This article will explore the trend toward third party ownership of medical facilities, some of the driving forces behind this trend, common models of third party ownership arrangements, as well as the perceived risks and benefits associated with these arrangements. It will then explore key real estate leasing and regulatory compliance issues that parties should consider when negotiating third party ownership arrangements.

**Background**

Prior to the late 1990s, most hospitals and health systems owned their real estate facilities. As coordinated approaches to patient care expanded, along with physician loyalty to a particular hospital, many hospitals designed and built their own medical office buildings ("MOBs") and provided the leasing and property management for them.

Over the past two decades, however, the trend has been to place ownership of medical real estate in professional real estate managers rather than in health care providers. This transition to third party (non-provider) ownership has manifested itself both in the "monetization" of existing facilities and the development of new facilities by professional developers of medical real estate. The changes have occurred both on hospital campuses and off-campus.

A number of factors have influenced this trend. (continued on page 8)
Changes in health care reimbursement (both from government and commercial payers), the need to invest in costly new medical technology, increased costs associated with aging facilities, and other financial constraints have created greater pressure on health care providers to generate large amounts of capital. Furthermore, during the past two decades, the emergence of institutional investment companies that are interested in the ownership of medical real estate and that are willing to offer attractive purchase prices have augmented the traditional sources of capital, such as the tax-exempt bond market and equity market.

Another factor influencing the trend towards third party ownership has been the increasing shift in the delivery of health care from inpatient to outpatient settings, including MOBs, ambulatory surgery centers, diagnostic centers, and urgent care facilities. The trend toward population health management has been enhanced by the emergence of technology allowing health care to be integrated into a single network of satellite facilities connected to the hospital hub.

These satellite facilities are increasingly developed by third party non-providers, especially as physicians have become less and less interested in developing MOBs.

Compliance concerns, namely, those related to hospital ownership of medical facilities occupied by separately owned physician groups and other providers, have also contributed to the trend towards third party ownership of medical facilities. Now more than ever, providers must carefully examine their health care facility arrangements so as to be sure that they avoid potentially significant liability under the Anti-Kickback Statute,¹ the Stark law,² and applicable state statutes regulating health care referrals (the “Health Care Referral Laws”).

Third Party Ownership Models

The large scale movement toward third party ownership of medical facilities began with the emergence

¹ 42 U.S.C. § 1320a-7b(b)
² 42 U.S.C. § 1395nn(a)(1)
of capital sources such as health care REITs, pension funds, and developers backed by private equity. These institutional third party owners have participated in the monetization of many existing health care facilities across the country, through purchases of the existing facilities and leases back to the health care providers. These transactions have allowed hospitals to free up capital tied up in real estate and re-deploy it to investments in equipment, new services, and acquisitions.

Third party owners are also developing new facilities, including on-campus MOBs and other non-acute care facilities, as well as off-campus facilities for physicians and services that tend not to be directly adjacent to the hospital. Off-campus facilities can often provide a cost efficient expansion of the hospital’s market since such facilities typically cost less to develop than on-campus facilities. In smaller markets, local real estate investors frequently develop these projects, and some are even being developed in mixed use or retail shopping centers.

The most common method for creation of third party ownership of on-campus facilities has been for the hospital to ground lease a parcel of land for the facility to the third party owner. Separate from the land, the building is sold to the third party, and the third party leases space in the building back to the hospital and possibly, to other providers. Ownership of the building typically reverts to the hospital at the end of the term of the ground lease.

A variation of this structure is a ground lease and sale of the building to the third party owner with a master lease back to the hospital of the entire building. One disadvantage of this approach is that the hospital must then act as landlord to any other health care tenants in the building. This arrangement leaves the hospital with the responsibilities and potential liabilities related to leasing and to compliance with the Health Care Referral Laws. The ground lease and building sale/
leaseback model can also be used for off-campus locations where the hospital wants to exercise heightened control over the operations of the MOB. The further the MOB is from the hospital campus, however, the more likely it is that the hospital will simply be a space tenant of the building, perhaps with other providers. This is certainly the case when the space is in a mixed use or retail center.

**Perceived Benefits and Risks of Third Party Ownership**

As noted earlier, one of the principal benefits to hospitals of third party ownership is that it frees up capital. In addition, third party ownership transfers away the burden of real estate leasing, management, and operation, thus freeing up hospital management personnel and resources for other tasks. If the third party owner uses an experienced property management organization and if the ground lease gives the hospital enough control, the owner and/or property manager will select appropriate providers for occupancy in the building that fit into the hospital’s strategic plan. The third party owners will assess credit risk of individual tenants, and negotiate lease terms that reflect market standards. In addition, professional property management can achieve various building operational and maintenance efficiencies.

