BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF	)
APPLICATION OF ENCOMPASS HEALTH REHABILITATION HOSPITAL FOR AN INPATIENT REHABILITATION HOSPITAL	)
Docket No. 18-16-2423	)

MEDSTAR NATIONAL REHABILITATION HOSPITAL'S INTERESTED PARTY COMMENTS

I. INTRODUCTION

MedStar National Rehabilitation Hospital ("MNRH") through undersigned counsel and pursuant to COMAR § 10.24.01.01 *et seq.*, hereby offers its Interested Party Comments as to Encompass Health Rehabilitation Hospital of Southern Maryland's ("ERH") application for an inpatient rehabilitation hospital ("IRF") in Bowie, Maryland (the "Project").

ERH's proposed Project fails to fulfill the general and project review standards of the State Health Plan and the applicable COMAR criteria for such facilities. The application fails to adequately describe existing barriers to access or explain the volume projections. It fails to demonstrate why maximum, as opposed to minimum need applies. It does not explain how it would achieve a market shift from existing facilities (such as MNRH, Adventist Hospital or skilled nursing facilities ("SNF"), nor does it adequately explore all viable alternatives.

As MNRH demonstrates below, the Southern Maryland Region is already well served by existing facilities, and even if the Project could redirect market share (which has not been shown), the costs per case would not be positively impacted. In short, there are better alternatives for acute rehabilitation care for residents of the Southern Maryland Region than a

new facility such as that envisioned by ERH. For all these reasons, and as shown below, the requested Certificate of Need should not be granted.

II. ARGUMENT

A. THE RELIABILITY OF THE APPLICANT'S DATA FOR COMPARISON PURPOSES IS PROBLEMATIC

Acute inpatient rehabilitation is classified by COMAR as a "specialized hospital service" that is best provided to a "substantial regional population" through a "limited number of hospitals." COMAR 10.24.09.03. The State Health Plan prescribes the standards that an applicant must meet to obtain a CON to provide this rehab service. Among other things, these standards require that an applicant demonstrate its ability to provide the "quality of care" required by COMAR and provide documentation (a) that it is licensed in good standing by the Maryland Department of Health and Mental Hygiene; (b) that it is accredited by the Commission for Accreditation of Rehabilitation Facilities and (c) that it is in compliance with the conditions of participating in the Medicare and Medicaid programs. COMAR 10.24.09.04A(2). ERH has attempted to demonstrate "through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services." COMAR 10.24.09.04A(2)(c). ERH addresses these standards beginning at page 71 of the application, through the presentation of various data and charts.

ERH is part of a class of IRFs, often referred to as "high-margin IRFs" that assess patient functional status differently than lower margin facilities at both admission and discharge -- measurement that is needed for both (1) case-mix classification and payment and (2) outcome evaluation.[1]

[1] See MedPAC March 2018, Chapter 10, Inpatient Rehabilitation Facilities, especially at 274-276. Also see MedPAC March 2016, Chapter 9, Inpatient Rehabilitation Facilities, especially at 257-65. The March 2016 report provides more detailed information on this issue.

The IRF industry standard for measuring patient functional status and functional gain -- from admission to discharge -- has been the Functional Independence Measure (FIM).[2] FIM measures a patient's motor function (*i.e.*, mobility, self-care) and cognitive function. The FIM is part of the IRF-PAI [IRF patient assessment instrument] that is used to evaluate rehabilitation patients at admission and discharge.

According to the Medicare Payment Advisory Commission ("MedPAC"), high-margin IRFs (1) score their patients at admission as more functionally limited and (2) score their patients at discharge as more functionally improved than similar patients at other rehabilitation facilities.[3] This enables high-margin IRFs to assert that they (1) serve more challenging patients to garner higher case-mix scores (and thus higher Medicare payment) and (2) provide superior performance relative to their peers.

These anomalous reporting practices were addressed by MedPAC in both its annual March 2016 and March 2018 reports.[4] MedPAC conducted a study of low and high-margin IRF[5] and compared (1) patient acuity in acute care with (2) patient function at admission to rehabilitation. Presumably, those coded more severely impaired in acute care would, on average, also be coded more severely limited upon rehabilitation admission:

> But once patients were admitted to and assessed by the IRF, the average patient profile changed, with patients treated in high-margin IRFs appearing to be more disabled than those in low-margin IRFs (as measured by motor impairment scores assigned by IRFs). This pattern persisted across case types.

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[2] CMS intends to replace the FIM starting in FY 2020 (October 1, 2019) and instead substitute measures from what is known as the CARE Tool that will allow comparisons across all sites of post-acute care. The FIM is currently used mainly in IRFs and has been the IRF industry standard since the 1980s. The FIM is also used to develop IRF case-mix groups for Medicare payment purposes.

[3] MedPAC. "Inpatient Rehabilitation Facility Services." Chapter 10. March 2018 at 267-290; especially at 274-76.

[4] See MedPAC March 2018 report, Chap. 10 at 274-75, in particular.

[5] For-profit IRFs had Medicare margins of 23.9% in 2016. MedPAC found that Medicare payments exceed marginal costs by a substantial amount, 40.9% for freestanding IRFs—most of which are for-profit, and among free-standing, for profit IRFs, over half are owned by Encompass Health. (Source: MedPAC).

Thus, MedPAC found that FIM scoring among high-margin IRFs at rehabilitation admission was out of sync with how patients were coded in acute care. Those counted as less severe in acute care were counted as more severe in rehabilitation among high-margin IRFs.[6] MedPAC findings create reasonable doubts about the use of ERH's data on quality for comparison with other IRFs.

These anomalies also affect other data on which ERH relies to advance its claim to superior results. For example, ERH claims it has superior "PEM" scores.[7] Yet, because the underlying measures of patient functional disability and outcomes are in question, as noted above, ERH's PEM scores are also in doubt.

MedPAC's doubts about high-margin IRF coding and scoring methods brings into question whether ERH is truly a low-cost provider, as it claims,[8] because it is not possible to know whether the mix of patients ERH treats is truly comparable to those treated by other providers. In addition, by using various national and local cost and payment averages (*e.g.*, App. at 40), the application masks other underlying cost differences. For example, ERH's rehabilitation facilities are located predominantly in the South where land costs are typically less than the national average. ERH's cost profile may also be lower because it prefers to locate its facilities in suburban or exurban areas where land is cheaper and away from core urban areas where land is costlier. Thus, ERH's national location strategy requires less capital outlay and makes its national cost comparisons less valid.

[6] See also MedPAC blog. For a more detailed discussion of how MedPAC conducted its study, see Appendix ("Apx.") 1.
[7] PEM = Performance Evaluation Model. PEM is defined as a case-mix and severity-adjusted metric that provides a composite performance score developed by UDSMR. PEM scores include the following variables: (1) discharge FIM score; (2) FIM gain from admission to discharge; (3) length of stay efficiency; (4) discharge to community; and (5) transfers to acute care.
[8] See App. at 8, 40, 41, 48, 58-60, 65 and 69.

Examples of how this skews the results of ERH's efforts to promote itself as a quality care, low cost provider are illustrated at section (a) on page 40 of the application where ERH claims that an average per diem Medicare payment at its Chesapeake Hospital was nearly 15% lower than at NRH, and section (b) on page 67, where ERH alleges that the cost for a rehabilitation stay for a stroke patient at NRH was 20% higher than the cost for a similar stay at ERH's Chesapeake facility. These are invalid comparisons for the following reasons:

1. The application overlooks wage differences between urban Washington, D.C. and non-urban Salisbury area. According to CMS, the FY 2019 wage index for Washington, D.C. is 1.0137 for Washington, D.C. and 0.9280—a 9.2% difference. Medicare payment takes wage differences into account.

2. Because of urban density, MedStar NRH is located in a multi-story building with multi-level parking, not in a semi-rural area that allows for one-level construction on vastly cheaper land and thus lower capital costs.

3. The comparison fails to take case-mix into account—and given doubts about Encompass Health's case mix classification, there is even more reason to question the validity of the comparison. We refer again to MedPAC's March 2016 and 2018 reports in which MedPAC challenges the reliability of case-mix scoring conducted by high-margin IRF providers such as Encompass Health especially with regard to stroke patients.

The above examples reflect just a few of the ways in which ERH's data has been used as justification for claims that the data cannot truly support. Analyses based on this data should be disregarded in determining whether ERH has met its burden of proof to obtain a CON.

