

HOGAN & HARTSON

Hogan & Hartson LLP
Columbia Square
555 Thirteenth Street, NW
Washington, DC 20004
+1.202.637.5600 Tel
+1.202.637.5910 Fax

www.hhlaw.com
Sheree R. Kanner
Partner
+1.202.637.2898
SRKanner@hhlaw.com

July 5, 2007

Ms. Sheila Lambowitz
Director, Institutional Post-Acute Care Division
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop C5-06-27
Baltimore, MD 21244

Dear Ms. Lambowitz:

Thank you for meeting with representatives of the Rehabilitation Hospital of South Jersey (RHSJ) in May to discuss the wage index applied to RHSJ for purposes of Medicare reimbursement under the inpatient rehabilitation facility (IRF) prospective payment system (PPS). I hope we conveyed the very real disadvantage RHSJ faces in hiring skilled staff such as physical therapists because RHSJ's wage index is markedly lower than the wage indices that apply to: the 262-bed acute care hospital just across the road, the closest other IRF, which is 45 minutes away, and each of the seven other acute care hospitals in the south Jersey area.

During our meeting, we presented one option for remedying this inequity. Namely, we proposed that the agency apply the statewide urban average wage index to IRFs such as RHSJ, which are located in a Core-Based Statistical Area (CBSA) with only one acute care hospital on which to determine the wage index, and that acute care hospital has been reclassified, redesignated or receives the rural floor. RHSJ has submitted a comment letter in response to the fiscal year 2008 IRF PPS proposed rule which presents a second option. We propose that, as an alternative remedy, CMS could apply to each such IRF the average wage index for all CBSAs contiguous with that of the IRF. The comment letter also discusses why we concluded that these were reasonable and workable options as well as how each option can be viewed as a "logical outgrowth" of the proposed rule.

Ms. Sheila Lambowitz
July 5, 2007
Page 2

We have enclosed a copy of RHSJ's comment letter for your convenience. Thank you again for your time and willingness to consider putting RHSJ on an equal footing with other hospitals in southern New Jersey by including our recommendation in the IRF PPS final rule for 2008.

Sincerely,



Sheree R. Kanner

Enclosure

cc (w/Enclosure):

Laurence Wilson
Marc Hartstein
Zinnia Ng
Bob Kuhl



**REHABILITATION HOSPITAL
of SOUTH JERSEY**

BY ELECTRONIC DELIVERY

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

**Re: CMS-1551-P (Medicare Program; Inpatient
Rehabilitation Facility Prospective Payment System for
Federal Fiscal Year 2008)**

Dear Administrator Norwalk:

Mediplex Cumberland Rehabilitation Hospital, d/b/a the Rehabilitation Hospital of South Jersey (RHSJ), appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2008 proposed rule regarding inpatient rehabilitation facility (IRF) reimbursement under the Medicare prospective payment system (PPS) (the "Proposed Rule").¹ RHSJ is an IRF located in Cumberland County, New Jersey, that provides high-quality, comprehensive physical restoration services and is reimbursed under the Medicare IRF PPS.

RHSJ's comments on the Proposed Rule are limited to the wage index, which is used by CMS to adjust an IRF's wage and wage-related costs to reflect the relative hospital wage level in the IRF's geographic area, as compared to the national average wage level. As you are aware, the wage index has a significant effect on a hospital's Medicare reimbursement, because labor costs constitute the majority of hospital costs. The wage index that would apply to RHSJ for FY 2008 under the Proposed Rule is substantially lower than the wage indices that would apply to the neighboring hospitals with which RHSJ competes for professional staff, including the only acute care hospital in the same Core-Based Statistical

¹ 72 Fed. Reg. 26,230 (May 8, 2007).

Area (CBSA),² seven other acute care hospitals in the region, and the nearest IRF. As a result of this material difference between RHSJ's wage index and the wage indices of all neighboring hospitals, RHSJ has been substantially disadvantaged in its efforts to compete for and retain skilled staff.

As described in more detail below, we request that CMS exercise its broad discretion under section 1886(j)(6) of the Social Security Act (the Act) and change the methodology for setting the FY 2008 wage index for RHSJ and the very small number of IRFs that are likely to be similarly situated. Specifically, we propose a change in the wage index applied to IRFs in CBSAs with only one acute care hospital on which to determine the wage index and that acute care hospital has been reclassified, redesignated or receives the rural floor. We urge CMS to make this change in the FY 2008 IRF PPS final rule.

