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November 22, 2019

VIA PDF & REGULAR MAIL

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Encompass Health Rehabilitation
Hospital of Salisbury
Matter No. 18-22-2435

Dear Mr. McDonald:

Attached please find four (4) copies of the response of Encompass Health Rehabilitation Hospital of Salisbury ("EHRHS") to a request for additional information contained in a letter from the Maryland Health Care Commission ("MHCC") dated October 16, 2019, relating to the EHRHS Certificate of Need ("CON") application to add ten (10) beds to its existing 64-bed special hospital rehabilitation in Salisbury, Wicomico County. These responses also have been submitted as of this date electronically, in both Word and PDF format, to Ruby Potter at ruby.potter@maryland.gov.

Response to MHCC Staff Request of Applicant (Rehabilitation Hospital Corporation of America, LLC d/b/a Encompass Health Rehabilitation Hospital of Salisbury)

The MHCC has inquired as follows:

> This information raises significant questions regarding why the IRF use rate in Encompass-Salisbury's service area is so much higher than the use rates elsewhere in Maryland. We would like you to elaborate on why this disparity exists, and provide an explanation as to why we should not conclude that – for some reason – there is overuse occurring in this market, and that additional beds should not be authorized in such an environment.

For the reasons explained in detail below, there is no overuse of inpatient rehabilitation facility ("IRF") services occurring in the Encompass-Salisbury service area and the MHCC should authorize the requested additional 10 beds. Moreover, the historical utilization of inpatient rehabilitation hospital beds within Maryland, including the Encompass-Salisbury service area has been recognized in the State Health Plan which projects a need for the additional

ten (10) beds proposed by EHRHS despite the high utilization reported for the Eastern Shore residents.

EHRHS has reviewed the data regarding the IRF use rate in its service area and provided below is an explanation of why the use rates for residents of the three Maryland counties in its service area during CY 2016 (*see* Exhibit 1) is higher than the use rates in other jurisdictions in Maryland and the Statewide use rate. To answer this question, EHRHS has looked to both local and national data as well as its local and national experience and expertise.

Unlike an acute care general hospital that operates an emergency room which is a significant if not primary source of its inpatient admissions, all patients seeking services at an IRF, including EHRHS, must be referred by a health care professional and must meet stringent admission standards. To admit a medically qualified patient who has been medically determined to benefit from IRF services, the IRF also must have an unoccupied bed available for that patient. The utilization of EHRHS has been well in excess of the applicable State Health Plan occupancy standard of 79% for the Eastern Shore Region. Unfortunately, qualified patients have been and are currently denied treatment at EHRHS due to lack of unoccupied beds.

As discussed in detail below, it is clear that the availability of an excellent freestanding rehabilitation hospital and its licensed beds alone do not result in its high utilization. Variance in utilization rates results from a number of factors, many of which result from a community's unique needs, and a high utilization rate does not mean overutilization.

To better understand utilization rates this analysis will show that: (1) variation in utilization is very common, (2) high utilization is not an indicator of overuse, and (3) utilization is driven by factors unique to each community including underlying community health indicators, the clinical referrals of the acute hospitals and their clinical teams, and the appropriate choice of post-acute care for each patient's optimal outcome.

When utilization rates are compared beyond Maryland, the picture becomes clear that this market is not over utilized. Exhibit 2 Maryland Ranks Below the US on Rehab Beds per 1000 65+ shows Rehab Beds per 1000 65+ for all 50 states. Maryland ranks 14th from the bottom for rehab beds per 1000 for individuals 65+ indicating that Maryland has fewer rehab beds for the 65+ population than 36 other states and the District of Columbia, including all neighboring states (highlighted in green columns). Thus, Maryland continues to lag behind the United States in bed availability for its elderly residents.

In addition, Maryland ranks low in the United States in the percentage of Medicare patients who are admitted for post-acute care in a rehabilitation bed following an acute care hospital stay. While the availability of beds starts the analysis, it is actual care that matters. Exhibit 3 On a Patient Care Metric, Maryland is also on the Lower Range of Rehab Utilization

uses Medicare data (the best source to compare across state lines) to track the ratio of Medicare Rehab Discharges to Medicare Acute Discharges; a measure of how many admitted acute hospital patients receive post discharge care in an inpatient rehabilitation facility. This patient care metric shows that Maryland ranks 17th lowest among 50 states on acute patients who receive rehab services (*see* Exhibit 3) and on the low range among many counties in neighboring states (*see* Exhibit 4).

