American Hospital Association

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July 16, 2007

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Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Disclosure of Financial Relationships Report ("DFFR"), Form Number CMS-10236, OMB#: 0938-New (Vol. 72, No. 96), May 18, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Information Collection Request (ICR) to mandate disclosure and reporting of a wide range of financial relationships between hospitals and physicians.

We appreciate CMS' effort to complete its study of physician investment interests in hospitals to assist in addressing the concerns raised by Congress in Section 5006 of the *Deficit Reduction Act of 2005* (DRA). The framework and format of the worksheets represent improvements over the prior survey instrument. However, some of the questions and instructions do not provide clear enough guidance to enable respondents to know precisely what is being asked, and at least one item from the original survey has been omitted from the revised instrument.

The AHA recommends that CMS test this survey instrument with a small group of intended respondents to further identify areas needing clarification and the necessary corrections. **Our more specific recommendations follow:**

- CMS should include the omitted question from the original survey that asked what percentage of hospital revenues come from referrals by physician owners.

- We are not sure that Worksheets 2 and 3 provide the information needed to ensure that there is proportional return on investment across individual physicians, and for physicians relative to other owners. While the forms capture detailed information on the investment shares of physician and non-physician owners, parallel information does not appear to be included for the return on investment for different types of owners and the organization as a whole.
- Consistent with the reporting obligation applying to the hospital but not the physician owner, CMS should revise the first general instruction to read: "The requested disclosures on Worksheets 1-5 pertain only to hospitals with physician ownership." Furthermore, directions on the survey form should be consistent with those in the instructions with regard to which schedules apply to hospitals without physician ownership (e.g., Question 27 is currently not consistent with the first general instruction). We suggest moving Worksheet 1, Question 27 to just after Question 11 and clarifying that the "disclosures" on Worksheet 1 are required only for hospitals with physician owners, as noted in the instructions.
- In some instances, the titles of the worksheets imply a different type or level of information is being requested than do the actual questions on the form. For example, the title of Worksheet 3, "Report by Individual Physicians," seems to imply something different than Question 11 on this same form. Question 11 indicates that the intent of this form is to collect information not only on "individual physicians" but also immediate family members, group practices and other entities that involve physician ownership. While the definition of "physician" includes immediate family members, more clarity on the actual forms would ensure that CMS receives the intended information.

However, the AHA is very concerned that the proposed ICR goes far beyond what is needed or warranted to address the DRA concerns. The *CMS Paperwork Reduction Act* package presents this ICR as an outgrowth of Section 5006 of the DRA, Congress' directive that the Department of Health and Human Services (HHS) develop a "strategic and implementing plan" to address certain issues relating to physician investment in "specialty hospitals." CMS also explains that the mandatory effort is, in part, intended to obtain responses from the 290 hospitals that failed to respond to the original voluntary survey CMS initiated in response to Congress' directive.

Instead of remaining focused on addressing the physician investment concerns of Section 5006 of the DRA, the ICR expands the scope of the information collected to include extensive data on compensation arrangements unrelated to physician ownership; reaches beyond the group of 290 hospitals that were part of the prior voluntary survey effort and did not respond to include another 210 hospitals; and significantly expands the burden of responding. In addition, the nature of some of the compensation questions raises due process concerns.

The AHA strongly recommends that CMS amend the proposed ICR to complete the survey effort it initiated to address the DRA's concerns about physician investment, rather than undertaking an expansive and extremely burdensome review of the compensation arrangements and compliance activities of 210 additional hospitals. If making the survey on

physician investment interests mandatory is necessary to complete that work, CMS should issue the survey to the hospitals that did not respond to the original survey and require them to complete it.

In going so far beyond the DRA-mandated inquiry, CMS has substantially and significantly underestimated the burden associated with its expanded survey. The proposed ICR will require responding hospitals to spend much more time – and divert many more resources – than hospitals that responded to the original voluntary survey. As CMS acknowledges, the proposed ICR poses questions that go well beyond Congress' charge to CMS under the DRA, but the rationale for the new survey emphasizes the lack of response to the voluntary survey. Subjecting a new group of hospitals to an expanded mandatory survey because a different set of hospitals did not respond to a prior survey is an unreasonable burden and, under the circumstances, appears punitive.

