

# MEDICAL LEASE PRIMER

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Due to the specialized nature of medical services and the myriad legal requirements governing them, medical office leases are unique and much more complex than standard commercial office leases.<sup>2</sup> Accordingly, medical office leases cannot be treated in the same manner as standard commercial office leases and require much more analysis and careful consideration by the drafter.

As will be discussed below, the Stark Law and the Anti-kickback Statute (collectively, "Healthcare Referral Laws") directly impact the types of leasing arrangements involving physicians,<sup>3</sup> physician organizations<sup>4</sup> and other healthcare providers<sup>5</sup> who furnish items or services payable by Medicare, Medicaid, or other federal healthcare programs. These statutes affect nearly every provision dealing with compensation and rent, areas that real estate attorneys often leave to brokers.

Moreover, certain leasing arrangements including block or timeshare leases (which are rare in standard office leases but somewhat common in medical leases) and per-click leases demand a much more detailed analysis than in typical office leases. Leases between commercial landlords, who do not themselves furnish healthcare services and are not owned by physicians or other healthcare providers, and tenants that are physicians or other healthcare providers typically will not need to address issues that arise solely from Healthcare Referral Laws, but will need to address other legal issues related to healthcare. Accordingly, the form of a lease between a landlord which is a physician, physician organization or other healthcare provider or is owned, directly or indirectly, by physicians or other healthcare providers is different from the form of a lease between a commercial landlord and tenants who are physicians or other healthcare providers.

## Dealing with Healthcare Referral Laws in a Lease

While all leases contain provisions that require the tenant to be in compliance with all applicable laws, medical leases must specifically address and require compliance with Healthcare Referral Laws. While there are many similarities between standard commercial office leases and medical office leases, many considerations pertaining to and regulations contained in the Stark Law<sup>6</sup> and the Anti-kickback Statute<sup>7</sup> are unique to medical office leases, especially leases where both the landlord and the tenant are physicians or other healthcare providers.

These Healthcare Referral Laws are designed to prevent physicians and other healthcare providers from receiving payments based on the volume and value of referrals of patients for certain healthcare items or services payable by a federal healthcare program. In a standard commercial lease, the ownership of the landlord and the ownership of the tenant rarely have an effect on the structure of the lease or the determination of the rental rate. In a medical leasing context, however, the ownership structure of a landlord and the ownership structure of a tenant and the referral relationships and other financial relationships between them impact the application of these Healthcare Referral Laws and are a key consideration.

Whenever a hospital is the landlord of a medical office building and rents space in the building to physicians or physician organizations, Stark issues will arise, since the physicians will likely refer patients to the hospital for in-patient services or other designated health services ("DHS")<sup>8</sup> such as diagnostic testing services. Similarly, Stark issues arise if the landlord is another type of healthcare provider that furnishes DHS and the tenant is a physician or physician organization. The Anti-kickback Statute is implicated in the foregoing arrangement and in any arrangement where there are referrals

for healthcare services between a healthcare tenant (i.e., a tenant who is, or is owned by, a provider of items or services payable by a federal healthcare program) and a landlord who is a provider or is owned by a provider. These relationships must be carefully analyzed in order to determine the impact of Healthcare Referral Laws. The manner in which the ownership structure of a landlord and of a tenant impacts the regulatory analysis and the lease will be discussed in greater detail after a brief review of Stark and the Anti-kickback Statute.

### Stark Law

The Stark Law regulates referrals for DHS payable in whole or in part by Medicare or Medicaid. Under Stark if the physician<sup>9</sup> (or an immediate family member of the physician)<sup>10</sup> has a specified financial relationship with an entity, including a space rental relationship, then the physician may not make referrals to the entity<sup>11</sup> for DHS unless the relationship qualifies for an exception under Stark. Space rental relationships arise in situations where a physician or physician group practice, by virtue of the stand in the shoes doctrine,<sup>12</sup> either rents office space from or to a DHS entity. For example, if a physician group practice rents office space in a building owned by a physical therapy practice and also refers patients to the physical therapy practice for physical therapy, a DHS, the compensation paid by the tenant physician practice to the physical therapy practice as rent must meet the space rental exception of Stark. Stark is violated if the arrangement does not meet the space rental exception.<sup>13</sup>

Stark is a strict liability law. If a relationship regulated by Stark fails to qualify for an exception to Stark, then the relationship violates Stark and is per se illegal. A physician who is a tenant or whose group practice is a tenant could not make referrals for DHS to the landlord. There are severe consequences for failing to comply with

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Stark. A healthcare provider who submits a claim for DHS pursuant to a prohibited relationship cannot be paid for the services provided and risks liability for up to \$15,000 in penalties for each bill submitted for payment. Additionally, the Office of Inspector General (“OIG”) may initiate administrative proceedings to impose civil monetary penalties on each party or to exclude a party from participation in federal healthcare programs.<sup>14</sup>

### Anti-kickback Statute

The Anti-kickback Statute applies to any person and to any healthcare items or services reimbursable by a federal healthcare program. The Anti-kickback Statute, an intent-based statute, makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. Remuneration includes the transfer of anything of value, in cash or in kind, directly or indirectly. Parties on both sides of an impermissible kickback transaction are subject to criminal liability, civil monetary penalties, and exclusions from participation in federal healthcare programs. The statute covers any arrangement where one purpose of the remuneration was to obtain money for a referral of services or to induce further referrals.<sup>15</sup> The Anti-kickback Statute contains a safe harbor for space rental.

The Anti-kickback Statute has a much broader reach than Stark because it applies to any referrals for items or services payable by a federal healthcare program. All healthcare providers participating in federal healthcare programs, not just physicians, must be concerned about whether referral relationships in which they participate could violate the Anti-kickback Statute.

Stark violations and Anti-kickback Statute violations can also result in violations of the False Claims Act.<sup>16</sup>

### Analyzing Lease Transactions for Compliance

A compliance analysis under either of these statutes requires looking beyond the form of the transaction into the substance of the transaction. The government may not agree that a transaction that has been labeled a “lease” is actually a bona fide lease. Contractual arrangements involving healthcare providers, including entities owned by a healthcare provider, are always carefully scrutinized by the government since a contractual arrangement that on its face seems to be appropriate may be a disguise for impermissible remuneration.

The ownership structure of the landlord and of the tenant is usually the starting point for a compliance analysis. It is important to determine whether a healthcare provider landlord furnishes DHS and is thus a DHS entity. If the landlord is not a healthcare provider, it is important to determine if the landlord has owners which are DHS entities, physicians or other healthcare providers who do not furnish DHS, or has owners which are passive investment entities which are owned by one or more physicians or other healthcare providers, some of whom may be DHS entities. Similarly, it is important to determine whether a healthcare provider tenant is a physician, physician organization or group practice or some other type of healthcare provider and whether that other healthcare provider furnishes DHS.

When a physician or group practice either rents office space to or from a DHS entity, the arrangement must comply with the Stark space rental exception in order for the physician or group practice to make referrals to the DHS entity. Where a healthcare provider either rents office space to a healthcare provider tenant or rents space from a healthcare provider landlord, the arrangement must comply with the Anti-kickback Statute’s space rental safe harbor if the parties are in a position to make referrals to one

another or generate business for one another, which generally they will be.

The compliance analysis is usually more complex than this due to the prevalence with which physicians and other healthcare providers own an interest in a landlord that is a DHS entity or healthcare provider. In these cases, there will also be an investment relationship between the landlord and the tenant to be considered separately from the rental relationship. The investment relationship is most often structured indirectly by having a healthcare provider, or its individual owners, form an investment entity which owns an interest in the landlord. Additionally, many landlords are special purpose entities, controlled by a single healthcare provider such as a hospital, whose only purpose is to own, manage, and operate a medical office building.<sup>17</sup>

If physicians or group practices own an interest in a landlord that is a DHS entity, either directly or through an investment entity, the arrangement, in addition to complying with the space rental exception, must be analyzed to determine whether it is required to comply with either the direct investment exception in Stark, in the case of direct ownership by the physicians, or with the indirect investment exception in Stark in the case of indirect ownership through an investment entity.<sup>18</sup>

There is a growing trend for a non-provider landlord who owns a medical office building to be affiliated with one or more of the healthcare provider tenants in the building through the landlord’s ownership structure. Under a fairly common ownership structure, a healthcare provider which rents or intends to rent space in the building forms an investment entity wholly owned by the healthcare provider or by the individuals who own the healthcare provider. Since the sole purpose of the investment entity is to invest in and own an interest in the nonprovider landlord,

the investment entity does not furnish any healthcare items or services. An increasingly common method of financing new office buildings, particularly when the owner of the office building has entered into a ground lease with a hospital, is to require every tenant in the building to invest in the landlord on a ratable basis, usually with each tenant purchasing a percentage interest in the landlord equivalent to the percentage of rentable space in the building that has been rented by the tenant. Thus, the nonprovider landlord is wholly owned by tenants or by each tenant's investment entity.

In these arrangements, the individuals (or entities) who own the healthcare tenant, through the investment in the nonprovider landlord, receive a share of the rent earned by the nonprovider landlord. Healthcare tenants are apt to make referrals to one another for DHS and other healthcare items or services payable by federal healthcare programs. Even if the investment entity is owned by physicians, Stark does not appear to be implicated by the investment relationship because the investment entities and the nonprovider landlord are not furnishing DHS.