To further examine the "high utilization" by Eastern Shore residents, EHRHS compared the Salisbury market rate with other regions in the United States. Encompass Health, as the largest inpatient rehab provider in the country, has many markets with both higher and lower use rates than Salisbury. Based on the experience of Encompass which operates 120 IRF's across the country, the Salisbury experience is somewhere in the middle, unlike its apparent high ranking within Maryland. Exhibit 5 Encompass' Experience in 120 Markets Also Shows Wide Variation in Utilization, but Demonstrates the Salisbury Rates are Quite Common shows that use rates across 120 Encompass markets vary widely. Although the Salisbury market shows slightly higher use rates than Encompass Health's average markets, Encompass Health serves 40 markets with use rates that exceed those of this market. There is no evidence that there is "overuse" in any of those 40 markets.

The Salisbury Community - IRF Utilization

There are factors unique to each community impacting the utilization of rehab services within that community. These factors include underlying health of the community (community health indicators), the referral practices of the acute care systems and their clinicians (acute care referrals), and the clinician's preference for care for complex patients (post-acute mix). Of course, patient choice also is essential.

Community Health Indicators Impact IRF Utilization

The best illustration that communities vary widely in their health indicators and need for rehab services is to look more closely at the single largest patient admitting diagnosis: stroke. In the United States, incidence of stroke is truly a scourge, is not uniform across the country, and accounts for a significant amount of care provided in both acute care general hospitals, inpatient rehabilitation hospitals, and in EHRHS. Not only does the evidence show that stroke patients are shown to clearly benefit from inpatient rehab, inpatient rehab is the optimal care for many stroke patients. Moreover, communities differ in how many patients are hospitalized with strokes each year. The Centers for Disease Control (CDC) tracks this data across the United States and publishes the data. This national data shows clearly that hospitalization rates for the underlying cause of Ischemic Stroke (the most common stroke) vary widely across the country. The CDC national map shows that the Mid-Atlantic region has a high stroke incidence rate. (*See* Exhibit 6) Of greater significance, the Eastern Shore region of Maryland is among the highest regions in

the State for stroke hospitalizations. (*See* Exhibit 7) This core "health" metric helps to explain why the inpatient rehabilitation discharge rate is high in the EHRHS service area. Inpatient rehabilitation services are needed at a higher rate to treat the service area population's higher number of stroke patients. Thus, underlying disease patterns among residents of the Eastern Shore do provide another reason why a "discrepancy" might exist in bed utilization in comparison to the residents of more affluent regions on the Western Shore.

For the reasons set forth above, there is no "overuse" of IRF services when the underlying health of the community and its significant and specific need for IRF services are taken into account.

Acute Care Systems in Community Impact IRF Utilization.

Another factor unique to each community is the community's acute care systems and the referrals of patients by acute care clinical teams. Over 90% of EHRHS patients are referred directly from an acute care hospitalization. The decision on where to place these patients is made by the clinical teams and discharge planners of the acute care systems. EHRHS works diligently to make this process truly seamless and deploys nurses as patient liaisons to meet with discharge planning teams and acute care patients and their families. The impact of this focus on seamless care is that referrals of acute care patients to rehabilitation are well coordinated with care plans and diligent review for appropriateness.

The largest acute care facility in the Salisbury service area is Peninsula Regional Medical Center ("PRMC"). Thus, EHRHS examined the data on discharges from PRMC for Medicare patients. *See* Exhibit 10. The top table on Exhibit 10 lists the most frequent 10 DRG's referred to rehab from PRMC. This shows a very narrow list of diagnoses focused on stroke, neurological, and orthopedic care and all of these typically fit into what is called "CMS 13" conditions (which will be defined below and explained with respect to the relevance of such diagnoses). As indicated, other non-CMS 13 cases such as Septicemia also are referred.

Per the chart on Exhibit 10 "Discharge Status of Rehab" it is clear that PRMC discharges patients in need of inpatient rehabilitation to this inpatient rehabilitation setting more often than its peers across the state. As explained above, inpatient rehab care is more intense than skilled nursing and is recommended by independent third parties such as the American Stroke Association for certain patients. *See* Exhibit 11. In this community, the acute care provider has seen the benefits from this level of care and refers more of its patients to inpatient rehab care than state averages. This is not clinical overutilization but clinical preference. PRMC obviously has concluded that EHRHS has demonstrated a long track record of excellent care and outcomes for appropriately referred patients.

