On-campus Medical Office Buildings: Is a Premium Warranted? If So, When and Why?

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Health care real estate assets are often referred to as being located "on-campus" or "off-campus." While real estate market participants may differ in their criteria for referring to a property as on- or off-campus, the Centers for Medicare & Medicaid Services (CMS) defines a hospital campus in the provider-based regulations at 42 C.F.R. § 413.65(a)(2) as follows:

> Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Attorneys, health care providers, and valuation professionals have grappled with whether it is permissible from a compliance perspective to adjust pricing (for lease or for sale) for an on-campus location. Similarly, the real estate investment community has analyzed the potential value impact of on-campus locations, with increased recent interest driven by health care's continued shift to outpatient settings. A variety of regulatory and analytical issues arise when evaluating the potential impact of a property's location on- or off-campus on fair market value (FMV). This article examines the on- versus off-campus FMV issue from a regulatory perspective, a sale perspective, and a leasing perspective.

Regulatory Overview: Proximity to a Referral Source

The Stark Law and the Anti-Kickback Statute often govern financial arrangements between health care providers, including arrangements for the sale or lease of a medical office building. If a proposed sale or leasing arrangement is subject to one or both laws, the parties must structure the arrangement in a manner that fits within the applicable Stark Law exception and Anti-Kickback safe harbor. In most cases, the arrangement must be structured in a commercially reasonable manner with a purchase price (in the sale context) or a rental rate (in the leasing context) that is consistent with fair market value.

The definitions of fair market value under the Stark Law and the Anti-Kickback Statute share several similarities and several differences. Under the Stark Law, the term "fair market value" is defined in 42 U.S.C. § 1395nn (h)(3) as follows:

> The term "fair market value" means the value in arms-length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) *and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee*. (emphasis added).[1]

Unlike the Stark Law, the Anti-Kickback Statute does not define "fair market value" in the general sense. Instead, "fair market value" is defined in the space rental safe harbor, 42 C.F.R. § 1001.952(b)(6), as follows:

> [T]he term "fair market value" means the value of the rental property for general commercial purposes, *but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs.* (emphasis added).

Both definitions describe fair market value in terms of the value paid by parties involved in an arm's length transaction. The definitions appear to focus on proximity in terms of leasing arrangements. However, providers should also be careful when establishing the purchase price in a sale transaction. If the Stark Law applies to a sale transaction, the parties would want the transaction to fit within the isolated transaction exception.[2] One of the requirements of the isolated transaction exception is that the purchase price cannot be determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals or business generated between the parties.[3] In other words, providers should avoid a situation where a premium is paid in a leasing or sale transaction solely because of proximity or convenience to a referral source. Doing so may be interpreted as remuneration in exchange for referrals.

In terms of leasing arrangements, the fair market value definitions are clear that rental rates should not be increased as a result of proximity or convenience to referrals.

What is interesting is that the definitions differ as to when proximity can and cannot be taken into account. Under the Stark Law definition, proximity should not be taken into account when the lessor is a potential source of referrals to the lessee.[4] The Anti-Kickback definition is broader in the sense that proximity should never be taken into account, regardless of the source of referrals.[5]

Over the years, legal counsel and valuation professionals have struggled to interpret the proximity restrictions when establishing rental rates for on-campus medical office build-

ings. In some cases, providers have elected to establish rental rates for on-campus medical office buildings that do not account for any on-campus premium, regardless of market trends. Providers are often concerned that applying an on-campus premium may be interpreted by regulators as remuneration in exchange for referrals. This approach, however, could result in below market rents. In other cases, providers have elected to incorporate an on-campus premium, when appropriate, to account for market trends that suggest that on-campus space commands a premium.

