AHLA PG Briefing

Common Compliance Pitfalls Involving Real Estate Lease Arrangements with Referral Sources

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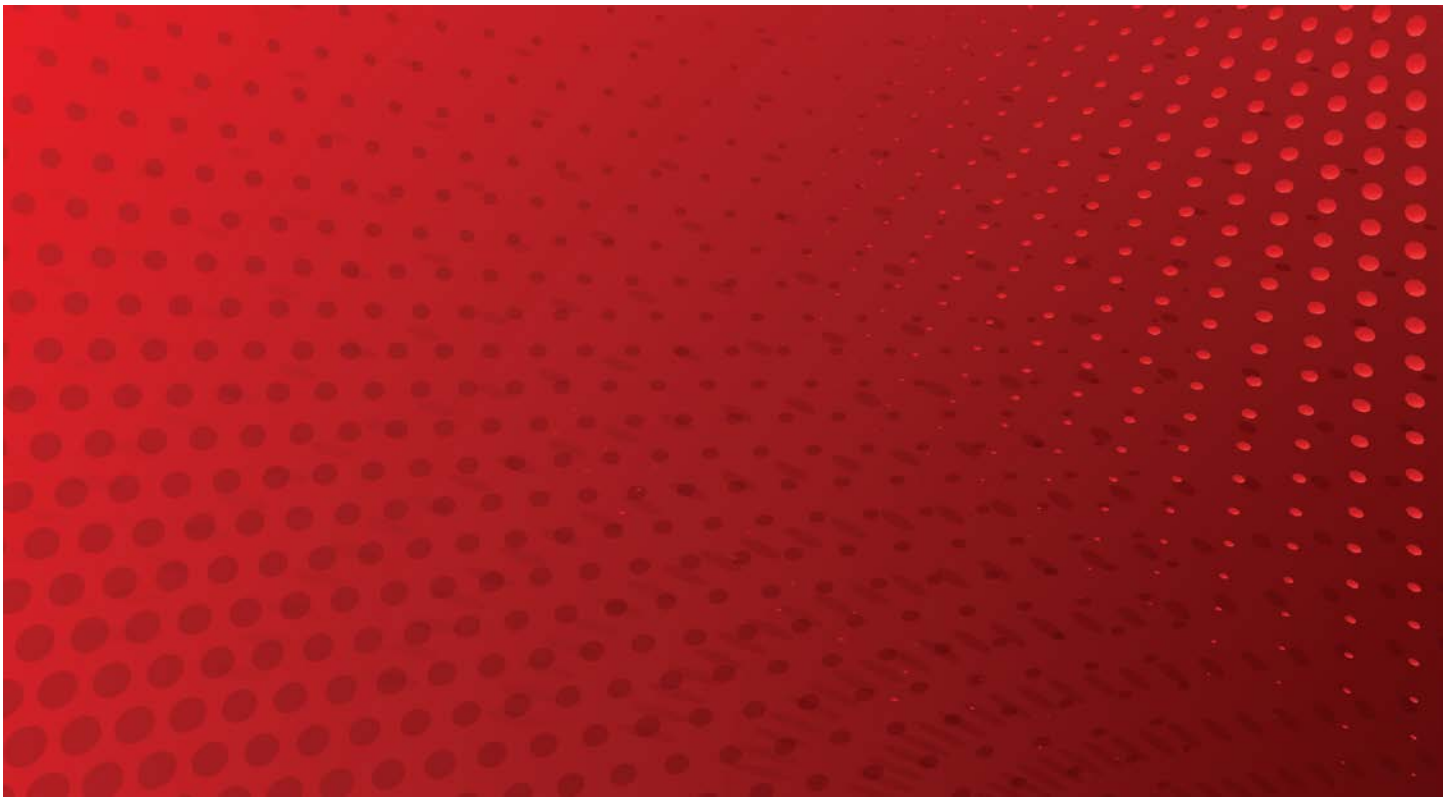

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–From a declaration of the American Bar Association.

Real estate lease arrangements between health systems and referring physicians present numerous compliance pitfalls, any one of which can trigger a violation under the Stark Law[1] and the Anti-Kickback Statute.[2] Compliance pitfalls associated with lease arrangements can be generally classified as "transactional" or "operational." Transactional compliance pitfalls stem from the lease arrangement itself and the specific structure of the transaction. Operational compliance pitfalls stem from the subsequent administration, or lack thereof, of the lease arrangements with referring physicians. Both types of compliance pitfalls are caused by structural deficiencies in health systems' compliance programs, and both types of compliance pitfalls can expose health systems to significant liability under the law. This article will identify common transactional and operational compliance pitfalls and address ways in which they can be mitigated.