Similarly, the Anti-kickback Statute does not appear to be implicated by the investment relationship per se since neither the investment entity nor the nonprovider landlord are furnishing any items or services payable by a federal healthcare program. These entities are not in a position to generate business for one another. However, the healthcare tenants who own the nonprovider landlord are in a position to generate healthcare business for one another and thus compliance with the Anti-kickback Statute is a concern. In many cases, the landlord has sought tenants for the building that are likely to refer patients to one another. Examples are obstetrical practices, pediatrician practices, oncology practices and radiation clinics.

There may be a subtle incentive to make these referrals since doing so helps

the profitability of the tenant receiving referrals and makes it more likely that the tenant will stay in business and continue to rent space in the building. Potentially, this creates issues with respect to the Anti-kickback Statute which has a broader reach than Stark since it covers all persons as well as all items and services payable by a federal healthcare program. It is difficult for privately owned entities to meet the few investment safe harbors to the Anti-kickback State that exist. In these situations, it is wise to ensure that the rental relationship between the landlord and each tenant meets the Anti-kickback Statute's space rental safe harbor. Doing so makes it seem less likely that the arrangement is a disguise for an illegal kickback.

Transactions involving a healthcare providers or entities owned by healthcare providers, even investment entities, need to be deconstructed and carefully analyzed given that the consequences of noncompliance are so severe.

In analyzing a leasing transaction under these Healthcare Referral Laws, the overall goal is to make sure that the lease does not create an economic benefit to a tenant group that could be interpreted as consideration for patient referrals. There should not be any benefit whatsoever that flows to a tenant that would not flow to a tenant in a relationship in a "non-medical" arms-length situation. The rental of office space exception in Stark and space rental safe harbor for the Anti-kickback Statute are primarily based on the underlying concepts that if rent is set at a fair market value rate and the provisions in the lease are commercially reasonable, consistent with the business purposes of the relationship and result from a bona fide transaction, the remuneration designated as "rent" in a lease is not apt to be a disguised payment for the value or volume of referrals. For the purposes of these two laws, remuneration includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.<sup>19</sup>

## Compensation Arrangement Exception – Rental of Office Space

To qualify for the rental of office space exception to Stark or the space rental safe harbor for the Anti-kickback Statute,<sup>20</sup> the lease arrangement must comply with the following requirements:

1. The lease must be in writing, signed by the parties and specify all of the rental space to be covered by the lease.
2. The lease term must be for at least one year. If the lease is terminated during the term, with or without cause, the parties cannot enter into a new agreement during the first year of the original term of the lease,
3. The rent charged must be consistent with fair market value for the property, be set in advance, and not take into account the volume or the value of referrals or other business generated between the lessor and lessee.<sup>21</sup>
4. The space rented or leased cannot exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee (and is not shared with or used by the lessor or any person or entity related to the lessor), except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.
5. The lease would be commercially reasonable even if no referrals were made between the landlord and the tenant.

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6. A holdover month-to-month rental can be no longer than six months immediately following the expiration of an agreement of at least one year provided that the holdover rental is on the same terms and conditions as the immediately preceding agreement.<sup>22</sup>

## Fair Market Value

The most important requirement to meet is that rent must be set at a fair market value, i.e., a value that is consistent with fair market rental value for the property. The fair market value is intended to reflect the value of rent that would result from an arm's length transaction consistent with the value of space for general commercial purposes.<sup>23</sup> The fair market rental value cannot in any way be determined by using a formula based on a percentage of revenue raised, earned, billed or collected or otherwise related to the business generated by the tenant. The fair market value cannot be adjusted to reflect the additional value that either the lessor or lessee attributes to the property as a result of being located next to a referral source such as a hospital.<sup>24</sup>

Surprisingly, there is very little case law or guidance from the Centers for Medicare and Medicaid Services ("CMS") on fair market value. The most instructive discussion of what is meant by a fair market value rental rate is set forth in *United States of America ex rel. Goodstein v. McLaren Regional Medical Center*.<sup>25</sup> In its analysis in this case, the court discussed the difficulty of conducting appraisals because rental rates vary widely depending on whether the lease is a triple net lease (in addition to the stated rental rate the tenant pays its pro rata share of taxes, insurance, and maintenance expenses), a gross lease (an all-inclusive lease in that the tenant does not pay any additional amounts for taxes, utilities, and insurance), or a modified gross lease (some expenses are billed to the tenant as additional rent). The court emphasized the appraisal process should include all buildings for

general office space within the relevant market area and in comparable buildings.<sup>26</sup> In order not to exclude any comparable buildings from the appraisal process, the appraiser must take into account whether the lease is a triple net lease, a gross lease or a modified gross lease and adjust rents accordingly.<sup>27</sup>

In conducting a fair market analysis, the effect of various lease terms on the rental rate also has to be considered. As further discussed below, the tenant improvement allowance and landlord concessions are two such provisions that can have a significant impact on an appraisal. These provisions can be used to transfer value from the landlord to the tenant. Additionally, these lease provisions need to be supported by a valid business purpose that is not based on the value or volume of business generated between the tenant and the landlord, particularly if the landlord is an entity to which the tenant will be making referrals for DHS.

In many cases, it may be difficult to determine the effect of a provision on the fair market value rent. A bona fide effort should be made to do so and the process by which an analysis is conducted should be documented. Real estate brokers and appraisers are very familiar with the provisions that are common to commercial leases and can provide valuable insight. Appraisals to support the fair market value rent should be obtained wherever feasible.

## Amending the Stated Rent

Initially, CMS interpreted the "set in advance" requirement set forth in the Stark space rental exception to preclude changing the rent stated in the lease.<sup>28</sup> CMS has recently changed its interpretation of this "set in advance" requirement. CMS now permits amendments to the lease to change the rent provided that the following criteria are met: (1) All of the requirements of the applicable exception are satisfied; (2) The amended rental charges or compensation (or compensation formula) is

determined before the amendment is implemented, and the formula is sufficiently detailed so it can be verified; (3) The formula for amended rental charges does not take into account the volume or value of referrals or other business generated by the referring physician; and (4) The amended rental charges or compensation (or compensation formula) remain in place for at least one year from the date of amendment.<sup>29</sup> Because this is a change in the interpretation of "set in advance," changes to regulations were not made.<sup>30</sup>

## Tenant Improvements

In analyzing leases, it is also important that tenant improvement allowances be taken into account in determining the remuneration passing between the landlord and tenant. Under most leases, the landlord, on behalf of the tenant, constructs some tenant improvements prior to a new tenant moving into a building.<sup>31</sup> The cost of the tenant improvements is typically amortized over the term of the lease if the improvements are of the general type that will benefit subsequent tenants. Improvements that are specific to the unique needs of a tenant are, depending on the circumstances, allocated to the tenant. Where the landlord pays for the tenant improvements, typically the landlord adjusts its asking rental rate based on the projected budget for the tenant improvements. Thus, the landlord recoups the cost of the tenant improvements over the term of the lease. Leases provide that at the end of a lease the tenant improvements become the property of the landlord. However, given the recent economic turmoil, landlords are offering additional money for improvements in order to entice tenants to their buildings.

This area is one that could be ripe for abuse. A tenant could impermissibly shift costs for tenant improvements to the landlord without a concomitant increase in rent, particularly if large amounts are being paid for the types of improvements such as carpeting, interior partitions, in-suite bathroom facilities,

and cabinetry, that have a useful life long enough to provide significant benefit to other tenants and the term of the lease is short. Similarly, if the landlord is paying for tenant improvements that are unique to a particular tenant and are not being reimbursed by such tenant, the tenant receives a benefit that could be impermissible remuneration. In each event, attention should be paid to what is common under the circumstances and in the particular market. For example, with the current depressed market conditions, generous tenant improvement allowances are not uncommon. When analyzing compliance with Healthcare Referral laws, it is important to look at the tenant improvement allowance and determine whether such an allowance, taking into account the rental rate, is at fair market value or whether it could be a disguised payment based on the value or volume of referrals.

### **Concessions**

When vacancy rates are high, landlords are inclined to grant certain concessions to tenants. For example, the landlord may agree to provide free janitorial service for the initial year, decorating allowances, or several months of free rent. If these types of concessions have become standard in commercial office leases, these concessions should be acceptable in a medical lease, provided all of the other conditions for a rental of space exception have been met and the value of the concessions is appropriately considered in determining fair market value.

### **Holdover Rent**

The fair market value analysis must include a consideration of any holdover rent to be charged to the tenant. Most leases require a holdover tenant (a tenant who continues to occupy the premises after a lease has expired) to pay a higher rate of rent during a holdover period. Such provisions provide an incentive for the tenant to either vacate the premises or enter into a new lease. Such a provision is standard in the market place and generally accepted at

125 percent to 150 percent of the rent specified for the initial term of the lease.

CMS has recently clarified that landlords may charge a higher rate of rent during the holdover period provided the rent during the holdover period is set forth in the written lease.<sup>32</sup> Such rent during the holdover period should also be consistent with what landlords in non-medical office buildings are charging as rent during a holdover period.

