IN THE MATTER OF Application of Encompass Health Rehabilitation Hospital for Inpatient Rehabilitation Hospital Docket No. 18-16-2423	* * * * * * * * *	BEFORE THE MARYLAND HEALTH CARE COMMISSION

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RESPONSE OF ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SOUTHERN MARYLAND TO MEDSTAR NATIONAL REHABILITATION HOSPITAL'S MAY 10, 2019 FILING

Encompass Health Rehabilitation Hospital of Southern Maryland ("EHR"), by its undersigned counsel and pursuant to the September 7, 2019 ruling of Commissioner/Reviewer Candice Peters, M.D., submits this response to the May 10, 2019 filing of MedStar National Rehabilitation Hospital ("MNRH") titled "Record Corrections in Support of Interested Party Comments." ("MNRH Record Corrections"). For the reasons set forth below, as well as in EHR's application and additional materials submitted into the record of this review, the Maryland Health Care Commission should grant a Certificate of Need ("CON") for the proposed project.

Introduction

EHR proposes to establish a 60-bed acute inpatient rehabilitation hospital in Bowie, Maryland, in the Southern Region, bringing access to rehabilitation services for a population of nearly 1.4 million Marylanders. MNRH, the only party to request interested party status in this review, filed interested party comments, and EHR responded to such comments, within the time period permitted by Commission regulation. EHR also filed a Motion to Strike MNRH's comments and opposed MNRH's request to be granted interested party status on the grounds that

MNRH does not meet the definition of an "interested party" under the State Health Plan chapter for acute rehabilitation services. *See* ERH April 2, 2019 Motion to Strike Comments and Opposition to MedStar National Rehabilitation Hospital's Request to be Granted Interested Party Status ("EHR Motion to Strike"). In an effort to submit additional arguments to the Commission after the opportunity to do so passed—and despite that it lacks standing as an interested party—MNRH then submitted an improper, unauthorized filing, styled as a "Record Correction."[1] MNRH's filing does not rely upon any new evidence unavailable to MNRH at the time of its initial filing, nor does MNRH use its filing to correct any objective, empirical data. Rather than presenting any genuine corrections to the record, MNRH simply offers reframed versions of its original arguments, couched behind inaccurate accusations that EHR misrepresented MNRH's positions.

Not only should MNRH's original comments be stricken because it is not a proper interested party, but the Commission should recognize MNRH's most recent improper filing for what it truly is: an improper attempt to have the last word. Nevertheless, MNRH has again failed to demonstrate that EHR's application, which will bring high-quality inpatient rehabilitation care to an underserved health planning region, should not be approved. EHR has satisfied all standards under the applicable State Health Plan chapter, and the Commission should therefore grant a CON for the proposed project.

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[1] Under the Commission's regulations governing the review of CON applications, an interested party may file written comments, but only the applicant has the opportunity to file a response. COMAR 10.24.01.08F(3). The regulations thus grant the applicant the last word in the comment phase.

I. EHR HAS SATISFIED THE QUALITY OF CARE STANDARD, COMAR § 10.24.09.04A(2), BY PRESENTING RELIABLE QUALITY MEASUREMENT DATA.

MNRH asserts that EHR has not satisfied the quality of care standard because it did not compare its quality reporting measures to other Maryland providers. Under the applicable State Health Plan quality of care standard, however, there is no requirement for an applicant that does not currently provide inpatient rehabilitation services and that seeks to establish a rehabilitation specialty hospital to compare its quality reporting to similar Maryland providers. Rather, the applicant is required to "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*." COMAR § 10.24.09.04A(2)(c) (emphasis added). Nevertheless, EHR *did* provide a comparison of the quality measures reported by HealthSouth Chesapeake (now named Encompass Health Rehabilitation Hospital of Salisbury and referred to herein as Encompass-Salisbury), an IRF owned by Encompass and located on the Eastern Shore of Maryland, with other Maryland providers. CON Appl., pp.108-110. In particular, EHR demonstrated that when measured against comparable patients in the region discharged to a SNF, Encompass-Salisbury patients had lower 30-day readmission rates and shorter total lengths of stay. Additionally, EHR provided extensive evidence that Encompass facilities consistently exceed national averages of quality measures across the continuum of post-acute care, including higher rates of discharge to the community, lower cost per discharge, and higher functional improvement gains. Thus, EHR provided evidence that Encompass quality reporting compares

favorably on both a regional, and a national level, with other similar providers and thereby satisfies the quality of care standard.[2] *See* COMAR § 10.24.09A(2); CON Appl., pp. 83-110.

MNRH also asserts that EHR failed to provide enough evidence to satisfy the quality of care standard. Not only did EHR submit thirty pages of quality reporting information demonstrating the consistent, high quality care Encompass facilities provide to patients, but the nature and extent of the data presented is comparable to the quality reporting evidence the Commission has found satisfactory in prior CON reviews. For example, in its CON application to relocate its rehabilitation hospital, Adventist Rehabilitation Hospital of Maryland ("ARH") submitted two pages of quality information including rehabilitation quality metrics data that compared favorably with other providers in the nation. *In Re Adventist Rehabilitation Hospital of Maryland, Inc.*, Docket No. 18-15-2428, ARH CON Appl., pp. 15-16. The Commission acknowledged that ARH reported a 30-day post-discharge readmission rate lower than the national average. *Id.*, Staff Report and Recommendation, p. 12.[3] The Commission also pointed out that ARH presented rates of falls with injury and incidences of certain infections that were lower than the weighted regional and national averages. *Id.* Following a brief, two paragraph analysis of ARH's quality of care reporting measures, the decision "concludes that the quality standard [was] met." *Id.* at p. 13. Thus, in evaluating whether ARH successfully satisfied the

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[2] EHR is an indirect subsidiary of Encompass Health Corporation ("Encompass"). Encompass Health is a national leader of inpatient rehabilitation hospitals and home-based care.