It appears that CMS had a specific scenario in mind when it crafted the proximity concept set forth in the Stark Law definition of fair market value. When asked about the proximity reference, CMS responded as follows:

> We interpret this requirement to allow rental payments that reflect the fair market value of the area in which the property is located, even if a lease is for medical property in a "medical community." To qualify, the payments should not reflect any additional value, such as an amount that is above that paid by other medical practitioners in the same building or in the same or in a similar location, just because the lessor is a potential source of referrals to the lessee. That is, the rental payments should be roughly equivalent to those charged to similarly situated parties in arrangements in which referrals are not an issue.[6]

Similarly, when the Office of Inspector General (OIG) was asked about the proximity reference in the Anti-Kickback definition of fair market value, it responded as follows:

> The safe harbor provision for space rental does not contemplate a single figure for fair market value. Rather, it contemplates a rental fee falling within a reasonable commercial range, but not taking into account any value attached by either party based upon the property's proximity or convenience to referral sources. To the extent there is a nexus between the location of property and the opportunity to engage in business reimbursable under Medicare or Medicaid, rental charges that take location into account may impermissibly generate referrals or other health care business. For example, we believe that a fair inference may be drawn that impermissible payments are being made when a group of doctors owns a medical arts building and rents space in that building to a diagnostic laboratory, and the rent is substantially above the laboratory's cost of renting the same sized space at a nearby location.[7]

After reading the commentary from CMS and OIG, it seems clear that both are concerned with arrangements where an increased rental rate is charged solely based on the proximity or convenience to a referral source. Said differently, when a tenant pays more than other tenants within a multi-tenant building or more than market rates, without non-referral based market justification, the leasing arrangement may be considered suspicious to government regulators.[8] If a provider is attempting to establish a fair market rental rate for on-campus medical office space, it would be wise to consider all relevant market factors. To the extent that on-campus space commands a premium in the market, the premium should be carefully supported by a valuation based on market data and other relevant factors and not simply because the space is on-campus. The following sections within this article describe a variety of factors that may justify an increased rental amount or purchase price for on-campus medical office assets.

Once a rental rate for the building has been established, the provider must take great care to charge the fair market rental rate to all tenants leasing similarly situated space in the building. Fair market rent should also include market parameters for operating expenses, escalations, term length, tenant improvements, and concessions. Any variation in rental rates charged should also be documented carefully based on market factors to avoid the appearance that proximity or convenience to referrals was the impetus for the increased rental rate.

MOB Investment Market

A logical starting point in determining whether a premium is warranted when valuing an on- versus off-campus medical office building (MOB) for purchase or sale is an examination of transactions between buyers and sellers where no referral relationship exists. Fortunately, health care real estate facilities are a highly sought after asset class, which has resulted in a large pool of buyers, including institutional investors such as publicly traded Real Estate Investment Trusts (REITs). Investors typically attempt to value a facility for acquisition based on its projected stabilized income stream. A common approach used by investors and valuation professionals to estimate market value is to perform a "direct capitalization" analysis, which converts a single year's projected net income into a value indication in one step, with anticipated changes in value and projected income implicitly accounted for in the selected capitalization rate ("cap rate"). Typically, the projected net operating income (NOI) for year one is divided by the cap rate to calculate an indication of value. Investors, appraisers, brokers, and analysts commonly refer to cap rates as an overall rate of return when analyzing a variety of commercial properties, including health care real estate assets. Another methodology employed in the analysis of income-producing commercial real estate is the discounted cash flow analysis, which involves applying a discount rate to each year of a projected income stream (including reversion, or sale, of the property at the end of the projected holding period). This discussion focuses on direct capitalization.

The following example illustrates how a cap rate is calculated and utilized: a 50,000-square-foot medical office building is leased for $900,000 ($18 per square foot annually) and sells

at an 8.0% cap rate, which equates to a price of $11,250,000 ($225 per square foot). This price is arrived at by dividing $900,000 by 8.0%. Comparatively, if the property sold at a 9.0% cap rate, the sales price would be $10,000,000 ($200 per square foot), whereas at a 7.0% cap rate the property would sell for $12,857,143 ($257 per square foot). The preceding demonstrates the significant impact on value that results from relatively modest changes in cap rates (100 basis points in either direction). An investor's determination of what cap rate they would pay for a property is affected by a variety of factors.

