The $36M Mistake: Why Hospitals and Health Systems Need to be Aware of Real Estate Risks

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Did you know that medical centers in Libertyville, Ill., and Detroit recently paid $36 million and $30 million in separate settlements of alleged violations of laws affecting physician self-referrals and their real estate assets?

Healthcare providers who think the Stark (physician self-referral) Law and Anti-Kickback Statute are "old news" and largely unenforced should think again. While some of these laws have been on the books for more than two decades, they've become more stringent because of other legislation that passed in 2010. The self-referral laws are being enforced more strictly than ever, and providers like those in Detroit and Libertyville have been impacted.

The changing landscape

In general, Stark makes it illegal for healthcare providers to submit claims for federal Medicare or Medicaid reimbursement for services provided to patients if the patients were referred by physicians who have a financial relationship with those providers. AKS criminalizes any scheme to induce referrals of patients through improper financial arrangements. The original intent of these laws is admirable: They're designed to eliminate conflicts of interest that could result in abuse of the Medicare and Medicaid programs, fraud, increased costs, overuse of services, unfair competition and reduced quality of care.

However, other recent legislation, including the Patient Protection and Affordable Care Act of 2010 and the Health Care Education and Reconciliation Act of 2010, have added onerous challenges for compliance with the Stark and AKS laws. Health providers are now required to self report to CMS any violations of these laws in a wide variety of areas, including: medical billing practices; personnel recruitment and remuneration; services, office space and equipment leases with physicians; and relationships with vendors and patients.

Failing to self report can result in significant penalties, including repayment of disqualified claims within 60 days of discovering them; fines of $25,000 per infraction and possibly prison under the AKS law; and fines of $15,000 for each fraudulent claim and $100,000 for each non-compliant arrangement under Stark. In the worse cases, providers could even face the ultimate "death penalty" — disqualification from receiving Medicare and Medicaid reimbursements.

It's important to note that these penalties are per infraction. Given that large hospitals and health systems process thousands of Medicare and Medicaid claims every day, those individual fines can quickly grow into the millions.

In addition to monetary fines and the potential loss of Medicare/Medicaid eligibility, providers found to be in violation of the Stark Laws might need to repay any disqualified Medicare/Medicaid claims already paid, which could date back many years. Providers also face legal costs, and individuals could face the loss of their jobs — even prison time in the case of AKS violations.

To encourage self reporting and possibly more favorable settlements, PPACA gives CMS authority to negotiate and settle self-disclosed violations without having to apply strict statutory penalties. Yet, certain aspects of the self-disclosure protocols can be more onerous. CMS can report voluntarily disclosed information to the Department of Justice, the Office of the Inspector General or both for further civil and/or criminal prosecution, and parties must agree not to appeal any penalties assessed as part of the settlement.

With the passage of healthcare reform and the implementation of these self-disclosure protocols, hospitals and physicians who treat Medicare and Medicaid beneficiaries are also now required to establish a formal compliance program. These compliance programs should include written policies and procedures, training, regular communication, internal monitoring, enforcement of standards and prompt responses to any violations. Most importantly, the programs should be managed by compliance professionals.

Also new under the Stark and AKS laws is increased funding for fraud and abuse enforcement, with projected expenditures
of $350 million through 2020.

**Increased responsibilities**

In just the real estate area alone, particularly when hospitals lease medical office space to physicians, health providers face a tremendous burden — and hospital executives, lease administration staff and property managers are all being held accountable. In the past, hospitals may have provided free or below-market rents and free tenant improvements to its physician tenants. Now, if those physicians refer Medicare and Medicaid patients to the hospital, every lease arrangement is governed by the compliance and self-referral laws and needs to be carefully scrutinized for violations.

Typical leasing fraud/abuse violations include: leasing space below fair market value, leasing space not adequately described in the lease, providing space under an expired lease, failing to enforce operating expense pass-throughs such as medical waste removal, neglecting to implement annual rent increases required by lease terms, providing tenant services not discussed in the lease, leasing space that is different from the space described in the lease, operating under unsigned leases and improperly allocating physician services that are shared with the hospital.

In many cases, so-called "technical" violations can be an innocent oversight such as when a provider and the physician tenants forget to sign a lease extension. While the AKS requires proof of criminal intent, under the more stringent Stark Law, no criminal intent is required to prove there's been a violation, and a provider might still face penalties whether the violation is intentional or inadvertent. Further, Stark provides no materiality threshold, so a very minor violation carries the same potential penalties as a serious violation.

