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United States Government Accountability Office
Washington, DC 20548

May 19, 2005

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

Subject: *Specialty Hospitals: Information on Potential New Facilities*

Beginning in the 1990s, there was a substantial increase in the number of short-term acute care hospitals that primarily treat patients with specific medical conditions or who need surgical procedures. Advocates of such hospitals, commonly referred to as specialty hospitals, contend that their focused missions and dedicated resources can both improve quality and reduce health care costs. Critics contend that specialty hospitals siphon off the most profitable procedures and patient cases, typically without providing emergency care or other vital community services, and thus erode the financial health of neighboring general hospitals. Critics also contend that the ability of physicians to invest in a specialty hospital and then refer patients to that hospital creates financial incentives that may inappropriately affect physicians' clinical and referral behavior.

In 2003, we issued two reports on the growth, characteristics, and performance of specialty hospitals.¹ More than two-thirds of the 100 specialty hospitals we identified as being in existence in June 2003 had opened their doors since the beginning of 1990.² The specialty hospitals in existence in fiscal year 2000, the most recent year for which we then had data, accounted for about 1 percent of Medicare spending for inpatient services. We also identified an additional 26 specialty hospitals under

¹*Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, [GAO-04-167](#) (Washington, D.C.: Oct. 22, 2003) and *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, [GAO-03-683R](#) (Washington, D.C.: Apr. 18, 2003).

²We considered a hospital to be a specialty hospital if the diagnosis-related group (DRG) classification for at least two-thirds of its Medicare patients (or two-thirds of all of its patients where such data were available) fell into no more than two major diagnosis categories, such as diseases of the circulatory system, or if at least two-thirds of its patients were classified in surgical DRGs. We excluded hospitals that were government owned or that specialized in providing long-term care or otherwise had missions largely distinct from the missions of short-term, acute care hospitals. Our analysis included specialty hospitals that were owned, in whole or in part, by physicians and those that had no physician owners.

development in 10 states. Approximately 70 percent of the existing specialty hospitals were owned, in part or in whole, by physicians.³

Subsequent to our reports, Congress, through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), established a moratorium which, in effect, temporarily halted further development of physician-owned specialty hospitals that focus on cardiac, orthopedic, or surgical procedures and mandated additional studies of specialty hospital issues.⁴ Specialty hospitals in operation as of November 18, 2003, are grandfathered under the moratorium and are allowed to expand within limits. Specialty hospitals not opened as of that date may apply to the Centers for Medicare & Medicaid Services (CMS) and request a determination of their development status. Hospitals not open as of November 18, 2003, but sufficiently advanced in their development may be grandfathered. The MMA moratorium expires June 8, 2005.

To help you consider the likely consequences of the moratorium's expiration, you asked us to provide updated information on the potential growth in the number of physician-owned specialty hospitals. This report responds to your request by presenting information that addresses the following questions: (1) How many applications for grandfather determinations has CMS received from specialty hospitals under development, what types of specialty hospitals applied, where were these hospitals located, and how many of the applications have been approved? (2) What information exists to indicate the likely number, location, and type of specialty hospitals not exempt from the moratorium that may be developed following its expiration?

We determined the number and characteristics of specialty hospitals under development that had applied for a grandfather determination by obtaining summaries of the applications from CMS. Facilities that submitted such applications included potential new specialty hospitals and existing specialty hospitals with expansions underway as of November 18, 2003. We included both new and expanding facilities in our analysis of the applications that CMS received and in that analysis refer to both types of facilities as "under development." To gather and assess information about the number of specialty hospitals potentially under development that are not exempt under the moratorium, we contacted representatives from national and selected state associations of community hospitals, including the American Hospital Association (AHA) and the Federation of American Hospitals

³In its 2005 report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that there were 48 physician-owned cardiac, orthopedic, or surgical specialty hospitals in 2002. MedPAC identified fewer specialty hospitals than we did in our previous reports primarily because MedPAC excluded from its count women's specialty hospitals and specialty hospitals that had no physician owners. See Medicare Payment Advisory Commission, *Report to the Congress: Physician-Owned Specialty Hospitals* (Washington, D.C.: March 2005).