Since cap rates are an important indicator of current market conditions within the health care real estate sector, numerous brokerage and valuation firms publish the results of investor surveys designed to track market cap rate trends. The results of these surveys often differentiate between on- and off-campus MOBs. A selection of these investor surveys is profiled in **Figure 1**, with the spread in basis points (BPS) between on- and off-campus calculated by deducting the average off-campus cap rate from the average on-campus cap rate (for the same asset class, as some investor surveys separate Class A and Class B properties).

While the surveys summarized on the preceding table utilize differing methodologies, include slightly different respondent groups, and were conducted at differing periods, the average response indicates that on-campus MOBs generally command a lower cap rate (i.e., higher purchase price). This difference has been fairly durable over time, as illustrated in **Figure 2** (which depicts cap rates as well as the spread in BPS over time) derived from PwC's Real Estate Investor Survey, which is published quarterly.

The survey data presented in the preceding figures illustrates investor preference for on-campus assets. However, apparent on- versus off-campus cap rate differences demonstrated in published surveys can actually be caused by conflating variables, as a multitude of other factors can contribute to variation in cap rates. These factors include, but are not limited to: age and location of the building, existing lease terms, area hospital performance, building construction characteristics, and quality of building amenities. For instance, an older, outdated on-campus building may warrant a significantly higher cap rate at sale as compared to a new, state-of-the-art, off-campus building. Investor survey responses should be closely evaluated, as cap rate differences that appear to be driven by on- versus off-campus locations may be attributable to other variables.

When a REIT or other non-provider investor acquires an on-campus asset at a lower cap rate than they would have paid for a similar off-campus building, the increased price is clearly not attributable to a potential landlord-tenant referral relationship, as the buyer is not a health care provider. Rather than being associated with referrals, the value premium is driven by the decreased perceived risk that is frequently associated with income streams from on-campus medical office buildings. This perception of decreased risk can be explained by higher tenant renewal rates, superior tenant credit ratings, and the constrained supply inherent to on-campus medical office buildings (as the barrier to entry for new on-campus space is often more significant as compared to off-campus). Basic economic principle dictates that constrained supply leads to unfulfilled demand, which typically results in an increase in value.

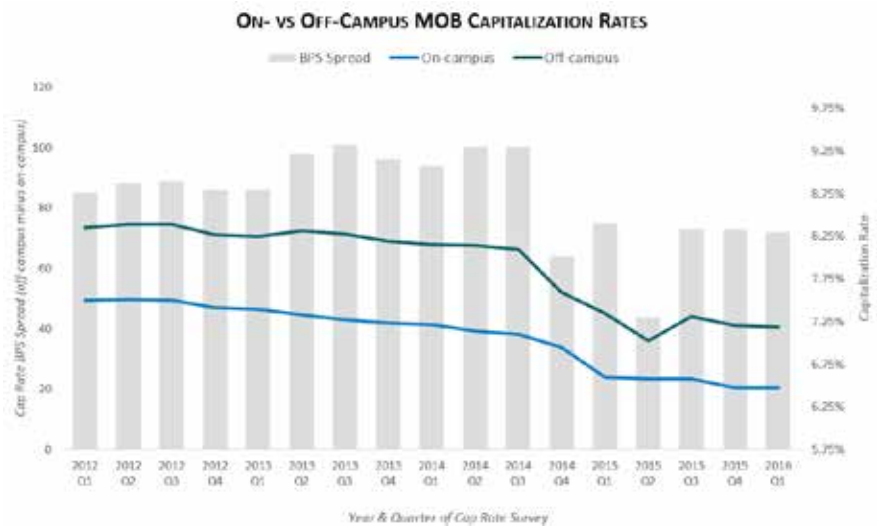
However, differentiation between on- and off-campus assets has diminished somewhat in recent years, and market participants differ in their current assessment of the issue. For the purposes of this article, VMG Health surveyed representatives from some of the largest health care real estate brokerage firms in the country, as well as investment banks focused in the health care sector. The survey was conducted in June 2016 and included questions pertaining to cap rate differences, lease

