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STATE OF MARYLAND

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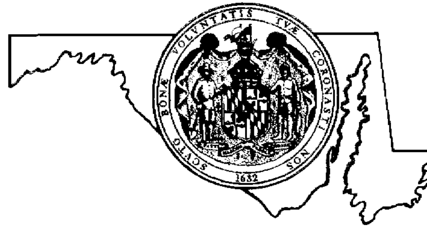

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

MEMORANDUM

TO: Commissioners

Counsel, Encompass Health Rehabilitation Hospital of Southern Maryland, LLC
Counsel, MedStar National Rehabilitation Hospital

FROM: Martin L. Doordan
Commissioner/Reviewer

RE: Recommended Decision
Application for Certificate of Need
Encompass Health Rehabilitation Hospital of Southern Maryland, LLC
Docket No. 18-16-2423

DATE: May 4, 2020

Enclosed is my Recommended Decision in my review of a Certificate of a Need (CON) application by Encompass Health Rehabilitation Hospital of Southern Maryland, LLC (Encompass-Southern Maryland) to establish a 60-bed, one-story special rehabilitation hospital to be located at the southwest corner of Melford Blvd. and Marconi Drive in Bowie (Prince George's County). Encompass Health Rehabilitation Hospital of Southern Maryland is a subsidiary of Encompass Health Corporation (Encompass Health), a publicly-traded proprietary corporation.

I reviewed the application for consistency with standards in COMAR 10.24.09, the Acute Inpatient Rehabilitation Services Chapter of the State Health Plan, and with COMAR 10.24.01.08G(3)(a), the general Certificate of Need review criteria. I considered the comments of interested party MedStar National Rehabilitation Hospital (MNRH) and the full record in this review. I found that the special rehabilitation hospital proposed by Encompass-Southern Maryland complies with all applicable standards and with the CON review criteria. I found that the hospital is needed and will have a positive impact on the residents of its proposed service area. For these and other reasons stated in my Recommended Decision, I recommend that the Commission **APPROVE** this project with the conditions that Encompass Health Rehabilitation Hospital of Southern Maryland, LLC shall:

1. In its request for first use approval, provide information, acceptable to Commission staff, that details the activities it has undertaken for outreach to the community regarding the availability of charitable services;

2. Maintain compliance with the provisions of COMAR 10.24.09.04A(1) regarding the availability of charity care and a sliding scale of discounted charges for low income individuals who do not qualify for full charity care; and

3. Prior to first use, provide written transfer and referral agreements, acceptable to Commission staff, with facilities, agencies, and organizations that are capable of managing cases that exceed its own capabilities and/or provide alternative treatment programs appropriate to the needs of the persons it serves.

I recommend that the Commission approve the application of Encompass-Southern Maryland to establish a 60-bed special in Bowie, Maryland because I believe that the hospital will benefit the residents of the four-county Southern Maryland health planning region, who will get improved access to services. A special rehabilitation hospital provides acute intensive rehabilitation therapy that generally consists of at least three hours of therapy per day, at least five days per week, in multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy). Physician supervision by a licensed rehabilitation physician is required. One of the therapy disciplines provided must be physical or occupational therapy. These acute inpatient rehabilitation services currently are not easily accessible in the Southern Maryland region.

Interested party MNRH, a special rehabilitation hospital located in the District of Columbia, has the largest market share of rehabilitation hospital patients originating in the Southern Maryland region (Calvert, Charles, Prince George's, and St. Mary's Counties. MNRH asserts that the proposed hospital is not needed, and that the applicant failed to meet several of the general and project review standards and criteria, particularly those related to need, quality, access, and impact. I addressed MNRH's comments in detail in my attached Recommended Decision, but rejected MNRH's assertions.

The proposed special rehabilitation hospital will be located in the four-county Southern Maryland health planning region, which currently has only ten acute rehabilitation beds. I go into much more detail in my Recommended Decision, but the Commission's bed need projections indicate that the current net bed need for acute inpatient rehabilitation beds in the region ranges from a minimum of 1 bed to a maximum of 85. This large variance results from the very low use of rehabilitation beds by residents of the region compared to statewide use rates. The low use rates may result from the lack of available beds in the region. I recommend approval of the application of Encompass-Salisbury because I believe that the establishment of a special rehabilitation hospital in Bowie will make the benefits of intensive inpatient rehabilitation therapy more available to the residents of the Southern Maryland region and southern Anne Arundel County.

REVIEW SCHEDULE AND FURTHER PROCEEDINGS

This matter will be placed on the agenda of a meeting of the Maryland Health Care Commission on May 21, 2020, beginning at 1:00 p.m. This meeting is expected to take place by webinar. The link to register to attend the meeting will be placed on the Commission's meeting page: https://mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/meeting_schedule.aspx?id=0 After registering, each person will receive a confirmation email containing information about joining the webinar. The Commission will make a final decision based on the record of the proceeding.

As provided in COMAR 10.24.01.09B, an applicant or interested party may submit written exceptions to the enclosed Recommended Decision. Written exceptions must identify specifically those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. Copies of exceptions and responses to exceptions must be emailed to all parties by the due date and time, but because of the current state of emergency, filing of paper copies with the Commission is not required.

I note that the schedule I propose below does not provide the five-day period for responding to exceptions that is set out in COMAR 10.24.01.09B(2)(b). If a party filing a response to exceptions desires the full five days to respond, this matter will have to be scheduled for the June 18, 2020 Commission meeting.

Oral argument during the exceptions hearing before the Commission will be limited to 10 minutes for the interested party and 15 minutes for the applicant, unless extended by the Chair or the Chair's designated presiding officer. The schedule for the submission of exceptions and any response to exceptions is as follows:

Submission of exceptions	May 11, 2020 By email no later than 12:00 noon
Submission of response	May 15, 2020 By email no later than 12:00 noon
Exceptions hearing	May 21, 2020 1:00 p.m.

cc: Ernest Carter, MD, Health Officer, Prince George's County
Nilesh Kalyanaraman, MD, Health Officer, Anne Arundel County
Laurence Polsky, MD, Health Officer, Calvert County
Suzan C. Lowry, MD, FAAP, Health Officer, Charles County
Meenakshi G. Brewster, MD, MPH, Health Officer, St. Mary's County

IN THE MATTER OF	*	
	*	
ENCOMPASS HEALTH	*	**BEFORE THE**
	*	
REHABILITATION	*	**MARYLAND HEALTH**
	*	
HOSPITAL OF SOUTHERN	*	**CARE COMMISSION**
	*	
MARYLAND, LLC	*	
	*	
Docket No. 18-16-2423	*	

* *

REVIEWER'S RECOMMENDED DECISION

May 21, 2020

(Released May 4, 2020)

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I. INTRODUCTION

A. The Applicant

The applicant, Encompass Health Rehabilitation Hospital of Southern Maryland, LLC (Encompass-Southern Maryland), is a Delaware limited liability company and a subsidiary of Encompass Health Corporation (Encompass Health), a publicly-traded proprietary corporation. Encompass Health, formerly known as HealthSouth Corporation, has a nationwide network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies that offer facility-based and home-based rehabilitation services. The network reports operation of 127 acute inpatient rehabilitation hospitals and 272 home health and/or hospice agencies in 36 states and Puerto Rico. This includes a special rehabilitation hospital, Encompass Health Rehabilitation Hospital of Salisbury (Encompass-Salisbury, formerly known as HealthSouth Chesapeake Rehabilitation Hospital), a 74-bed special rehabilitation hospital located in Wicomico County. (DI #5, pp. 6-7).

B. The Project

Encompass-Southern Maryland proposes to establish a 60-bed special rehabilitation hospital at the southeast corner of Melford Boulevard and Marconi Drive, Bowie (Prince George's County), Maryland. The applicant states that it is seeking 42 new acute rehabilitation beds for this project. It purchased 18 existing acute rehabilitation beds from the University of Maryland (UM) Laurel Regional Hospital when that hospital decided to downsize its acute rehabilitation beds prior to relocation of ten acute rehabilitation beds to UM Prince George's Hospital Center.

Acute inpatient rehabilitation (or acute rehabilitation) is an intensive rehabilitation therapy program, defined by the Centers for Medicare & Medicaid (CMS) that generally consists of at least three hours of therapy per day for at least five days per week in multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy). One of the therapy disciplines provided must be physical or occupational therapy. The program requires supervision by a licensed rehabilitation physician including face-to-face visits with the patient at least three days per week throughout the patient's stay to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. In Maryland, special hospital rehabilitation services are intended to be available to a substantial regional population base in a limited number of hospitals to promote both high quality care and an efficient scale of operation.

Encompass-Southern Maryland states that its proposed special rehabilitation hospital will provide patients with the required three hours of intensive therapy daily and round-the-clock nursing care, which will permit admission of medically complex patients. The applicant notes that inpatient rehabilitation helps shorten acute care lengths of stay, increases timely discharge to the community, and reduces hospital readmissions, which lowers total costs of care. Although the facility will admit patients aged 18 years and older, Encompass Health reports that the average age of its acute rehabilitation patients is 71. Based on the applicant's experience, the most frequent diagnoses of its acute rehabilitation patients are stroke, brain injury, amputation, spinal cord injury, fractures, neurological disorder, multiple trauma, congenital deformity, burns, arthritis, joint replacement, and systemic vasculitis. (DI #5, pp. 4-5).

The applicant proposes construction of a 61,810 square foot (SF) building with 60 private patient rooms, a kitchen, dining room, space for occupational and physical therapy services, day room, business offices, a centrally-located nurse station between three wings of the building, nourishment area, utilities, and staff lounge and dictation area. The total estimated project cost is $39,019,894 and the detail of that estimate is shown in the following table. Encompass Health plans to fund the project with cash. (DI #21, Table E).

Table I-1: Project Budget Estimate

Uses of Funds	
New Construction	
Building	$17,840,840
Bed purchase	2,321,000
Site and infrastructure	2,093,600
Architect/engineering fees	1,665,227
Permits (building, utilities, etc.)	555,076
Subtotal	**$24,475,742**
Other Capital Costs	
Movable equipment	$2,500,000
Contingency allowance	1,110,151
Gross interest during construction period	840,000
Technology equipment	1,600,000
Subtotal	**$6,050,151**
Total Current Capital Costs	**$30,525,894**
Land purchase	$6,305,000
Total Capital Costs	**$36,830,894**
Financing Cost and Other Cash Requirements	
Legal fees	$600,000
CON consulting, community support	750,000
Appraisal, traffic study, title costs, engineering	150,000
ACE-IT installation	289,000
Subtotal	**$1,789,000**
Working capital startup costs	$400,000
TOTAL USES OF FUNDS	**$39,019,894**
Sources of Funds	
Cash	**$39,019,894**

Source: DI #21, Table E.

C. Background

There are 510 licensed or approved acute rehabilitation beds in Maryland, the majority of which are located on the campuses of 11 general hospitals. In FY 2019, the average annual occupancy rate of acute rehabilitation beds in Maryland was 77.3 percent.

The Commission projects the need for rehabilitation hospital beds on a regional basis using five health planning regions for this purpose. The Southern Maryland region for which this project is proposed consists of Calvert, Charles, Prince George's and St. Mary's Counties. A range of bed need is calculated, based on the trend in regional use rates for this service and the statewide trend in use rates.

Bed need projections for a target year of 2021 were published on April 13, 2018. The projections identify a gross need for 11 to 95 rehabilitation hospital beds in this region. This large variance is the result of the very low use of rehabilitation beds when examined at the regional level and the much higher statewide use rate. At that time, the only rehabilitation hospital beds operated in this region were 28 beds located at the UM Laurel Regional Hospital in Prince George's County. Since that time, UM Laurel Regional Hospital was converted to a freestanding medical facility and ten of its acute rehabilitation beds were relocated to UM Prince George's Hospital Center, which now operates a ten-bed unit. Encompass-Southern Maryland purchased the remaining 18 acute rehabilitation beds from UM Laurel Regional Hospital for use in this project. Based on this revised bed inventory, the net bed need projected for 2021 ranges from a minimum of one bed to a maximum of 85 beds.

D. Reviewer's Recommendation

I found that the proposed establishment of a special rehabilitation hospital in Bowie (Prince George's County) complies with the standards in COMAR 10.24.09, the Acute Inpatient Rehabilitation Services Chapter of the State Health Plan and with the general Certificate of Need review criteria. The applicant demonstrated the need for the project, its cost-effectiveness, and its viability. I found that the impact of the project on access to rehabilitation services for residents of the four counties that comprise the Southern Maryland region will be positive. For these reasons, I recommend that the Commission **APPROVE** this project with the conditions that Encompass Health Rehabilitation Hospital of Southern Maryland, LLC shall:

1. In its request for first use approval, provide information, acceptable to Commission staff, that details the activities it has undertaken for outreach to the community regarding the availability of charitable services.

2. Maintain compliance with the provisions of COMAR 10.24.09.04A(1) regarding the availability of charity care and a sliding scale of discounted charges for low income individuals who do not qualify for full charity care.

3. Prior to first use, provide written transfer and referral agreements, acceptable to Commission staff, with facilities, agencies, and organizations that are capable of managing cases that exceed its own capabilities and/or provide alternative treatment programs appropriate to the needs of the persons it serves.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 1, Record of the Review.

B. Interested Party in the Review

MedStar National Rehabilitation Hospital (MNRH) submitted comments contesting the application and seeking interested party status in this review. MNRH is an acute rehabilitation

hospital located in the District of Columbia which has the largest market share of rehabilitation hospital patients originating in the Southern Maryland region. MNRH requested that the Commission deny the application for a Certificate of Need (CON) for the proposed project based on its assertion that the proposal fails to meet several of the general and project review standards and CON review criteria. I will address MNRH's comments in detail in this Recommended Decision.

In its comments, MNRH questions the validity of the data the applicant presented to "promote itself as a quality care, low cost provider." It also states that Encompass-Southern Maryland's application fails to show that out-migration is attributable to access barriers or to demonstrate a credible plan to mitigate barriers to access. MNRH questions the applicant's responses to the subparts of the need standard and insists that Encompass-Southern Maryland's proposed project will adversely impact existing local providers' ability to maintain staff. It questions the project's financial feasibility based on its view that the applicant's projected utilization is overstated. MNRH also asserts that there are more cost-effective alternatives, including adding the service to the hospital being built as a replacement of UM Prince George's Hospital Center in Largo. (DI #27).

Commissioner Candice Peters, M.D. was initially appointed as Reviewer for this project. However, before she issued a ruling regarding MNRH's eligibility for interested party status she resigned from the Commission, and I was appointed in her place.

After reviewing the interested party filings and the applicant's response, I ruled, on March 5, 2020, that MNRH did not qualify for interested party status under the definition of "adversely affected" in COMAR 10.24.01.01B(2)(a), upon which it relied as the specific basis for its qualification for interested party status.[1] I found that MNRH did not meet the requirement of COMAR 10.24.01.01B(2)(c) that it demonstrate that it "[w]ould suffer a substantial depletion of essential personnel or other resources by approval of the application by the Commission ....". It did not show the "substantial depletion" required by Paragraph .01B(2)(c). I also found that

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[1] COMAR 10.24.01B(2) provides:

> 'Adversely affected', for purposes of determining interested party status in a Certificate of Need review … means that a person:
> (a) Is authorized to provide the same service as the applicant, in the same planning region used for purposes of determining need under the State Health Plan or in a contiguous planning region if the proposed new facility or service could reasonably provide services to residents in the contiguous area;
> (b) Can demonstrate that the approval of the application would materially affect the quality of care at a health care facility that the person operates, such as by causing a reduction in the volume of services when volume is linked to maintaining quality of care;
> (c) Would suffer a substantial depletion of essential personnel or other resources by approval of the application by the Commission; or
> (d) Can demonstrate to the reviewer that the person could suffer a potentially detrimental impact from the approval of a project before the Commission, in an issue area over which the Commission has jurisdiction, such that the reviewer, in the reviewer's sole discretion, determines that the person should be qualified as an interested party to the Certificate of Need review.

MNRH did not make a demonstration that convinced me that it met the definition of "adversely affected" under Paragraph .01(2)(d) and should be recognized as an interested party in this review.

On March 25, 2020, MNRH filed a Motion for Reconsideration of my ruling denying interested party status. Encompass responded to this motion on April 8, 2020, withdrawing its opposition to the qualification of MNRH as an interested party. On April 20, 2020, I granted MNRH interested party status.

C. Local Government Review and Comment

No comments on this application were received from the Prince George's County Health Department.

D. Community Support

The CON application included 15 letters of support for this project. (DI #4; DI #5, p. 4 & Exh. 11; DI #11). Encompass-Southern Maryland stated that it anticipates the full support of the University of Maryland Medical System (DI #5, p.4) and provided letters of support for the project from the following:

- Nneka Ezunagu, Stroke Program Coordinator at University of Maryland Prince George's Hospital Center
- Sherry Perkins, Executive Vice President and CEO for University of Maryland Capital Region Health
- Trudy Hall, M.D., Interim President & Vice President for Medical Affairs at University of Maryland Laurel Regional Hospital
- Kisha Perkins Brown, M.D., Medical Director for Physical Medicine and Rehabilitation at University of Maryland Prince George's Hospital Center
- Bruce Neckritz, Rehabilitation Medical Director at University of Maryland Laurel Regional Hospital

The following representatives of educational institutions also submitted letters in support of the proposed project:

- Melinda Bunnell-Rhyne, Vice President for Student Engagement at Capital Technology University in Laurel
- Charlene Dukes, President of the Prince George's Community College
- Frank Principe, Jr., Chief of Staff of University of Maryland University College

The following government officials submitted letters in support of the proposed project:

- State Senator Douglas Peters
- State Delegate Geraldine Valentino-Smith
- G. Frederick Robinson, the Mayor of Bowie
- Dannielle Glaros, Chair of the Prince George's County Council

Two community providers expressed support for the project:

- Kanwaljit Ahuja, M.D., a neurologist
- C. Obi Onyewu, M.D., a practitioner at Choice Pain & Rehabilitation Center, LLC, which has two locations in Prince George's County, in Hyattsville and Lanham

Jim Coleman, President and CEO of the Prince George's County Economic Development Corporation, submitted a letter of support.

III. REVIEW AND ANALYSIS

The Commission is required to make its decisions in accordance with the general CON review criteria at COMAR 10.24.01.08G(3)(a) through (f). The first of these six general criteria requires the Commission to consider and evaluate this application according to applicable State Health Plan standards and policies.

A. STATE HEALTH PLAN

COMAR 10.24.01.08G(3)(a) State Health Plan.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant chapter of the State Health Plan for Facilities and Services is COMAR 10.24.09: Specialized Health Care Services – Acute Inpatient Rehabilitation Services (Acute Inpatient Rehabilitation Chapter).

COMAR 10.24.09 — State Health Plan for Facilities and Services: Specialized Health Care Services – Acute Inpatient Rehabilitation Services

10.24.09.04 Standards.

A. General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

Applicant's Response

The charity care policy standard requires an applicant to make a determination of probable eligibility within two business days of a request for charity care services or application for medical assistance. Encompass-Southern Maryland's process requires a patient seeking such assistance to provide only their name, household income, and family size to receive an initial determination of probable eligibility for charity care. A final determination will be made after review of a complete financial assistance application. (DI #15, p. 3; DI #17, Att. 6).

The applicant states that information regarding its charity care policy will be available in the admitting and registration areas of the hospital, on the website, and in patient billing statements. (DI #15, pp. 3-4). It notes that a notice that encourages patients to seek more information will be found in the registration area. (DI #15, Att. 4).

Encompass-Southern Maryland also states that it will disseminate information in the community by "marketing charity care" to hospital case managers and physicians, as well as by working with the local health department and non-profit community organizations "to assure the

community is aware of the availability of its services to those who are unable to pay in part or in full." (DI #17, p. 3). The applicant states that it will publish an annual notice of the availability of financial assistance in local newspapers and will participate in local health fairs to disseminate information about its charity care and financial assistance policies. (DI #20, p. 3).

Encompass-Southern Maryland's policy states that it will provide services free of charge to patients with up to 200 percent of federal poverty limits. It provides a sliding scale up to 400 percent of federal poverty limits. (DI #15, Exh. 1, Att. B). Encompass-Southern Maryland makes a commitment to provide an amount equivalent to two percent of total operating costs to charity care patients. (DI #21, Table J).