Legal Background

To avoid violating the Stark Law, lease arrangements between referring physicians and health systems must comply with the rental of office space exception (Lease Exception).[3] One of the key elements of the Lease Exception is the requirement for the lease arrangement to be consistent with fair market value (FMV), as that term is defined under the Stark Law.[4]

Additionally, under the Lease Exception, the lease arrangement must be commercially reasonable, as that term is defined under the Stark Law.[5] A lease arrangement between a health system and a referral source that is not consistent with FMV and/or that is not commercially reasonable will result in the violation of the Stark Law and could expose health systems to liability.

[1] 42 U.S.C. § 1395nn and its associated regulations, 42 C.F.R. § 350 *et seq*.
[2] 31 U.S.C. § 1320a-7b(b).
[3] *See* 42 U.S.C. § 1395nn(e)(1) and 42 C.F.R. § 357(a).
[4] *See* 42 C.F.R. § 411.351.
[5] 69 Fed. Reg. 16054, 16093 (Mar. 26, 2004).

As it relates to leases, the Anti-Kickback Statute is similar to the Stark Law, in that it prohibits space leasing arrangements between health systems and referral sources unless the arrangement meets the space rental safe harbor, which contains similar elements to the Lease Exception.[6] Therefore, the compliance pitfalls outlined in this article not only expose health systems to potential liability under the Stark Law, but to potential liability under the Anti-Kickback Statute as well.

Transactional Compliance Pitfalls

Health systems face a myriad of transactional compliance pitfalls when entering into lease arrangements with referral sources. Some, such as the term of the lease being less than one year, are obvious. Others, particularly compliance pitfalls associated with FMV and commercial reasonableness requirements, can be more subtle. Health systems should be especially cognizant of the compliance pitfalls associated with rent rates, classification of leases, tenant improvement allowances, and square footage measurements of leased premises.

Rent Rates

Health systems are legally obligated to charge referral sources rent rates that are consistent with FMV. The FMV range is typically provided by an independent valuation consultant in an FMV report and should account for factors like the quality of the space, the length of the proposed lease term, the size of the leased premises, rent escalators, rent abatements, type of a lease arrangement, tenant improvement allowances, and square footage measurements of leased premises. A rent range for a medical office building (MOB) should be based primarily on comparable MOBs instead of general office buildings because MOBs typically demand a rent premium due to higher construction costs. Additionally, adjustments should be made to account for the quality

[6] *See* 42 C.F.R. § 1001.952(b).

of the building in which the space is located, with higher quality space demanding higher rent rates.

Leases with longer terms and larger spaces typically demand lower rent rates than leases with shorter terms and smaller premises. Leases with longer terms and larger premises generate higher total revenues, and, as a result, the landlord may be willing to charge a slightly lower rent rate. Conversely, leases with shorter terms and smaller premises generate less total revenue and may require additional costs to release. Consequently, landlords will demand rent premiums to account for these additional costs and decreased overall revenue.

Annual rent escalators and rent abatements also impact the FMV of rent rates. In most markets, rent rates increase on an annual basis. A long-term lease with no annual rent escalators can result in rent rates in subsequent years that are not consistent with FMV. Additionally, the absence of annual rent escalators in leases may automatically raise potential compliance concerns from a commercial reasonableness perspective if the inclusion of rent escalators is consistent with the local market.

Rent abatements are also market specific and, therefore, may not be appropriate to include in leases with referral sources in some markets. If rent abatements are included in lease arrangements, the rent rates should account for them because they lower total revenues under leases. If rent abatements are not accounted for, a rent rate that may appear to be consistent with FMV may effectively be below FMV when examined in the context of total lease revenues.

Most importantly, health systems should ensure to not treat referral and non-referral sources differently under their lease arrangements. Nothing casts more suspicion on a lease arrangement with a referral source than a situation in which a referral source is paying a lower rent rate than a non-referral source for similar medical office space with a similar lease term.

Classification of Leases

Different types of leases command different rent rates. Leases can be generally subdivided into net leases (i.e., tenant pays base rent for the premises and additional rent which may, depending on the type of a net lease (single, double, or triple), cover operating expenses and common area maintenance fees (CAM), taxes, and property insurance) and gross leases (i.e., the tenant pays a single, "all in" rent, and the landlord is responsible for paying property taxes, insurance, and CAM). Regardless of which type of a lease is entered into, health systems should accurately classify their leases with referral sources and charge appropriate rent rates. Charging referral sources triple-net rent rates for full service gross leases will likely result in health systems charging rates that are below FMV.