### **Subleasing and Timesharing Arrangements**

Subleasing arrangements between physician organizations and persons or entities to which physicians in these organizations make referrals are common, as are subleasing arrangements between non-physician providers and persons or entities to which the non-physician providers make referrals. Some of these arrangements result from the renting of space to a subtenant, such as clinical laboratories, diagnostic testing facilities, physical therapy or occupational therapy groups, who will perform DHS for patients of the practice. In other cases, physicians or non-physician providers sometimes rent office suites that are larger than necessary for their current needs so that the practice has room for future expansion. While there are extra examination or treatment rooms available, a physician practice may sublease these examination rooms to other physicians or healthcare providers.

All subleases must independently qualify for an exception or safe harbor to Healthcare Referral Laws. The OIG, which is charged with identifying and eliminating fraud, abuse and waste in programs administered by the Department of Health and Human Services, has issued a fraud alert which pertains to subleasing arrangements between a physician practice and persons to which the practice makes referrals.<sup>33</sup>

An example of arrangements of concern to the OIG includes mobile diagnostic suppliers that perform diagnostic tests for patients of the practice in

space rented from the practice. The OIG is concerned that any rent paid by the mobile independent diagnostic testing facility ("IDTF") is a disguised kickback to the physician landlord to induce referrals. In such arrangements, it is imperative that the parties to a sublease carefully analyze and document the process by which they negotiated the rent and obtain outside support, such as rent comparables for general office space in the immediate area that support the rent being charged to the sublessee. The rent itself cannot be based on the value or volume of business generated between the parties. This means that rent cannot be based on a percentage of the gross or net revenue or billing of the sublessee. In such a situation, OIG cautions that the rent charged to the sublessee should not exceed the rate paid by the physician practice in the primary lease for their office space.<sup>34</sup> Physicians who sublease to other physicians or providers often would like to charge more to their sublessee, particularly if rental rates have increased in the area since the physician entered into his or her own lease. The burden will be on the lessor to prove that such an arrangement meets the fair market value requirement.

In a subleasing arrangement, as with a standard medical lease, the sublessee must rent only that space necessary to meet the needs of the sublessee. Depending on the circumstances, the sublessee's rental rate can consist of rent for exclusive office space (i.e., the examination rooms exclusively used by the sublessee), interior office common space (i.e., reception area, break room, restrooms, assuming the sublessee has the right under the sublease to use these areas), and building common space (i.e., elevators, stairways, corridors, parking areas). The sublessee may be required to pay rent, on a prorated basis, for the use of the interior common office space. If so, the charge for the maintenance of interior common space (i.e., a "CAM" charge) should be allocated among all physicians and sublessees based on the amount of non-common space they occupy and, in

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the case of a part-time sublease, the duration of such occupation.

Subleasing arrangements often involve the provision of other services such as scheduling by the sublessor's staff or the sharing of staff (such as receptionists) or the rental of equipment. The personal services rendered must qualify separately for a personal services compensation exception under Stark, if Stark applies to the relationship, and the Anti-kickback Statute personal services compensation safe harbor.<sup>35</sup> Equipment rental arrangements must qualify for the equipment rental exception to Stark, if Stark applies to the relationship, and the Anti-kickback Statute's equipment rental safe harbor.<sup>36</sup>

Block leases, also sometimes referred to as timesharing arrangements, are permitted under the rental of office space exception. In a block lease, a party leases a specific office space or piece of equipment for a set period of time such as three mornings from 8:00 am to 12:00 noon each week. For a block lease to qualify for an exception, the space and equipment being leased must be used exclusively by the lessee during the time period that it is leased and is not shared with or used by the lessor during those time periods. Equipment that is shared may be located in common areas only if it is the type of equipment that is not typically separately leased. For example, scales for weighing patients could be located in a common area. Imaging equipment probably could not be.

CMS has cautioned that these block lease arrangements are "suspect." If the lessee is leasing the space or equipment in small blocks of time or for long blocks of time (which may indicate the lessee is leasing space or equipment it cannot use as a means of compensating the lessor for referrals) the arrangements may be impermissible.<sup>37</sup> If the increments of time are too small, the lease becomes a prohibited per-click lease and the arrangement is then

noncompliant. Special attention must be given to determining whether the sublessee is leasing only such space as is required for the sublessee's needs.

One of the reasons these block leases are suspect is that in some cases, they have been used to disguise arrangements that are disfavored joint venture arrangements.<sup>38</sup>

Another leasing arrangement that has been disfavored by OIG is the leasing of space in a physician's office or other healthcare provider's office by a supplier of durable medical equipment, prosthetics, orthotics, and supplies (collectively, "DMEPOS") who uses the rented space for a consignment closet.<sup>39</sup> The OIG has long questioned whether such an arrangement is a valid rental arrangement or is in reality a kickback. CMS has significantly limited consignment closet arrangements pursuant to an amendment to the Medicare Program Integrity Manual that will be implemented as of March 1, 2010.<sup>40</sup> DMEPOS suppliers who keep an inventory at a healthcare provider's office will no longer be permitted to bill Medicare beneficiaries for supplies furnished to them from the inventory. The healthcare provider furnishing the supplies is required to bill Medicare for the supplies. CMS has not prohibited DMEPOS suppliers from maintaining an inventory but has imposed substantial conditions on the arrangement.<sup>41</sup> Even though the arrangement meets the billing requirements, physicians must still be concerned about complying with Stark and the Anti-kickback Statute. The Stark in-office ancillary services exception is applicable to only limited items of durable medical equipment ("DME") such as canes, crutches, walkers, folding manual wheelchairs, blood glucose monitors, and certain infusion pumps.<sup>42</sup>

Some arrangements between hospitals and physicians do not require a lease but raise issues concerning compliance

with Healthcare Referral Laws. For example, some hospitals have arrangements with a group practice to use physicians employed by the group practice to provide outpatient services. The hospital may provide fully equipped office space within the hospital's campus or elsewhere to the group practice as well as personnel who are employees of the hospital to carry out administrative functions (i.e., providing secretarial services, scheduling appointments, handling patient sign-in and check-out procedures, collecting payments from patients at checkout, and billing).

Since the physicians employed by the group practice will typically refer patients to the hospital for various services, these arrangements must comply with the Anti-kickback Statute and with Stark if referrals are made for DHS. The contractual arrangement with the group practice must require the group practice to pay for the personnel and other items provided to the group practice by the hospital including wages, fringe benefits, rent for the space provided, and utilities. Applicable safe harbors under the Anti-kickback Statute include the personal services and management contract safe harbor.<sup>43</sup> This safe harbor contains requirements that parallel those of the space rental safe harbor. As is true with the space rental safe harbor, OIG does not consider payments for services to be set in advance if the payments are based on a percentage of revenue or a per unit of service fee. Depending on the details of the arrangements, the Stark exception for personal services, indirect compensation, or fair market value compensation may be applicable.<sup>44</sup>

### Ground Lease Arrangements

Rather than become the landlord of a medical office building, hospitals will frequently enter into a long-term ground lease with an entity that leases, owns or will own a medical office building constructed on the land.<sup>45</sup> It is

imperative that such a transaction be structured so that the rent being paid by a physician-owned ground lease tenant for the ground lease fits within an exception to the Healthcare Referral Laws. The ground leases are analyzed in the same manner as other leases.

A corollary to the above discussion is a concern about “favored” treatment being given by a hospital to certain physicians on staff who generate significant business for the hospital. Such favored treatment is granted in the form of offering a favorable business opportunity to such favored physicians. For example, a practice group that generates surgical referrals for the hospital may be offered the opportunity to enter into a ground lease for property on the hospital’s campus. The convenience of having offices near the hospital is very attractive to physicians and their patients. The physicians who are given the opportunity to enter into the ground lease can be expected to benefit financially from the ability to construct and operate a medical office building near a hospital.

In these cases, the compensation arrangement between the hospital and physicians who own the medical office building will need to independently comply with Healthcare Referral laws. While the issue being discussed is above and beyond the scope of this Article, it is important to be aware of these potential complications.

There is some concern that the granting of the right to enter into a ground lease and then construct a medical office building that will generate rent for its owners is a kickback. In at least one False Claims Act case, the issue was raised that offering physicians preferential opportunities not available to the general public to obtain equity interests in a hospital’s healthcare operations through partnership or corporate structure arrangements was a disguised payment for referrals.<sup>46</sup> Because this case was dismissed on other grounds, the issue was not decided. This remains a concern, however.<sup>47</sup>

### **Periodic Increases in Rent and Increases on Renewal of the Lease**

Multi-year leases protect both the tenant’s right to continue to lease the space and the landlord’s interest in not having to look for new tenants. In such leases, the rent charged during the term of the lease changes periodically (generally in an upward direction). For the initial term of the lease, the lease will often specify the yearly increases in the rent. These increases have to be consistent with a fair market rental rate. Because yearly rent increases are common to both standard office leases and medical leases, such increases are to be expected and will be commercially reasonable, if consistent with the general practices in the area.<sup>48</sup> In order to set the rent in advance, the lease must either specify the dollar amount of the increase or set forth a very specific, verifiable formula for determining the yearly increases in rent, such as the yearly change in the consumer price index. The formula used should be one that is commercially reasonable and used frequently in standard commercial leases.

