MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

MEMORANDUM

TO: Commissioners

FROM: Wynee Hawk, Chief, Certificate of Need

DATE: October 20, 2022

SUBJECT: 10 Bed Addition to Encompass Health Rehabilitation Hospital of Southern Maryland, LLC
Docket No. 22-16-2458

Enclosed is the staff report and recommendation for a ten-bed addition to the previously approved 60-bed Encompass Health Rehabilitation Hospital of Southern Maryland, LLC (or Encompass-Southern Maryland). On May 21, 2020, the Maryland Health Care Commission (or Commission) approved a Certificate of Need for Encompass-Southern Maryland, to establish a 60-bed special rehabilitation hospital in Bowie, Maryland. The applicant now proposes to add ten beds to the originally approved 60-bed hospital. The additional ten beds were acquired from University of Maryland Capital Regional Health. The beds were previously located at University of Maryland Laurel Regional Hospital before it converted to a freestanding medical facility. In a March 2018 determination of coverage, the Commission approved the relocation of the inpatient rehabilitation facility from University of Maryland Laurel Regional to the now closed University of Maryland Prince George's Hospital Center who then requested temporary delicensure of 18 of the 28 total beds at University of Maryland Laurel Regional because it could not accommodate more than ten rehabilitation beds and subsequently sold those 18 beds to Encompass Health as a contribution to the original hospital project.

The proposed ten bed addition would add 5,899 square feet of new construction including ten private patient rooms, a nursing unit, storage space, a day room and general circulation. The additional ten bed unit will be prebuilt, brought onsite and then joined to a corridor of the original 60-bed design. Only minimal changes in the approved design at the point of connection will be required. The estimated total project budget to complete the ten-bed addition is $13,109,242 which the applicant will fund with a cash loan from its parent company, Encompass Health.

Based on the 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 Chapter of the State Health Plan, staff concludes

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 applicant's ability to provide inpatient rehabilitation services demanded in its service area.

The conditions of the CON are as follows:

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 can manage 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	*	
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ENCOMPASS HEALTH	*	**BEFORE THE**
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REHABILITATION	*	**MARYLAND HEALTH**
	*	
HOSPITAL OF SOUTHERN	*	**CARE COMMISSION**
	*	
MARYLAND, LLC	*	
	*	
Docket No. 22-16-2458	*	

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STAFF REPORT AND RECOMMENDATION

October 20, 2022

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I. INTRODUCTION

A. Background

The State Health Plan (COMAR 10.24.09) defines "acute inpatient rehabilitation" (or "acute rehabilitation") as "an intensive rehabilitation therapy program as described in 42 CFR Part 412. It generally consists of at least three hours of therapy per day in multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) at least five days per week. One of the therapy disciplines provided must be physical or occupational therapy. In addition, it is a program that requires physician supervision by a licensed rehabilitation physician. This supervision must consist of face-to-face visits with the patient at least three days per week throughout the patient's stay in the IRF (inpatient rehabilitation facility) 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." There are 12 acute inpatient rehabilitation programs operating in Maryland and a 13th special rehabilitation hospital, which is the subject of this report, is currently under development. There are four special rehabilitation hospitals in operation. The other eight existing programs are located on general hospital campuses.

On May 21, 2020, the Maryland Health Care Commission (MHCC or Commission) conditionally approved a Certificate of Need (CON) for Encompass-Southern Maryland, to establish a 60-bed special rehabilitation hospital in Bowie (Prince George's County) which will only serve adults. (Docket # 18-16-2423). The approved project is a single-level, 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 the three wings of the building, nourishment area, utilities, and staff lounge and dictation area. The site is approximately 6.5 acres. The total approved project cost of $39,019,894 was based on the project budget estimate presented by the applicant in its CON application. The applicant anticipated funding the project with cash. The conditions adopted as part of the CON are as follows:

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

On March 18, 2021, MHCC approved a change in the special hospital CON The approved project cost was raised to $45,982,206 (+17.8%). The project funding source continued to be all cash.

The applicant states that following first use of the hospital there will be a change in the "upstream ownership" and Encompass Health Corporation, the parent of the applicant, and University of Maryland Medical System (UMMS) will be entering into a joint-venture affiliation agreement through which ownership of the hospital will be shared, with each of the two organizations directly owning 50 percent of the facility. (DI #2, p.8). The parties anticipate that the joint-venture affiliation will close in either the third or fourth quarter of CY2023 following the opening of the hospital facility in June 2023. (DI #9, p.2).

B. 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. Encompass Health operates 148 acute inpatient rehabilitation hospitals, 252 home health agencies, and 99 hospice agencies in 35 states and Puerto Rico. (DI #2, p.8). This includes a special rehabilitation hospital in Maryland, Encompass Health Rehabilitation Hospital of Salisbury (Encompass-Salisbury), a 78-bed special rehabilitation hospital located in Wicomico County.

C. The Project

The applicant proposes to add ten beds to the originally approved 60-bed hospital. The additional ten beds were acquired from University of Maryland (UM) Capital Region Health (CRH), a health care system headquartered in Prince George's County. The beds were previously located at UM Laurel Regional Hospital (LRH) before it converted to a freestanding medical facility (FMF). In a March 2018 determination of coverage, the Commission approved the relocation of the inpatient rehabilitation facility from LRH to the now closed UM Prince George's Hospital Center (PGHC). PGHC requested temporary delicensure of 18 of the 28 total beds at LRH because PGHC could not accommodate more than ten rehabilitation beds and sold those 18 beds to Encompass Health as a contribution to the original hospital project. A timeline for the bed licensure changes is included in Appendix 3.

The proposed project would add 5,899 square feet of new construction including ten private patient rooms, a nursing unit, storage space, a day room and general circulation. The ten-bed unit will be prebuilt, brought onsite and then joined to a corridor of the original 60-bed design. Only minimal changes in the approved design at the point of connection will be required. (DI #9, pp.1-2). The proposed addition will be integrated into the design of the original 60-bed hospital and will be constructed to meet all the requirements of the International Building Code and National Fire Protection Agency. As previously noted, the hospital in development is a one-story building with surface parking. (DI #2, p. 6).

Based on the applicant's experience, the most frequent diagnoses of its projected acute rehabilitation patient population are stroke, brain injury, amputation, spinal cord injury, fractures, neurological disorder, multiple traumas, congenital deformity, burns, arthritis, joint replacement, and systemic vasculitis. (DI #2, p.10).

D. Staff Recommendation

Staff concludes that the proposed ten-bed addition to the originally approved 60-bed special rehabilitation hospital in Bowie (Prince George's County) complies with the applicable standards of COMAR 10.24.09, the applicable State Health Plan (SHP) chapter of regulation. The project can be approved under the bed need standard of the SHP. It is the most cost-effective approach to increasing rehabilitation bed capacity in the area given that the hospital under development will be the only rehabilitation hospital in the Southern Maryland region. The project is likely to be viable. The impact of the original project on access to inpatient rehabilitation services for residents of southern Maryland could be positive if population demand for beds increases. Substantially. Adding ten beds will not substantially change the impact on other providers of this service previously found to be acceptable when the 60-bed hospital was approved by MHCC in 2020. For these reasons, staff recommends that the Commission **APPROVE** this project with the same conditions imposed on the original CON.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 1, Record of the Review.

B. Interested Parties in the Review

There are no interested parties in this review.

C. Local Government Review and Comment

There were no letters from the Prince George's County Health Department

D. Community Support

The CON application included 20 letters of support for this project. (DI #2, Exh. 8).

- Trudy Hall, M.D., Physical Medicine and Rehabilitation, UM Capital Region Health and UMMC Medical Center Midtown Campus
- Kisha Perkins Brown, M.D. Medical Director, UM Capital Region Medical Center
- Nathaniel Richardson, President, UM Capital Region Medical Center
- Patricia Scripko, M.D., Neurologist, UM Capital Region Medical Center
- Mohan Suntha, M.D., President, UMMS

- Renwu Chen, M.D., Medical Director, Stroke Program UM Capital Region Medical Center
- Lyn Clark, R.N., Director, Case Management, UM Capital Region Medical Center
- Cynthia Kelleher, President, UM Capital Region Rehabilitation and Orthopedic Institute
- April Miskell, R.N., Stroke Program Coordinator, UM Capital Region Medical Center
- Paul Newman, M.D. Faculty, UM Capital Region Medical Center

Additionally, the following representative of an educational institution submitted a letter in support of the proposed project:

- Arminta Breaux, PhD, President, Bowie State University

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

- Angela Alsobrooks, County Executive, Prince George's County
- Geraldine Valentino-Smith, State Delegate, Maryland House of Delegates
- Todd Turner, Council Member District 4, Prince George's County Council
- Ron Watson, Senator, State of Maryland
- Tim Adams, Mayor, City of Bowie
- Alexis Allen-Shorter, Director Business Development, Prince George's County Economic Development Cooperation
- David Iannucci, President, Prince George's County Economic Development Cooperation

Two community providers expressed support for the project:

- C. Obi Onyewu, M.D. Practitioner, Choice Pain and Rehabilitation Center
- Jared Reaves, M.D. Medical Director, NeuroRestorative

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 require 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).

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 applicant's charity care policy is attached to the application as Exhibit 7. 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 procedures state that a patient is required to provide only their name, household income, and family size to receive an initial financial assistance determination of probable eligibility for charity care within two business days. (DI #2, p.21).

The applicant states that information regarding its charity care policy will be available in the admitting and registration areas of the hospital, ambulance entrance, finance office, on the website, and in patient billing statements. (DI #2, p.21). Encompass-Southern Maryland also states that it will disseminate information in the community and meet with hospital case managers and physicians. It states it will work with the local health department and non-profit community organizations to make sure the community is aware of its charity care services. (DI #2, p.21). In addition, 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 #2, p.21).

Encompass-Southern Maryland's policy states that it will provide services free of charge to patients with household income up to 200 percent of federal poverty limits. It also provides a sliding scale for patient with household income up to 400 percent of federal poverty limits as seen in the table below. (DI #2, p.21 and Exh.7).