[3] The Staff Report became the final decision of the Commission when unanimously approved at the March 21, 2019 meeting. MHCC Meeting Minutes, March 21, 2019, Action Item 4.

standard of COMAR § 10.24.09.04A(2), the Commission focused solely on whether ARH's quality metrics compared favorably to other providers.

Despite the voluminous evidence EHR submitted demonstrating the superior Encompass measures and the extensive description of the Encompass quality management programs, *see* CON App., pp. 83-110, MNRH essentially argues that the Commission should apply a far more stringent standard to the EHR application than it has to other CON applicants because EHR will be part of a hospital system with "high margin" IRFs.[4] Neither the State Health Plan nor the Commission's prior decisions permit the Commission to apply different review standards to a "high margin" IRF versus a "low margin" IRF. On the contrary, the Commission must evaluate whether an applicant meets the quality of care standard by assessing whether that applicant's quality reporting compares favorably to other providers. *See, e.g.*, *In Re Adventist Rehabilitation*

[4] In questioning the reliability of EHR's quality measure reporting, MNRH relies on the 2016 and 2018 MedPAC reports, which concluded that some "high-margin IRFs" engage in inconsistent coding and scoring practices. Setting aside the fact that neither of these MedPAC reports found any wrongdoing by Encompass, nor did they conclude that Encompass manipulates its data, Encompass uses industry standard quality reporting methods that the Commission has recognized as reliable. Encompass uses the Uniform Data System for Medical Rehabilitation (UDSMR) to generate its quality reporting data, which allows it to evaluate and track patients, assess the effectiveness of treatment, and benchmark its performance against other national performance data. Encompass also uses the Medicare standardized "CARE" patient assessment tool to assess functional impairments. In recommending approval of the CON application for Memorial Hospital at Easton (now known as University of Maryland Shore Medical Center at Easton), the Commission Staff highlighted the applicant's plan to implement a plan for program evaluation using a formal utilization review process focused on clinical outcomes, and employ the UDSMR, concluding that the applicant would "apply accepted industry standard outcome measures that 'meet the *general standards of validity, reliability, and sensitivity*.'" *In re Memorial Hospital at Easton*, Docket No. 02-20-2128, Sept. 14, 2004 Staff Recommendation, p. 13, excerpts attached as **Exhibit 1**. While MNRH implores the Commission to adopt its overbroad extrapolation of the MedPAC report findings to conclude that Encompass manipulates data, Encompass's use of quality measuring tools recognized by the Commission as general standards of "validity, reliability, and sensitivity" speaks for itself.

Hospital of Maryland, Inc., Docket No. 18-15-2428, Staff Report and Recommendation, pp. 12-13. The Commission should conclude that EHR satisfies the quality of care standard because the Encompass quality metrics consistently reflect above-average marks for Encompass facilities as compared to other national and regional providers. CON Appl., pp. 83-110.

II. EHR DEMONSTRATED THAT BARRIERS TO ACCESS EXIST, AND THAT THE PROPOSED PROJECT WILL ADDRESS THOSE BARRIERS, COMAR § 10.24.09.04.B(1).

In its improper filing, MNRH alleges that "EHR'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." MNRH Record Corrections, p. 6. To the contrary, EHR provided ample evidence of the health disparities, lack of convenient inpatient rehabilitation service providers, and lower than average use rates in the Southern Region, thereby demonstrating that barriers to access exist. *See, e.g.*, CON Appl., pp. 25, 30, 32, 43, 121; EHR April 2, 2019 Resp. to Interested Party Comments ("EHR Resp."), pp. 2-11 and Exs. 2-4, 8. Through the proposed establishment of a 60-bed acute inpatient rehabilitation hospital in Bowie, Maryland, EHR has presented a compelling plan to address those barriers as required by COMAR § 10.24.09.04B(1).

A. EHR's rehabilitation facility will provide needed services to an underserved region.

MNRH's improper response filing does not substantively rebuke EHR's evidence that significant health disparities exist in the Southern Region. First, the Southern Region includes Prince George's County, Maryland's second most populous and most diverse jurisdiction. As compared to neighboring counties, Prince George's County residents suffer worse health care outcomes, including higher rates of diabetes, heart disease, asthma, and cancer. *See* Public

Health Impact Study, EHR Resp., Ex. 2, p. iv. Despite higher rates of chronic disease and consistently low ranks in clinical care factors, Prince George's County residents have less access to primary and specialty care than residents in surrounding counties and the State as a whole. Public Health Impact Study, EHR Resp., Ex. 2, pp. iv-vii; Prince George's County Health Department, 2016 Community Health Needs Assessment, EHR Resp., Ex. 4, p. 16. To address these thoroughly documented health disparities, industry stakeholders including the University of Maryland Medical System ("UMMS"), the State of Maryland, and Prince George's County have concluded that the location and accessibility of care at all levels in the County requires improvement. Public Health Impact Study, EHR Resp. Ex. 2, pp. i-xxvii. EHR, with the support of UMMS, seeks to further the collective goal of improving health care delivery in Prince George's County by creating an inpatient rehabilitation facility located within County itself.[5] *See* UMMS Letter of Support, CON Appl., Ex. 2.

