BEFORE THE MARYLAND HEALTH CARE COMMISSION

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

MEDSTAR NATIONAL REHABILITATION HOSPITAL'S RECORD CORRECTIONS IN SUPPORT OF INTERESTED PARTY COMMENTS

I. INTRODUCTION

In its response to the interested party comments filed by MedStar National Rehabilitation Hospital ("MNRH"), Encompass Health Rehabilitation Hospital of Southern Maryland ("ERH") did not refute any of the evidence MNRH presented which showed that under the Commission's well-established rules and guidelines ERH's CON Application should be denied.

Instead, ERH misrepresented, or falsely stated what MNRH had argued, and shaped these misleading statements into a series of "straw man" arguments which ERH then attempted to rebut. Nothing ERH has said, however, refutes the fully substantiated arguments set forth in MNRH's Comments. However, because of the glaring misstatements ERH has presented to the Commission -- perhaps best illustrated by ERH's ridiculous claim that MNRH argued that the entire Southern Region needs no more than ten beds -- MNRH submits the following to correct the record and to ensure that the Commission has an accurate understanding of MNRH's position as an interested party in this proceeding.

II. ERH HAS FAILED TO DEMONSTRATE THE RELIABILITY OF ITS QUALITY MEASURE REPORTING AND THUS CANNOT MEET COMAR'S QUALITY OF CARE STANDARD

A. ERH Misconstrues MNRH's Comments About ERH's Quality Measure Reporting

MNRH's comments observed that ERH can only meet COMAR's quality of care standards, as set forth in COMAR 10.24.09.04A(2)(b) and (c), by demonstrating through its quality measure reporting that it provides high quality health care as compared to other Maryland providers that provide similar services. MNRH Comments at 2. MNRH then demonstrated that the data upon which ERH relies to meet this requirement is of questionable reliability. MNRH Comments at 3.

ERH does not dispute that it can only meet COMAR's quality of care standards by relying on its quality care reporting. Yet ERH fails to directly address MNRH's argument, but rather evades it. Thus, under the heading "EHR's Quality Data is Reliable," ERH claims that MNRH "ignores the evidence provided by EHR showing that [EHR] provides quality care." ERH Response at 11. This claim is specious because MNRH did not "ignore" the evidence of care quality; it challenged the data's reliability.

Likewise, ERH argues that its data shows "unparalleled quality of care," but this argument completely misses the point. ERH Response at 12. MNRH's argument is that what the data purportedly shows about ERH performance cannot be accepted as accurate because the reliability of the data is inherently suspect. MNRH Comments at 2-5. [1]

[1] Indeed, ERH's claims about "unparalleled quality" of care is as suspect as ERH's data. For example, CARF's website indicates that only three of Encompass Health's 130 IRFs have been CARF accredited. That means ERH is operating 127 facilities that are not accredited by CARF.

To be clear, MNRH supported its position by citing the 2016 and 2018 MedPAC reports which found that among high-margin IRFs like ERH, FIM scoring at rehabilitation admission was inconsistent with how patients were coded in acute care. Those patients coded as less severe in acute care were coded as more severe in rehab care. MNRH Comments at 4. In its just-released report (March 2019), MedPAC reaffirms its earlier findings on this issue:

> As noted in our March 2016 report to the Congress, the consistent finding that high-margin IRFs have patients who are, on average, less severely ill in the acute care hospital but appear more functionally disabled upon assessment in the IRF suggests that assessment and scoring practices contribute to greater profitability in some IRFs, especially given the comparatively low level of costs and cost growth observed in high-margin facilities. If providers differ in their assessment and scoring of patients' motor and cognitive function, payments will not be properly aligned with the resource needs of patients. Some IRFs will receive payments that are too high relative to the costs incurred in treating their patients, while other IRFs will receive payments that are too low.[2]

An IRF's patient scoring methods affect five key variables—case-mix, payment/revenues, costs, margins, and outcomes. If the fundamental methods of patient scoring are in doubt, then claims of superior outcome and cost performance relative to other IRF providers are also suspect. ERH has no answer for this and, indeed, makes no effort to explain the MedPAC conclusions about high-margin provider data issues.