Table: III-1 Sliding Scale for Discounting of Charges
Encompass Hospital, Bowie

Income Level	Reduction of Total Charges
0-200% FPL	100%
201-300% FPL	75%
301-400% FPL	50%

DI #2, Exh.7

(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.

This subpart of the standard is intended to be used in evaluating general hospitals rather than special hospital projects. However, as a point of comparison, the most recent HSCRC Community Benefit Report in 2019, that used 2018 data, showed the bottom quartile boundary would have been a charity care level of 1.1 percent. (Median care level for all hospitals was 1.8 percent.) The same report identified the charity care levels of the Maryland acute rehabilitation hospitals most comparable to the proposed project (other than Encompass-Salisbury), in 2018, were:

- Adventist Rehabilitation-Rockville - 0.5 percent
- Levindale, Baltimore City - 1.3 percent
- UM Rehabilitation and Orthopedic Institute, Baltimore City- 2.1 percent[1]

By comparison, Encompass Salisbury's 2018 charity care level was 0.07 percent. (DI #9, p.3). Encompass Salisbury achieved a 0.66 percent charity care level in 2019 and 1.49 percent in 2020, a year in which the initial Bowie hospital CON application was under review. In 2021, the charity care level dipped to 0.49 percent, a decline largely attributed to the COVID-19 pandemic. Encompass Salisbury reports a charity care level of 0.77 percent in the first six months of 2022. (DI #9, p.3).

(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

Upon staff's request, the applicant submitted charity care information for Encompass Salisbury, a related subsidiary of Encompass Health. Encompass Salisbury received a CON to add beds on December 19, 2019 (Docket # 18-22-2435), committing to reach and maintain a charity care level of two percent. The CON was issued 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.

At the time Encompass-Salisbury submitted a request for First Use, the most recent charity care level at this hospital was 0.5 percent, short of the 2 percent outlined in the condition.

[1] Of interest, staff notes the UM Rehabilitation and Orthopedic Institute charity care level of 2.1% in 2018 and the reported Salisbury level of .07% in that same year. As noted, MHCC has been informed by UMMS and Encompass that these entities anticipate changing the ownership of the Bowie hospital after the project is completed so that a joint venture comprised of the two entities will own the hospital. This may be a basis for optimism that the hospital can employ strategies for outreach and service to uninsured low-income households going forward that better demonstrate achievement of its commitments.

Encompass-Salisbury outlined its charity care efforts and provided a detailed explanation about the shortfall in the provision of charity care. Encompass-Salisbury stated it had challenges during the COVID-19 pandemic that affected its provision of charity care including fewer in person meetings with referral sources who were more focused on responding to the pandemic. It was also suggested that increased turnover among referral source managers led to a decline in referrals. Finally, Encompass Salisbury reported a decline in collaboration with local health departments and other community health agencies in 2020 and 2021 as these agencies largely focused on more urgent public health needs. (DI #9, pp.4-6).

Encompass-Salisbury also noted that Maryland is a Medicaid-expansion state with a declining uninsured population. Encompass-Salisbury stated that, between 2013 and 2017, Maryland's uninsured population declined from 12 percent to seven percent. Additionally, it noted that most of the hospital's patients are Medicare patients, reducing the number of uninsured patients that might seek charitable rehabilitation hospital services when compared to other types of hospital care. (DI #9, pp.4-5).

On December 17, 2021, Encompass-Salisbury received first use approval from the Commission for the project. The applicant states that Encompass-Salisbury's charity care level was approximately 0.8 percent in the first six months of 2022 (based on an assigned value of $98,078), and reports on eight charity care referrals in this period.

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

As part of its 60-bed hospital project, Encompass-Southern Maryland submitted a plan for achieving the level of charitable care provision to which it committed (two percent), including collaboration with the Prince George's County Health Department and the Department of Social Services, marketing to acute care hospital case managers to identify the need for charity care and 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. This plan has not changed.[2]

Staff Analysis and Findings

In subpart (a) the applicant provided a charity care policy that it states will be posted appropriately and that it will require modest levels of information from patients to apply financial assistance. The applicant is entering a new market and will need more time to do community outreach and provide information on its charitable services. Subpart (b) is not applicable. With respect to subpart (c), the proposed hospital is still under construction and therefore there is no historical data for charity care provision on which to rely. The charity care data for Encompass-Salisbury shows that it failed to achieve the level of charity care (two percent of total operating expenses) in a condition placed on the hospital in a 2019 CON expanding the hospital.
Staff is concerned about Encompass-Salisbury's failure to meet its charity care level commitment. Its experience is relevant to MHCC's consideration of the seriousness of the applicant's same

[2]CON Docket # 18-22-2435, Addition of Special Hospital Beds, Encompass
https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2020_decisions/con_emcompass_2423_decision_20200521.pdf

commitment with respect to this Bowie project. Staff notes that the special hospital project being enlarged has two conditions addressing charity care which will establish a basis for monitoring and assuring appropriate access to acute rehabilitation for all households in the hospital's service area no matter what wealth, income, or insurance coverage characteristics are applicable to the patients in need. With that concern noted, staff recommends a finding of compliance with this standard.

(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). It acknowledges 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 #2, p.23).

(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.

The applicant did not specifically respond to this subpart. It submitted relevant information in subpart (c) below.

(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.

The applicant responded to subpart (c) of this standard, however, the applicable subpart is (b) because Encompass Health is an established provider of inpatient rehabilitation facility (IRF[3]) services both in Maryland and nationally. The applicant's performance on quality measures for an existing Maryland facility can be reviewed as part of the standard. The applicant states that Encompass Health is an experienced provider and has achieved both national recognition and certifications. (DI #2, p.24).

The applicant provides data showing that all existing Encompass Health subsidiaries comply with CMS's IRF Quality Reporting Program and report to the CMS Health Compare website. Encompass Health consistently meets or exceeds expectations in outcome measures that measure a patient's improvement from admission to discharge as seen in Table III-2 below.

Table: III-2 Encompass Health Quality Metrics Ending May 6, 2022
(Rolling 12 Months and Year to Date 2022)

	Rolling 12 Months		YTD 2022	
National Avg. or Entity	**Self-Care**	**Mobility**	**Self-Care**	**Mobility**
National Risk Adjusted Avg., All Providers	12.3	29.0	12.2	28.9
Encompass Health National Average	14.0	34.4	14.0	34.5
Encompass-Salisbury, Risk-Adjusted[4]	12.3	30.7	12.2	31.1
Source: Uniform Data System for Medical Rehabilitation ("UDS_{MR}"). Note: The national, risk-adjusted averages are based on information from the UDS_{MR}, a data gathering and analysis organization for the rehabilitation industry which represents approximately 80% of the industry, including Encompass Health sites. Data has been adjusted by applying Encompass Health IRF case mix to non-Encompass Health UDS IRFs. Higher scores are better.				

DI #2, p.25

In addition, the applicant references high performance in CMS quality indicator data for Encompass-Salisbury, a related subsidiary of Encompass Health, relative to national providers for discharging patients back to the community, reducing re-hospitalization rates and performance on clinical outcomes. See Table III-3 below.

[3] 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.

[4] Encompass Health provided risk-adjusted data to account for patient severity so that meaningful comparisons can be made. Risk adjustment is a statistical analysis that accounts for the differences in patient case mix that influence health care outcomes. (DI #9, pp. 7-8).

Table: III-3 CMS Quality Indicators – Encompass Salisbury and National Average

Quality Indicator	Encompass-Salisbury	National Average
Successful Return to Home and Community *(Higher is better.)* (a)	72.33%	64.74%
Readmission rate of potentially preventable hospital readmissions 30 days after discharge from an IRF *(Lower is better.)* (a)	5.87%	6.74%
Readmission rate of potentially preventable hospital readmissions during an IRF stay	5.29%	4.34%
Payment and Value of Care *(Lower is better.)* (a)	0.98	1.00
Percentage of patients who are at or above an expected ability to care for themselves at discharge *(Higher is better.)* (b)	67.8%	58.3%
Percentage of patients who are at or above an expected ability to move around at discharge *(Higher is better.)* (b)	66.4%	56.2%
Change in patients' ability to care for themselves *(Scores above 0 are better.)* (b)	13.1	N/A
Change in patients' ability to move around *(Scores above 0 are better.)* (b)	34.2	N/A
Medication reconciliation: percentage of patients whose medications were reviewed and who received follow-up care when medication issues were identified *(Higher is better.)* (b)	98.6%	97.5%

Source: Medicare.gov, Inpatient Rehabilitation Facility (IRF) Compare.
Notes: Data for Medicare patients.
Medicare spending per beneficiary (MSPB) for patients in IRFs shows whether Medicare spends more, less, or about the same on an episode of care for a Medicare patient treated in a specific IRF compared to the national average. A ratio that is less than the national average of 1.00 means that Medicare spends less per patient for an episode of care initiated at this IRF than it does per episode of care across all IRFs nationally.
(a) Data for 10/1/2017-9/30/2019.
(b) Data for 7/1/2020-6/30/2021.

DI #2, p.27 and DI #9, p.7

Staff Analysis and Findings

Encompass Health has maintained licensure, accreditation, and Medicare/Medicaid certification at its other facilities and staff concludes that Encompass-Southern Maryland has satisfied paragraph (a) of the quality-of-care standard.

Subpart (b) of the standard requires an applicant to 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 meet quality of care standards. Staff reviewed CMS's Compare Care quality measures for the existing freestanding special rehabilitation hospitals and Encompass-Salisbury compared well with the other Maryland IRF providers. Encompass-Salisbury exceeded the national average in all measures except for readmissions during the patient's IRF stay which was only slightly higher than the national average. See Table III-3 above. (DI #9, p.7). Encompass Health has experience reporting on the required quality measures. The performance on those measures is comparable with the

performance of other providers. For these reasons, staff concludes that the applicant meets the requirements 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.