Figure 1

Medical Office Building Cap Rates

Investor Survey	On-campus	Off-campus	BPS Spread
Cushman & Wakefield - 2015 MOB Investor Survey, Class A	5.97%	6.49%	52
Cushman & Wakefield - 2015 MOB Investor Survey, Class B	7.36%	8.31%	95
PwC - 1st Quarter 2016 MOB Real Estate Investor Survey	6.47%	7.19%	72
Marcus & Millichap - 2015 Outlook - Medical Research Report	7.00%	7.35%	35
NGKF - 2015 Healthcare RE Survey - Primary Market, Multi-Tenant	6.32%	6.69%	37
NGKF - 2015 Healthcare RE Survey - Secondary Market, Multi-Tenant	6.83%	7.63%	80
CBRE - 2015 Healthcare Real Estate Investor/Developer Survey, Class A	6.33%	6.78%	45
CBRE - 2015 Healthcare Real Estate Investor/Developer Survey, Class B	7.05%	7.56%	51
Average	*6.67%*	*7.25%*	*58*

Figure 2



rate differences, and general differences in investor sentiment for on- versus off-campus assets. A selection of cap rate related survey responses are presented as follows:

Garth Hogan, Executive Managing Director, Global Healthcare Services, Newmark Grubb Knight Frank:
"Higher demand for medical office space located on a hospital campus drives market rent growth, reduces general vacancy, decreases downtime between vacating tenants, and causes greater tenant retention. These factors reduce risk for investors and drive cap rates lower (by 15 to 30 bps). [However], investors are less focused on on- vs off-campus and are paying more attention to how the property is positioned in the market as well as to demographics. Investors are also focusing more on tenant financials and the equipment and health care services that the tenant provides in their spaces."

Scott Herbold, First Vice President, CBRE:
"With all variables being equal, I believe the on-campus premium is largely gone. That being said, on-campus cap rates are often lower because on-campus MOBs often have stronger credit on the rent roll (hospital system) than their off-campus counterparts. Often off-campus MOBs have stronger retail qualities (visibility from major highways, convenient and accessible locations)."

Anonymous Vice President with health care real estate focused investment bank:
"On-campus properties would command a cap rate premium of 50 to 100 basis points due to perception of higher rollover risk with off-campus MOBs. That said, if the off-campus MOB is situated in a highly desirable real estate location, that spread may not exist, as off-campus buildings in desirable real estate locations are becoming more sought after by all investor types."

John Smelter, Senior Director, Healthcare Real Estate Group, Marcus & Millichap:
"Yes, there is a difference and the 2015 average difference was 31 basis points. [However], off-campus facilities have become more important as many services are being moved off of hospital campuses due to the ACA and the associated cost cutting measures. We have seen the average cap rates compress between on and off campus properties in recent years and I would expect that compression to reverse to a more typical approximately 50 basis point spread in the coming years. The caveat to this statement is that single tenant off-campus properties with lease terms of 10 years or more will continue to closely resemble similar on-campus assets."

Drew Arvay, Managing Partner, Cushman & Wakefield:
"Investors are increasingly emphasizing tenant credit and have warmed up to off-campus acquisitions, though the site neutral payment legislation [in its current iteration, wherein on-campus buildings and buildings located within 250 yards of a hospital campus may be eligible for higher levels of reimbursement] may alter this trend by creating more tenant demand for on-campus space."

Toby Scrivner, Senior Director of Healthcare Real Estate, Stan Johnson & Company:
"In today's market we have seen numerous examples of transactions in which the difference between the above stated scenarios saw little to no difference in the cap rates being paid. If I'm underwriting a deal, I typically use 25 basis points as a discount for off-campus assets, but I will acknowledge to the seller that the current market may not discount at all."