Tenant Improvement Allowances

Careful consideration should be given to the amount of the tenant improvement allowances that are granted to referral sources. Tenant improvement allowances should be addressed in the FMV report, and the recommended rent rate range should account for them. Failing to account for tenant improvement allowances can result in what would otherwise be a rent range that is consistent with FMV drop below market value.

Additionally, providing overly generous and unnecessary tenant improvement allowances to referral sources can lead to transactions not being commercially reasonable. For example, providing a $100,000 tenant improvement allowance for a lease arrangement that will generate $50,000 in total rent revenue would likely not be commercially reasonable unless there is a compelling second generation use for the space and the improvements.

Some health systems create internal benchmarks and caps for tenant improvement allowances, which can create additional compliance pitfalls. First, tenant improvement allowances that exceed health system's internal benchmarks and caps may be indicative of potential compliance risks. Health systems need to be able to justify why a

referral source is receiving tenant improvement allowances in excess of the internal benchmarks. Additionally, basing tenant improvement allowances on standard benchmarks as opposed to actual tenant improvements that are needed for a particular space could potentially be interpreted as remuneration to a referral source. For example, if the space is in a turn-key condition that requires little work to prepare for the incoming tenant, providing a standard tenant improvement allowance well in excess of actual work that needs to be performed can be interpreted as remuneration for inducing or rewarding patient referrals.

As a matter of best practice, tenant improvement allowances should be addressed in the FMV reports. Internal benchmarks for tenant improvement allowances should not be exceeded absent a compelling and documented reason. Finally, each specific lease arrangement should be internally analyzed to determine the extent of tenant improvements that may reasonably be needed in the space.

Square Footage Measurements

While it is critically important for health systems to charge referral sources rent rates that are consistent with FMV, ensuring that the size of the leased premises is accurately measured is equally important. Remuneration to referral sources can be accomplished by charging rent rates below FMV or by not charging the referral source for all the space that is being leased to it.

Similarly, health systems should be consistent internally and with the local market in structuring leases based on “usable” square footage (i.e., does not include a square footage allocation of common areas of the building to the leased premises) or “rentable” square footage (i.e., includes a square footage allocation of common areas of the building to the leased premises) and charging appropriate rent rates based on the lease structure. Rent rates for leases based on usable square footage should be higher than rent rates based on rentable square footage because the referral source is being charged for less total square footage than it is ultimately using.

To mitigate these risks, health systems should ensure that the FMV report provides a rent rate consistent with the square footage structure used in the lease. Health systems should also consider purchasing building software programs or hiring qualified firms to accurately measure the spaces in their real estate portfolio using the same, unified standard of measurement that has been approved by reputable organizations like the Building Owners and Managers Association. Those measurements should be regularly updated to account for any changes in the spaces that can be caused by tenant improvements, consolidation or separation of spaces, and renovations of MOBs.

Operational Compliance Pitfalls

The proper administration of the lease arrangement is just as important as structing lease arrangements properly and in compliance with applicable health care regulations. A properly structured lease arrangement can expose health systems to compliance violations if the arrangement is not properly administered. Common operational compliance pitfalls involve rent collections, operating expense reconciliations, off lease benefits, space creep, and timeshares.

Rent Collections

To avoid liability, health systems must collect all rent due under their lease arrangements with referring physicians. Many health systems, however, regularly fail to do so. Sometimes, tenant physicians simply fail to pay rent for their spaces, and health systems allow them to continue occupying their spaces. When this happens, many health systems fail to send notice of default letters and seek available remedies under the law. If and when the delinquent tenants finally decide to pay their outstanding rent, many health systems often fail to impose and collect late fees on those delinquent rent payments even though their lease arrangements may require them to do so.

Similar issues arise with rent escalators and holdover premiums. Most lease arrangements contain annual lease escalators through which tenant's base rent

increases typically between 2%-4% each year throughout the term of the lease. These rent escalations, however, are not always captured by health systems. Similar problems arise with holdover premiums. Many lease arrangements require physicians who go into holdover to pay a higher rent, which is typically between 125% and 200% of the base rent rate for the year immediately preceding the holdover period. Just like with late fees and rent escalators, these holdover premiums are oftentimes not imposed and collected.

In addition to creating transactional compliance pitfalls, tenant improvement allowances can also create operational compliance pitfalls. Typically, tenant improvement allowances are capped by the landlord, and most lease arrangements require tenants to pay for costs of improvements in excess of the tenant improvement allowance as additional rent. Problems arise when health systems fail to charge and collect these tenant improvement allowance overages as additional rent.