⁴MMA imposed an 18-month moratorium during which a physician who has an ownership or investment interest in a new specialty hospital (or has immediate family members who do) may not refer Medicare patients to that hospital for designated health services. Thus, in effect, the moratorium halted further development of physician-owned specialty hospitals. Pub. L. No. 108-173, §507, 117 Stat. 2066, 2295-97.

(FAH); several large companies that own and operate specialty hospitals; the American Surgical Hospital Association; and the Medicare Payment Advisory Commission (MedPAC). Many of these representatives provided us with information about specific facilities that they had tentatively identified as specialty hospitals under development. Because MMA's moratorium applies only to physician-owned cardiac, orthopedic, and surgical specialty hospitals, our analysis focused on facilities that had been tentatively identified as such by one or more of the above representatives. We then sought to ascertain the characteristics and status of each facility by contacting a facility official or, if that was not possible, obtaining corroborating information from news reports or other sources. We also solicited the views of the representatives mentioned above regarding the potential for specialty hospital growth. Additional details regarding our methodology are contained in enclosure I. Our work was performed during April and May 2005 in accordance with generally accepted government auditing standards.

Results in Brief

As of April 29, 2005, CMS had received 40 applications from specialty hospitals under development seeking determinations that they were grandfathered under MMA's moratorium. CMS received 38 applications for new specialty hospitals and 2 applications for specialty hospital expansions. Slightly more than half (22) of the 40 applications were from surgical hospitals, while the rest were from cardiac hospitals (9), orthopedic hospitals (5), or hospitals that did not indicate their specialty (4). Three-fourths of the applications came from hospitals in four states: Texas (19), Louisiana (6), California (3), and Oklahoma (3). Of the 40 applications it received, CMS issued 12 favorable opinions (approvals) and 2 unfavorable opinions (denials). One of the 40 applications had been withdrawn.

Comprehensive information about specialty hospitals that may be developed when the moratorium expires is both difficult to acquire and verify, although what does exist indicates continued growth in the number of specialty hospitals—in California, South Carolina, and Texas. Of the 52 facilities tentatively identified by AHA, FAH, and others as specialty hospitals under development, and that did not apply for a determination on whether they were subject to the moratorium, we were able to obtain information corroborating that 6 of the facilities will be physician-owned specialty hospitals. One of the 6 new facilities is planned as a cardiac hospital; the remaining 5 new facilities are slated to be surgical hospitals. Four of the 52 facilities had already opened as physician-owned specialty hospitals, while 4 others were no longer under development. We were unable to obtain sufficient information to determine the status and characteristics of 17 facilities. Finally, the available information for the remaining 21 of the 52 facilities indicated that they would not be physician-owned specialty hospitals. In short, the group of 52 facilities could include anywhere from 6 to 23 specialty hospitals under development. Additional facilities, especially those in the early planning stages, could also be under development as specialty hospitals. Representatives of community hospitals are concerned that the number of specialty hospitals could grow rapidly following the moratorium's expiration. In contrast, most representatives of specialty hospitals said that

continued uncertainty over future federal actions and other factors would cause any such growth to be both moderate and gradual.

Upon reviewing a draft of our report, CMS acknowledged the usefulness of our report and provided context for the scope of the specialty hospital issue.

Background

Federal law, in general, prohibits physicians from referring Medicare patients for designated health services to facilities in which they (or an immediate family member) have an ownership or investment interest. In addition, the law prohibits such facilities from billing Medicare or the beneficiary for services rendered as a result of a prohibited referral.⁵ Before MMA, an exception to this general prohibition, commonly called the “whole hospital” exception, allowed physicians who have an ownership or investment interest in an entire hospital, and who are authorized to perform services there, to refer patients to that hospital. MMA’s specialty hospital moratorium excludes from this exception those hospitals that are primarily or exclusively engaged in the care and treatment of patients with cardiac or orthopedic conditions, or patients receiving surgical procedures or other specialized categories of services designated by the Secretary of Health and Human Services.^{6,7} Therefore, a physician with an ownership or investment interest in a specialty hospital may not refer Medicare patients to that hospital, and the hospital may not bill Medicare or the beneficiary, for inpatient or outpatient hospital services or other designated health services while the moratorium is in effect.