The diversity of survey responses, as well as the data presented previously, reinforces the point that the analysis of on- versus off-campus is a complex and evolving issue that should be handled on a case-by-case basis, with specific consideration given to a particular property as well as current market trends. The following section considers on- and off-campus in the context of the leasing market.

MOB Leasing Market

Outpatient migration has occurred across the health care spectrum, and inpatient bed utilization has declined. The national average occupancy for acute care hospitals, based on the Medicare Payment Advisory Commission's March 2016 report,[9] was 61% as of 2014. This is down from 64% in 2008 and from 77% in 1980. Concurrently, outpatient surgical procedures have increased. According to the American Hospital Association, in 1990 approximately 50% of all surgeries were performed in an inpatient setting; by 2013, only 35% were performed in an inpatient setting.

Despite the pervasive shift toward outpatient care, on-campus assets remain highly sought after by the investment community, as evidenced by the data presented previously. Parsing data in the leasing market to determine whether a potential premium exists in lease rates of on-campus buildings as compared to off-campus buildings is difficult. The off-campus sector, in particular, has high variability of data, with observed rental rates ranging substantially due, in part, to the wide range in quality and location of off-campus buildings. This variability in data contributes to the difficulty in providing robust market evidence that proves or disproves whether an adjustment for on-campus is warranted in a given market at a specific location. To further complicate the issue, more recently built on-campus buildings are sometimes constructed on a "build-to-suit" basis, whereby a developer constructs the building for a health system or physician group, with the lease rate based upon a return on development cost. In these cases, the development agreement should be analyzed for reasonableness, along with the budgeted costs and return rates.

VMG Health surveyed a variety of market participants concerning leasing trends for on- versus off-campus medical office properties. Selected responses (to whether higher lease rates would be expected with on-campus versus off-campus locations) are presented as follows:

Scott Herbold, First Vice President, CBRE:
"I would expect that landlords of on-campus MOBs get higher lease rates (+/-10%) as they know it is much more difficult to replicate alternative on-campus options. Practices valuing the proximity to surgical hospitals will have less options and generally will pay a premium to be on-campus."

Garth Hogan, Executive Managing Director, Global Healthcare Services, Newmark Grubb Knight Frank:
"$1.00 to $3.00 per square foot" [general lease premium for on-campus versus off-campus]

John Smelter, Senior Director, Healthcare Real Estate Group, Marcus & Millichap:
"10-15%." [general lease premium for on-campus versus off-campus]

Drew Arvay, Managing Partner, Cushman & Wakefield:
"In many cases, on-campus buildings were built in the 1980s or earlier, whereas competitive off-campus product is often newer and built out with state-of-the art features. We're beginning to more frequently see situations where the off-campus real estate is better—newer buildings in locations with higher traffic counts, superior visibility, and better demographics."

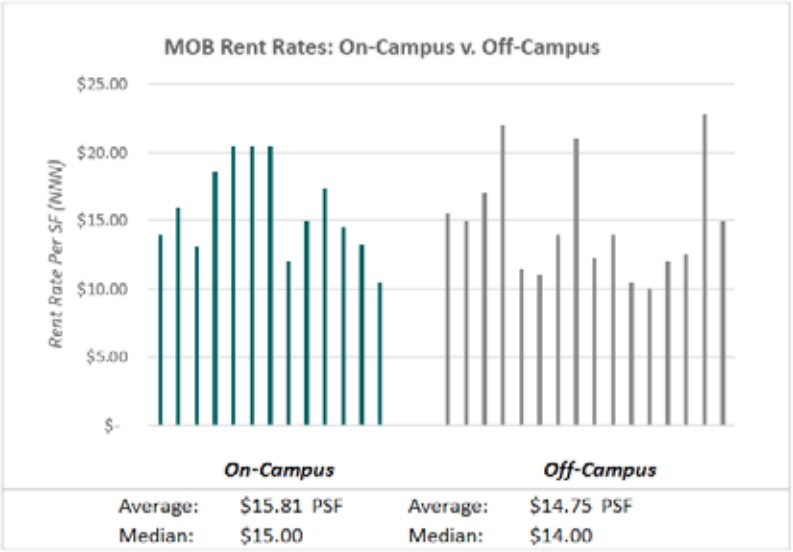
Toby Scrivner, Senior Director of Healthcare Real Estate, Stan Johnson & Company:
"Little to no difference. The cost of construction would be relatively comparable in both scenarios. The only difference would be in situations where the land cost was not part of the construction cost."