Inpatient rehabilitation care also provides a clear and compelling benefit to PRMC. Patients who are referred to rehab have an approximately one day lower average length of stay ("ALOS") than other patients. Please see "Acute ALOS (days)" on Exhibit 10. This is not unexpected due to the focus on continuity of care and the ability to place these complex patients in a post-acute setting that is a hospital which is able to deliver hospital level care to the most complex patients ready for transfer. Another reason for the apparent "discrepancy" in utilization is the favorable impact of the availability and utilization of EHRHS by patients discharged from PRMC. Each time a Medicare patient is appropriately discharged and transferred to EHRHS, there is the potential for reducing ALOS at PRMC. This pattern of use has been shown to lower PRMC's ALOS below the comparable statewide average for all Maryland hospitals.

Thus, this higher rate of rehab referrals from PRMC is not an indicator of "overuse" but an indicator of the need for beds at EHRHS as the optimal care setting for complex patients. In this case, the "disparity" in utilization rates, therefore, has been influenced by the local hospital's recognition of the effectiveness of IRF services for qualifying patients.

Furthermore, when the Medicare discharges to both inpatient hospital rehabilitation beds and to skilled nursing beds are combined, the Salisbury service area post-acute care utilization is neither high nor low in comparison to the State. It should be noted that PRMC discharges far more patients to Maryland nursing homes than to EHRHS. *See* Exhibit 12.

EHRHS also looked at the patient-by-patient evaluation practices of the community of providers serving the residents of the Eastern Shore and examined the reasons why certain patients are not admitted to EHRHS. Clearly, the high bed occupancy of EHRHS is one factor, and when no bed is available an otherwise appropriate admission will be denied or delayed. But there are other reasons for non-admission as well, which results in the utilization of alternative post-acute care for many patients. These reasons include: (a) patients who may not be able to tolerate the requirement that three hours per day of therapy must be provided five days per week; (b) patients who have other needs that can better be addressed in a skilled nursing facility, or by the therapists of a licensed home health agency; (c) patients who do not meet the medical criteria for admission; (d) patients who are rejected by third-party payers; and (e) patients or patients' families who prefer an alternative treatment plan or provider. In every case, patients referred to EHRHS must be evaluated by an independent (non-employed) member of its medical staff for clinical appropriateness, leaving the final decision to the patient and the patient's family. All of the possible reasons for non-admission to EHRHS are shown on Exhibit 13.

Rigorous Admission Criteria Assure Admission of Patients Medically Appropriate for Inpatient Rehabilitation

All IRFs, including EHRHS, operate in a highly regulated environment and must meet stringent standards for Medicare participation and Medicare reimbursement, licensure, and accreditation. *See* Exhibit 8. By way of illustration, these standards are distinctly different and much more stringent than those that apply to Skilled Nursing Facilities. *See* Exhibit 9.

IRFs provide intensive rehabilitative services to patients with various neurological, musculoskeletal, orthopedic, and other conditions resulting from trauma or a physical disability. Only patients who require the intensity of the specific rehabilitation services provided by IRFs can be admitted to an IRF, regardless of their condition. Rigorous admission criteria involving extensive clinical evaluation prior to admission prevent overutilization of this service and limit its use to those patients who qualify for a hospital level of inpatient rehabilitation.

Amongst other IRF requirements, CMS requires preadmission screening for all patients to ensure that each prospective patient is likely to benefit from an intensive inpatient rehabilitation program. Each patient's preadmission screening must be reviewed and approved by a rehabilitation physician prior to admission. Patients must meet the following criteria prior to admission:

- The patient requires active and ongoing therapy in at least two modalities one of which must be physical or occupational therapy;
- The patient can participate in and benefit from at least three hours of therapy per day five days per week; and
- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.

The stringent requirements on an IRF continue after a patient is determined to be appropriate for admission. The rigorous standards for each patient's treatment provide insight into the intensity of inpatient rehabilitation services, including the following:

- Create a treatment plan for each inpatient which is established, reviewed, and revised by a physician in consultation with other professional personnel providing services to the patient.
- Ensure that each patient receives close medical supervision as evidenced by at least three face to face visits per week by a licensed physician with a specialty in inpatient rehabilitation.
- Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, occupational therapy, speech therapy, social/psychological services, and orthotic/prosthetic services.