MMA grandfathers specialty hospitals that as of November 18, 2003, were in operation or under development. Hospitals may apply to CMS and request an advisory opinion on their development status as of November 18, 2003. In determining whether a hospital was under development as of that date, CMS is required to consider whether the following had occurred: architectural plans were completed; funding was received; zoning requirements were met; and necessary approvals from appropriate state agencies were received. CMS may also consider other evidence in reaching its determination. Specialty hospitals that had Medicare provider agreements in effect as of November 18, 2003, were considered to be in operation as of that date and thus grandfathered under the moratorium. During the moratorium, a grandfathered specialty hospital is not allowed to bill for physician investor referrals of Medicare designated health services if the hospital expands by

⁵Certain aspects of the physician self-referral prohibition have been made applicable to the Medicaid program, 42 U.S.C. §1396b(s)(2000).

⁶CMS has not issued guidance to define the phrase “primarily or exclusively engaged.” For example, CMS has not stated whether the definition of “primarily” is based on the number of patients, percent of revenues, or other factors.

⁷Certain types of hospitals, for example, psychiatric hospitals and children’s hospitals, cannot be designated specialty hospitals for the purposes of the moratorium. CMS has not designated other types of specialty hospitals in addition to the ones (cardiac, orthopedic, and surgical) specifically mentioned in MMA.

increasing the number of its physician investors, changing the specialized services it provides, or increasing its size by more than five beds or 50 percent of the number of beds in the hospital as of November 18, 2003 (whichever is greater).⁸

Although MMA’s moratorium specifically pertains to physicians’ referrals of Medicare patients and any corresponding billing for the referred services, the moratorium in effect curtails further development of physician-owned specialty hospitals. Existing specialty hospitals grandfathered under the moratorium, although limited in their ability to expand, may continue to bill for services rendered to patients referred to them by physicians who have ownership or investment interests in the facilities.

Forty Specialty Hospitals Applied for a Determination of Their Development Status under the Moratorium

As of April 29, 2005, CMS had received 40 applications for grandfather determinations from specialty hospitals that sought to continue to develop or expand under the moratorium.⁹ CMS had approved 12 of the applications. Two of the applications were denied, although 1 of these 2 decisions is being reviewed by CMS at the request of the specialty hospital. Another of the 40 applications was withdrawn, while the remaining 25 applications are pending. The tables below provide detailed information on the status of the applications by type of application—new facilities or expansions of existing facilities (see table 1), hospital specialty (see table 2), and hospital location (see table 3).

Table 1: Status of Applications for Specialty Hospital Grandfather Determinations, by Type of Application, April 29, 2005

Application type	Application status				Total
	Approved	Denied	Withdrawn	Pending	
New facility ^a	12	2	1	23	38
Expansion	0	0	0	2	2
Total	12	2	1	25	40

Source: CMS.

^aNew facilities include ambulatory surgery centers that were being converted to specialty hospitals.

⁸An increase in the number of beds is allowed only on the main campus of the hospital.

⁹CMS indicated that 3 of the 40 applicants also requested determinations that the hospital in question was not a specialty hospital. In addition to the 40 applications, CMS received 8 applications from physician-owned specialty hospitals seeking advisory opinions on issues other than whether or not the hospital was under development as of November 18, 2003.

Table 2: Status of Applications for Specialty Hospital Grandfather Determinations, by Hospital Specialty, April 29, 2005

Hospital specialty	Application status				Total
	Approved	Denied	Withdrawn	Pending	
Cardiac	1	1	0	7	9
Orthopedic	2	1	1	1	5
Surgical	9	0	0	13	22
Uncertain ^a	0	0	0	4	4
Total	12	2	1	25	40

Source: CMS.

^aApplication did not indicate hospital's specialty.

Table 3: Status of Applications for Specialty Hospital Grandfather Determinations, by Hospital Location, April 29, 2005

Hospital location	Application status				Total
	Approved	Denied	Withdrawn	Pending	
Texas	7	1	0	11	19
Louisiana	3	0	0	3	6
California	1	0	0	2	3
Oklahoma	0	1	0	2	3
Other ^a	1	0	1	7	9
Total	12	2	1	25	40

Source: CMS.

