. While the physician is no longer the center of the sphere and the patient is the driver, the fact is that technology has also, according to our experts, made the patient more accountable in the process.

One of the biggest challenges in the integration of technology into the provider-patient equation, as Mr. Stack of Devenney Group Architects puts it, is providing the "network of systems" necessary to meet the Federal requirements for portability and privacy under the HIPPA regulations. Of course the EMR directive is designed to share information within the delivery mechanism - doctors, nurses, insurers - all while maintaining the privacy of the patient. This is no small task and is why so much capital is spent on information technology to meet these needs.

It is this technology that captures the attention of Jason Anzalone of Irgens who now analyzes property with a perspicuity toward "ensuring they will be efficient in this new health care marketplace." This efficiency also allows for logistical options that are not available in the MOB of the 80's. The new designs place a dedicated premium on technology as the driver of care, and as Margaret Blue of Desert Practice Management indicates "there are an infinite number of combinations for using space that are being utilized." It is also true in this dynamic that the traditional financing options are changing as technology advances. Nick Reed says "Due to the unsecured nature of a software license, we hang the loan on the strength of the practice." It will be incumbent on the stakeholders in these new arrangements to understand the changing dynamics of not only the delivery of care, but the agreements necessary to ensure against a zero- sum-game outcome.

DISCERNING FROM THE MURKINESS

Much like the 2700 pages of the Affordable Care Act and the nearly 9,000 pages of rules circulated to implement the legislation; our roundtable particpants delivered a substantial amount of information. Yet, the critical trends from the intersection of the Affordable Care Act and the commercial real estate market are straightforward against the backdrop of the law's complexity.

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Medical Office Buildings will be as much information technology centers as they are patient treatment centers. From the continued implementation of Electronic Medical Records to Telemedicine, and interactive care; the infrastructure of these spaces will have to necessarily adapt to technological evolution.

The new dynamic will be a focus on patient-centered medicine rather than physician centered medicine with technology playing a critical role in this transition. Even as MOBs change, Mr. Jensen articulates, "being close to the patient is the foundation of our service, the ACA does not change that."

One of the ironies of the Affordable Care Act is that its reach and directive to drive operational efficiencies, lower costs, and better quality care is anathema to its own bureaucratic inefficiencies, yet unwritten rules, and layers of desultory organizational functionalities. What the participants of this roundtable implicitly understand is that health care is invariably about delivery of the highest quality product at the lowest effective cost. Whether this delivery is via a regional hospital system, a network of local practitioners, or the entrepreneurial physician the desired outcomes do not change. It is this long-run view that allows those in the business of health care to have the vision and stamina to steer their way through the mess, confusion, and the unanticipated yet to come.