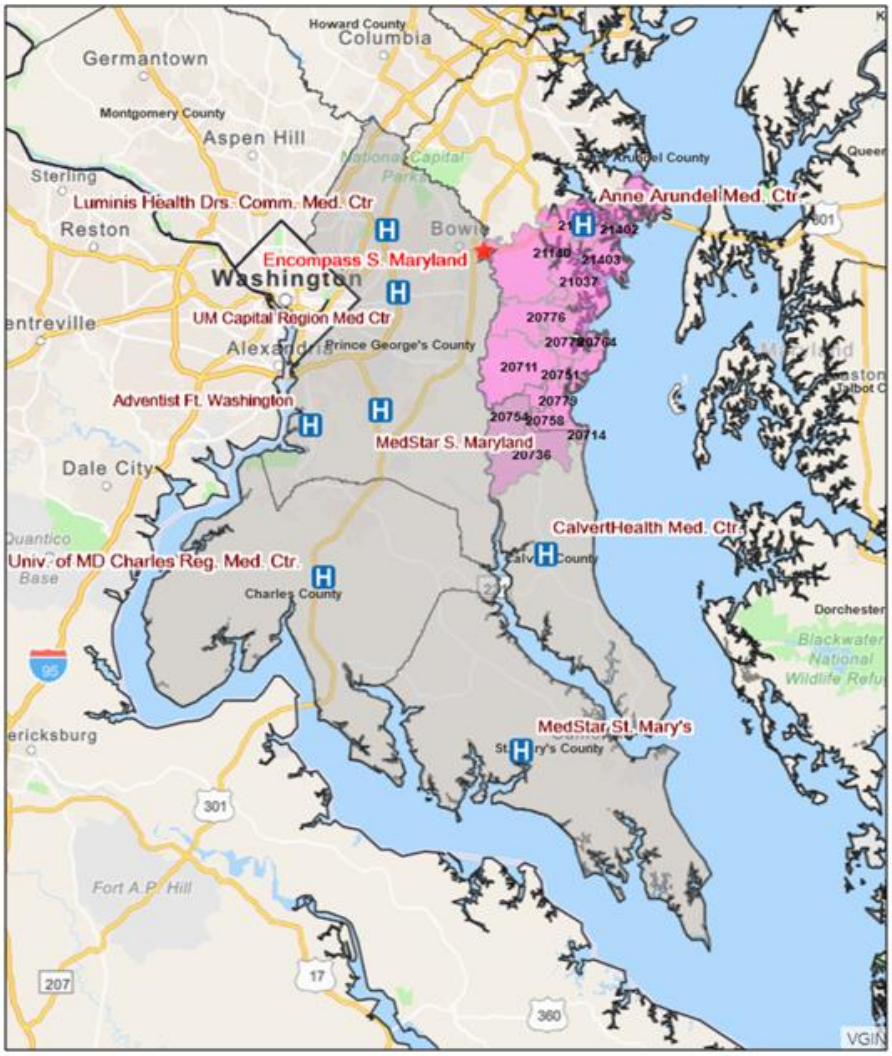
Applicant's Response

The applicant states that the first part of the standard does not apply because this application is not for a new or relocated acute rehabilitation hospital or subunit looking for a location to optimize accessibility for its service area population. The applicant notes, however, that it passed this standard in the original 60-bed hospital project. In the prior application the Commission found that the applicant had demonstrated that travel time and resource levels are barriers in the Southern Maryland Health Planning Region (HPR), creating a demand for IRF services. Applicant states that access barriers are worse since the 2020 CON decision and the previously recognized barriers persist. (DI #2, p.31). The ongoing barriers (maldistribution of beds, limited acute rehabilitation options, travel time, family engagement, underutilization of acute rehabilitation services, and disruption in continuity of care) can be improved by the ten-bed addition to the 60-bed hospital. (DI #2, p.31).

The applicant also expresses hope that the joint venture, which will result in the facility becoming part of the University of Maryland Rehabilitation Network, will support the efforts to overcome the current barriers. It states UMMS has dedicated years of strategic planning to determine how best to improve health care delivery in the Southern Maryland region to reduce the inequity of care that has historically existed. By improving health care delivery locally, patients will have increased access to high quality care without needing to travel to surrounding counties. As a result, larger numbers of patients will seek care locally as they move throughout the health care continuum, including post-acute inpatient rehabilitation care.

Service Area and Population Projections

The applicant began its access analysis with a review of the service area for the ten-bed addition stating that it has not changed since CON approval of the 60-bed hospital project. The service area includes the Southern Maryland HPR (Prince George's, Calvert, Charles and St, Mary's counties) and some zip codes in Anne Arundel County as seen in the map below. (DI #2, p.31).



Source: ArcGIS.

Southern Maryland Health Planning Region

Anne Arundel-South

General Acute Care Hospital

Encompass Southern Maryland

The applicant then reviewed the service area population projections, focusing on the 65 and older cohort. The applicant states that because of the service area population growth, coupled with access barriers that currently exist, the ten-bed addition is needed to ensure sufficient inpatient rehabilitation beds in the service area to meet the need. In addition, it states that the preservation of the ten inpatient rehabilitation beds in an historically underserved area will play a role in the ongoing efforts to improve and revitalize the healthcare delivery system in Prince George's County and the surrounding area. (DI #2, p.45). Table III-4 below demonstrates that the 65 and older service area population, which is the largest cohort consuming IRF services with almost 80 percent Medicare inpatient days, will increase significantly from 2025 to 2035.

Table: III-4 Population 65 and Older, Defined Project Service Area and State

County	2025	2030	2035	% Increase, 2025-2035
Prince George's	150,778	174,651	191,757	27.2%
Charles	27,320	34,124	39,918	46.1%
Calvert	18,960	22,841	24,778	30.7%
St. Mary's	19,406	23,594	26,166	34.8%
Southern Maryland HPR	**216,464**	**255,210**	**282,619**	**30.6%**
Anne Arundel	105,868	119,347	125,915	18.9%
State of Maryland	*1,139,636*	*1,139,636*	*1,296,675*	*13.8%*
Source: Maryland Department of Planning, Projections and State Data Center, December 2020.				

The table shows that the 65 and older cohort in the Southern Maryland HPR, excluding the identified Anne Arundel County zip code areas, will grow much faster, at 30.6 percent, in comparison to the state, which is only expected to grow 13.8 percent in the decade following 2025.

Utilization/Bed Ratio

The applicant also provided an analysis that compares use of inpatient rehabilitation services by Medicare beneficiaries by home county in CY19 and CY20 (the most recent two full years for which data is available). Table III-6 below shows that jurisdictions in this project's defined service area have Medicare use rate that straddle the state average, except for Anne Arundel, that has a reported use rate that is a third of the state average. Charles and Prince George's have use rates slightly above the state average; Calvert and St. Mary's are slightly below.

The applicant states that because the use rates are based on the Medicare beneficiary's home address regardless of where the service was received, IRF Medicare utilization accounts for any out-migration of services, and the data in Table III-5 captures total discharges from inpatient rehabilitation in all states and Washington, DC. The applicant also states that Medicare data was the only data available when the CON application was submitted and recommends it as appropriate to determine need for rehabilitation hospital services.[5] The Washington, D.C. utilization data is shown for comparison purposes only. (DI #2, p.33).

Table III-5: Inpatient Rehabilitation Utilization Rate for Medicare Beneficiaries by Home County, CY 2020

Rank	County	Inpatient Rehab Conversion Rate
1	Wicomico	12.17%
2	Worcester	10.41%
3	Somerset	8.82%
4	Kent	8.41%
5	Dorchester	6.80%
6	Caroline	4.82%
7	Queen Anne's	4.26%
8	Cecil	4.14%
9	Montgomery	4.11%
10	Talbot	3.23%
11	Garrett	3.10%
12	**Charles**	**2.60%**
13	**Prince George's**	**2.08%**
14	**Calvert**	**1.74%**
15	Carroll	1.73%
16	**St. Mary's**	**1.50%**
17	Allegany	1.25%
18	Frederick	0.94%
19	Howard	0.76%
20	**Anne Arundel**	**0.50%**
21	Washington	0.40%
22	Harford	0.26%
23	Baltimore	0.25%
24	Baltimore City	0.16%
Maryland		1.86%
District of Columbia, DC		2.72%

Source: Centers for Medicare and Medicaid Services (CMS) Geographic Variation Public Use Files (PUF).
Note: conversion rate represents the Medicare IRF discharges as a percentage of total Medicare acute care discharges.

DI#2, p. 36

The applicant also provided information on bed to population ratios (Table III-6 below), highlighting that the SHP's Southern Maryland region has a higher ratio of adult population to hospital rehabilitation beds than the state's other four regions, when the 70 beds proposed by Encompass are accounted for in the bed inventory.

Table III-6: Adult Population to Rehabilitation Hospital Bed Ratios
Maryland Health Planning Regions and Maryland

Health Planning Region	2022 Adult Population (Ages 18+)	# CON-Approved Rehab Beds	Adult Population per Bed
Eastern Shore	291,322	89	3,273:1
Central Maryland	2,290,692	260	8,810:1
Montgomery	836,692	87	9,617:1
Western Maryland	419,183	33	12,703:1
Southern Maryland	**1,021,954**	**70**	**14,599:1**
Total	4,859,843	539	9,016:1

Sources: Claritas; Maryland Health Care Commission Bed Inventory; April 13, 2018, Maryland Register, Gross, and Net 2021 Bed Need Projections for Acute Rehabilitation Beds by Health Planning Region, as adjusted to reflect (1) addition of 10 beds in Eastern Shore pursuant to December 19, 2019, Decision *in Encompass Health Rehabilitation Hospital of Salisbury*, Docket. No. 18-22-2435; and (2) net addition of 32 beds in Southern Maryland pursuant to (a) May 20, 2020, Decision *in Encompass Hospital, adding 60 beds to the region*; and (b) closure of Laurel Regional Hospital, resulting in a loss of 18 beds in the region. The 10 beds transferred to University of Maryland Prince George's Hospital Center and subsequently delicensed are included in the adjusted inventory.

DI #2, p.37

The applicant states that the high ratio of population to beds in the Southern Maryland region demonstrate a lack of adequate access to inpatient rehabilitation services in the region.