Reviewer's Analysis and Findings

I find that Encompass-Southern Maryland complies with Paragraph (a) of the standard because its policy contains the required provisions and requirements regarding public notice.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

Applicant's Response

As a proposed new facility, the applicant initially noted that it does not have a track record to consider. Upon staff's request, the applicant submitted information showing that Encompass Health's rehabilitation hospital in Salisbury (Encompass-Salisbury, formerly HealthSouth Chesapeake Rehabilitation Hospital) provided $1,266 in charity care in 2017 and $10,000 in 2018, which amounted to 0.01 percent of operating expenses in 2017 and 0.06 percent of operating expenses in 2018. (DI #17, p. 4).

Reviewer's Analysis and Findings

HSCRC does not report on special rehabilitation hospitals in its Community Benefit Report, which covers general hospitals. The most recent report, for 2018, indicates that the average level of charity care provided by general hospitals in 2018 was 7.7 percent (i.e., a value of charity care equivalent to 7.7 percent of total operating expenses). The bottom quartile for the state's

general hospitals was 1.1 percent and less. Adventist HealthCare Rehabilitation, the only acute rehabilitation hospital included in that report, reported charity care valued at 0.54 percent of its total operating expenses. The existing Encompass-Salisbury location provided charity care valued at $750 in 2016, equivalent to just 0.004 percent of its $19.1 million in total operating expenses. As previously noted, Encompass-Salisbury's level of charity care reported for 2017 was about 0.01 percent of operating expenses and, in 2018, about 0.06 percent of operating expenses. (DI #17, p. 4).

I note that, in December 2019, the Commission approved Encompass-Salisbury's Certificate of Need application to add ten beds to its existing facility (Docket No. 18-22-2435). In that review, Encompass-Salisbury committed to provide two percent of its total operating expenses to eligible charity care patients. The hospital's previous negligible provision of services on a charitable basis, as outlined in the Staff Report, was the basis for authorizing the project with a condition requiring it to report on its activities to increase its charity care and to report on its progress in doing so. I recognize, as Commission staff and the Commission[2] recognized in that review, that a special hospital will have a payor mix that may appropriately warrant a lower level of charity care than one would expect for a general hospital or another special hospital. The decision compared Encompass-Salisbury's payor mix to that of Adventist Rehabilitation Hospital, the only comparable special rehabilitation hospital in Maryland, which showed Encompass-Salisbury to have a significantly higher mix of Medicare patients, and fewer commercially insured patients, than the Adventist Rehabilitation Hospital.

In its application, Encompass-Southern Maryland projects that it will provide charity care with a value equivalent to two percent of its total operating expenses. Such a level, if achieved, would be almost four times greater than the level of charity care percentage provided by Adventist HealthCare Rehabilitation in 2018 and place its provision of charity care in the top half of the 51 Maryland hospitals in HSCRC's Community Benefit Report.[3] I find the applicant's projections and its planned outreach, discussed in Paragraphs (a) and (c) of this standard, show an intent to deliver its fair share of uncompensated care. I find that the applicant has met Paragraph (b) of this standard, and recommend that the Commission require as conditions of the CON that Encompass Health Rehabilitation Hospital of Southern Maryland, LLC shall:

1. In its request for first use approval of the hospital, provide information, acceptable to Commission staff, that details the activities it has undertaken for outreach to the community regarding the availability of charitable service; and

2. Maintain compliance with the provisions of COMAR 10.24.09.04A(1) regarding the availability of charity care and a sliding scale of discounted charges for low income individuals who do not qualify for full charity care.

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

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[2] The Staff Report became the Commission's decision when adopted by the Commission.

[3] If Encompass-Southern Maryland provides charity care with a value equivalent to two percent of its operating expenses, it would rank 20th of the 51 hospitals included in the most recent published Community Benefits Report.

Applicant's Response

Encompass-Southern Maryland submitted a plan for achieving the level of charitable care provision to which it committed, including collaboration with the Prince George's County Health Department and Department of Social Services, marketing to acute care hospital case managers to identify and meet the need for charity care for rehabilitation services, and working with non-profit community-based organizations to ensure that the community is aware of its charity care and financial assistance services. The applicant identifies the following local organizations to include in communication plans: American Stroke Association, CASA de Maryland, Catholic Charities, City of College Park Seniors' Program, Gwendolyn Britt Senior Activity Center, Korean Community Services Center of Greater Washington, Laurel-Beltsville Senior Activity Center, Mary's Center, Salvation Army of Prince George's County, and the local YMCA. The applicant also plans to participate as a stakeholder at the Prince George's County Health Department's Prioritization Meetings, as a post-acute provider for the community needs assessment. (DI #15, p. 3; DI #20, pp. 2-4).

Reviewer's Analysis and Findings

I conclude that the plan put forward by the applicant satisfies Subparagraph (c)(ii) of the standard. However, as previously noted, Encompass Health's existing rehabilitation hospital in Salisbury has provided little charity care in 2017 and 2018. (DI #17, p. 4). While I believe that the actions described satisfy this part of the standard, it has not yet proven the effectiveness of its plan. The conditions I have already recommended are intended to reflect the Commission's expectation that Encompass-Southern Maryland meet its charity care commitment, in order to obtain favorable consideration of future projects in Maryland.

(2) Quality of Care. A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

Applicant's Response

Encompass-Southern Maryland states that it will obtain licensure by the Department of Health as a special rehabilitation hospital and will also obtain accreditation by the Commission for Accreditation of Rehabilitation Facilities (CARF) as a "Comprehensive Integrated Inpatient Rehabilitation" facility. It acknowledges that it must (and states that it will) maintain compliance

with the conditions of participation of the Medicare and Medicaid programs. The applicant notes that all Encompass Health rehabilitation hospitals are accredited by the Joint Commission or CARF. (DI #5, p. 94).

Reviewer's Analysis and Findings

Encompass Health has maintained licensure, accreditation, and Medicare/Medicaid certification at Encompass-Salisbury. I find that Encompass-Southern Maryland has satisfied Paragraph (a) of the quality of care standard.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

Background

The Commission's December 2019 decision regarding the Encompass-Salisbury expansion project, contains the following table:

Table III-1: Medicare IRF Compare:
Comparison of Freestanding Special Rehabilitation Hospitals in Maryland and U.S.

Quality of Patient Care Measures	Encompass Health Rehab	Adventist Rehab	National Average
Rate of pressure ulcers that are new or worsened	0.4%	0.4%	0.6%
% of IRF patients who experience one or more falls with major injury during their IRF stay	0.1%	0.2%	0.2%
% of patients whose functional abilities were assessed and functional goals were included in their treatment plan	98.1%	99.8%	99.8%
Catheter-associated urinary tract infections (CAUTI)	No different than national benchmark		1.155
Clostridium difficile Infection (CDI)	No different than national benchmark		0.714
Influenza Vaccination Coverage Among Healthcare Personnel	73.0%	99.0%	87.0%
Percent of residents/patients assessed and appropriately given influenza vaccine	67.7%	97.7%	93.5%
Rate of successful return to home and community from an IRF	Better than national rate		64.82%
Medicare Spending per Beneficiary for Patients in IRFs	1.01	1.01	1.01

Source:
https://www.medicare.gov/inpatientrehabilitationfacilitycompare/#compare&cmpids=213028%2C213029&cmpdists=125.3%2C48.9&loc=21030&lat=39.5116069&lng=-76.6990172&dist=250&cmpnames=ENCOMPASS%20HEALTH%20REHAB%20HOSPITAL%20OF%20SALISBURY%2CADVENTIST%20REHABILITATION%20HOSPITAL%20OF%20MARYLAND&cmpdists=125.3%2C48.9&viewall=0

Applicant's Response

The applicant states that all existing Encompass Health subsidiaries comply with CMS's IRF[4] Quality Reporting Program and report to the CMS HealthCompare website. Encompass-Southern Maryland responds to Paragraphs (b) and (c) of quality standard under the following headings.

Distinctions in the level of care and quality performance between IRFs and SNFs.

Encompass-Southern Maryland states that IRFs are qualitatively different from skilled nursing facilities[5] (SNFs) that provide rehabilitation services because they provide higher intensity medical and nursing services, employ specialized rehabilitation professionals to provide a multi-disciplinary approach to care, and utilize more state-of-the art technology for rehabilitation care. The applicant maintains that special rehabilitation hospitals accommodate more complex patients and initiate rehabilitation sooner. According to the applicant, IRFs feature simulated environments and more equipment enabling them to match the therapy regimen with the requirements of individualized care plans, with more formalized programs for family engagement and education.

The applicant notes that these resources and protocols result in shorter inpatient stays for rehabilitation patients in IRFs when compared to SNFs. To illustrate the favorable comparison, Encompass-Southern Maryland includes the following table in its application. (DI #5, pp. 75-76).

[4] Inpatient Rehabilitation Facility (IRF) is CMS's term for the health care facility that is regulated and licensed in Maryland as a special hospital-rehabilitation.

[5] Skilled nursing facilities (SNFs or nursing homes) are regulated and licensed in Maryland as comprehensive care facilities (CCFs).

Table III-2: Differences Between Inpatient Rehabilitation Facilities and Skilled Nursing Facilities

Inpatient Rehabilitation Hospital		Nursing Home	
Average length of stay	= 12.7 days	Average length of stay	= 38.5 days
Discharge to community	= 76.0%	Discharge to community	= 38.8%
Requirements:		Requirements:	
IRFs must also satisfy regulatory/policy requirements for hospitals, including Medicare hospital conditions of participation.		No similar requirement; Nursing homes are regulated as nursing homes only	
All patients must be admitted by a rehab physician.		No similar requirement	
Rehab physicians must re-confirm each admission w/n 24 hours.		No similar requirement	
All patients, regardless of diagnoses/condition, must demonstrate need and receive at least three hours of daily intensive therapy.		No similar requirement	
All patients must see a rehabilitation physician "in person" at least three times weekly.		No similar requirement; some SNF patients may go a week or longer without seeing a physician, and often a non-rehabilitation physician.	
IRFs are required to provide 24 hour, 7 days per week nursing care; many nurses are RNs and rehab nurses.		No similar requirement	
IRFs are required to use a coordinated interdisciplinary team approach led by a rehab physician; includes a rehab nurse, a case manager, and a licensed therapist from each therapy discipline who must meet weekly to evaluate/discuss each patient's case.		No similar requirement; Nursing homes are not required to provide care on a interdisciplinary basis and are not required to hold regular meetings for each patient.	
IRFs are required to follow stringent admission/coverage policies and must carefully document justification for each admission; further restricted in number/type of patients (60% Rule).		Nursing homes have comparatively few policies governing the number or types of patients they treat.	

Source: DI #5, p. 76.

Encompass-Southern Maryland describes a list of factors that distinguish services provided by an IRF from those provided by a SNF. (DI #5, pp. 76-80). The applicant states that an IRF provides:

- Nursing care 24 hours per day;
- Face-to-face rehabilitation physician visits three days per week (compared to SNF physician visits of only one day per month);
- IRF patients meet strict admission requirements, including the need for two therapy modalities and the ability to tolerate a minimum of three hours of therapy per day;
- IRFs can admit acute care patients after a one- or two-day hospital stay, which minimizes acute care length of stay and initiates rehabilitation services as soon as possible;
- An IRF is required, by CMS, to serve a patient population in which at least 60 percent of the patients fall within a specified list of diagnostic groups;
- IRFs initiate therapy within 36 hours following midnight of the day of admission and must implement an overall plan of care within four days of admission;
- IRFs are required to provide an interdisciplinary approach that includes a rehabilitation physician, a registered nurse with specialized experience in rehabilitation, a social worker or case manager, and a licensed or certified therapist for each therapy discipline involved in the patient's treatment plan;
- IRFs are required to contract with a Medical Director with training and experience in rehabilitation medicine, and this clinician must be available on a full-time basis;

- IRFs are required to use the Functional Independence Measure (FIM)®[6] to measure and evaluate outcomes and treatment efficiency. FIM® Gain is a measure of functional improvement from admission to discharge and indicates the degree of practical improvement toward the patient's rehabilitation goals, and
- IRFs are required to use the CARE tool as a part of the Medicare Post-Acute Care Payment Reform Demonstration; this patient assessment tool was developed for use at acute hospital discharge, at post-acute care admission, and at discharge.

Encompass-Southern Maryland cites MedPAC[7] statistics that document that 76 percent of IRF patients are discharged to the community, in contrast to 39 percent of patients discharged to the community from SNFs. It states that, nationally, the average length of stay (ALOS) for a rehabilitation patient at a SNF is 38.5 days while the ALOS at an IRF is 12.7 days. (DI #5, p. 81).

Encompass Health's scope of operations, clinical advances through technology, clinical management initiatives, continuous quality improvement, and quality performance indicators.

In its application, Encompass-Southern Maryland discusses its utilization of the Uniform Data System for Medical Rehabilitation (UDSMR®), which it describes as the rehabilitation industry's most widely recognized outcomes measurement tool, to monitor overall patient outcomes. According to the applicant, Encompass Health's existing network has higher rates of discharge to the community, lower rates of discharge to acute care settings, lower rates of discharge to SNFs, lower than average cost per discharge, and higher functional improvement gains, as compared to other national providers reporting to UDSMR®. (DI #5, pp. 83-84).

Encompass-Southern Maryland describes its use of UDSMR® data to compare FIM® scores and FIM® Gain against peers and national benchmarks, as outlined in the following table.

Table III-3: Average Length of Stay and FIM® Metrics, Expected versus Actual Performance, Encompass Health Hospitals, CY 2017

	UDSMR® Expected	Actual Performance - All Encompass Health Hospitals
Average Length of Stay	13.3 days	12.7 days
FIM® Score at Admission	56.4	54.7
FIM® Score at Discharge	88.8	91.1
FIM® Gain	32.4	36.5

Source: DI #5, p. 88; Applicant's analysis of Uniform Data System for Medical Rehabilitation (UDSMR®), UB Foundation Activities Inc.

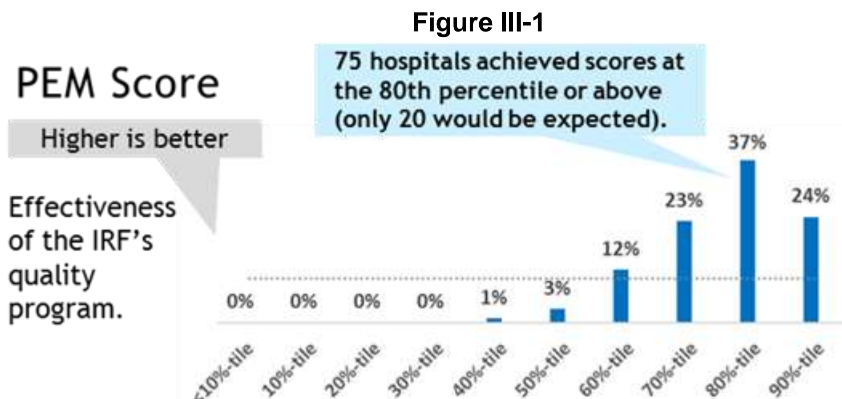
Encompass-Southern Maryland states that it has a track record of achieving higher than expected Performance Evaluation Model (PEM) scores, which use discharge FIM®, FIM® Gain, LOS efficiency, discharge-to-community and transfers to acute care general hospitals to rank

[6] Functional Independence Measure (FIM)® is an 18-item, 7-level functional assessment designed to evaluate the amount of assistance required by a person with a disability to perform basic life activities safely and effectively. The tool is used to assess a patient's level of disability as well as changes in patient status in response to rehabilitation or medical intervention. FIM® assessments are used clinically to monitor the outcomes of rehabilitative care as required by the Joint Commission and CARF.

[7] MedPAC is the Medicare Payment Advisory Committee, an independent congressional agency that advises Congress on issues affecting the Medicare program. 204.12.124.188/-about-medpac-

rehabilitation patient outcomes. According to the applicant, "Encompass Health operates significantly more hospitals in the higher deciles of the PEM distribution than would be expected from a purely statistical analysis," as shown in the illustration below, which is provided by the applicant. (DI #5, p. 91).

Figure III-1



Source: DI #5, p. 92.

The applicant also describes its internal tool called TeamWorks, which is used to identify best practices and standardize the practices across all Encompass Health hospitals. (DI #5, p. 97).

Encompass Health has experience in population health management and value-based contracting.

According to the applicant, Encompass Health's experience as a participant in bundled payment initiatives, accountable care organizations, and value-based contracts serves as evidence that it is equipped to perform successfully under these initiatives through evidence-based protocols, electronic information exchange, real-time cost/quality performance monitoring, and supportive transitioning of patients to the community. Encompass Health is actively participating as a risk-bearing participant in the Comprehensive Care for Joint Replacement Model with 25 IRFs and 29 home health agencies (HHAs) in proposed mandatory markets. Encompass Health operates 11 IRFs and 13 HHAs in proposed voluntary markets. (DI #5, p. 106).

Encompass-Southern Maryland also includes information about Encompass Health being awarded Medicare's Bundled Payments for Care Improvement (BPCI) initiative. Eight Encompass Health hospitals participated in BPCI Model 3, 60-day, post-acute initiatives in episode types that include stroke, simple pneumonia, sepsis, double-lower extremity joint replacement, and upper extremity joint replacement. The applicant states that this experience enabled Encompass Health to analyze and identify additional opportunities to expand participation in bundling initiatives and risk-sharing arrangements. The applicant notes Encompass Health accounted for eight of the nine IRFs that participated in the program. (DI #5, pp. 106-107).

Encompass Health in Maryland has improved waiver performance through high quality performance and lower costs of care.

The applicant includes performance measures from Encompass Health's Rehabilitation Hospital in Salisbury as evidence that the applicant will be a high quality, cost-effective provider. The applicant offers the following statistics to support its claims: (DI #5, pp. 109-11).

- In 2017, Encompass-Salisbury received referrals from 19 acute care general hospitals, as evidence of its partnership with general hospitals in creating a continuum of care;
- *Length of stay reduction for high potential rehabilitation patients.* The applicant presents a comparison of Medicare patients from Wicomico, Worcester, and Somerset counties who received rehabilitation care at Encompass-Salisbury and patients who received rehabilitation care at SNFs. The applicant reports that its analysis indicates the ALOS for patients at Encompass-Salisbury was shorter relative to the post-acute length of stay at SNFs. Comparable Medicare patients showed an ALOS for rehabilitation of 14.6 days at Encompass-Salisbury as compared with an ALOS of 38 days at SNFs for patients receiving "ultra-high rehabilitation therapy" services, defined as involving at least 720 minutes of rehabilitation services per week;

  The applicant notes that the combined ALOS of patients discharged from Encompass-Salisbury, including the general hospital stay prior to admission and the stay at its facility was shorter for patients discharged from the three-County Eastern Shore region, a combined ALOS of 19 total days, as compared to the combined ALOS for patients discharged from SNFs, at 45 total days;
- *Fewer readmissions.* Encompass-Salisbury documents a 30-day readmission rate of 17.2 percent compared to a 30-day readmission rate of 22.6 percent for comparable patients discharged to a SNF; and
- *Other performance indicators.* According to the applicant, Encompass-Salisbury has outperformed peers in measures such as FIM® Gain (32.6, compared to an expected score of 32.1), rates of discharge to the community (78.5 percent, compared to an expected 76.0 percent), as well as the previously-mentioned lower readmission rate, when compared with patients discharged by SNFs.

Interested Party Comments

MNRH calls into question the data offered by the applicant "to promote itself as a quality care, low cost provider" (DI #27, p. 5). Referring to 2016 and 2018 reports published by MedPAC, MNRH states that the reports create reasonable doubts about the applicant's statements on quality, especially as it relates to attaining improved FIM® scores. (DI #27, p. 4).

According to MNRH, these MedPAC reports suggest that the class of IRFs with the greatest profitability, a group which it states includes Encompass Health IRFs, tend to score patients as more functionally limited at admission than they really might be. MNRH suggests that 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." MNRH asserts that

> MedPAC found that FIM® scoring among high-margin IRFs at rehabilitation admission was out of sync with how patients were coded [upon discharge from]

> acute care. Those counted as less severe in acute care were counted as more severe in rehabilitation among high-margin IRFs, [and that] MedPAC's doubts about high-margin IRF coding and scoring methods brings into question whether ERH [Encompass Rehabilitation Hospitals] is truly a low-cost provider, as it claims, because it is not possible to know whether the mix of patients ERH treats is truly comparable to those treated by other providers.
> (DI #27, pp. 2-4).

MNRH states that the resulting impact on FIM® scores and FIM® Gain works to the benefit of facilities that may be engaged in this questionable scoring, which empirically seem to be the higher-margin facilities.