B. ACCESS

Because ERH seeks to justify its application on the basis of barriers to access, it is incumbent on ERH to "present *evidence* to demonstrate that barriers to access exist for the population in the service area of the proposed project, *based on studies or other validated sources of information*." COMAR 10.24.09.04B(1). ERH must then demonstrate a credible plan to address those barriers, also based on supporting evidence from research studies and empirical evidence. ERH has not met either of these tests.

ERH claims that the following barriers to access exist: inequitable distribution of acute rehabilitation beds, limited options in the region, travel time hardship, travel time discouragement of family engagement, underutilization/low use rates and disruption of continuity. *See* App. at 112 - 124. Nowhere however does ERH provide the type of evidence mandated by the State Health Plan to demonstrate the existence of any of these so-called barriers.

1. **Inequitable distribution**.

ERH claims that a maldistribution of beds is demonstrated by the higher population-to-bed ratio in the Southern Maryland Region, as compared to other Maryland regions. (App. at 115). ERH's evidence does not account for the normal travel patterns of the residents of this Region to acute inpatient rehabilitation providers, other specialized inpatient health care services and employers in both Washington, D.C. and Montgomery County. Further, ERH's data ignores the rehab services provided by NRH. According to the applicant, in CY 2016, 36% of MNRH's patients were residents of the Southern Maryland Region. *See* App. at 23, 33. When some proportion of MNRH's beds are included (an inclusion of 36% of MNRH's 137 beds) in ERH's calculations of population to bed ratios, a much more equitable distribution is apparent. When the 49 MNRH beds are included, reflecting the current Southern Maryland Region resident use of MNRH, this produces a bed to population ratio of 8.6 in the Southern Maryland Region close to the state average of 11.3. *See* Apx.2 Table 1. Importantly, ERH's analysis also excludes the beds currently available in Takoma Park, which are well within the reach of many Southern Maryland residents and would show an even more equitable distribution.

Furthermore, Table 1 also shows that rather than the Southern Maryland Region being the outlier in terms of bed availability, it is the Eastern Shore, where the only Maryland facility

owned by Encompass is the dominant market leader, that is the real outlier, with a bed to population ratio of 28.3, almost three times the state average![9]

Because MNRH, a well-respected rehab provider, is just 20 miles from the proposed new facility site, and because Southern Maryland residents routinely travel to Washington, D.C. and Montgomery County, ERH cannot demonstrate that there is an access barrier based on "inequitable distribution."

2. **Limited options**

As we have shown, acute rehab is easily available at MNRH. Another option is Washington Adventist Rehabilitation Hospital at Takoma Park, soon to be relocated and expanded with 42 beds at White Oak,[10] which is also very close to the proposed site (both less than 20 miles according to MapQuest). *See* Apx. 3. These are well within a reasonable travel time for a specialized regional service.[11] These additional beds will be available at least 12 months before the completion of ERH's proposed facility (and possibly more considering the normal delays in projected construction completion dates).

The residents of the proposed service area who live in the southern zip codes of Anne Arundel County have reasonable access to these two providers as well as to the providers in the Central Maryland Region, in which all of Anne Arundel County resides. MNRH is no less convenient than the proposed Bowie site for most of the Southern Maryland region or the southern Anne Arundel County portion of the proposed service area.

[9] Health South Chesapeake had 59 licensed beds in CY 2016, and has 64 licensed beds as of October 2018, with plans to add ten more beds through a pending CON application, filed October 5, 2018. That application states that the facility would then be licensed for 74 beds, with a physical capacity for 80 beds, if the expansion is approved. That would result in as many as 100 rehab beds on the Eastern Shore.

[10] *See* MHCC Docket No. 19-15-2428.

[11] The State Health Plan states that for specialized services, including acute inpatient rehabilitation, the public is best served if a limited number of hospitals provide specialized services to a substantial regional population base (p.3).

3. **Travel time**

The application states that travel time is also a barrier due to the related "costs and family hardship," and that "many families choose to sacrifice the rehab component because the commute is simply unworkable." There is no supporting evidence for any of these claims as this standard requires, and even if there was, this would be true regardless of whether the rehab facility was at MNRH, PGHC, or Bowie.

Further, the travel data presented by ERH is misleading. The application states that drive time for some residents of the proposed service area to MNRH is between 60-100 minutes (App. at 116). The data in the application, however actually shows that travel time to MNRH from Prince George's County is only 38 minutes, and between 56 and 106 minutes for the rest of their proposed service area (App. at 43, 121).[12] This data, combined with the number of patients that already travel to MNRH or Montgomery County for acute rehab, refute ERH's purported "evidence of demand" for a new facility. Moreover, ERH has presented no evidence, such as research studies – as it must in order to prevail -- of any hardship due to these travel patterns.[13]

4. **Poor family engagement**

The application states that travel time/distance discourages family engagement, but no evidence, much less persuasive evidence of this has been presented. If there is a lack of family engagement, it is just as likely that the new location would have no significant impact. Furthermore, distance from home and convenience factors have presumably already been accounted for through the process of patient choice and family involvement in decisions about

[12] From Charles County, MNRH is actually closer by 4 miles.
[13] No actual evidence of hardship, either in cost or in 'family hardship', was provided. For a regional service, the proposed improvement in travel time is meaningless. (App. at 43). Rehabilitation is considered a regional service, with expected longer travel times.

where to go for post-acute care. For example, if a patient has selected a particular rehabilitation services provider that happens to be further from their personal residence than another, it is understood that distance is not a factor, which helps to explain current outmigration patterns. A Southern Maryland resident whose loved ones work in the District may choose MNRH despite its distance from their home, because the family member already travels to the District for work, and is more available to visit the facility during their lunch break, or after work, and thereby able to participate in family training when 9-5 staff are onsite at the facility. Again, there is no "proof" sufficient to establish access barriers for purposes of a Certificate of Need.

5. **Underutilization/ low use rates**

The application states that underutilization of acute rehabilitation is a result of these excessive travel times, and that this discourages people who might benefit from using acute rehab. First, low use rates are not a barrier to access, they would be the *result* of some barrier. [14] ERH's argument is just a restatement of the previously unsupported claim of a lack of available beds within the relevant geographic boundary. Second, ERH cites no validated evidence to support its claim that a significant number of Southern Maryland residents are 'discouraged' from using acute rehabilitation services. *See* App. at 118.

The application also states that use rates in Southern Maryland are markedly lower than other Maryland counties. A closer look at these use rates by jurisdiction, however, shows a different story. As shown in the application (App. at 118) and repeated in Apx. 2 Table 2,

[14] ERH's argument also does not include those residents who get rehabilitation from SNFs in Southern Maryland (App. at 117-18). Comprehensive care facilities with a skilled nursing component for rehabilitation are CON approved by the MHCC, with the understanding that they are appropriately treating those rehab patients. MHCC makes no distinction between the number of patients that are appropriate for SNF rehab, and those appropriate for IRF or hospital-based rehab.

Maryland's average use rates include very high use rates on the lower Eastern Shore, where the other Encompass facility, HealthSouth Chesapeake, is located. While notably higher in the 18-64 age group, it is the 65+ age group use rates on the lower Shore that are significantly out of line with the rest of the state. The Southern Maryland use rate of 4.4 discharges per thousand population for the 65+ age group appears consistent with the state average of 6.7. *See* Apx. 2 Table 2. This might suggest underutilization everywhere except the lower Eastern Shore and Allegany County, as the applicant believes. Alternatively, it could suggest that Eastern Shore use rates are evidence of OVER utilization. Thus, instead of the claimed underutilization in Southern Maryland having "serious implications for quality of care" (App. at 118), a case could be made for significant overutilization on the lower Eastern Shore. The State Health Plan states that over-utilization, as well as under-utilization, should be discouraged. (SHP at 6).

Note that while these six lower Eastern shore counties[15] account for just 4.8% of the state's population, they account for 14% of the state's adult (18+) rehabilitation discharges. For the 65+ population, the difference is even more striking. The six lower shore counties account for 6% of the State's population, and 19% of the State's rehabilitation discharges.