The best ERH can do is to argue that "[t]here is no evidence to support [MNRH's] assertion" apparently forgetting that it is ERH's burden to prove why its data is probative. ERH Response at 12. Moreover, ERH's perfunctory "no evidence" defense is wrong, because MNRH supported its assertions about the infirmities of ERH's data with analyses and data provided by MedPAC in its March 2016 and March 2018 reports. MNRH Comments at 4-5.

[2] MedPAC, "Inpatient Rehabilitation Facility Services." (Chapter 10). *Report to Congress: Medicare Payment Policy.* Washington, D.C. March 2019. p. 260.

B. ERH'S Low Cost Claims Do Not Take Into Account Its Mix of High and Low Cost Patients

In responding to MNRH's criticism of ERH's "low cost provider" claims, ERH misconstrues MNRH's point. MNRH did not argue that ERH "cherry picks" its patients, as ERH complains. (ERH Resp. at 12. Instead, MNRH disputes ERH's low cost status on the basis of the ample evidence that high-margin facilities (such as ERH) have a mix of patients different from other facilities, that leads to lower costs and greater profitability.

In its March 2016, 2018, and 2019 reports, MedPAC notes that high-margin IRFs serve proportionately fewer stroke patients and proportionately more "other neurological" patients and suggests that "patient selection contributes to provider profitability," *i.e.*, higher margins. In its March 2018 report, MedPAC observes:

> A previous Commission analysis of differences in the mix of cases across IRFs suggested that patient selection contributes to provider profitability (Medicare Payment Advisory Commission 2016). We found that IRFs with the highest margins in 2013 had a higher share of other neurological cases and a lower share of stroke cases. Further, we observed differences in the types of stroke and other neurological conditions admitted to high-margin and low-margin IRFs. Stroke cases in the highest margin IRFs were two-and-a-half times more likely than those in the lowest margin IRFs to have no paralysis. Likewise, other neurological cases in the highest margin IRFs were almost three times more likely than those in the lowest margin IRFs to have a neuromuscular disorder (such as amyotrophic lateral sclerosis or muscular dystrophy) as opposed to conditions like multiple sclerosis or Parkinson's disease.
>
> **As noted in our March 2016 report to the Congress, these findings suggest that, under the IRF PPS, some case types are more profitable [higher margins] than others.** The Commission plans to assess variation in costs within the IRF CMGs and differences in relative profitability across CMGs in future analyses.[3]

[3] MedPAC, "Inpatient Rehabilitation Facility Services." (Chapter 10). *Report to Congress: Medicare Payment Policy.* Washington, D.C. March 2018. p. 274 (emphasis supplied).

ERH's mix of stroke and other neurologic patients is nearly identical to the case-mix of all for-profit freestanding IRFs reported in MedPAC's March 2019 report. The table below compares ERH's self-reported case-mix for its facilities with MedPAC-reported case-mix for for-profit and non-profit free-standing rehabilitation hospitals nationally.

Rehabilitation Impairment Category (RIC)	Percent of Discharges in 2017		
	All For-profit Freestanding IRFs	Encompass Health	All Non-profit Freestanding IRFs
Other neurologic conditions	21%	21.6%	8%
Stroke	16%	18.0%	26%

Source: The percentages for Encompass Health 2017 come from p. 78 of its CON application. The percentages for all non-profit free-standing facilities come from MedPAC's March 2019 report, p. 259.

Also, throughout its CON application, ERH builds much of its case on how it serves stroke patients (stroke is mentioned 96 times). Yet, on a national level, it serves proportionately fewer stroke patients than do its non-profit free-standing counterparts—perhaps because they are less profitable.