The primary source of the additional and substantial burden imposed through the proposed ICR is a direct result of expanding the original survey to include a detailed inventory of **all physician "compensation" relationships** in addition to ownership interests, and a comprehensive production of supporting documentation. The four-hour time estimate for completing the request is greatly understated. It appears to assume that any and all information necessary to respond to the compensation questions will be readily available in one location. Nothing in the law mandates that hospitals maintain information in the format requested, and we understand that many hospitals do not do so. In addition, the nature and extent of the compensation information requested and the certification is likely to require significant involvement of auditors and legal counsel, increasing the expenditure and diversion of financial resources of the hospital. CMS has not demonstrated a problem or a need that merits this burden and diversion of resources for either small or large hospitals, where the magnitude of the task – which may involve hundreds of contracts – will be significantly greater. Even if it had, a 45-day turnaround with a threat of a $10,000-per-day penalty for late responses is unreasonable and excessive.

The proposed ICR would require responding hospitals to submit legal conclusions as to the significance of information disclosed, and then require senior officers of responding hospitals to certify the accuracy of those legal conclusions, infringing on the due process rights of the hospitals. For example, on Worksheet 6 hospitals are asked to go beyond providing an inventory of compensation relationships by transaction type (e.g., an isolated transaction, receipt of a charitable donation from a physician) to require an articulation of the hospital's conclusions as to the legality of those transactions (e.g., Was a payment fair market value?; Did a payment exceed the financial limits of a statutory or regulatory exception?). An information request has effectively been converted into a tool for a law enforcement investigation without the benefit of any of the legal constraints or protections that would normally apply.

We urge CMS to reconsider its proposal in full, and to complete collection of the information it originally sought to compile on physician ownership. In its final report to Congress on implementation of Section 5006 of the DRA, HHS said it would begin a required

disclosure initiative with the non-responding hospitals. The ICR offers no explanation for the change of plan, nor is a change necessary. While a stated goal of the new survey is to assist CMS in proposing a regular financial disclosure process that would apply to all Medicare-participating hospitals, the agency has offered no explanation of why a survey of the 290 hospitals that did not elect to respond to the original survey would not serve the same end, or why an expansive survey of additional hospitals is preferable to a more limited pilot program. **CMS should withdraw the compensation questions, modify the request to focus on the physician investment information necessary to address the DRA concerns, and limit the hospitals surveyed to those who did not respond to the original voluntary survey.**

If you have any questions, please feel free to contact me or Maureen Mudron, Washington counsel, at (202)626-2301 or mmudron@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

cc: CMS Office of Strategic Operations
And Regulatory Affairs
Attention: William Parham, III

#2

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Charles N. Kahn III
President

July 16, 2007

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By Overnight Mail

William H. Parham, III
Division of Regulations Development
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard Room C4-26-05
Baltimore, MD 21244-1850

Re: Comments on Disclosure of Financial Relationships Report (Form CMS-102362)

Dear Mr. Parham:

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services ("CMS") proposed information collection activity for implementation through a new Disclosure of Financial Relationships Report ("DFRR") and supporting documentation. (*See* 72 *Fed. Reg.* 28,056 (May 18, 2007).)

FAH appreciates that CMS continues to implement the strategic and implementing plan required by section 5006 of the Deficit Reduction Act of 2006 ("DRA"). In developing that plan, CMS identified important issues and concerns about physician-owned limited service hospitals which require appropriate follow up. FAH believes strongly that federal health care regulatory and enforcement agencies must take several steps to foster a level playing field among all hospital providers. Such an environment will result in safe, high quality care for all Medicare beneficiaries free from improper influence due to the inherent conflict of interest of physician ownership and self-referral in physician-owned limited service facilities. We look forward to CMS taking additional actions in the future to address the serious ongoing and growing concern of physician-owned limited service facilities.