I. The Medicare Wage Indices Applied to RHSJ and Neighboring Facilities

The proposed FY 2008 wage index for RHSJ is substantially below the proposed wage index for the acute care hospital located directly across the street, as well as the other facilities with which RSHJ competes for staff. We describe below the effects on RHSJ of these wage index "cliffs" between neighboring hospitals and counties and the implications for patient access to IRF care in South Jersey.

RHSJ is the only rehabilitation facility in Cumberland County, New Jersey. Despite being located only 35 miles from Philadelphia, Cumberland County is a largely rural county. In addition to serving Cumberland County, RHSJ also serves the surrounding counties of Salem, Gloucester and Cape May, New Jersey, which do not have any IRFs. RHSJ provides physical restoration services of an intensity and scope that are not available in sub-acute or nursing home programs. Patients at RHSJ receive three hours of physical therapy per day as well as access to all services that the patient would receive from an acute care hospital, including cancer care, hemodialysis, and radiology services.

RHSJ opened in March 2003 and has been reimbursed under the IRF PPS since that time. The hospital is licensed for 30 inpatients, with a temporary extension from the State of New Jersey to 34 beds, and serves about 20-25 outpatients per day.

² A CBSA is a geographic entity defined by the Office of Management and Budget (OMB). OMB standards designate and define two types of CBSAs: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas. 70 Fed. Reg. 47,880, 47,918 (Aug. 15, 2005).

RHSJ is located directly across the street from a 262-bed acute care facility, the South Jersey Healthcare (SJH) Regional Medical Center, which is the only acute care hospital in the same CBSA (47220). RHSJ is also located within 25 miles of four other acute care hospitals (Burdette Tomlin Memorial Hospital, Memorial Hospital of Salem County, Kessler Memorial Hospital and Kennedy Memorial Hospitals-Washington Township) and within 37.5 miles of three additional hospitals (Shore Memorial Hospital, AtlantiCare Regional Medical Center, and Underwood-Memorial Hospital). The nearest IRF is Bacharach Institute for Rehabilitation, located in Atlantic County, which is contiguous with Cumberland County. This IRF is located less than an hour away from RHSJ, and has an outpatient rehabilitation facility located within five miles of RHSJ.

RHSJ must draw its therapy staff from across southern New Jersey and southeastern Pennsylvania because there is no natural base of trained therapists in Cumberland County. Only 24% of RHSJ's physical therapists live in Cumberland County, with most commuting at least 20 miles. Other professional staff commute from a wide area as well. Only 50% of RHSJ's other professional staff live in Cumberland County.

RHSJ has seen extraordinary growth in salaries for therapy staff. Its salaries have increased over 10% per year for the last two years in an effort to remain competitive with salaries at competing facilities. Several of RHSJ's current therapists are supplied by staffing agencies, which puts even greater pressure on the hospital's finances because of the higher rates charged by these agencies.

RHSJ must compete for professional staff with SJH Regional Medical Center, the other seven hospitals located in the region, the IRF in Atlantic County and its local outpatient facility, and several private physical therapy staffing agencies. Although RHSJ competes for the same workforce as these facilities, the wage index to be applied to RHSJ for FY 2008 is substantially lower than those of its competitors. Table 1 sets forth the wage indices to be applied to RHSJ, Bacharach Institute for Rehabilitation, SJH Regional Medical Center, which has been reclassified to CBSA 48664 for FYs 2008-2010, and other neighboring acute care hospitals for FY 2008:

Table 1. Proposed Wage Indices for FY 2008 for RHSJ and Neighboring Hospitals³

Provider	Wage Index	% Higher than RHSJ Wage Index
RHSJ	0.9832	***
Bacharach Institute for Rehabilitation	1.1831	20%
SJH Regional Medical Center	1.0752	9%
Burdette Tomlin	1.0864	10%
Shore Memorial Hospital	1.2095	23%
AtlantiCare Regional Medical Center	1.2095	23%
Underwood Memorial Hospital	1.0777	10%
Kessler Memorial Hospital	1.2095	23%
Memorial Hospital of Salem County	1.0752	9%
Kennedy Memorial Hospitals	1.0522	7%

These county-level “cliffs” in the wage indices put RHSJ at a severe disadvantage in hiring and retaining therapy staff, particularly as compared