Frequently, leases contain automatic renewal provisions or an option to renew the lease for an additional period of time. Leases tend to renew on the same terms and conditions as stated in the initial lease except for a change in rent. It is wise to provide for an appraisal mechanism to use to determine the base rent to be changed in the renewal term of the lease. There are risks to using other methods, such as relying on the increase in the consumer price index, even though this mechanism is common in standard commercial office leases. To protect landlords, renewal provisions will normally specify that rent during the renewal period will be no lower than rent for the prior term. Such a provision will be problematic in a medical lease if rates have decreased and the rent for the initial term is not fair market value at the time of renewal.<sup>49</sup>

### **Change of Ownership Provisions**

Most leases contain provisions requiring the consent of landlord to a change in the ownership of a tenant. The general purpose behind these provisions in a standard office lease is to give the landlord an opportunity to review the general reputation and creditworthiness of the proposed new tenant. However, with provider or provider affiliated landlords and physician and other healthcare provider tenants, change of ownership can impact compliance with Healthcare Referral Laws. Both changes in the ownership of the landlord and changes in ownership of a healthcare provider tenant need to be reviewed by counsel who can determine whether any compliance issues will arise and take appropriate steps to restructure or terminate relationships before any noncompliance occurs.

Generally contracts such as leases are freely assignable unless there is a provision to the contrary in the lease. Accordingly, in the absence of such a provision, a landlord has the right to assign the lease to another party without the consent of the tenant. In standard commercial office leases, such an assignment should not be a concern to the tenant. In a medical leasing situation, tenants need to protect themselves in the event such a transfer by the landlord results in an impermissible compensation arrangement. Tenants should negotiate the right to terminate a lease under these conditions or, if possible, to amend the lease to meet regulatory requirements.

Optimally, medical office leases should contain a provision that prohibits the transfer of any interest in a lease or in ownership of the building to any person where such transfer would result in a violation of a Healthcare Referral Law. Such a provision should be coupled with a notice requirement for each party to notify the other of any changes in ownership and specifically identify the intended new owners. If a

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compliance issue would result, either a party has the right to veto the change in ownership or the right to terminate the leasing arrangement.

### **Amendment for Compliance Purposes**

Because of the seriousness of violations of Healthcare Referral Laws, leases for medical office buildings need to have clauses in them to address what happens when an arrangement, due to a change in law or ownership, no longer complies with Stark or the Anti-kickback Statute. As an example, recent clarifications and revisions to Stark have made it clear that Medicare providers cannot share office space such as examination rooms and has called into question many time-share arrangements.<sup>50</sup>

A provision permitting a lease to be amended, if such an amendment would cure noncompliance, can be a valuable provision that benefits both the tenant and the landlord, particularly when the landlord itself is subject to Stark and the Anti-kickback Statute. Such a provision can take many forms. To protect both parties, such a provision can provide that, upon the written opinion of either party's healthcare law attorney that the arrangement no longer complies with Stark or the Anti-kickback Statute, the landlord and tenant shall negotiate an amendment to the lease that cures the noncompliance. Each party should be required to take all reasonable steps needed to cure noncompliance. If such an amendment is not possible, then the provision should specify that the lease shall terminate.

The foregoing amendment provision is tenant-favorable since it allows the tenant to terminate the lease without having breached it. Such a provision will be acceptable to a landlord in circumstances where both the tenant and the landlord are entities that will be negatively impacted if there is noncompliance. Landlords are willing to enter into such a termination provision

because the financial impact of noncompliance is apt to be far greater to the landlord than the costs of having a vacant office suite while finding a replacement tenant.

Nevertheless, these provisions need to be carefully crafted so that a tenant (or a landlord) who wishes to get out of a lease cannot purposefully make changes that will bring the tenant (or landlord) into noncompliance with Stark. One such change could be changing the corporate structure of the tenant in a manner that creates an impermissible referral relationship. The trigger for the provision must be a change in the statute or its implementing regulations, not an act of the tenant or the landlord that results in noncompliance.

The recent changes to the Stark space and equipment rental exceptions illustrate the importance of the foregoing provision. On October 1, 2009, the prohibition against unit-based (per click or percentage based) arrangements for the rental of office space and equipment rental became effective.<sup>51</sup> Under the amended exceptions, rent may not be determined using a formula based on a "percentage of revenue raised, earned, billed, collected or otherwise attributable to the services performed or business generated" in the office space to the extent that such charges reflect services provided to patients referred between the lessor and the lessee.<sup>52</sup>

The amendments to the exception will apply to all existing and future compensation arrangements. Accordingly, any existing per-unit or percentage based lease which relies on the Stark rental of office space (or equipment rental) exception to protect a per-unit or percentage rental arrangement between a lessor who refers patients to the lessee for DHS needs to be revised to bring the lease into compliance. If the lease cannot be so revised, then the tenant is effectively placed between a rock and a hard spot, having to choose whether to break a lease or not bill for any DHS provided to a

patient referred by the lessor. State laws may further prohibit a physician from billing any health insurance provider for DHS of the type that would be payable by Medicare regardless of the source of payment.<sup>53</sup>

### **Protection for Hospitals – Medical Qualifications Provisions**

In cases where the medical office building is either owned, directly or indirectly, by a hospital or has been built on land leased from a hospital (or from a hospital owned entity), the landlord will usually require that all tenants are owned by physicians and all physician owners or physicians employed by the tenant must be on staff at the hospital.<sup>54</sup> If a physician loses staff privileges, the lease typically specifies that the physician can no longer practice from the leased premises.

Other events can also cause a physician to lose the ability to practice from the leased premises. These include being subject to a disciplinary action from a state licensing board or subject to an exclusion order with respect to participation in any federal or state healthcare program. Of course, if a physician loses his license to practice medicine, the physician cannot practice from the leased space. In cases where a group practice has leased the premises, the practice can continue to operate from the leased premises. However, if the tenant's practice was solely owned by such a physician, then the tenant must either find someone to sublease the space or the tenant must be evicted.

It is important to have these provisions drafted in a manner that is fair to both the hospital and to the tenant. Considerations in drafting such provisions include a definition of what it means to have staff privileges. Hospitals have different categories of staff privileges such as full staff privileges, provisional staff privileges or courtesy

staff privileges. A hospital's medical staff bylaws will specify the conditions under which staff privileges may be suspended or terminated and usually provide for a fair hearing prior to taking an adverse action on such privileges.<sup>55</sup> In drafting these medical qualification provisions, attention should be given to the definition of being "on staff" and when a physician is no longer "on staff." The provision should also address how physicians who have retired from practice are treated in investment entities.

Tenants may want to insist that as long as at least one of the physicians has staff privileges at the hospital, the practice can continue renting the premises.

Leases may also specify that all physicians who practice from the leased location must be appropriately licensed and in compliance with all state licensing requirements, specialty certifications, without any restrictions. Additionally, a lease may specify that the physicians practicing from the location cannot be excluded from any federal healthcare program. These provisions must be carefully drafted.

### **Protection for Hospitals – Use Restrictions**

A hospital that is operated by or has an affiliation with a religious organization may also restrict certain procedures such as abortions, stem cell harvesting from fetal tissue, sterilizations, or the dispensing of contraceptives from being performed in the leased premises.

In other cases, a landlord that is a hospital or is owned by a hospital may want to protect its own lucrative areas of practice from competition from its tenants by restricting the types of healthcare providers that lease space in a building. Examples of the practices which might be restricted are as follows: (1) out-patient surgical centers; (2) physical therapy facilities; (3) respiratory therapy services; (4) clinical laboratories; (5) pathology laboratories; (6) pharmacies; (7) diagnostic testing facilities.

## **Provisions Unique to Medical Leases**

There are several issues unique to healthcare tenants that must be considered when negotiating a lease for medical office space. Some of these issues are dictated by laws that apply to all healthcare tenants; others are dictated by specific needs of healthcare tenants.

### **HIPAA**

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")<sup>56</sup> impacts the relationship between a healthcare provider tenant and a landlord. Healthcare provider tenants, who are covered entities within the meaning of HIPAA, are required to implement appropriate administrative, technical, and physical safeguards to protect the privacy and security of protected health information ("PHI").<sup>57</sup> Covered entities must also make reasonable efforts to prevent disclosures of PHI that are not permitted by the HIPAA Privacy Rule.<sup>58</sup> The HITECH Act ("HITECH"), part of the American Recovery & Reinvestment Act of 2009 signed February 17, 2009, amended HIPAA and expanded its scope.

A landlord does not become a covered entity with respect to PHI held by a healthcare provider tenant by virtue of the landlord-tenant relationship. Accordingly, the landlord does not have a statutory duty under HIPAA to protect a tenant's PHI nor is a landlord likely to be, or even agree to be, a business associate of a tenant.<sup>59</sup>

However, it is possible to use lease provisions to impose contractual obligations on a landlord to protect the privacy of any PHI incidentally disclosed to the landlord. As part of its obligation to implement safeguards to protect the privacy and security of its PHI, a healthcare tenant should negotiate appropriate lease provisions to limit incidental disclosures of PHI to the landlord, protect the confidentiality of any PHI incidentally disclosed to the landlord, protect its PHI from unauthorized access by a landlord, and address

physical access controls to the building and the tenant's suite.