I. The Scope of the DFRR is Overly Broad

a. Universe of Targeted Hospitals Exceeds Current Compliance Concerns

The Supporting Statement accompanying the DFRR indicates CMS's plan to require, over time, all hospitals to provide periodic reports to CMS with information on their investment and compensation relationships with physicians. In the initial rollout, CMS plans to send the DFRR to 500 hospitals. The reason CMS is considering this new disclosure policy stems from its work on the DRA's strategic and implementing plan for physician-owned limited service hospitals (*i.e.*, so-called "specialty hospitals" as defined under section 1877(h)(7) of the Social Security Act ("the Act")). However, CMS did not raise any concerns about physician ownership or investment in non-specialty hospitals at that time, nor does the documentation currently accompanying the DFRR.

FAH believes strongly that this disclosure requirement should apply solely to hospitals that meet the definition at section 1877(h)(7). The main purpose of the Paperwork Reduction Act, which is the reason for this *Federal Register* notice, is to minimize the burden on the private sector resulting from data collection by the federal government. (*See* 44 U.S.C. § 3501(1).) By extending this disclosure requirement beyond the physician-owned limited service facilities, CMS seeks to implement a data collection policy that is inconsistent with this fundamental purpose. Accordingly, CMS should narrow the scope of targeted hospitals to those defined in section 1877(h)(7).

At the very least, CMS should not make this an annual reporting requirement. The costs and burden associated with this reporting activity greatly outweigh the potential benefits to the government, not to mention the significant resources in which the government would need to invest in even to be able to review large volumes of annual responses.

b. Types of Reportable Financial Arrangements Exceeds Current Compliance Concerns

The DFRR seeks information on physician ownership of, and investment in, hospitals, which is consistent with the focus of the DRA-required strategic and implementing plan for limited service facilities. However, the DFRR goes further by requesting information on hospitals' compensation arrangements with all their physicians, regardless of whether they are owners or investors. Compensation information goes well beyond the physician ownership and self-referral problem identified by Congress and studied by CMS. FAH believes firmly that CMS should limit its prospective data collection activities to ownership and investment information.

In addition to the threshold concern, we also are troubled by the design of worksheet 6. The form basically asks hospitals to make legal conclusions about particular arrangements, and goes well beyond gathering basic facts for the government's review. Because of the required certification, this potentially creates the risk of false claims or false statements liability if ultimately the government disagrees with a hospital's legal conclusion. Therefore, we believe that hospitals should not be asked to make such representations on this worksheet.

If the ownership information received by CMS reveals the need to investigate a particular facility and physician(s), the federal government has a variety of tools to compel the production of relevant compensation arrangements. But to require the production of all compensation arrangements now, even for non-owners, is overly burdensome and is not supported by the compliance concerns that

have been detailed to date. The sheer volume of compensation arrangements ensures that CMS will receive reams of paper as part of this initiative. Therefore, there is good reason for CMS to limit its collection activities to ownership or investment interests only.

The Supporting Statement cites section 1877(f) as the authority for collecting this compensation information. However, the proposed reporting requirements appear to exceed CMS' statutory authority under that section, which provides:

> "Each entity providing covered items or services for which payment may be made under this subchapter shall provide the Secretary with the information concerning the entity's . . . compensation arrangements, including—
>
> (1) the covered items and services provided by the entity, and
>
> (2) . . . the names and unique physician identification numbers of all physicians . . . with a compensation arrangement (as described in subsection (a)(2)(B) of this section), in the entity, or whose immediate relatives have such . . . a compensation relationship with the entity."

Section 1877(a)(2)(B) of the Act describes compensation arrangements that do not satisfy the Stark exceptions under section 1877(c),(d) or (e) of the Act. In the preamble to the proposed Stark II regulations published in 1998, CMS acknowledged that the reporting requirement therefore can be read as requiring entities to report only compensation relationships that either fail to satisfy any exception under Stark, or that satisfy only an exception under 1877(b). [1/]

Although CMS gave the requirement a more expansive reading in 1998, and proposed extensive reporting requirements (which it later withdrew), FAH continues to believe that Congress intended the requirement to be limited to arrangements that do not meet any of the exceptions described in sections 1877(c),(d) and (e). Under the principle of *expressio unius est exclusio alterius*, listing certain information that entities must report effectively excludes other information. Although CMS might argue that this interpretive principle should not apply when items follow the word "including," in this case the word "including," under principles of *ejusdem generis*, is used by Congress to define the precise scope of the reporting requirement and does not permit CMS to add reporting obligations to those specified.[2]

In summary, FAH recommends that CMS eliminate compensation arrangements from the scope of the DFRR. Alternatively, CMS should limit the scope of compensation information requests to those described under section 1877(a)(2)(B) of the Act.