Appendix 2 Table 3 shows the same information, excluding the six counties of the lower Eastern Shore with very high use rates. This demonstrates a drop in the state average use rate for the 65+ population from 6.7 discharges per 1,000 population to 5.8 discharges per thousand, again showing that Southern Maryland seniors use rate of 4.4 is not inappropriately low. The other age categories are not significantly affected. As a possible reason for these low use rates (other than higher use of SNFs), the application states that 'clinicians and social workers *may not* be strongly promoting rehabilitation care at an IRF" (App. at 117). It is impossible for the

[15] Caroline, Dorchester, Somerset, Talbot, Wicomico and Worchester counties.

applicant to produce data to support their assertion that clinicians and social workers are not strongly promoting rehabilitation care at an IRF, since an analysis of referrals to IRF and SNF and admission rates compared to available benchmarks would be necessary. Hospital systems that operate IRF beds do have access to such data, which suggest consistent trends in IRF referrals per bed within the MedStar system, refuting the applicant's claim. This interested party believes strong promotion of rehabilitation care at an IRF is more easily achieved in acute care hospitals affiliated with hospital systems that operate IRF beds themselves, since ongoing education about the benefits of IRF is critical, especially when considering frequent turnover of case management staff in acute hospitals. In short, ERH's suppositions on the matter do not constitute evidence.

6. **Disruption in continuity**

The application claims that dependence on out-of-area providers can result in breaks to continuity of care and less effective care management. (App. at 119). The applicant did not document this as a barrier, or provide any actual evidence or research studies supporting this claim.

In any event, it is not the use of out of *area* providers that results in continuity problems. Instead, the problem is a result of out of *network* providers, which lack common methodologies and procedures for treating patients. When MedStar patients, for example, go to MNRH, they stay within the MedStar system by choice, maintaining continuity (and benefit from a world class rehab provider). MedStar Health believes that patients benefit from care within one system from a variety of perspectives, importantly, the following:

- Continuity among providers who work together consistently and whose experience and expertise are familiar to each benefits the coordination of care between subspecialties;
- Ready, ongoing communication of specific patient details between providers through a common medical record facilitates prompt, effective and efficient care;

- Transitions between levels of care - at familiar sites of service (i.e., inpatient to rehabilitation to outpatient and vice versa) are smoother for providers and patients;
- 'Significant others' develop familiarity with the rhythms of care within one system, making navigation more manageable and comfortable; and
- Cost-savings accrue through greater efficiency in patient management and less redundancy in testing, travel and billing processes.

Quality of care suffers, however, when patients must navigate between disparate providers, who are unfamiliar with one another, use different documentation systems, and do not properly communicate. These and similar circumstances can lead to duplicative services, and confusion and distrust among providers and patients -- ultimately driving up costs for the patient and the health care system overall. ERH's proposed Project would suffer just these shortcomings, as it would be a stand-alone facility lacking direct, same-ownership affiliation with referring facilities.

We note also that MNRH currently operates six outpatient sites in the Southern Maryland Region, offering rehabilitation services in Hollywood, Clinton, Mitchellville, Oxon Hill, Hyattsville and Brandywine, as well as two hospital locations in St. Mary's County and in Prince George's County, and multiple other outpatient sites in Washington, D.C., Montgomery County, and elsewhere in Maryland and Virginia, evidence that a coordinated system of care already exists for rehabilitation patients in the Southern Maryland Region.

C. NEED

1. Failure To Meet Project Review Standards

The State Health Plan standard provides that a project shall be approved "only if a net need for adult acute rehabilitation beds is identified by the need methodology." COMAR 10.24.09.04B(2). Parts (a) and (b) of this standard require consideration of the identified bed

need in the Region, and in the "contiguous regions or states" based on cross-regional or cross-state migration patterns. *Id.*

ERH fails to address the current need prong of subpart (a) of the standard because the application states only that need is defined to include Southern Anne Arundel County. ERH has not -- as it must-- addressed need in the contiguous regions or states, which would include Washington, D.C., Montgomery County and Central Maryland. *See* Apx. 2 Table 4. In Montgomery County the State Health Plan projects an excess capacity of eight beds at the minimum range. The Central Maryland Region has excess capacity of 36 beds. (App. at 124). There is no projection for acute rehab beds in Washington D.C., but the average rehab occupancy rate shown in the application as 61% in CY2016 was 69% when corrected for MNRH's actual number of licensed beds. Therefore, there is nothing in the contiguous regions that would support the need for the proposed new facility, and in fact strongly suggests that there is no need for a new one.

As for subpart (b) (how assumptions of in- and out-migration affect the applicant's need projection), ERH claims that the goal of its proposal is to reduce outmigration. But to demonstrate how it might achieve this goal, ERH assumes a decrease in outmigration only to Washington, D.C. rehab providers. No evidence is presented regarding reducing outmigration from Montgomery County or Central Maryland, suggesting that ERH's projections are illogical, incomplete or simply contrived to support the theme of ERH's application. Residents of the Southern Maryland region traveled to Montgomery County and Central Maryland in significant numbers, as well as to Washington, D.C. and Virginia for acute rehabilitation, as shown in Apx. 2 Table 5.

ERH also fails to satisfy Part (c) of the need standard which requires it to show why outmigration is due to access barriers and demonstrate a credible plan to mitigate the barriers to access identified. COMAR 10.24.09.04B(2)(c). The fact is, outmigration to Washington, D.C. is part of normal commuting patterns in the Washington metropolitan region and is not attributable to an access barrier. Although ERH claims that a major goal of the project is to reduce outmigration to other regions "in order to relieve travel hardships" and to "support greater continuity of care," App. at 125, ERH has not shown the existence of any travel hardships that would rise to the level of an access barrier, and certainly nothing that locating a facility in Bowie would solve.

Part (d) requires the same documentation of access barriers when a proposal is not clearly consistent with the projected need. ERH claims that because the maximum need is more appropriate than the minimum need, this requirement is not applicable to their project. App. at 126. However, the requirement in part (c) of this standard requires identification of actual barriers to access in order for anything above the minimum need to be applicable. As described above, the application fails to identify and document any barriers to access.

The application states that the maximum need, based on *statewide* average use rates rather than *regional* use rates, is appropriate for several reasons:

- because ERH's goal is to reduce outmigration and improve access and increase utilization;
- because the regional use rates are too low;
- because projected demographic growth and 'new patient populations' support using the maximum need; and
- because they assume that migration patterns will change significantly if a new facility is built.

App. at 125 -127.

None of these 'reasons,' however, are either proven, or advisable. None provide clear justification for using maximum bed need over the minimum need, particularly considering available capacity in surrounding regions and Washington, D.C., in area SNFs, and the complete lack of evidence of access barriers.

2. Volume Projections

The burden of proof for demonstrating need is on the applicant. In a CON review, the identified bed need, as well as the veracity of the applicant's volume projections, are the core of the process. Among the unsupported claims made in the application, volume projections are among the most troubling. While ERH presents volume projections to support the number of beds proposed, it has not shown that those volume projections are likely to be achieved. ERH's volume projections are described in four categories as shown in Apx. 1 Table 6. These categories are 1) shifting existing volume from existing providers to reduce outmigration, 2) shifting volumes from SNFs to 'increase rehab use rates', 3) population growth, and 4) tapping into 'new markets', such as direct admits, organ transplant patients and out of area patients. (App. at 50-51).

a. *Shifting Volume from Existing Providers (Reducing Outmigration)*

ERH's volume projections are primarily based on redirecting volume from existing acute rehabilitation providers in Washington. ERH states that it will reduce outmigration to Washington D.C. by 341 discharges annually, primarily from MNRH. However, the application presents little or no support for this claim. This assumption is not backed up with evidence that either these established travel patterns are really a true 'hardship' or that they can actually change them at the numbers projected. Seeking care at MNRH is consistent with established travel patterns for care (as well as for work and recreation). ERH offers no reason why this

pattern should change, nor does it provide a credible plan for changing current migration patterns. ERH offers no evidence that any physician or discharge planner would change referral patterns to the extent suggested by the applicant. Without such evidence, there is no reason why any of the 341 cases claimed by ERH should be accepted.

ERH also ignores outmigration to the large rehab provider in Montgomery County, as well as outmigration of residents in the southern Anne Arundel County portion of MHCC's Central Maryland Region to rehab providers in the Central Maryland Region. Because the proposed service in Southern Anne Arundel County is part of the Central Maryland Region, ERH should have addressed how Southern Anne Arundel County residents use Central Maryland Region providers, as well as providers in Washington, D.C. or Montgomery County, including use of Adventist Rehabilitation Hospital by Southern Maryland Residents. By failing to do so, ERH's projections are, at best, incomplete.

b. *Shifting Volume from SNFs*

ERH's claims of SNF volume shifts of as many as 418 cases are also not supported with evidence. No evidence has been presented that rehab care currently provided at area SNFs is inappropriate, that SNF patients would generally have preferred another setting, or that any physicians or discharge planners would change referrals to the extent suggested by the applicant. The application's only evidence as to the desirability of shifting volume away from SNFs to IRFs is highly questionable. Its main source is a report by Dobson & DaVanzo Associates (App. at 68), a consulting firm in Vienna, Virginia that advertises its claimed ability to "influenc[e] public policy decisions" and provide "litigation support."[16]

[16] Website accessed 7 March 2019, www.dobsondavanzo.com.