C. ERH Misconstrues MNRH's Cost Comments

In its Comments, MNRH notes (on p. 4) that:

> ERH's rehabilitation facilities are located predominantly in the South where land costs are typically less than the national average [hence, its previous name, HealthSouth.] ERH's cost profile may also be lower because it prefers to locate its facilities in suburban or exurban areas where land is cheaper and away from core urban areas where land is costlier. Thus, ERH's national location strategy requires less capital outlay and makes its national cost comparisons less valid.

ERH's response is that it "should be applauded" for locating in more distant and cheaper locations. Once again, this response misconstrues MNRH's point that ERH's national cost comparisons may not be a valid basis for evaluating anticipated costs at its proposed new facility. Furthermore, by locating where it typically does, ERH is choosing to avoid serving patients in

more challenging and costly inner urban environments where patients are prone to have greater needs and present more challenging socio-economic issues based on e.g., poverty, lack of social support, housing less suited to their disabilities, etc. Locating in areas to avoid such problems is not a strategy that should be "applauded."

III. ERH'S RESPONSE MISCONSTRUES, RATHER THAN REFUTES, MNRH'S COMMENTS ABOUT BARRIERS TO ACCESS

MNRH's Comments showed that the ERH CON should be denied because ERH failed to present evidence demonstrating that barriers to access exist for the relevant population, along with a plan to address those barriers. *See* COMAR 10.24.09.04B(1); MNRH Comments at 5-12. ERH's Response not only falls short of meeting the burden of proof imposed by COMAR, it relies on a series of misleading or false claims about the substance of MNRH's Comments. For example, just alleging lack of IRF providers and citing current travel time does not satisfy the showing required by COMAR. Nor is ERH correct in claiming that MNRH has not "substantively criticized" ERH's application. ERH Response at 5. What MNRH has repeatedly shown is that ERH did not provide the required evidence. *See* MNRH Comments at 5.

A. <u>Inequitable Distribution and Limited Options</u>

MNRH's Comments showed that maldistribution is not an access barrier, and that patients have a variety of options, because there is a more than adequate number of beds available to Southern Maryland Region residents. MNRH Comments at 7-8. Rather than confront MNRH's showing with substantive rebuttal evidence, ERH falsely states that MNRH's position on the issue is "that no more than ten beds should exist in the . . . Southern Region." ERH Response at 2. MRNH, however, never made such an argument and, not surprisingly, ERH offers no citation in support of this claim.

Rather, what MNRH said was that there is more than adequate capacity to appropriately serve the needs of the residents of the proposed service area. Indeed, ERH's CON application shows the large number of beds, with available capacity, in Washington, D.C. and in Montgomery County. In these three adjacent jurisdictions, there are 268 acute rehabilitation beds[4] available within normal drive times for a specialized service. In view of these numbers, there is no 'inequitable distribution' or limit in options from the community's perspective, notwithstanding the SHP's political boundaries.[5]

B. <u>Travel Time</u>

ERH states that distance to acute inpatient rehabilitation care "may be" a significant determinant of whether a patient seeks that care, ERH Resp. at 6. ERH falsely claims that MNRH suggested that MNRH is "somehow more convenient" that the proposed Bowie location. That is not correct; rather, the Comments said only that the MNRH location is "no less convenient," and there is no convincing evidence, based on studies or other validated sources of information, of an access barrier. MNRH Comments at 7. Indeed, as MNRH pointed out, ERH's CON Application nowhere correlates travel time with actual evidence of hardship, and this lack of proof is carried forward in ERH's Response. *See Id.* at 8.

[4]137 at NRH (corrected), 16 at GW, 87 in Montgomery County, and all 28 controlled by Dimensions.

[5] In footnote 6 of its Response, ERH states that "Washington DC was expressly considered and rejected from the definition for the Southern Region." If the desired implication is that Washington, D.C. should not be considered for purposes of need, that implication is wrong, The meeting minutes ERH cites (ERH Response Exhibit 9) clearly show that the Commission staff believed Washington, D.C. <u>should be considered</u> for purposes of need because a significant percentage of the region's residents use Washington D.C. facilities. *See* ERH Exhibit 9 at 7. ERH also fails to explain why Adventist Hospital, which is accessible to and used by many patients in the Southern Region, is not relevant to the discussion of distribution.