MNRH states that the MedPAC reports also suggest that certain case types are more profitable than others. According to the interested party, certain facilities may appear to have better outcomes due to inconsistent FIM® scoring and more attainable outcome measures for certain case types. (DI #27, p. 3). A few examples from the MedPAC findings regarding higher or highest margin IRFs include:

- Higher margin IRFs had a higher share of other neurological cases and a lower share of stroke cases;
- Stroke cases that were treated at higher margin IRFs were 2.5 times more likely than those at the lowest margin IRFs to report no paralysis; and
- Other neurological cases in the highest margin IRFs were almost three times more likely than those in the lowest margin IRFs to have a neuromuscular disorder (such as amyotrophic lateral sclerosis or muscular dystrophy) as opposed to conditions like multiple sclerosis or Parkinson's disease.

MNRH also questioned the applicant's claim that it is a low-cost provider. MNRH argues that because the applicant is part of the Encompass Health network with facilities located primarily in the South, away from core urban areas, in locations with cheaper land and lower wages than is found in urban areas, favorable cost comparisons are less valid. To illustrate its point, MNRH notes that the District of Columbia, where MNRH is located, has a 9.2 percent higher wage index than the Salisbury, Maryland area, where Encompass-Salisbury is located. MNRH also notes that it is located in a multi-story building with multi-level parking, and on more expensive land with higher capital costs. (DI # 27, p. 5).

Based on this reasoning, MNRH believes that the data used by the applicant as justification for claims of quality of care and/or lower costs should be disregarded in determining whether the applicant has met its burden of proof to obtain a CON.

<u>Applicant's Response to Interested Party Comments</u>

Encompass-Salisbury responded to MNRH's assertions concerning the validity of the data it provided in its application by stating "MNRH's assertions about the quality of care provided at Encompass facilities are without merit and without support." The applicant also characterized "MNRH's attempts to detract from Encompass's solid track record of high quality inpatient

rehabilitation…through contortion of unsubstantiated observations" as "unsuccessful," stating that the interested party presented no evidence to establish a connection between "high margin" and lower quality of care. (DI #28, pp. 11, 12).

The applicant reiterated that it will be a high-quality, lower-cost provider and that the data it presented to demonstrate that is reliable, citing its use of the rehabilitation industry's most widely recognized outcomes measurement tool, UDSMR®). The applicant states that this tool allows uniform comparisons to national providers, and that those comparisons show:

- Consistently higher rates of discharge to the community;
- Lower discharge rate to the acute care setting;
- Lower rates of discharge to skilled nursing facilities;
- Lower than average cost per discharge, relative to hospital-based units and freestanding facilities; and
- Higher than expected functional improvement gains.

(DI #28, pp. 11-12; DI #APP, pp. 83-110).

The applicant states that "[t]here is no evidence to support [MNRH's] assertion." that Encompass-Southern Maryland may not be a low-cost provider because "it is not possible to know whether the mix of patients that Encompass Health treats is truly comparable to those treated by other providers" and suggestions that Encompass Health "cherry picks" its admissions. (DI #28, p. 12).

Finally, the applicant dismisses MNRH's contention that, because its choices to locate its facilities in cost-effective places should somehow undermine its claim to being a low-cost provider, asserting that strategic decisions to locate facilities in areas where land and construction is less expensive are responsible health planning strategy, rather than a reason to discount or ignore those advantages. (DI #28, pp. 12-13).

Reviewer's Analysis and Findings

In order to comply with this Paragraph (b) of the standard,[8] an applicant must report on applicable quality measures required by federal regulations or State agencies and include information on how the applicant compares to other Maryland acute inpatient rehabilitation providers and how it will meet quality of care standards. I reviewed CMS's Compare quality measures for the existing freestanding special rehabilitation hospitals in Maryland, as outlined in the preceding Table III-1. Encompass-Salisbury compared well with the exception of influenza vaccination rates for staff.

Both the applicant and the interested party refer to MedPAC reports to address quality of care, with the applicant seeking to bolster its argument that IRFs provide more complex care than SNFs and with the interested party seeking to question the validity of the applicant's claims of superior patient outcomes and lower costs.

[8] Paragraph (c) of the standard is not applicable in this review.

The applicant's assessment is that acute care in an IRF setting provides a more complex provision of services than care at nursing homes. I find this assessment reflective of the Commission's view, as the Acute Inpatient Rehabilitation Chapter acknowledges and regulates these services separately. Regarding a comparison of the quality of care and patient outcomes between acute rehabilitation hospitals and nursing homes, COMAR 10.24.09.03 references a number of studies that address the most appropriate rehabilitation setting for certain cases, with some pointing to the benefit of IRFs.

> To some extent, skilled nursing facilities may substitute for acute inpatient rehabilitation services. Several studies have focused on whether one setting is better than the other for various conditions, such as stroke, hip fracture, and joint replacements. There is some evidence that suggests stroke victims achieve greater functional gain with the more intense IRF setting than in SNFs.[9] The evidence regarding patients with hip fractures is mixed, with some studies concluding that such patients have better health outcomes in IRFs, and other studies concluding that there is not a difference.[10] For joint replacement patients, one recent study concluded that the advantage of either setting is not clear-cut.[11] The PAC-PRD project led to some conclusions about the relative benefit of IRFs compared to SNFs for certain types of patients. Patients with nervous system disorder, including stroke patients, had 32 percent better functional improvement in self care than SNF patients at discharge, after controlling for patient case-mix characteristics.[12] For musculoskeletal cases, there were no significant differences in self-care outcomes for patients in SNFs compared to IRFs.[13]
> COMAR 10.24.099.03 *Issues and Policies, Quality of Care*, p. 5.

MNRH challenges Encompass-Southern Maryland's quality and cost efficiency comparisons by referencing MedPAC studies to suggest that high-margin IRFs may receive higher payments and have higher FIM®[14] scores than lower-margin IRFs due to coding discrepancies. I reviewed those findings. First, in those reports, MedPAC found that patient selection contributes to provider profitability, and recommends the need to research the variation in costs for certain

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[9] Buntin, M.B., Colla, C.H., Deb, P., Sood, N., and Escarce, J.J. "Medicare Spending and Outcomes After Postacute Care for Stroke and Hip Fracture." Medical Care. 48(9):776-84.

[10] Buntin, M.B., Colla, C.H., Deb, P., Sood, N., and Escarce, J.J. "Medicare Spending and Outcomes After Postacute Care for Stroke and Hip Fracture." Medical Care. 48(9):776-84. Chan L, Sandel ME, Jette AM, Appelman J, Brandt DE, Cheng P, Teselle M, Delmonico R, Terdiman JF, Rasch EK. "Does Postacute Care Site Matter? A Longitudinal Study Assessing Functional Recovery After a Stroke." Archives of Physical Medicine and Rehabilitation. 93 (12):1067-2.

[11] Tian, W., DeJong, G. Horn, S.D., Putman, K., Hsieh, C., DaVanzo, J.E. "Efficient Rehabilitation Care for Joint Replacement Patients: Skilled Nursing Facility or Inpatient Rehabilitation Facility?" Medical Decision Making. 32(1):176-87.

[12] Gage, B., Morley, M., Smith, L., Ingber, M.J., Deutsch, A., Kline, T., Dever, J., Abbate, J. Miller, R., LydaMcDonald, B., Kelleher, C., Garfinkel, D., Manning, J. Murtaugh, C.M., Stineman, M., Mallinson, T. "Post-Acute Care Payment Reform Demonstration: Final Report Volume 1 of 4." March 2012. <https://www.cms.gov/ResearchStatistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/PAC-PRD_FinalRpt_Vol1of4.pdf>

[13] *Id.*

[14] See footnote 6, *supra*, p. 6

services and calibrate payments to avoid overpayments and reduce incentives for providers to admit certain types of cases and avoid others. Regarding the finding that patients in high-margin IRFs were less severely ill and resource intensive than patients in lower-margin IRFs, MedPAC recommends that CMS help improve payment accuracy by reviewing medical records merged with IRF patient assessment data to reassess reliability across IRFs.

MedPAC's findings regarding discrepancies in coding and payment policies among IRFs are pertinent to policy makers and should be of general concern. It was noted in the Commission's December 2019 decision on the Encompass-Salisbury expansion project that Encompass Health had agreed to pay $48 million to resolve allegations under the Fraudulent Claims Act that Encompass Health IRFs had "provided inaccurate information to Medicare to maintain their status as an IRF and to earn a higher rate of reimbursement." The Salisbury hospital was not an IRF implicated in the settlement and Encompass Health argued that the fact that entering into a Corporate Integrity Agreement was not required as part of the settlement indicates that Encompass Health was not required to change any of its coding practices.

I do not find MNRH's arguments pertinent to consideration of whether the applicant complies with this quality of care standard. The interested party itself did not offer evidence that Encompass Health misuses the payment system or that it systematically provides services to higher-margin cases. For instance, among MedPAC's findings were that high-margin IRFs may avoid treating stroke patients. In its application, Encompass-Southern Maryland places emphasis on the ability of Encompass Health's Stroke Centers of Excellence to address this chronic disease and projects that 30 percent of historic SNF stroke patient volume will shift to its facility, as shown in projection assumptions under the need standard.

I also do not accept the interested party's argument that the comparison of the cost of services is invalid because land and labor are less expensive in areas where the applicant operates. While the difference in the cost of inputs among various markets will obviously have a bearing on broad cost comparisons, the market for IRFs is highly skewed toward Medicare patients and all IRFs face the constraint of keeping costs within the prospectively established Medicare reimbursement rates established for IRFs. I do not believe that the applicant should be penalized for having a large proportion of its facilities in lower cost regions of the country.

Encompass-Southern Maryland has demonstrated its ability to provide quality inpatient rehabilitation care. Encompass Health has experience as a licensed and accredited rehabilitation provider, with experience reporting the required quality measures, and its performance on those measures is comparable with the performance of other providers. For these reasons, I find that the applicant meets the requirements of Paragraph (b) of the quality standard.

B. PROJECT REVIEW STANDARDS.

In addition to these standards, an applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall 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. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

Applicant's Response

In its application, Encompass-Southern Maryland discusses numerous barriers to access that it believes exist in the Southern Maryland health planning region that it states prevent patients from obtaining medically necessary acute inpatient rehabilitation services. The applicant categorizes these barriers as follows:

- Maldistribution of beds;
- Limited acute rehabilitation options;
- Travel time;
- Family engagement;
- Underutilization of acute rehabilitation services, and
- Disruption in continuity of care.

(DI #5, pp. 111-23).

A summary of Encompass-Southern Maryland's response follows each heading below. The applicant also addresses the proposed project's financial feasibility and community support.

Maldistribution of beds

Encompass-Southern Maryland discusses what it views the unequal distribution of acute rehabilitation beds across the State, and notes that the lowest bed-to-population ratio found is in the Southern Maryland health planning region. According to the applicant, as shown in Table III-4, the statewide bed-to-population ratio is one acute rehabilitation bed per 9.7 thousand residents who are 18 years of age or older. In the Southern Maryland region, there is one acute rehabilitation bed per 35 thousand adults (based on the previous bed inventory of 28 beds). (DI #5, pp. 115-16).

Table III-4:

 # Adult Population per Rehabilitation Bed in Maryland

By Health Planning Region

CY 2016

Health Planning Region	Adult Population Age 18+	# Licensed Rehab Beds	Adult Population: Bed Ratio
Eastern Shore	279,236	79	3,535:1
Central Maryland	2,219,888	255	8,705:1
Montgomery	812,040	87	9,334:1
Western Maryland	397,975	33	12,060:1
Southern Maryland	980,122	28	35,004:1
Total	**4,689,261**	**482**	**9,729:1**

Sources:

[1] Licensed Beds: Maryland Health Care Commission, 2017

[2] Population: Nielson-Claritas

Notes:

UMROI includes 82 licensed rehabilitation beds and excludes 16 dually licensed chronic/rehabilitation beds

Source: DI #5, p. 116.

Limited acute rehabilitation options

Encompass-Southern Maryland notes that the Southern Region's only acute rehabilitation program is at UM Laurel Regional Hospital, which recently discontinued its 28-bed acute inpatient rehabilitation services, with ten beds moved to UM Prince George's Hospital Center, an affiliated hospital. (DI #5, p. 116). The remaining 18 beds were acquired by Encompass-Southern Maryland

Travel time and family engagement

Encompass-Southern Maryland contends that distance to acute inpatient care is a determinant of whether a patient seeks that care, pointing out that the Acute Inpatient Rehabilitation Chapter states that "the distance to providers, relative to a patient's residence may be a more powerful predictor of the use of acute inpatient rehabilitation services than the clinical characteristics of patients."[15] As evidence that this is a barrier to seeking or receiving rehabilitation services, the applicant notes that more than 90 percent of rehabilitation patients within the proposed service area traveled outside of the defined service area of Southern Maryland and Anne Arundel County for services in CY 2016. More than half (52 percent) of those traveled to the District of Columbia for services.

The applicant estimates that the incremental travel time for residents to access acute inpatient rehabilitation services in the District of Columbia can be between 60 to 100 minutes, imposing hardships on patients and families and presenting an access barrier. Elaborating on the hardships, the applicant lists travel costs and family members who want to visit regularly and be

[15] COMAR §10.24.09.03, *Issues and Policies, Access to Care,* p. 5 (citation omitted).

actively engaged in the rehabilitation process having to take time off from work. The applicant claims that the impact is particularly difficult because the ALOS for acute rehabilitation patients is two weeks, meaning the trip may be undertaken several times. According to Encompass-Southern Maryland, clinicians report that families choose to sacrifice the rehabilitation component because commuting to visit family members is unworkable. (DI #5, p.34 & pp. 117-18).

According to Encompass-Southern Maryland, increased travel time burdens family members and limits family education and engagement in patient recovery. This makes care transitions more difficult and may slow patient progress upon the patient's return home. (DI #5, p. 118).

Underutilization of acute rehabilitation services

The applicant presented data to show that the proposed service area it defines for the project, the Southern Maryland health planning region and Anne Arundel County, has a lower use rate for acute rehabilitation than the state as a whole. The applicant calculates that, for the population 65 years of age and older (who made up about 57 percent of Maryland's inpatient rehabilitation patients in CY 2016), the statewide utilization rate is 6.72 discharges per thousand population. By contrast, Encompass-Southern Maryland calculates a use rate of 4.42 per thousand elderly in the Southern Maryland health planning region and 2.67 per thousand elderly population in Anne Arundel County. Table III-5 provides an overview of acute rehabilitation use rates for Maryland.

Table III-5: Adult Rehabilitation Discharges per 1,000 by County & 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
Dorchester	-	40	111	151	6,706	18,495	6,473	24,968	-	2.16	17.15	6.05
Kent	-	14	12	26	4,366	14,141	5,980	20,121	-	0.99	2.01	1.29
Queen Annes	-	23	42	65	9,710	26,672	7,797	34,469	-	0.86	5.39	1.89
Talbot	-	38	173	211	6,812	20,218	10,136	30,354	-	1.88	17.07	6.95
Somerset	-	18	66	84	4,217	15,950	3,760	19,710	-	1.13	17.55	4.26
Wicomico	-	130	449	579	22,275	63,537	15,035	78,572	-	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 Georges	16	661	559	1,220	206,094	595,173	110,357	705,530	0.08	1.11	5.07	1.73
Saint Marys	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	23	594	944	1,538	246,181	661,182	150,858	812,040	0.09	0.90	6.26	1.89
Subtotal: Montgomery	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	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	**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**

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2016 Final
[2] DC hospitals: DCHA Database; CY2016 Final
[3] Population Data: Nielson-Claritas Population Data; CY2016
Notes:
[a] Acute Rehab: Based on State Health Plan definition (see Technical Notes)

Source: DI #5, p. 119

The applicant attributes the lower use rates in its proposed service area to the limited bed capacity at the single program in the region; the hardships and added costs imposed by having to use out-of-area programs, discouraging use of the service; and clinicians and social workers who may not be strongly promoting rehabilitation care at an IRF because providers in Southern Maryland may not have had enough experience with IRFs to appreciate the superior outcomes in terms of clinical outcomes and costs of care savings. (DI #5, p. 119).

Disruption in continuity of care

According to the applicant, using out-of-area providers typically means a disruption in medical management or a more challenging task for discharge planners/case managers to arrange community-based services post-discharge. It states that discharge planners are typically less familiar with local resources and arranging community-based services for post-discharge typically takes more time. (DI #5, p. 120).

Encompass-Southern Maryland states that its proposal addresses those barriers and that it is well-positioned geographically and programmatically to improve access to rehabilitation services, promote effective use of acute rehabilitation services, support continuity of care, and provide Southern Maryland residents with more options for high quality rehabilitation services. (DI #5, pp. 121-124).

Some features and benefits that the applicant maintains will be realized in its proposed project, which will advance the populations access to care, include:

- Its location in Bowie, near the densely populated communities in Prince George's County and southern Anne Arundel County, will reduce travel time for the service area population;
- Its location near the new UM Capital Region Prince George's Hospital Center, which is projected to serve more than 30 percent of Prince George's County inpatients, with accompanying increase in local demand for rehabilitation services;
- Its ability to treat complex medical needs at an inpatient facility;
- Expected accreditation by the Joint Commission and CARF, and accreditation for disease-specific programs. Several of these programs will align with disease management programs now operating across hospitals in Southern Maryland and will support Maryland's goals for chronic disease management, like certified stroke programs supported by state-of-the-art equipment and professionals who have completed specialty program training in stroke care;
- Its presence at all area hospitals through its team of Rehabilitation Liaisons to provide evaluation and transfer of patients;
- Its accommodation of direct admissions from physician offices and the community;
- Working partnerships with area hospitals and accountable care organizations, and through participation in Medicare Advantage contracts; and
- Support from area hospitals and clinicians who describe similar barriers, as expressed in letters of support for the project.
  (DI #5, p. 132 and Exh. 11).

Interested Party Comments

MNRH states that Encompass-Southern Maryland's application does not meet its requirement to (1) 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"* and then to (2) demonstrate *"a credible plan to address those barriers"* based on supporting evidence. As summarized below, MNRH attempts to refute each key point and states that the applicant does not provide the type of evidence mandated by the State Health Plan to demonstrate the existence of any of the stated barriers. (DI #27, pp. 5-6).

Unequal distribution

MNRH states that Encompass-Southern Maryland's contention that a lower population-to-bed ratio in the Southern Maryland health planning region indicates a maldistribution of beds does

not take into account the normal travel patterns of the residents of this region to acute inpatient rehabilitation providers, other specialized inpatient health care services and employers in the District of Columbia and Montgomery County. It further states that the applicant does not account for the beds at MNRH and Washington Adventist Rehabilitation Hospital at Takoma Park, which MNRH argues should be included in the inventory.[16] (DI #27, p. 6).

MNRH recommends several adjustments to the way bed inventory and use rates are calculated in considering the data presented by Encompass-Southern Maryland. First, MNRH suggests that since 36 percent of MNRH's discharges in CY 2016 were residents of the Southern Maryland region, the bed inventory for the Southern Maryland region should take that into account and include 36 percent of MNRH's beds, which would amount to 49 beds (36 percent of 137 beds at MNRH). MNRH calculates that when its 49 additional beds are included in the Southern Maryland supply, the population-to-bed ratio in the Southern Maryland region would become 8.6, which is closer to the State average of 11.3. It states that, if the analysis includes beds used at Washington Adventist Rehabilitation Hospital in Montgomery County, the ratio would be even closer to the State average. (DI #27, pp. 6-7).

MNRH also points out that the Eastern Shore rather than the Southern Maryland region is "the real outlier" in Maryland, with a population-to-bed ratio of 28.3, and points out that Encompass Health operates a facility there, suggesting that over-use may be a concern there with respect to statewide averages. (DI #27. pp. 6, 9-10).

MNRH also maintains that because MNRH is just 20 miles from the proposed project location, and because Southern Maryland residents routinely travel to the District of Columbia and Montgomery County for other daily activities, there is no access barrier based on inequitable distribution of acute inpatient rehabilitation services. (DI #27, pp. 6-7).

Limited acute rehabilitation options

MNRH reiterates its position that acute rehabilitation services are easily available to residents of the Southern Maryland region at MNRH and Adventist Rehabilitation Hospital at Takoma Park, which will soon be relocated and expanded with 42 beds at White Oak, which is also very close to the proposed site. It notes that these beds will be available at least 12 months prior to the projected completion of this proposed project. It argues that these two locations are as convenient for residents of the proposed service area as the proposed new rehabilitation hospital. (DI #27, p. 7).

Travel time and family engagement

MNRH asserts that there is no supporting evidence for the statements made by the applicant that travel time is a barrier due to related "costs and family hardship" and that "many families choose to sacrifice the rehab component because the commute is simply unworkable." MNRH also argues that the applicant presented travel time data that is misleading. While Encompass-Southern

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[16] The Commission authorized this special rehabilitation hospital to relocate to the campus of Adventist HealthCare's White Oak Medical Center campus in Silver Spring, approximately six miles north of its current Takoma Park location.