ERH also cites a study prepared by Encompass Health, Blue Health Intelligence and a national accounting firm (unnamed) showed that use of Encompass Health's IRFs was considerably more cost effective than the average SNF as measured by the total cost of care and as measured by hospital readmissions." This study is difficult to evaluate absent a copy of the study and its methodology. It appears to be a proprietary study that is not in the public domain and has not been peer-reviewed for publication. And absent a randomized trial, propensity scoring, or systematic evaluation of various patient covariates, we do not know if study SNF and IRF stroke patients were even roughly equivalent for comparison purposes. Moreover, given the long shadow that MedPAC reports have cast on high-margin IRF's patient classification and scoring, we have even more reason to be cautious about such comparisons.

In addition, the MHCC has routinely granted CONs for SNF beds in nursing homes for rehab services. We question the consistency of a CON decision that would contradict that policy by suggesting that the SNF beds are not an appropriate site of care. Without such evidence, all, or at least some portion of these 418 cases should be rejected.

c. *Population Growth*

ERH's projections of increasing volume are also based in part on projected population growth, calculated separately for the IRF and SNF populations, as shown in Apx. 2 Table 6. ERH's claim that rehabilitation admissions will increase as population increases (p.34-35) is unfounded, as no evidence of such a potential change is presented. The application shows historical trends with no growth in rehab admissions between 2012 and 2016 *see* App. at 22, despite population growth. There were 12,479 discharges in CY 2016, down from 12,906 in CY 2012. *See* Apx. 2 Table 7. Given that capacity exists in Washington, Montgomery County and Central Maryland for any patient needing acute rehabilitation, it appears that rehabilitation use

has not historically been a function of population growth. Therefore, the projected 377 new cases due to population growth can be rejected.

d. *Organ Transplants and New Markets*

ERH claims that organ transplants and "new markets" in the form of direct admits from the community and EDs will produce up to 85 new cases. First, no evidence is presented that targeting Medicare transplant patients, ER patients, or direct admits, is appropriate or necessary, or even that these would be 'new cases' rather than just redirected cases that otherwise would have been admitted elsewhere. Second, transplant cases needing rehabilitation are typically treated on an outpatient rather than inpatient basis. Third, admits from ED are extremely rare. MNRH, located across the street from a very busy urban ED and Level 1 trauma center within the same health system, rarely gets direct admits from such facilities.

e. *Maryland's Total Cost of Care and Federal Payment Policy*

Another critical flaw in ERH's volume projections is ERH's failure to adequately consider the impact of changes in post-acute payment policy at both the state and federal levels. First, shifting 418 SNF-appropriate cases annually to higher cost IRFs will certainly increase the cost per case. The applicant's claim of an off-setting lower length of stay does not account for specific case mix comparisons and therefore must be rejected. Second, the applicant's plan to help fill its beds with 'new cases' will significantly increase the total cost of care. And, if the applicant increases use rates consistent with its historical approach on the Lower Eastern Shore, as demonstrated above, the Total Cost of Care will increase even more.

Finally, state and federal payment policy changes will soften, not increase, the demand for IRF care. At the state level, all indications are that as Maryland's Total Cost of Care all-payer model expands (Phase II waiver), it will increase acute hospital system incentives to

bypass IRFs in favor of lower-cost post-acute providers such as SNFs, home health, and outpatient care. At the federal level, CMS continues to ramp up its bundled episode-based payment program. One pattern already seen is the manner in which bundled payment patients are being channeled away from costlier post-acute care venues such as LTCH's, IRFs, and SNFs to less costly settings such as home care and outpatient rehabilitation.[17,18] One study found that, among joint replacement patients, for example, the single largest cost reduction was in the use of post-acute care.[19] While largely "experimental" in recent years, bundled payment arrangements are expected to expand rapidly going forward.[20]

More ominous for IRFs, however, is the federal government's push toward "site-neutral" post-acute payment in which Medicare will pay more based on clinical characteristics of the patient and less on the features of a particular care setting. We are likely to see a shift from IRFs to SNFs as site-neutral payment systems favor SNFs. MedPAC has been relentless in promoting the concept of site-neutral payment for post-acute care and it is expected to become policy in one form or another.[21, 22]

At both the national and state levels, the Medicare Advantage program continues to increase Medicare market share. Nationally, Medicare Advantage enrollment has doubled over the last decade and now enrolls 34% of the Medicare beneficiaries (as of 2018). In Maryland, Medicare Advantage enrolls only 11% of Medicare beneficiaries and has room to grow relative

[17] Aaron Glickman, Claire Dinh, and Amol Navathe. "The Current State of Evidence on Bundled Payments: Effects on Cost, Quality, Access, and Equity." *Issue Brief,* October 8, 2018, Vol. 22, No. 3., p. 5. Accessed March 3, 2019.
[18] Avalere. "Bundle Payments: Implications for Providers." November 2015, p. 10. Accessed March 3, 2019.
[19] Amol S. Navathe, Andrea B. Troxel, Joshua M. Liao, *et al.* "Cost of Joint Replacement Using Bundled Payment Models." *JAMA Internal Medicine.* 2017;177(2):214-222. doi:10.1001/jamainternmed.2016.8263.
[20] Michel D. Dalzell. "2019 Year in Preview: Why Bundled Payments are Poised to Take Off." *Managed Care,* November 25, 2018. Accessed March 3, 2019.
[21] MedPAC, March 2018 report, pp 187-199).
[22] The bi-partisan IMPACT Act of 2014 also calls for a study of a site-neutral post-acute payment system signaling Congress' interest in such a payment system.

to national enrollment rates. Medicare Advantage plans are known to use less post-acute care overall and when they do use post-acute care, they use less institutional-based care (e.g., IRF and SNF care and more home care).[23, 24]

For all these reasons, we believe that changes in both the state and federal level will adversely affect the applicant's volume projections—changes that the applicant does not take adequately take into account and thus fails to demonstrate consistency with State Health Plan standard .04B(2).

D. IMPACT

Part (d) of SHP standard B(3) [COMAR 10.24.09.04B(3)] requires the applicant to support, with documentation and analysis, its estimate of the impact of its proposal on the ability of existing providers to maintain the necessary specialized staff.

ERH claims that it can staff the facility through its network of providers, and not impact existing local providers. ERH, however, offers no evidence to support this claim. Indeed, there is substantial evidence refuting this claim. Nationally, Encompass has posted 914 nursing vacancies. They offer sign-on bonuses of $5,000 to $10,000 for registered nurses and therapists to incentivize them to leave their current employers, which include existing providers of IRF services who are already challenged with recruiting staff to deliver this intense level of specialty services in this tight labor market. Appendix 1 Table 8 also shows 2,056 positions nationwide as of March 12, 2019, with large numbers of those in nursing, physical and occupational therapy. Looking more locally in Virginia, Pennsylvania, Delaware, Maryland and New Jersey facilities,

[23] Fred Bentley and Erica Breese. "Medicare Advantage Patients Less Likely to use Post-acute Care." Washington, DC. May 9, 2017. Accessed March 2, 2019.
[24] Peter J Huckfeldt, Jose J. Escarce, Brendan Rabideau, Pinar Karaca-Mandic, and Neeaj Sood. "Less Intense Postacute Care, Better Outcomes for Enrollees in Medicare Advantage than Those in Fee-for-Service." *Health Affairs*, January 2017, 36:1, 91-100.

there are a significant number of vacant positions in the Encompass facilities here too. See Apx. Table 9.

IRFs like MNRH make a commitment to provide a higher level of patient care, and therefore must successfully recruit and retain a variety of types of medical professionals who are in scarce supply. By adding licensed rehabilitation beds in the Washington D.C. Metropolitan Area, the proposed facility will only add to the shortage of nurses. The number of inpatient rehabilitation nursing job openings posted on the Encompass website is evidence of this crisis. While MNRH invested significant resources to be part of the solution by creating a summer nurse extern program and training new graduates to become rehabilitation nurses, Encompass's plan would impede MedStar's ability to realize a return on these investments.

