



American Hospital  
Association

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200 Independence Avenue, S.W., Room 445-G  
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***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

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Page 4 of 4

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](mailto:mmudron@aha.org).

Sincerely,

Rick Pollack  
Executive Vice President

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