The survey responses point to some of the variables that must be considered in conjunction with any analysis of on- versus off-campus locations. In addition to survey data, VMG Health has performed numerous analyses across the country examining lease rates at MOBs located on hospital campuses as compared to competitive off-campus MOBs located in the same market. The results of these analyses suggest that a premium can exist in the leasing market, though it depends on a variety of factors.

For example, VMG Health recently examined lease rates at MOBs in a secondary market in the southeastern United States. The market consisted of a population between one million and three million people and between four and eight acute-care hospital campuses. VMG Health analyzed a dataset of 30 medical office buildings that comprised the majority of the large multi-tenant medical office buildings located in the market. After adjusting all asking rates to a net equivalent basis (but applying no other adjustments), the dataset ranged as depicted in **Figure 3**.

The dataset included a total of 30 comparable medical office buildings, with 13 on-campus medical office projects and 16 off-campus medical office projects (and one proposed on-campus project). We interviewed brokers in the community and inquired as to whether a premium was warranted at specific campuses. After controlling for age and general quality

Figure 3[10]



of the building, the median broker response in this market suggested a premium of $1.00 to $2.00 per square foot per year (for buildings located on-campus versus off-campus competition in the same neighborhood), which equated to a percentage adjustment of between 7% and 13%, considering average lease rates were observed to be approximately $15.00 per square foot. These market interviews were supported by the data presented in **Figure 3**. As noted, the off-campus market demonstrates significant variability in rent rates, largely due to variation in year of construction, locational quality, and overall construction quality among off-campus MOBs. Specific illustration of confounding factors can be found by examining each indicator. Within the previously presented dataset, three of the off-campus comparables featured higher rent rates than any of the on-campus comparables, whereas the lowest lease rate was found at an on-campus building. While this appears to contradict the premise that an on-campus location would command a premium in this market, a more thorough examination reveals otherwise. The three off-campus properties with high rental rates were constructed recently and located in premium locations; their high asking lease rates were driven by their construction quality and overall locational attributes rather than whether they were located on- or off-campus. Conversely, the on-campus building that had the lowest rental rate (of the 30 comparables) was attached to a struggling host hospital that was facing potential closure at the time of the analysis; its low rental rate was driven by its age and the performance of the host hospital. After accounting for these (and other) locational and physical factors, a measurable premium in lease rates was found to be warranted for the on-campus building that was the subject of the analysis.

The preceding discussion illustrates two significant points, both specific to this particular market: (1) there is a wide range in rental rates within the MOB sector, and each indicator must be carefully analyzed and adjusted; and (2) on average, the on-campus sector often exhibits higher rates, though these rates may or may not be driven by factors independent of a building's on-campus location. Ultimately, caution must be exercised in extrapolating conclusions derived from one market and applying them to other markets.

VMG Health has performed similar studies at other markets across the United States. As a contrast to the study summarized above (which found a premium at a particular hospital), a 2015 analysis of lease rates for MOBs in a similarly sized market in the southwestern United States revealed no premium at most area hospital campuses, primarily due to the following factors: (a) the subject acute care hospital (and its nearest competitors) were struggling due to declining demographic trends; (b) the on-campus MOB sector was oversupplied; and (c) the available on-campus MOB buildings featured older construction and were of inferior quality—there was not sufficient demand for on-campus space in the market to warrant new construction of good quality MOBs.