- Use a coordinated multidisciplinary team approach in the rehabilitation of each patient.

These admission and treatment requirements assure that only appropriate patients are admitted to EHRHS who will benefit from IRF services, regardless of the condition being treated. In addition to all of these requirements, CMS requires IRFs to comply with the "60% rule," which puts parameters on the types of conditions treated for at least 60% of an IRF's patients. To be classified for payment under Medicare's IRF prospective payment system, at least sixty percent (60%) of the inpatient population of an inpatient rehabilitation hospital or an inpatient rehabilitation unit must require treatment for one or more of 13 conditions listed in 42 CFR 412.29(b)(2) (the "CMS 13"):

(i) Stroke.
(ii) Spinal cord injury.
(iii) Congenital deformity.
(iv) Amputation.
(v) Major multiple trauma.
(vi) Fracture of femur (hip fracture).
(vii) Brain injury.
(viii) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.
(ix) Burns.
(x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less-intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
(xi) Systemic vasculitides with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less-intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
(xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate,

aggressive, and sustained course of outpatient therapy services or services in other less-intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation (a joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement).

(xiii) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

(A) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

(B) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission.

(C) The patient is age 85 or older at the time of admission to the IRF.

All IRF Medicare patients, not only the patients with CMS-13 conditions, must meet the stringent admission criteria for the IRF stay to be considered reasonable and necessary to be reimbursable by Medicare. To be eligible for Medicare reimbursement of the IRF stay, the patient must "due to the complexity of their nursing, medical management, and rehabilitation needs, require . . . an inpatient stay" in an IRF. CMS Medicare Benefit Policy Manual, Chapter 1, Section 110. CMS makes it clear that all patients admitted to an IRF, "regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions," must meet these admission requirements. CMS Medicare Benefit Policy Manual, Chapter 1, Section 110. Therefore, 100% of IRF patients must require IRF services, not 60%.

Patients who present with diagnoses outside the scope of the CMS 13 conditions are equally appropriate for IRF care and often equally, if not more, complex. To illustrate that EHRHS treats patients with conditions outside the CMS 13 with complexity similar to or more complex than CMS 13 patients, provided below are examples of patients currently or recently treated at EHRHS who do not fit within the CMS 13 conditions but require the intensity of rehabilitation provided by an IRF:

(i) Patient age in 80s, long term pain management with recurrent pneumonia and urinary tract infections, extensive history of rheumatoid arthritis, idiopathic pulmonary fibrosis causing severe shortness of breath with exertion, a thoracic compression fracture at T12, hypertension, congenital abnormality of left upper extremity, history of cancer, COPD, GERD, obesity, osteoporosis (patient had multiple recent ER trips to both PRMC and AGH and sent home with HH, prior level of function was modified to independent living alone), current level of function substantial assist including ADLs including toileting, and not ambulating at a household distance, CMI is 1.48.

(ii) Patient age in 80s, rheumatoid arthritis, patient began experiencing severe edema of bilateral lower extremities and long term left shoulder pain due to RA, patient was being seen on an outpatient basis with no progress being made and worsening edema, patient history of hypertension, COPD and GERD, PCP has been adjusting RA meds over prior three months with no relief, prior level of function was modified independent ambulating with rolling walker, admitted at W/C dependent level with goal of getting back to RW, patient needs assistance with ADLs, goal to return home with family and resume outpatient therapy, discharged home, CMI was 1.40.

(iii) Patient age in 70s, patient had a fall resulting in multiple spinal fractures (C5,C6), patient has spinal stenosis, suffers from shortness of breath, patient now NPO and on peg tube for nutrition due to dysphagia/laryngeal edema, patient on chest tube for recurrent pleural effusions, patient has a loop recorder placed for cardiac monitoring following syncopal episodes, monitoring for seizure activity, prior level of function of the patient was independent, current level of function was substantial assist, goal is home with home health, CMI is 1.433.

(iv) Patient age in 70s, patient had lumbar spinal fusion L2 - L4 and went home post surgery, patient fell getting out of bed within 48 hours of returning home from surgery and was back in the ER, patient is a long term pain management patient, with diabetes, obesity, and hypertension, patient arrived with substantial assist to dependent for transfers and non-ambulatory, weakness is overall generalized and not focused enough to determine a neurological diagnosis, goal is discharge home, CMI is 1.511.