A lease needs to address a landlord's access to PHI during business hours and non-business hours. In order to perform repairs and maintenance tasks as well as respond to emergencies, a landlord's workforce will have access to a tenant's office suite during business hours while the tenant's workforce is conducting treatment and administrative functions. While present in the office suite, a landlord or members of its workforce may see PHI on desks and computer monitors as members of the tenant's workforce perform their job duties, and on patient charts placed on the doors to examination rooms. Additionally, the landlord's workforce may overhear conversations with or about patients. These types of disclosures to the landlord's workforce that occur while the tenant is using PHI for treatment or healthcare operations are the types of disclosures that HIPAA treats as permitted incidental disclosures.<sup>60</sup> The tenant has the obligation to limit these incidental disclosures.

Accordingly, the tenant should insist on lease provisions that require the landlord and its workforce, while present in the office suite during business hours, to be accompanied by someone from the tenant's workforce, prohibit access to an examination room while a patient is present in such room, and, except for bona fide emergencies, enter the office suite only on reasonable advance notice to the tenant. This permits the tenant to see if the landlord or a member of its workforce attempts to gain unauthorized access to PHI and gives the tenant the opportunity to minimize the files, records and other items visible to the landlord or its workforce.

In addition, it is imperative that a lease contain a provision requiring the landlord to protect the confidentiality of any PHI disclosed to the landlord or its workforce. Ideally, such a confidentiality provision should require the landlord to impose a confidentiality requirement on its workforce and to train its workforce regarding same. A provision in the lease

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in which the landlord agrees to not gain or try to gain unauthorized access to PHI held by the tenant and to take reasonable measures to prevent its workforce from doing so as well is beneficial. Additionally, indemnification provisions can require the landlord to hold harmless the tenant for any losses, costs and expenses stemming from a landlord's unauthorized access to PHI.

After-hours access to a tenant's suite by the landlord also poses as concern, as such access gives members of the landlord's workforce the opportunity to try to gain unauthorized access to PHI, particularly paper medical records and PHI stored on computers. After-hours access is almost impossible to avoid, since the landlord's workforce typically cleans tenant's office suites after the close of business and because a landlord must be able to access a suite at any time to respond to emergencies. Accordingly, to reduce the risk it may be liable if a member of the cleaning crew discloses PHI held by the tenant a landlord may want to include a provision in a lease that requires the tenant to place all documents containing PHI in locked storage drawers, cabinets or closets at the end of each day and to turn off and lock all computers. The parties may wish to include a provision in the lease in which the landlord agrees to not gain or try to gain unauthorized access to PHI held by the tenant and to take reasonable measures to prevent its workforce from doing so as well. Additionally, indemnification provisions can require the landlord to hold harmless the tenant for any losses, costs and expenses stemming from a landlord's unauthorized access to PHI.

In the event of an emergency that could result in the destruction of documents and computers if the same are not removed from the office suite, the lease should provide that the landlord, wherever possible, contact the security officer for the tenant so that the security officer can attend to securing any documents or

computers that must be removed from the office suite. A provision should also provide procedures for the landlord to follow in the event documents or computers must be removed prior to the arrival of the security officer in order to protect them from damage. The lease should also address procedures to be used to protect the security of files and computers containing medical records in the event that during an emergency, the landlord needs to remove filing cabinets or computers from the tenant's premises in order to prevent them from being damaged.

Although necessary, the lease provisions themselves are not sufficient to adequately protect a tenant. Under the HIPAA Security Rule, a healthcare tenant subject to HIPAA has the obligation to protect the security of PHI by adopting reasonable safeguards to prevent physical access to the areas of the office suite in which medical records are stored and in which the tenant's computer servers are stored. Lease provisions by themselves are not adequate to protect the security of the PHI held by a tenant. Prior to entering into a lease, a prospective healthcare tenant may want its own security advisers to evaluate whether the landlord has adequate security measures in place to protect access to the building itself during non-business hours, to identify such as through security cameras and access control cards persons who enter the building during non-business hours, itself during non-business hours and to monitor who does access the building during non-business hours.

In general, a tenant may not be able to do much to can do little to change the landlord's security measures for the building itself. However, a tenant should be able to require the landlord to install what is needed to make the tenant's leased premises secure, including a separate area, which is locked, to house a tenant's main computer facilities such as its servers, separate locked storage areas for paper files, security alarms, and access

controls to the suite and to locked areas within the suite so the tenant will know who enters the suite and these areas after-hours. Tenant improvement allowances can be used for such purposes. Whatever physical measures the tenant deems appropriate to protect its PHI should be addressed in the lease if such measures involve physical modifications to the leased premises. Any restrictions placed on the landlord's access to the suite should also be addressed.

Perhaps best of all, a healthcare tenant should take appropriate steps to comply with HITECH's safe harbor by rendering PHI stored in electronic form unusable, unreadable or indecipherable to unauthorized individuals specified by the Secretary of HHS.<sup>61</sup> By doing so, the tenant's PHI will be considered secured. This offers some degree of protection to both the tenant and the landlord in the event an intruder or a member of the landlord's workforce takes one of the tenant's computers or, while present in the tenant's suite, gains unauthorized access to PHI stored electronically on the tenant's computers. Landlords knowledgeable about HIPAA may even include such a requirement in the lease.

### **HIPAA Issues – Landlord's Lien**

Commercial leases frequently contain a "landlord's lien" provision which gives the landlord a contractual lien and security interest in all property, chattels or merchandise that may be placed in the leased premises. Additionally, a landlord's lien may arise under state statutory or common law. Whether contractual or statutory, the landlord has the right to foreclose upon such a landlord's lien in the event the tenant defaults in the payment of rent or other sums due under a lease. Medical records, an important and necessary asset of any healthcare practice, and any computers located in the leased premises upon which such medical records or other records containing PHI are stored, as assets of the tenant, are subject to contractual and statutory landlord's liens.

A landlord's lien is foreclosed by selling the assets subject to the lien. Healthcare tenants that are subject to HIPAA risk HIPAA violations should a landlord, take possession of medical records or computers containing PHI in electronic form or on computers.<sup>62</sup> Accordingly, medical tenants should insist that a landlord's lien provision be drafted in a manner that excludes medical records from the scope of the landlord's lien. Additionally, the tenant must be given the right to destroy any PHI that resides on any computers that are subject to a landlord's lien prior to the time that a landlord takes possession of such computers.

### **ADA Compliance**

Some patients are apt to have a physical or mental impairment that qualifies the patients as being disabled under The Americans with Disabilities Act of 1990 ("ADA").<sup>63</sup> The ADA defines a disability as: (1) a physical or mental impairment that substantially limits one or more of the major life activities of an individual; (2) a record of such an impairment; or (3) being regarded as having an impairment.<sup>64</sup> The private offices of a healthcare provider are typically viewed as a service establishment and as such are classified as places of public accommodation under the ADA.<sup>65</sup> A healthcare provider qualifying as a public accommodation under the ADA must provide adequate physical accessibility to its facilities by removing architectural or communication barriers, structural in nature, where such removal is readily achievable.<sup>66</sup>

Both the landlord and tenant are subject to these accessibility requirements.<sup>67</sup> Under the regulations, the landlord is responsible for making readily achievable changes and providing auxiliary services in common areas of a building. The tenant is responsible for the same within its office suite. The parties, however, can allocate their compliance responsibilities through the provisions of a lease. Such an allocation that pertains to common areas of a building may not be feasible in a multi-tenant building.

Tenants may be able to use a tenant improvement allowance to modify the leased premises to be compliant with the ADA.

The availability of adequate handicapped parking is an important component of making a building accessible to patients with disabilities. A medical office building needs to have more handicapped parking spots than a commercial office building of comparable size given the greater incidence of disabilities among patients than among the general public who visit commercial office buildings. It is often necessary for a medical office building to have significantly more handicapped parking spaces than required by local zoning ordinances, which typically do not distinguish between medical office buildings and general purpose commercial office buildings.

### **Lease Arrangements with an Excluded Individual or Entity**

The OIG has established a program to exclude certain individuals and entities from participating in federally funded healthcare programs. The bases for exclusion include convictions for federally funded healthcare program fraud, convictions for patient abuse, licensing board actions, and defaults on Health Education Assistance Loans.<sup>68</sup> An exclusion from a federal healthcare program precludes the excluded individual or entity from being employed by or under contract with any practitioner, provider or supplier to provide any items and services reimbursed by a federal healthcare program, either directly or indirectly.<sup>69</sup> If a healthcare provider arranges or contracts with an individual or entity who is excluded by the OIG from program participation for the leasing of an item or service payable by a federally funded healthcare program, the provider may be subject to civil monetary penalty liability.

A healthcare tenant can contract with an excluded individual or entity for the rental of space in a medical office buildings. Excluded individuals, in their role as a landlord leasing office space,

are not providing an item or service that is reimbursable by a federally funded healthcare program. Thus, an excluded individual can own a medical office building and rent office suites in the building to providers who bill federally funded healthcare programs.<sup>70</sup> However, these rental payments cannot be a sham, or a scheme to get medical funds to the excluded individual.