Discharges

The applicant states that 91 percent of patients admitted to an Encompass IRF are patients directly discharged from a general acute care hospital. Further, due to these referral patterns, it is likely that a lack of access to acute care hospitals would have an impact on utilization of inpatient rehabilitation facilities. The applicant found that there is comparable access to acute care hospital services relative to Encompass-Salisbury's service area, however, the IRF utilization in the Southern Maryland HPR is among the lowest in the state. It states the discrepancy between general hospital utilization rates and post-acute rehabilitation services indicates that Maryland Medicare beneficiaries have access to acute care hospitals, however, when they are ready for discharge there are too few IRF beds available. (DI #2, p.39)

The applicant also states that patients who are appropriate for inpatient rehabilitation services are often either discharged to a nursing home, home health, or a facility outside their community and sometimes they may totally forgo the needed rehabilitation all together. The applicant states that physicians and other healthcare professionals' express frustration at the wait

time for inpatient rehabilitation beds, especially for advanced rehabilitation and stroke or brain injury patients. (DI #9, pp.10-11). Table III-7 below shows the Southern Maryland HPR discharge disposition data. According to the applicant, three percent of IRF appropriate patients[6] were discharged to IRFs, 16.7 percent to SNFs, 18.6 percent with home care, and 53.2 percent discharged home with no home health rehabilitation care at all.

Table: III-7:
Discharge Disposition for Service Area Residents' IRF Appropriate Discharges
From General Acute Care Hospitals in Maryland
FY21 (July 1, 2020 – June 30, 2021)

Discharge Disposition	Discharges	% Of Total
Inpatient Rehabilitation Facility (IRF) or Rehabilitation Distinct Part Units of Another Hospital	673	3.0%
SNF with Medicare Certification in anticipation of Skilled Care	3,695	16.7%
Home under Care of an Organized Home Health Service Organization in anticipation of Covered Skilled Care	4,130	18.6%
Routine Discharge to Home or Self Care	11,801	53.2%
Another Acute Care Hospital for Inpatient Care (includes transfers to acute care units within the same hospital)	1,101	5.0%
Left Against Medical Advice or Discontinued Care (includes Administrative Discharge, Escape, Absent without Official Leave)	301	1.4%
Another Type of Health Care Institution Not Defined Elsewhere in Code List	286	1.3%
Custodial or Supportive Care Facility (Includes Intermediate Care Facilities if State Designated, Nursing Facilities that are Not Certified by Medicare or Medicaid, and Assisted Living Facilities)	127	0.6%
Medicare-Certified Long Term Care Hospital (LTCH)	34	0.2%
Nursing Facility Certified Under Medicaid but not Medicare	3	0.0%
Federal Health Care Facility (Includes VA Hospital, VA SNF, or DOD Hospitals)	8	0.0%
Unknown	4	0.0%
TOTAL	**22,163**	**100.0%**

Source: Maryland HSCRC Abstract Inpatient Database, FY21 data.
Note: discharges excluded from the analysis include patients who expired or were discharged to a designated cancer center, a psychiatric facility, to court/law enforcement, hospice at home, or a hospice facility.

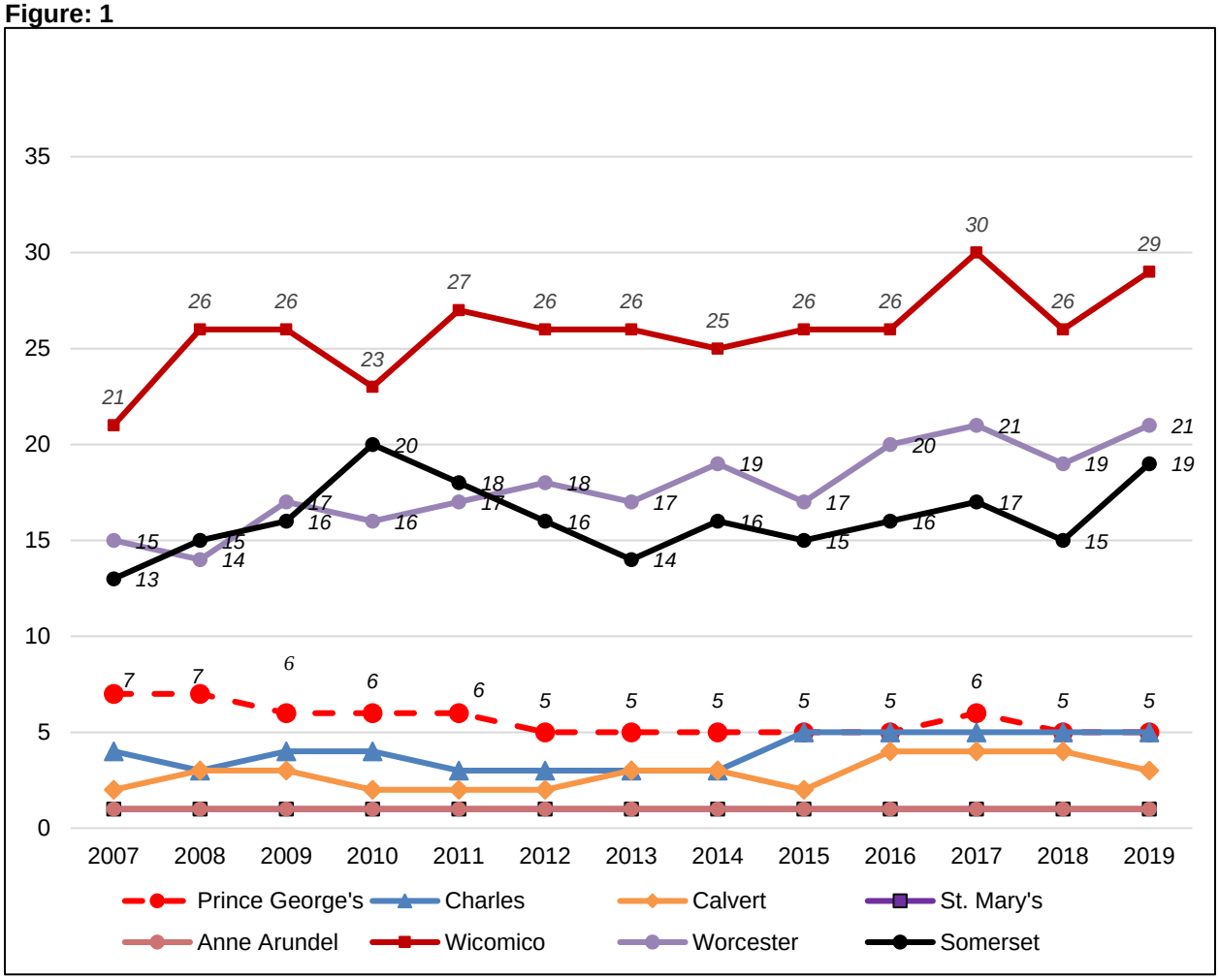
DI #9, p9.11-12

The applicant presented the following graph to support its contention that the Southern Maryland HPR and Anne Arundel County have a low number of "appropriate" acute rehabilitation discharges when compared to the rest of the state. The 2019 statewide average acute rehabilitation discharge rate was four discharges per 1,000 Medicare beneficiaries.

[6] "IRF appropriate patients" are those patients who were diagnosed with one of a select listing of MSDRGs that Encompass Health has identified as those diagnoses that most commonly necessitate intensive inpatient rehabilitation care.

Service Area Counties' IRF Discharge Rates are Far Below the Counties with the Highest Discharge Rates in the State (IRF Discharges per 1,000 Medicare Beneficiaries)

Figure: 1



DI #2, p.38

The applicant states that the continuing decline of low use rates may be attributed in some part to the relocation of the 42-bed rehabilitation hospital in Takoma Park to White Oak Medical Center in Silver Spring, Maryland (Montgomery County) in October of 2018. It states that the new location is less accessible to patients in the Southern Maryland HPR.

Travel Times

Next the applicant looked at travel times, comparing the geographic location of existing acute rehabilitation alternatives to the midpoints of each county in the proposed service area, shown in Table III-8 below.

Table: III-8: Estimated Drive Time from Counties in the Proposed Service Area to Existing Acute IRF Facilities and the Proposed Project Site

County Geographic Midpoints	UM Rehab and Ortho. Institute	Adventist Rockville	Adventist White Oak	Proposed Project Site in Bowie
Anne Arundel	37 minutes	54 minutes	40 minutes	16 minutes
Calvert	82 minutes	86 minutes	71 minutes	49 minutes
Charles	82 minutes	61 minutes	67 minutes	56 minutes
Prince George's	55 minutes	56 minutes	46 minutes	29 minutes
St. Mary's	123 minutes	119 minutes	105 minutes	87 minutes

Source: Google Maps

The applicant states that the proposed project in Bowie offers a closer alternative for acute rehabilitation services for residents of Southern Maryland. The applicant states that travel time barriers suggest 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. In addition, the project site in Bowie is approximately 9.5 miles from University of Maryland Capital Region Health (UM-CRH), which is expected to be a referral source. The applicant also states that the drive time data is consistent with the Commission's recognition that distance to providers may be a more powerful predictor of acute inpatient rehabilitation service use than the clinical characteristics of patients. COMAR §10.24.09.03, *Access to Care*. (DI #2, p.37).

The applicant states the decreased access to nearby beds that were formally at Laurel Regional Hospital has exacerbated challenges in accessing IRF care. Data shows that 50 percent of IRF service area residents are going to Adventist HealthCare at White Oak Medical Center for FY21, which is an average of 65.8 miles for the service area counties.

Wait Times

Applicant could not provide a typical wait time for an IRF bed in the service area; however, it states that UM-CRH continues to experience longer than necessary average lengths of stay for patients ready for discharge, but not yet able to be discharged home. The applicant states that lack access to IRF beds in Southern Maryland is a factor driving a longer length of stay. It also states that this issue will persist without additional IRF beds in the region, given that alternative post-acute care settings, such as home health or nursing homes are not always an option for patients. (DI #9, p.12).