Access to IRFs

Finally, looking at the patterns of utilization in other regions of the state, EHRHS agrees that there are lower discharge rates. There are a number of counties in the state in which no inpatient hospital rehabilitation services are located. In other jurisdictions and regions, although there are no freestanding IRFs, rehabilitation units located inside acute general hospitals do provide an additional measure of access to care. Where the dominant providers of these services are acute care general hospitals, it appears that they mainly provide inpatient services to patients who have obtained acute care general services in those same hospitals, and those patients are subsequently transferred to their own on-site rehabilitation units and the discharge rates to skilled nursing facilities are higher. In those Maryland jurisdictions where access to care is either limited by geography, or by hospital and provider clinical practice, out-of-facility discharge rates are understandably lower than in the case of the service area of EHRHS.

In the EHRHS service area, the geography of the lower Eastern Shore favors the Salisbury location as the single central location for the utilization of inpatient rehabilitation hospital services. In addition, the clinical practices of physicians, nurses, discharge planners, and related health care practitioners in the service area utilize EHRHS for the post-acute care their patients need. After all, no patient is admitted to inpatient rehabilitation care unless and until multiple evaluations are performed to document the clinical needs for an admission to EHRHS and to permit an inter-facility transfer, most likely from PRMC, the dominant medical center on the Eastern Shore.

It also should be pointed out that residents of the EHRHS service area have complete access to a full range of alternative post-acute services, including skilled nursing care facilities, home health agencies, and other outpatient providers.

Summary

EHRHS has explained that clinical rigor inherent in and required by the IRF environment assures that EHRHS accepts only medically appropriate patients who will clearly benefit from inpatient rehab services. The comprehensive evaluation applied on a patient-by-patient basis assures that optimal care is delivered to the patients who need it most in this community. EHRHS has explained why wide variation in use rates is not only common but that high use rates often are an indicator of optimal care and access, not overutilization. And finally, EHRHS shared four drivers of utilization apart from bed availability that explain why use rates in the Salisbury market are higher than average: centralized access, community health indicators including high stroke hospitalization rates, breadth of services offered, and patient choice.

These evidence-based analyses clearly show that there is a reasonable and valid explanation for higher than average utilization rates in the EHRHS service area. There is no evidentiary or factual basis for a conclusion that there is overutilization or that the requested ten (10) additional beds should not be CON-approved.

In conclusion, EHRHS is at full occupancy and year to date has declined care for 258 patients at least in part because no bed was available at EHRHS. As the population of the EHRHS service area grows, even more patients who need inpatient rehabilitation care will be turned away because of lack of capacity. Moreover, given the projections made in the CON Applications from both EHRHS and University of Maryland Shore Medical Center at Easton, the proposal to add 10 additional inpatient hospital rehabilitation beds to EHRHS is entirely consistent with the State Health Plan projection for 89 beds for the Eastern Shore Region. *See* Exhibit 14.

Last, given the excellent performance of EHRHS meeting patients' needs, as documented by the number of patient referrals it receives for the services it provides and its year-after-year track record of high bed occupancy, EHRHS respectfully requests approval of its proposal to renovate its facility and add the ten (10) beds proposed in its CON Application.

Sincerely,

Carolyn Jacobs

Carolyn Jacobs

Please see attached signature pages

cc: Ruby Potter

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I hereby declare and affirm under the penalties of perjury that the facts stated in this November 22, 2019 Encompass Rehabilitation Hospital of Salisbury Response to request for additional information and attachments are true and correct to the best of my knowledge, information and belief.

11.22.19
Date

Signature

Associate General Counsel – Encompass Health
Position/Title

Carey B. McRae
Printed Name

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11/22/2019
Date

Signature

CEO
Position/Title

Steven D. Walas
Printed Name

I hereby declare and affirm under the penalties of perjury that the facts stated in this November 22, 2019 Encompass Rehabilitation Hospital of Salisbury Response to request for additional information and attachments are true and correct to the best of my knowledge, information and belief.

Edward H. Stall Jr.

11-22-2019

Date

Signature

Partner Emeritus, DHG HealthCare

Position/Title

Edward H. Stall Jr.

Printed Name

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11/22/19
Date

RT Cunningham
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