³ Sources: Table 1 of the Proposed Rule, “Hospital Case-Mix Indexes For Discharges Occurring in Federal Fiscal Year 2006; Hospital Wage Indexes For Federal Fiscal YEAR 2008; Hospital Average Hourly Wages For Federal Fiscal Years 2006 (2002 Wage Data), 2007 (2003 Wage Data), and 2008 (2004 Wage Data); Wage Indexes And 3- Year Average of Hospital Average Hourly Wages – (Correction)” and “FY 2008 Wage Index Final Rule Worksheet S-3 Wage Data File” available at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage> and Table 2 of the CMS proposed rule regarding the hospital inpatient PPS for FY 2008, 72 Fed. Reg. 24,680 (May 3, 2007).

to Bacharach Institute for Rehabilitation, the IRF located in adjacent Atlantic County.

In addition to being at a competitive disadvantage for FY 2008 due to its low wage index, RHSJ was at a competitive disadvantage for earlier years for the same reason. For example, for FY 2007, RHSJ's wage index was 0.9827, while the neighboring SJH Regional Medical Center received the statewide rural floor of 1.1402, which was 16% higher than the wage index applied to RHSJ. The wage index for the IRF in Atlantic County was 1.1615 – a full 18% higher than the wage index applied to RHSJ. The other acute care hospitals in the region had wage indices ranging from 1.1402 to 1.1692, or 16 to 19% higher than the wage index applied to RHSJ.

If RHSJ is not able to compete for therapists and other professional staff, patients in Cumberland and surrounding counties will be unable to get access to the high-quality IRF services that the hospital provides. RHSJ estimates that application of the current wage index policy is costing RHSJ hundreds of thousands of dollars or more each year. The effects on RHSJ's operations and access to IRF services in Cumberland County are substantial:

- **Turnover:** The rate of staff turnover at RHSJ was 38% in 2006, which is up substantially from prior years. Exit interviews with departing staff cite rate of pay as the reason for the resignation in almost every case. Even with the recent wage increases, physical therapists still leave because of the very competitive market for therapy staff. This competitive market also affects turnover of other staff. Because of the upward pressure on wages for therapy staff, RHSJ has not been able to raise salaries for non-therapy staff since 2005.
- **Reduced Access to IRF Services:** If RHSJ cannot staff the full number of beds for which it is licensed, patients in Cumberland County cannot get access to the hospital's high quality IRF services. The hospital's goal is to have a staff of 15 therapists per day. It is currently five therapists short of this goal. RHSJ estimates that over a four-month period, 69 inpatients have been unable to get access to its inpatient therapy services due to staffing shortages. RHSJ has also had to close outpatient programs because of staffing constraints. For example, the hospital has not been able to open its day program for patients with head injuries.

II. IRF PPS Wage Index Policy

As CMS has itself recognized, "acute care hospitals compete in the same labor market areas as IRFs."⁴ Where the wage index applicable to an

⁴ 70 Fed. Reg. at 47,927.

IRF is substantially lower than the wage indices applicable to neighboring acute care hospitals, the IRF will be significantly disadvantaged in its ability to compete for staff. This is precisely what is happening to RHSJ, which is across the street from a competing facility that currently receives a wage index that is 16% higher than the wage index applied to RHSJ.

As noted above, there is only one acute care hospital in RHSJ's CBSA (47220). In discussing its methodology for setting the IRF wage index, the agency has acknowledged the potential problems in relying on a single hospital to create a wage index.⁵ In its IRF PPS final rule for FY 2006, CMS noted that, where there are few hospitals in a labor market area, "the wage indices for IRFs in those areas could become relatively unstable as they might change considerably from year to year."⁶ It also noted the "increase[d] . . . potential for dramatic shifts in those areas' wage indices from one year to the next because a single hospital . . . could have a disproportionate effect on the wage index of the area."⁷ In light of these concerns, CMS decided to treat all Micropolitan Areas, which OMB defines as areas with at least one urban cluster with a population of at least 10,000 but less than 50,000, and which tend to include fewer hospitals, as part of the statewide rural labor market area.

The risk of volatility and potential inaccuracy in relying on data submitted by a single hospital to establish an area wage index, particularly where that hospital's costs may be idiosyncratic, was also highlighted at the March 2007 meeting of the Medicare Payment Advisory Commission (MedPAC) on wage index reform as well as in MedPAC's June 2007 report to Congress.⁸ These problems may be exacerbated where, as in CBSA 47220, the only acute care hospital in the CBSA has been reclassified or is reimbursed based on the statewide rural floor, rather than its own reported wage data. Because such hospitals are reimbursed based on a higher wage index, they may be less concerned about their own wage data, and may arguably have less need to ensure a high degree of accuracy in reporting the data on which the wage index for their CBSA is based.