Staff Analysis and Findings

MHCC concluded, several years ago, that Southern Maryland should have better access to acute rehabilitation facilities, when it authorized establishment of the Encompass hospital. There were no special rehabilitation hospitals or programs operating in the region at that time. The addition of ten beds to the approved hospital does not alter that conclusion. If high use levels are achieved, it may provide a marginal improvement in availability and accessibility. Thus, staff concludes that the application is consistent with the standard.

Staff remains concerned about the outlier use rates that appear to be associated with the operation of an Encompass hospital on the Eastern Shore. (See Table III-5 above). We agree that use rates that are very low may indicate an inappropriate underuse of acute rehabilitation hospital services. But we note that the use rates in Eastern Shore jurisdictions (4.1 percent to 12.2 percent) are much more prominent outliers among Maryland jurisdictions relative to the state average (1.9 percent) or median (2.3 percent) than are the lower end of the use rate values. We believe that inappropriate overuse of acute rehabilitation resources can occur and do not believe that a significant increase in use rates that might be the result of introducing a new provider to a region is an unqualified good.

(2) Need.

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.

Applicant's Response

The applicant's defined its service area as the Southern Maryland HPR, and the following Anne Arundel County zip code areas, in its need analysis:

Figure: 2

20711 Lothian	20776 Harwood	21140 Riva
20733 Deale	20778 Shady Side	21401 Parole
20751 Deale	20779 Fairview	21402 Annapolis
20758 Friendship	21035 Davidsonville	21403 Annapolis
20764 Shady Side	21037 Edgewater	21409 Arnold

DI #2, p.48

(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.

The applicant states that Medicare IRF utilization accounts for any out-migration of services because the utilization is based on the Medicare beneficiary's home address regardless of where the service was received. The applicant states that for all states and Washington D.C., 86 percent of total revenue for acute rehabilitation comes from Medicare. (DI #2, Exh.1, Table G). Since there

are currently no IRF beds in the Southern Maryland HPR there is no in-migration pattern to analyze.

(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.

This subpart is not applicable, there is no adjustment based on out-migration**.**

(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.

This subpart is not applicable, the project is consistent with the MHCC bed need projections.

(d) 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.

This subpart is not applicable. No specialized programs are proposed.

(e) 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.

This subpart is not applicable. There will be no dual bed licensure.

Staff requested historical use trends for the 28 beds located at Laurel Regional Hospital as shown in the Table III-9 below.

Table: III-9
Historical Use of Laurel Regional Hospital 28 Bed Inpatient Rehabilitation Unit, 2016-2018

Indicator	FY 2016	FY 2017	FY 2018
Patient Days	2,440	2,340	2,535
Average Daily Census	6.7	6.4	6.9

Source: UMMS internal data.

The applicant stated that the low utilization was not based on a lack of need, rather the result of poor leadership, staffing challenges, and low referrals that generated rumors of the hospital closing before it was acquired by University of Maryland Medical System. The applicant stated that the rumors likely caused patients to be reluctant to seek care at Laurel Regional Hospital. (DI #9, pp.14-15).

Encompass-Southern Maryland stated that the Commission's 2018 bed need projections support the need for the proposed project.

It also provided an alternative bed need analysis incorporating information on use of the CRH facilities operated in the region in the past, the project's expected service area for the Bowie hospital, and its assumptions concerning "appropriate" use of acute hospital rehabilitation services. (See the preceding standard.) The applicant believes these analyses support the notion that use rates in the region can appropriately increase in ways that support use of 70 beds in Bowie.

Staff Analysis and Findings

The most recent MHCC rehabilitation bed need projections would allow for development of a 70-bed hospital in Southern Maryland. The net bed need projection would allow for up to 72 additional beds in the region.

The proposed project is consistent with this standard.

(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 notes the ten beds it seeks to add in Bowie were included in the inventory considered by the Commission at the time the 60-bed special rehabilitation hospital was approved. Because the ten beds were previously in service and the regional data continues to support this bed need, the applicant does not anticipate any adverse impact to other inpatient rehabilitation

providers that have historically operated in the region with these additional ten beds in service. The applicant also does not anticipate any adverse impact on the patient volume, average length of stay, or case mix at other acute inpatient IRF providers. (DI #2, pp. 53-54).

In addressing the access standard, the applicant states that there are significant barriers to IRF care which have created a gap in care for patients of the Southern Maryland HPR. The addition of ten beds to the already approved 60 bed hospital will, according to the applicant, provide the region with improved access to the services they need and will not result in significant losses of discharges from other providers in surrounding regions. The following table uses the most recent data available (July 1, 2020 – June 30, 2022) to update the distribution of rehabilitation patient admissions to Maryland hospitals for residents in the defined service area, which includes Calvert, Charles, Prince George's, and St. Mary's counties and selected zip code areas in southern Anne Arundel County. (Patient origin for Washington D.C. hospital is not included.)

Table: III-10
Inpatient Rehabilitation Admissions for Service Area Residents,
Maryland Hospitals
FY 2021 (July 1, 2020 – June 30, 2021)

Hospital	Calvert	Charles	Prince George's	St. Mary's	Anne Arundel*	Total	% Of Discharges
Adventist Rehabilitation (Rockville)	2	2	64	2	3	73	8.1%
Adventist Rehabilitation (White Oak)	11	26	379	9	23	448	50.0%
Encompass Salisbury	2	0	2	0	2	6	0.7%
Johns Hopkins	6	4	41	3	25	79	8.8%
Johns Hopkins Bayview	4	5	37	4	26	76	8.5%
Levindale	0	1	3	0	0	4	0.4%
Sinai	3	0	19	1	3	26	2.9%
MedStar Good Samaritan	0	4	19	2	1	26	2.9%
Meritus	0	0	0	0	1	1	0.1%
UMROI	8	26	81	4	34	153	17.1%
UM Shore at Easton	0	2	1	0	1	4	0.4%
Total	**36**	**70**	**646**	**25**	**119**	**896**	**100.0%**

Source: Maryland HSCRC Abstract Inpatient Database, FY21 data (excluding 73 discharges from Mt. Washington Pediatric Hospital).
*__Notes__: Selected zip code areas in Anne Arundel County.

The applicant claims that Adventist HealthCare Rehabilitation at White Oak Medical Center is too geographically far away to be affected. To the extent there is some marginal impact on other providers, the applicant states that the greatest impact will be on the UM Rehabilitation and Orthopedic Institute (UMROI), located in Baltimore, Maryland. In FY 2021, UMROI served 119 residents from the Southern Maryland HPR. The applicant expects a portion of these patients will seek care at the Bowie hospital when it opens, although the applicant does not expect there will be an impact on UMROI's volume of spinal cord or traumatic brain injury patients because UMROI is a specialty hospital for these types of patients. (DI #2, p.53).

(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;

The applicant states that the project will not result in any reduction in the availability or accessibility of services. Instead, it states that the ten-bed addition will improve access to inpatient

rehabilitation services including access for patient who are indigent, uninsured or under insured. (D#1, p.54).

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

Encompass Hospital states it does not anticipate any reduction in the quality of care at other providers because of the ten-bed addition. (DI #2, p.54).

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

The applicant does not expect any reduction in existing providers' ability to maintain staffing due to the applicant's ability to recruit both regionally and nationally. The applicant states it works with an array of clinical programs to build a pipeline of potential staff. (DI #2, p.55). In addition, the proposed ten-bed addition will require a minimal number of FTEs (21.3). The applicant also refers to the previous 60-bed hospital project decision that determined that the 60-bed project may have an impact on surrounding post-acute care providers because it would create a more competitive staffing market. It states that Commission found that increased competition for staffing is not adverse impact but impact that follows from the improved access. Thus, even if the addition of ten beds results in competition for staffing, this effect would not be an unwarranted adverse impact.

Staff Analysis and Findings

Staff concludes that the impact of this increment of ten additional beds at the Bowie hospital campus is not likely to be significant. The new hospital will reduce future use of the other hospitals in Maryland that provide acute rehabilitation services and provide a new competitor for staffing needed by these hospitals, but this impact will not be existential and increasing the size of the hospital by ten beds, the project under review here, will not substantially change this impact.

Staff concludes that the standard is met.

(4) Construction Costs.

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

Applicant's Response

The applicant provided a letter of verification for construction cost from Fred. C. Frederick, of Frederick and 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 $1,381 per square foot for the ten-bed addition. There will also be architectural and engineering costs of $779,534 including civil engineering. By comparison, the

approved 60-bed facility had estimated construction costs of $527 per square foot. The applicant states that the ten-bed addition has higher cost per square foot because of significant and unprecedented inflation, increased labor costs, and the project's small scale. The applicant states that as a rule, costs per square foot are typically lower for larger projects. Smaller projects still require mobilization, set-up, and demolition costs along with general construction costs. Encompass Health's Salisbury project, an addition of beds, involved new construction of 1,437 square feet, with construction costs for new construction (building plus site/infrastructure line items) of $1,125,445, or $783 per square foot in new construction cost, for a project approved in 2019.

The letter also states that the project will be designed with construction documents prepared to adhere to the current State Health Plan chapter, and the applicable codes of the City of Bowie, International Building Codes and FGI Guidelines for Design and Construction of Healthcare Facilities. (DI #2, Exh. 9).

(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.

Subpart (b) is not applicable because special rehabilitation hospitals are not rate regulated by the HSCRC.

Staff Analysis and Findings

Staff concludes that the smaller scale construction project contributes in part to the higher cost. In addition, aside from the increased inflation, the construction costs are in line with the previous Encompass-Salisbury project. The credibility of the cost estimate has been established. The applicant has met this standard.

(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 Commission determined the applicant satisfied this standard in its 2018 application for the 60-bed facility. It states the hospital (including the ten-bed addition) is designed to meet rehabilitation patients' needs which require extensive physical therapy space and the use of large equipment. It also states that the design will include features intended to improve safety such as barrier free space, appropriate floor material and finishes to prevent falls, critically placed handrails, strategically placed lighting to assist in patient movement, and a centrally located nurse station. Encompass-Southern Maryland also states the addition is being designed to meet all applicable requirements of the Internal Building Code and National Fire Protection Agency including having a full sprinkler system (DI #2, p.56). A copy of the project floor plan drawing is included in Appendix 2.