Maryland emphasizes that travel time for some residents of the proposed service area is between 60-100 minutes (DI #5, p. 116), MNRH points out that the applicant shows travel time to MNRH from a midpoint in Prince George's County is only 38 minutes, and between 56 and 106 minutes for the rest of the proposed service area (DI #5, pp. 43 & 121). MNRH maintains that this data, combined with the number of patients that already travel to MNRH or Montgomery County for acute rehabilitation refutes the applicant's claim that there is any hardship due to travel time. Further, the applicant has not provided any evidence, such as research studies to indicate that such hardship due to travel patterns exists, according to MNRH. (DI #27, p.8).

MNRH states that Encompass-Southern Maryland provides no persuasive evidence or proof that travel time or distance discourages family engagement, or that the proposed location would have any significant impact if there is lack of family engagement. MNRH asserts that distance and convenience factors have already been factored into patient choice and family involvement in decisions about where to go for post-acute care, and cited the example of a patient who chooses to receive services farther away from his/her personal residence because of loved ones who already travel to the District of Columbia for work, contributing to current out-migration patterns. (DI #27, pp. 8-9).

Underutilization and low use rates

MNRH states that the applicant presents false connections between underutilization and travel times and that this argument is just a restatement of its unsupported claim of a lack of available beds within the relevant geographic boundary. According to MNRH, there is no evidence that residents are discouraged from using acute rehabilitation services. Additionally, MNRH disagrees that utilization rates in Southern Maryland are markedly lower than other Maryland counties, if looked at by jurisdiction. MNRH references data presented in the application and states that use rates are very high on the lower Eastern Shore, which could suggest overuse that skews the statewide average. MNRH states that the Southern Maryland average use rate of 4.4 discharges per thousand population for the 65+ age group is consistent with the state average of 6.7. Rather, a case could be made for overutilization on the lower Eastern Shore, which the State Health Plan also discourages. MNRH presents data that excludes Caroline, Dorchester, Somerset, Talbot, Wicomico, and Worcester Counties that shows, when these counties are excluded, the state average use rate for the 65+ population is 5.8 discharges per thousand. Thus, it contends the Southern Maryland use rate of 4.4 discharges per thousand is not inappropriately low. (DI #27, p. 9-11).

MNRH states that the applicant's claim that "clinicians and social workers may not be strongly promoting rehabilitation care at an IRF" is unsubstantiated. MNRH states that its data within the MedStar system suggest consistent trends in IRF referrals with the MedStar system. MNRH states that it believes strong promotion of rehabilitation care at an IRF is more easily achieved in acute care hospitals affiliated with hospital systems that operate acute rehabilitation beds themselves, since ongoing education about the benefits of IRF is critical, especially when considering frequent turnover of case management staff in acute hospitals. (DI #27, pp. 9-11).

Disruption in continuity

MNRH states that the applicant did not document or provide evidence for its claim that dependence on out-of-area providers results in breaks to continuity of care and less effective care management. Instead, MNRH argues that the problem described by the applicant is a result of *out of network providers*, rather than out of area providers. To further refute the applicant's claim, according to MNRH, when MedStar patients go to MNRH they stay within the MedStar system and maintain continuity, benefitting in the following ways:

- 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), 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.

(DI #27, pp. 11-12).

MNRH goes on to state that quality of care suffers when patients must navigate between disparate providers with different documentation systems that do not properly communicate, which can lead to duplicative services, confusion, and distrust among providers and patients, ultimately driving up costs for the patient and the health care system overall. MNRH states that the proposed project would suffer shortcomings, as it would be a stand-alone facility lacking direct, same-ownership affiliation with referring facilities. The interested party maintains that acute rehabilitation patients benefit from staying within MedStar's health care system. MNRH currently operates six outpatient sites in the Southern Maryland region in Hollywood, Clinton, Mitchellville, Oxon Hill, Hyattsville, and Brandywine, as well as at a MedStar hospital in St. Mary's County and at a MedStar hospital in Prince George's County, and at multiple other outpatient sites in Washington, D.C., Montgomery County, and elsewhere in Maryland and Virginia. It states that this is evidence that a coordinated system of care already exists for rehabilitation patients in the Southern Maryland region. (DI #27, p. 12).

<u>Applicant's Response to Interested Party Comments</u>

Encompass-Southern Maryland asserts that MNRH "has not substantively criticized any part of " Encompass-Southern Maryland's plan, "other than to suggest that MNRH's out-of-state facility, which requires a longer drive time than EHR's proposed facility, is somehow more convenient for patients in EHR's proposed service area." (DI #28, p.5).

Encompass-Southern Maryland states that it has demonstrated that barriers to access exist by showing "the lack of inpatient rehabilitation providers in the Southern Maryland region, and the relative travel time to the closest providers," pointing out that although the region is the second most populous health planning region for rehabilitation services, it has the fewest inpatient

rehabilitation beds. (DI #28, p. 6). To support those statements, the applicant points out that the Commission has reported that the Southern Maryland region has the lowest use rate in the State and has also projected a need for more beds in the region. (DI #28, p. 6).

Encompass-Southern Maryland believes that distance to acute inpatient care is a determinant of whether a patient seeks that care. Answering MNRH's criticism that it does not provide evidence of this, Encompass-Southern Maryland references the COMAR §10.24.09.03, Access to Care, which states that "the distance to providers, relative to a patient's residence may be a more powerful predictor of the use of acute inpatient rehabilitation services than the clinical characteristics of patients."

As further illustration of the effect that distance from a provider might have, Encompass-Southern Maryland references a number of letters of support for its proposed project that provide anecdotal evidence that poor geographic access presents a barrier to care. One example is an excerpt from a letter from Nneka Ezunagu, the Stroke Program Coordinator for UM Prince George's Hospital Center:

> One of the biggest barriers that we face is access to post hospital care and rehabilitation after the patient is discharged …. [M]any times these patients are forced to choose less intensive arenas …. To have a reputable intensive rehabilitation facility for the patients we serve in a central location to their home would be welcoming and considered an extreme blessing.
> (DI #28, pp. 6-7).

Encompass-Southern Maryland argues that MNRH "does not credibly dispute" the evidence of access barriers it has presented. The applicant maintains that MNRH's comments "reflect a deep misunderstanding of the policy and definitions of the State Health Plan Chapter," when it advocates to classify a portion of MNRH's beds, i.e., a percentage of its beds pro-rated to match the proportion of its patients who reside in the Southern Maryland planning region, as part of the bed inventory of the region.

> The Commission articulated policy goals for rehabilitation services by, in part, defining health planning regions … and the planning is premised on a regional bed need methodology. COMAR § 10.24.09.05. MNRH's suggestion that these definitions should be disregarded, and that access should be evaluated on a statewide and even a multi-state basis strains such policy beyond any reasonable meaning. Accounting for a portion of MNRH's beds (MNRH suggests EHR should have included 37 of MNHR beds in its need projections for the Southern Region) not only is unsupported by the applicable State Health Plan, such a projection would contradict the State Health Plan chapter's express definitions, which do not include Washington, D.C. in the Southern Region … [and] the recognition that these services are best provided on a regional basis does not support MNRH's contention that the Commission should disregard the very regions it defines for these services.
> (DI #28, pp. 7, 8).

The applicant also refutes MNRH's complaints that the travel time analysis in the application is misleading and states, for clarification, that travel time for residents of Prince George's County is 27 minutes, on average, to the proposed facility, compared to 38 minutes to MNRH.

The applicant next responded to MNRH's critique that it did not provide evidence that travel distance/time discourages family engagement, and that such engagement would be just as likely at the proposed location. Encompass-Southern Maryland states that access barriers such as travel time have an impact on both the patient and the patient's family. Thus "[t]he travel time study showing that the majority of patients needing rehabilitation services must leave the region for care is equally applicable to family members residing with or near the patients." (DI #28, pp. 8-9).

Encompass-Southern Maryland also dismisses MNRH's argument that the comparatively low use rate of inpatient rehabilitation services in the Southern Maryland region is related more to the upward skewing of the statewide utilization rate due to overutilization on the lower Eastern Shore than it is to barriers to access, as well as MNRH's inference that such overutilization may be related to "the other Encompass facility" that is located there.

First, the applicant states that there is "absolutely no evidence of overutilization at Encompass Health Rehabilitation Hospital of Salisbury" and that "Encompass Health, both as a national organization and on an individual facility level, has compliance activities and checks and balances to assure that patients are appropriately coded from admission through discharge."[17] Encompass-Southern Maryland asserts that there is no basis to analyze a statewide use rate excluding six counties of the lower Eastern Shore. Further, Encompass-Southern Maryland dismisses MNRH's assertion that "the Southern Maryland use rate of 4.4 discharges per thousand population for the 65 plus age group appears consistent with the state average of 6.7," pointing out that the region's use rate is "only two thirds of the statewide use rate." (DI #28, p. 9).

Next Encompass-Southern Maryland rebuffs what it describes as MNRH's argument that continuity of care can only be achieved when patients receive care within the same health care system, which "seems to suggest patients should be referred to and receive care only at facilities within the same system." The applicant asserts that this argument ignores patient choice and that patients should not be expected or required to receive care only within one health care system. Encompass-Southern Maryland also maintains that quality of care does not suffer when patients navigate between providers, citing MedStar's use of the Chesapeake Regional Information System for our Patients (CRISP) as a vehicle by which providers can share and access medical records and relevant patient information across health care systems. The applicant states that Encompass Health expects to integrate with CRISP in Maryland to enable real time reporting systems, support care coordination, and leverage all the tools that have been built in Maryland. Finally, the applicant referenced Encompass Health's national presence and experience treating patients and

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[17] As evidence of its own compliance activities and checks and balances, Encompass Health provides a web link to the Encompass Health Corporation's ethics and compliance Health 360 statements. (DI #28, p. 9). https://360.encompasshealth.com/Corporate/Compliance/Pages/Home.aspx; Encompass Health Rehabilitation Hospital of Salisbury site regarding vendor compliance, http://encompasshealth.com/vendorcompliance.

successfully interacting with all referring providers without disruption, and stated that it expects to coordinate its system of care with UM Capital Region Medical Center and cites the letter of support from Dr. Bruce M. Neckritz, that describes this proposal as an opportunity for Prince George's County to work collaboratively with a high-quality rehabilitation center. (DI #28, pp.10-11).

Reviewer's Analysis and Findings

The purpose of the access standard is to ensure that the acute inpatient rehabilitation project optimizes accessibility for the service area population. At issue here is whether Encompass-Southern Maryland presented evidence to demonstrate that barriers to access exist and that it has developed a credible plan to address those barriers. The applicant states that the Southern Maryland health planning region has barriers to access such as an unequal distribution of and lack of beds and excessive distances and travel time which hinder family engagement, resulting in low utilization rates and a disruption in continuity of care. The interested party argues that the applicant has neither provided evidence of barriers to access, nor demonstrated a credible plan to address barriers. MNRH also suggests that some of the data presented by the applicant may be misleading or skewed.

My evaluation considers whether research studies or empirical evidence support a finding that there is a geographic access barrier or limited availability to acute rehabilitation beds for patients who originate in the Southern Maryland health planning region. If so, I consider whether limited availability leads to an impediment in receiving acute rehabilitation service, whether the proposed plan is a mechanism for addressing the barrier(s), whether the plan is financially feasible, and whether members of the communities affected by the project support the plan.

The applicant presented several intertwined issues as evidence of barriers to access in the region. As presented in the application, they include: the unequal distribution of beds; limited provider options; travel time to existing providers; barriers to family engagement; relatively lower utilization rates in the region; and concerns about continuity of care.

To summarize the applicant's view, the Southern Maryland health planning region has a single provider with 10 beds currently available in the region, located at UM Prince George's Regional Medical Center. The region has fewer providers than any other region besides the single-county region of Montgomery County, and the fewest beds in number and per capita. Currently, 90 percent of the patients originating in the region are out-migrating for acute rehabilitation services. The applicant claims that the lack of beds and a high out-migration rate are determinants of an access barrier, along with associated less family engagement and disruptions in continuity of care when patients must travel out of their region for services.

The interested party counters that the lack of beds in the defined region does not present a barrier to patients who live in the region because travel to the District of Columbia is part of their routine travel patterns. It argues that, because this is a fact of life in the region, the acute rehabilitation beds at MNRH and Adventist Rehabilitation Hospital should be considered as part of the bed inventory available for the planning region's patients, prorated to the degree that Southern Maryland utilizes those beds, which would bring the bed-to-population ratio closer to the

State average. The interested party claims that the applicant does not provide supporting evidence for statements regarding travel barriers, hardships related to family engagement, or any breaks in continuity of care related to receiving services from out-of-area providers.

Rather, MNRH argues that it already has an established coordinated system in the Southern Maryland planning region with six outpatient sites, two hospitals, and other outpatient sites in Washington, D.C., Montgomery County, and elsewhere in Maryland and Virginia, for rehabilitation patients in the health planning region. It states that the applicant is more likely to have issues with navigating between disparate providers, duplicating services, and ultimately driving up the costs of healthcare.

Evidence of Barriers to Access

I approach this analysis believing that out-migration for a regional specialty service, in and of itself, is not necessarily a problem or evidence of an access barrier when the region under analysis is designated by county boundaries. Political lines have no bearing on how far patients might travel or their proximity to services across boundaries. Indeed, many residents of Maryland live in one county but are closer to a health care facility in another county, another state, or the District of Columbia.

Similarly, I believe that a lack of beds in a health planning region, alone or in combination with evidence of out-migration, is not necessarily evidence that the lack of beds in the region constitutes a barrier to access. I considered comments made by the interested party suggesting that regional bed inventories or use rates should be modified based on out-migration trends, and that we should ignore statewide comparisons because county utilization rates vary widely. I have decided not to consider the pro-rata "shifting" of beds from one other region to another, nor will I exclude the utilization of any region from the statewide average calculation because the interested party suggests that the region is an "outlier." Utilization rates calculated for the Commission's net bed need projections include in-migration and out-migration trends when calculating bed need, and thus accounts for residents of the Southern Maryland health planning region who travel to MNRH.

My goal is to answer the question of whether the geographic proximity to existing IRFs might play a role in whether a patient receives services and whether the out-migration that the applicant cites might point to a barrier based on travel time rather than regional delineations.

I concur with the applicant that comparing utilization rates among different counties in the State provides useful information. The question is, if differences in utilization exist does that indicate that the lack of beds in the region is a geographic barrier to access? The following Table III-6 shows the utilization of acute rehabilitation services for Maryland residents who received services in Maryland or District of Columbia hospitals over the most recent six-year period of data available.

Table III-6: Acute Rehabilitation Utilization Rates by County of Residence (Population aged 15 years and older)

Jurisdiction	Use Rate (Discharges/1,000 Population)					
	2012	2013	2014	2015	2016	2017
Allegany County	3.8	3.7	3.4	2.6	3.4	3.8
Anne Arundel County	***1.4***	***1.2***	***1.2***	***1.2***	***1.2***	***1.1***
Baltimore County	2.7	2.6	2.7	2.5	2.4	2.5
Baltimore City	3.3	3.0	3.1	3.1	3.2	3.2
Calvert County	*0.9*	*1.1*	*1.0*	*1.1*	*1.2*	*1.0*
Caroline County	4.1	3.2	3.4	2.4	3.2	3.7
Carroll County	1.5	1.4	1.3	1.3	1.4	1.4
Cecil County	0.5	0.7	0.6	0.4	0.4	0.4
Charles County	***1.0***	***1.0***	***1.1***	***1.1***	***1.1***	***1.0***
Dorchester County	5.6	5.3	5.5	5.4	5.9	5.6
Frederick County	1.1	1.3	1.1	1.2	1.1	1.0
Garrett County	0.8	0.6	0.8	0.3	0.8	0.7
Harford County	1.9	1.7	1.9	1.8	1.6	1.5
Howard County	2.4	2.2	1.7	1.7	1.5	1.2
Kent County	1.3	1.1	1.6	1.4	0.8	1.3
Montgomery County	1.7	1.7	1.9	2.0	1.8	1.9
Prince George's Co.	***1.7***	***1.7***	***1.7***	***1.8***	***1.7***	***1.6***
Queen Anne's County	2.1	1.8	1.9	2.2	1.9	2.0
Somerset County	3.4	3.7	3.6	4.4	3.7	4.8
St. Mary's County	***0.7***	***0.7***	***0.8***	***0.8***	***0.9***	***0.9***
Talbot County	6.9	6.7	6.6	6.4	6.8	6.2
Washington County	3.5	3.7	3.3	3.0	2.8	2.7
Wicomico County	5.8	6.2	6.3	6.9	6.9	7.3
Worcester County	6.3	6.0	6.9	6.1	7.0	7.2
State	**2.2**	**2.1**	**2.1**	**2.1**	**2.1**	**2.1**

Source: HSCRC discharge abstract data and chronic files; D.C. discharge abstract data; Claritas Population File

The utilization rate data shows that the counties in the proposed service area of the proposed rehabilitation hospital (in ***bold italics*** in the table) have consistently shown a use rate in the bottom half of counties in Maryland. In 2017, Calvert, Charles and St. Mary's Counties fell in the bottom quartile with a utilization rate of 1 per 1,000 population 15 years or older. St. Mary's had the third lowest use rate of all counties; Charles the fifth lowest, and Calvert the sixth lowest. Anne Arundel (seventh lowest) and Prince George's Counties fell in the third quartile, with respective utilization rates of 1.1 and 1.6 per 1,000 population. Compared to a statewide use rate of 2.1 per 1,000 population, residents of this region do not receive acute rehabilitation service as much as would be expected. In 2017, all but one of the five counties included in the service area are in the bottom ten counties in utilization rate.

Next, I reviewed a travel time analysis comparing the geographic location of existing acute rehabilitation alternatives to the midpoints of each county in the proposed service area, shown in the table below.

Table III-7: Estimated Drive Time from Counties in the Proposed Service Area to Existing Acute Rehabilitation Facilities and Proposed Project

County Geographic Midpoints	MedStar National Rehabilitation Hospital	Adventist Rehabilitation Hospital – Takoma Park	University of Maryland Rehabilitation & Orthopaedic Institute
Anne Arundel County	41 minutes	40 minutes	37 minutes
Calvert County	69 minutes	68 minutes	82 minutes
Charles County	53 minutes	65 minutes	82 minutes
Prince George's County	36 minutes	40 minutes	55 minutes
St. Mary's County	102 minutes	105 minutes	123 minutes

Source: Google Maps

This shows that the three counties in the proposed service area which had the lowest utilization rates, St. Mary's, Charles, and Calvert, in order of lowest to highest use rate, also are the counties with midpoints farthest away from any existing acute rehabilitation facility. This leads me to concur with the applicant's citation of research published by Buntin, et al. that appears in the Acute Inpatient Rehabilitation Chapter as guidance for health planners, and "suggests that the distance to providers, relative to a patient's residence may be a more powerful predictor of the use of acute inpatient rehabilitation services than the clinical characteristics of patients." Here, evidence suggests that the lower utilization rates in certain counties may be tied to longer distance from an acute rehabilitation provider. Thus, the addition of a provider in closer proximity is likely to address that barrier to access.

While I think it is logical that the level of family engagement may also be lower when patients receive services farther away, I find that the applicant did not provide research or other evidence to support this assertion. Similarly, I find that the applicant did not provide evidence to support its statements that receiving acute rehabilitation services in another jurisdiction than a patient's residence leads to any systematic disruption in the continuity of care or increases hurdles to arranging services for post-discharge care. Rather, in my view, because a large percentage of discharges at MNRH originate from the Southern Maryland health planning region and MNRH has an outpatient presence in the region, I would assume that staff at MNRH are familiar with the local system of post-acute resources. I find that neither the applicant nor the interested party provided any empirical evidence regarding whether out-of-area or cross-system continuity should be a concern.

To further assist in determining whether, as the interested party contends, travel to the District of Columbia is routine for Southern Maryland residents, I looked to see what the rate of travel to the District of Columbia was for regional residents for general medical/surgical (MSGA) inpatient use. The following table shows the market share of each jurisdiction's MSGA discharges at acute care hospitals in the Southern Maryland health planning region and in the District of Columbia.