Rather than respond directly to EHR's ample evidence that the Southern Region has insufficient access to care, MNRH instead reargues, without support, and contrary to the Commission's need methodology, that there "is a more than adequate number of beds available to Southern Maryland Region residents." MNRH Record Corrections, p. 6. MNRH also

[5] In responding to EHR's evidence that it will be a low cost provider, MNRH implies that, because Encompass typically locates its facilities in suburban areas where land is cheaper, it "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." MNRH Record Corrections, pp. 5-6. This comment completely ignores the comprehensive findings of the Public Health Impact Study and EHR's thorough discussion in its response to MNRH's initial comments. In reality, it is clear that EHR has chosen to locate in a region where patients suffer significantly worse health outcomes than neighboring regions. That it can do so in an efficient and cost-effective manner further supports approval of the CON application.

suggests that EHR "falsely states" that MNRH believes no more than ten beds should exist in the Southern Region. *Id.* Even though MNRH never explicitly framed its position in those exact words, it is the only logical conclusion to be drawn from its argument. If the Commission does not approve EHR's CON application, there will only be ten inpatient rehabilitation beds in the Southern Region. CON Appl., p. 32. MNRH's argument therefore relies upon the premise that because a large number of beds exist in Washington, D.C. and Montgomery County, residents of the Southern Region can travel to those regions to receive care. MNRH Record Corrections at 7. The Commission's regional bed need methodology, however, is based upon defined health planning regions. COMAR § 10.24.09.05.

To accept MNRH's position that the beds in Washington, D.C. and Montgomery County should be considered when determining whether the *Southern Region* has an adequate number of beds would ignore the express health planning policy embodied in the State Health Plan. This is not the first time MNRH has asked the Commission to overlook the established health planning regions created and codified by regulation. MNRH similarly asked the Commission to grant it interested party status in this CON review, despite that COMAR § 10.24.09.05C does not include Washington, D.C. within a health planning region for acute rehabilitation services.[6] EHR Motion to Strike, p. 2. The Commission should decline MNRH's repeated requests to disregard its own regulatory definitions of the health planning regions.

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[6] MNRH argues that because it is located in a "contiguous planning region," it has standing to oppose EHR's CON application as an interested party. The State Health Plan for acute rehabilitation services, however, includes five distinct health planning regions, none of which include Washington, D.C. Therefore, as a Washington, D.C. provider, MNRH does not operate in a contiguous planning region in the context of acute rehabilitation services and cannot be an interested party. *See* EHR Motion to Strike, pp. 1-2.

B. EHR presented sufficient evidence to show that barriers to access exist in the Southern Region.

To show that barriers to access exist under COMAR § 10.24.09.04B(1), an applicant must present evidence of those barriers based on studies or other validated sources of information. EHR met this standard by demonstrating the lack of geographic access to inpatient rehabilitation providers in the Southern Region and the longer travel time to the closest providers in neighboring regions. CON Appl., pp. 32, 43, 121. EHR offered empirical data to support the existence of these barriers, through submission of a travel time analysis and an academic study concluding that use of post-acute care correlates with its geographic availability. *See* CON Appl., pp. 32, 43, 121; How Much is Postacute Care Use Affected by its Availability? Health Services Research 40(2):414-43, EHR Resp., Ex. 8. Further, the State Health Plan itself states that "research suggests that the distance to providers, relative to a patient's residence may be a more powerful predictor of the use of acute inpatient rehabilitation services than the clinical characteristics of patients." COMAR § 10.24.09.03. This statement recognizes that patients are less likely to seek needed care as their access, measured in terms of travel time, diminishes.

MNRH does not provide any genuine challenge to the reliability of EHR's evidence that barriers to access exist in the Southern Region. Instead, it takes issue with EHR's characterization of MNRH's argument that traveling to D.C. to receive care is "somehow more convenient" than traveling to Bowie, when MNRH instead asserted that traveling to D.C. "is no less convenient." MNRH Record Corrections, p. 7. MNRH's parsing of words reveals no substantive difference from EHR's comments. At bottom, MNRH failed to show that it would be "no less convenient" for a patient to travel to D.C. rather than receive care within the Southern Region, aside from postulating (without data) that many residents of southern

Maryland regularly commute to D.C. for work or for fun. MNRH does not provide any evidence that patients prefer equally to seek medical care far from their homes and families.[7] MNRH's unsupported conjecture does not undermine the position of EHR and the State Health Plan chapter that patients deserve to have access to care within their communities.