Health systems attempting to sell medical office buildings and other facilities, especially those leased to physicians, also face additional responsibilities. These facilities could have any number of technically non-compliant leases, and when those are uncovered during the due diligence process associated with a potential sale, the entire transaction could come to a sudden halt.

CMS, the agency overseeing compliance with these laws, has published self-disclosure protocols that spell out in great detail what providers must do when self reporting non-compliant arrangements. The entire documentation process is burdensome and time-consuming, but then providers face even more delays because CMS has a backlog of claims. Some estimate the agency has completed only 10 percent of the current volume.

The intent of the new protocols is to encourage health systems to self disclose under the assumption that they will receive more favorable treatment. It's too early to tell if this is true, and many providers may be reticent to do so, especially when they hear about huge, costly settlements.

For example, the Libertyville and Detroit medical centers cited earlier paid settlements of $36 million and $30 million, respectively, for leasing space below fair market value, and the Detroit facility had physician leases that were not in writing. A hospital in Texas paid a $4.1 million settlement and a Wyoming hospital paid $635,000, both for leasing space below fair market value; and a hospital in Montana settled for $275,000 for leases that were not in writing.

**Minimizing your risks**

Providers can take a number of key steps to minimize their compliance risks with respect to the Stark Laws and AKS by creating what attorneys refer to as "safe harbor" leases. An obvious step is to make sure that all leases and contracts for services are in writing before providing those services and rental space, and that the leases are for at least one year. While the compliance laws do allow a 60-day "grace period" before the leases need to be signed, it's probably wise to ensure that all parties sign the leases as soon after they're finalized as possible so no one overlooks this crucial requirement.

In addition to new leases, it's important to examine all existing leases to make sure there's an effective lease governing each space provided to tenants, that no leases have lapsed, and that they accurately describe the space, services, equipment and amenities provided to tenants.

Providers also need to ensure they're being paid fair market value for the tenant space. Fair market value is defined as the value in arm's length transactions consistent with general market value and also can include additional costs the provider incurred to develop or upgrade the property. To make sure they're in compliance, providers would do well to commission rent studies of similar properties in the market and price their leased space accordingly. The appraisers should be experienced and reasonably well-versed in the fair market value concept in healthcare real estate. Specifically, rent should not be determined in a manner based on volume or value of referrals. Also, aggregate rent should be set in advance over the term of the lease and the parties involved should make sure the lease meets the standard of a "commercially
reasonable business purpose."

In addition, providers need to take seriously their responsibility to implement a compliance program. Providers should ensure there is a heightened awareness about the need to keep lease transactions in compliance and educate all staff who deal with financial arrangements with referral sources. It's all about making sure that the entire organization is prepared for greater accountability.

But the reality for many hospitals and health systems is that it's expensive and time-consuming to stay on top of industry regulations and laws and the documentation requirements. Plus many of them lack the internal expertise needed to deal with real estate matters.

Providers that own medical real estate should consider hiring a third-party real estate firm to provide professional real estate advisory, leasing and property management services. The most experienced firms are knowledgeable about the self-referral laws, and understand how the laws are changing and how seriously these laws can affect health providers. Most importantly, property managers can assist in establishing formal compliance programs throughout the organization and counsel health system executives on the most appropriate ways to communicate, monitor and enforce the compliance standards. This is particularly important in healthcare organizations with limited real estate experience and staffing.

In addition, a third-party real estate firm can offer its specialized expertise and knowledge, freeing up the hospital leadership to focus on their core competencies of providing high-quality healthcare and superior patient outcomes.

An even more definitive way to manage that real estate risk is for providers to get out of the real estate business and simply develop and lease space from independent third-party real estate firms. Accountability for compliance with the AKS and Stark Laws resides with building owners, whether those are hospitals or third parties. Thus having someone else own the buildings effectively mitigates the hospital's real estate risks. As an added benefit, those third-party owners assume direct responsibility for all the leasing and property management chores described above.

Allowing others to develop and own new buildings or acquire existing buildings might also be attractive to hospitals and health systems that have other pressing capital needs. Yet even without direct hospital ownership, agreements can be crafted to ensure the third parties own, lease and manage the facilities in a fashion that continues to support the best interests of the health systems, hospitals, physicians, staff and patients.

CMS is increasing scrutiny of health providers across the country and the stakes have never been so high for violating Stark and AKS laws. But by being aware of the changes in the laws, understanding their increased responsibilities and seeking outside real estate expertise when needed, health providers will be able to minimize the risks associated with noncompliance.

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