Table III-8: Medical/Surgical Hospital Discharges at Maryland and District of Columbia Hospitals Originating from Calvert, Charles, Prince George's, St. Mary's, and Southern Anne Arundel Counties, CY 2017

Jurisdiction of Residency	Total Discharges	Discharges at Hospitals in Proposed Service Area	Percent	Discharges at Hospitals in District of Columbia	Percent
Calvert	6,092	4,250	69.8%	1,140	18.7%
Charles	10,120	6,455	63.8%	2,676	26.4%
Prince George's	56,764	28,182	49.6%	14,503	25.5%
St. Mary's	7,468	5,151	69.0%	1,724	23.1%
Southern Anne Arundel County (18 ZIP Codes)	9,639	7,696	79.8%	395	4.1%
Total Proposed Service Area	**90,083**	**51,734**	**57.4%**	**20,438**	**22.7%**

Source: HSCRC discharge abstract data and D.C. discharge abstract data.

I present this data to put the interested party's statements about the routine pattern of travel for Southern Maryland residents into perspective. Acute rehabilitation is a regional service and not a routine medical service, and it is entirely appropriate to plan for an increased travel time for these services and consider cross-regional availability when planning for these services. However, MNRH suggests that the residents of the proposed service area do not have a barrier to access because travel to the District of Columbia is routine. For more routine medical services, 23 percent of medical/surgical inpatients travelled to the District of Columbia in 2017. Here again, with the exception of Anne Arundel County, the counties with midpoints that are farthest away from existing IRF alternatives, Calvert and St. Mary's Counties, also have a higher rate of receiving services within the Southern Maryland region.

As I noted above, high out-migration for acute rehabilitation services, in and of itself, does not necessarily prove that there is a barrier to access. However, when I consider a constellation of facts including: a higher level of out-migration for services; fewer beds located in the region; lower use rates in the region; and the migration patterns for general acute services, I find that the data supports the conclusion that a geographic barrier to access is likely to be a factor contributing to the significantly lower rate of utilization of acute inpatient rehabilitation services in the Southern Maryland health planning region. The academic research by Buntin, et al., which is part of the policies section of the Acute Inpatient Rehabilitation Chapter and by the applicant, states that distance (or travel time) to providers may be a more powerful predictor of the use of acute rehabilitation services than patient characteristics.

Geographic Proximity to Services for the Service Area Population

This standard requires my evaluation of whether the proposed project is located to optimize accessibility to acute rehabilitation for its projected service area. The Acute Inpatient Rehabilitation Chapter does not define optimal accessibility, so to analyze whether the location of the proposed project would optimize accessibility for the service area population, I looked at where patients from the service area have been receiving inpatient rehabilitation. The most recent inpatient discharge data available, shown in the following table, indicates that more than three-

quarters of discharges originating from the four counties in the proposed service area obtained those services at three hospitals: 42 percent at MNRH in the District of Columbia; 20 percent at Adventist Rehabilitation Hospital, in Montgomery County; and four percent at UM Rehabilitation and Orthopaedic Institute in Baltimore.

Table III-9: Acute Inpatient Rehabilitation Discharges Originating from Calvert, Charles, Prince George's, St. Mary's, and Anne Arundel Counties, CY 2017

Hospital	Calvert County Discharges	Charles County Discharges	Prince George's County Discharges	St. Mary's County Discharges	Anne Arundel County Discharges	Total Discharges from Selected Counties	Percent of Discharges
Maryland Hospitals							
AHC Rehabilitation	13	12	342	11	11	389	19.6%
Encompass-Salisbury			1		2	3	0.2%
Good Samaritan	1	1	8		30	40	2.0%
Johns Hopkins	4	2	16	1	49	72	3.6%
Johns Hopkins Bayview	2	3	12	2	70	89	4.5%
Laurel	1	1	101	2	52	157	7.9%
Meritus		1	1			2	0.1%
Sinai	1	1	10	2	28	42	2.1%
UM Memorial at Easton					3	3	0.2%
UM Rehabilitation and Orthopaedic Institute	6	8	48	5	215	282	14.2%
Western Maryland	1					1	0.1%
Subtotal						**1,080**	**54.7%**
District of Columbia Hospitals							
Washington University	7	8	50	1	4	70	3.5%
MedStar National Rehabilitation	43	94	600	55	39	831	41.8%
Subtotal						**901**	**45.3%**
Total						**1,981**	**100%**

Source: HSCRC discharge abstract data and chronic files; D.C. discharge abstract data.

Next, I compared the geographic location of the proposed project to the most utilized existing alternatives. The following table shows the distance from the midpoints of each county included in the proposed service area to each of the selected existing service providers and the proposed project location using the fastest route in the usual traffic.

Table III-10: Estimated Drive Time from Counties in the Proposed Service Area to Existing Acute Rehabilitation Facilities and the Proposed Project Site

County Geographic Midpoints	MedStar National Rehabilitation Hospital	Adventist Rehabilitation Hospital Takoma Park	UM Rehabilitation & Orthopaedic Institute	Proposed Project Site in Bowie	Difference in Drive Time: Project Site and Closest Existing Facility
Anne Arundel	41 minutes	40 minutes	37 minutes	16 minutes	21 minutes
Calvert	69 minutes	68 minutes	82 minutes	49 minutes	19 minutes
Charles	53 minutes	65 minutes	82 minutes	56 minutes	-3 minutes
Prince George's	36 minutes	40 minutes	55 minutes	29 minutes	7 minutes
St. Mary's	102 minutes	105 minutes	123 minutes	87 minutes	15 minutes

Source: Google Maps

This project offers a closer alternative for acute rehabilitation services for residents of Anne Arundel, Calvert, Prince George's, and St. Mary's Counties. It decreases drive time from the midpoint in St. Mary's County by 15 minutes, from the midpoint in Calvert County by 19 minutes, and from the southern part of Anne Arundel County by more 21 minutes. While the project is located in Bowie in Prince George's County, the trip from the midpoint in Prince George's County would be just 7 minutes shorter. I note that my calculation differs slightly from the applicant's analysis that travel time for residents of Prince George's County would decrease by 11 minutes. However, it is closer than existing facilities for 13 of the 36 zip code areas in Prince George's County.

However, this analysis undercuts the applicant's assertion that the estimated travel time for the Southern Maryland health planning region's residents to acute inpatient rehabilitation services in the District of Columbia is between 60 to 100 minutes for residents in the region, an assertion that the interested party challenged. My analysis found that just two counties have a drive time from their midpoints to MNRH of more than 60 minutes, Calvert and St. Mary's Counties. From the midpoint in Charles County, the proposed facility would actually be a longer drive than to MNRH. Though, it would be geographically closer for 6 out of 21 zip code areas in the county. (DI #28, p. 8).

The applicant proposes a project located in Bowie, in closer proximity for most of the proposed service area, approximately 9.5 miles from the new location for UM Prince George's Hospital Center, which is expected to be a referral source. I find that the project would be well-positioned as proposed.

Additional Accessibility Factors for the Service Area Population

I note that the applicant presents a proposed project that is designed as an accessible, one-story building with surface parking and ease of entry for caregivers with adequate space for new technology, educational programs, family-focused services, and specialty-focused staff. (DI #5, p. 59).

Plan to Address Barriers

The proposed acute inpatient rehabilitation hospital, located in the Southern Maryland health planning region in Bowie, will provide additional inpatient rehabilitation bed capacity in the region. The applicant aims to decrease out-migration and increase utilization rates in the proposed service area, a five-county area in which the geographic midpoints of three counties ranges from more than 50 minutes to more than 100 minutes away from an existing acute rehabilitation facility. I find the proposed project provides closer access to services for residents in parts of the proposed service area who have some of the lowest utilization rates in Maryland. I conclude that this proposed project is likely to raise acute rehabilitation utilization rates in the region. Based on the community support expressed in letters from local referral sources, education institutions, and the business community, I conclude that this project will be welcomed and supported by residents of Southern Maryland as an alternative to travelling to services in the District of Columbia.

Financial Feasibility

Financial feasibility often hinges on accurate utilization projections. The applicant's volume projection methodology, and the interested party's comments on them, are discussed in detail under the following consideration of the need standard, *infra*, pages 38-49.

Summary

I find that the applicant has demonstrated that travel time and resource levels are barriers to acute rehabilitation care in the Southern Maryland planning region. It is a region with little capacity to serve the region's demand for these services, resulting in a high level of out-migration for the services. The health planning region has a relatively low use rate of acute rehabilitation services, which is not a surprising finding in a region with little service capacity and with some areas, specifically the three southernmost counties of the region, located a considerable distance from existing service providers. I find that the location of the proposed facility will improve access and encourage higher levels of acute rehabilitation use for appropriate patients.

(2) Need.[18]

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

[18] The applicant and interested party addressed both the need standard and the need criterion together. For ease of discussion, I have consolidated all of the pertinent discussion of need in this section of my Recommended Decision.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

Applicant's Response

Encompass-Southern Maryland asserts that the Commission's bed need projections point out the need for the proposed project in the Southern Maryland health planning region. The following table summarizes the Commission's net bed need projection published in the *Maryland Register* on October 17, 2014, which was the most up-to-date projection at the time the application

was submitted.[19] As shown, at that time, the Commission projected a 2017 need range of -9 beds (i.e., a bed surplus) to 66 beds for the region.

Table III-11: Net Bed Need Projections for Acute Rehabilitation Beds: Maryland, 2017

Health Planning Region	Current Licensed Bed Capacity	Net Bed Need Range	
Central	277	Minimum	-31
		Maximum	21
Eastern Shore	74	Minimum	-22
		Maximum	13
Montgomery	87	Minimum	-18
		Maximum	26
Southern	28	Minimum	-9
		Maximum	66
Western	33	Minimum	5
		Maximum	13

Source: *Maryland Register*, October 17, 2014; DI #5, p. 25.

Addressing the range in need shown above, the applicant builds its projections in a need calculation illustrated in the following table. Its projections assume that the proposed acute rehabilitation hospital will:

- Capture 90 percent of discharges served at Laurel Regional Hospital;[20]
- Shift 40 percent of the existing service area cases that currently migrate to MedStar National Rehabilitation Hospital and George Washington University Hospital;
- Shift more medically complex cases from existing nursing homes in the service area: 30 percent of stroke transfers, five to 10 percent of traumatic brain and spinal cord injury transfers, and two to three percent of all other acute rehabilitation transfers;
- Treat new organ transplant cases in the service area;
- Capture an additional 10 percent of cases projected to migrate in from out of the projected service area (including those from the caseload at Laurel Regional that in-migrated);
- Capture five percent of cases as direct admissions from the community; and
- Capture 75 percent of the demand linked to future population growth in the projected service area.

[19] In 2018, the Commission published an updated bed need projection for 2021. See discussion, *supra*, pp. 47-48.

[20] Laurel Regional Hospital converted to a freestanding medical facility and no longer provides inpatient services. As noted earlier, its remaining 10 licensed acute rehabilitation beds have been moved to UM Prince George's Hospital Center.

Table III-12: Encompass Health Rehabilitation Hospital of Southern Maryland's Volume Projections for the Proposed Project

Projected Patient Category	CY 2016 Actual Discharges	Projected Share	Proposed Project's 2023 Projected Discharges
Projected shift from existing acute inpatient rehabilitation hospitals			
Laurel Regional Hospital total discharges	259	90%	233
NRH service area discharges	788	40%	315
GWU service area discharges	65	40%	26
Subtotal			**574**
Population growth associated with this category	298	75%	223
Projected shift from existing SNFs in proposed service area			
Stroke transfers	1,079	30%	324
TBI/SCI transfers	841	7.5%	63
Other acute rehabilitation	1,238	2.5%	31
Subtotal			**418**
Population growth associated with this category			154
Organ transplants in service area	96	10%	10
Additional out of service area			46
Additional direct admissions from physician offices/community (at 5% of total)			75
Total Projected Discharges			**1,500**
Average Length of Stay			**13.5**
Total Projected Patient Days			**20,212**
Occupancy Rate for 60 beds			**92.3%**

Source: DI #5, p. 52, Table I

In summary, the applicant projects obtaining 992 (66 percent) of the projected 1,500 discharges expected to come from its proposed service area (based on historical utilization) along with another 377 (25 percent) discharges from that area attributable to population growth. The remaining 121 discharges are expected to come from new in-migration and direct admissions from the community.

The proposed project intends to address need for additional acute rehabilitation inpatient beds in the Southern Maryland health planning region and 18 zip code areas in southern Anne Arundel County, part of the contiguous Central Maryland region, because the applicant states that the same barriers to access exist there as those affecting the Southern Maryland population, and the applicant believes that the project has the potential to meet those needs. According to the applicant, Anne Arundel County reports similarly low use rates for acute rehabilitation services, and the 18 zip code areas it targets in southern Anne Arundel County face the same geographic access problems for rehabilitation care as do the residents of Southern Maryland, i.e., no acute rehabilitation beds operating in Anne Arundel County and a thirty mile trip to the nearest acute rehabilitation program. As an illustration of travel patterns for this group, the applicant points out that adult residents from the 18 zip code areas in Anne Arundel County use Calvert Memorial Hospital (now CalvertHealth Medical Center) as their second most utilized general hospital for medical/surgical care, after Anne Arundel Medical Center. (DI #5, pp. 24-26, 124).

Encompass-Southern Maryland expects that its proposed hospital will reduce out-migration to the District of Columbia by capturing 40 percent of existing patients who migrate to MNRH and George Washington University Hospital, and will ultimately serve slightly more than 50 percent of the acute rehabilitation demand in its proposed service area. In order to illustrate its assumption that special rehabilitation hospitals typically capture a large share of acute impatient rehabilitation discharges, the applicant holds out Adventist Rehabilitation Hospital, which captured 78 percent of the Montgomery County health planning region discharges, and HealthSouth Chesapeake (now Encompass-Salisbury), which captured 70 percent of the discharges in the Eastern Shore health planning region, as examples. (DI #5, p. 50).

Based on Encompass Health's corporate experience, the applicant assumes that there will be no reduction in out-migration to existing Maryland hospital-based programs, and that in-migration will equal 10 percent of its projected cases. It notes that, nationally, seven percent of patients at Encompass Health facilities come from outside of the service area. (DI #5, p. 26).

The applicant assumes that population growth will account for one-quarter of the utilization. The Southern Maryland health planning region's four counties have a population of approximately 1.2 million residents. The 18 zip code areas in southern Anne Arundel County account for an additional 175,000 residents. The following table shows population growth of the proposed service area, as presented by the applicant. The proposed service area is projected to grow by 1.6 percent between CY 2016 and CY 2023, with the largest growth projected in in the age group 65 years and older, at 5.4 percent. (DI #5, pp. 34-35, 125).

Table III-13: Encompass Health Rehabilitation Hospital of Southern Maryland's Proposed Service Area Population Growth by County & Age Group, CY 2016-2023

	Age 0-17		Age 18-64		Age 65+		Total Population	
County	**CY2016**	**CY2023**	**CY2016**	**CY2023**	**CY2016**	**CY2023**	**CY2016**	**CY2023**
Charles	36,599	35,068	98,312	104,884	17,854	25,219	152,765	165,171
Prince George's	206,094	216,163	595,173	607,536	110,357	155,094	911,624	978,794
Anne Arundel - South	36,516	37,707	109,072	109,796	30,100	38,982	175,688	186,486
Subtotal: Primary Service Area	279,209	288,939	802,557	822,217	158,311	219,295	1,240,077	1,330,451
St. Mary's	28,417	28,898	72,552	74,882	14,384	19,111	115,353	122,892
Calvert	16,916	15,518	15,328	72,641	9,664	13,038	41,908	101,197
Subtotal: Secondary Service Area	45,333	44,416	87,880	147,524	24,048	32,150	157,261	224,089
Total: HealthSouth Service Area	**324,542**	**333,355**	**890,437**	**969,741**	**182,359**	**251,444**	**1,397,338**	**1,554,540**
# Population Change, 2016-2023		8,813		79,304		69,085		157,203
Average Annual Growth Rate		0.39%		1.27%		5.41%		1.61%

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2015, CY2016 Final
[2] DC hospitals: DCHA Database; CY2015, CY2016 Final
[3] Population Data: Nielson-Claritas Population; CY2016 Estimate & CY2021 Projection

Source: DI #5, p. 33.

The applicant created a population-based estimate of the need for rehabilitation beds. In the following table the applicant shows: population estimates for the years 2016, 2021, and 2023; current use rates per thousand for both the projected service area and the statewide; calculates the

number of discharges that would result in each of those years at the two different use rates; and finally, calculates the number of beds needed to meet that level of need. The net result shows:

- 1,661 discharges and an average daily census of 63 at the current area use rate in 2016;
- 1,959 discharges and an average daily census of 72 at the current area use rate in 2023;
- 2,780 discharges and an average daily census of 102 at the statewide use rate in 2023.

The applicant states that a primary goal of its proposed rehabilitation hospital is to reduce the 90 percent out-migration seen in the region for acute rehabilitation services. The applicant believes that this high out-migration pattern is attributable to access barriers, particularly a lack of available acute inpatient rehabilitation beds in the Southern Maryland region, which also results in underutilization of acute rehabilitation services.[21] (DI #5, pp. 124-27). Thus, Encompass-Southern Maryland states that the maximum bed need projection should be used to determine need in this review because the minimum need projection is based on the region's low use rate and high out-migration. It states that the maximum projection reflects need based on the statewide utilization rate and out-migration rates, which results in a more appropriate bed need projection for the region. (DI #5, pp. 126-27). The applicant's view is that, given the projected population growth in the proposed service area, bed need should be projected based on CY 2023 population projections. (DI #5, p. 127).

[21] See discussion of the access standard, *supra*, pp. 21-38.

Table III-14: Projected Acute Rehabilitation Census - Encompass Health Rehabilitation Hospital of Southern Maryland for the Proposed Service Area Population, CY 2016-2023

		Actual	At Service Area CY2016 Use Rate			Actual	At Statewide CY2016 Use Rate		
		Current	Year 1	Year 2	Year 3	Current	Year 1	Year 2	Year 3
	Age Group	**CY2016**	**CY2021**	**CY2022**	**CY2023**	**CY2016**	**CY2021**	**CY2022**	**CY2023**
Population	0-17	324,542	330,764	332,023	333,286	324,542	330,764	332,023	333,286
	18-64	920,869	937,311	940,634	943,970	920,869	937,311	940,634	943,970
	65+	182,359	229,369	240,135	251,407	182,359	229,369	240,135	251,407
	Total	**1,427,770**	**1,497,444**	**1,512,793**	**1,528,663**	**1,427,770**	**1,497,444**	**1,512,793**	**1,528,663**
Use Rate per 1,000	0-17	0.09	0.09	0.09	0.09	0.09	0.05	0.05	0.05
	18-64	0.99	0.99	0.99	0.99	0.99	1.14	1.14	1.14
	65+	3.97	3.97	3.97	3.97	3.97	6.72	6.72	6.72
	Total	**1.16**	**1.25**	**1.26**	**1.28**	**1.70**	**1.75**	**1.78**	**1.82**
Discharges	0-17	29	30	30	30	29	16	16	16
	18-64	908	924	927	931	908	1,067	1,071	1,075
	65+	724	911	953	998	724	1,540	1,613	1,688
	Total	**1,661**	**1,864**	**1,911**	**1,959**	**1,661**	**2,624**	**2,700**	**2,780**
Patient Days		23,100			26,246				37,247
# of Cases Change since 2016		-			298				1,119
Average Length of Stay		13.9			13.4				13.4
Average Daily Census		63			72				102

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2015, CY2016 Final
[2] DC hospitals: DCHA Database; CY2015, CY2016 Final
[3] Population Data: Nielson-Claritas Population; CY2016 Estimate & CY2021 Projection
Notes:
[a] Acute rehab: Based on State Health Plan definition (see Technical Notes)
[b] Average Length of Stay (ALOS) for Year 3 of Service Area Use Rate and Statewide Use Rate is half a day less than current ALOS
[c] TBI/SCI volume: Assumed to be 8% of total discharges based on CY2016 actual

Source: DI #5, p. 35

Interested Party Comments

MNRH states that the applicant does not address the need standard requirements at COMAR 10.24.09.04B(2), and that, for this reason, the Commission should find the applicant not compliant in responding to this standard.

MNRH contends that the portion of Encompass-Southern Maryland's projections that are based on population growth are unfounded. MNRH states that the data shown in the following table show that rehabilitation discharges declined from 12,906 in CY 2012 to 12,479 four years later. Thus, it concludes that rehabilitation use does not appear to be a function of population growth and suggests that the 377 new cases that the applicant projected based on population growth should be discounted. (DI #27, pp. 17-18).

Table III-15: Adult Acute Rehabilitation Discharges from Proposed Service Area Maryland and District of Columbia 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
Average Length of Stay	12.0	11.8	12.0	12.1	12.7
Average Daily Census	424	409	422	414	433

Source: DI #27, Exh. 2.