Staff Analysis and Findings

Staff concludes 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 and 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.

Applicant's Response

The applicant's outlined its main assumptions:

- Construction costs are consistent with industry standards;
- Budget contingencies are estimated at one percent of construction costs;
- Interest during construction is related to a cash loan provided by Encompass Health Cooperation at an interest rate of 5.16 percent;
- Project years represent projected operational years;
- Tables H and K include two percent annual inflation;
- Revenues/expenses rely on patient volume projections;
- Occupancy levels in Tables F and I reflect rates that increase over time;
- Charges are based on expected acuity levels per patient day averaging $2,286;
- Contractual allowances are the difference between gross charges and third part payments;
- Other deductions from revenue are for self-pay, charity care, indigent care, and non-payments; and
- Expenses are based on historical expenses incurred at other Encompass hospitals (DI #2, Exh.1).

(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.

The applicant noted in its list of assumptions under the Patient Utilization heading that its projections are based on what is typically experienced in Encompass Health facilities. (DI #2, Exh.1). For example, Encompass Health opened a new inpatient rehabilitation hospital facility in 2014. Encompass Health Rehabilitation Hospital of Middletown, Delaware (Encompass-Middletown). The following table shows the average annual bed occupancy of Encompass-Middletown over a five-year period, beginning with the first full year after the facility opened and continuing through 2019.

Table: III-11
Encompass Middletown Average Annual Occupancy Percentage
Year 1 to Year-to-Date

Years 1 – 5 After Opening (Pre-COVID)					COVID Impact		
2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**YTD 2022**
83%	95%	90%	95%	97%	94%	97%	98%

Source: Encompass Health internal data. Hospital is a 40-bed hospital.
Note: data are for calendar years. YTD2022 is January 1 through May 31, 2022.

As a comparable facility in a contiguous state, the applicant states that Encompass Middletown's first five-year occupancy data supports the applicant's projections that it will reach 94 percent occupancy by the fifth year of operation consistent with its experience in what the applicant states is a similar market. The applicant plans to implement education and outreach initiatives in Bowie that were used by Encompass-Middletown. (DI #9, p.26).

(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;

In its statement of assumptions under the heading Patient Utilization it states that Encompass-Southern Maryland based its estimates of revenue on utilization projections based on what is typically experienced in Encompass Health facilities. (DI #2, Exh.1).

(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

Staffing expense figures are consistent with utilization projections based on the experiences of Encompass Health. In its assumptions, the applicant states that nursing staffing levels are based on experience and standard hours of care and then applied to anticipated patient volumes/acuity.

The applicant states that support staff staffing levels are based on fixed cost duties without regard to the census. Salaries and benefits (benefits calculated at 25.6%) are based on the labor market and Encompass Health's experience as an IRF provider throughout the country. (DI #2, Exh.1).

The applicant's projected staffing expenses also correlate with projected patient volume, patient acuity, and facility design, as summarized below. Encompass Hospital's projected staffing expenses are comparable to other Encompass facilities.

Table: III-12
Proposed Project's Staffing Expense Projections are Comparable to Other Providers

Factor	Encompass Bowie[1]	Encompass Salisbury[2]	Encompass Northern Virginia[2]	Encompass Mid-Atlantic Region[2]
Total FTEs	197.9	190.1	166.8	2,929.4
Average Daily Census	65.8	59.6	53.5	913.9
FTE/Occupied Bed	3.0	3.2	3.1	3.2
Salary Expense	$15,740,320	$11,651,731	$12,840,599	$188,577,311
Salary Expense per FTE	$79,537	$61,293	$76,982	$64,375

[1] Source: Table L – Workforce Information, CON Year 5.
[2] Source: Encompass Health, 2019 data.

(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 profitability in its first year of operation. This will include debt services expenses, plant, and equipment depreciation. (DI #2, p.57).

Table: III-13 Encompass Health Rehabilitation Hospital of Southern Maryland Revenue, Expenses, and Income Projections, first 5 Years of Operation

	Year 1	Year 2	Year 3	Year 4	Year 5
Discharges	1,564	1,726	1,922	1,969	2,001
Patient Days	18,759	20,709	23,079	23,634	24,017
ALOS	12	12	12	12	12
Beds	70	70	70	70	70
Average Annual Bed Occupancy Rate	73.4%	81.1%	81.1%	92.5%	94%
Net Operating Revenue	$31,386,590	$35,286,333	$39,942,757	$41,650,780	$43,181,179
Total Operating Expenses	$28,609,500	$30,695,067	$33,225,603	$34,227,606	$35,097,397
Net Income	**$2,700,664**	**$4,464,914**	**$6,532,298**	**$ 7,218,888**	**$ 7,861,316**

DI #1, Exh.1 Tables F and H

Staff Analysis and Findings

To demonstrate financial feasibility, an applicant is required to submit financial projections (based on historic trends) demonstrating that it is consistent with utilization projections, revenue projections, and staffing/expense projections. An applicant also must show that it will generate net income if the applicant's forecasts are achieved within five years. The applicant has credibly demonstrated both.

Staff concludes that 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.

Applicant's Response

This project proposes addition of ten beds to an approved 60-bed rehabilitation hospital.

(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.

The previously approved 60-bed hospital was projected to achieve an occupancy rate of 94 percent by its fifth year of operation. (DI #2, Exh. 1, Table F). The minimum occupancy standard for a hospital with an average daily census of 50-99 cases is 75 percent occupancy which will be achieved by the second year. (DI #2, p.58). By year three the applicant is projecting an average daily census (ADC) of 63.2 for the entire 70-bed facility as seen in Table III-14 below.

Table: III-14
Utilization Projections, Encompass Bowie

	Year 1	Year 2	Year 3
Beds	**70**	**70**	**70**
Discharges	1,564	1,726	1,922
Patient Days	18,759	20,709	23,079
ALOS	12.0	12.0	12.0
ADC	**51.4**	**56.7**	**63.2**
Occupancy %	73.4%	81.1%	90.3%
Beds	**10**	**10**	**10**
Discharges	199	208	261
Patient Days	2,379	2,491	3,145
ALOS	12.0	12.0	12.1
ADC	**6.5**	**6.8**	**8.6**
Occupancy %	65.2%	68.2%	86.2%

Sources: CON Exhibit 1, Tables F, and I.

Staff Analysis and Findings

The applicant hospital project exceeds the minimum size standard and projects being able to meet occupancy rate expectations. Staff concludes that the applicant complies with this standard.

(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.

Applicant's Response

The applicant expects its admission sources to mirror Encompass Health's sources nationally, with most referrals originating from general acute care hospitals. The applicant provided a copy of its transfer agreement with the University of Maryland Capital Region Medical Center for the transfer of cases that exceed the acute rehabilitation hospital's own capabilities. (DI #2, Exh. 10).

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 #2, pp.58-59). The applicant states that it has not yet executed transfer and

referral agreements with these providers, because the facility is not expected to open until June 2023 but does not anticipate any difficulties obtaining the necessary transfer and referral agreements, particularly given its joint-venture arrangement with UMMS. (DI #9, p.23).

Staff Analysis and Findings

Staff concludes that this standard requires an applicant to document written transfer and referral agreements prior to licensure and notes that the original CON establishing the Bowie hospital has the following condition:

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

The applicant has complied with this standard.

(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 is discussed under the Need standard, *supra, pp. 22-24.*

Staff Analysis and Findings

There is an applicable need analysis in the SHP and adding ten beds is consistent with this analysis.

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 the primary goals/objectives of the ten-bed addition are to improve access to post-acute inpatient rehabilitation care in the Southern Maryland HPR and to provide a home for the ten temporarily delicensed beds that were originally to be located at UM Prince George's Hospital Center. (DI #9, pp.23-24). The applicant states that its addition to the originally approved 60 bed hospital is the most cost-effective option for the relocation of the ten temporarily delicensed beds.

First Alternative -UM-CRH Invests in Capital Expenditure

If UM-CRH were to consider a capital expenditure, the minimum size requirement review standard in the State Health Plan requires that a special rehabilitation hospital have a minimum of 30 beds. COMAR § 10.24.09.04B(7). The applicant states that the Commission's most recent bed need projections do not demonstrate need for a new 30 bed hospital in the HPR, nor would it be more cost effective than relocating the beds to an existing facility. (DI #2, p.62).

Second Alternative-Nursing Homes and Home Health

The second alternative considered by the applicant was the use of other post-acute care facilities/services such as nursing homes and home health agencies. The applicant states that due to the lack of available IRF beds in the service area, patients may have no choice but to receive services in a less intensive setting such as a nursing home or at home with home health, however, these settings do not provide the same level of specialized care.