With substantial problems staffing their own existing facilities, how then can ERH expect to staff a new facility without poaching staff members of existing facilities? The truth is, the proposed project will negatively impact MedStar/MNRH'S ability to maintain staff. Not only will it compete for very scarce clinical staff, it will also unnecessarily duplicate non-clinical staff, adding to the total cost of care. This State Health Plan standard recognizes the importance of maintaining optimal staffing levels of highly trained clinical professionals. Therefore, MHCC should reject this application, as the applicant has not and cannot demonstrate that the proposal will not have an unwarranted adverse impact on the ability of existing providers to maintain optimal staffing levels.

E. FINANCIAL FEASIBILITY

To demonstrate that its proposal is financially feasible, an applicant is required to submit financial projections and documents demonstrating that (a) its utilization projections are consistent with historic trends; (b) its revenue projections are consistent with utilization projections and based on current data; (c) its staffing and expense projects are consistent with

utilization projects and are based on current data; and (d) the hospital will generate net income if the applicant's utilization forecast are achieved within five years. COMAR 10.24.09B(6); *see also* 10.24.01.08G(3)(d)(Viability of the Proposal).

As described above, the applicant's utilization projections are significantly overstated. If ERH does not achieve the volumes it projects, it cannot meet its financial projections and thus the financial feasibility for this proposal is not demonstrated. Revenue projections also do not account for potential changes in state and federal reimbursement policy that will affect this facility in the near future, if built. This omission is inconsistent with the State Health Plan, which states:

> Due to recent and anticipated changes that may significantly alter the capacity required for acute inpatient utilization, a need projection based on historic patterns should not be the sole factor used to determine whether additional acute inpatient rehabilitation capacity is required (SHP at 6).

F. NEED (COMAR 10.24.01.08G(3)(b))

The Commission set a precedent in a similar case resulting in a negative finding under this criterion on need, and the following criterion (3(c)) on cost effective alternatives. *See* Harford Memorial Hospital, Docket No 12-12-2335, Recommended Decision dated August 23, 2013.

In *Harford,* a proposal to establish an acute inpatient rehabilitation service in the Central Maryland Region was based on closure of another acute inpatient rehabilitation provider in the region, as in this case. It was also based on use rates, suggesting that a significant number of area residents were receiving care at area comprehensive care facilities' SNF units specializing in rehabilitation. Demonstration of need by the applicant was based on low use rates of acute inpatient rehabilitation, and on the expressed desire for better geographic distribution, calling the

travel time to Baltimore, where there are a number of acute rehab providers, an 'extraordinary hardship.'

However, as in this case, the applicant provided no analysis or documentation of this hardship, nor were normal commuting patterns of area residents considered. In *Harford,* the applicant claimed that acute rehabilitation could not be provided effectively in the SNF setting, and the resulting underuse of acute rehabilitation in the proposed service area resulted from inadequate accessibility of existing providers (Decision at 46).

The Commission found that because the new provider would not have "a meaningful improvement in access (travel time) for most of the affected population," travel time was not a barrier to access. The applicant could not provide any evidence that outcomes were substantially better in an acute care setting than in the SNF setting. The Commission found that the applicant had not demonstrated an unmet need, that access was reasonable in terms of travel time, that there was no great disparity in use rates between the Harford County area and the statewide average, and also that any unmet need could be met more cost effectively by utilization of the excess capacity of existing programs. (Decision at 47 and 61-2). Similar findings here would be appropriate.

G. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

This criterion requires the Commission to compare the cost effectiveness of the proposed project with the cost effectiveness of providing the services through alternative existing service providers. *See* COMAR 10.24.01.08G(3)(c). In this regard, ERH claims that:

- Utilizing Laurel Regional Hospital or the new PGHC are not viable alternatives, and that the chosen location for a new freestanding facility is ideal for the targeted patient populations in Southern Maryland and southern Central Maryland;
- Many hospitals do not have or will not sacrifice space for acute rehab; and

- A PGHC opportunity "does not exist" since the new PGHC was "required to downsize."

See App. at 58-60.

1. **Other Options**

If PGHC is to be the applicant's largest referral source, as stated in the application, then adding space to that hospital in the construction phase would be significantly more cost effective than a whole new facility. New construction adds infrastructure costs not incurred by the use of existing facilities. The Commission has already allowed Washington Adventist Hospital to do what ERH claims is not possible. Adventist has received approval to modify its CON for a replacement hospital to accommodate a new floor for acute inpatient rehabilitation service that had originally been planned to remain elsewhere. There is no reason to believe the same is not possible in this case -- the new PGHC could also make cost effective space for a state-of-the-art rehabilitation unit to fully utilize the Laurel rehab beds that have been temporarily delicensed. With UMMS as a partner, the cost effectiveness of this should have been explored.

2. **No evidence of capacity constraints or access barriers**

Promoting new utilization, as the application describes, absent proof of barriers to access in this regard, is not cost effective. Existing occupancy rates show that there is sufficient capacity in Washington D.C., Montgomery County and, for residents in the Anne Arundel portion of the proposed service area, in the Central Maryland Region as well. New construction is not cost effective when excess capacity exists in the acute rehab settings that already serve residents residing in the two regions. Investing in new building and services, when there is capacity in existing facilities, increases overall healthcare costs. Reimbursement differences is not sufficient reason for new construction, particularly when reimbursement policy can, and soon will, address these differences. Duplicative infrastructure and capital costs would create

inefficiencies for all facilities and undermine the efforts to reduce the total cost of care. Finally, MHCC's decision in the *Harford* matter (discussed earlier) found that a proposal similar to the one now offered by ERH was *not* cost effective.

III. CONCLUSION

For all the foregoing reasons, Interested Party MNRH respectfully requests that the requested Certificate of Need by denied.

Respectfully submitted,

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March 18, 2019

CERTIFICATE OF SERVICE

I hereby certify that on March 18, 2019, a copy of the foregoing was served by e-mail and first-class mail on:

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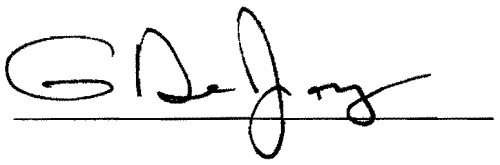
Affirmation

"I hereby declare and affirm under the penalties of perjury that the facts stated in this document are true and correct to the best of my knowledge, information, and belief."

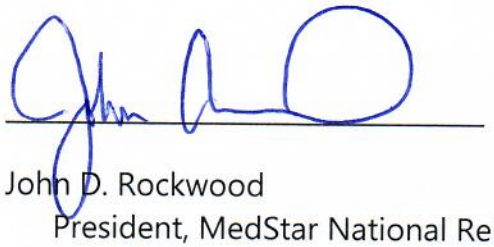


March 18, 2019

Gerben DeJong (date)
Senior Fellow for Health Policy & Post-acute Care
MedStar Health

Affirmation

"I hereby declare and affirm under the penalties of perjury that the facts stated in this document are true and correct to the best of my knowledge, information, and belief."



3/18/19

John D. Rockwood
President, MedStar National Rehabilitation Network
Senior Vice President, MedStar Health

(date)

Affirmation

"I hereby declare and affirm under the penalties of perjury that the facts stated in this document are true and correct to the best of my knowledge, information, and belief."

PJ Cameron

18 MARCH 2019

Patricia G. Cameron
Director, Regulatory Affairs, Maryland
MedStar Health

(date)

Appendix 1

MedPAC Study on High-margin IRF
Coding & Scoring

In preparing for its annual March reports in 2016 and 2018, MedPAC conducted a study that compared (1) patient acuity in acute care with (2) patient function at admission to rehabilitation. Presumably, those coded more severely impaired in acute care would, on average, also be coded more severely limited upon rehabilitation admission.