In addition to submitting empirical evidence that Southern Region residents, on average, must travel longer distances to receive care in Washington, D.C. than they would to obtain treatment at the proposed EHR Bowie facility, EHR adequately supported its position that the low use rates in the Southern Region demonstrate a barrier to access. Instead of refuting EHR's evidence that low use correlates to a barrier to access in the Southern Region, MNRH argues that EHR misrepresented MNRH's comments regarding high use rates on the Eastern Shore. In its comments, MNRH stated that high use rates on the Eastern Shore "could suggest Eastern Shore use rates are evidence of OVER utilization." MNRH Mar. 18, 2019 Interested Party Comments ("MNRH Comments"), p. 10 (capitalization in original). It then suggested that Maryland's average use rates may be skewed by such overutilization on the Eastern Shore, resulting in inaccurate averages statewide. MNRH relied upon these unsupported hypotheses to conclude that Southern Maryland's low use rates do not evidence any lack of access to care. Not only does MNRH's argument rest on baseless theories for which it did not provide any concrete evidence, but it also ignores the fact that even when the Eastern Shore is excluded from the

[7] MNRH also takes issue with EHR's argument that travel time impacts both the patient and the patient's family. While there is no "family engagement" standard in the State Health Plan and applicants are not required to prove this factor to obtain a CON, it is common sense that families face the same burdens and challenges as patients regarding the distance and availability of services. The travel time analysis data shows that many patients are currently forced to travel long distances to receive care. Their families are also affected by the time and expense associated with such regular travel.

statewide average calculation, the use rate in the Southern Maryland region is still comparatively low. MNRH Comments, p. 10. [8]

EHR offered data and reported research to show that low use rates represent a barrier in access to care in the Southern Region. CON Appl., p. 118. The Commission should thus conclude that EHR has satisfied the barriers to access review standard.

III. EHR MET THE APPLICABLE NEED PROJECT REVIEW STANDARD, COMAR § 10.24.09.04B(2)

EHR's CON application includes ample evidence in support of the need review standard. *See* CON Appl., p. 51 (calculating outmigration projections); CON Appl. 125 (explaining EHR's rationale for relying on the maximum model and addressing outmigration calculations). Though MNRH presents a long list of factors that EHR allegedly failed to prove, instead of addressing these points with analysis and evidence, MNRH argues that EHR raised "frivolous arguments based on misleading or flat out wrong interpretations" of MNRH's arguments. MNRH Record Corrections, p. 9.

First, MNRH addresses EHR's volume and outmigration projections. EHR conservatively projects that it will capture 40% of the patient volume that currently migrates from the Southern Maryland region to receive care in Washington, D.C. CON App., p. 51. EHR reached this conclusion based on careful calculation and reasonable assumptions, as presented in the CON application. CON Appl., pp. 51-57. Rather than challenging the methodology behind

[8] As EHR pointed out in its Response to Comments, even applying MNRH's logic, which is flawed and should be rejected, the statewide average use rate for all regions *excluding* the Eastern Shore is 5.8. MNRH Comments, p. 10; EHR Resp., p 9, FN 8. This is still significantly greater than the use rate for the Southern Region. MNRH's use of an unauthorized filing to repeat without change illogical and unsupported arguments unnecessarily consumes the time and resources of the parties and the Commission.

EHR's outmigration projections, MNRH instead accuses EHR of misrepresenting MNRH's position. In particular, MNRH objects to EHR's characterization of MNRH's argument that, because patients prefer to receive care in Washington, D.C., outmigration from the Southern Region would not decrease due to the construction of a new IRF in Bowie, Maryland. While MNRH may not have explicitly used those words, its argument against EHR's outmigration projections almost exclusively relies on the premise that because Southern Region residents travel to D.C. regularly for work and recreation, they must similarly prefer to receive their medical care there.[9]

MNRH does not address EHR's evidence that patient use correlates with the accessibility of a facility, nor does it acknowledge that current outmigration rates are likely fueled by the lack of available inpatient rehabilitation services in the Southern Region. Instead, by taking trivial issue with EHR's wording of its argument, MNRH attempts to draw attention away from the thorough documentation EHR provided to support its volume projections, including the number of patients who will be captured by reducing outmigration by construction of a facility in the Southern Region. CON Appl., pp. 51-57. These projections demonstrate that EHR has satisfied the need standard at COMAR § 10.24.09.05.

Second, MNRH raises a similar argument regarding skilled nursing facilities ("SNFs"), generally asserting that EHR failed to support its claim that some patients in SNFs would be better served in inpatient rehabilitation facilities. MNRH centers its objection on the fact that EHR cited a study conducted by the consulting firm Dobson and DaVanzo in support of the

[9] As a practical matter, if MNRH truly believed that EHR's proposed IRF would not meaningfully impact outmigration to Washington, D.C., it would not have sought interested party status and would not have challenged EHR's conservative projections.

proposition that some patients may have better outcomes when treated in an IRF instead of a SNF. The study contained strong evidence to support that the use of IRFs correlates with improved functional outcomes and reduced morbidity rates for patients when compared with SNFs. CON Appl., pp. 66-69. It also concluded that IRFs operated by Encompass provide more cost-effective care than the average SNF. *Id.*

MNRH does not challenge the underlying assertions of the study. Instead, it criticizes the firm itself, arguing that because it offers litigation support and performs services for compensation, it cannot be considered "unbiased." MNRH Record Corrections, p. 11. At no point, however, does MNRH attempt to disprove or disagree with the findings of the study—presumably because it is widely accepted that IRFs provide better outcomes for certain patients than SNFs. In fact, in MNRH's own words, the position that there is no evidence that certain SNF patients would be better served in an IRF "is pure fantasy." MNRH Record Corrections, p. 10. EHR adequately supported its projection of a volume shift in patients from SNFs to its proposed IRF, and MNRH failed to credibly dispute that position.