MNRH states that the applicant failed to respond to the requirement in Paragraph (a) to address need in contiguous regions or states. MNRH contends that the applicant must address need in the District of Columbia, Montgomery County, and Central Maryland. MNRH interprets the Commission's bed need projections to show an excess capacity of 8 beds in Montgomery County and an excess of 36 beds in the Central Maryland planning region. According to the MNRH, there is no bed need projection for the District of Columbia, but the occupancy rate is 69 percent. MNRH states that this information for contiguous regions suggests that there is no need for the proposed project. (DI # 27, pp. 12-13).

MNRH contends that the applicant's response to Paragraph (b) is insufficient and that its claims that the proposed project will reduce out-migration are problematic. MNRH points out that the applicant's projections include out-migration to only the District of Columbia, without considering out-migration to Montgomery County or Central Maryland, which MNRH believes leads to incomplete projection assumptions. (DI #27, pp. 13-16).

MNRH states that Encompass-Southern Maryland failed to show that out-migration is due to barriers to access or to demonstrate a credible plan to mitigate barriers to access. MNRH argues that out-migration to the District of Columbia is part of normal travel patterns for residents in the Southern Maryland region, not attributable to a barrier to access. MNRH contends that the applicant failed to show that any travel hardships need to be relieved or that there is a need for greater continuity of care among providers. Further, MNRH maintains that the applicant did not show that a facility located in Bowie would solve any access barrier. (DI # 27, pp.6-9; 13-14).

Finally, MNRH contends that Encompass-Southern Maryland must address Paragraph (d), which requires documentation of access barriers when a proposal is not consistent with the projected need. MNRH argues that the applicant has not provided clear justification for using the maximum bed need over the minimum need, particularly considering available capacity in surrounding regions and the District of Columbia, in area nursing homes, and a lack of evidence of barriers to access. (DI #27, pp. 13-15).

<u>Applicant's Response to Interested Party Comments</u>

In its response, Encompass-Southern Maryland reiterates that the Commission has projected a need for more beds in the Southern Maryland region, that the region has the lowest use rate in the State, and that it is the second most populous health planning region for rehabilitation services and has the fewest inpatient rehabilitation beds. (DI #28, p. 6).

Encompass-Southern Maryland notes that a major goal of the proposed project is to reduce out-migration for acute rehabilitation services. Included in its projections are 400 discharges that

currently out-migrate to the District of Columbia for rehabilitation services which would shift from District of Columbia hospitals to its proposed project.

The applicant contends that this sufficiently accounts for a portion of patients who will continue to choose to seek care at MNRH, which the applicant assumes to be 60 percent of their current share. The 341 (existing) cases projected to shift from the District of Columbia to the proposed facility include what are projected transfers from the new hospital replacing UM Prince George's Hospital Center, which itself projects capturing market share for acute care services controlled by District of Columbia hospitals, including cardiac surgery, interventional cardiology, orthopedic surgery, and trauma services. The applicant notes that some of these patients will be in need of acute inpatient rehabilitation services in the Southern Maryland region. (DI #28, pp. 13-14).

Encompass-Southern Maryland acknowledges that it did not include shifts from other existing providers in Montgomery County and the Central Maryland planning region in its volume projection, which it views as conservative; in fact, volume shifts from these providers would further support the need for the proposed facility. Encompass-Southern Maryland states that such a potential shift to Encompass-Southern Maryland would not make a significant change in the expected volume, noting that,

> [a]pplying the same 40% capture assumption to Southern Region discharges treated at Adventist Rehabilitation Hospital in Montgomery County in CY 2016 would produce an additional 148 projected discharges, and adding the Southern Anne Arundel County discharges treated in the Central Maryland region would produce an additional 11 projected discharges. (DI #28, p.13)

The applicant took issue with MNRH's assertion that patients from the Southern Maryland health planning region seek inpatient rehabilitation there in the same way they choose to visit the District of Columbia for work and recreation, stating that "quite simply, and not surprisingly, patients prefer to be treated close to home." Encompass-Southern Maryland points out that research supports a finding that the distance between a rehabilitation patient and the location of the provider is a powerful predictor of rehabilitation services use. (DI #28, p. 6 &3-14). It notes that the cited research referenced by the Commission in the Acute Inpatient Rehabilitation Chapter demonstrate that limited geographic access is a significant barrier to care for inpatient rehabilitation services.[22] (DI #28, Exh. 8).

The applicant believes that the lack of inpatient rehabilitation beds, longer travel time to the closest providers, and low use rates in Southern Maryland demonstrate that barriers to access exist for the residents in the proposed service area. Further, it notes that the Commission has projected need for more beds in the Southern Maryland region. (DI #28, pp. 6-7 & 18).

Encompass-Southern Maryland again quotes the letter of support from Nneka Ezunagu, the Stroke Program Coordinator for UM Prince George's Hospital Center, as anecdotal evidence of the barrier that lack of geographic access has on patient care:

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[22] Buntin, M.B., Garten, A.D., Paddock, S., Saliba, D., Totten, M., and Escarce, J.J. "How Much Is Postacute Care Use Affected by Its Availability?" Health Services Research 40(2): 413-34.

> One of the biggest barriers that we face is access to post hospital care and rehabilitation after the patient is discharged…. [M]any times these patients are forced to choose less intensive arenas…. To have a reputable intensive rehabilitation facility for the patients we serve in a central location to their home would be welcoming and considered an extreme blessing.
> (DI #5, Exh. 11; DI #28, p. 7).

Reviewer's Analysis and Findings

Projected Regional Bed Need

The proposed 60-bed acute inpatient rehabilitation hospital would be located in the Southern Maryland health planning region in Prince George's County with a proposed service area that includes the counties in the region (Charles, Calvert, Prince George's and St. Mary's), as well as 18 zip code areas in southern Anne Arundel County.

To evaluate whether the proposed project meets the requirements of this standard, I first considered the projected need for adult acute rehabilitation beds identified by the need methodology in COMAR 10.24.09.05. The most recent bed need projection at the time of the application was published on October 17, 2014, showed a need for acute rehabilitation beds that ranged from a surplus of nine beds to a need for 66 beds. Since that time, the Commission published an update to its net bed need projection in the *Maryland Register* on April 13, 2018, shown in the following table. This includes a projection for the Southern Maryland region that ranges from a surplus of 17 beds to a need for 67 adult acute rehabilitation beds.

Table III-16: 2018 Net Bed Need Projections for Acute Rehabilitation Beds: Maryland, 2021

Health Planning Region	Current Licensed Bed Capacity	Net Bed Need Range	
Central Maryland	260	Minimum	-36
		Maximum	14
Eastern Shore	79	Minimum	-30
		Maximum	10
Montgomery County	87	Minimum	-8
		Maximum	32
Southern Maryland	28	Minimum	-17
		Maximum	67
Western Maryland	33	Minimum	1
		Maximum	9

Source: *Maryland Register*, Volume 45, Issue 8, April 13, 2018, p. 443.

I also note that the Commission's published calculation for the Southern Maryland region includes 28 licensed beds at UM Laurel Regional Hospital. Since publication of this bed need projection, UM Laurel Regional decommissioned 18 of those beds, effective December 27, 2018. Ten beds now operate at UM Prince George's Hospital Center. Thus, the latest net bed need projection overstates available bed capacity in the Southern Maryland region. I adjusted and recalculated the need projection to reflect the current situation. With this nod to current reality,

the net bed need in the region for 2021 would range between 1 and 85 beds, further emphasizing the project's "fit" with the Commission's bed need projection, as shown in the table below.

Table III-17: Recalculation of Readily Available Beds in Southern Maryland Health Planning Region

	Minimum Occupancy Standard	Range	Total Days Projected	Current ~~Licensed~~ *Available* Bed Capacity	Available Bed Days	Gross Bed Need Range	Net Bed Need Range
Southern Region	0.75	Minimum	3,133	~~28~~ *10*	~~10,220~~ *3,650*	11	~~-17~~ *1*
		Maximum	26,109			95	~~67~~ *85*

Encompass-Southern Maryland's projection of capturing slightly less than 50 percent of the market originating from the service area is reasonable. I find that the applicant's proposal to add 60 beds in the Southern Maryland health planning region is in line with the Commission's identified net need for adult acute rehabilitation beds.

Additional Demand from Outside the Southern Maryland Health Planning Region

In addition to the need projected for the Southern Maryland health planning region, the applicant assumes that it will serve the adult acute rehabilitation needs of the residents of 18 zip code areas in southern Anne Arundel County, on the rationale that that population faces similar barriers to access and shows one of the lower use rates in the State. The applicant states that its analysis of travel patterns for medical surgical care showed that CalvertHealth Medical Center had the second-most discharges for residents of southern Anne Arundel County. I note that my analysis did not validate that, showing that hospital to rank fifth. Nonetheless, it is true that the proposed facility would be the closest option for eight of these zip code areas, assumedly making it an attractive option.

I also note that the applicant appears to be conservative in its projections. Encompass-Southern Maryland projects that it will capture slightly less than 50 percent of the market originating from its service area, despite data that shows two other special rehabilitation hospitals' capture of over 70 percent of the discharges from their health planning regions. In CY 2017 Adventist Rehabilitation captured 79 percent of the rehabilitation discharges from the Montgomery County health planning region, while Encompass–Salisbury captured 71 percent of the rehabilitation discharges from the Eastern Shore health planning region.[23]

MNRH correctly points out that utilization rates for acute rehabilitation have been declining. However, the applicant's projected discharges that come from population growth are based on the region's currently low utilization rates, and are, thus, inherently conservative. The regional utilization rate declined from 1.5 discharges per 1,000 population in CY 2012 to 1.4 discharges per 1,000 in CY 2016, while the statewide utilization rate declined from 2.2 discharges per 1,000 to 2.1 discharges per 1,000 over the same time period. A goal of this project is the

[23] Source: HSCRC discharge abstract data and chronic files; D.C. discharge abstract data.

improvement of access to acute rehabilitation services, which is likely to increase the region's use rate.

Finally, I do not agree with the interested party that residents of the Southern Maryland health planning region should be expected to travel to facilities in the District of Columbia, Montgomery County, or the Baltimore area simply because these areas may have excess capacity.

I find that the proposed project is needed and likely to be utilized to the degree projected by the applicant. The expressed support from existing health systems and practitioners that currently serve the region supports this finding.

Summary

For the reasons noted earlier, I find that the applicant has demonstrated that there is a need for the proposed project, which is evidenced by Commission's net bed need projection for acute rehabilitation beds in the Southern Maryland health planning region. I find that the applicant's utilization projections further support the need for the proposed special rehabilitation hospital.

(3) Impact.

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

Applicant's Response

The applicant projects that 40 percent of patients who currently migrate from the service area to facilities in the District of Columbia will shift to Encompass-Southern Maryland based on geographic proximity, state-of-the-art facilities, and its relationship with University of Maryland Capital Region Health. Thus, Encompass-Southern Maryland projects that its proposed project will shift patient volume from MNRH and George Washington University Hospital (GWUH) in the District of Columbia.

Based on 2016 volume and patient origin at these facilities, the applicant estimates that, if it were in existence in 2016, 315 of 2,198 acute rehabilitation discharges at MNRH (14.3 percent), and 26 of 366 GWUH discharges (7.1 percent) would have occurred at Encompass-Southern Maryland (see second column of the following table). The applicant states that this impact will ultimately be offset by projected population growth in the District of Columbia, Montgomery County, and Northern Virginia. From 2016 to 2023, the adult population is projected to grow 17.8 percent in the District of Columbia, 9.1 percent in Montgomery County, and 9.1 percent in

Northern Virginia, according to data presented by the applicant. (DI #17, p. 5-7).[24] The following table summarizes the applicant's projected impacts on these facilities, based on historical patient volume, patient volume shift assumptions, and population growth forecasts.

Table III-18: Projected Impact of Encompass-Southern Maryland's Proposed Acute Inpatient Rehabilitation Hospital on Acute Rehabilitation Discharges at Facilities in the District of Columbia

	Actual Discharges (CY 2016)	Projected Shift to Encompass-Southern Maryland	Projected Discharges from Population Growth	Projected Impact	Projected Impact as % of Total 2016 Discharges
MedStar NRH	2,198	(315)	187	(128)	(5.8%)
GWU	366	(26)	44	18	4.9%
Total Discharges	2,564	(341)	231	(110)	(4.3%)

The applicant also projects that approximately 13 percent of existing patient volume from comprehensive care facilities (CCFs) in the service area will shift to Encompass-Southern Maryland. In CY 2016, this would have amounted to 418 discharges dispersed among 10 nursing homes in the region. The applicant submitted an analysis of data that shows that occupancy rates of area CCFs before and after the entry of an Encompass acute rehabilitation hospital into their markets have not historically suffered a significant decline. Encompass-Southern Maryland does not believe that any single nursing home will experience a significant impact as a result of its project. In CY2015, CCFs in Southern Maryland reported an average annual occupancy rate of 91 percent. Citing the projected growth of the over-65 population, Encompass-Southern Maryland states that nursing homes are not likely to experience a significant decline in admissions even as rehabilitation candidates are referred to Encompass-Southern Maryland. (DI #5, pp. 62-64).

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

Applicant's Response

The applicant states that there will be no reduction in service availability or accessibility as a result of the project. It projects total patient volume to increase for patients in its proposed service area since residents of the proposed service area are currently underserved in terms of acute inpatient rehabilitation services. (DI #28, p. 20-21).

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[24] 2016 Population Estimate: https://demographics.coopercenter.org/sites/demographics/files/2018-05/Census_2016_AgeSexEstimates_forVA.xls
2020 Population Projection:
https://demographics.coopercenter.org/sites/demographics/files/VAPopProjections_AgeSex_2020-2040.xls

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

Applicant's Response

Encompass Health states that it has no basis for anticipating any reduction in the quality of care at other providers as a result of its proposed project. (DI #5, p. 129).

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

Applicant's Response

Encompass-Southern Maryland points out that the State of Maryland has invested heavily in the UM Capital Region Medical Center project, replacing the existing UM Prince George's Hospital Center and other population health initiatives with the intent to expand and upgrade the health care workforce in the region, and that the Medical Center's affiliation with the University of Maryland Medical System is "designed explicitly to strengthen both primary care and specialty care and elevate the quality of care in Prince George's County." The applicant further notes that Encompass Health will provide a high quality professional training site for both physicians and therapists and that its presence in the region is likely to help train and retain high quality rehabilitation providers as well as attract additional rehabilitation professionals. The applicant states that it plans to partner with local universities and schools to improve recruiting efforts. (DI #5, p. 129).

Interested Party Comments

MNRH projects that Encompass-Southern Maryland's proposed project will negatively impact its ability to maintain staff. MNRH states that, nationally, Encompass Health has posted 914 nursing vacancies and that it offers sign-on bonuses of $5,000 to $10,000 for registered nurses and therapists to incentivize them to leave current employers. MNRH claims that, as of March 12, 2019, Encompass Heath had 2,056 vacant positions nationwide, with a significant number of vacant positions in Virginia, Pennsylvania, Delaware, Maryland, and New Jersey facilities. (DI #27, p. 20).

According to MNRH, by adding licensed rehabilitation beds in the District of Columbia Metropolitan Area, the proposed facility will only add to the shortage of nurses. It points to the number of inpatient rehabilitation nursing job openings posted on the Encompass website is evidence of this crisis. MNRH notes that it invested significant resources to be part of the solution by creating a summer nurse extern program and training new graduates to become rehabilitation nurses. It believes that Encompass-Southern Maryland's plan would impede its ability to realize a return on these investments. 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. MNRH states that, because this Acute Inpatient Rehabilitation Chapter's standard recognizes the importance of maintaining optimal staffing levels of highly trained clinical professionals, that the Commission should reject the application because the applicant has not demonstrated that the proposed project

will not have an unwarranted adverse impact on the ability of existing providers to maintain optimal staffing levels. (DI #27, pp. 20-21).

Applicant's Response to Interested Party Comments

The applicant maintains that the proposed project will not have an adverse impact on the ability of other providers to maintain the necessary specialized staff to support their facilities. Encompass-Southern Maryland states that MNRH offers no evidence that it has problems recruiting or maintaining the specialized staff necessary to operate, or that any staffing changes would be a result of the proposed project. Encompass-Southern Maryland restates its view that its employees are likely to be residents of the Southern Maryland health planning region. It contends that other arguments made by MNRH are without merit, including any relationship between Encompass Health system's national vacancies and employment projections in the Southern Maryland market. The applicant states that it will work closely with the UM Capital Region Health system, which will likely result in an expanded and upgraded health care workforce in the Southern Maryland region, from which it can recruit. (DI #28, p. 20-21).

Reviewer's Analysis and Findings

The impact standard is meant to ensure that a project does not have "an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services…[or] an unwarranted adverse impact on the availability of services, access to services, or the quality of services."

The applicant projects that 40 percent of the patient volume originating in its projected service area that currently obtain acute rehabilitation services in the District of Columbia will shift to Encompass-Southern Maryland, but projects no market shift from existing Maryland providers. I question the latter part of the applicant's assumption. MNRH is approximately 19 miles from the proposed project location, while Adventist Rehabilitation Hospital is 23 miles away, and providers in the Baltimore area are approximately 30 miles away. Because the applicant states that its proposed project location is more geographically accessible to the service area than MNRH, it is fair to conclude that this is also true regarding locations that are even farther away. Thus, I question the assumption that residents who travel out of the service area to the District of Columbia will shift to a new provider in the region, but those who travel outside to other planning regions in Maryland will not.

Even though MNRH notes that 36 percent of its patient volume resides in the Southern Maryland health planning region, it does not specifically state that the project would have an adverse impact on its case volume. Nevertheless, I thoroughly considered the likely impact of the proposed special hospital. In the following table, showing what facilities received the patient volume that originated from the proposed service area counties, and what percentage of the facilities' total volume came from those areas during CY2017.

Table III-19: Acute Inpatient Rehabilitation Discharges Originating from Calvert, Charles, Prince George's, St. Mary's, and Southern Anne Arundel Counties, CY 2017

Hospital	Calvert	Charles	Prince George's	St. Mary's	Anne Arundel / 18 ZIP codes for MD	Total Discharges from Selected Jurisdictions	Total Acute Rehab Discharges at Hospital	Percent of Discharges
Maryland Hospitals								
Adventist Rehabilitation	13	12	342	11	5	383	1,933	19.8%
Encompass-Salisbury			1			1	1,544	0.1%
Good Samaritan	1	1	8		4	14	1,091	1.3%
Johns Hopkins	4	2	16	1	12	35	545	6.4%
Johns Hopkins Bayview	2	3	12	2	17	36	673	5.3%
Laurel	1	1	101	2	10	115	233	49.4%
Meritus		1	1			2	430	0.5%
Sinai	1	1	10	2	9	23	1,154	2.0%
UM Memorial at Easton					1	1	356	0.3%
UM Rehab and Ortho Inst.	6	8	48	5	25	92	1,556	5.9%
Western Maryland	1					1	336	0.3%
District of Columbia Hospitals								
Washington University	7	8	50	1	4	70	398	17.6%
MedStar National Rehab	43	94	600	55	39	831	1,971	42.2%

Source: HSCRC discharge abstract data and chronic files; D.C. discharge abstract data.

As shown, MNRH was the leading provider of acute rehabilitation services to patients from the proposed service area, which volume made up 42 percent of its CY2017 discharges. Adventist Rehabilitation Hospital was the second leading provider for the proposed service area, with nearly 20 percent of its CY2017 discharges originating there.

If, as it projects, the applicant shifts 40 percent of the MNRH patient volume that originates in its proposed service area, MNRH would suffer a decrease of approximately 16 percent of its total discharges. If the applicant's projected population-based market growth is correct, some of that volume (about 8 percent), would be backfilled, assuming continuation of the assumed market shares used in the analysis to this point, although observed declines in acute rehabilitation use rates may overstate this mitigation.

Despite the projected shift outlined above, the interested party did not argue that it will be impacted by volume shifts. Based on its sophisticated and evidence-based arguments in other sections, e.g., those presented under the quality of care and access standards, I believe that MNRH would have commented if this volume shift were a concern. Instead, its comments under this standard focused on an assertion that the applicant will have an adverse impact on existing providers' ability to staff rehabilitation services, making general statements about nursing shortages and providing a snapshot of Encompass Health's current job postings for its network. MNRH's comments did not offer any insight into specific staffing challenges. Without any specific evidence, which the interested party could have readily provided, I conclude that the impact of a new provider's entry into a densely populated market will not have an undue adverse impact on an incumbent provider's ability to maintain staffing levels.