Another key benefit of third party ownership can be the avoidance of compliance issues under the Health Care Referral Laws. To summarize briefly, whenever a hospital is the landlord of a MOB and rents space in the building to physicians or physician groups, analysis under the Anti-Kickback Statute must confirm that there is no knowing or willful solicitation, receipt, offer, and payment of any remuneration to induce or reward the referral of any individual for the furnishing of (or purchasing, leasing, ordering, or arranging for) any item or service paid for by a federal health care program. If a third party, rather than the hospital, acts as landlord of the MOB, then the hospital likely would not be in a position to offer kickbacks to provider tenants, thus avoiding Anti-Kickback concerns as they may relate to space rental.

The arrangement described above may also implicate the Stark law. The federal Stark law prohibits a physician from referring Medicare beneficiaries for the furnishing of designated health services (“DHS”) to entities with which the physician has a financial relationship, unless the relationship strictly complies with the requirements of one of the exceptions. The physicians will likely refer patients to the hospital for in-patient services or other DHS (i.e., diagnostic testing services). If a third party, rather than the hospital, participates in a leasing arrangement with the referring physicians, then a financial relationship between the hospital and the physicians may be avoided and Stark may not be an issue (at least, in this context). Stark violations and Anti-Kickback Statute violations can also result in violations of the False Claims Act, which would implicate even more significant penalties.

Leases between health care provider tenants and non-provider landlords (i.e., third party owners who do not themselves furnish health care services and are not

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owned by physicians or other health care providers), typically will not raise issues under the Health Care Referral Laws. The issues, however, become more complicated when tenant physician groups or other providers acquire an ownership interest in the third party non-provider landlord, either directly or through an investment entity. These relationships must be carefully scrutinized for compliance with the Health Care Referral Laws. For example, situations can arise in which co-tenants of a MOB who also are part owners of the MOB may engage in referrals to one another. Although there is no landlord/tenant relationship between the two providers, they may receive indirect benefits because of the increased profitability of the enterprise. Given the severe penalties for violation of the Health Care Referral Laws, the structure of the third party owner should be carefully scrutinized.

Typically, a hospital's greatest concern regarding the transfer of medical facilities to third party owners is loss of control. A hospital's ability to have a sufficient degree of control over its facilities and operations, particularly on campus, is crucial. Also crucial for proper operation is physical integration of facilities into campus infrastructure and systems. Ground leases must address the necessary control by the hospital and integration into the remainder of the campus. If they do not, there would be an unacceptable risk of disruption to health care operations.

The third party ownership models discussed above can result in arrangements in which the hospital is a landlord (as ground lessor) and/or a space tenant of a MOB (along with other health care providers). Next this article will explore key real estate leasing and regulatory compliance issues that parties should consider when negotiating third party ownership arrangements.

**Key Lease Provisions – Hospital as Ground Lessor**

In a typical commercial ground lease, the land owner is
frequently passive. However, a ground lease between a hospital and third party (non-provider) owner of the MOB (especially one that involves a portion of the hospital campus) must contain provisions not found in a typical commercial ground lease so that the hospital can retain much more control over the use, operation, and management of the MOB than it would typically retain in a standard ground lease. Prior to entering into a ground lease of a portion of the campus, a review of zoning and subdivision regulations should consider whether the transaction can proceed as planned or whether the structure of the transaction needs to be modified. Provisions that should be incorporated into the ground lease include the following:

a. **Integration of Systems and Physical Plant.** The ground lease must contain cross easements and agreements to ensure that the MOB being placed into separate ownership will be integrated into the campus. It must properly address cost sharing associated with those arrangements. These issues have particular importance when the building being transferred is physically connected to other buildings on the campus. Negotiation of the ground lease should consider utility systems, central heating and cooling plants, security and life safety systems, computer systems, and other campus-wide systems.

b. **Maintenance and Management.** The ground lease should also include detailed maintenance standards. The hospital will likely want to retain the right to approve the management company selected by the third party owner and to approve physical alterations to the MOB.

c. **Parking.** Hospitals and other health care facilities have greater parking requirements than do most other commercial developments, and thus the ground lease should provide the hospital the right to control the parking areas situated on the development.

d. **Use Restrictions/Non-Competition.** Where there are other tenants of the MOB, the hospital will want to ensure that those tenants’ use of their space harmonizes with the hospital’s goals and strategy for the campus. The hospital should consider faith-based issues and it should require that the tenants be physician groups and other providers having staff privileges at the hospital. The hospital will want the building owner and tenants to comply with campus rules and regulations of general applicability. In some cases, the hospital may want to negotiate a covenant by the third party owner and its affiliates not to develop competing buildings within a certain radius of the MOB location, or to give the hospital a right of first offer with respect thereto. The drafting of lease provisions related to these concepts is highly technical and the parties would be wise to seek experienced legal counsel.

e. **Limitations on Sublessees.** Related to the previous issue, the ground lease should limit subleases to active members of the hospital’s medical staff consistent with the use restrictions contained in the lease.

f. **Rights of First Refusal.** The ground lease should give the hospital a right of first refusal with respect to any proposed sale of the building and

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The rent established in the ground lease should be reflective of fair market value. Although the fact that the ground lease is to a non-provider should avoid most issues under the Health Care Referral Laws, it is possible that the transaction as a whole could be scrutinized to determine whether a reduced ground rent was established in return for concessions given by the hospital.