Finally, MNRH argues that EHR improperly incorporated population growth projections in its volume projection calculations. MNRH essentially argues that because rehabilitation volume did not steadily increase statewide in accordance with population growth between 2012 and 2016, the Commission should not consider population growth at all in its review of EHR's application. To accept MNRH's argument, however, the Commission must disregard its own regulations mandating how to calculate bed need. COMAR § 10.24.09.05. The Commission's methodology for projecting adult acute rehabilitation bed need instructs an applicant to use the most recent year that discharge data is available as the base year, and to calculate projections to a target year five years thereafter. COMAR § 10.24.09.05A. The methodology necessarily

requires factoring in population growth over the five years between the base year and the target year to achieve accurate projections. Like other CON applicants, EHR relied upon this methodology to calculate its volume projections, as required by the State Health Plan. MNRH would have the Commission apply a different, heightened standard to EHR's application, rather than the methodology mandated by the State Health Plan. To do so would be improper.

Conclusion

By submitting a reply filing styled as a "Record Correction," MNRH has attempted to circumvent the standard procedure for CON filings and have the last word. Not only did it violate the rules by filing such a reply, but MNRH failed, for a second time, to meaningfully challenge the evidence presented by EHR in support of its CON application. EHR has demonstrated that its application satisfies all the required standards under the State Health Plan. For the reasons set forth above, and in its application and response to MNRH's prior comments, EHR respectfully requests that the Commission approve the proposed project to establish an inpatient rehabilitation hospital in Bowie, Maryland and grant a CON.

Respectfully submitted,

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October 4, 2019

CERTIFICATE OF SERVICE

I hereby certify that on the 4th day of October, 2019, a copy of the Response of Encompass Health Rehabilitation Hospital of Southern Maryland on the Record Corrections in Support of Interested Party Comments of MedStar National Rehabilitation Hospital was sent via email and first-class mail to:

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EXHIBIT 1

STATE OF MARYLAND

Fom
File

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MEMORANDUM

TO: Commissioners

FROM: Susan Panek
Chief, Certificate of Need Program

DATE: September 14, 2004

SUBJECT: **The Memorial Hospital at Easton – Establishment of a Twenty-Bed Acute Inpatient Rehabilitation Unit – Docket No. 04-20-2128**

The Memorial Hospital at Easton ("Memorial-Easton"), a 132-bed acute general hospital in Talbot County on Maryland's Eastern Shore, has sought Certificate of Need ("CON") approval to establish a twenty-bed comprehensive integrated inpatient rehabilitation ("CIIR") unit, which would be located in what is now the Memorial-Easton subacute care unit, on the hospital's fifth floor. The area intended for the proposed rehabilitation unit currently houses a skilled nursing unit with 33 comprehensive care facility beds. Memorial – Easton is a member, with Dorchester General Hospital, of the Shore Health System. Residents of the five counties of the mid-Eastern Shore – Kent, Queen Anne's Caroline, and Dorchester, in addition to Talbot County – account for approximately 96% of the hospital's total discharges each year.

Memorial-Easton seeks Commission approval, concurrent with the Certificate of Need application, to close the subacute care unit (possibly in phases, as patient needs dictate) and retain the 33 CCF beds as "temporarily delicensed," under the Commission's regulations at COMAR 10.24.01.03C, to permit the exploration of possible alternatives uses for the bed capacity. Pursuant to Health-General Article §19-120(l), Memorial-Easton will have to obtain an exemption from Certificate of Need, through Commission action, before resolving the status of the 33 temporarily-delicensed beds, since the permanent closure of the skilled nursing unit results in the closure of a medical service at a hospital, a jurisdiction with only one hospital.

In order to convert its use to inpatient rehabilitation, Memorial-Easton would undertake a major interior renovation of its Five-South Unit, originally constructed in 1966, that would affect a total of 14,300 square feet of current hospital space. This includes 7,200 square feet to house the 20 inpatient rehabilitation beds (arrayed as 4 private and 8 semi-private patient rooms) and

standard support space, to conform to the requirements of the 2001 edition of the *American Institute of Architects Guidelines for Design and Construction of Hospitals and Health Care Facilities*, and of the Americans with Disabilities Act; 4,200 square feet for rehabilitation spaces (including a gym, space for dining and recreation, and a kitchen and bathroom facilities for ADL-related therapies) and also offices for the rehabilitation staff; 1,700 square feet for mechanical needs, utilities, stairs, elevators, and other structural details; and 1,200 square feet of space for use by staff of Memorial-Easton's Maternal Health Unit, to replace space taken by the rehabilitation renovations. Memorial-Easton proposes to complete its construction-level architectural design for the rehabilitation unit within five months of CON approval, and to complete construction over 15 months, in two phases.