⁵ Id. at 47,921.

⁶ Id. at 47,920.

⁷ Id. at 47,921.

⁸ See MedPAC, Report to the Congress: Promoting Greater Efficiency in Medicare 129 (June 2007) ("Areas with only one or two hospitals may also see volatility in the wage index if wages change suddenly—for example, because of a new labor agreement or because of errors in reporting costs and hours."); Transcript of MedPAC Public Meeting, March 8, 2007 at 332, 341-42. See also id. at 336 ([I]n a one hospital MSA, there's really not any assurance that what gets reported is that the underlying labor costs. Or it could be very idiosyncratic to that particular hospital.").

III. Recommended Change to Current IRF PPS Wage Index Policy

In section 1886(j)(6) of the Act, Congress gave CMS broad authority to develop an appropriate IRF wage index. CMS has recognized the breadth of its discretion under section 1886(j)(6): “[CMS] has broad authority under 1886(j)(6) to update the wage index on the basis of information available to [CMS] (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services.”⁹ CMS has exercised its discretion to adjust the IRF wage index on a number of occasions. For example, CMS exercised this authority in circumstances where the data for determining the wage index were inadequate, such as with respect to Micropolitan Areas. CMS also exercised its broad latitude regarding the IRF wage index for urban IRFs located in geographic areas with no corresponding wage data. In the FY 2006 IRF PPS final rule, CMS determined that urban IRFs in geographic areas without hospital wage data would receive a wage index based on the average wage index for all urban areas in the state.¹⁰

Most recently, CMS has proposed to exercise its extremely broad discretion with respect to the IRF wage index for IRFs in rural areas where there are no rural hospital wage data. In the IRF PPS proposed rule for FY 2008, CMS said that, for such facilities, it intends to use the average wage index for all CBSAs that share a border with the CBSA of such facility as “a reasonable proxy for the rural area within a State.”¹¹ CMS determined that this approach would be the best imputed proxy because it would (1) use pre-floor, pre-reclassified hospital data, (2) be easy to evaluate, (3) use the most local data, and (4) be easily updateable from year-to-year.

CMS similarly should exercise its discretion under the Medicare statute to adjust the wage index for IRFs located in a CBSA with only one acute care hospital on which to determine the wage index, and that acute care hospital has been reclassified, redesignated or receives the rural floor. We recommend that the agency apply the statewide urban average wage index to each IRF in such circumstances. Alternatively, RHSJ recommends that CMS apply to each such IRF the average wage index for all CBSAs contiguous with that of the IRF.

Application of the statewide urban average wage index to IRFs in CBSAs with only one acute care hospital on which to determine the wage index, where the acute care hospital has been reclassified, redesignated or receives the rural floor, is well within CMS’s broad authority under section 1886(j). Consistent with the factors identified by CMS, the statewide urban average wage index is a reasonable proxy because it would use pre-floor, pre-

⁹ 70 Fed. Reg. at 47,927.

¹⁰ *Id.* at 47,927.

¹¹ 72 Fed. Reg. at 26,244.

reclassified hospital data, would be easy to evaluate, would use data from the hospital's own state, and would be easily updateable. We note that this is the same solution that CMS has adopted to apply to urban hospitals in CBSAs without any wage index data.

Alternatively, CMS could apply to IRFs such as RHSJ the same policy that the agency has proposed for rural areas where there are no rural hospital wage data; that is, CMS could use the average wage index for all contiguous CBSAs. CMS has already determined that this approach meets its criteria for the best imputed proxy where there are no hospital wage data, and we believe that it is also a reasonable proxy where there are data only for a single acute care hospital and that hospital has been reclassified, redesignated, or receives the rural floor.