[1/] One might ask why Congress believed that entities should report arrangements under 1877(b) of the Act, given the expansive nature of this reporting requirement. Section 1877(b) permits referrals: (1) for in-office ancillary services; (2) for services covered by HMOs; or (3) pursuant to CMS regulations. Thus, it is quite possible that Congress believed that reporting financial relationships under (1) and (2) would ***not*** be especially burdensome (group practices would merely report on their own physicians and HMOs are already required to report financial arrangements with physicians), and under 1877(b)(3), it was important to gather information about arrangements protected by exceptions to both ownership and compensation that are created by regulation, rather than statute).

[2] See e.g., Adams v. Dole; 927 F. 2d. 771, 776-77 (4th Cir. 1991) (discussing Congress' use of the word "including" in a statute to limit and define the statute's scope to specific items listed).

II. The Initial Group of Hospitals Should Be Limited To Prior Non-Responders

As stated above, CMS plans to send the DFRR to 500 hospitals. Of the 500 hospitals, 290 will be hospitals which did not respond to the voluntary survey issued by CMS in 2006.[3] CMS will select another 210 hospitals, although the background documents do not explain how these hospitals will be selected and whether the selection area will be from a broader geographic area than the original voluntary survey (*i.e.*, 17 states).

FAH urges CMS to limit its dissemination to those 290 hospitals that did not respond to the initial voluntary survey. In implementing the strategic and implementing plan, CMS sought information from 500 hospitals located in markets with a limited service facility, and the agency received responses from 210 entities. We understand CMS's desire to obtain information from those 290 facilities. But we see no reason why this total number needs to be expanded to more than 700 hospitals. A sample of 500 hospitals should provide CMS with plenty of data from which to assess the various market implications of physician-owned limited service facilities.

Moreover, unlike the previous voluntary survey, the DFRR and supporting documents focus solely on financial relationships between hospitals and physicians. CMS does not seek to collect information on Medicaid utilization or charity care. For the voluntary survey, CMS explained that it was sending inquiries to full-service hospitals for the purpose of developing comparative data to assess limited service facility operations in certain markets. Now, there is no indication that CMS is interested in this information. As result, we believe that CMS need only seek information from those of the 290 non-responders that are physician-owned limited service facilities. For the same reason, we believe it is unnecessary for CMS to plan for an eventual roll out to all non-specialty hospitals.

CMS plans to send the DFRR to the targeted hospitals by electronic mail. We do not think this is a good approach, especially given the problems CMS encountered and acknowledged related to the earlier voluntary survey sent for DRA purposes. Electronic mail presents concerns about actual receipt of a message and even the timing of receipt if a transmission is caught by a spam filter. Given the substantial civil penalties in play for not responding in a timely manner, CMS should take a more formalized approach to disseminating the DFRR to hospitals. We recommend sending the survey by certified mail (return receipt requested) to the designated official and hospital address noted on the relevant Medicare enrollment form. In that transmittal, CMS could identify a website link for the spreadsheet so that people could download an electronic file if they wish. This would establish a clear record of receipt and the date that triggers the response period.

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[3] The Supporting Statement can be read to imply that there may have been nefarious reasons why these 290 hospitals did not respond to the initial survey. We believe any such implication is inappropriate, as there are many reasons why a hospital may not have responded to the original survey. First, the survey was voluntary and CMS's representations regarding their plans to protect from disclosure such important business information do not provide a sufficient comfort level that such information would not become public. For this reason, it was reported that many attorneys advised clients not to complete the survey. Second, as CMS has admitted, their dissemination of the original survey by electronic mail was not as successful as the agency wished, and resulted in many hospitals not receiving the transmission. Third, the timeframe for completing the survey was insufficient and, as a result, mandatory regulatory obligations were placed as higher priorities in hospital operations. Accordingly, we do not believe that any negative inferences should be drawn about the level of non-responsiveness.