Memorial-Easton estimates that the total cost to convert the 33-bed hospital-based skilled nursing facility to a 20-bed rehabilitation unit will be $4,287,520. Of this total, proposed current capital costs account for $3,785,000, $422,520 is budgeted as an inflation allowance and for capitalized construction interest, and $80,000 is allocated to financing costs and other cash requirements, including legal and auditing costs. The source of funds for the Memorial-Easton project will be $230,000 in cash, and $4,057,520 in authorized bonds, either as a bond issue through the Maryland Health and Higher Education Facilities Authority, or through self-funding.

In supporting the need for a new inpatient rehabilitation program to serve the mid-Eastern Shore counties that comprise its primary and secondary service areas, Memorial-Easton maintains that a significant unmet need for this service exists in its mid-Eastern Shore service area, as a function of a population that is older, proportionately, than either the lower three Eastern Shore Counties or the State as a whole, and experiencing the higher rate of hospital utilization associated with advancing age. In its need analysis, Memorial-Easton argues that this higher hospitalization rate correlates closely to a greater need for inpatient rehabilitation services, while the current use rate for inpatient rehabilitation services among the 65 and older population on the mid-Shore decreases significantly as the distance increases from Chesapeake Rehabilitation Hospital in Salisbury, the Maryland's Eastern Shore's only rehabilitation provider.

For reasons presented in its review and analysis of the hospital's Certificate of Need application, Staff recommends that the Commission **APPROVE** the proposed new 20-bed inpatient rehabilitation unit at the Memorial Hospital at Easton.

policies regarding patient transfer to other facilities and copies of some of its written transfer agreements with other facilities. Memorial-Easton complies with this standard. Staff will discuss the hospital's communication and collaboration with area nursing facilities – necessitated by the change of its focus from skilled nursing care to inpatient rehabilitation – under the Rehabilitation Plan's CON review standard, below.

O7b. All inpatient and residential facilities and organized service providers must participate in or have utilization review programs and treatment protocols, including written policies governing admission, length of stay, and discharge planning and referral, and must document such programs and protocols when applying for Certificate of Need for new or expanded services and when otherwise required by the Commission.

Memorial-Easton complies with this standard, since it has in place "an active utilization review, control programs, and treatment protocols" that use "clinical pathway approaches" to patient care, and comply with the requirements of licensing statute, at Health-General Article §19-319(d). The hospital included both a copy of its utilization review plan and the Scope of Services statement of its Clinical Information Management Department with its application materials.

The hospital intends to establish the "SIR (Shore Inpatient Rehabilitation) Utilization Management" program, which will involve the medical director, Shore Health System management, clinical staff, and the unit's case manager in the evaluation of admissions and discharges, use of resources, and the provision of services. Memorial-Easton discussed this plan for utilization and outcomes evaluation more fully under the first section of its response to the policies articulated in the specific Plan for rehabilitation services. Staff will review and examine this issue under the next section of this report.

Standards from State Health Plan – Specialized Health Services -- Acute Inpatient Rehabilitation Services, COMAR 10.24.09

The following State Health Plan standards, specific to rehabilitation services, are designed to insure that these services "provide an intense program of coordinated and integrated medical and rehabilitative care," and that "practitioners who comprise the interdisciplinary team have special training and experience in evaluating, diagnosing, and treating persons with limited function as a consequence of diseases, injuries, impairments, or disabilities."[6]

COMAR 10.24.09.04B: Acute Inpatient Rehabilitation Services: Issues and Policies

(1) Effectiveness and Efficiency of Acute Inpatient Rehabilitation Services.

[6] COMAR 10.24.09.04A.

Facilities providing acute inpatient rehabilitation services should document the outcomes that are achieved by persons who receive the services as well as the cost of providing the services. Reasonable time frames for the accomplishment of goals should be estimated at the time of admission, and the provision of services in this setting should continue until the established functional goals are realized, or significant and measurable progress toward the goals is no longer evident. The measures of effectiveness should meet the general standards of validity, reliability, and sensitivity. Facilities should also use existing resources efficiently. In this Plan, the Commission will use occupancy as a measure of the efficient use of bed capacity.

Policy 1.0 Rehabilitation hospitals and units should provide services effectively and efficiently.

Shore Health System intends that the Shore Inpatient Rehabilitation program will be the "core of a comprehensive rehabilitation continuum of care," which will complete an existing array of rehabilitative services already provided by its two member hospitals, and at its existing Outpatient Rehabilitation Centers in Easton, Cambridge, and Denton. This coordinated approach also incorporates Memorial-Easton's working relationships with the region's providers of skilled nursing, home health care, "long term acute care hospitals" (neighboring states' equivalent to Maryland's chronic care hospitals), and other acute rehabilitation hospitals. In furtherance of that goal, Memorial-Easton will seek CARF accreditation – in fact, has already begun that process – and employ the standard, accepted outcomes measurement tools now available.

In its application, Memorial-Easton explains its overall plan for Program Evaluation, beginning with a formal Utilization Review process that will involve the Vice President of Medical Affairs and members of the medical staff in the "ongoing review of performance against expectations." Outcomes management will focus on the accomplishment of objectives from among seven different areas, with the first, Clinical Outcomes, assigned the highest priority.[7] The program's Program Evaluation activities will adopt and refine these objectives based on "clinical benchmarks, budgetary expectations, plans, and other sources," and apply a combination of external and internal measures that will enable comparison of program performance both against national and regional experience, and against the program's own performance once it begins operation. Memorial-Easton has already begun to apply both its principal internal measurement – a national data system of describing disability and measuring improvement – and its primary external benchmark, CARF accreditation, to the current operation of its skilled nursing unit.