Either of these alternatives would provide a narrowly-tailored solution for RHSJ's situation that would likely apply to a very limited universe of IRFs. Based upon our analysis, we estimate that only about six IRFs in the nation would be similarly situated with RHSJ and, therefore, eligible for an increase in their wage index. CMS stated in the FY 2006 IRF PPS final rule that there are only 49 Metropolitan Statistical Areas with only one hospital.¹² Under our recommendation, this group would be limited further to only those areas in which the acute care hospital has been reclassified or is subject to the rural floor *and* in which an IRF is located. Based on our analysis of the IRF and IPPS wage index data files, we estimate that for FY 2007 there were only seven to nine IRFs located in CBSAs with only one acute care hospital, where the provider number of the IRF is different from the provider number of the acute care hospital. For this group, we found that six of the acute care hospitals had been reclassified, redesignated, or received the rural floor. Thus, although we are not able to determine precisely how many IRFs would be affected by our recommended change, these estimates strongly suggest that RHSJ's recommendation would apply to a very small number of IRFs.¹³

In developing our recommendation for addressing RHSJ's problem, we concluded that it would not be necessary to change the wage index policy other than for IRFs located in a CBSA with one acute care hospital, where the acute care hospital has been reclassified, redesignated or receives the rural floor. In CBSAs with two acute care hospitals, even if both of those hospitals have been reclassified, redesignated or receive the rural floor, there is an "averaging effect," which "allows for more data points to be used to calculate the representative standard of measured labor costs within a market area."¹⁴ As CMS has recognized, "[i]n labor market areas with a

¹² 70 Fed. Reg. at 47,921.

¹³ We were not able to derive an estimate for FY 2008 because the final IRF data files for FY 2008 were not available. We have no reason to believe, however, that the number of affected IRFs would be significantly different for FY 2008.

¹⁴ 70 Fed. Reg. at 47,921.

single hospital,” there is no “counterbalancing averaging” of wage costs.¹⁵ We also do not believe that this policy change should extend to IRFs that share the same provider number as the acute care facility, because these IRFs do not have the same concerns about data quality and accuracy. Unlike RHSJ, an IRF that is affiliated with an acute care facility should have some ability to control the Medicare cost data submitted by that acute care facility as well as recourse if there is a concern that the data do not accurately reflect the facility’s wage costs.

IV. CMS Can Make RHSJ’s Recommended Change in the FY 2008 Final Rule Without the Need for Any Additional Notice and Comment

Incorporation of the limited change RHSJ has recommended into the final rule without undergoing additional notice and comment is consistent with the requirements for notice in section 553 of the Administrative Procedure Act (APA).¹⁶ Although CMS did not explicitly propose this specific change to the IRF wage index, notice was adequate because the proposed rule suggested a related modification, and it thereby raised for consideration the general issue of changes to the IRF wage index to correct for inadequate data in particular circumstances.¹⁷ Furthermore, CMS had previously expressed both a concern that wage indices based on data from a small number of hospitals would be unstable and inequitable and a desire to calculate wage indices that more accurately reflect the true nature of local labor costs.¹⁸ To minimize instability and inequity, CMS adjusted its formula for calculating wage indices for IRFs located in Micropolitan Areas in a manner similar to what is proposed here – by using a statewide wage index.¹⁹ Accordingly, because CMS had previously made comparable changes to the IRF wage index for related reasons, interested parties in the present circumstance were put on notice that CMS might consider similar changes even absent an explicit proposal.

The case law confirms that in circumstances such as these, the notice provided is adequate under the APA. Courts generally inquire whether the final rule is a “logical outgrowth” of the proposed rule, the rulemaking proceedings, or the comments received; if so, notice is deemed sufficient and an additional notice and comment period is not required.²⁰ If, however, the

¹⁵ Id.

¹⁶ 5 U.S.C. § 553 (2006).

¹⁷ 72 Fed. Reg. at 26,244 (proposing to revise the methodology used to determine wage indices for rural areas without hospital wage data).

¹⁸ 70 Fed. Reg. at 47,920-21.

¹⁹ Id. at 47,921.

²⁰ See, e.g., Ne. Md. Waste Disposal Auth. v. E.P.A., 358 F.3d 936, 951-52 (D.C. Cir. 2004) (“an agency satisfies the notice requirement, and need not conduct a further round of public comment, as long as its final rule is a ‘logical outgrowth’ of the rule it originally

final rule “deviates too sharply” from or is the opposite of the proposed rule, “affected parties will be deprived of notice and an opportunity to respond to the proposal.”²¹ Because courts encourage administrative agencies to modify proposed rules in response to comments²² as well as to use new information learned during the comment period in formulating the final rule,²³ a final rule satisfies the “logical outgrowth” test so long as “at least the ‘germ’ of the outcome is found in the original proposal.”²⁴ Furthermore, courts are willing to generalize from specific examples in proposed rules to conclude that final rules that include changes that fall within the same general category as the specific examples in the proposed rule satisfy the logical outgrowth test.²⁵