III. The DFRR Should Be Revised To Ensure Greater Clarity

The DFRR is designed to seek comprehensive information on financial relationships between hospitals and physicians. FAH urges CMS to revise its DFRR and related instructions in the areas noted below. We also find other parts of the various forms to be unclear and difficult to interpret. Because there are significant civil penalties for failure to respond properly, we believe CMS should first test the revised DFRR with a pilot group of hospitals so that any additional ambiguities can be identified and resolved before the report is rolled out widely.

a. Use of the Term "Stock"

Many worksheet questions refer to physician investment or ownership interest in "stock." A more generic term that would capture a wider variety of arrangements or investment types seems more appropriate. We suggest that CMS use the term "investment interest" instead.

b. Return on Investment

The variable on returns on investment ("ROI") needs to be featured more prominently in the DFRR. While Worksheet 3 appears to seek this information, it also would be best if ROI was reported on Part III of Worksheet 2 in a new column. This approach would provide clear comparative information about initial investment and the return on that investment over time. The ROI can be taken from the physicians' federal tax returns. We also recommend that CMS capture information on annual rates of ROI since the investment was made, and not just one final number at a date certain in 2006. We believe annual rates of return on investment will provide a clearer picture of the favorable physician arrangements, which can be characterized only as sweetheart deals, present in certain limited service hospitals.

c. Legal and Confidentiality Protections

We appreciate CMS's representations that information provided on the DFRRs will be held confidentially. The Supporting Statement indicates that CMS is prevented by the Trade Secrets Act from releasing to the public confidential business information, except to the extent *permitted* by law. We think CMS should make a policy decision only to release information under the Trade Secrets Act to the extent *mandated* by law. CMS should forego the right to release information when it only has permission to do so.

We appreciate CMS's statements about the protections of Exemption 6 of the Freedom of Information Act ("FOIA"). We believe that a footnote should be added to all pages of the DFRR indicating that CMS will abide by both the Trade Secrets Act and FOIA protections.

IV. CMS Should Add Additional Data Elements to the DFRR

CMS should seek additional financial relationship information from limited service facilities to better understand the complete nature of their ownership and investment interests. Additional data elements to consider include: (1) physician options to sell back their investments and under which terms; (2) hospital rights to repurchase the physician's investment and under which terms; (3) minimum investment guarantees for physicians; and (4) whether ownership interests are tied to the

continuing ability to refer to the entity providing designated health services (*e.g.*, medical staff privileges).

To help reduce the response burden, we recommend that CMS refrain from requiring detailed narrative descriptions and instead require that hospitals provide the various underlying agreements related to these arrangements. These agreements could be memorialized in several documents, and obtaining those documents will provide a fuller picture for CMS.

CMS also should consider directing that the following disclosures be made: (1) whether physicians currently disclose to patients their ownership or investment interest; (2) the percentage of total hospital revenue that comes from referrals from physician-investors. These items likely could be inserted into the proposed worksheets.

V. The DFRR Should Capture Information on Both Direct and Indirect Ownership or Investment Interests

Worksheets 2 and 4 request information on a physician's direct ownership interests in a hospital. While this information is important, it will not tell the entire story. It is important as well for CMS also to collect information on a physician's indirect ownership interests. In many cases, a physician may be part of a professional corporation, a medical group practice, or a family-based corporation or trust that in turn has an ownership interest in the hospital. As drafted, the DFRR would not appear to capture those situations. So, CMS should revise the DFRR so that it collects information on indirect ownership interests. This would ensure that physician-owners are not shielded from the disclosure requirements by virtue of having established an elaborate corporate structure as a way to participate in hospital ownership.

It also should be relevant for DFRR responses to indicate whether individual physicians are part of a group practice so that CMS can determine the total percentage ownership of a group by rolling up the appropriate individual physician identifiers. Total ownership interests related to one group is an important variable for CMS to understand.