The Shore Inpatient Rehabilitation program will employ the Uniform Data System for Medical Rehabilitation (UDSMR), a data set that is used to document and communicate outcomes of medical rehabilitation, to show measurable functional improvement for patients admitted to the facility. This data set includes the Functional Independence Measure (FIM™), or a scale known as the FIM™ instrument, which tracks changes in functional status from admission through discharge and follow-up. In addition, UDSMR includes demographic, diagnostic, and financial elements. The FIM™ is comprised of 13 motor activities and 5 cognitive skills in the

[7] The other areas include Operational Performance, Financial Performance, Business Development, Program Development, Advocacy and Rehabilitation Education, and Information Management. Application, page 21.

areas of self-care, sphincter control, transfers, locomotion, and social cognition; each of these 18 elements receives a rating on a seven-level ordinal scale, with Level 7 representing Complete Independence and Level 1 describing Total Assistance. The sum of the item scores describes the severity of an individual's disability, and reflects the amount of assistance that is required for an individual to complete daily activities; the possible total score ranges from 18 (lowest) to 126 (highest) level of independence. Investigations of the psychometric properties of the FIM™ instrument have found the instrument to be reliable, valid, feasible, and responsive to change.[8]

As noted, Memorial-Easton already subscribes to the UDSMR data instrument, and begun training staff in its skilled nursing unit on its application to functional improvement of patients in its skilled nursing facility. The hospital is steadily gaining experience in the use of this data collection and analysis tool, which applies the same patient outcome requirements to its post-acute patients as those required by the Centers for Medicare and Medicaid Services (CMS) for freestanding inpatient rehabilitation facilities, which are subject to a prospective payment system.[9]

Similarly, the hospital began its progress toward CARF accreditation, in order to firmly establish the mission, core values (including dignity, respect, and consumer involvement), and knowledge of CARF's Standards Manual in the current context of its skilled nursing unit. At the time it submitted its application for Certificate of Need, Memorial-Easton informed the Commission that its newly-engaged Executive Director – who brought to the job over ten years of experience as a CARF surveyor and survey team leader, and as an administrator of CARF-accredited rehabilitation facilities – had begun the "internal policy and practice changes" needed to conform to the CARF accreditation standards. The hospital's goal was to "assure that the program is fully in conformance with industry "best practice" as it transitions from skilled nursing licensure to acute rehabilitation licensure."[10]

In early July, Staff requested an update from Memorial-Easton on its continued progress toward meeting the standards for CARF accreditation. Mr. Johnson provided an item-by-item summary of the hospital's conformance with each of these standards, in three major categories: Business Practices, Rehabilitation Process for the Persons Served, and Comprehensive Integrated Inpatient Rehabilitation Program. In the last area, Memorial-Easton's update notes CARF's statement that, depending on the acuity level and medical stability of an individual patient, "a Comprehensive Integrated Inpatient Rehabilitation Program may be provided in a hospital, *hospital based skilled nursing facility*, skilled nursing facility, or long term acute care hospital."[11] (Emphasis in original.) Memorial-Easton characterizes its compliance with CARF requirements in the CIIR program category as "good but partial compliance"; its priority is the "recruitment of a medical director/attending physician who meets applicable training and experience criteria and standards." As this process continues, the hospital has already set in motion additional training needed to achieve Certified Rehabilitation Registered Nurse certification for the unit's staff,

[8] See the Reviewer's discussion of this data instrument in "In the Matter of Kessler Adventist Rehabilitation Hospital At Washington Adventist Hospital" Docket No. 02-15-2096, June 2003.

[9] Memorial-Easton Application, page 23.

[10] Memorial-Easton Application, page 26.

[11] Document provided in electronic mail from Jeffrey Johnson to Susan Panek, July 5, 2004.

through collaborative arrangements with National Rehabilitation Hospital in Washington DC and Kernan Hospital in Baltimore.

As part of Policy 1, the Commission is also required to assess the efficient use of existing resources (or bed capacity), which is measured by the occupancy rate. The State Health Plan establishes benchmark occupancy standards under the Certificate of Need Approval rule. The Commission has deemed that a minimum occupancy rate of 80 percent is appropriate for a licensed capacity of fewer than 50 beds, and 85 percent for a licensed capacity of 50 to 99 beds. This report will examine the related issues of projected and achievable occupancies under the related Certificate of Need standards at COMAR 10.24.09.04C, below. With regard to the Policy 1 requirement to demonstrate that a proposed new acute inpatient rehabilitation program will operate "effectively and efficiently," Staff finds that Memorial-Easton's intended plan of program evaluation and outcome measurement complies with this Plan policy, because it will apply accepted industry standard outcome measures that "meet the general standards of validity, reliability, and sensitivity."

(2) Specialization within Rehabilitation.