^aOther states include Arizona, Arkansas, Colorado, Indiana, Kansas, Nevada, Ohio, and Pennsylvania.

Limited Verifiable Information Suggests Continued Growth in the Number of Specialty Hospitals When the Moratorium Expires

Comprehensive information about specialty hospitals that did not apply for a grandfather determination and that may be developed when the moratorium expires is not readily available, variable in its quality, and often difficult to verify. Although AHA, FAH, and others had tentatively identified 52 facilities as potential physician-owned specialty hospitals under development, the information available to us corroborated this status for only 6 facilities. Available information on the remaining facilities was either insufficient for us to determine the status and characteristics of the facility or it indicated that the facility was not under development or was not a physician-owned specialty hospital. Other facilities, in addition to the 52 we attempted to confirm, could be under development as specialty hospitals. This is particularly true of facilities that are in the early planning stages, because those efforts are often not publicized. Because of the lack of comprehensive, verifiable information, the extent to which the number of specialty hospitals will increase when the moratorium expires is uncertain. Representatives of community hospitals told us they believe that there will be a rapid expansion in the number of new specialty hospitals, while most representatives of the specialty hospital industry said they believe that any such growth will be both modest and gradual.

Of the 52 facilities tentatively identified as specialty hospitals under development, we obtained corroborating information that 6 were being planned as physician-owned specialty hospitals. (See table 4.) Five of the 6 specialty hospitals were slated to be

surgical hospitals and 1 was being built as a cardiac hospital. (See table 5.) The 6 specialty hospitals are located in three states: California (2), South Carolina (1), and Texas (3). An additional 4 facilities had opened as physician-owned specialty hospitals during the moratorium.¹⁰ We also identified 4 facilities that had been under development as specialty hospitals, but those projects had been terminated.

Table 4: Characteristics of Facilities Identified as Potential Specialty Hospitals under Development that Did Not Apply for Grandfather Determinations, April 2005

Physician-owned specialty hospital?	Facility characteristics	Number of facilities
Yes	Under development	6
	Opened after November 18, 2003	4
	No longer under development	4
Uncertain	Information insufficient to determine characteristics	17
No	Physician-owned general hospital	12
	Not a hospital or not physician owned ^a	9
Total		52

Source: GAO.

Note: The facilities included in the table had been identified by representatives of community hospitals, state hospital associations, representatives of specialty hospitals, and GAO as potential specialty hospitals under development. We classified each facility based on available corroborating information regarding the characteristics of that facility.

^a Five of the nine facilities are ambulatory surgery centers, two are general hospitals that are not physician-owned, one is a physician’s office, and one is a recovery center.

Table 5: Location and Type of Specialty Hospitals that Did Not Apply for Grandfather Determinations and Were Verified as under Development, April 2005

State	Specialty type		Total
	Cardiac	Surgical	
California	0	2	2
South Carolina	1	0	1
Texas	0	3	3
Total	1	5	6

Source: GAO.

Note: We did not identify any orthopedic specialty hospitals under development.

The information available on 17 of the 52 facilities was insufficient for us to determine whether they were being developed as physician-owned specialty hospitals. Consequently, the 52 facilities could include from 6 to 23 physician-owned specialty hospitals under development. In another 21 of the 52 cases, the available information indicated that the facility would not be a physician-owned specialty hospital.

Many community hospital representatives that we spoke with said that the expiration of the moratorium will lead to a rapid increase in the number of specialty hospitals. The representatives stated that such development would occur, in part, because

¹⁰None of the four specialty hospitals (one cardiac, one orthopedic, and two surgical) had applied to CMS for a determination of their development status under the moratorium. CMS stated that the agency strongly recommends, but does not require, entities to seek a favorable grandfather determination before opening as a specialty hospital.

physicians view specialty hospitals as an attractive financial opportunity. Community hospital representatives said that, in some instances, it would be relatively easy for physician-owned general hospitals to change their missions and begin functioning as specialty hospitals. The representatives also raised concerns about some physician-owned hospitals, in existence and under development, that classify themselves as general hospitals. The representatives said that some of these self-classified general hospitals predominately focused, or will focus, on surgical procedures, and thus should be considered specialty hospitals by CMS and be subject to MMA's moratorium.