In summary, I find that the applicant has met the impact standard. While the proposed project is likely to have an impact on MNRH, reducing the important segment of demand for its services that originates from Southern Maryland and creating a more competitive market for the therapeutic and nursing personnel needed by acute rehabilitation providers, I find that this impact is not an unwarranted adverse impact. It is an impact that follows from the improved local availability and access to acute rehabilitation services that the project affords residents in the Southern Maryland health planning region and in southern Anne Arundel County.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant's Response

The applicant provided a letter of verification for construction cost from Fred. C. Frederick, AIA of Frederick & Associates-Architects, Inc. This letter states that the proposed construction costs will be reasonable and consistent with current industry and cost experience in Maryland. Estimates are based on two recent Encompass Health projects, adjusted for location. The architects estimated a cost of construction of $275 per square foot, with an adjustment for inflation to arrive at $289 per square foot.[25] The letter states that the project will be designed with construction documents prepared to adhere to the current applicable codes of the State Health Plan and the City of Bowie, including International Building Codes and FGI Guidelines for Design and Construction of Healthcare Facilities. (DI #5, Exh. 15).

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[25] Encompass calculated MVS benchmark costs for new construction of a convalescent hospital at $263 per square foot (SF) in CON Matter No. 18-22-2435, which means the construction cost is 4.6 percent per SF more than the benchmark and the cost with inflation is 9.9 percent more per SF foot than the benchmark.

Reviewer's Analysis and Findings

As a special rehabilitation hospital rather than a general hospital, the applicant is not rate regulated by the Health Services Cost Review Commission (HSCRC) in a comprehensive manner. Because the proposed project will not be rate regulated by the HSCRC, I find that a key feature of this standard is inapplicable, but note that the applicant proposes a project with construction costs that are reasonable and consistent with current industry and cost experience in Maryland.

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

Applicant's Response

The applicant states that the hospital was designed to meet the clinical and safety needs of rehabilitation patients, which require extensive physical therapy space and the use of large equipment. It states that the design also focused on enhancing and improving patient safety with features such as appropriate floor material and finishes, critically placed handrails, strategically placed lighting to assist in patient movement, and a centrally located nurse station for quick response and visual control as just a few features that have evolved from constant review and development of Encompass Health's standards. (DI #5, p. 129).

Encompass-Southern Maryland notes that Encompass Health utilizes a Patient Safety Task Force, representing nurses, therapists, dieticians, plant engineers, case managers, and quality and risk and operations, which meets monthly by phone and annually face-to-face to define patient safety projects and collect data, research industry best practices, and develop innovative strategies to improve patient safety in these areas. Encompass Health's STOP program (Stop, Think, Organize, Position) focuses on safe patient mobilization, frequent assessment to ensure the safest possible transfer at the bedside, and Smart slide sheets.

A copy of the project floor plan drawing is included in Appendix 2. (DI #5, p. 129 and Exh. 6).

Reviewer's Analysis and Findings

I conclude that Encompass-Southern Maryland has demonstrated that the design of its project takes patient safety into consideration and has included features that enhance and improve patient safety. I find that the project is consistent with this standard.

(6) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital CON application must be accompanied by a statement containing each assumption used to develop the projections.

The applicant's main assumptions are:

- The proposed project will realize full utilization in Year 3 at 92.3 percent average annual occupancy and operate at this level going forward;
- Length of stay will remain consistent at 13.5 days;
- At full utilization, payor mix will be 77 percent Medicare, with the balance consisting of Medicaid and private payment sources; and
- Respective reimbursement per Medicare case is $21,179 in Year 3 at full utilization, increasing to $21,862 in Year 5 at an assumed annual inflation rate 1.6 percent. Non-Medicare per diem rates are $1,162 in Year 3 at full utilization, increasing to $1,209 in Year 5 at an assumed annual inflation rate of 2.0 percent.

(DI #21, attachment to Table K).

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

As the applicant noted in its response to the need standard,[26] its projected utilization numbers are derived from projected shifts from hospital providers in the District of Columbia and skilled nursing facilities in its proposed service area, an increased rate of demand for acute rehabilitation services within its service area, and population growth.

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

Encompass-Southern Maryland based its estimates of revenue on the utilization projections in its response to the need standard, noted above. The level of current charges, reimbursement rates, contractual adjustments and discounts, and bad debt are based on Encompass Health's experience at Encompass-Salisbury and other Encompass rehabilitation hospitals across the country. (DI #5, p. 131).

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

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[26]See discussion at pp. 39-44, *supra.*

Staffing expense figures correlate with staffing volume projections, based on the experiences of Encompass Health Rehabilitation Hospital of Salisbury and Encompass Health (formerly HealthSouth) Rehabilitation Hospital of Northern Virginia. (DI #21, Tables H & J, pp. 11 & 18). The applicant projects that the proposed project will require 169.1 full-time equivalent (FTE) staff, including: seven administration positions; 129.9 direct care staff positions; and 32.2 support staff FTEs. It bases staffing volume and expense figures on experience at Encompass-Salisbury and Encompass Health Rehabilitation Hospital of Northern Virginia. (DI #21, Tables H, J, and pp. 11, 18).

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

The applicant projects an excess of revenues over expenses by Year 2, followed by continued profitable operation, as shown in Table III-21. (DI #21, Table J, p. 12).

Table III-20: Encompass Health Rehabilitation Hospital of Southern Maryland Revenue, Expenses, and Income Projections, FY 2021 through FY 2025

	2021	2022	2023	2024	2025
Discharges	904	1,218	1,500	1,500	1,500
Patient Days	12,207	16,422	20,212	20,212	20,212
ALOS	13.5	13.5	13.5	13.5	13.5
Beds	60	60	60	60	60
Average Annual Occupancy Rate	55.7%	75.0%	92.3%	92.3%	92.3%
Net Operating Revenue	$15,994,080	$22,393,000	$27,667,220	$27,667,220	$27,667,220
Total Operating Expenses	$721,699	$2,459,488	$4,845,988	$4,826,171	$4,801,401
Net Income	**$(683,041)**	**$2,327,744**	**$4,586,408**	**$4,567,653**	**$4,544,210**

Source: DI #21, Tables I & J, p. 12

__Interested Party Comments__

MNRH believes that Encompass-Southern Maryland's utilization projections are overstated.[27] It notes that, if Encompass-Southern Maryland does not achieve its projected volumes, it cannot meet its financial projections and the financial feasibility for this proposal is not demonstrated. MNRH also states that the applicant's revenue projections do not account for potential changes in State and federal reimbursement policy that will affect this facility in the near

[27] See MNRH's comments on the applicant's response to the need standard, *supra*, pp. 44-45.

future.[28] MNRH references the following language from the Acute Inpatient Rehabilitation Chapter as evidence that the application is not consistent with the standard:

> 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.
> (DI #27, p. 21-22, quoting COMAR 10.24.09.03, *Issues and Policies, Need for Capacity*, at p. 6).

<u>Applicant's Response to Interested Party Comments</u>

Encompass-Southern Maryland rebutted MNRH's assertion that its financial feasibility is based on overstated volume projections by stating that its volume projections are "reasonable, if not conservative." The applicant states that MNRH incorrectly argues that its volume projections are based primarily on redirecting volume from existing acute rehabilitation providers in Washington, D.C., stating that, instead, just 341 of 1,500 projected discharges will derive from capturing out-migration from MNRH and George Washington University Hospital in the District of Columbia. It reiterates its position that patients would prefer to obtain care closer to home. Further, the applicant rejects MHRH's assertion that population growth would lead to growth of rehabilitation volume as "unfounded," pointing out that "the regulatory methodology projecting adult acute rehabilitation bed need that governs this review explicitly relies on future year population projections. (COMAR §10.24.09.05, p. 16)." Encompass-Southern Maryland also cited a recent Commission decision in which the applicant maintained, and the Commission accepted, that the basis for need for the proposed project was that "projected growth is primarily a function of population growth in its service area (primarily Montgomery and Prince George's Counties) and an aging population." (DI #28, p. 16).

In addition, Encompass-Southern Maryland states that the proposed project would be financially feasible even if its volume projections turn out to be substantially lower. The project would break even in terms of net revenue with 993 discharges, assuming the same length of stay and revenue per patient day. (DI #28, pp. 21-22).

<u>Reviewer's Analysis and Findings</u>

To demonstrate that its proposal for a special rehabilitation hospital is financially feasible, an applicant is required to submit financial projections and documents demonstrating that: its utilization projections are consistent with historic trends; its revenue projections are consistent with utilization projections and based on current data; its staffing and expense projects are consistent with utilization projects and are based on current data; and it will generate net income if the applicant's utilization forecasts are achieved within five years.

I find that the applicant provided utilization projections that are consistent with historic trends in acute inpatient rehabilitation in the Southern Maryland health planning region, as

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[28] In its comments MNRH was not specific in explaining what these changes might be, or how they would affect rehabilitation providers.

previously discussed under the need standard,[29] showing the applicant's projected volume to consist primarily of: the migration of cases from existing acute rehabilitation beds at Laurel Regional Hospital (which discontinued its acute inpatient rehabilitation services); migration of cases from existing hospitals outside of the region; cases from the region's nursing homes that are more appropriately served at an acute inpatient rehabilitation hospital; and growth due to a growing and aging population. I also find revenue and expense estimates and staffing projections to be consistent with utilization projections based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision experienced by other Encompass Health acute rehabilitation hospitals.

The applicant projects an ability to generate income by the second year of operation. I note that a project of this type, which proposes to provide a hospital service that cannot be identified as a growth market, based on consistently positive trends in population use, and proposing to disrupt existing patterns of use may not have the expected impact on acute rehabilitation use in its service area succeed in shifting market share from existing providers. However, even if the special rehabilitation hospital does not generate excess revenue over expenses within two years as it projects, I find that it is likely to do so within five years, in accordance with the standard. I find that residents of the Southern Maryland planning regions and southern Anne Arundel County will benefit from the proposed modern and reasonably-sized acute rehabilitation hospital.

I find the proposed project is consistent with the financial feasibility standard.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

<u>Applicant's Response</u>

The proposed acute inpatient rehabilitation hospital contains 60 beds and is projected to maintain an average daily census of 55 patients within three years, which amounts to an occupancy rate of 92.3 percent. (DI #5, application table package, pp. 6-7). The minimum occupancy standard for a hospital with an average daily census of 50-99 cases is 80 percent occupancy.

<u>Reviewer's Analysis and Findings</u>

I find that the applicant complies with this standard.

[29] See my analysis of compliance with the need standard, *supra*, pp. 47-49.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

<u>**Applicant's Response**</u>

The applicant provided a copy of its transfer agreement between the proposed acute inpatient rehabilitation hospital and UM Prince George's Hospital Center, for the transfer of cases that exceed the acute rehabilitation hospital's own capabilities. (DI #5, Exh. 16).

The applicant also states that, prior to licensure, it plans to obtain written transfer and referral agreements with facilities, agencies, and organizations that provide alternative treatment programs appropriate to the needs of patients who have sub-acute care needs. Such agreements will be with specific outpatient therapy providers, home health agencies, nursing homes, and hospice providers. (DI #17, p. 13).

<u>**Reviewer's Analysis and Findings**</u>

This standard requires an applicant to document written transfer and referral agreements prior to licensure. I recommend that, if the CON is awarded by the Commission, it include the condition that will ensure these agreements with sub-acute facilities are in place when services are initiated, specifically that Encompass Health Rehabilitation Hospital of Southern Maryland, LLC:

> Prior to first use, provide written transfer and referral agreements, acceptable to Commission staff, with facilities, agencies, and organizations that are capable of managing cases that exceed its own capabilities and/or provide alternative treatment programs appropriate to the needs of the persons it serves.

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system as a whole.

This standard is not applicable to the proposed project.

B. NEED

COMAR 10.24.01.08G(3)(b) Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Encompass Southern Maryland's response to this criterion, MNRH's comments, and the applicant's response are discussed under the need standard, *supra*, at pages 39-49.

Reviewer's Analysis and Findings

I discussed the project's alignment with COMAR 10.24.09.04B(2), the need analysis in the Acute Inpatient Rehabilitation Chapter of the State Health Plan, earlier in this Recommended Decision, *supra*, at pages 47-49. The applicant demonstrated that the Southern Maryland health planning region has a need for additional inpatient rehabilitation beds due to the lack of existing, geographically accessible options, evidenced by comparably low use rates and out-migration of residents from the region. The applicant aims to reduce out-migration and increase the utilization rates of acute rehabilitation services within the region.

I find that the applicant has satisfied both the need standard and the need criterion.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant's Response

The applicant states that it sought to determine the most cost-effective option for meeting the need for additional acute inpatient rehabilitation beds in the Southern Maryland health planning region that offered high caliber, state-of-the-art, patient-focused care. (DI #5, p. 60). Encompass-Southern Maryland provided the following information about alternative existing (or under-construction) settings that could meet the need for additional acute inpatient rehabilitation beds: (DI #5, pp. 58-59).

- Laurel Regional Hospital. At the time the application was submitted Laurel Regional Hospital operated the only hospital-based acute inpatient rehabilitation unit in the region, with 28 licensed beds.[30] It is also not centrally located in Prince George's County to effectively serve the targeted population, according to the applicant.
- A new hospital-based acute rehabilitation unit at the new UM Capital Region Medical Center. According to the applicant, facility plans for the new hospital do not include a

[30] The hospital has since been converted to a freestanding medical facility and no longer operates inpatient services.

new rehabilitation unit. The CON awarded for this replacement hospital by the Commission did not include an acute rehabilitation unit.

- Other general hospital-based acute rehabilitation units. Many acute care hospitals do not have space or are unwilling to use space to establish an inpatient rehabilitation program that is not a core program for the acute care hospital. Inpatient rehabilitation units may require comparatively larger room and bathroom sizes, additional sinks, and convenient gym space. It is often costly to retrofit an acute floor to a rehabilitation unit in order to meet CMS requirements regarding separate physical spaces; patient, family, and staff access; and other Medicare conditions of participation.

In discussing the most cost-effective alternative the applicant provided cost and payment comparisons per rehabilitation discharge across several alternative settings, asserting that the data indicates lower cost and payment per discharge at Encompass Health facilities.

Table III-21: Average Cost and Payment per Discharge by Provider Setting, FY 2018

Provider Setting	Average Estimated Total Cost per Discharge	Average Estimated Total Payment per Discharge
Encompass Health	$12,903	$19,776
Other Freestanding	$17,363	$20,749
Hospital-based Units	$20,798	$21,153
Total Rehab Inpatient	$17,753	$20,665

Source: DI #5, p. 60; Encompass Health analysis based on CMS Cost Reports and Rate Filings.

The applicant concluded that building the proposed freestanding hospital is the best alternative to meet the need for acute inpatient rehabilitation services in the Southern Maryland health planning region. It points out that, in initiating a search for a site, it took several factors into account: identification of underserved areas, especially with a large and/or growing 65+ population; convenience for both physicians and families; a sufficiently large site to accommodate a one-story hospital, which is the floor plan Encompass Health chooses so as to maximize efficiency and avoid having to transport rehabilitation patients up and down elevators; and close proximity to its largest referral source, the new UM Capital Region Medical Center, in Largo, which is approximately 15 minutes from the chosen site. (DI #17, pp. 12-14).

Based on these factors the applicant notes that it assessed several options in Prince George's County, "as far south as Waldorf, as well as north and west in Glenn Dale, Prince George's County...[and]…evaluated the existing Laurel Regional campus [about which]… at the time of filing, University of Maryland Capital Region's decision had not been made in regard to the future of that hospital. [However,] [e]ven if the future of the hospital had been clearer, it was felt that this location was too far north to best serve the overall planning region." (DI #17, p. 14).

Interested Party Comments

MNRH states that a more cost-effective option would be to add space to UM Prince George's Hospital Center, and cites the Commission's decision to approve Washington Adventist Hospital's decision to accommodate a new floor for acute inpatient rehabilitation at its replacement hospital rather than continuing to operate the rehabilitation hospital on a freestanding basis in

Takoma Park. MNRH argues that UMMS should have explored the cost-effectiveness of this option.

MNRH also states that the applicant provides no evidence of capacity constraints to serve patients of Southern Maryland or access barriers, stating that existing occupancy rates for providers in the District of Columbia, Montgomery County, and Central Maryland indicate sufficient capacity. MNRH argues that new construction is not cost-effective when excess capacity exists across those regions because investing in new building and services when there is capacity in existing facilities increases overall healthcare costs. MNRH argues that differing reimbursement levels is not a 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, MNRH asserts that the Commission set a precedent in a 2013 Reviewer's Recommended Decision (Harford Memorial Hospital, Docket No 12-12-2335), which recommended denial of a proposal to establish an acute inpatient rehabilitation service in circumstances that MNRH views as similar to this project. The interested party describes that scenario as an application being submitted following the closure of another acute inpatient rehabilitation provider in the same region. MNRH summarizes the Commission's findings in that review as: the applicant did not demonstrate an unmet need; access in terms of travel time was reasonable; there was no great disparity in use rates between the proposed service area and the statewide average; and the unmet need could be met more cost-effectively at other existing programs. MNRH suggests that "similar findings in this case would be appropriate." (DI #27, pp. 22-25).

<u>Applicant's Response to Interested Party Comments</u>

The applicant responded to MNRH's argument that a cost-effective alternative would be to add an inpatient rehabilitation unit within the UM Capital Region Medical Center under construction in Largo by stating that it does not have the ability to control the development of the new regional medical center and cannot cause UM Capital Region Health to seek approval to add space for a rehabilitation unit in the hospital.

In addition, the applicant states that, even if UM Prince George's Hospital Center were to seek approval for more space in the new hospital for inpatient rehabilitation services, that would not be the most cost-effective approach to adding inpatient rehabilitation capacity in the Southern Maryland region. The applicant asserts that single level freestanding rehabilitation facilities provide more convenient and accessible locations to patients and families, and incur lower costs and charges than hospital-based acute rehabilitation units. The applicant quotes MedPAC regarding IRFs and Encompass Health's efficiency:

> Although all types of facilities were represented in the relatively efficient group of IRFs, they were much more likely to be freestanding and/or for profit. In fact, over half of Encompass Health facilities (formerly HealthSouth) were in the relatively efficient IRF group. Hospital-based nonprofit IRFs were less likely to be in the

> relatively efficient group, although they accounted for over a third (37.2 percent) of this group.
> (DI #28, pp. 22-23, Exh. 13, quoting MedPAC March 15, 2019 Report to the Congress, p. 272).

Regarding MNRH's assertion that existing capacity is sufficient to treat volume originating from the Southern Maryland health planning region, the applicant states that it has demonstrated that barriers to access exist and that the establishment of the proposed hospital will address those barriers. The applicant asserts that patients and their families in the region should not be forced to leave the region to obtain inpatient rehabilitation services. (DI #28, p. 23).

Reviewer's Analysis and Findings

At issue here is whether Encompass-Southern Maryland chose the most cost-effective approach to providing acute inpatient rehabilitation services to the population of its proposed service area. I previously found that the 60 proposed beds for the Southern Maryland health planning region are needed. The applicant states that it engaged in a thorough process resulting in its decision that new construction of a freestanding 60-bed specialty rehabilitation hospital in Bowie is the alternative that delivers the most cost-effective solution to meeting the demand for beds in the region with an accessible building convenient for patients, families, and physicians. It notes that the site will be fairly close to referring hospitals from which it expects to obtain transfers.

Development of an acute rehabilitation program on an existing hospital campus in Southern Maryland may have merit as an alternative project able to achieve a lower ration of costs to effectiveness. However, no existing hospital has proposed such a project and the applicant can hardly be faulted for not including this approach, which it is unable to implement.

I also reviewed the Reviewer's 2013 Recommended Decision (not adopted by the Commission) regarding the CON application filed by Harford Memorial Hospital (HMH). I first note that the applicant in that matter withdrew its application prior to Commission action on the Reviewer's Recommended Decision and that, for this reason, the Recommended Decision is not precedent of the Commission. HMH applied to relocate 18 of 33 temporarily delicensed beds from UM Medical Center's Midtown Campus to HMH. To contrast that case with this application: the unit at UMMC-Midtown had low occupancy in the period prior to the application. The Reviewer found that the Central Maryland region had an adequate supply of acute rehabilitation facilities and beds, and that Harford County was not an area with an exceptionally low use rate. Additionally, HMH's hospital system had plans to replace itself within five years, which the Reviewer deemed to be problematic with respect to the issue of cost-effectiveness.

I find that the applicant has demonstrated that the establishment of a freestanding 60-bed acute inpatient rehabilitation specialty hospital in Bowie is a cost-effective alternative for establishing a special rehabilitation hospital in the Southern Maryland health planning region.

D. VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Applicant's Response

Availability of Resources to Implement the Proposed Project

The estimated total project budget to complete the project is approximately $39 million, which the applicant will fund with cash. The project budget is shown in Table III-22.