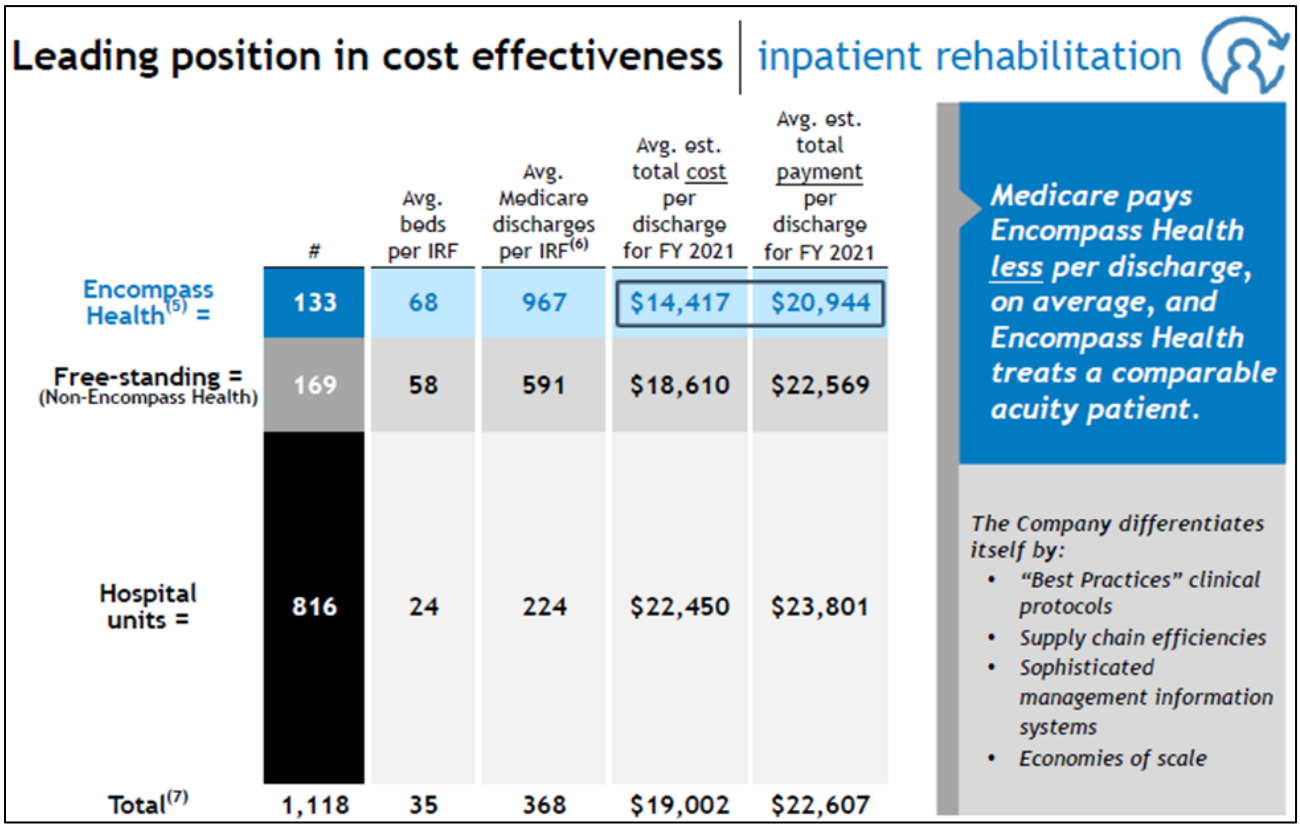
The applicant also included a 2014 study entitled *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities After Discharge* which found that when patients are matched on similar characteristics, rehabilitation in IRFs leads to lower mortality, fewer readmissions, and fewer ER visits than in a nursing home. (DI #2, Exh.11). Lastly, the minimum three hours of therapy per day, five days a week that must be provided by an IRF is set by federal regulation as a condition for payment by Medicare. However, the applicant states there is no regulatory minimum requirement for therapy hours provided to patients in nursing homes or home health. (DI #2, p.65).

The applicant states that patients who receive post-acute care in the home health settings may have many of the same barriers found in nursing homes such as less therapy times per day and less physician involvement. In addition, IRFs have specialized equipment for intensive IRF care such as overhead track systems, platform therapy, and virtual reality augmented biofeedback technology that are not available in a patient's home setting. (DI #2, p.65). Lastly, the applicant states that because patients receive more intensive therapy services in an IRF they have a higher likelihood of functional improvement when receiving treatment and can recover in less time achieving long-term cost savings when compared to home health. (DI #2, p.65).

Third Alternative-Use of Other IRFs

The applicant continues by discussing the American Heart Association/American Stroke Association's 2016 Guidelines which recognize that although inpatient rehabilitation services may result in higher costs compared to other types of providers, who may achieve cost savings in the long term, that the reduced medical morbidly outweighs any cost savings. (DI #2, p.64). Inpatient rehabilitation facilities have also been shown to result in superior functional status improvements for stroke patients and those with acute trauma. The applicant states that this demonstrates the benefit that additional IRF beds will provide in the Southern Maryland region. Moreover, the research indicates that additional inpatient rehabilitation bed capacity will reduce costs of post-acute care overall by providing patients with the specialized services they need to recover as quickly as possible. This leads to the last alternative considered which was looking at a comparison between the applicant and other IRF providers as shown in the chart below.

Figure 4: Encompass Provides Cost-Effective Care



DI #2,p.29

The conversion to Section GG on October 1, 2019, the COVID-19 pandemic's impact on patient and payor mix, the suspensionof sequestration(8), and the use of CARES Act relief funds by other providers may distort these measures in the future. The average estimated total payment per discharge, as stated, does not reflect a 2% reduction for sequestration(8) .

(5) The 133 for Encompass Health excludes Encompass Health Rehabilitation Hospital of Murrieta (opened February 2020), University of Iowa Health Network Rehabilitation Hospital, a venture with Encompass Health (opened June 2020), Encompass Health Rehabilitation Hospital of Sioux Falls (opened June 2020) and Encompass Health Rehabilitation Hospital of Toledo (Opened November 2020).

(6) In 2019, the Company averaged 1,436 total Medicare and Non-Medicare discharges per IRF in its then 129 consolidated IRFs that were open the full year.

(7) Source: FY 2021 CMS Final Rule Rate Setting File and the last publicly available Medicare cost reports (FYE 2018/2019/2020) or in the case of new IRFs, the June 2020 CMS Provider of Service File.

(8) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation. The CARES Act temporarily suspended the automatic 2% sequestration reduction for the period from May 1 through December 31, 2020. The 2021 Budget Act extends the sequestration suspension through March 31, 2021.
Source: Investor Reference Book, Post Q2 2020 Earnings Release Updated March 9, 2021, Encompass Health

Staff Analysis and Findings

Staff concludes that the project is, obviously, the most cost-effective approach to adding ten rehabilitation beds in the jurisdiction, given that it will be implemented by adding a modular unit lengthening a corridor of the hospital under development.

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 ten-bed addition is $13,109,242 which the applicant will fund with a cash loan from its parent company Encompass Health as shown in Table III-15 below.

Table: III-15 Project Budget Estimate

Uses of Funds	
New Construction	
Building	$8,148,616
Site and infrastructure	526,247
Architect/engineering fees	779,534
Permits (building, utilities, etc.)	117,715
Fixed Equipment	350,000
Subtotal	**$9,922,112**
Other Capital Costs	
Movable equipment	$600,000
Contingency allowance	100,000
Gross interest during construction period	219,130
Technology equipment	300,000
Subtotal	**$1,219,130**
Total Current Capital Costs	**$11,141,242**
Bed purchase	$1,620,000
Inflation Allowance *	
Total Capital Costs	**$12,761,242**
Financing Cost and Other Cash Requirements	
Legal fees	$100,000
Other consulting	$100,000
Pre-opening costs**	$100,000
ACE-IT installation	$48,000
Subtotal	**$348,000**
TOTAL USES OF FUNDS	**$13,109,242**
Sources of Funds: Cash Loan from Encompass Health	

Source: DI #2, Table E

* an inflation factor for the construction costs of the project within individual line items, was referenced in the architect's letter at CON Application, (DI #) Exhibit 9. "Due to the fact that this estimate was derived from this year's averages and construction will commence in 2024, an adjustment for inflation has been added to arrive at $1,381 per square foot." Exhibit 9. The estimated construction cost, $8,148,616, includes 15 months of added escalation at 1.5%/month.

** a budget provision of $100,000 for anticipated pre-opening costs comprised primarily of marketing and community outreach expenses

The applicant provided audited financial statements that show that Encompass Health Corporation and subsidiaries have access to the cash necessary to fund this project. (DI #2, Exh.12).

Availability of Resources to Sustain the Proposed Project

The applicant's utilization and financial forecast is discussed in the Financial Feasibility Standard, *supra pp.28-31*. The applicant projects that it will reach an occupancy rate of 94 percent by the fifth year of operation. The applicant also projects that it will generate positive net income by the first year of operation, growing as patient volume increases 28 percent from 18,759 to 24,017 patient days in the first five years from the CON approval. Salaries and other expenses such as supplies are also projected to increase in cost along with patient volume. (DI #2, Table J and Assumptions).

In addition, the proposed ten bed addition is projected to require an additional 21.3 additional full-time equivalent employees including 12.2 in nursing, five in therapy, 0.7 in care management, 1.2 in maintenance, and 2.2 in other support (liaison and admissions liaison). (DI #2, Table L and DI #9, p.27). The applicant states that it will rely on its established recruitment and retention strategies including competitive pay and benefits to sustain its staffing. (DI #2, p.68).

The applicant also referred to its 20 letters of support from state and local government, educators, and executives and clinicians (some of which are associated with the UMMS) demonstrating support for the project. (DI #2, Exh.8).

Staff Analysis and Findings

The applicant's audited financial statements demonstrate that Encompass Health has available financial resources to implement the project. As for sustaining the project, the approved 60-bed hospital and proposed ten bed addition are community supported projects and the applicant also projects positive net income by the first year of operation and projects that its margin will increase over time.

Staff concludes that the project is viable.

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.

Applicant's Response

The Commission granted Encompass Hospital a CON on May 21, 2020, to establish a 60-bed rehabilitation hospital in Bowie, Maryland. MHCC approved the project with three conditions including: (1) In its request for first use approval, provide information that detail activities it has undertaken for outreach to the community regarding charity care services; (2) compliance with charity care provisions including discounted charges using a sliding scale; and (3) provide written transfer and referral agreements. Changes to the CON were approved on March 18, 2021, and May 19, 2022. The three conditions to the CON have remained unchanged for both. Although it is still under construction, Encompass Hospital is currently in compliance with the terms and conditions of its CON.