Most of the specialty hospital representatives we spoke with expected that any growth in the number of specialty hospitals following the moratorium's expiration would likely be both modest and gradual. Officials representing companies that own specialty hospitals said that continued uncertainty regarding future federal restrictions would dampen their interest in developing new specialty hospitals and make it difficult to obtain the financing necessary for such projects.¹¹ Some company representatives said that the lack of a clear definition of what constitutes a specialty hospital has led their companies to avoid investments in certain facilities. The representatives said that they were concerned that if Congress extends the moratorium, CMS could later classify the facility as a specialty hospital, potentially subject to the moratorium or other restrictions. Specialty hospital representatives also said that not all physician-owned specialty hospitals have been financially successful and that some such hospitals have closed and physicians have lost their investments. Some representatives added that, although physicians are primarily interested in specialty hospitals for nonfinancial reasons, the financial risks are now more apparent and may dampen some enthusiasm for future development. The representatives said they believed that any growth in the number of specialty hospitals will be gradual because not all of the specialty hospitals under development will open immediately and that it typically takes 2 or more years to develop, construct, and open a new facility. Finally, they added that it is likely that some of the planned specialty hospitals, especially those in the early stages of planning, may never be built or opened.

Concluding Observations

Whether or not MMA's moratorium is allowed to expire, the number of physician-owned specialty hospitals will increase from present levels. If the moratorium is extended, at least 12, and perhaps eventually as many as 37, new specialty hospitals could be completed and opened within a year or two. The exact increase would depend in part on the number of applications that CMS approves. If the moratorium is allowed to expire, the increase would likely be greater, but how much greater is uncertain. Specialty hospitals under development whose applications for grandfather status have been denied, and specialty hospitals that have not applied, could open.

¹¹Some specialty hospital representatives stated that uncertainty also exists with regard to potential state legislative efforts. Several states are considering legislation that would prohibit or discourage future specialty hospital growth.

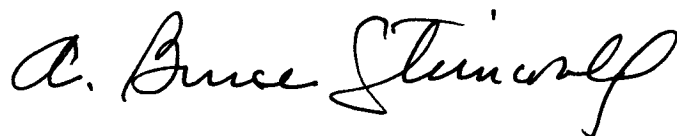
We identified 6 specialty hospitals under development that had not applied. In addition, some or all of the 17 facilities where we had insufficient information to classify the facility could also be physician-owned specialty hospitals under development. The lack of comprehensive, verifiable information makes it difficult to know exactly how many hospitals may be under development. Ultimately, the extent to which physicians and other investors are attracted to specialty hospitals, or are deterred by the uncertainty of future federal restrictions or other factors, will decide how quickly the industry grows when the moratorium expires.

Agency Comments

We provided a draft of our report to CMS for review. In written comments, CMS acknowledged the usefulness of our report concerning physician-owned specialty hospitals under development. CMS provided context for the relative potential growth of physician-owned specialty hospitals, stating that if the agency were to approve all pending applications for grandfather determinations and if all of the 37 potential specialty hospitals identified by GAO were to open, the number of acute care hospitals would increase by just over 1 percent. We have reprinted CMS's letter in enclosure II. CMS also provided technical comments, which we incorporated where appropriate.

As agreed with your offices, we plan no further distribution of this report until 30 days after its date. At that time, we will send copies of this report to appropriate congressional committees and other interested parties. We will also make copies available to others upon request. This report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staffs have any questions, please call me on (202) 512-7101 or James Cosgrove on (202) 512-7029. Other contributors to this report include Zachary Gaumer and Jennifer Podulka.



A. Bruce Steinwald
Director, Health Care

Enclosures

Scope and Methodology

This enclosure provides additional details about the scope of our work, our methodology, and key limitations. First, it describes the data that we obtained from the Centers for Medicare & Medicaid Services (CMS) regarding specialty hospitals under development that applied for a determination that they were grandfathered under the moratorium. Second, it describes the approach we used to identify information about other specialty hospitals under development and to verify the accuracy of this information.

Information on Specialty Hospitals under Development that Applied for Grandfather Determinations

CMS provided information on the 40 specialty hospitals under development that had applied for grandfather determinations as of April 29, 2005. From CMS, we obtained summary information on each hospital's name, state location, and area of specialization; whether the application was for a new facility or an expansion of an existing one; and the current status of the application: approved, denied, withdrawn, or pending.