We recommend an exception to our proposed collection of indirect ownership information. Physicians who have an ownership interest by virtue of publicly-traded securities should not be required to disclose that information. The logic behind this proposed exception is similar to the existing Stark exception for publicly-traded securities. Notably, our proposed exception mirrors the waiver recommended by the Medicare Payment Advisory Committee in response to CMS's proposed physician ownership disclosure policy included in the FY 2008 Medicare inpatient hospital prospective payment system proposed rule.

VI. CMS's Time Burden Estimate For Completing the DFRR is Grossly Underestimated and Time Frame for Submission Insufficient

As required by the Paperwork Reduction Act, CMS estimates that each hospital will need four hours to complete the DFRR. We believe that CMS's time estimate is grossly underestimated and does not present a realistic picture of the time burden that hospitals will shoulder in completing this report. CMS should revise this estimate by taking into account that initially it will take around two hours to read and understand the report and its instructions. From there, it will take a considerable amount of time to gather relevant information and prepare a response. The inclusion of compensation arrangements in the DFRR adds significantly to this time burden, but the current estimate still would be inadequate even if CMS were to eliminate the compensation arrangement worksheet.

Due to the nature of the required certifications, the hospital process for completing the DFRR will involve multiple disciplines within a hospital, including the attention of contract management, legal, and senior management, and possibly, outside consultants. Also, physician-owners affected by the disclosure may seek to review the submission before transmission, further adding to the time burden. For these reasons, we believe CMS's time estimate should be considerably higher, probably at least ten times the amount of time currently estimated.

A related issue is the proposed 45-day period for completing this proposed report. Because the CMS time estimate for completion is so understated, we think the 45-day period is too short. Given CMS's authority to impose very significant civil penalties for late submissions, it is incumbent upon the agency to provide a fair and adequate time frame for completing the report. We recommend that CMS adopt a 90-day response period, which would take into account the additional burden of this project as well as its placement with a hospital's other significant and time sensitive priorities, such as patient care and other regulatory and business obligations it faces daily. Alternatively, if CMS were to eliminate compensation arrangements from the scope of the DFRR, then a 45-day response period may be appropriate.

We also think the financial cost associated with this project is understated. The estimated hourly wage does not reflect the appropriate average of the fair market value of the personnel time associated with the positions that will be involved in gathering information and preparing the DFRR. Moreover, CMS does not include any estimate for the expenses related to copying and producing the supporting documentation to accompany the spreadsheet, which will be costly. Also, given the quick turnaround of 45 days, large providers may be forced to purchase or lease contract management software to help with this task, which also can be a large expense and require a multi-year commitment. In revising its estimate, we believe CMS should take all of these issues into account so that an appropriate Paperwork Reduction Act estimate can be developed.

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FAH appreciates the opportunity to comment on the proposed DFRR and the supporting documentation. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,

cc: Donald Romano, CMS
Jacqueline Proctor, CMS
John Davis, CMS

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July 16, 2007

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National Surgical Hospitals

CMS
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – B
Attention: William N. Parham, III
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Parham:

National Surgical Hospitals ("NSH"), representing multiple physician owned healthcare facilities nationwide, is pleased to offer comments on the proposed information collections program and the new Disclosure of Financial Relationships Report ("DFRR") form. As the nation's leading developer and manager of specialty surgical hospitals, we are pleased to provide information relevant to CMS' examination of issues related to information collection.

There are a number of issues related to Form CMS-10236 and the new information collection instrument that will be used by CMS to obtain information necessary to analyze each hospital's compliance with Section 1877 of the Social Security Act. Our primary concern is that the DFRR does not go far enough in requiring hospitals to disclose their indirect financial arrangements with physicians.

The instructions for the DFRR should make clear that the reporting hospital must also disclose employment-like relationships with physicians. For example, in Texas, and other states, a hospital can't directly employ a physician. However, Texas law permits physicians to form organizations that can employ the physician and through which the hospital retains the physician's services. They are called 501A corporations, and are unique in the country. CMS should be clear in requiring hospitals to disclose all personal services arrangement, including indirect arrangements through entitles such as 501A corporations. Some hospitals might otherwise assume that an arrangement with a 501A organization is exempt from reporting because it is not a direct agreement with a physician.

We appreciate the opportunity to comment on the proposed DFRR form.

Sincerely,

Scott B. Clark
Vice President
National Surgical Hospitals