Modifying the wage index for the limited set of IRFs that are in a CBSA with only one acute care hospital, where that acute care hospital has been reclassified, redesignated, or receives the rural floor, is a logical outgrowth of the Proposed Rule. The Proposed Rule contained a proposal to change the methodology for calculating the IRF wage index for situations in which the data that would otherwise be used were inadequate.²⁶ Thus, interested parties “should have anticipated” that CMS was contemplating exercising its discretion to adjust the IRF wage index, generally, for particular situations in which relevant data were substandard.²⁷ The particular change to the IRF wage index recommended by RHSJ is similar to the specific change proposed by CMS because it, too, seeks to correct for inadequate data. Therefore, because this particular change to the IRF wage index is related to CMS’s own proposed change and is within the same general category of changes, it is a logical outgrowth of the Proposed Rule, and additional notice and comment is not required prior to final promulgation.²⁸

proposed”) (quoting First Am. Discount Corp. v. Commodity Futures Trading Comm’n, 222 F.3d 1008, 1015 (D.C. Cir. 2000)).

²¹ Small Refiner Lead Phase-Down Task Force v. E.P.A., 705 F.2d 506, 547 (D.C. Cir. 1997). See also Envtl. Integrity Project v. E.P.A., 425 F.3d 992, 997 (D.C. Cir. 2005) (“This flip-flop complies with the APA only if preceded by adequate notice and comment.”).

²² Ne. Md. Waste Disposal, 358 F.3d at 951.

²³ American Coke and Coal Chemicals Inst. v. E.P.A., 452 F.3d 930, 939 (D.C. Cir. 2006) (citing BASF Wyandotte Corp. v. Costle, 598 F.2d 637, 642-46 (1st Cir. 1979)).

²⁴ National Ass’n of Psychiatric Health Sys. v. Shalala, 120 F. Supp. 2d 33, 39 (D.D.C. 2000) (quoting Natural Res. Defense Council v. Thomas, 838 F.2d 1224, 1242 (D.C. Cir. 1988)).

²⁵ See, e.g., Small Refiner, 705 F.2d at 546-48 (D.C. Cir. 1983).

²⁶ 72 Fed. Reg. 26,230, 26,244 (May 8, 2007).

²⁷ Ne. Md. Waste Disposal, 358 F.3d at 952 (quoting City of Waukesha v. E.P.A., 320 F.3d 228, 245 (D.C. Cir. 2003)).

²⁸ See National Ass’n of Home Builders v. United States Army Corps of Eng’rs, 453 F. Supp. 2d 116, 126 (D.D.C. 2006) (when interested parties were aware that the final rule would be more protective of the environment, a final rule that was more protective than the proposed rule was a “logical endpoint” and was therefore a logical outgrowth of the proposed rule).

Finally, although MedPAC has submitted a report to Congress on the Medicare wage index that includes recommendations regarding alternative methods for computing the wage index, CMS should not delay making RHSJ's recommended narrowly-tailored change to IRF wage index policy for FY 2008. MedPAC has recommended that Congress repeal the existing wage index statute and give the Secretary authority to establish new wage index systems.²⁹ This legislative change may never be enacted; moreover, even if it is enacted, it may take years to implement. In the meantime, the current IRF wage index policy is causing significant financial harm to RHSJ. Its wage index is substantially lower than the wage indices that apply to the acute care hospital directly across the street and the inpatient rehabilitation hospital located less than an hour away, as well as other hospitals in the region. The limited administrative solution that we propose is well within CMS's authority, would apply to only a small number of IRFs, and is very much consistent with the one of the apparent goals of the MedPAC recommendations, as discussed at the March and April public meetings: to reduce the inherent unfairness where one provider receives the pre-reclassification wage index while a neighboring or adjacent hospital-based provider receives a higher wage index.

* * *

RHSJ greatly appreciates the opportunity to comment on the proposed wage index for RHSJ for FY 2008, and we sincerely hope that CMS will give thoughtful consideration to our comments and will incorporate our recommendation into its final rule. Thank you for your attention to this very important matter.

Respectfully submitted,



Francis J. Bonner, Jr., MD
Medical Director/CEO

²⁹ See MedPAC, Report to the Congress: Promoting Greater Efficiency in Medicare 144 (June 2007).