C. Use Rates

ERH says that low use rates are evidence of a barrier to access, ERH Response at 6, but ERH does not identify with any precision what "barrier" the low use rates demonstrate. The Response falsely claims that MNRH suggests that Southern Maryland Region residents need less inpatient rehabilitation than other state residents. ERH then states that MNRH suggests that the Southern Maryland use rates are a result of overutilization outside of the Southern Maryland Region. *See* ERH Resp. at 9. That is a preposterous claim. The Comments merely point out that there is no evidence presented to support the claims in the application, and certainly does not causally relate Southern Maryland use rates to Eastern Shore use rates. Instead, the Comments show that it is the lower Eastern Shore use rates that are the true outlier.

D. Family Engagement

Regarding the Comments about family engagement, (MNRH Comments at 8-9), ERH offers the conclusory assertion that "it is axiomatic and self-evident" that travel time impacts "both the patient and the patient's family." ERH Response at 8. "Axioms" and "self-evident" claims are no substitute for the "studies or other validated sources of information" that COMAR requires an applicant to cite to support its access barriers claims. Indeed, such claims simply mean that ERH still has no proof to support its claims regarding family engagement.

IV. ERH'S RESPONSE FAILS TO DEMONSTRATE SATISFACTION OF THE APPLICABLE NEED STANDARD

MNRH's Comments at 12-20 showed that ERH had failed to satisfy the need standards required by the SHP because, among other things, ERH (a) failed to consider outmigration to areas other than Washington, D.C.; (b) focused on maximum, rather than minimum need; (c) failed to prove travel hardships in relation to barriers to access; (d) failed to provide proof of any access barriers required for demonstrating need when outmigration is present or for use of

showing projected need above the minimum; and (e) failed to prove the reasonableness of its volume projections.

Other than making an unsuccessful attempt to justify its volume projections, ERH's Response makes no effort to refute MNRH's showing that ERH's application failed to meet the required need criteria. Instead, ERH raises a series of frivolous arguments based on misleading or flat out wrong interpretations of the substantive arguments MNRH has raised.

A. ERH Volume Projections

MNRH's Comments showed that the CON application failed to show, as it must, that its volume projections are likely to be achieved. MNRH Comments at 15-20.[6] ERH's Response does nothing to cure this fatal flaw in the application. Instead, ERH misconstrues and reconstructs what MNRH has said into straw arguments that ERH presumably believes it can handle.

For example, ERH (at 13) argues that MNRH challenged ERH's claim that it will reduce outmigration on the ground that "patients from the Southern Region prefer to seek inpatient rehabilitation care in Washington, D.C." Not surprisingly, ERH provides no cite for this argument which, as a matter of fact, MNRH never made.

[6] The Response states that in spite of the concerns about the volume projections, the project would be financially feasible if the volumes turn out to be lower than projected, and that it could break even with only 993 discharges in Year 1 of the project. This is a surprising statement, given the questions raised about changing payment policies. Does this assume that most discharges would come from the new Prince George's Regional Medical Center (PGRMC)? Given UMMS' apparent financial connection to this project, including the alleged patient referral arrangement between the PGRMC and the proposed IRF, the applicant should provide much more clarity/detail about the full nature of the relationship between UMMS and Encompass.

Indeed, MNRH's Comments said nothing about patient preferences in addressing this issue. Instead, the Comments argued that ERH's "application presents little or no support" for [its] claim that outmigration will be reduced by 341 discharges annually. "This assumption is not backed up with evidence that these established travel patterns are really a true hardship or that they can actually change them at the numbers projected." MNRH Comments at 15. ERH's Response does not even try to refute this argument, which is the one MNRH actually made.[7]

B. ERH's Claims About Skilled Nursing Facilities

Similarly, ERH's Response fails to address MNRH's comments about skilled nursing facilities. ERH claims that MNRH took the "surprising" position that "there is no evidence that certain SNF patients would be better served in an IRF." ERH Comments at 14. This position is not just "surprising" as ERH claims. It is pure fantasy because this is not something MNRH ever said.