> ". . . we [MedPAC] examined patient characteristics in the IRF and in the preceding acute care hospital stay by patients' type of condition, as coded by the IRF at IRF admission. Our approach allowed us to compare patient characteristics as coded in the acute care hospital with those coded in the IRF. Ideally, we would evaluate IRF patient characteristics by comparing IRF patient assessment data with complete patient assessment information recorded for the beneficiary during the preceding acute care hospital stay. However, because acute care hospitals do not submit patient assessment data to CMS, no such data exist. Nevertheless, though acute care hospital claims data do not provide information about a patient's motor function and provide only limited information about a patient's cognition, they can tell us about patients' diagnoses, severity of illness, and relative resource requirements during the hospital stay preceding admission to the IRF.
>
> "Overall, when we compared patients in high-margin and low-margin IRFs, we found that patients in high-margin IRFs were less severely ill and resource intensive during the acute care hospitalization that preceded the IRF stay:
>
> - Patients in high-margin IRFs had, on average, a lower case-mix index in the acute care hospital as well as a lower level of severity of illness and a shorter length of stay.
> - Patients in high-margin IRFs were less likely to have been high-cost outliers in the acute care hospital or to have spent four or more days in the hospital intensive care or coronary care unit.
>
> But once patients were admitted to and assessed by the IRF, the average patient profile changed, with patients treated in high-margin IRFs appearing to be more disabled than those in low-margin IRFs (as measured by motor impairment scores assigned by IRFs). This pattern persisted across case types.
>
> "We found that the difference in average motor impairment scores between high-margin and low-margin IRFs was particularly wide for stroke cases with no paralysis: Cases in the highest margin IRFs had a motor impairment score that was 18 percent lower, on average, than cases in the lowest margin IRFs. (In IRFs, motor impairment is measured using a 13-item Functional Independence Measure™ (FIM™) scale to assess the level of disability in motor functioning and the burden of care for a patient's caregivers. Lower scores indicate greater disability and generally result in higher payment.) Indeed, in 2013, nonparalyzed

stroke patients in the highest margin IRFs had an average motor FIM score (29.0) that was almost the same as the average motor score of paralyzed stroke patients in the lowest margin IRFs (29.2) (Table 10-3).

Table 10-3 from MedPAC March 2018 Report
Nonparalyzed stroke patients in the highest margin IRFs had the same average FIM motor impairment score as stroke patients with paralysis in the lowest margin IRFs, 2013.

Type of stroke case	Average FIM motor impairment score	
	Lowest margin IRFs	Highest margin IRFs
With paralysis	29.2	24.6
Without paralysis	35.3	29.0

Source: MedPAC analysis of Medicare Provider Analysis and Review data, Inpatient Rehabilitation Facility–Patient Assessment Instrument data, and cost report data from CMS. MedPAC March 2018 report, Chapter. 10, p. 275.

"This finding was surprising because stroke patients with paralysis typically have worse motor function than stroke patients without paralysis. All else being equal, Medicare's payments for these two types of stroke patients with a motor FIM score of 29 would be the same—even though stroke patients with no paralysis had an IRF length of stay that was, on average, more than two days shorter than that of stroke patients with paralysis."

In short, MedPAC found that FIM scoring among high-margin IRFs at rehabilitation admission was out of sync with how patients were coded in acute care. Those counted as less severe in acute care were counted as more severe in rehabilitation among high-margin IRFs.[1]

We recommend that regulators review both MedPAC reports—Chapter 9 in the March 2016 report and Chapter 10 in the March 2018 report.[2]

[1] See also MedPAC blog.
[2] For-profit IRFs mounted a response to MedPAC's 2016 report with a report by Dobson Davanzo & Associates. "Analysis of Variation in Medicare Margins for Inpatient Rehabilitation Facilities." Vienna, VA. Decomposition of Medicare Costs for IRFs by Margin Quintile in 2013. However, MedPAC doubled-down on its original findings in its March 2018 report and again in its just-released March 2019 report.

Appendix 2

Tables

Table 1. Rehabilitation Beds per 100,000 Population by Health Planning Region, CY 2016

Region	18+ Population	Licensed Rehab Beds	Bed to Pop Ratio
Eastern Shore*	279,236	79	28.3
Central Maryland	2,219,888	255	11.5
Montgomery County	812,040	87	10.7
Western Maryland	397,975	33	8.3
Southern Maryland	980,122	28	2.9
Southern Maryland**	980,122	84	8.6
Total w/o NRH	4,689,261	482	10.3
Total w/ NRH	4,689,261	538	11.5
Total w/o Eastern Shore	4,410,025	459	10.4

* includes 59 licensed beds at Health South Chesapeake

** with allocation of 56 MNRH beds (36% of 157)

Table 2. Adult Acute Rehabilitation Discharges per 1,000 by County and Age Group
Based on SHP Definition of Acute Rehabilitation
CY 2016

	Discharges				Population				Use Rate Per 1,000			
County	0-17	18-64	65+	18+	0-17	18-64	65+	18+	0-17	18-64	65+	18+
Caroline	1	26	65	91	7,886	20,330	5,419	25,749	0.13	1.28	11.99	3.53
Dirchester	-	40	111	151	6,706	18,495	6,473	24,968	0.00	2.16	17.15	6.05
Kent	-	14	12	26	4,366	14,141	5,980	20,121	0.00	0.99	2.01	1.29
Queen Anne's	-	23	42	65	9,710	26,672	7,797	34,469	0.00	0.86	5.39	1.89
Talbot	-	38	173	211	6,812	20,218	10,136	30,354	0.00	1.88	17.07	6.95
Somerset	-	18	66	84	4,217	15,950	3,760	19,710	0.00	1.13	17.55	4.26
Wicomico	-	130	449	579	22,275	63,537	15,035	78,572	0.00	2.05	29.86	7.37
Worcester	1	63	264	327	9,685	31,201	14,092	45,293	0.10	2.02	18.73	7.22
SubTotal: Eastern Shore	2	352	1,182	1,534	71,657	210,544	68,692	279,236	0.03	1.67	17.21	5.49
Charles	8	85	54	139	36,599	98,312	17,854	116,166	0.22	0.86	3.02	1.20
Calvert	2	49	42	91	21,464	58,742	12,748	71,490	0.09	0.83	3.29	1.27
Prince George's	16	661	559	1,220	206,094	595,173	110,357	705,530	0.08	1.11	5.07	1.73
St. Mary's	3	50	32	82	28,417	72,552	14,384	86,936	0.11	0.69	2.22	0.94
SubTotal: Southern Maryland	29	845	687	1,532	292,574	824,779	155,343	980,122	0.10	1.02	4.42	1.56
Montgomery County	23	594	944	1,538	246,181	661,182	150,858	812,040	0.09	0.90	6.26	1.89
Baltimore City	3	878	856	1,734	144,969	431,808	88,133	519,941	0.02	2.03	9.71	3.33
Baltimore County	1	650	939	1,589	169,899	494,731	131,970	626,701	0.01	1.31	7.12	2.54
Carroll	1	76	119	195	35,068	102,814	26,796	129,610	0.03	0.74	4.44	1.50
Cecil	-	23	14	37	23,638	64,176	15,029	79,205	0.00	0.36	0.93	0.47
Harford	-	162	173	335	56,319	156,841	38,009	194,850	0.00	1.03	4.55	1.72
Howard	-	173	201	374	74,885	204,839	40,647	245,486	0.00	0.84	4.95	1.52
Anne Arundel	1	308	208	516	125,370	346,116	77,979	424,095	0.01	0.89	2.67	1.22
SubTotal: Central Maryland	6	2,270	2,510	4,780	630,148	1,801,325	418,563	2,219,888	0.01	1.26	6.00	2.15
Allegany	-	34	185	219	13,006	46,453	14,817	61,270	0.00	0.73	12.49	3.57
Frederick	4	121	115	236	60,409	163,014	34,846	197,860	0.07	0.74	3.30	1.19
Garrett	-	3	16	19	5,274	16,330	5,724	22,054	0.00	0.18	2.80	0.86
Washington	2	127	224	351	32,618	92,581	24,210	116,791	0.06	1.37	9.25	3.01
SubTotal: Western Maryland	6	285	540	825	111,307	318,378	79,597	397,975	0.05	0.90	6.78	2.07
Total Maryland	66	4,346	5,863	10,209	1,351,867	3,816,208	873,053	4,689,261	0.05	1.14	6.72	2.18

Source: Application, p. 118

Table 3. Adult Acute Rehabilitation Discharges per 1,000 by County and Age Group
Based on SHP Definition of Acute Rehabilitation
CY 2016
Revised to Exclude Six Lower Shore Counties