The Commission granted the affiliated Rehabilitation Hospital Corporation of America, LLC, d/b/a Encompass Health Rehabilitation Hospital of Salisbury (Encompass-Salisbury Hospital) a CON on December 19, 2019, to add 14 private patient rooms and convert four semi-private rooms to private rooms. The conditions of that CON required Encompass-Salisbury to provide information, in its request for first use approval, on its efforts to increase the amount of charity care to patients and which demonstrates its progress towards increasing its charity care

threshold towards the amount it committed, which was two percent to total operating expenses. Encompass Salisbury state in its quarterly report:

> *We developed an enhanced charity care program to re-train all hospital liaisons and further educate referral sources, local health departments, senior living communities, and community members on our commitment to serve charity care patients. As required by the condition placed on this CON, we provided a detailed report of these efforts in the First Use Approval Request filed with the Commission on September 3, 2021.*
>
> *We have continued our efforts in reaching out to local health departments. Our CEO, Steve Walas, spoke at the Wicomico County Local Health Improvement Coalition Meeting on April 2, 2021 in regards to our hospital's charity care program and will be speaking to this group again at the Coalition's October 2021 meeting to continue to raise awareness of the hospital's resources available for charity care patients. Additionally, our liaisons are continuing to present charity care cases for admission as they become available. As we onboard new liaisons, we continue to prioritize training on patient qualifications for charitable services to further emphasize our commitment to serving charity care patients. When COVID-19 visitor restriction policies are lifted, we will be scheduling in-person meetings with referral sources and others in the community to educate and promote further awareness of our charity care program.*
>
> *The charity care percentage for 2021 (through June 30, 2021) is approximately 0.87%.*

At the time of review, MHCC determined that, while Encompass- Salisbury had not met the level of charity care it had committed to however, it did detail activities that it had undertaken in its efforts and challenges they faced during the COVID-19 pandemic. Encompass provided updated numbers showing that through June 30, 2022, Encompass-Salisbury provided more charity care in dollars than it did in 2021, equivalent to 0.77 percent of its operating expenses. (DI# pp 3-4).

The applicant states that Encompass-Salisbury Hospital complied with the terms of the condition, as evidenced by the Commission granting First Use approval on December 17, 2021.

Staff Analysis and Findings

Staff concludes that the applicant has not been able to document achievement of the charity care level to which it committed itself at its Encompass Salisbury hospital in 2019. It has provided information on why this level of charity care provision has been difficult to achieve in the recent years in which COVID-19 has disrupted hospital operations. It has also reiterated its plans for increasing the level of charity care it provides.

At this time, given that it took on this Salisbury commitment only three years ago and has provided an explanation of factors underlying its failure to meet the 2019 commitment and restated a plan for increasing its charity care level, staff does not believe that a finding of non-compliance with this standard is warranted.

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.

Encompass-Southern Maryland's response to this criterion is discussed under the Impact standard, *supra, pp. 24-26.*

Staff Analysis and Findings

Staff concludes that the impact of this ten-bed project will not be substantively different from the acceptable impact found for the establishment of the 60-bed hospital.

IV. SUMMARY OF STAFF RECOMMENDATION

Based on the 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 Chapter of the State Health Plan, staff concludes 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 applicant's ability to provide inpatient rehabilitation services demanded in its service area.

Therefore, staff recommends the Commission **APPROVE** the application of Encompass Health Rehabilitation Hospital of Southern Maryland, LLC for a Certificate of Need to add an additional ten beds to its 60-bed acute inpatient rehabilitation hospital in Bowie (Prince George's County) with the following conditions:

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 can manage 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. 18-16-2458	*	

*** ***

FINAL ORDER

Based on staff analysis, it is this 20th day of October 2022, **ORDERED**:

That the application of Encompass Health Rehabilitation Hospital of Southern Maryland, LLC for a Certificate of Need to add an additional ten beds to its 60-bed special rehabilitation hospital in Bowie (Prince George's County), Maryland, at an estimated total cost of $13,109,242 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 can manage 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

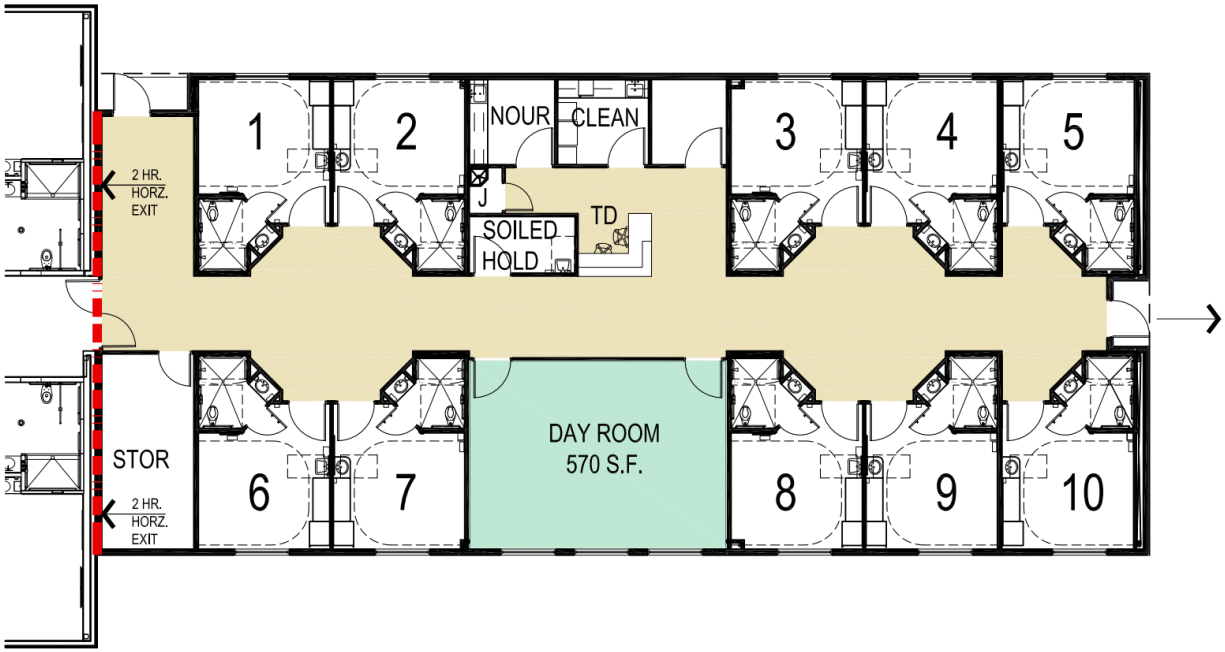
MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: RECORD OF THE REVIEW

Docket Item #	Description	Date
1	Applicant submitted letter of intent	4/5/22
2	Applicant submitted CON application	6/3/22
3	Receipt of application	6/15/22
4	Request to publish notice Washington Times	6/15/22
5	Request to publish notice Maryland Register	6/15/22
6	Request for completeness information	6/16/22
7	Receipt received Washington Times	6/17/22
8	Applicant requests for extension to respond to completeness through July 15, 2022, and staff approved	6/22/22
9	Applicant submitted completeness response	7/15/22
10	MHCC informed applicant of the formal start of the review on August 12, 2022	7/27/22
11	Washington Times Request to publish notice of the formal start of the review	7/27/22
12	Maryland Register Request to publish notice of the formal start of the review	7/27/22
13	Formal start of review Washington Post	7/27/22

APPENDIX 2: FLOOR PLANS

10-Bed Addition Floor Plan



BUILDING DATA

60 BED INITIAL

59,575 sq. ft.

- 56 PRIVATE PATIENT ROOMS
- 4 BARIATRIC PATIENT ROOMS
- ACTIVITY AREA DESIGNED FOR 60 BEDS
- THERAPY GYM IS 3529 SF = 58 SF / 60 PATIENTS
- 143 TOTAL PARKING SPACES PROVIDED

70 BED CAPACITY

65,474 sq. ft.

- 66 PRIVATE PATIENT ROOMS
- 4 BARIATRIC PATIENT ROOMS
- ACTIVITY AREA DESIGNED FOR 70 BEDS
- THERAPY GYM IS 3529 SF = 50 SF / 70 PATIENTS
- 143 TOTAL PARKING SPACES PROVIDED

FLOOR PLAN

SCALE: 1 / 16" = 1'-0"

FREDERICK & ASSOC. - ARCHITECTS
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SARASOTA, FLORIDA 34236
PHONE: 941.366.3231
FAX: 941.366.3245

Encompass Health
BOWIE, MD

ENCOMPASSH HEALTH
REHABILITATION FACILITY of
SOUTHERN MARYLAND

APRIL 25, 2022
TEST FIT

A1

APPENDIX 3: BED LICENSURE CHANGES

Timeline Bed Licensure Changes

UM Laurel Region Hospital held a special hospital license for 28 acute inpatient rehabilitation beds. All the bed licensure changes detailed below originated from these 28 beds.

March 9, 2018
MHCC approves University of Maryland Laurel Regional Hospital's (UM LRH) CON application to convert to a freestanding medical facility. As a part of the same determination, the parties disclose that ten beds from UM LRH would be transferred to University of Maryland Prince George's Hospital Center (UM PGHC) for use in the replacement hospital, UM CRH, as part of that determination.

April 13, 2018
MHCC publishes bed need projections showing a need for a minimum of -17 and a maximum of 67 beds in the Southern Maryland health planning region.

October 2018
MHCC temporarily delicenses 18 beds from UM PGHC because although it had 28 licensed beds, it could not accommodate more than ten beds, leaving 18 beds unused.

May 21, 2020
MHCC approves the CON filed by Encompass to establish a 60-bed inpatient rehabilitation hospital comprising of 42 new acute inpatient rehabilitation beds that would be added to the region's inventory and 18 beds that Encompass purchased from UM LRH following the Commission's May 21, 2020, decision.

March 8, 2021
University of Maryland Capital Regional Health (UM CRH) cannot accommodate ten of the rehabilitation beds and notifies MHCC that it wants to temporarily delicense the beds while options are explored to relocate the ten beds somewhere in Prince George's County.

April 1, 2021
MHCC approves the temporary de-licensure of UM PGHC ten special hospital acute rehab beds effective April 15, 2021.

April 5, 2022
Encompass files a CON application to add ten rehabilitation beds to its already approved 60 bed rehabilitation hospital in Bowie, Maryland and announces the rehabilitation hospital will now be jointly owned with UMMS.