Table III-22: Encompass Health Rehabilitation Hospital of Southern Maryland Project Budget for Establishment of an Acute Inpatient Rehabilitation Specialty Hospital

Use of Funds	
New Construction	
Building	$17, 840,840
Bed purchase	$2,321,000
Site and infrastructure	$2,093,600
Architect/engineering fees	$1,665,227
Permits (building, utilities, etc.)	$555,076
Subtotal	$24,475,742
Other Capital Costs	
Moveable equipment	$2,500,000
Contingency allowance	$1,110,151
Gross interest during construction period	$840,000
Technology equipment	$1,600,000
Subtotal	$6,050,151
Land Purchase	$6,305,000
Total Capital Costs	**$36,830,894**
Expenses related to the CON application	$1,350,000
Expenses related to appraisal, traffic study, title costs, engineering	$150,000
IT Installation	$289,000
Working Capital Startup Costs	$400,000
Total Uses of Funds	**$39,019,894**
Sources of Funds	
Cash	**$39,019,894**

Source: DI #21, Table E.

The applicant provided financial statements audited by PricewaterhouseCoopers LLP that show that Encompass Health Corporation and subsidiaries have access to the cash necessary to fund this project. (DI #5, Exh. 19).

Availability of Resources to Sustain the Proposed Project

The applicant's utilization and financial forecast is shown in the following table. The applicant projects that it will generate net income by the second year of operation, as patient volume increases. Salaries and expenses for supplies are projected to increase along with patient volume. (DI #21, Table J and Assumptions, pp. 12, 17).

Table III-23: Key Utilization and Financial Projections, FY 2021 – FY 2025

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Utilization					
Discharges	904	1,218	1,500	1,500	1,500
Patient Days	12,207	16,422	20,212	20,212	20,212
Revenues					
Gross Revenues	$24,125,590	$33,661,771	$41,515,424	$41,515,810	$41,516,292
Allowance for Bad Debt	162,986	228,194	281,940	281,940	281,940
Contractual Allowance	7,634,595	10,640,589	13,107,244	13,107,244	13,107,244
Charity Care	333,929	399,988	459,020	459,406	459,888
Net Operating Revenue	***$15,994,080***	***$22,393,000***	***$27,667,220***	***$27,667,220***	**27,667,220**
Expenses					
Salaries & Wages	10,961,859	13,432,913	15,654,744	15,654,744	15,654,744
Project Depreciation	1,378,210	1,387,853	1,402,318	1,421,603	1,445,710
Supplies	685,488	922,193	1,135,024	1,135,024	1,135,024
Other Expenses	3,670,893	4,256,425	4,758,936	4,758,936	4,758,936
Total Operating Expenses	**16,696,450**	**19,999,384**	**22,951,022**	**22,970,308**	**$22,994,415**
Income Taxes	-19,329	65,872	129,790	129,259	128,596
Net Income	***($683,041)***	***$2,327,744***	***$4,586,408***	***$4,567,653***	***$4,544,210***

Source: DI #21, Tables I, J.

The proposed project is projected to require 169.1 full-time equivalent employees: 7 administration positions including a Chief Executive Officer, Chief Nursing Officer, Director of Therapy Operations, Controller, Human Resources Director, Director of Quality, and Director of Pharmacy; 129.9 direct care staff positions including nursing, therapy, pharmacy, care management, and food services; and 32.2 support staff. (DI #5, application table package, p. 14). The applicant states that these levels are based on Encompass Health's experience at its existing acute inpatient rehabilitation hospitals, including Encompass-Salisbury.

The applicant also referred to letters of support from executives and clinicians associated with the University of Maryland Medical System demonstrating support for the project. (DI #5, p. 61).

Interested Party Comments

MNRH commented on the applicant's response to this criterion in its comments on the applicant's response to the financial feasibility standard. The interested party contends that, because the applicant's utilization projections are significantly overstated, it would achieve neither the projected volumes and revenue it projects nor its financial projections, and thus the financial feasibility for this proposal is not demonstrated. (DI #27, p. 22).

Applicant's Response to Interested Party Comments

Encompass-Southern Maryland again responded to MNRH's assertion that its financial feasibility is based on overstated volume projections by stating that its volume projections are "reasonable, if not conservative." It challenged MNRH's assertion that its volume projections are based primarily on redirecting volume from existing acute rehabilitation providers in Washington, D.C. and stated that population growth would lead to growth of rehabilitation. (DI #28, p. 16). In addition, Encompass-Southern Maryland states that the proposed project would be financially feasible even if its volume projections turn out to be substantially lower. It states that the project would break even in terms of net revenue with 993 discharges, assuming the same length of stay and revenue per patient day. (DI #28, pp. 21-22). For more detail, see the applicant's response to the financial feasibility standard.[31]

Reviewer's Analysis and Findings

This criterion requires consideration of three issues: availability of resources to implement the proposed project; the availability of resources to sustain the proposed project; and community support for the proposed project.

Availability of Resources to Implement the Proposed Project

The applicant's financial statements demonstrate the availability of financial resources to implement the project using cash. (DI #5, Exh. 19).

Availability of Resources to Sustain the Proposed Project

Encompass-Southern Maryland projects that it will reach an occupancy rate of 92.7 percent. I find the utilization projections feasible, as discussed under the need standard, based on historical and projected utilization of acute inpatient rehabilitation. Also, the applicant correctly notes that the proposed project would be financially feasible even if its volume projections turn out to be substantially lower than anticipated. (DI #28, p. 22).

[31] See pp. 56-57, *supra*.

After reviewing the applicant's financial statements, it is apparent that the applicant has sufficient financial resources to implement the project. The applicant also provided letters of support from community representatives, educational institutions, and medical service providers in the service area, particularly the University of Maryland Medical System, which provides evidence of a key referral source for patients in the region, helping to reach and sustain the projected utilization.

I find that the proposed project is financially feasible and that the proposed hospital will be viable over the long-term.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 10.24.01.08G(3)(e) Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

Reviewer's Analysis and Findings

At the time of the application, neither Encompass-Southern Maryland nor its parent Encompass Health had been awarded a previous Certificate of Need. (DI #15, p. 5). On December 19, 2019, the Commission approved the Certificate of Need application by Rehabilitation Hospital Corporation of America, LLC, d/b/a Encompass Health Rehabilitation Hospital of Salisbury to expand its special rehabilitation hospital in Salisbury by adding 14 private patient rooms and converting four semi-private rooms to private rooms, for a net increase of ten beds at a cost of $5,717,000, with the following condition:

> In its request for first use approval of any or all of the approved beds, Encompass-Salisbury shall provide information, acceptable to Commission staff, that: details the activities it has undertaken following approval of the Certificate of Need to increase the amount of charity provided to patients; and demonstrates its progress in achieving the level of charity care to which it has committed (i.e., charity care equivalent to two percent of total operating expenses). If staff concludes that Encompass-Salisbury's demonstration of progress is not satisfactory, further action regarding this Certificate of Need may be considered by the Commission at a public meeting.

I note that performance and reporting requirements have been stayed until 30 days after the termination of the state of emergency declared by Governor Lawrence J. Hogan, Jr. on March 5, 2020. Thus, it is too early to know whether Encompass-Salisbury will establish a track record in compliance with all terms and conditions of its CON.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 10.24.01.08G(3)(f) Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

This criterion directs the Commission to consider the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Encompass-Southern Maryland's response to this criterion, MNRH's comments, and the applicant's response to comments are discussed in the impact standard, *supra*, at pages 49-52.

<u>Reviewer's Analysis and Findings</u>

The Acute Inpatient Rehabilitation Chapter, at COMAR 10.24.09.04B(3), includes an impact standard, which was considered earlier in this report.[32] The standard provides that a project shall not have an unwarranted adverse impact on the cost of hospital services, the financial viability of an existing provider of acute inpatient rehabilitation services, the availability of services, access to services, the quality of services, or the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

In its response to the impact standard, COMAR 10.24.09.04B(3), the applicant evaluates the impact the project will have on patient volume at other providers in the District of Columbia. The ALOS and case mix at other acute inpatient rehabilitation providers is projected to remain the same. While the interested party submits that the project will impact its ability to maintain qualified nursing staff, I found that the applicant is proposing a project that is likely to allow for shifts and increases in patient volume in the region without having an unwarranted negative impact on other acute rehabilitation providers, including MNRH. The project is likely to have an impact on MNRH by creating a more competitive market in the Southern Maryland planning region. This is a necessary consequence of establishing an alternative provider of acute rehabilitation services that will, in essence, replace the only available acute rehabilitation services in the region, a small and underutilized 10-bed program located at UM Prince George's Hospital Center, which will cease operation when its replacement hospital is completed. The addition of 60 acute rehabilitation beds in the Southern Maryland health planning region will improve access for residents of its service area. I find that the impact of this project satisfies this criterion.

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[32] See discussion of the impact standard, *supra*, pp. 49-54.

IV. SUMMARY OF REVIEWER'S RECOMMENDATION

Based on my review of the proposed project's compliance with the Certificate of Need review criteria, COMAR 10.24.01.08G(3)(a)-(f), and with the applicable standards in COMAR 10.24.09, the Acute Inpatient Rehabilitation Services Chapter of the State Health Plan, I have found that the project complies with the applicable standards, is needed, is a cost-effective approach to meeting the project's objectives, is viable and will have an impact that is positive with respect to the applicants' ability to provide inpatient rehabilitation services demanded in its service area. The applicant has demonstrated that the project is needed, based on the Commission's bed need projections and other credible evidence of barriers to access. The project will have a positive impact on patient access to these services and on the cost to the health care delivery system. It will not have an unacceptably negative impact on other providers, including interested party MNRH.

MNRH provides acute inpatient rehabilitation services located in the District of Columbia, an area to which to the majority of patients from the Southern Maryland health planning region currently migrate for acute inpatient rehabilitation services. MNRH argues that much of the data presented by Encompass-Southern Maryland was not credible. However, I find that the data presented by Encompass-Southern Maryland is based on objective and reliable data, much of which is used in the same way by the Commission.

Therefore, based on my findings that result from my review and analysis of the full record in this review, I recommend that the Commission **APPROVE** the application of Encompass Health Rehabilitation Hospital of Southern Maryland, LLC for a Certificate of Need to establish a 60-bed acute inpatient rehabilitation hospital in Bowie (Prince George's County) with conditions that Encompass Health Rehabilitation Hospital of Southern Maryland, LLC:

1. In its request for first use approval, provide information, acceptable to Commission staff, that details the activities it has undertaken for outreach to the community regarding the availability of charitable services;

2. Maintain compliance with the provisions of COMAR 10.24.09.04A(1) regarding the availability of charity care and a sliding scale of discounted charges for low income individuals who do not qualify for full charity care; and

3. Prior to first use, provide written transfer and referral agreements, acceptable to Commission staff, with facilities, agencies, and organizations that are capable of managing cases that exceed its own capabilities and/or provide alternative treatment programs appropriate to the needs of the persons it serves.

IN THE MATTER OF	*	
	*	
ENCOMPASS HEALTH	*	**BEFORE THE**
	*	
REHABILITATION	*	**MARYLAND HEALTH**
	*	
HOSPITAL OF SOUTHERN	*	**CARE COMMISSION**
	*	
MARYLAND, LLC	*	
	*	
Docket No. 18-16-2423	*	

* *

FINAL ORDER

Based on the analysis and findings in the Reviewer's Recommended Decision, it is this 21st day of May 2020, **ORDERED**:

That the application of Encompass Health Rehabilitation Hospital of Southern Maryland, LLC for a Certificate of Need to establish a 60-bed special rehabilitation hospital at the southeast corner of Melford Boulevard and Marconi Drive, Bowie (Prince George's County), Maryland, at an estimated cost of $39,019,894 is **APPROVED,** with the conditions that Encompass Health Rehabilitation Hospital of Southern Maryland, LLC shall:

1. In its request for first use approval, provide information, acceptable to Commission staff, that details the activities it has undertaken for outreach to the community regarding the availability of charitable services.

2. Maintain compliance with the provisions of COMAR 10.24.09.04A(1) regarding the availability of charity care and a sliding scale of discounted charges for low income individuals who do not qualify for full charity care.

3. Prior to first use, provide written transfer and referral agreements, acceptable to Commission staff, with facilities, agencies, and organizations that are capable of managing cases that exceed its own capabilities and/or provide alternative treatment programs appropriate to the needs of the persons it serves.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: Record of the Review

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: Record of the Review

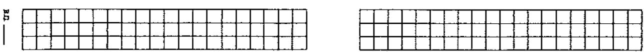
Docket Item #	Description	Date
1	Commission publication of the notice soliciting additional letters of intent for rehab services in the *Maryland Register.*	10/26//2017
2	Commission acknowledged receipt of Letter of Intent for HealthSouth to propose a 60-bed acute inpatient rehabilitation hospital and closing date for filing application, from Carolyn Jacobs, of the law offices of Jacobs & Dembert, P.A.	1/26/2018
3	Commission received notification of applicant's name change from HealthSouth to Encompass-Southern Maryland.	4/3/2018
4	Commission received letters of support for the applicant's CON application.	4/16/2018 4/18/2018
5	Carolyn Jacobs, of the law offices of Jacobs & Dembert, P.A., submitted a Certificate of Need application on behalf of ENCOMPASS-SOUTHERN MARYLAND, proposing the development of a 60-bed inpatient rehabilitation hospital ASF (Matter No. 18-16-2423) located in Prince George's County, Maryland.	4/20/2018
6	Commission acknowledged receipt of CON application.	4/23/2018
7	Commission requested publication of notification of receipt of the Encompass-Southern Maryland proposal in the *Washington Times.*	4/23/2018
8	Commission requested publication of notification of receipt of the Encompass-Southern Maryland proposal in the *Maryland Register*.	4/23/2018
9	Applicant submitted a revised Exhibit 2 to CON application.	5/1/2018
10	The *Washington Times* provided the notice of the receipt of application that published.	5/3/2018
11	Applicant submitted additional letters of support for the application, to be included with Exhibit 11.	5/16/2018
12	Applicant submitted a purchase and sale agreement for the proposed project property.	5/29/2018
13	Following completeness review, Commission staff found the application incomplete, and requested additional information.	8/23/2018
14	Applicant requested and Commission staff approved an extension to file completeness questions until 9/12/2018.	9/6/2018
15	Commission received responses to the request for additional information.	9/11/2018
16	Following review of additional information, Commission staff found the application incomplete, and requested additional information.	10/26/2018
17	Commission received responses to the request for additional information.	11/9/2018
18	Following review of additional information, Commission staff found the application incomplete, and requested additional information.	12/10/2018

Docket Item #	Description	Date
19	Applicant requested and Commission staff approved an extension to file completeness questions until 1/4/2019.	12/19/2018
20	Commission received responses to the request for additional information.	1/4/2019
21	Applicant submitted Modification to Certificate of Need application.	1/4/2019
22	Commission notified Encompass-Southern Maryland that its application is docketed for formal review on February 15, 2019.	1/28/2019
23	Commission requested publication of notice of formal start of review for the Encompass Health proposal in the *Washington Times*.	1/28/2019
24	Commission requested publication of the notice of formal start of review in the *Maryland Register*.	1/28/2019
25	Commission sent copy of the application to the Prince George's Health Department for review and comment.	1/28/2019
26	Commission received notification of the formal start of review for Encompass-Southern Maryland as published in the *Washington Times*.	2/8/2019
27	Commission received interested party comments from MedStar National Rehabilitation Hospital, from Tobin of Tobin, O'Connor & Ewing.	3/18/2019
28	Applicant filed response to interested party comments	4/2/2019
29	Applicant filed motion to strike comments and opposition to MedStar National Rehabilitation Hospital's Interested Party Comments.	4/2/2019
30	MNRH filed opposition to motion to strike comments and opposition to request to be granted interested party status.	4/11/2019
31	Applicant filed a reply in further support of motion to strike comments and opposition to MNRH being granted interested party status.	4/29/19
32	MNRH filed record corrections in support of its interested party comments.	5/10/19
33	Applicant requested that Commission rule that applicant be permitted to file a response to MNRH's record correction and deem the record closed.	5/24/19
33A	Applicant filed an additional letter in support of previous correspondence on 5/10/19 and 5/24/19	7/19/19
34	Commissioner Reviewer Peters sent letter to applicant and interested party notifying them of her ruling on the request to file response.	9/7/19
35	Commission received a request from the applicant to file response by 10/4/19.	9/18/19
36	Commission received a response from the applicant to MNRH's request for interested party status.	10/4/19
37	Commission received a request from the applicant for prompt action on review of matter.	12/11/19
38	Commission received a request for status report on review.	1/15/20
39	Commission received a motion filed by the MNRH to reconsider and reverse.	3/25/20
40	Commission received a response from the applicant to MNRH's motion to reconsider and its withdrawal of opposition to MNRH's participation as an interested party.	4/7/20

Docket Item #	Description	Date
41	Commission received a reply from MNRH filed in support of its motion to reconsider and reverse.	4/16/20
42	Commissioner Doordan sent a letter ruling to applicant and MNRH recognizing MedStar as an interested party.	4/20/20

APPENDIX 2:

Site and Floor Plans



MELFORD BOULEVARD

MARCONI DRIVE

PROPOSED
ENCOMPASS HEALTH
60 BED REHABILITATION
HOSPITAL

COURT
YARD

MAIN
ENTRANCE

SERVICE
AREA

SCALE: 1" =40'

S—1

SITE
PLAN

APRIL 11, 2018

ENCOMPASS HEALTH REHABILITATION HOSPITAL OF MELFORD

MELFORD, MARYLAND

60 BED FACILITY

FREDERICK & ASSOCIATES — ARCHITECTS
330 SOUTH PINEAPPLE AVENUE
SUITE 204
SARASOTA, FLORIDA 34236
PHONE: 941. 366.3231
FAX: 941. 366.3245

APPLICABLE CODES

- 2015 INTERNATIONAL BUILDING CODES W/ PRINCE GEORGE'S COUNTY AMENDMENTS (IBC)
- 2015 INTERNATIONAL PLUMBING CODES W/ PRINCE GEORGE'S COUNTY AMENDMENTS (IBC)
- 2015 INTERNATIONAL MECHANICAL CODES W/ PRINCE GEORGE'S COUNTY AMENDMENTS (IBC)
- 2015 INTERNATIONAL GAS CODES W/ PRINCE GEORGE'S COUNTY AMENDMENTS (IBC)
- 2015 INTERNATIONAL FIRE PREVENTION CODE W/ PRINCE GEORGE'S COUNTY AMENDMENTS (IBC)
- 2015 INTERNATIONAL ENERGY CONSERVATION CODE (IBC)
- 2012 MARYLAND ACCESSIBILITY CODE (MAC)
- 2015 NFPA 101 LIFE SAFETY CODE (NFPA)
- 2014 NATIONAL ELECTRICAL CODE (NFPA)
- 2014 FGI GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTHCARE FACILITIES (FGI)

TYPE OF CONSTRUCTION

1. I.B.C. TYPE II-B
2. NFPA 220 TYPE II (0,0,0)
3. BUILDING IS FULLY SPRINKLERED

OCCUPANCY CATEGORY

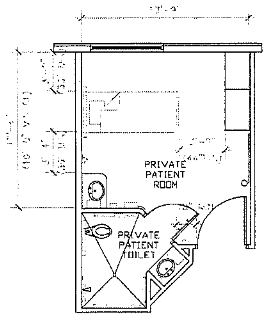
1. I.B.C. – INSTITUTIONAL GROUP I-2
2. NFPA – NEW HEALTHCARE

BUILDING AREA

NEW BUILDING
ONE STORY 61,810 GSF

REHABILITATION BED COUNT

PRIVATE BEDS:	60
TOTAL PATIENT BEDS:	60



PRIVATE ROOM PLAN
SCALE: 1/4" = 1'-0"

MINIMUM DIMENSIONS SHOWN PER (FGI)

GROSS ROOM AREA: 197 S.F.
NET ROOM AREA: 148 S.F. (140 S.F. REQUIRED)

GLASS AREA REQUIRED: (FGI) 197 X .08 = 15.76 S.F.
GLASS AREA PROVIDED: 28.70 S.F.

SERVICE COURT
KITCHEN
DINING
ADMIN
THERAPY GYM
THERAPY COURTYARD
NURSE STATION
ACTIVITY AREA 1578 sf
PATIENT TRANSFER
VISITOR ENTRANCE

FLOOR PLAN
SCALE: 1/16" = 1'-0"
0 10' 20' 30'

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ENCOMPASS HEALTH REHABILITATION HOSPITAL OF MELFORD

MELFORD, MARYLAND
60 BED FACILITY

APRIL 11, 2018

FUNCTIONAL LAYOUT
A-0