The prohibition against contracting with excluded individuals extends to items and services that are indirectly furnished by an excluded individual or entity regardless of who bills for those items or services. To indirectly furnish means to provide items or services manufactured, distributed, or otherwise supplied by individuals or entities who do not directly submit claims to federal healthcare programs, but provide such items or services to providers, practitioners, or suppliers who submit claims to those programs for the items and services.<sup>71</sup> Accordingly, a medical tenant could not purchase or lease durable medical equipment from an excluded individual or from an intermediary, sell or lease it to a patient, and then bill Medicare for the durable medical equipment.

### **Use Provisions and Transfer Restrictions**

Most standard office leases will limit the use of the premises to a "general purpose" such as professional office space, medical office space, or retail space. Medical leases go one step further and try to control the type of medical uses that are permitted (i.e., pediatricians' offices, internal medicine, dermatology, urology, nephrology, etc.). The use limitation prevents the tenant from changing its particular specialty to another (or from becoming a multi-specialty practice) and providing services that compete with another tenant in the building. The goal of such a use restriction is to prevent competition among tenants for patients.

In many cases, tenants favor these types of use restrictions as long as they are repeated in restrictive covenants or

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addressed equally and uniformly, since it protects tenants from competition. At the same time, such a restriction can make it more difficult for a tenant to sublease the space should the tenant wish to do so. Landlords generally do not like non-competition provisions because the provisions make it more difficult for the landlord to relet the space, since the landlord can relet only to the same type of medical practice or provider. This raises the possibility that a landlord may increase the rent if such a non-compete provision is included in a lease.

Some landlords may wish to prohibit classes of procedures from being performed in the leased premises. In some cases, part of a tenant's normal practice may include some minor surgical procedures. For example, dermatologists may remove small moles and other skin growths in their regular offices. Such procedures are billed as surgical procedures. Arguably, a use clause that prohibited the use of the leased premises for out-patient surgeries would be triggered. Similarly, many internists take diagnostic x-rays as part of their normal practice or conduct simple lab tests. Arguably, these procedures would be prohibited under a use clause which specified that the leased premises could not be used for diagnostic testing purposes or as a clinical laboratory.

A tenant who performs a prohibited activity as a routine part of its practice can be protected by including a carve-out that permits a tenant to conduct these activities if they are of the kind usually and customarily provided in a physician's office. Tenants could also be protected by a provision that allowed them to conduct "prohibited" activities so long as gross revenues from such procedures did not exceed a certain percentage of total gross revenue.

Not all use restrictions are designed to protect a tenant's market. In some cases, the landlord wants to prohibit

specific uses. Two very different purposes are served by such prohibitions. First, some types of tenants have special requirements that a landlord is not always willing or able to meet. The landlord must be cognizant of the physical limitations of the facility and whether it is possible for such a tenant to locate within the facility. The tenant must discuss these issues up front to avoid surprises down the road in negotiations. For example, some of the heavy equipment used by a diagnostic imaging facility, such as MRI machines and CAT scanners, require floors that are capable of supporting the equipment. Onsite pharmacies may increase the risk of break-ins; thus many landlords do not wish to permit onsite pharmacies.

Special issues about transfer restrictions arise in the context of ownership of a condominium. The Master Deed for a condominium project must address any restrictions on the ability of an owner of a condominium unit to alienate its interest in the unit. Accordingly, covenants that restrict the ability of an owner to rent its unit to a specific type of tenant must be contained in the Master Deed. Tenants need to carefully review the Master Deed, the Articles of Incorporation for the Condominium Association, the Bylaws of the Condominium Association and the rules and regulations established by the Condominium Association that govern use of the common elements while negotiating the lease for a condominium unit.

### Medical Wastes

The generation and disposal of medical waste must be addressed in a lease for medical offices. In general, medical waste regulatory acts define medical waste and establish methods for handling and disposing of such waste.<sup>72</sup> Each entity that is subject to such an act is typically required to register with a state agency such as the public health department and have a written medical waste management plan. These acts contain specific requirements for the

packaging, containment, handling, disposal and incineration of medical waste. Regulatory schemes typically treat medical waste differently from hazardous wastes. Accordingly, the types of hazardous wastes provisions in standard office leases will need to be supplemented with a provision specifically addressing medical wastes and the obligations of the landlord and tenant with respect to the disposal of medical waste.

Generally, the tenant that generates the medical waste is liable for properly handling and disposing of the medical waste. Careful drafting is required in order to ensure that the lease properly allocates the responsibility for disposing of this waste.

Even when the landlord assumes the responsibility for removing the medical waste from the building, the tenant often is required to store the waste it generated within the premises until the landlord's medical waste disposal company picks up waste for the building. These obligations must be carefully spelled out. Tenants should consider requiring the landlord to indemnify the tenant once the landlord takes possession of the waste, such as when the waste is placed in a common area designated by the landlord to receive medical waste.

A critical part of identifying each party's responsibilities is defining what is meant by "medical waste" or "infectious medical waste" as the obligations for handling each may be somewhat different. Generally, medical waste is a more inclusive term than infectious waste.

A lease must require the tenant to immediately separate any medical or infectious medical wastes, upon production or generation, from other types of office waste and place such waste in a container that is marked "biohazard," "infectious medical waste" or the like. The lease can further specify that the container be leak-proof, moisture-proof, puncture-resistant, or

of sufficient strength to resist, tearing, ripping, or bursting in the course of normal usage or handling.

Landlords generally prefer that a tenant directly contract with an appropriately licensed medical refuse company which operates in compliance with all federal, state and local laws, rules and regulations pertaining to the proper removal and destruction of medical waste. This limits the liability of the landlord should a tenant fail to remove medical wastes. Landlords can also protect themselves from the failure of a tenant to remove medical waste by including a provision in the lease that gives the landlord the right to remove the medical waste and then bill the tenant for the costs of removing such waste.

If the landlord agrees to dispose of medical wastes generated by the tenant, then the lease may create liability for the landlord beyond just the care of the medical waste itself. Such liability is based on the landlord's control over the premises or parts thereof. If the landlord allows medical waste to be stored outside of a tenant's space, then the landlord assumes liability for the ultimate disposal of such waste.<sup>73</sup> The landlord thus needs to give contractual control over the medical waste storage areas to the tenants and prohibit storage of medical waste in common areas or other areas under the landlord's control. Indemnification provisions should also be utilized to allocate liability for a tenant's failure to comply with the medical waste disposal provisions of a lease. However, note that an indemnification provision is of value only to the extent that the tenant is capable of paying the costs thereof or if there is a security deposit that can be used.

Additional issues can arise upon termination of a lease if the tenant has not removed all of its medical wastes. Under a nuisance theory, a landlord may be liable for hidden dangers of which a tenant has not been informed. Thus, the lease needs to address abandonment of medical waste at the termination of a lease. To protect the landlord, the lease should give the landlord the right to dispose of the medical

### MEDICAL LEASE CHECKLIST

- Standard office lease review
- Stark Issues
  - In writing, signed by parties, identify rental space
  - Term for at least one (1) year
  - Rent at fair market value
    - Set in advance (four (4) elements for amended rent)
    - Tenant improvement allowances
    - Landlord concessions
    - Holdover rent must be consistent with market
  - Amount of space is reasonable and necessary for proposed use
  - Lease is commercially reasonable even if no referrals
  - Holdover no longer than six (6) months
- Subleasing and Timesharing Arrangements
  - Subleases must independently qualify
  - Sharing of common space/staff issues
  - General prohibition on per-click arrangements
  - Durable medical equipment issues
- Protect against issues created by change in tenant/landlord ownership
- Allow amendments for compliance with regulations
- Medical qualification provisions – hospital staff obligations
- Hospital-imposed use restrictions
- HIPAA privacy and security concerns
- ADA compliance issues
- Excluded individuals
- Use restrictions to limit practice area
- Medical wastes – clearly document responsibilities
- Utility services – ensuring continued service
- Signage issues

wastes and charge the tenant for any of landlord's costs in doing so.

Normally, the landlord provides janitorial services to all the tenants in a building. The landlord needs to ensure that these workers are adequately trained to recognize the containers that are marked for medical waste and to avoid handling the containers marked for medical waste. Additionally, such workers

should be trained to recognize medical waste that may have been inadvertently left laying about an office suite and either how to place such medical waste in an appropriate container or notify the tenant to do so. Indemnification provisions should deal with this as well.

Given its danger, nuclear medical waste presents a special problem. Often, medical nuclear waste is classified as low

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level radioactive waste. Because of the potential danger from such nuclear waste, landlords often want lease provisions that prohibit the tenant from generating any nuclear waste or from conducting nuclear medicine tests or procedures in the leased premises.