Information on Other Specialty Hospitals under Development

To gather information about specialty hospitals potentially under development that had not applied for a determination that they were grandfathered under the moratorium, we consulted organizations and individuals most likely to be aware of such development. Specifically, we contacted the two government agencies mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to study specialty hospital issues for Congress: CMS and the Medicare Payment Advisory Commission. Because hospital officials and hospital associations are likely to be aware of developments in their industry, we contacted representatives from both community hospitals and specialty hospitals. Specifically, the community hospital representatives included officials from the American Hospital Association, the Federation of American Hospitals, the Coalition of Full-Service Community Hospitals, and nine state hospital associations.¹² We selected the nine state hospital associations because our October 2003 report on specialty hospitals identified those states as having concentrations of specialty hospitals in existence or under development at that time.¹³ Officials of specialty hospitals that we contacted represented the American Surgical Hospital Association and five corporations that own specialty hospitals: Baylor Health Care System, Hospital Partners of America, MedCath Corporation, National Surgical Hospitals, and United Surgical Partners

¹²The nine states were Arizona, California, Idaho, Kansas, Louisiana, Oklahoma, South Dakota, Texas, and Wisconsin.

¹³[GAO-04-167](#).

International. Many of the organizations and individuals we contacted provided us with information on specific facilities that they said were likely specialty hospitals under development and offered their views on the potential for specialty hospital growth after the moratorium expires.

We consolidated the information we obtained from the sources described above, along with the information on specialty hospitals under development that we had identified for our October 2003 report. After excluding those facilities that had submitted applications for grandfather determinations to CMS, we were left with a list of 52 potential new specialty hospitals.

We then sought corroborating information that the 52 facilities in question (1) were under development, (2) would specialize in treating cardiac or orthopedic patients or in treating patients that need surgical procedures, and (3) that these facilities would be owned, at least in part, by one or more physicians. If sufficient information was available, we attempted to contact a representative of the facility. When we were successful in making contact, we used the information we obtained to determine the status of the facility. If we could not make contact with the facility directly, we turned to a variety of independent news sources to obtain information about the facility. These sources included local newspapers, local business journals, health care industry publications, and company Web sites. Following the process outlined above, we determined the status of 35 of the 52 facilities tentatively identified as specialty hospitals under development. In 17 instances, we could not locate sufficient information within the time frames allotted for the study to determine the status of the facility. Although our findings are based on the best information available to us, it is very likely that we do not have a complete list of all specialty hospitals under development. Some facilities, particularly those in the initial planning stages, may not have come to the attention of the individuals and organizations we contacted. Our work was performed during April and May 2005 in accordance with generally accepted government auditing standards.

Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: **MAY 9 2005**

TO: A. Bruce Steinwald
Director, Health Care - Economic
and Payment Issues

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Government Accountability Office's (GAO) Draft Report: *Specialty Hospitals: Information on Potential New Facilities* (GAO-05-647R)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on this report. The growth of physician-owned specialty hospitals in the last ten years has been the subject of much debate. Much of the concern has focused upon the impact of these new specialty hospitals upon community hospitals, the type of care rendered by these facilities, the types of patients treated at these facilities, and particularly financial incentives for physician owners to refer patients to facilities in which the physicians have an ownership or investment interest. This report is particularly timely in light of the Medicare Payment Advisory Commission's recently released study and our soon to be released study and recommendations concerning this issue.

As of May 3, 2005, there are approximately 5,000 acute care hospitals currently participating in the Medicare program. There are 25 "under development" advisory opinion requests pending a determination from CMS. In addition, the GAO report projects that between 11 and 37 additional specialty hospitals may open within a year or two. To provide some context, if CMS were to approve all pending advisory opinion requests, and if all those specialty hospitals plus the projected 11 to 37 additional specialty hospitals actually opened, this would represent only a 1.24 percent increase in the current number of acute care hospitals.

Thank you for your efforts to study this matter. The report will assist us in formulating recommendations to the Congress concerning the impact of specialty hospitals. Attached are our technical comments on the report.

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