Failure to collect rent can often be traced to lack of communication between different health system departments (e.g., billing, real estate, and legal departments), lack of adequate training, administrative oversights, and health system's conscious decisions to not engage in actions that could upset physicians.

Hiring third-party property managers to collect rent and interacting with physician tenants can mitigate these compliance pitfalls. Experienced property managers have internal systems in place to ensure that all rent is collected timely and accurately. If physicians cannot pay rent, using independent, third-party property managers to send notice of default letters and interact with nonpaying physician tenants during the rent collection process can help insulate health systems from the unpleasantries associated with those types of situations. The use of a third-party property manager can also be used to shift these compliance risks from the health system and onto the third-party property manager. Specifically, for claims brought under the Anti-Kickback Statute, the use of third-party property managers can help health systems negate the Anti-Kickback Statute's requisite element of intent.

Operating Expenses

Health systems face additional compliance pitfalls when they enter into net leases. As mentioned, those types of leases require tenants to pay for their share of operating expenses based on the amount of space they occupy in the buildings. Many health systems fail to reconcile operating expenses, which results in referring physicians not paying for all the operating expenses they are responsible for. Additional pitfalls may involve inclusions or exclusions of various property expenses in or from operating expenses. For example, health systems may fail to include estimated insurance premiums when the health systems are self-insured in operating expenses, which results in tenant physicians not having to pay for their share of insurance on the property.

To mitigate these risks, health systems should require its third-party property managers to issue annual certifications of operating expense reconciliations. Similarly, health systems should implement internal protocols through which the property accountants reconciling the operating expenses are working together with health systems' legal counsel to ensure that all costs are included and accurately passed through to tenants pursuant to the terms of the applicable lease arrangements.

Off-Lease Benefits

Health systems should be aware of providing free benefits to referral sources that may not be referenced in the lease arrangements. Examples include complimentary medical waste removal services, free parking in certain markets, complimentary meals, and free transportation services. These free benefits could be interpreted as remuneration to referral sources. As a matter of best practice, physician tenants should not be provided with any type of benefits that are not expressly referenced and accounted for in their lease agreements.

Space Creep

Another common issue arises when health systems allow physicians to use additional spaces (e.g., vacant suites, storage closets, administrative areas) for free. These additional spaces are not covered by physicians' existing lease arrangements, which is a violation under the Stark Law. Additionally, physicians arguably receive remuneration from health systems by not paying for these additional spaces.

As a matter of best practice, physicians should never be allowed to use any space in a building, regardless of how small or immaterial it may appear to be, without first executing an amendment to their existing lease agreements that will incorporate the additional space into the leases and provide the additional rent the physician will have to pay for the additional spaces.

Timeshare Lease Arrangements

With the passage of the CY 2016 Medicare Physician Fee Schedule final rule, the Centers for Medicare and Medicaid Services created a new exception under the Stark Law for timeshare arrangements (Timeshare Exception).[7] As a result, timeshare arrangements can be structured around the Timeshare Exception or the Stark Lease Exception.

Regardless of which Stark Law exception the parties rely on, ensuring that the physicians do not use their spaces for longer than provided for in their leases/licenses can be difficult. A physician could, advertently or inadvertently, use the space longer than allotted under the lease/license, which could result in remuneration to the physician.

Space creep issues can be prevalent with timeshares. Because physicians are not occupying the spaces full time, they often bring patient records and other materials with them and store them in closets or spaces that are not covered by their leases/licenses. Similarly, the spaces leased by physicians typically include several exam rooms that are

[7] *See* 42 C.F.R. § 411.357(y).

located inside of a larger suite. Although the physician should only use exam rooms that are covered by the lease/license, as a practical matter, the physician will sometimes use additional exam rooms inside the suite that are not covered by the lease/license.

To mitigate the operational compliance dangers posed by time share leases, health systems should adopt occupancy schedules and have property managers strictly enforce those occupancy schedules, so that a physician comes and leaves within the time blocks allotted under the lease/license. As a matter of best practice, health systems should not allow the physician to use any space (storage closet, administrative space, extra exam room, etc.) that is not covered by and paid for under the lease/license.

Conclusion

Lease arrangements between health systems and referring physicians are fraught with regulatory compliance pitfalls. It is critical for health systems to implement strong regulatory compliance frameworks that are designed to address some of the transactional and operational compliance pitfalls outlined above. Additionally, the use of experienced health care counsel, real estate advisors, valuation consultants, property managers, and accountants is a crucial element to structuring and administering lease agreements with referral sources in accordance with the applicable health care regulations. The investment in these third-party resources will generate massive returns for health systems by helping keep their lease arrangements with referral sources in compliance with the applicable health care laws and regulations.