	Discharges				Population				Use Rate Per 1,000			
County	0-17	18-64	65+	18+	0-17	18-64	65+	18+	0-17	18-64	65+	18+
Kent		14	12	26	4,366	14,141	5,980	20,121	-	0.99	2.01	1.29
Queen Anne's		23	42	65	9,710	26,672	7,797	34,469	-	0.86	5.39	1.89
SubTotal: Eastern Shore	-	37	54	91	14,076	40,813	13,777	54,590	-	0.91	3.92	1.67
Charles	8	85	54	139	36,599	98,312	17,854	116,166	0.22	0.86	3.02	1.20
Calvert	2	49	42	91	21,464	58,742	12,748	71,490	0.09	0.83	3.29	1.27
Prince George's	16	661	559	1,220	206,094	595,173	110,357	705,530	0.08	1.11	5.07	1.73
St. Mary's	3	50	32	82	28,417	72,552	14,384	86,936	0.11	0.69	2.22	0.94
SubTotal: Southern Maryland	29	845	687	1,532	292,574	824,779	155,343	980,122	0.10	1.02	4.42	1.56
Montgomery County	23	594	944	1,538	246,181	661,182	150,858	812,040	0.09	0.90	6.26	1.89
Baltimore City	3	878	856	1,734	144,969	431,808	88,133	519,941	0.02	2.03	9.71	3.33
Baltimore County	1	650	939	1,589	169,899	494,731	131,970	626,701	0.01	1.31	7.12	2.54
Carroll	1	76	119	195	35,068	102,814	26,796	129,610	0.03	0.74	4.44	1.50
Cecil	-	23	14	37	23,638	64,176	15,029	79,205	-	0.36	0.93	0.47
Harford	-	162	173	335	56,319	156,841	38,009	194,850	-	1.03	4.55	1.72
Howard	-	173	201	374	74,885	204,839	40,647	245,486	-	0.84	4.95	1.52
Anne Arundel	1	308	208	516	125,370	346,116	77,979	424,095	0.01	0.89	2.67	1.22
SubTotal: Central Maryland	6	2,270	2,510	4,780	630,148	1,801,325	418,563	2,219,888	0.01	1.26	6.00	2.15
Allegany	-	34	185	219	13,006	46,453	14,817	61,270	-	0.73	12.49	3.57
Frederick	4	121	115	236	60,409	163,014	34,846	197,860	0.07	0.74	3.30	1.19
Garrett	-	3	16	19	5,274	16,330	5,724	22,054	-	0.18	2.80	0.86
Washington	2	127	224	351	32,618	92,581	24,210	116,791	0.06	1.37	9.25	3.01
SubTotal: Western Maryland	6	285	540	825	111,307	318,378	79,597	397,975	0.05	0.90	6.78	2.07
Total Maryland	64	4,031	4,735	8,766	1,294,286	3,646,477	818,138	4,464,615	0.05	1.11	5.79	1.96

Table 4. Occupancy Rates and Net Bed Need by Region, CY 2016

Region	Beds	Occupancy CY 2016	Minimum Projected Net Bed Need
Washington, DC	173	61%	n/a
Montgomery County	87	82%	-8
Central Maryland	271	60%	-36
Southern Maryland	28	25%	-17

Source: App. at 21 and 23.

Table 5. Acute Rehabilitation Discharges for Encompass Proposed Service Area, FY 2017

Facility	CALVERT County	CHARLES County	PRINCE GEORGE'S County	ST. MARY'S County	Anne Arundel Segment	Total
MNRN	51	102	614	70	43	880
Adventist Rehab	12	14	331	7	9	373
UM Rehab & Ortho	9	18	81	6	53	167
Laurel		1	121		6	128
GW University	5	6	53	2	2	68
Johns Hopkins	5	3	22	1	14	45
Sinai		2	11	3	6	22
MGSH	1		10		9	20
Chesapeake Rehab			3		1	4
Mertius		1			1	2
Other: Virginia	10	49	128	19	10	216
TOTAL	93	196	1,374	108	154	1,925

Source: DCHA inpatient database (12/26/18); rehabilitation discharges, FY17.

Table 6. Categories of Projected Admissions and Projected Volume

Source of Admissions	Projected Volume
1) Shifting IRF Volume	
Laurel Regional Hospital	233
DC Providers	341
Montgomery County Providers	0
Central Maryland Providers	0
2) Shifting SNF Volume	418
3) Population Growth	
IRF Volume	223
SNF Volume	154
4) New Markets	
Direct Admits	75
Organ Transplant Patients	10
Out of Area Residents	46

Table 7. Adult Acute Rehabilitation Discharges, Utilization Patterns Total Maryland and Washington, DC Facilities, CY 2012 - 2016					
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Total Discharges	12,906	12,652	12,872	12,501	12,479
Total Patient Days	154,632	149,382	153,993	151,276	157,907
ALOS	12.0	11.8	12.0	12.1	12.7
Average Daily Census	424	409	422	414	433
Source: Application p.22					

Table 8. Encompass Staffing Vacancies, National

2,056 postings placed in duplicate categories	Encompass National Postings @ 3/12/19
Nursing	914
Environmental/Food Services	242
Physical Therapy	177
Occupational Therapy	120
Clinical Marketing	107
Hospital Leadership	90
Case Management	84
Speech Therapy	63
Therapy Technician	58
Pharmacy	50
Administrative/Clerical	42
Physician	31
Home Office	28
Quality	15
Human Resources	10
Clinical Leadership	8
Compliance/Risk/Workers Comp	5
CEO	4
Communications/Creative Services	2
Accounting/Finance	1
Information Technology	1
Leadership	1
Legal	1
Supply Chain	1
Clinical	123
Manager	54
Nonclinical	400
Other Clinical	73
Staff	1333
Supervisor/Manager	46
Therapy	596

* Inpatient Rehabilitation Division shows 2,056 positions nationwide as of 3/12/19

* Sign-on bonuses for RN's: $5K PA, SC, TN, AL, ME, AK, KS; $7,500 OH; $8K KY: $10K PA, VA, SC, AK, TN, KS, KY

* 23 RN positions offering a $10K sign-on bonus

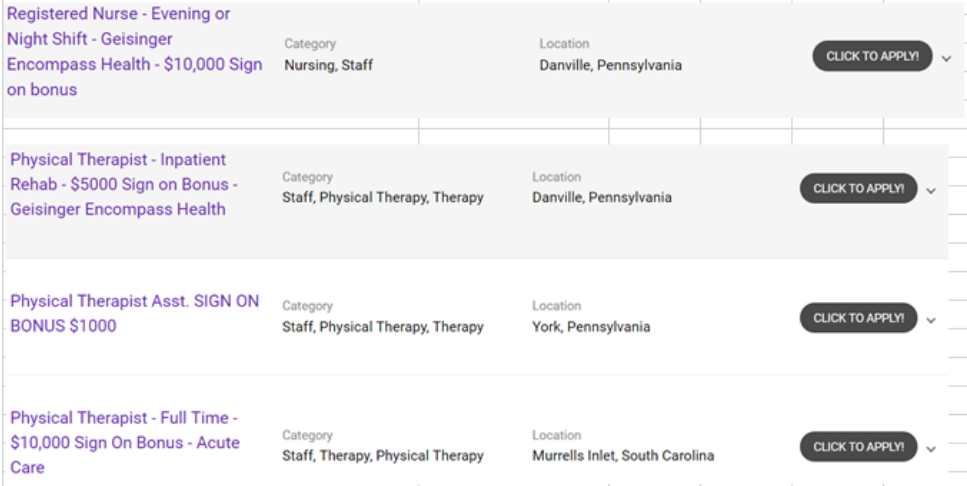


Table 9. Encompass Staffing Vacancies, Regional

	Aldie, VA	Fredericksburg, VA	York, PA	Middletown, DE	Salisbury, MD	Mechanicsburg, PA	Vineland, NJ	Reading, PA	All Area Locations
IRF Beds	60	58	90	37	64	75	50	60	**494**
Physical Medicine & Rehabilitation Physician			1					1	**2**
Rehabilitation Nurse/RN			6	1	3	4	1	2	**17**
Rehabilitation Nursing Technician	2	1	4	1	2		2	4	**16**
Physical Therapist	1	2	3			1			**7**
Nutrition Services Aide	2		2	1		1			**6**
Rehabilitation Liaison	2	1	1	1			1		**6**
Environmental Services Aide	1			1		1		1	**4**
Case Manager							1	2	**3**
Maintenance Mechanic		1			1	1			**3**
Occupational Therapist	2				1				**3**
Speech-Language Pathologist	1	1						1	**3**
Dietitian	1				1				**2**
Director of Case Management			1		1				**2**
Pharmacy Tech			1	1					**2**
Physical Therapist Assistant			2						**2**
Therapy Tech	1							1	**2**
Admissions Rep			1						**1**
Controller			1						**1**
Enrichment Therapist							1		**1**
Medical Records Clerk			1						**1**
Occupational Therapy Assistant		1							**1**
Pharmacist				1					**1**
TOTALS	**13**	**7**	**24**	**7**	**9**	**8**	**6**	**12**	**86**