The criteria for grouping rehabilitation patients may include diagnosis, nature of injury (traumatic versus non-traumatic), severity of impairment or functional disability, and age. An important issue is where the individuals will be best served and where the outcomes will be better. Pediatric patients and individuals who have spinal cord or brain injuries should be referred to the areas of expertise chosen by them or their representatives, once fully informed about the availability of specific services related to their needs. Persons who have similar profiles because of their needs or disabilities may be admitted to specialized acute inpatient rehabilitation services; however, the majority of patients should fulfill the criteria established for those services.

Five regional service areas are designated for the planning of acute inpatient rehabilitation services: Eastern Shore, comprised of Cecil, Kent, Queen Anne's, Talbot, Caroline, Dorchester, Worcester, Wicomico, and Somerset counties; Southern Maryland, comprised of Prince George's, Charles, Calvert, and St. Mary's counties; Montgomery County; Central Maryland, comprised of Baltimore City and Harford, Baltimore, Anne Arundel, and Howard counties; and Western Maryland, comprised of Carroll, Frederick, Washington, Allegany, and Garrett counties. An inpatient brain injury program or spinal cord rehabilitation system of care must demonstrate an adequate number of admissions to maintain accreditation as a specialized program or system. Specialized programs should be placed in geographic locations that can draw sufficiently from a population base and referral sources that support the services.

Policy 2.0 Rehabilitation hospitals and units should continue to provide access to specialized programs that meet the requirements for licensure.

Although it intends to serve "a wide variety of persons with significant impairments, limitations, and activity restrictions" resulting from illness, injury, or congenital conditions,

In its application, Memorial-Easton presents data showing that "the growth of Chesapeake Rehabilitation Hospital's admissions between 1996 and 2003 has come from the Lower Shore Area, Delaware, and Virginia," and that during the same period, the percentage of discharges from the Mid- and Upper Shore service areas has steadily decreased. Even the discharges from Dorchester County, the part of Shore Health System's service area that is closest to Chesapeake Rehabilitation Hospital, have decreased during this period, by 26.2%.[38] Other data provided by Memorial-Easton's application show that the population of elderly, prime users of rehabilitation services, is projected to increase by 14-16% across the entire Eastern Shore, so the absolute numbers of potential patients is likely to grow. Also between now and 2010, the population of Sussex County, Delaware is projected to increase by 20.6%; fourteen percent of Chesapeake Rehabilitation Hospital's admissions in 2003 came from that jurisdiction.

With regard to the impact of Memorial-Easton's conversion of an existing hospital-based skilled nursing facility to a 20-bed rehabilitation unit on area nursing facilities, Staff has already outlined the extensive efforts made by the hospital to inform them of the possibility of this change, and to work closely with the facilities' administrators to make the transition a positive one. Many of the nursing homes have stepped up their admission of Memorial-Easton's post-acute patients, and also begun to tailor some of their own programs to serve specific medical needs of rehabilitation patients discharged from the hospital, by adding intravenous infusion programs, behavioral health units, and dialysis services. Some of the area's nursing facilities have considered establishing ventilator care and weaning programs, to care for more medically fragile patients. These actions should help to compensate for the closure of the 33 special comprehensive care facility beds, which will occur soon after a Commission approval of the new rehabilitation unit, in order to permit the start of renovation. Shore Health System will seek temporary delicensure of the beds, under the appropriate Commission regulations, to determine if an existing nursing facility in Talbot County has interest in acquiring the beds, and seeking CON approval to relocate and re-implement them.

Memorial-Easton states in its application that its "intent is to improve the accessibility of high-quality and comprehensive acute inpatient rehabilitation services" to the Mid- and Upper Eastern Shore, and that it believes that its proposed new unit will have a "minimal impact" on the region's only existing rehabilitation provider, Chesapeake Rehabilitation Hospital. Based on its analysis of patient origin data, Staff agrees with this assessment, and believes that the Commission's approval of Memorial-Easton's proposal to establish this 20-bed inpatient unit is consistent with this criterion.

IV. CONCLUSION AND STAFF RECOMMENDATION

Having reviewed this application for Certificate of Need by the Memorial Hospital at Easton, Staff has found that the project complies with all applicable State Health Plan review standards at COMAR 10.24.07 and COMAR 10.24.09, and also with the general Certificate of Need review criteria at COMAR 10.24.01.08G(3). Accordingly, Staff recommends that the Commission **APPROVE** the requested Certificate of Need to establish a twenty-bed acute inpatient rehabilitation unit in existing, renovated space at the hospital.

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[38] Memorial-Easton Application, page 84.

IN THE MATTER OF	*	
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THE MEMORIAL HOSPITAL AT	*	
	*	**BEFORE THE**
EASTON – ESTABLISHMENT OF A	*	
	*	**MARYLAND HEALTH CARE**
TWENTY-BED REHABILITATION UNIT	*	
	*	**COMMISSION**
DOCKET NO. 03-20-2128	*	
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Based on the Commission's review of the Staff Report and Recommendation, it is this 14th day of September 2004 ORDERED, by a majority of Commissioners present and voting,

That the proposal by The Memorial Hospital at Easton, Docket No. 03-20-2128, to establish a twenty-bed acute inpatient rehabilitation unit in renovated existing space at the hospital, for a total project cost of $4,287,520, is APPROVED.

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(Date)	Barbara Gill McLean Executive Director