In commenting on ERH's claims of SNF volume shifts as high as 418 cases, MNRH did not comment on whether SNFs or IRFs provide better care. What MNRH did argue was that ERH had not "supported [its claims about SNFs] with evidence. No evidence has been presented that rehab care currently provided at area SNFs is inappropriate." MNRH Comments at 16. It is ERH's burden to back up its claims of volume shifts, and what MNRH's Comments showed was ERH had not met this burden.

ERH also claims (at 15) that MNRH has not challenged the underlying assertions of the Dobson & DaVanzo Associates study which the CON application cites to support its claims

[7] MNRH Comments at 14 also demonstrated that ERH had failed to show why the outmigration was due to specifically identified access barriers, as it is required to do under subpart (c) of the need standard. ERH's response continues to ignore this required showing, saying only that people prefer to be treated closer to home, without citing any supporting evidence for this presumption. ERH Response at 13.

about SNFs and IRFs. ERH, however, is wrong. In fact, MNRH noted that Dobson & DaVanzo is a Virginia consulting firm that solicits clientele to hire it to "influence public policy decisions" and to provide "litigation support." MNRH Comments at 16. In other words, Dobson & DaVanzo is not an independent, unbiased research group whose conclusions are those of a neutral observer. Rather, the firm is a "cheerleader," paid to advocate its clients' preferred positions.

C. ERH's Claims About Population Growth

MNRH showed in its Comments (at 17) that volume is not likely to increase with population growth based on, among other things, the empirical evidence which shows that rehab volume has not grown with population growth over the five-year period between 2012 and 2016.[8]

In its Response, ERH tries to dispute MNRH's assertions by arguing (ERH Response at 16-17) that in another proceeding, the MHCC "accepted" the Adventist Rehabilitation Hospital ("ARH") volume projections which were based, according to ERH, on the notion that projected growth is a function of population growth and an aging population. However, this is not entirely correct. ARH's application was not for a new facility, or even for an increase in capacity. The applicant merely proposed to relocate an existing service from the Takoma Park facility to a new facility currently under construction. Population growth was never at issue in ARH's application, and the applicant's assertions of growth were never evaluated by MHCC for relevance nor challenged by an interested party. The decision in ARH is thus irrelevant to

[8] The MHCC's need methodology uses a range of bed need, the minimum to account for more conservative assumptions, in this case including the effect of population growth. This is another reason for the MHCC to apply the minimum of the bed need range rather than the maximum, since population growth has not affected utilization, and thus likely will not in the near future.

whether ERH should succeed in asking the MHCC to ignore five years' worth of actual data showing the lack of correlation between growth in rehab volume and population growth.

V. CONCLUSION

ERH's Response made numerous claims about MNRH's Comments that we have shown to be inaccurate. In the interest of efficiency, we have not responded to all the many inaccurate or frivolous assertions ERH makes. We have instead focused just on those which we believe are most serious and relevant to the issues the Commission needs to consider in evaluating ERH's application.

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May 10, 2019

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on May 10, 2019, a copy of the foregoing was served by e-mail and first-class mail on:

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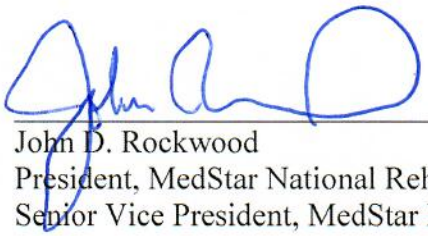
Affirmation

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



5/10/19

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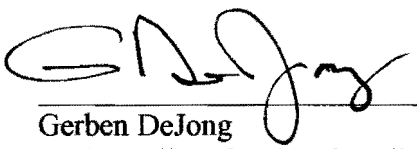
I hereby declare and affirm under the penalties of perjury that the facts stated in this document are true and correct to the best of my knowledge, information, and belief.



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

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10 MAY 2019
Date