### Utility Services

Utility services take on a much more critical role for certain medical offices. Many medical offices store expensive vaccines or medications on premises that must be refrigerated. In addition, certain medical wastes must be frozen until the waste can be hauled away for permanent disposal. These tenants will need to have a provision in a lease that ensures the continual delivery of electricity to the office suite. Landlords rarely want to guarantee uninterrupted utility service, since there is little the landlord can do if the public utility providing electricity cannot deliver electricity to the building. The most a tenant can do is either require the landlord to have backup generators so that utility service will not be interrupted or negotiate a provision that allows the tenant to install a generator.<sup>74</sup> In some cases, landlords may require medical tenants that have a large demand for electricity due to specialized equipment to agree to a separate electrical meter.

Medical tenants may have very specific physical needs, some dictated by the practical concerns of the practice and others dictated by statutory requirements or accreditation standards. Landlords need to be aware that these types of requirements may force a landlord to make accommodations in order to rent to certain tenants.

For example, most states strictly control pharmacies and have requirements that prohibit anyone from having access to the area where prescription medications are stored unless a licensed pharmacist is present. This regulation

conflicts with standard lease language allowing the landlord access to the premises at any time upon reasonable notice. Landlords are not comfortable with such restrictions because they may impede a landlord's ability to respond to an emergency condition such as a burst pipe or water leak, each of which can have devastating consequences. An appropriate middle ground may be to give the landlord phone numbers of authorized individuals in the event of such emergencies. Tenants should not expect a landlord to be aware of these types of requirements and must be prepared to fully identify all such needs early on in the lease negotiations process.

### Signage

Healthcare tenant leases typically contain provisions requiring landlord approval of all signs and advertising placed by the tenant anywhere in an office building or its surrounding outdoor areas, except for signs and advertising that are placed within the interior of the leased office suite. Prior to signing a lease, tenants should determine what signage and advertising a landlord permits and obtain approval for any signage or advertising the tenant wishes to place in the outdoor areas of the office building and the common interior areas of the building.

### Conclusion

When negotiating leases for medical office buildings, it is imperative to enlist the services of an attorney who has a background specifically in the leasing of medical office buildings. Such an attorney can address the compliance issues and the special needs of medical tenants as well as issues common to all leases. Most relationships between tenants and landlords that have a sound business purpose and are commercially reasonable can be structured in a manner that complies with Healthcare Referral Laws and other requirements.



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### Endnotes

- <sup>1</sup> Our thanks to Gary A. Kravitz of Frank, Haron, Weiner and Navarro who drafted the Medical Lease Checklist and provided insightful comments on this article.
- <sup>2</sup> The term medical office building is used to refer to any building whose tenants consist primarily of healthcare providers. The term medical office refers to space rented by a healthcare provider and used to carry out healthcare operations.

- 3 Physician, for the purposes of this Article, has the same meaning as provided in the Stark regulations. The regulations define a physician as a doctor of medicine, osteopathy, dental surgery or dental medicine, podiatric medicine, optometry, or chiropractic. 42 C.F.R. § 411.351.
- 4 Stark defines a physician organization to be a “physician (including a professional corporation of which the physician is the sole owner), a physician practice, or a group practice that satisfies the Stark ‘group practice’ definition. 42 C.F.R. § 411.351.
- 5 A healthcare provider includes physicians and non-physician practitioners who can enroll in Medicare including audiologists, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, clinical social workers, nurse practitioners, occupational therapists, physical therapists, physician assistants, psychologists, and suppliers who can enroll in Medicare including independent clinical laboratories, independent diagnostic testing facilities, mammography centers, portable x-ray facilities, radiation therapy centers, and home health agencies. The term “other healthcare provider” will be used in this Article to refer to a healthcare provider who is not a physician.
- 6 The Stark Laws consist of Section 1877 of the Social Security Act, codified as 42 U.S.C. § 1395nn and its implementing regulations, 42 CFR § 411.351 *et seq.*
- 7 Section 1128B(b) of the Social Security Act, codified at 42 U.S.C. § 1320a-7b(b) and its implementing regulations, 42 CFR §§ 1001, 951 *et seq.*
- 8 The text of 42 C.F.R. section 411.351(1) defines designated health services (“DHS”) to mean any of the following services (other than those provided as emergency physician services furnished outside of the U.S.), as they are defined in this section: (i) clinical laboratory services; (ii) physical therapy, occupational therapy, and outpatient speech-language pathology services; (iii) radiology and certain other imaging services; (iv) radiation therapy services and supplies; (v) durable medical equipment and supplies; (vi) parenteral and enteral nutrients, equipment, and supplies; (vii) prosthetics, orthotics, and prosthetic devices and supplies; (viii) home health services; (ix) outpatient prescription drugs; and (x) inpatient and outpatient hospital services.
- 9 The Stark Law defines a physician as a doctor of medicine, osteopathy, dental surgery or dental medicine, podiatric medicine, optometry or chiropractic. 42 C.F.R. § 411.351.
- 10 An immediate family member or member of a physician’s immediate family means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild. 42 C.F.R. § 411.351.
- 11 The term entity refers to the provider or supplier that furnishes DHS to a patient pursuant to the order of a physician and submits a claim to Medicare for the DHS. A person furnishes DHS if it is the person or entity performing the DHS or presenting a claim for payment to CMS. Such an entity will be referred to as a DHS entity.
- 12 A physician stands in the shoes of his or her physician organization for purposes of analyzing financial relationships and is deemed to have the same compensation arrangement (with the same parties and on the same terms) as the physician organization itself. This concept has the effect of treating some indirect compensation arrangements as direct compensation arrangements. It also affects the link to be analyzed in indirect compensation chains that remain indirect even after the stand in the shoes rule is applied.
- 13 The space rental exception is the only Stark exception applicable to this direct relationship. By its terms, the general purpose fair market value exception does not apply to space rental relationships. 42 C.F.R. § 411.357(l).
- 14 The OIG’s authority to exclude persons from participation in federally funded healthcare programs arises from the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Public Law 95-142, the Civil Monetary Penalties Law, Public Law 97-35, the Balanced Budget Act of 1997, Public Law 105-33, and the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93.
- 15 *United States v Greber*, 760 F.2d 68 (3d Cir. 1985).
- 16 Stark and Anti-kickback Statute violations can also result in violations of the False Claims Act. 42 U.C.S.A. § 1320a-7b(a). Falsely certifying compliance with Stark or the Anti-kickback Statute in connection with a claim submitted to a federal funded insurance program is actionable under the False Claims Act. See *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 902 (5th Cir. 1997); *United States v. Rogan*, 459 F.Supp.2d 692, 717 (N.D.Ill.2006). It is beyond the scope of this Article to discuss the False Claims Act. Additionally, for licensed healthcare professionals, violations of Healthcare Referral Laws can result in a violation of the requirements for being licensed as a healthcare professional. The federal False Claims Act, an intent-based statute, imposes criminal penalties for knowingly and willfully making or causing to be made any false statement or representation of material fact in any application for any benefit of payment under Medicare, Medicaid or any other federally funded healthcare program.
- 17 In any type of commercial real estate, due to liability issues and financing requirements, most entities that own an office building are single purpose entities.
- 18 An investment entity refers to an entity that does not furnish healthcare items or services or conduct any active business operations. Its only purpose is to own and hold an interest in another entity which engages in active business operations and can pass its earnings to the investment entity.
- 19 Remuneration means any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind unless specifically exempted by the regulations. 42 C.F.R. § 411.351.
- 20 Stark applies in situations in which a physician owned tenant (including one owned by immediate family members of a physician) is in a position to make referrals to a DHS entity that is a landlord or a landlord owned by physicians (or their immediately family members) or a physician organization makes referrals to a tenant that is a DHS entity.
- 21 This requirement generally precludes percentage or per use leases from falling within the Anti-kickback Statute safe harbor or the Stark space rental exception. The concern is that if the lessor can increase his payments through his or her referrals to the lessee, there is an incentive for overutilization.
- 22 The Stark exception for rental of space is set forth at 42 C.F.R. § 357(a)(1)-(7). The Anti-kickback Statute rental of space safe harbor is set forth at 42 C.F.R. § 1001.952(b)(1)-(6).
- 23 42 C.F.R. § 411.351.
- 24 56 Fed. Reg. 35952, 35972 (July 29, 1991); 42 C.F.R. § 411.351.
- 25 *United States of America ex rel. Goodstein v. McLaren Regional Medical Center*, 202 F.Supp.2d 671 (E.D. Mich 2002).
- 26 *Id.* at 676.
- 27 *Id.*
- 28 42 C.F.R. § 357(a).
- 29 73 Fed Reg 48697 (2008).
- 30 The CMS interpretation of “set in advance,” which applies to Stark exceptions only, appears to be inconsistent with the interpretation of the “set in advance” requirement of the Anti-kickback Statute space rental safe harbor. 42 C.F.R. § 1001.952(b). Space rental relationships between any healthcare provider (physicians and hospitals included) and persons to which such healthcare providers make referrals must comply with the Anti-kickback Statute. Failure to comply with the safe harbor, however, does not make the arrangement per se illegal (i.e., noncompliant with the Anti-kickback Statute). The intent of the parties will largely determine whether the arrangement, as amended, will be viewed as complying with the Anti-kickback Statute.
- 31 In some cases, the tenant shares in the cost of the tenant improvements over a certain budgeted amount.
- 32 Preamble to the Stark Phase III Regulations, 72 Fed Reg 51045 (2007).
- 33 Special Fraud Alert, “Rental of Space in Physician Offices by Persons or Entities to Which Physicians Refer” issued by the Office of Inspector General February 2000 available online at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/office%20space.htm>.
- 34 *Id.*
- 35 The personal services Anti-kickback Statute safe harbor is set forth at 42 C.F.R. § 1001.952(b). The personal services exception to Stark is set forth at 42 C.F.R. § 411.357(d).
- 36 The equipment rental safe exception to Stark is set forth at 42 C.F.R. § 411.357(b). The equipment rental Anti-kickback safe harbor is set forth at 42 C.F.R. § 1001.952(c).