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the third party owner to its health care tenants.

Key Lease Provisions – Health Care Provider as Space Tenant

When the hospital or other health care provider is leasing space in an MOB from the third party owner, a different set of issues arises. Among the issues that are distinct from standard commercial building leases are the following:

a. Construction Issues. MOBs have special requirements for tenant fit-up which translate into higher costs of design and construction. There are generally more extensive plumbing requirements, increased electrical and HVAC needs, and special fixturing and accessibility requirements. Accordingly, a standard office or retail space design may need to be substantially modified. The increased cost of construction translates into higher rents per square foot than for most other uses. Furthermore, the lease needs to clearly address the allocation of responsibility between landlord and tenant for improvements relating to accessibility under the Americans with Disabilities Act.

b. Parking. Parking requirements are usually greater for MOBs than for office and most retail spaces, and the percentage of handicapped spaces generally must be greater. The lease should provide for these requirements and as a result, the rent costs will likely be greater.

c. Access and Confidentiality Issues. Standard landlord lease forms give the landlord the right to enter the tenant’s space in a number of circumstances, such as in order to make repairs, inspect for lease compliance, and show the space to prospective mortgagees, purchasers or tenants. MOB leases must restrict access by landlord and its agents and contractors as necessary to comply with the patient information confidentiality requirements in HIPAA and other privacy laws. For example, the lease should require that the landlord’s agents and contractors be accompanied by a tenant representative while in the premises; it should prohibit access to examination rooms when patients are present; it should impose confidentiality obligations on the landlord with respect to information incidentally disclosed; and it should establish procedures for dealing with emergency access. In addition, adequate security systems should protect the space.

d. Exclusive Use and Prohibited Uses. A health care tenant with sufficient bargaining power may wish to negotiate the exclusive right to engage in a certain specialty within the MOB in order to prevent competition from other tenants. A separate issue relates to the prohibitions against “noxious” or “offensive” uses contained in many standard landlord lease forms. Such provisions may need to be modified to make sure the language will not be interpreted to restrict prospective health care activities.

e. Environmental Provisions. Standard environmental provisions found in commercial leases should be modified to include provisions relating to medical and biological waste. The lease (continued on page 15)
should both allow for the generation of such waste and clearly allocate responsibilities for its proper disposal.

f. **Landlord’s Lien.** It is common for commercial leases to grant the landlord a lien on the tenant’s property, so that the landlord may foreclose in case of a default by the tenant. Such a lien may exist as a matter of statute even if the lease itself does not create the lien. Such a lien is very troublesome for a medical tenant, since the tenant has usually financed expensive equipment on site. Such landlord liens should be waived or at least subordinated to the tenant’s financing. At a minimum, the lien should exclude medical records and computers containing medical records so that foreclosure of a lien would not compromise patient information.

g. **Assignment / Transfer; Changes in Law.** Commercial leases usually restrict a tenant’s right to assign its lease or sublet the premises without the landlord’s consent. These provisions may need to be modified to allow for future changes in the practice group. With regard to transfers of ownership by the landlord, it is unusual for a commercial lease to restrict a landlord’s right to transfer its property. In the context of a medical lease, however, the health care tenant should protect itself from a potential violation of the Health Care Referral Laws caused by a transfer of ownership to a health care provider entity or an entity that is owned in whole or in part by a health care provider. If the tenant cannot negotiate an outright prohibition on such transfers, it may be able to obtain the right to either terminate the lease or renegotiate the terms of the lease to make it comply with the Health Care Referral Laws. Tenants may also consider including a provision allowing for modification of the terms of the lease in the event of an amendment of the Health Care Referral Laws.

(continued on page 16)
h. Health Care Referral Laws. If the lease implicates the Health Care Referral Laws because of the initial or subsequent ownership structure of the landlord, the terms of the lease will need to be structured so as to comply with these laws. The lease will comply with the Stark law if it meets all of the elements of the space rental exception. The Anti-Kickback Statute has a similar safe harbor exception for space leases. The provisions of the lease with respect to the description and amount of space, term of the lease, rent, common area charges, and holdover must be carefully drafted in accordance with the space rental exception and safe harbor, and the lease must be commercially reasonable without regard to any referrals.

6 42 C.F.R. § 411.357(a)  
7 42 C.F.R. § 1001.952(b)

Conclusion

This article has provided only a summary of the many issues that arise in connection with the relationship between health care providers and third party owners of medical facilities. Such transactions should be carefully planned and implemented in order to achieve the hospital or health care provider's goals, and to ensure compliance with the Health Care Referral Laws.

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