APPENDIX 3

MAPS

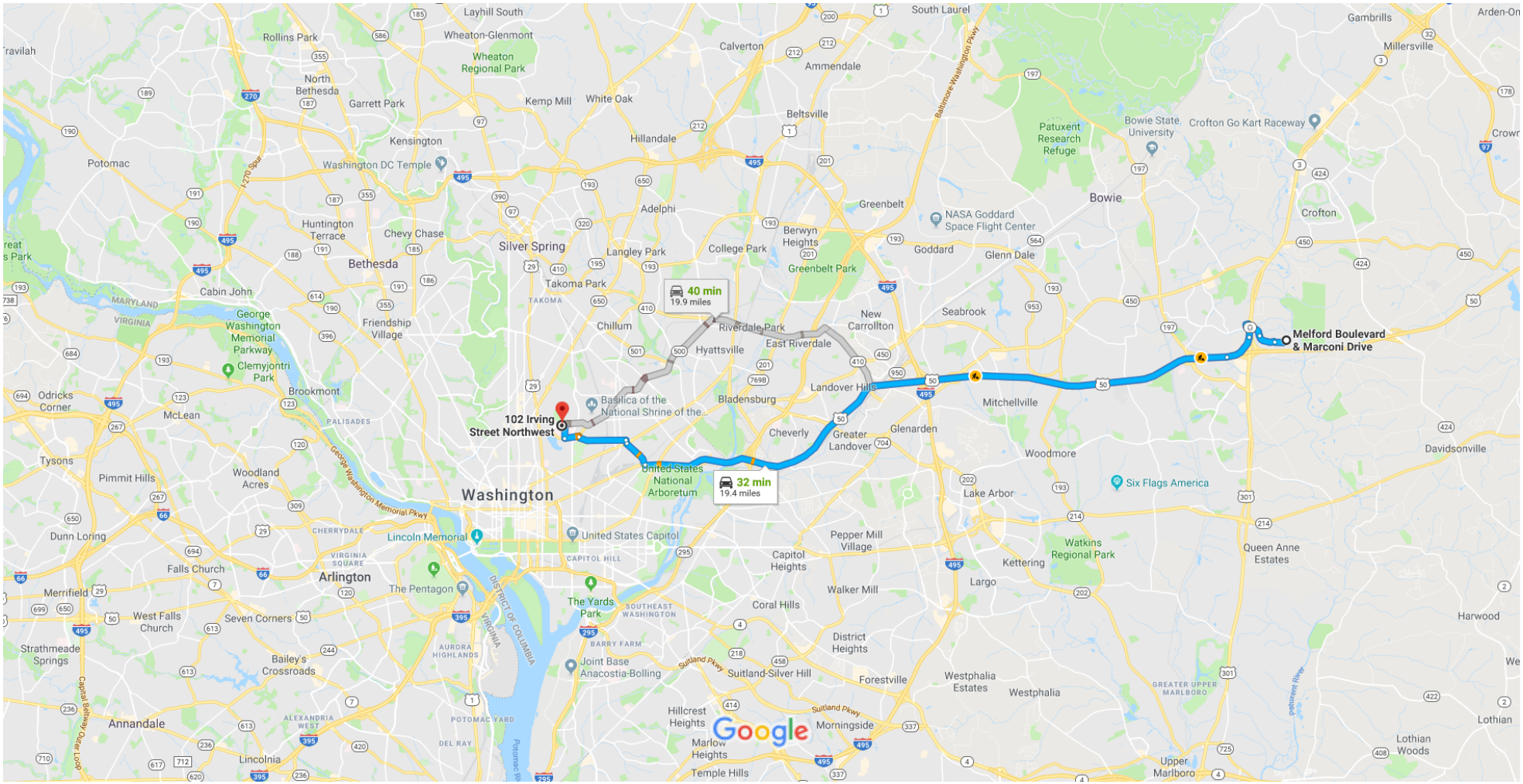
Map 1. Encompass Site Distance to National Rehabilitation Hospital

Map 2. Encompass Site Distance to Adventist Rehabilitation Hospital site at White Oak

Google Maps

Melford Boulevard & Marconi Drive to 102 Irving St NW

Drive 19.4 miles, 32 min



Map data ©2019 Google 2 mi

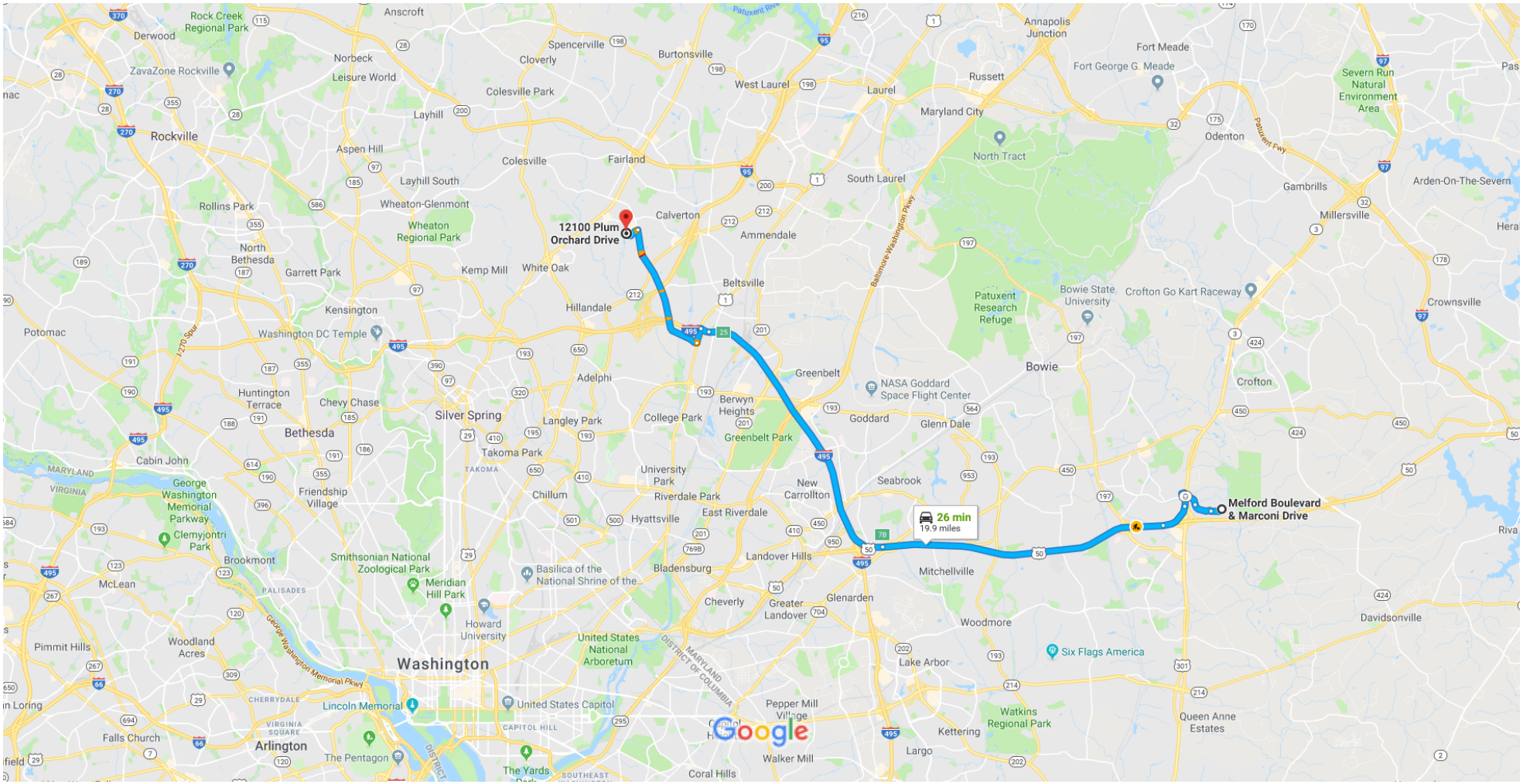
via US-50 W — 32 min

Fastest route, the usual traffic — 19.4 miles

via US-50 W and MD-410 W — 40 min

19.9 miles

Google Maps Melford Boulevard & Marconi Drive to 12100 Plum Orchard Dr Drive 19.9 miles, 26 min



Map data ©2019 Google 2 mi

via US-50 W and I-495 N/I-95 N 26 min

Fastest route, the usual traffic 19.9 miles