This example reinforces the point that a carte blanche adjustment for on-campus should not be applied. However, when an adjustment is warranted, factors that contribute to an on-campus premium include, but are not limited to: location, supply constraint, reimbursement trends, and amenities. These factors are discussed in further detail below.

Location Acute care hospitals can have a significant impact on neighborhoods in which they are located, sometimes contributing to a variety of residential and commercial development in the immediate area. A particular campus' locational attributes (including demographics, payer mix, traffic counts, and other features) should be analyzed in comparison to the surrounding market. If the host hospital (or area acute care hospital market as a whole) is struggling (or performing well), the value of

on-campus medical office buildings can be significantly affected.

Supply Constraint As previously noted, on-campus medical office buildings often face supply constraints due to impediments to development. Sometimes hospitals are located in densely developed neighborhoods where parking and/or developable land is limited, and on-campus may be one of the few locations within a neighborhood with sufficient available parking; sometimes use restrictions imposed by host hospitals suppress supply of on-campus space available in a given market. Despite the preceding, supply constraint is not a given at all hospital campuses or in all markets and should be evaluated on a case-by-case basis.

Reimbursement Trends Hospital providers are typically able to take advantage of increased reimbursement rates for services delivered in certain departments of the hospital. Under current regulations, a hospital is generally not permitted to establish an outpatient department at a location more than 250 yards from the main hospital facility. The 250-yard rule limits the number of locations that may be leased or purchased by the hospital if it wants to pursue provider-based billing. This fact could contribute to a hospital paying an increased rental rate (as compared to a non-hospital tenant) for space in a building within 250 yards of the main hospital in order to take advantage of certain reimbursement benefits.

Amenities There are often differences in a particular market between the amenities present at on- and off-campus buildings. For instance, an on-campus building may be connected to a covered parking garage as well as to the host hospital via a climate-controlled, elevated skybridge. An on-campus building may also benefit from convenient access to amenities located in the host hospital, such as a cafeteria or wellness center. The potential contributory value of these amenities can be analyzed based on area market data as well as on a return-on-cost basis. If demand for on-campus space is sufficient to support development cost, then a higher lease rate for on-campus properties may be partially reflective of a reasonable return-on-cost of a skybridge or other desirable building feature that exists at an on-campus building but does not exist at comparable off-campus buildings.

Conclusion

As demonstrated throughout this article, isolating the impact of an on-campus location on the fair market value of health care real estate is complex. Analysis and understanding of the hospital campus on which a property is located is critical in determining its value compared to off-campus assets in the same market. While a value premium can exist that is not attributable to the volume or value of referrals, that premium is highly variable and dependent on a number of factors. From a compliance perspective, providers and regulators should be aware of these issues in acquisition, disposition, or leasing of health care real estate. Investors, brokers, analysts, and appraisers should also remain abreast of current trends in this sector. The evolution of our health care delivery systems promises myriad future changes, and the market's evaluation of on- versus off-campus locations will likely continue to shift. C

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Endnotes

1 A more detailed definition of fair market value can be found in the regulations interpreting the Stark Law. *See* 42 C.F.R. § 411.351.
2 42 C.F.R. § 411.357(f).
3 *Id.*
4 42 C.F.R. § 411.351; *see also* 66 Fed. Reg. 855, at 945 (Jan. 4, 2001).
5 42 C.F.R. § 1001.952(b)(6).
6 66 Fed. Reg. 855, at 945 (Jan. 4, 2001).
7 56 Fed. Reg. 35952 (July 29, 1991).
8 *See United States ex rel. Goodstein v. McLaren Reg'l Med. Ctr.*, 202 F. Supp. 2d 671 (E.D. Mich. 2002).
9 Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy (Mar. 2016), *available at* http://www.medpac.gov/docs/default-source/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=0.
10 Source MOB market data compiled by VMG Health (location market in southeastern United States).