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- 37 73 Fed Reg 48719 (Aug. 19 2008).
- 38 See, e.g., OIG's Special Fraud Alert on Joint Venture arrangements, reprinted in the *Federal Register* in 1994 (59 Fed Reg. 65362, 65363); Special Advisory Bulletin on Contractual Joint Ventures (68 Fed. Reg. 23148) available online at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html>.
- 39 See, e.g., Special Fraud Alert, "Rental of Space in Physician Offices by Persons or Entities to Which Physicians Refer" issued by the Office of Inspector General February 2000 available online at <http://oig.hhs.gov/fraud/fraud/docs/alertsandbulletins/office%20space.htm>.
- 40 The Medicare Program Integrity Manual, Chapter 10, Section 21.8 was amended. The CMS transmittal discussing the amendment to the Medicare Program Integrity Manual is available online at <http://www.cms.hhs.gov/Transmittals/downloads/R300PI.pdf>.
- 41 These conditions are designed to limit the DMEPOS supplier to acting as a vendor. The consignment arrangement must meet the following conditions: (i) title to the DMEPOS is transferred from the DMEPOS supplier to the healthcare practitioner at the time the DMEPOS are furnished to a patient; (ii) the healthcare professional bills for the DMEPOS using the healthcare practitioner's own enrolled billing number; (iii) the healthcare practitioner, not the DMEPOS supplier, pays for services related to fitting or use of the DMEPOS; and (iv) the healthcare practitioner directs the Medicare beneficiary to consult the practitioner and not the DMEPOS supplier for any questions or problems regarding the DMEPOS. Additionally, only one DMEPOS supplier can be located at the same practice location. Each practice location must have a separate entrance and a separate physical address.
- 42 42 C.F.R. § 411.355(b).
- 43 42 C.F.R. § 1001.952(d).
- 44 The personal services Stark exception is set forth at 42 C.F.R. § 411.357(d); the indirect compensation Stark exception, at 42 C.F.R. § 411.357(p); and the fair market value Stark exception, at 42 C.F.R. § 411.357(l).
- 45 In a ground lease, the tenant leases the land from its owner and takes on all responsibility for the care and maintenance of the land and the taxes. A building situated on the land may be separately owned.
- 46 *United States ex rel. Thompson v Columbia/ HCA Healthcare Corporation*, 125 F.3d 899 (5th Cir. 1998).
- 47 Business relationships between a hospital and a physician or entity owned by one or more physicians are based at least in part on the expectation that the physician will choose to refer patients to the hospital. However, it is not a violation of either Stark or the Anti-kickback Statute to hope for referrals from a physician merely if the business relationship has a business purpose or legal reason for existence entirely distinct from this collateral hope for referrals. *United States v. McClatchey*, 217 F.3d 823, 834 (10th Cir. 2000). This collateral hope for referrals is different from and apparently does not rise to the level of a motivating factor. Clearly, if any purpose of the relationship is to pay remuneration to induce referrals, then the compensation paid would violate the Anti-kickback Statute assuming a safe harbor was not met.
- 48 For example, yearly increases are the norm. It would be highly unusual for a standard commercial lease to specify monthly increases in the base rental rate. A provision providing for such an increase would not be commercially reasonable. Note, in leases other than gross leases, the term base rent is the per square foot rental rate charged. Additional rent is the term used for common area maintenance expenses and pass through expenses such as real estate taxes and the landlord's insurance cost.
- 49 Such decreases in rent could occur when an area becomes overbuilt and there are high vacancy rates or when an area becomes economically distressed.
- 50 73 Fed Reg 48697 (2008). 72 Fed Reg 51045 (2007); 73 Fed Reg 48713-4874.
- 51 See 73 Fed. Reg. 48752-03 (2008); 42 C.F.R. § 411.357(a)(5)(ii) or (b)(5)(ii).
- 52 This is a significant change from the proposal CMS stated in the 2008 Proposed Physician Fee Schedule. The proposal would have prohibited use of per-click payments involving space and/or equipment leases in those situations where a physician (or entity owned by a physician) refers patients to the lessee for DHS. 72 Fed Reg 38182-38183 (2007). CMS also solicited comments on whether it should prohibit per-click payments in situations in which the physician is the lessee and a DHS entity is the lessor. *Id.*
- 53 See for example, Michigan Compiled Laws, 333.16221(e)(iv)(B) which makes a Stark violation a violation of the public health code, which can result in sanctions against a physician's license to practice medicine. For the purposes of this statute, Michigan ignores the source of payment for designated health services in considering whether there is a violation. Accordingly, the statutory provision applies when private insurers are the payors.
- 54 There is a growing trend for leases to contain such provisions.
- 55 Joint Commission standards for accreditation require such hearings. Some state laws provide that hospitals must comply with Joint Commission accreditation standards in order to be licensed by the State.
- 56 Public Law 104-191.
- 57 Protected health information is individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. 45 C.F.R. § 160.103. Individually identifiable health information is information, including demographic information collected from the individual, and is created or received by a covered entity that relates to the past, present, or future physical or mental health or condition of an individual, the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. *Id.*
- 58 See, 45 C.F.R. Part 160 and Part 164, Subparts A and E.
- 59 Under HIPAA and the HITECH Act, a business associate is a person who, on behalf of a covered entity or organized healthcare arrangement, other than as part of the covered entity's workforce, performs or assists in the performance of a function or activity involving the use or disclosure of PHI or any other function or activity regulated by HIPAA or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for such covered entity where the provision of the services involves disclosure of PHI from such covered entity. 45 C.F.R. § 160.103. Landlords do not regularly perform any functions that necessarily involve the handling of or disclosure of PHI.
- 60 Incidental disclosures are by-products of a permissible use of PHI for the tenant, cannot be reasonably prevented, and are limited in nature. The incidental disclosures are permitted provided that the tenant has complied with applicable requirements set forth in the 42 C.F.R. sections 164.502(b), 164.514(d) and 164.530(c). 45 C.F.R. § 164.502(a)(iii).
- 61 74 Federal Reg. 19007-19010, April 27, 2009, addressed and updated in Interim Final Rule implementing HITECH effective September 23, 2009.
- 62 HITECH, which amended the HIPAA Privacy Rule, makes it a violation for a HIPAA covered entity, without authorization of the affected individual, to directly or indirectly receive remuneration in exchange for PHI except in connection with the sale or merger of the covered entity. 45 C.F.R. § 164.501. When a landlord's lien is foreclosed by selling the assets subject to the lien, the proceeds are applied to the rent and other amounts owed by the covered entity under the lease. Accordingly, the covered entity receives remuneration when the sales proceeds are so applied. This same issue arises with lenders that take a security interest in a medical tenant's assets in order to secure a loan provided to the tenant. Security agreements should contain similar provisions to those recommended for inclusion in a lease.
- 63 42 U.S.C.A. §§ 120007 et seq.
- 64 42 U.S.C.A. §§ 12102(2).
- 65 See "ADA Title III Technical Assistance Manual" available online at <http://www.ada.gov/taman3.html>. The Technical Assistance Manual clearly states that the private offices

of healthcare providers are considered places of public accommodation for the purposes of the ADA. Even if an office suite is considered a commercial facility and not a public accommodation, the office suite is subject to the requirement that new construction and alterations conform to the ADA Accessibility Guidelines. The other requirements applicable to public accommodations do not apply to commercial facilities.

<sup>66</sup> The guidelines also require a healthcare provider to comply with the requirement that new construction and alterations conform to the ADA Accessibility Guidelines. The other requirements applicable to public

accommodations listed above do not apply to commercial facilities. <http://www.ada.gov/t3hlight.htm>

<sup>67</sup> 42 U.S.C.A. § 12183(a).

<sup>68</sup> See Special Advisory Bulletin on the Effect of an Exclusion, available online at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm>.

<sup>69</sup> 42 C.F.R. § 1001.1901.

<sup>70</sup> The OIG's long-standing policy on an excluded individual renting out office space to providers was confirmed in a phone conversation on October 6, 2009.

<sup>71</sup> OIG Advisory Opinion No. 07-17 discusses the indirect provision of items and services to a practitioner.

<sup>72</sup> See, e.g., MCL 333.1380 et seq.

<sup>73</sup> *Castro v New York Life Ins.*, 586 N.Y.S. 2D 695 (1991).

<sup>74</sup> Tenants with specialized needs for utilities should inquire with local utility providers about the availability of special programs to give them priority service in the event of a utility outage. In some cases, electric utilities can provide generators that automatically switch to natural gas or propane in the event that electric service is interrupted.

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